

CULPABILITY COMPARED: MENTAL CAPACITY, CRIMINAL OFFENCES AND THE ROLE OF THE EXPERT IN COMMON LAW AND CIVIL LAW JURISDICTIONS

Chrisje Brants, Adam Jackson and Frans Koenraad*

Abstract: This article compares the situation in which an individual with diminished mental capacity is prosecuted for a criminal offence in England and Wales and in the Netherlands, with a particular focus on the role of the expert medical witness.

It is not unreasonable to assume that, whatever the jurisdiction, the existence of a condition affecting the mental capacity of the defendant may affect how the culpability of the accused is assessed by the courts and translated into a verdict. By comparing culpability in the context of the role of experts, consideration will be given to how substantive and procedural law hang together in the different jurisdictions. A comparison between England and Wales (as an example of a common law jurisdiction) and the Netherlands (as an example of a civil law jurisdiction) may reveal very different outcomes with regard to the verdict and the way it is reached that have far-reaching consequences for the person involved. This article will examine why such differences may occur, in particular whether they are the result of the common law's reliance on just two possible reasons for the absence of culpability in such cases (insanity or automatism, or, conceivably, diminished responsibility if murder is the charge), while the civil law is based on a theoretically underpinned doctrine that allows for a greater range of defences with regard to culpability (and its relative absence) in general.

The topic not only has possible practical implications, but could also contribute to the growing body of comparative scholarship: comparisons of substantive criminal law, unlike its many procedural aspects, are few and far between. One of the reasons is that substantive law is shot through with moral considerations that are very difficult to ascertain and muddy the comparative waters considerably. In this case, however, the issue is not the offence itself, but whether and how a mental condition may affect culpability. While it could be said that the recognition of such conditions is also contingent on their social and moral connotations, the effect of this is likely to be much less than in a comparison of (perpetrators) of sexual offences per se.

Keywords: *comparative criminal law; mental capacity; criminal liability; experts in criminal process; mental condition defences*

* Chrisje Brants is Professor of Criminal Law at Northumbria Law School, Northumbria University and Emeritus Professor at Willem Pompe Institute for Criminal Law and Criminology, Utrecht University; Adam Jackson is Senior Lecturer and Deputy Director at the Centre for Evidence and Criminal Justice Studies, Northumbria Law School, Northumbria University; and Frans Koenraad is Chair of Forensic Psychology and Psychiatry at Willem Pompe Institute for Criminal Law and Criminology, Utrecht University.

I. Introduction

The situation in which a person commits a criminal offence while affected by a condition that influences their (mental) capacity to act and, more importantly, to understand the implications of their actions, can occur, we may presume, in any country and therefore under any jurisdiction. That condition may be an inherent medical or mental problem (temporary or otherwise), it may be caused by ingesting certain substances (alcohol, drugs, medication), by other external factors such as extreme fear or distress or by a combination of any or all of these factors. It is also not unreasonable to assume that, whatever the jurisdiction, the existence of the condition will affect how the culpability of the accused is assessed by the courts and incorporated into the verdict.

While the outcome of a trial is a legal matter and culpability a normative legal concept, the question of whether a defendant lacks (a degree of) mental capacity is not in itself one that judges or average members of a jury are trained to answer. Experts such as psychologists and psychiatrists therefore play an important role in helping determine whether a defendant (1) suffers (or suffered at the time of the offence) from any medical and/or mental problem and (2) what the effect of that problem was on their capability to act and to know or correctly assess the consequences of their actions. So, the necessity of calling in the assistance of experts is also a feature of all jurisdictions if the defendant raises a defence that calls his mental capacity, and thus culpability, into question.

However, even a superficial comparison between common law and civil law jurisdictions reveals that there are some major differences in both how experts define mental conditions and how courts translate these situations into the possibility that the defendant should not be held responsible under the law for what they have done. Such differences influence the verdict and have far-reaching consequences for the person involved. This article examines the factors that affect the occurrence of these discrepancies, drawing on (case) law and (court) practice in England and Wales as an example of a common law jurisdiction with an adversarial trial mode, and from the civil law jurisdiction of the Netherlands, where the mode of trial is predominantly inquisitorial.

Our topic — capacity, culpability and the role of the expert — not only has possible practical implications, but could also contribute to the growing body of comparative scholarship. Comparisons of substantive criminal law, unlike its many procedural aspects, are few and far between. One of the reasons is that substantive law is shot through with cultural-moral considerations that are very difficult to ascertain and muddy the comparative waters considerably. In this case, however, we are not concerned with the offence itself, but with whether and how a mental condition may affect criminal liability, and the reasons for and consequences of differences between jurisdictions. We are also concerned with the relationship between these substantive questions and the procedural issue of the expert at trial. Although it could be said that how such conditions are or are not recognised and

defined in law is also contingent on their social and moral connotations, the effect of this is likely to be much less than in a comparison of (perpetrators) of criminal offences per se. In any event, comparing culpability in the context of the role of experts will hopefully shed some light on how substantive and procedural law hang together in different jurisdictions, thus providing a framework for determining whether changes — be they substantive or procedural — are feasible.

As always in a comparative study, a caveat is in order with regard to language. The use of English, although the most widely accepted *lingua franca* of the academic world, complicates matters, for it is also the language of the common law. English words in a legal context therefore refer to common law concepts, but may mean something quite different in the civil law world. Sometimes, the concept to which an English word refers derives its meaning from the specific adversarial style of the criminal process that is characteristic of the common law and simply does not, or rather cannot, exist in the inquisitorial process. A guilty plea in the English (or American) sense, for example, is never entered in the Netherlands and means nothing in the Dutch context, simply because defendants do not plead in order to end the trial process; they may confess, but the court will still go on to investigate the case — the confession being no more than a piece of evidence, albeit an important one. Sometimes the words appear to mean the same thing, but have different connotations or consequences that relate to differences in procedure (eg prosecutor, witness, impartiality), or in substantive law (eg murder, manslaughter, intent, self-defence). We have tried to avoid the misunderstandings that such discrepancies may cause by explaining, where necessary, the wider context in which concepts are embedded and from which they draw their specific meaning.¹

In the following, we first explore the differences between the Netherlands and England and Wales with regard to matters of mental capacity and criminal liability. We then look more closely at the role played by experts in helping the court reach a verdict. Given the differences between the jurisdictions that are immediately obvious, our first question is whether these are the result of the common law's reliance on just two possible reasons for the absence of culpability (insanity or automatism, or diminished responsibility if murder is the charge), while the civil law is based on a theoretically underpinned doctrine that allows for a greater range of defences with regard to culpability (and its relative absence) in general. This is further compounded by the issue of "fitness to plead", which, while it appears to exist in Dutch law, is actually a different concept with different connotations (and consequences). An additional reason to compare these two countries is that, despite substantive legal and procedural differences, in the field of forensic mental

1 For a discussion of how to try to surmount the conceptual difficulties of language and difference in legal culture, see C Brants and S Field, "Legal Cultures, Political Cultures and Procedural Traditions: Towards a Comparative Interpretation of Covert and Proactive Policing in England and Wales and the Netherlands" in D Nelken (ed), *Contrasting Criminal Justice: Getting from Here to There* (Aldershot, Dartmouth: Ashgate, 2000) pp.77–115.

health, both countries are eager to know and learn from each other's system. Most interest from abroad in the Dutch forensic mental health system stems from the United Kingdom.² Recent innovations in the UK were inspired by the program and system in the Netherlands: the Medium Secure Units and the Dangerous and Severe Personality Disorder program are recent examples in the UK, while in the 1960s, Maxwell Jones's therapeutic community model was followed in Dutch forensic treatment hospitals.³

Two major interrelated questions then arise. The first concerns the concept of capacity and culpability in substantive law, and how this relates to specific defences. Could it be that experts define conditions in a way that allows them to be translated into what the law and the courts require? In other words, what is the relationship between the empirical knowledge of the psychologist or psychiatrist and the normative demands of the criminal law? The second question is related to differences in procedural styles. The position and role of the expert in an adversarial and inquisitorial trial setting, respectively, differ significantly. Could the fact that the expert in the Netherlands is appointed to the court, not as a witness but in a specific and legally defined role (and moreover, since recently, needs to be included in the official register of court experts), promote both greater consensus and a more specific, individual-based approach to defences regarding mental capacity than is possible in a jurisdiction where expert witnesses in an adversarial trial appear for either the defence or the prosecution?

II. Mental Capacity and Criminal Liability

English and Dutch criminal law and procedure differ fundamentally in two ways — in how the law is found and in how the truth is found. The latter refers to the difference in procedural style: adversarial or inquisitorial; the former to the primary source of law: tradition and judicial interpretation and decision-making (and the related principle of *stare decisis*),⁴ or codification by the legislature that is binding on the judiciary, respectively. This no longer holds entirely true for either country; certain inquisitorial elements have crept into English procedure and England and Wales also have statutory criminal law, whereas Dutch procedure has some moderately adversarial features and courts in the Netherlands interpret codified provisions to an extent never envisaged in civil law theory. Nevertheless, this distinction remains fundamental and has important implications for the issue of mental capacity and criminal liability.

2 MJF Van der Wolf, *TBS veroordeeld tot vooroordeel* (Oisterwijk: Wolf Legal Publishers, 2012) pp.687–698.

3 F Koenraadt, "The Boost of Forensic Psychiatry Embedded in Utrecht Cooperation" in F de Jong (ed), *Overarching Views of Delinquency and Deviancy: Rethinking the Legacy of the Utrecht School* (Den Haag: Eleven International Publishing, 2015) pp.89–134.

4 P Reichel, *Comparative Criminal Justice Systems: A Tropical Approach* (Upper Saddle River, NJ: Pearson/Prentice Hall, 2005) pp.143–144.

Because of its firm roots in the continental civil law system, the application of Dutch criminal law is strictly regulated by a Criminal Code (CC) and a Code of Criminal Procedure (CCP), and by the accompanying doctrinal rules. Case law plays a part because judges are required to interpret the provisions of the Codes if necessary, on which the Supreme Court of the Netherlands, should defendant or prosecution dispute the interpretation by the tribunal of fact, has the final word (a process known as cassation). The Supreme Court's decisions do not have the status of *stare decisis*, ie a lower court is free to deviate from them. (This, of course, risks the decision being overturned in cassation, but can also lead to the Supreme Court's accepting a new interpretation of the law.) True to these points of departure, binding provisions of substantive and procedural law provide the framework within which Dutch courts set about determining a defendant's criminal liability.

A. *The Netherlands*

There is no jury in the Netherlands, indeed no lay participation at all, and in serious cases criminal courts consist solely of panels of three professional judges (five on appeal, which takes the form of a full retrial). Articles 348–350 of the CCP exhort the court to run through two sets of questions to reach a verdict. The first concerns procedural matters (such as whether the charge has been correctly formulated and the summons correctly served). Article 350 of the CCP is concerned with the offence itself and the defendant's guilt and responsibility. The court must first decide whether there is sufficient evidence to sustain the charge, that is to say, have all the elements contained in the offence as described in the CC been proven? Although to English readers this may appear to refer to the *actus reus*, that is not necessarily the case, because some provisions also explicitly contain *mens rea* elements; in others these are implicit. The provision on intentional homicide, for example, explicitly mentions intent (art.287 of the CC: "He who *intentionally* deprives another of life ..."),⁵ which is thus an element that the prosecutor must prove; if murder is the issue, then premeditation is an extra *mens rea* element requiring proof. In cases of theft, however, (art.310 of the CC: "He who takes a commodity belonging in whole or in part to another ...") intent is implicit in the verb "to take". One hardly "takes" by accident; and here, only the taking and not the intent to take requires specific proof, although the prosecutor must prove the special intent behind the taking ("to unlawfully appropriate that commodity").

If there is insufficient proof of any element, the court must deliver a verdict of acquittal. If there is sufficient proof, it must then decide first whether, under the circumstances of the case, what has been proven actually constitutes a *criminal* act and, second whether, the defendant can be held responsible for it. If the answer to

⁵ The word "manslaughter" should be avoided here, as culpable homicide is a separate offence, as is murder.

either is “no”, the verdict is not one of acquittal (not proven),⁶ but dismissal from prosecution (in Dutch: *ontslag van alle rechtsvervolging — ovar*). The reasoning behind this distinction is that it is impossible to not prove an offence if there was none to prove in the first place, and that if criminal responsibility is lacking, the defendant has nevertheless been found guilty of a proven offence and cannot be acquitted, but should not be further prosecuted. The distinction is important in cases of lack of responsibility because an acquittal cannot be accompanied by forced detainment in a mental hospital, but dismissal from prosecution can.

B. *Justifications and excuses*

Dutch criminal law doctrine therefore distinguishes clearly between whether the act is punishable under the criminal law, and whether the defendant is punishable because he can be held responsible.⁷ This is expressed in the distinction between justifications and excuses, the definitions of which are found in the CC. It is not for the defendant to prove the existence of a justification or excuse beyond reasonable doubt, only to convince the court of its likelihood. The presence of a justification means that, although the elements of a potentially criminal act have been proven, with hindsight, that act is not criminal at all. Because this is rarely, if ever, the case if a defendant claims to have been suffering from a mental condition when the offence was committed, the example of self-defence (art.41.1 of the CC) may suffice: in case of an unlawful attack, a person has the right to defend themselves or their property, or another person, by using force or violence that is reasonable and proportionate in the circumstances. The justification removes the potentially criminal nature of the response, turning it into legitimate action.

If the court is satisfied that there is no justification for the offence, it moves on to the next question: Can the defendant be held responsible for his actions, or is there an excuse for this law-breaking? This is not just a matter of mental capacity in the sense of insanity or mental disorder. According to case law, it may well be that the defendant was mistaken as to the circumstances in which the offence was committed.⁸ Take, for example, putative self-defence: the defendant thought, wrongly, that they were being unlawfully attacked and responded with violence or force while in reality there was no such attack. Obviously this could occur as a result of a mental disorder, but it would be unlikely to be accepted as a defence if only because the criterion of reasonability plays an important part: Would any “normal”

6 This does not have the same connotations or consequences as the Scottish verdict of not proven. There is no distinction between not guilty and not proven in the Netherlands. However, it is established doctrine that an acquittal can never mean “not guilty” in the sense of absolute certainty; an acquittal reflects a legal truth based on the fact that the defendant’s guilt has not been duly proven.

7 For a discussion on affirmative defences in Dutch criminal procedure, see P Bal and F Koenraadt, *Het psychisch onvermogen terecht te staan: Waarborg of belemmering van het recht op een eerlijk proces* (Den Haag: Boom Juridische uitgevers, 2004).

8 Already established in 1914, the so-called *Melk-en water arrest* (Milk and Water decision): HR 14 February 1916, W 9958, NJ 1916, p.861.

reasonably thinking person have made the same mistake? That implies “normal” reason, which is precisely what is usually lacking or impaired in defendants with mental disorders.

The defence that one’s mental capacity was impaired can take different forms under Dutch law: total incapacity or diminished capacity because of a mental disorder, or temporarily diminished (or lack of) capacity because of psychological duress. Intoxication may also cause impairment, but will only be recognised as contributing to an excusable lack of capacity if the defendant is not to blame for the fact that they were intoxicated in the first place (*culpa in causa*): being drunk behind the wheel is not an acceptable excuse for causing a car accident, though being under the influence of medication could be if the driver could not reasonably be expected to have known that the medication would cause a lack of capacity. Severe addictions, or even a (temporary) mental disorder such as a psychotic episode resulting in severely diminished capacity, will not remove responsibility if caused by the use of a substance the potential effects of which were known to and understood by the defendant.⁹

Psychological duress is not likely to succeed as a defence if the defendant is mentally disturbed, because of the stringent criteria the law requires the court to apply: the defendant cannot be held responsible for committing the offence due to psychological duress if their action was the result of external pressure such that they could not, and could not be expected to, resist. Whether that is the case depends on how acute and pressing the circumstances were and whether, in such circumstances, any other “normal” person would be expected to resist.¹⁰ The fact that the cause of the duress must be external and the shadowy presence of the “normal other” that determines whether resistance could have been required, more or less preclude a defence of psychological duress in cases of mental disorder, the latter being an internal factor that also prevents comparison with “normality”.

C. Total mental incapacity and diminished capacity

That leaves the defence of total incapacity or diminished mental capacity, which in fact comes first in the Code’s enunciation. Article 39 of the CC declares that “no person shall be punished for actions for which they cannot be held responsible because of the defective development or pathological disorder of their mental faculties”. This seems to imply no responsibility at all. However, the law is not specific as to what pathological disorder or limited development means, so the courts must interpret this provision. It is generally agreed that its abstract and criminally relevant meaning is that mental incapacity inhibits the exercise of free

⁹ See eg Hof’s Hertogenbosch, 30 June, 20/0011369-05neHR.

¹⁰ Excessive self-defence, also a defence specified in art.41 of the CC — the situation in which disproportional and unreasonable force was used as a result of the psychological pressures of the situation, ie the unlawful attack — is a specific form of psychological duress that does not justify, but does excuse.

will, a concept to which much Dutch philosophical-legal literature is devoted:¹¹ only those capable of exercising their will freely are deserving of punishment for their actions, even though they may need to be removed from society in some other way, ie by imposing an order for detainment in a secure mental hospital (a so-called *tbs-order*).¹² Conversely, anything less than total incapacity leaves room for punishment, although the defendant's mental state can be taken into consideration in sentencing. Courts, however, consider more than the degree of mental capacity in determining the nature and length of a sentence: such matters as the risk of reoffending, the seriousness of the offence and the shock to public opinion also play a part.¹³

Because of the way in which Dutch courts decide according to the questions they must answer on the basis of the Code of Criminal Procedure, diminished or total lack of mental capacity will often result in a defendant being found guilty, but then — in case of total incapacity — dismissed from prosecution. This does not, however, imply that the defendant will walk free: the court may issue an order that the offender be detained and treated in a forensic mental hospital (*tbs-order*).¹⁴ In cases where the court delivers a verdict of guilty, but with diminished responsibility, it may take that mitigating circumstance into account in sentencing, but may also impose a prison sentence combined with a *tbs-order* or a (partly) conditional sentence requiring the offender to voluntarily submit to treatment, depending on the severity of the disorder causing the incapacity. Sometimes, however, legal doctrine and the civil law dependence on the written code make it impossible to address the underlying psychological or psychiatric issue. This is the case if the description of the offence contains the word “intentional” or “intent”. A person whose mental capacity is diminished to such a degree that there is no free will, cannot be said to be capable of acting intentionally, so that one of the (*mens rea*) elements of the offence — intent — cannot be proven. The only logical verdict then is acquittal.

Article 37 of the CC allows detainment in a mental hospital (*tbs*) only in cases of dismissal from prosecution, not acquittal. The consequences become clear from the following case, in which the defendant was charged with “intentionally destroying part of the electricity network in a hospital and causing

11 See the special issue of the journal *Justitiële Verkenningen: Vrije wil en verantwoordelijkheid* (“Free Will and Responsibility”) (Den Haag: Boom Lemma uitgevers, 2013).

12 TBS, an acronym for *ter beschikking stelling*, in literal translation means “to place at the disposal of”.

13 T den Boer and J van Mulbregt, “Two Faces of Accountability: A Forensic Mental Health Perspective” in F de Jong (ed), *Overarching Views of Delinquency and Deviancy: Rethinking the Legacy of the Utrecht School* (Den Haag: Eleven International Publishing, 2015) pp.435–453. The authors maintain that the severity of the mental disorder is not necessarily decisive for the forensic mental health expert opinion on the degree of accountability of the accused and on the court's ruling on whether the assessed person is criminally accountable for a specific criminal offence (p.449).

14 F Koenraad and A Mooij, “Mentally Ill Offenders” in M Boone and M Moerings (eds), *Dutch Prisons* (Den Haag: BJu Legal Publishers, 2007) pp.167–186; see Van der Wolf, *TBS veroordeeld tot vooroordeel* (n.2).

a life-threatening situation”.¹⁵ He was found, after the electricity had failed, in a confused state and without shoes in one of the hospital corridors. The clinical psychologist appointed as an expert in this case concluded that, at the time of the offence, the defendant was schizophrenic, psychotic and suffering from delusions and hallucinations, in particular that he was part of the computer game *Silent Hill* to which he was addicted, and in which he thought he was acting when he committed the offence; he was, therefore, not capable of making any free choice as to his actions — the classic description of mental incapacity as a lack of free will — and thus incapable of acting “intentionally”. This opinion was confirmed by the other reporting expert, a psychiatrist. However, the presence of the word “intentional” in the description of the offence with which he was charged meant that in this case, contrary to the wishes of the prosecution, the defendant could not be detained for compulsory treatment.

III. England and Wales

There is an immediately obvious difference between the Netherlands and England and Wales; in England and Wales there is no general “diminished capacity” defence, although diminished responsibility is a special partial defence to murder which, if successfully pleaded, reduces the defendant’s liability to (voluntary) manslaughter.¹⁶ Aside from diminished responsibility in murder cases, if a defendant denies liability based on some form of medical condition or mental incapacity, the defence will usually be either insanity (sometimes referred to as “insane automatism”) or automatism (sometimes referred to as “non-insane automatism”). The defendant’s condition may also raise an issue regarding their “fitness to plead” (and therefore stand trial).

A. *Insanity (or insane automatism)*

The elements of the insanity defence were established in *R v McNaughten*¹⁷ in 1843 (the *McNaughten* rules) and have remained largely unaltered since. To successfully plead insanity, it must be proved that:

“at the time of the committing of the act, [the defendant] 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 that what he was doing was wrong”.¹⁸

15 Rb Zwolle-Lelystad 27 October 2009, LJN: BK 1516.

16 Homicide Act 1957, s.2 as amended by Coroners and Justice Act 2009, s.52.

17 (1843) 10 Cl & F 200, 8 ER 718.

18 *Ibid.*, 210.

To establish a “defect of reason” it must be proven that the defendant’s powers of reasoning were impaired, more than to the extent of a simple inability to resist impulses or exercise emotional control.¹⁹ In *R v Clarke*²⁰ it was held that a “momentary failure” of the accused’s concentration was insufficient to constitute a defect of reason because the accused had not been “deprived of the power of reasoning”.²¹ The term “disease of the mind” has been given a wide interpretation by the courts and does not necessarily require that a mental illness be established.²² In *Kemp*²³ the court observed that “... [t]he law is not concerned with the brain but with the mind, in the sense that ‘mind’ is ordinarily used, the mental faculties of reason, memory and understanding”.²⁴

Once it has been established that the accused person is labouring under a defect of reason caused by a disease of the mind, the jury must then consider whether he understood the nature and quality of the act committed or, if so, whether the accused knew that what they were doing was wrong. In *Sullivan*²⁵ the court interpreted the first limb, the requirement that the accused did not know the nature and quality of the act, as meaning the accused “did not know what he was doing”.²⁶ The second limb, that the accused, despite “knowing what they were doing”, did not know that what they were doing was wrong, has been interpreted as meaning legally (rather than morally) wrong.²⁷ Ronnie MacKay criticises this “extremely narrow cognitive approach towards the rules ensuring that their application would be restricted to fundamental or extreme intellectual defects”.²⁸

Where the defence of insanity is raised, the jury must be satisfied that the defendant did the act or made the omission charged (ie that the defendant committed the relevant *actus reus* of the relevant offence). The defendant then carries the burden of proof to satisfy the jury on the balance of probabilities that he was insane at the time of committing the relevant act. Where the defence of insanity is successfully established, a special verdict of “not guilty by reason of insanity” is returned.²⁹ Following a successful insanity plea and by virtue of the special verdict, the court has a number of disposal options available, specifically, a hospital order (with or without a restriction order), a supervision order, or an order of absolute discharge.³⁰

19 *R v Kopsch* (1927) 19 Cr App R 50.

20 (1972) 56 Cr App R 225.

21 *Ibid.*, 228.

22 Examples include arteriosclerosis (*R v Kemp* [1957] 1 QB 399), epilepsy (*R v Sullivan* [1984] AC 156) and diabetes (*R v Hennessy* [1989] 1 WLR 287).

23 *Kemp* (n.22).

24 *Ibid.*, 407.

25 *Sullivan* (n.22).

26 *Ibid.*, 173.

27 *R v Windle* [1952] 2 QB 826.

28 R Mackay, *Mental Condition Defences in the Criminal Law* (Oxford: Clarendon Press, 1995) p.97.

29 Criminal Procedure (Insanity) Act 1964, s.1.

30 *Ibid.*, s.5 as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence Crime and Victims Act 2004, s.24(1).

B. *Non-insane automatism*

The distinction between insanity and non-insane automatism is an important one for an accused because whereas insanity imposes a reverse burden of proof on the accused person, an automatism defence must be disproved by the prosecution to the criminal standard of proof.³¹ Moreover, where successfully pleaded, automatism provides a full defence to any charge leading to a full acquittal rather than a special verdict and potential disposal options. Although automatism does not have a single agreed definition, a plea of non-insane automatism essentially amounts to a denial of “voluntary control”³² by an accused person. In *Watmore v Jenkins*³³ the court considered the term automatism to be a “modern catch-phrase which the courts have not accepted as connoting any wider or looser concept than involuntary movement of the body or limbs of a person”.³⁴ The meaning of automatism was further considered by the House of Lords in *Bratty v A-G for Northern Ireland*³⁵ in which Viscount Kilmuir LC accepted the Court of Criminal Appeal’s definition of automatism:

“as connoting 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”.³⁶

This was articulated in *Re A-G’s Reference (No 2 of 1992)* by Lord Taylor CJ as requiring a “complete destruction of voluntary control”.³⁷

C. *Distinguishing insanity and automatism*

Where the accused’s defence is based on involuntary conduct and medical evidence is adduced in support, the trial judge must decide whether the accused’s defence amounts to insane or non-insane automatism. Making this determination can be difficult and requires the judge to identify whether the defendant’s condition at the time of the offence was caused by an external factor or whether it arose from a “disease of the mind”³⁸ (an internal factor). A cogent example of the difficulties caused by rigid adherence to the internal/external factor test can be found by examining the approach of the courts to diabetic defendants. In *Quick*³⁹ the defendant was acquitted following appeal of a charge of assault

31 The accused person bearing merely the “evidential” burden of raising some evidence of automatism.

32 Law Commission of England and Wales, *Insanity and Automatism: Supplementary Material to the Scoping Paper* (Law Com SP/SM, July 2012) para.1.12.

33 [1962] 2 QB 572.

34 *Ibid.*, 586.

35 [1963] AC 386.

36 *Ibid.*, 390.

37 [1994] QB 91, 105.

38 *R v Quick* [1973] QB 910; *Sullivan* (n.22); *Hennessy* (n.22); *R v Burgess* [1991] 2 QB 92.

39 *Quick* (n.38).

occasioning actual bodily harm. The defendant suffered from diabetes and had taken insulin prior to the incident but had not eaten. The Court of Appeal held that the defendant, suffering from hypoglycaemia, had acted unconsciously and in a state of non-insane automatism caused by the external factor of having taken the insulin. Conversely, in *Hennessey*,⁴⁰ the Court of Appeal determined that insanity was the appropriate defence where the defendant, again a diabetic, had failed to eat or take insulin due to stress and depression and suffered a hyperglycaemic episode as a result. The court held that the cause of D's behaviour was "internal" (ie his medical condition) with no identifiable external cause. As can be seen by reference to the two cases highlighted previously, the distinction between whether the defendant's condition was caused by an external or internal factor is often an arbitrary one.

IV. To Sum Up

At first sight and in comparison to the Netherlands, the defences on which a defendant in England or Wales can rely seem much less nuanced in the sense of being geared towards the many different situations that can arise. Neither is there any philosophical-theoretical underpinning of criminal liability as dependent on the exercise of free will. However, the concepts of "voluntary control" and "mind" ("the mental faculties of reason, memory and understanding") that have been developed in English case law come very close to the Dutch court's terminology: the "capability to make free choices as to one's actions". Indeed, although Dutch law distinguishes possible underlying reasons for a lack of free will and different degrees of capacity which are binding on the courts, "defective development or pathological disorder of the mental faculties" is a broad and non-specific description that leaves the specifics to be developed in case law.

Moreover, English case law reveals many similarities in the factors that courts must take into account in both countries. The most important question, at least in terms of the consequences of the answer, is whether mental impairment (of the "mind" or "free will") is the result of internal or external factors, for in both countries the former may result in a hospitalisation order. In this context, a closer look at how Dutch and English courts deal with the defence that the crime was committed while the accused was asleep or was suffering from some sort of sleep disorder — and thus had no voluntary control over their actions — is illuminating. Sleep disorders (parasomnias) are frequently seen in mental patients and in Western countries increasingly regarded as comorbid problems or disorders that need careful diagnosis and effective treatment (sexsomnia is a special category of sleep disorder, in which particular — sometimes violent — sexual behaviour or experiences occur,

⁴⁰ *Hennessey* (n.22).

mostly in the early non-REM-sleep).⁴¹ In the majority of cases, sleep disorders do not lead to a criminal accusation.⁴² In some cases, however, a criminal process follows and, like in many domestic violence offences, witnesses are lacking or are victims. Where in forensic mental health assessment malingering always has to be taken into consideration, Schenck warns that “experts should be very cautious when they are diagnosing sexsomnia in order to prevent legal exploitations”.⁴³

Sleep disorder as an incapacity defence is interesting for a number of reasons and not only because it apparently offers an opportunity to “exploit the law”. To start with, it is usually part of wider mental health issues and does not often (in either country) give rise in itself to a defence of incapacity. In most cases, sleep disorders are compounded by, or the result of, other existing mental problems (post-traumatic stress disorder, attention-deficit hyperactivity disorder, borderline personality, psychosis) and/or the accompanying medication or other intoxication. Sleep disorder is then simply one of the possible contributing factors or consequences, or more usually, part of a vicious circle. As a specific mental health issue, sleep disorder is relatively new and not always accepted; indeed, a senior Dutch judge remarked of sexsomnia that “there are believers and non-believers, especially where violent sexual activities are concerned”;⁴⁴ currently, in cases of sexual abuse or incest, being asleep or sleepwalking are normally not accepted in the Netherlands as forms of lack of (or diminished) capacity.⁴⁵ Given the unfamiliarity with the condition, and because the relation between sleep disorders and a criminal offence is seldom clear cut, courts struggle to fit a defence of parasomnia into the legally relevant categories of acceptable defences. This results in discrepancies in expert assessments and court decisions in both the Netherlands and England and Wales, in which the distinction between internal and external factors appears to be particularly difficult.

Because of the scarcity of cases and the case-specific considerations that underlie verdict and sentencing, it is impossible to give any sort of general indication of how Dutch courts deal with sleep disorders and their relation to total or diminished mental capacity. Indeed, the case in which both prosecution and defence defended the position that the defendant lacked intent (will and awareness) to kill her husband by taking a hammer to him in her sleep, and the court concluded that

41 M Lancel, “Slaapstoornissen in de psychiatrie: Prevalentie en mogelijke gevolgen” and M Gordijn, “Slapen als onderdeel van een gezonde leefstijl” in M Lancel, P. Meerlo and J Koolhas (eds), *Gestoorde slaap: Een onschuldige probleem?* (Oisterwijk: Wolf Legal Publishers, 2016).

42 See eg DGH Krol, “Sekssomnia tijdens behandeling met een selectieve serotonineheropnameremmer” [Sexsomnia during treatment with a selective serotonin reuptake inhibitor] (2008) 50(11) *Tijdschrift voor Psychiatrie* 735–739.

43 CH Schenck, “Update on Sexsomnia, Sleep Related Sexual Seizures, and Forensic Implications” (2015) 13(4) *NeuroQuantology* 518–541.

44 Y Van Kuijk, “Het fenomeen van de slaapstoornis in de rechtspraak” in M Lancel, P Meerlo and J Koolhas (eds), *Gestoorde slaap* (n.41).

45 See eg Rb Utrecht 12 September 2011, ECLI:NL:RBUTR:2011:BS8705; this appears to be the only Dutch case in which a defence of sexsomnia seems to have been raised — and rejected by the court.

she was guilty of intentional attempted homicide but could not be held responsible, possibly because of a sleep disorder, is highly unusual.⁴⁶ It is also a debatable verdict, given that Dutch legal doctrine regards an attempt as inherently intentional (an inadvertent attempt is a contradiction in terms), which was the position argued in this case by prosecution and defence. The verdict should, therefore, have been an acquittal (the defendant lacked the freedom of choice necessary for the required intent), but instead she was dismissed from further prosecution.

Other cases in the Netherlands (drawn from a trawl though the case law databank for cases relating to sleep disorder) reveal inconsistencies in judgment and sentencing. Consider, for example, two cases involving arson.⁴⁷ In one case, according to the expert psychologist, the defendant suffered from sleep disorder, pain disorder, benzodiazepine dependency and borderline personality, and the court concluded diminished responsibility.⁴⁸ In the other case, a personality disorder and a sleep disorder led the court to conclude “slightly diminished responsibility”.⁴⁹ While this difference may have been due to the relative severity of the respective defendants’ mental conditions and the related risks of reoffending as assessed by mental health experts, other cases show more obvious discrepancies. There is the lorry driver, convicted of drunk driving and attempted homicide for driving on the wrong side of the road while a motorcycle was approaching and punching the motorcyclist in the head. According to the mental health expert, during the offence, the defendant was prey to paranoid delusions due to stress at work, and suffered from a sleep disorder because of the stress and financial and domestic problems. The court found him guilty, but not responsible and dismissed him from further prosecution on the basis of art.39 of the CCP, the latter an indication that the underlying condition was regarded as the result of internal factors.

A comparable case in which the defendant hit the victim several times on the head, arm and fingers with an axe while, according to the expert, suffering from fear, stress and lack of sleep, also ended in a guilty verdict and dismissal from prosecution, but in this case because of psychological duress. The defendant had been mentally and probably physically abused by her victim for months prior to the offence, which had undermined her capacity for rational thought and caused extreme anxiety — an external cause, and therefore, not an internal mental disorder.⁵⁰ In a very similar case, in which a man could not sleep because of, and had become obsessive about, the noise made by his neighbour and eventually attacked her with an axe, expert opinion that the defendant suffered from a pervasive development disorder, apparently led the court to find him guilty of attempted homicide, but with

46 Rb 's-Gravenhage 24 May 2012, ECLI:NL:RBSGR:2012:BW6539.

47 See also L Dalhuisen and F Koenraad, “The Observation of Mental Disorder and Dangerousness in Arsonists: A Contemporary Appraisal of Changes in Dutch Forensic Mental Health Cases” (2015) 21(8) *Psychology, Crime and Law* 733–746.

48 Rb Noord-Holland 16 August 2013, ECLI:NL:RBNHO:2013:8270.

49 Rb Zutphen 20 November 2012, ECLI:NL:RBZUT:2012:BY3608.

50 Rb Rotterdam 9 November 2005, ECLI:NL:RBROT:2005:AU6707.

diminished responsibility.⁵¹ It is therefore unclear how the courts assess the causal role of external factors that would give rise to a defence of psychological duress (not usually a reason for a tbs-order): To what extent has some external event (such as a noisy neighbour or abusive ex-partner) pushed an already mentally unstable and exhausted defendant over the edge?

In England and Wales, as in the Netherlands, there are only a small number of reported cases of either sleepwalking or sexsomnia being used as the basis for a criminal defence; and in respect of sexsomnia, there are no appellate court decisions. Usually where a sleep disorder is used as the basis for a defence, it is as a denial of voluntary conduct in relation to the commission of the offence itself. The approach of the courts when such a defence is raised, however, seems somewhat arbitrary in that there is a clear contrast in legal outcome (and consequences for the defendant) between somnambulism in the form of “sleepwalking” (usually where the defendant has engaged in some form of violent behaviour during the sleepwalking episode) and cases of sexsomnia (where the defendant engages in sexual activity whilst asleep), notwithstanding the fact that both are considered medically to be forms of parasomnias or “abnormal episodic events occurring during sleep”.⁵²

In *Burgess*⁵³ the defendant was charged with wounding with intent after stabbing a woman. The defendant claimed that he was asleep at the relevant time and adduced evidence of two psychiatrists who each testified that he was sleeping at the time. The trial judge directed the jury that, if they accepted the medical evidence, the correct defence was one of insanity and the jury returned the special verdict. The trial judge’s direction was confirmed by the Court of Appeal which held that the appropriate defence was insanity because “this was an abnormality or disorder, albeit transitory, due to an internal factor whether functional or organic which had manifested itself in violence”.⁵⁴ In 2005 Jules Lowe was found not guilty by reason of insanity and made subject to a hospital order for the murder of his father, whom he had stabbed to death whilst sleepwalking.⁵⁵ By contrast, in cases involving sexsomnia as a defence to a charge under the Sexual Offences Act 2003,⁵⁶ the courts in England and Wales appear to have favoured the use of the automatism defence resulting in acquittal in cases where the jury accepts that the defendant was in fact asleep when engaging in the sexual activity.⁵⁷ In England and Wales over the last ten years, there have been

51 Rb Limburg 11 April 2014, ECLI:NL:RBLIM:2014:3623.

52 See eg ICD–10 and DSM–V; CM Shapiro, NN Trajanovic and JP Fedoroff, “Sexsomnia: A New Parasomnia?” (2003) 48 Can J Psychiatry 311–317.

53 *Burgess* (n.38).

54 *Ibid.*, 101.

55 I Morrison, JM Rumbold, and RL Riha, “Medicolegal Aspects of Complex Behaviours Arising from the Sleep Period: A Review and Guide for the Practising Sleep Physician” (2014) 18(3) Sleep Medicine Reviews 249–260.

56 Sexual Offences Act 2003; usually a charge of rape (s.1) or sexual assault (s.3).

57 See eg *Bilton*, *The Guardian* (20 December 2005); A Jackson, G Rees and N Wortley, “Sleep Disorders/ Sexsomnia: The Role of the Expert and the External/Internal Factor Dichotomy” in L Ben, R Alan and W Nikola (eds), *Mental Condition Defences and the Criminal Justice System: Perspectives from Law and Medicine* (Cambridge: Cambridge Scholars Publishing, 2015) pp.236–274.

approximately two to three cases per year in which the sexsomnia defence has been raised and, to our knowledge, all have resulted in a conviction for the substantive offence or a full acquittal on the basis of automatism.⁵⁸

Defences based on (different forms of) parasomnia are also raised in other common-law jurisdictions.⁵⁹ Canada, for example, that already adopts a slightly more liberal approach to applying the internal/external factor test in cases involving insanity or automatism, has managed to avoid the peculiar dichotomy between the (temporarily) insane sleepwalker and the sane sexsomnia on automatic pilot. In *R v Parks*,⁶⁰ the Ontario Court of Appeal held that the appropriate defence in a case where the defendant killed whilst sleepwalking was that of non-insane automatism. On appeal, the Canadian Supreme Court⁶¹ decided against following the approach adopted by the Court of Appeal in England and Wales in *Burgess*,⁶² and upheld the earlier decision of the Ontario Court of Appeal, La Forest J determining that the external/internal factor test should be used as an “analytical tool, and not as an all-encompassing methodology”.⁶³ This was followed in Canada in *R v Stone*,⁶⁴ in which the court suggested a “holistic approach” should be taken when attempting to identify whether the defendant was suffering from a disease of the mind. Successful sexsomnia defences raised in Canada also appear to result in an acquittal on the basis of non-insane automatism.

V. Fitness to Plead (or to Stand Trial)

Where the defences of insanity or automatism (and in the Netherlands art.39 of the CC or psychological duress) hinge on the substantive criterion of external or internal cause, the defence of fitness to plead takes us into the realm of procedural law, where differences between jurisdictions are attributable to the distinction between the adversarial procedure characteristic of common law jurisdictions and the inquisitorial procedural style that obtains in civil law jurisdictions. Much has been made of the fact that adversarial and inquisitorial are adjectives indicative of ideal types that no longer exist in practice. In Europe, harmonising factors such as binding fair trial norms emanating from the European Union and the case law of the European Court of Human Rights and Fundamental Freedoms (ECtHR) have led to

58 Morrison, Rum Bold and Riha, “Medicolegal Aspects of Complex Behaviours Arising from the Sleep Period” (n.55).

59 A Organ and JP Fedoroff, “Sexsomnia: Sleep Sex Research and Its Legal Implications” (2015) 17(5) Current Psychiatry Reports 34; CH Schenck, I Arnulf and MW Mahowald, “Sleep and Sex: What Can Go Wrong? A Review of the Literature on Sleep Related Disorders and Abnormal Sexual Behaviors and Experiences” (2007) 30(6) Sleep 683–702.

60 (1990) 56 CCC (3d) 449.

61 *R v Parks* [1992] 2 SCR 871.

62 *Burgess* (n.38).

63 *Parks* (n.61), [11].

64 [1999] 2 SCR 290.

a degree of convergence that mitigates many distinguishing features, in particular in inquisitorial procedure.⁶⁵ However, criminal procedure in England and Wales and the Netherlands still display fundamental characteristics of these ideal types, which profoundly influence the issue of fitness to plead.

While both procedural styles are concerned with establishing the truth in a fair manner, the most immediately obvious difference is not, as is often maintained, that the “truth” in an adversarial trial is the truth according to the most persuasive party whereas state officials in an inquisitorial trial seek to establish “the real truth” (although there is some truth in this),⁶⁶ but how they set about truth finding and thus define fairness (and vice versa, given that this is a dialectical relationship). In adversarial procedure, the truth is considered best found in open debate between equal autonomous parties (defence and prosecution), each presenting their own version of events before an impartial tribunal of fact; this corresponds with the basic common law tenet that individuals have intrinsic rights which they can invoke to defend themselves against intrusion into their freedom by the state. Fairness and truth are interrelated in that both require that defendants be able to present their case, through a legal representative, on an equal footing with the prosecution; should there be no such possibility or equality, the different versions of the truth that the tribunal of fact will hear will not carry equal weight, which will unfairly skew “the truth” even before it is found.

In inquisitorial systems, true to basic tenets of the civil law in which the state is considered the guarantor of the individual freedom of citizens, truth finding is regarded as best entrusted not to individual parties, but to state officials who conduct investigations thoroughly and impartially. Here, fairness depends on the thoroughness of the investigation and the impartiality of the prosecutor and his commitment to taking all interests, including those of the defendant into account.⁶⁷ Brants and Field offer the following:

“Thus in the Netherlands, a thorough investigation supervised by an impartial prosecutor⁶⁸ with the resulting evidence both for and against guilt recorded in an official file, is assumed to provide an active

65 S Field and A West, “Dialogue and the Inquisitorial Tradition: French Defence Lawyers in the Pre-trial Criminal Process” (2003) 14 Criminal Law Forum, 261–316; Brants and Field, “Legal Cultures, Political Cultures and Procedural Traditions” (n.1) pp.77–115; C Brants and A Ringnalda, *Issues of Convergence: Inquisitorial Prosecution in England and Wales? Preadvies voor de Nederlandse Vereniging voor Rechtsvergelijking* (Nijmegen: Wolf Legal Publishers, 2011).

66 The implication of this, that a party’s truth cannot be the real truth, while those from adversarial jurisdictions do not care if it is or not, seems obviously unacceptable, while the truth established in an inquisitorial trial is established in a process, the agenda for which (as set out in the case dossier) is set by the prosecutor.

67 C Brants and S Field, “Truth-Finding, Procedural Traditions and Cultural Trust in the Netherlands and England and Wales: When Strengths Become Weaknesses” *The International Journal of Evidence and Proof* (forthcoming 2016).

68 Originally this would have been an investigating judge comparable to the French *juge d’instruction*.

fact-finding judge with the capacity to find truth at trial. Within the adversarial tradition in England and Wales, autonomous party rights to collect the evidence that suits their case are said to provide a basis for strong defence narrative building and the opportunity to effectively challenge prosecution witnesses at trial through cross-examination. This allows the equality of arms in argument at trial upon which accurate adversarial fact-finding is thought to depend”.⁶⁹

Insanity and automatism both concern the mental state of the accused person at the time that they committed the alleged offence with which they are charged. Consideration of the mental state of the accused may also be relevant at the time that they fail to be tried if their mental state might render them unfit for such a process or unable to obtain a fair trial. Whether or not an accused person is fit to stand trial in England and Wales is determined by identifying whether or not that person is “fit to plead”.⁷⁰ Fundamentally, according to the Law Commission:

“[u]nfitness to plead differs from insanity [and automatism] in that it is concerned with the question of an accused’s mental state at the time of his or her trial and not at the time of the offence”.⁷¹

Arlie Loughnan states that, at least in common law jurisdictions:

“unfitness to plead has two main functions: it provides a safeguard for a defendant who cannot be tried fairly, and at the same time, if he or she is ‘dangerous’ (in the sense of likely to reoffend), protects victims of his or her alleged offence, and the public more broadly, by providing the court with special disposal powers”.⁷²

The test for identifying whether an accused is fit to plead (and therefore to stand trial) was set out in *R v Pritchard*⁷³ in 1836 and considers, in general terms, whether the accused person “has sufficient understanding to comprehend the nature of [the] trial, so as to make a proper defence to the charge”.⁷⁴ In most cases the question of

69 Brants and Field, “Truth-Finding, Procedural Traditions and Cultural Trust in the Netherlands and England and Wales” (n.67).

70 The Law Commission of England and Wales in its consultation paper — Unfitness to Plead: A Consultation Paper (Law Com No 197, 2010) describes the term “unfit to plead” as “somewhat misleading” observing that it “conflates the issues of the accused’s ability to enter a plea to the charge and his or her ability to stand trial” (para.1.18). In practice, the term “fitness to plead” is used almost interchangeably with “fitness to be tried”; see eg *R v Ghulam* [2010] 1 WLR 891.

71 Law Commission, Unfitness to Plead (n.70) para.1.16.

72 A Loughnan, “Between Fairness and ‘Dangerousness’: Reforming the Law on Unfitness to Plead” (2016) 7 Crim LR 451–466, 451.

73 (1836) 7 Car & P 303, 173 ER 135.

74 *Ibid.*, 304, 135.

whether the defendant is fit to plead will be raised by the defence; however, it may also be raised by the prosecution or by the court (judge).⁷⁵ It is not sufficient that the judge is satisfied that the accused is not capable of acting in their best interests;⁷⁶ instead the accused must satisfy the requirements of the *Pritchard* test, which were expressed in *R v M (John)*⁷⁷ in 2003 (*John M*). The formulation adopted in *John M* identified that an accused should be found unfit to plead if it was beyond his capability to do one or more of the following things: understand the charges; decide whether to plead guilty; exercise his right to challenge jurors; instruct solicitors and/or advocates; follow the course of proceedings; and give evidence in his own defence.⁷⁸ The decision as to whether the accused is fit to plead is made by a judge in the absence of the jury.⁷⁹ To make such a determination, the judge must receive evidence from “two or more registered medical practitioners at least one of whom is duly approved”.⁸⁰ In this context, “duly approved” means a medical practitioner who is approved under s.12 of the Mental Health Act 1983, meaning: “a practitioner approved ... by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder”.⁸¹ In practice, the finding of unfitness to plead requires a “consensus of psychiatric opinion”,⁸² however, there is currently no prescribed test for use by psychiatrists in making assessments of fitness to plead.⁸³ Rogers *et al.*, identify that:

“In England and Wales, the all-or-nothing finding of unfitness is rare. It requires a very high level of disability, at the extreme end of a spectrum of ‘psycho-legal’ ability. Many defendants who undergo trial suffer significant levels of impairment without ever reaching this threshold”.⁸⁴

This criticism is echoed by De Than and Elvin, who argue that the “binary” nature of the fitness-to-plead rules fail to provide an adequate safeguard for defendants with diminished but partial capacity.⁸⁵ The binary nature of the

75 Criminal Procedure (Insanity) Act 1964, s.4(1).

76 See eg *R v Robertson* [1968] 1 WLR 1767; *R v Berry* (1978) 66 Cr App R 156.

77 [2003] EWCA Crim 3452.

78 *Ibid.*, [20].

79 Criminal Procedure (Insanity) Act 1964, s.4(5), as amended by Domestic Violence, Crime and Victims Act 2004, s.22(2).

80 Criminal Procedure (Insanity) Act 1964, s.4(6) as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s.2.

81 Mental Health Act 1983, s.12.

82 Law Commission, Unfitness to Plead (n.70) para.4.2.

83 *Ibid.*, para.4.1.

84 T Rogers, N Blackwood, F Farnham, G Pickup and M Watts, “Fitness to Plead and Competence to Stand Trial: A Systematic Review of the Constructs and Their Application” (2008) 19(4) *The Journal of Forensic Psychiatry & Psychology* 576–596, 593.

85 *Cf.* C De Than and J Elvin, “How Should the Criminal Law Deal with People Who Have ‘Partial Capacity’?” in L Ben, R Alan and W Nicola (eds), *Mental Condition Defences and the Criminal Justice System* (Cambridge: Cambridge Scholars Publishing, 2015) pp.295–317, 296.

distinction between the defendant who is fit to plead and the defendant who is not fit, can be equally applied to the defences of insanity and automatism (discussed previously); the availability of either defence (and indeed the decision as to which defence applies) determined by whether the defendant meets the required legal threshold.

If the judge finds that an individual is fit to enter a plea, then the trial proceeds as normal. If, however, the judge determines that the accused person is unfit to plead, then a hearing must take place pursuant to s.4A of the Criminal Procedure (Insanity) Act 1964 (CP(I)A).⁸⁶ Section 4A provides that, following a finding that the accused is unfit to plead, the trial shall not proceed and a jury shall determine whether the accused did the act or made the omission charged against him as the offence. This process is often called a “trial of the issue”⁸⁷ or “trial of the facts”⁸⁸ and relates only to establishing that the accused committed the *actus reus* of the relevant offence.⁸⁹ If, following a trial of the facts, the jury is not satisfied that the accused person did the relevant act or made the relevant omission, then the correct verdict is an acquittal as if the trial had proceeded to conclusion.⁹⁰ If, however, the jury is satisfied that the accused person did the relevant act or made the relevant omission, then it must make a finding to that effect.⁹¹ Where a finding against an accused person is made, the disposal options available are the same as those following the return of a special verdict of not guilty by reason of insanity (discussed previously), namely, a hospital order (with or without a restriction order); a supervision order; or an order for the accused person’s absolute discharge.⁹² Once a finding of unfitness to plead has been made against an individual, a criminal prosecution can only be recommenced where the court has made a hospital order and imposed restrictions on the individual.⁹³

The ECtHR considered the circumstances in which the detention of a person of “unsound mind” could be compatible with art.5(1) of the European Convention on Human Rights in *Kolanis v United Kingdom*.⁹⁴ The ECtHR applied the so-called *Winterwerp Criteria*⁹⁵ (a decision against the Netherlands involving a commitment order in a civil case) in the following terms; there must be reliable objective medical expertise showing the patient to be suffering from a mental disorder; the disorder must be of a “kind or degree” warranting compulsory confinement; and the validity of any continued detention depends upon the persistence of a true mental disorder of a kind or degree warranting compulsory detention, established upon

86 As inserted by Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s.2.

87 Law Commission, Unfitness to Plead (n.70) para.1.5.

88 Loughnan, “Between Fairness and ‘Dangerousness’” (n.72) p.459.

89 *R v Antoine* [2001] 1 AC 340.

90 Criminal Procedure (Insanity) Act 1964 (as amended), s.4.

91 *Ibid.*, s.3.

92 *Ibid.*, s.5.

93 Criminal Procedure (Insanity) Act 1964, s 5A(4).

94 (2006) 42 EHRR 12.

95 Derived from the earlier ECtHR decision in *Winterwerp v Netherlands* (1979–80) 2 EHRR 387.

objective medical expertise.⁹⁶ In the context of this decision and the jurisprudence of the ECtHR, the Law Commission conducted a detailed evaluation of the fitness to plead procedure in England and Wales, publishing a Consultation Paper in 2010,⁹⁷ an issues paper⁹⁸ in 2013 and finally a two-part report in January 2016.⁹⁹ It suggests that “national law will be compatible with the Convention as long as it requires some objective medical evidence which establishes that the person is suffering from a mental disorder warranting compulsory detention”.¹⁰⁰ Ultimately the Law Commission concluded that the common law test should be abolished and replaced with a statutory test (outlined in volume 2 of their report).¹⁰¹ The proposed statutory test would be based on the defendant’s “capacity to participate effectively in the trial”.¹⁰² The government’s interim response, however, suggests that implementation is unlikely in the short term.¹⁰³

The issue of fitness to stand trial can occur in the Netherlands too (art. 16 of the CCP) and is in some ways similar, yet also very different. Article 16 of the CCP also pertains to the situation at the time of the trial and not to criminal responsibility at the time when the offence was committed.¹⁰⁴ Whether or not the defendant is fit to stand trial is also assessed by a forensic mental health expert. However, the issue seldom arises (at most just a few times a year in the whole country) and the criterion for the assessment is very much simpler: To what extent does this defendant have any idea of the fact that he will have to stand trial at all? Article 16 therefore really only applies to defendants suffering from severe mental disorders like psychosis, in which they have lost touch with all reality. If that is found to be the case, the trial will be postponed and the accused committed to a mental hospital, where they will remain until their situation has improved to the extent that hospitalisation is no longer necessary. Having been discharged from hospital, they may well be considered fit to stand trial. Given this scenario, it is not impossible that the court could as yet deliver a verdict of total or diminished (in) capacity and impose a tbs-order. Indeed, a mental health expert might be required to advise the court on both issues at the same time, although with a different perspective in time and, of course, different further implications. In England and Wales, where the

96 *Kolanis* (n.94), [67].

97 Law Commission, *Unfitness to Plead* (n.70).

98 *Ibid.*, para.4.1.

99 Law Commission of England and Wales, *Unfitness to Plead: Volumes 1 & 2* (Law Com No 364, 2016).

100 Law Commission, *Unfitness to Plead* (n.70), Appendix A: Mental Health Legislation, para.A.6.

101 Law Commission, *Unfitness to Plead* (n.99).

102 Clause 1(2) Criminal Procedure (Lack of Capacity) Bill.

103 M Penning, MP, Ministry of Justice, “Government Interim Response to the Law Commission’s Report on Unfitness to Plead” (30 June 2016), available at http://data.parliament.uk/DepositedPapers/Files/DEP2016-0605/Mike_Penning_Government_interim_response_on_Unfitness_to_Plead.pdf (visited 22 August 2016).

104 PL Bal and F Koenraadt, *Het psychisch onvermogen terecht te staan. Waarborg of belemmering van het recht op een eerlijk proces* (Den Haag: Boom Juridische uitgevers, 2004); L Van den Anker, L Dalhuisen and M Stokkel, “Fitness to Stand Trial: A General Principle of European Criminal Law?” (2011) 7(3) *Utrecht Law Review* 120–136.

defence of unfit to stand trial is raised much more often than in the Netherlands, the question of accountability does not arise because a defendant committed to hospital due to chronic mental disorder will remain there and never come to trial.

The difference between unfit to stand trial in England and Wales and the Netherlands derives directly from the differences between adversarial and inquisitorial procedure. By definition, the adversarial criterion must depend on whether the accused is capable of conducting a defence; the very nature of the trial requires that defendants are autonomous and capable of determining whether they should plead guilty or not and of putting forward their own case, or at least instructing another to do so for them. This matter does not arise in the same way in inquisitorial jurisdictions, where the prosecutor — whose impartiality and task of finding the “real” truth require that he include both inculpatory and exculpatory evidence in the dossier — is expected to take the defendant’s case into account. A fair trial here depends less on the autonomy of equal parties than on the prosecutor fulfilling his role according to the expectations that flow from inquisitorial proceedings, ie impartially and thus fairly. That it would be unfair to try someone who has not the faintest idea of what is going on seems to derive more from humanitarian criteria than from any procedural necessity (although it is true that the defendant should be available for the trial judge to question, in order to test the prosecution case).¹⁰⁵

The definition and form of “unfit to stand trial” can thus be seen to depend on the style of procedure and concomitant roles and expectations of the participants. That is also true of the position of experts in criminal proceedings, where they are expected to assist the court (judges or jury) in determining whether the defendant has mental capacity and can therefore be held responsible for the offence he has committed.

VI. The Position of the Expert

In both the Netherlands and in England and Wales, cases where the mental condition of the defendant is in question mean that the court and jury must rely heavily on the opinion of psychological and/or psychiatric experts (known in the Netherlands as forensic mental health experts). It is, of course, obvious that the difference between an adversarial court setting with a jury as in England and Wales, and an inquisitorial court with professional judges as in the Netherlands, is huge and is immediately significant for the fact that the expert in the first case will be acting for one of the parties and in the second as an appointee to the court. While both are subject to professional and ethical standards that are, we may presume, if not the same, then at least very similar, their position in court and role in the process are very different.

¹⁰⁵ In terms of human rights and fair trial, it could also be said that the right to know the charge and the evidence and to challenge it (art.6 of the ECHR) implies that defendants must be capable of at least understanding that there is a charge and evidence that may be brought against them and of mounting a challenge.

Adversarial experts (if we may call them that) are witnesses for the defence or prosecution, will expect to give oral evidence, possibly to be contradicted by the expert for the other side and to be subject to cross-examination; their evidence will be geared towards the defence raised. Inquisitorial experts are not witnesses but have their own position as “experts”, reporting *pro Justitia* as a regular part of their job; their most important task is to produce a written report on the defendant’s mental condition, and if required, to appear in court to clarify their opinion by answering any questions the judges may have as to the mental state of the defendant, the risks of reoffending and the chances of successful treatment. That raises the question of how experts fulfil the role demanded of them in the respective court settings, what procedural and professional rules guide their actions, how they define mental (in)capacity and how their definitions and opinions relate to categories that are meaningful in criminal law.

A. *England and Wales*

In all cases involving insanity/automatism based on the medical/mental condition of the defendant (and indeed the question of the defendant’s fitness to plead), expert evidence will play a vital role. A verdict of not guilty by reason of insanity can only be returned if there is written or oral evidence from two or more registered medical practitioners of whom at least one is approved by the Home Secretary as having special experience in the field of mental health.¹⁰⁶ In the context of diminished responsibility, whilst there is no statutory requirement that expert medical evidence is adduced, the courts have described it as a “practical necessity”.¹⁰⁷ Because the burden of proof rests on the defence to establish the defences of insanity or diminished responsibility, the jury must be satisfied that the defences have been proven on the balance of probabilities. In practice, if the medical evidence is uncontested, the judge will direct the jury to return the appropriate verdict.¹⁰⁸ In cases involving a defence of automatism, expert medical testimony will often be necessary to identify the “external” cause of the defendant’s condition.

Recent changes to Pt.19 of the Criminal Procedure Rules and the Criminal Practice Direction (CrimPD) on expert evidence¹⁰⁹ have sought to introduce a pre-trial consideration of the reliability of expert evidence in criminal proceeding. Factors which the court may now take into account in determining the reliability of expert opinion, and especially of expert scientific opinion, include:¹¹⁰

- (1) the extent and quality of the data on which the expert’s opinion is based, and the validity of the methods by which they were obtained;

106 Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, s.1.

107 *R v Dix* (1982) 74 Cr App R 306; *R v Bunch* [2013] EWCA Crim 2498.

108 See eg *R v Brennan* [2015] 1 WLR 2060.

109 Criminal Practice Direction [2015] EWCA 1567, V Pt.19A.

110 *Ibid.*, Pts.19A.5, 19A.6.

- (2) if the expert's opinion relies on an inference from any findings, whether the opinion properly explains how safe or unsafe the inference is (whether by reference to statistical significance or in other appropriate terms);
- (3) if the expert's opinion relies on the results of the use of any method (for instance, a test, measurement or survey), whether the opinion takes proper account of matters, such as the degree of precision or margin of uncertainty, affecting the accuracy or reliability of those results;
- (4) the extent to which any material upon which the expert's opinion is based has been reviewed by others with relevant expertise (for instance, in peer-reviewed publications), and the views of those others on that material;
- (5) the extent to which the expert's opinion is based on material falling outside the expert's own field of expertise;
- (6) the completeness of the information which was available to the expert, and whether the expert took account of all relevant information in arriving at the opinion (including information as to the context of any facts to which the opinion relates);
- (7) if there is a range of expert opinion on the matter in question, where in the range the expert's own opinion lies and whether the expert's preference has been properly explained; and
- (8) whether the expert's methods followed established practice in the field and, if they did not, whether the reason for the divergence has been properly explained.

Furthermore, "in considering reliability, and especially the reliability of expert scientific opinion, the court should be astute to identify potential flaws in such opinion which detract from its reliability".¹¹¹ Such potential flaws include the expert's opinion: (1) being based on a hypothesis which has not been subjected to sufficient scrutiny (including, where appropriate, experimental or other testing), or which has failed to stand up to scrutiny; (2) being based on an unjustifiable assumption; (3) being based on flawed data; (4) relying on an examination, technique, method or process which was not properly carried out or applied, or was not appropriate for use in the particular case; or (5) relying on an inference or conclusion which has not been properly reached.¹¹²

B. The Netherlands

In the Netherlands, approximately 5,000 forensic mental health reports are made each year on the order of the public prosecutor or examining magistrate in a particular case. Pre-trial forensic mental health assessment can be carried out on an outpatient basis or in a special residential setting. There are several types of

¹¹¹ *Ibid.*, Pt.19A.6.

¹¹² *Ibid.* See also Law Commission, *Expert Evidence in Criminal Proceedings in England and Wales* (Law Com No 325, 2011) para.5.17.

forensic mental health assessment that can be ordered in the Dutch criminal justice system. The examining magistrate or public prosecutor is guided in his decision to order a particular type by staff of the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP), and before making recommendations, the NIFP forensic psychiatrist or psychologist visits the accused for a brief consultation. After it has become clear that there is a need for a forensic mental health report, by a forensic psychiatrist, a forensic psychologist, or both, the public prosecutor asks the NIFP for one or two experts. The NIFP approaches the expert(s) and in fact matches the request by the public prosecutor and the supply of the available and specialised expert(s). The public prosecutor decides and appoints the expert.

The types of assessment are as follows: A single psychological assessment may occur on an outpatient basis when there is a suspicion of personality problems, or a single psychiatric assessment may occur on an outpatient basis when there is a suspicion of disorders of a specifically (medical) psychiatric nature. A psychological and psychiatric assessment may occur on an outpatient basis (if a tbs-order is on the cards). A tbs-order with compulsory care requires recently written and signed reports from two different mental health experts. The results of the assessment may be set out in two separate reports or a single report signed by both experts. A triple mental health assessment may occur on an outpatient basis, and is carried out by a psychiatrist, a psychologist and a social worker, who collaborate to produce a report. The results of the assessment may be set out in three separate reports or a single report signed by all three experts. A multidisciplinary in-patient assessment may occur in a (specialist) psychiatric hospital or at the Pieter Baan Centre (PBC). This centre of the Ministry of Security and Justice is a forensic psychiatric hospital, not meant for treatment but for forensic mental health observation and assessment. In cases of serious, strange or bizarre offences, legally complex cases, cases with a lot of publicity, cases of (young) recidivists with an ongoing or escalating pattern of offences, extra dangerous detainees or cases of detainees with a high risk of escape, the assessment is likely to take place at the PBC where the intensive observation and assessment takes six weeks. Other indications for assessment in the PBC might be a strange or bizarre detainee, a strange or bizarre exchange between the detainee and his social environment (eg network of incest, offence in a relationship), a possible starting criminal career in a young detainee, an insufficient previous assessment, or already a long-lasting tbs-measure, with the question of whether to extend the measure or not. The assessment in the PBC is an integral part of a residential stay in a ward, on an involuntary basis, by a multidisciplinary team of experts using a multi-method approach,¹¹³ in one of the four wards, each for eight detainees. A total of approximately 220 PBC reports are made per year.¹¹⁴

113 F Koenraadt and E Muller, "Hoofdstuk 8: Het psychologisch onderzoek en de daarop gebaseerde rapportage pro Justitia" in HJC van Marle, PAM Mevis and MJF van der Wolf (eds), *Gedragkundige rapportage in het strafrecht* (Deventer: Kluwer, 2nd ed., 2013) pp.269–346.

114 F Koenraadt, AWM Mooij and JML van Mulbregt (eds), *The Mental Condition in Criminal Law: Forensic Psychiatric and Psychological Assessment in a Residential Setting* (Amsterdam: Dutch University Press, 2007).

In essence, an inpatient forensic mental health assessment differs little from an outpatient assessment. The differences in the intensity of the assessment, the breadth of the techniques brought to bear and the special division of responsibilities in the multidisciplinary assessment team determine the nature of the two types of report, assessment on an inpatient or on an outpatient basis. A psychologist or psychiatrist carrying out an outpatient assessment visits the accused in a remand centre, juvenile custodial institution, psychiatric hospital or mental institution: it is the expert who is mobile, not the person being assessed. If the accused has not been remanded in custody and is therefore at large, the meeting usually takes place at the expert's practice or the office of the NIFP. Assessments on an outpatient basis generally require three or four visits, sometimes a few more or less, depending on the nature and severity of the problems.

In England and Wales, the verdict will depend on which expert witness successfully supports or undermines a plea of insanity, automatism or unfitness to plead, by most persuasively showing, or contradicting, the existence of a disorder that can be classified according to DSM-IV, DSM-5 or ICD-10 classification.¹¹⁵ In the Netherlands, the verdict does not depend on the expert's being able to define the disorder on which the defence is based in any particular way. The existence of a classifiable disorder is not necessary and not enough to arrive at a qualification of a "disorder in a legal sense". It is not necessary because there is no reason why a disorder that affects the capacity for careful consideration, but is not classifiable, should not be viewed as a relevant disorder in the sense of the law; it is not adequate because the DSM classifications, certainly in the field of personality disorders, predominantly describe interaction strategies stipulated on the basis of external behavioural criteria.¹¹⁶ Dutch criminal law, therefore, uses the open definition of mental disorder: whether the offender is suffering from defective development or pathological disorder of the mental faculties. In this broadly formulated criterion "defective development of the mental faculties" relates (roughly) to problems and/or impairment in social, emotional, cognitive, sexual or personality development and "pathological disorder" is related to severe psychiatric disorders and conditions.

In practice, the court will rely heavily on the reports by forensic mental health experts, but is not bound to follow that opinion. Crucial in the forensic mental health report is that it is individually tailored. What the court needs to reach a fair and adequate verdict is information about the specific case of this accused individual. When all information is integrated, the accused is examined in his uniqueness and the forensic mental health expert(s) must assess whether what is true on a group level also applies for this individual. The role of the assessment and the report is

115 The Diagnostic and Statistical Manual of Mental Disorders (DSM) stems from the American Psychiatric Association and is the Diagnostic and Statistical Manual of Mental Disorders. The International Statistical Classification of Diseases and Related Health Problems (ICD) stems from the World Health Organization.

116 F Koenraadt and A Mooij, "Mentally Ill Offenders" in M Boone and M Moerings (eds), *Dutch Prisons* (Den Haag: BJu Legal Publishers, 2007) pp.167–186.

to clarify whether a mental disorder is present and if so, whether it can explain the offence alleged. The law requires causality between mental incapacity and the offence (which is both a medical and a legal question) and case law has developed a sliding scale of capacity to determine responsibility: undiminished, somewhat diminished, diminished, highly diminished and total incapacity. However, whatever the degree of incapacitation, the disorder itself does not create an offence. To avoid a circular argument, the building blocks of diagnosis should not be taken from the offensive behaviour itself. Furthermore, it cannot be that an acquittal could cancel the diagnosis.

Such forensic mental health assessment goes beyond simply reaching a diagnosis. The diagnostic classification as such says little about the severity and degree of disability implied in the mental disorder. It is important to explain which aspects of the disorder lead to which limitations in daily life. The forensic mental health expert must make clear how the disturbed functions lead to any problems in any circumstances and, moreover, how this may have contributed to committing the offence. To this end, he must answer the question whether, and if so, which aspects of the disorder in these specific circumstances may have led to the person in question being restricted in his freedom to determine his actions, and if so, to what extent. Relations of this kind can only be revealed in an individualising assessment. The expert report will therefore describe, first, the nature and severity of the mental disorder and the way and extent to which it affects the capacity for careful consideration (freedom to determine one's will). Secondly, the report assesses how and to what extent the disorder has impacted the offence charged. Of course, this does not always have to be done explicitly it can also become implicitly evident from the description of the behavioural or psychopathological background of the offence.¹¹⁷

The Dutch Experts in Criminal Cases Act (*Wet deskundige in strafzaken*) stipulates that court experts must meet certain competency standards. It sets up a register to safeguard competency. However, it is still possible to use an expert not listed in the register, although the court must give reasons for doing so. Engaging one of the registered experts assumes that the expert in question has the necessary professional skills in their field of expertise, outlined by the Board of Court Experts. Using the register is meant to increase the quality of the judicial procedure by ensuring a reliable and consistent standard of professionalism.¹¹⁸ This relieves the court from the burden of having to consider whether the expert is actually an expert in the required field and whether the methods used are valid. Both are questions that courts are not really competent to answer and usually arise only after prompting by the defence, and have until now been governed by case law.¹¹⁹

117 A Mooij, *Psychiatry as a Human Science: Phenomenological, Hermeneutical and Lacanian Perspectives* (Amsterdam/New York: Rodopi, 2006).

118 Nederlands Register Gerechtelijk Deskundigen, available at <http://www.nrgd.nl>.

119 See eg HR 27 January 1998, NJ 1999, p.404 (orthopaedic shoemaker decision) and HR 28 February 1989, NJ 1989, p.748 (anatomically correct dolls decision).

VII. Conclusions

It would seem logical that the reliance on judicial decision-making/case law in England and Wales in itself provides a mechanism that promotes case-by-case pragmatism and gives the common law flexibility and the capability for change. Reliance on written codification in the Netherlands, even given the interpretative powers of the Supreme Court, means that change is slow and the law is not easily adaptable — the (political) legislative process being lengthy and unpredictable. In the case of mental capacity, the opposite seems to be true. English law relies on a very limited number of recognised defences, which circumscribes the role of experts by requiring them to tailor their diagnosis to what the courts need to hear in legal terms, while the very looseness of the mental disorder concept under Dutch criminal law and how this relates to the role of the expert in informing the court of the individuality of the defendant, seem to make Dutch law more flexible and more adaptable on a case-by-case basis. In the field of mental health, at least, the common law would seem to force experts to define conditions in a way that allows them to be translated into what the law and the courts require, making of an empirical science a normative practice and precluding individualisation per case. To a certain extent, that is, of course, also true in the Netherlands: law is a normative business that reflects the cultural-historical values of a society, while psychology and psychiatry are internationalised fields whose (changing) insights need not, and often do not, coincide with established legal practice.

Indeed, in both countries, many legal problems are the same: the problematic legal distinction between external and internal factors which will often make the difference between compulsory hospitalisation or not; the fact that a jury (or judge) is dependent on which expert seems most persuasive, with the Dutch court not bound by the expert's opinion (because it need not be convinced by it and will moreover take other factors into account); the disposal of cases through compulsory hospitalisation orders also seems similar, reflecting underlying notions — historically, more pronounced in Dutch criminal law doctrine — that those who have no control over their will should not be punished, but that society should nevertheless be protected from them. But there are many differences that appear related to the differences in substantive law (eg the extensive defences of lack of or diminished capacity in the Netherlands that cater to many different situations) and to the adversarial c.q. inquisitorial structure of the trial. In an adversarial setting, the majority of the process happens in court (before a jury), whereas the considered opinion of the expert in the inquisitorial system is embedded in extensive pre-trial structures that are part of the justice system. Both have their advantages, depending on one's point of view. Dutch criminal process, with its impartial and all-powerful prosecutor, and registered experts conferring before trial to reach a consensual opinion — indeed, one collaborative report! — upon which the judge can rely, leaves little room for a defendant to be considered as an autonomous subject at law, although it may boost legitimacy that, in the

Netherlands, depends on a high degree of trust in (the representatives of) state power and its ability to deliver “the truth” and thus just verdicts. Public trust in the Netherlands in political and social institutions is generally high.¹²⁰ It is no coincidence that the introduction of the expert-register in the Netherlands has coincided with diminishing public trust in, and the public contestation of, the court system in general and a number of verdicts and the experts on whose opinion they relied, in particular. The problem with this system is that the individual defendant, faced with the powers of the state and its registered experts, has little control over what happens at trial and thus over their own life.

As discussed previously, a great deal of work has been undertaken by the Law Commission of England and Wales to establish the need for reform in relation to both the defences of insanity and automatism and, latterly, fitness to plead (stand trial). Despite the fact that the case for reform of both (related) areas has been well made, there appears to be a lack of political will to make the necessary legislative changes, at least in the short to medium term. In England and Wales the adversarial nature of the trial as a contest between equal parties perhaps goes some way in explaining the “binary” nature of the concept of capacity and the lack of a legal concept of partial capacity.¹²¹ Nevertheless, it remains an issue that both the availability of defences and the question of a defendant’s fitness to plead are “all or nothing” determinations with nothing available for the mentally vulnerable defendant whose diminished capacity is insufficient to meet the required thresholds.

It is however noteworthy that, through incremental legislative and procedural changes, and most recently the procedural rule changes relating to the reception of expert evidence in criminal proceedings in England and Wales, there appears to have been a move towards adopting a quasi-inquisitorial approach to the determination of a defendant’s mental capacity, with the expert witness playing a central role.

The receipt of expert evidence is now a statutory requirement of the insanity defence¹²² and, where the medical evidence is uncontested, the judge will likely direct the jury to return the special verdict.¹²³ Expert evidence is a “practical necessity”¹²⁴ in establishing a diminished responsibility defence and, by extension, a defence of automatism based on a medical condition (such as *sexsomnia*).¹²⁵ The question of an accused person’s fitness to plead has potentially seen the greatest move towards a quasi-inquisitorial process. The determination is made by a judge

120 K Brants, “Trust, Cynicism and Responsiveness: The Uneasy Situation of Journalism in Democracy” in C Peters and M Broersma (eds), *Rethinking Journalism: Trust and Participation in a Transformed Media Landscape* (Abingdon: Routledge, 2013) pp.15–28.

121 De Than and J Elvin, “How Should the Criminal Law Deal with People Who Have ‘Partial Capacity’?” (n.85) p.296.

122 Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 (n.106).

123 *Brennan* (n.108).

124 *Dix; Bunch* (n.107).

125 See the works cited in note 57.

in the absence of the jury and expert evidence is again a statutory requirement with the court usually beholden to the “consensus of expert opinion”.¹²⁶

Significant recent developments in the Criminal Procedure Rules (Pt.19) and the associated CrimPD¹²⁷ have sought to introduce a “procedural” reliability test. This places much greater emphasis on the pre-trial process (usually the point at which an individual’s fitness to plead is determined) as a means of identifying and dealing with issues of reliability in the context of expert testimony. The rules now contain a non-exhaustive list of reliability criteria against which the expert’s evidence may be tested or challenged. The rule changes place an onus on the expert to identify problems/areas of uncertainty, provide for mechanisms such as pre-trial meetings for experts to resolve issues (which reflect practices more commonly seen in inquisitorial systems) and also reflect the idea that the expert has a duty to the court that overrides any obligation to the person from whom they receive instructions or by whom they are paid. The amended CrimPD, by encouraging experts to meet pre-trial and to identify issues for the court is attempting to move experts away from the traditional “defence expert v prosecution expert” approach and towards having the experts there primarily to assist the court. It could well be the case that these rule changes further embed an inquisitorial approach or element into the determination of a defendant’s mental capacity.

It remains the case that without legislative changes, both the courts and experts in England and Wales are operating within the constraints of an anachronistic and binary framework for dealing with defendants with diminished mental capacity. It is hoped that the incremental introduction of seemingly quasi-inquisitorial elements may allow for a more individualised assessment of the needs of particular defendants, as is seen in the Netherlands. However, there is always the risk that the introduction of a strange (in this case quasi-inquisitorial) element will not fit the overall structure of the process and could indeed destabilise it.

126 Law Commission, *Unfitness to Plead* (n.70).

127 See the work cited in note 109.