Mental Capacity as a Concept in Negligence: Against an Insanity Defence

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A defendant's 'insanity' will not excuse his or her negligence. According to corrective justice theory, if A injures B, then A should compensate B – that A's actions may be attributable to a mental illness is therefore immaterial. Some tort scholars argue the law should excuse insane defendants from liability because they lack the mental capacity to commit negligence. 'Capacity' therefore lies at the core of the case for insanity defence. This article argues that 'capacity' fails as a framework concept for the insanity defence. It is poorly defined, fails to map onto the structural features of negligence and poses significant evidential challenges. It also has a spurious relationship with insanity. This paper prefers the status quo and concludes that the case for excusing the insane from negligence liability is conceptually flawed and normatively unconvincing.

Key words: capacity; defence; disorder; excuse; health; insanity; mental; negligence; tort.

1. Introduction

There is no insanity¹ defence² in English tort law. A mentally disordered defendant who commits negligence will be liable, even if his or her actions could be attributable to illness. Since a seventeenth-century dictum indicating that a 'lunatic' would be answerable in trespass,³ the courts have been unwilling to excuse mentally ill defendants' tortious liabilities.⁴ *Dunnage v Randall*⁵ suggests there is no appetite to change this position. While an 'insane' defendant may have a defence in criminal law,⁶ no equivalent excusatory mechanism applies to civil wrongs. There has been much debate about the fairness of this arrangement: some scholars support introducing an insanity defence into the law of tort;⁷ others prefer the status quo.⁸ Those in favour argue that the law should excuse insane defendants from liability because mental disorders destroy or inhibit a person's capacity. 'Capacity' (that is, *mental* capacity) therefore

lies at the core of the case for the insanity defence. Despite its purported significance, this notion of a 'mental capacity to commit a tort' is hitherto unexplored in common law scholarship.

This article makes an original contribution by analysing 'capacity to commit' as it pertains to the tort of negligence. Although some of what follows will apply to other torts, 'capacity' is most vexing in negligence, which concerns 'failure to comply with a legally specified standard of conduct, pure and simple'.⁹ Therefore, establishing a mentally-disordered defendant's lack of capacity to commit negligence – and thus his entitlement to rely on an insanity defence – poses a significant challenge. It is likely to be much easier to evaluate defendants' capacities to commit torts containing mental elements comparable to the *mentes reae* of criminal offences.¹⁰ Elsewhere, a defendant's 'capacity to commit' will be wholly

immaterial.¹¹ This article also assumes that the tort of negligence serves a different purpose from criminal law. As Cane states, criminal law focuses on the agent's 'conduct and mental state at the expense of the interests of those directly and indirectly affected by [his] conduct ... [whereas] tort law is as much concerned with the interests of victims'.¹² This paper proceeds on the assumption that an insanity defence excusing liability in negligence warrants distinct justification.

Section 2 of this article explores the difficulties inherent in defining 'insanity'. Those who support the introduction of an insanity defence in tort law invariably define 'insanity' with reference to 'capacity'. The deleterious effect mental disorders are presumed to have on a person's capacity therefore gives arguments for the insanity defence moral force. Yet what 'capacity' means is unclear, raising questions about its utility as a framework concept for the insanity defence. Section 3 locates this debate in its theoretical and doctrinal context. It posits that corrective justice theory provides an explanatory model for the objective standard of care in negligence and the absence of an insanity defence. Section 3 also reflects on the Court of Appeal's decisions in *Dunnage v Randall* and *Mansfield v Weetabix Ltd*¹³ and contends that 'incapacitation' is a plausible means of distinguishing them. The case law suggests that there must be a compelling basis on which to displace negligence's 'corrective function'. The insanity defence therefore depends on whether considerations of capacity can convincingly effect such a displacement. Section 4 reveals that 'capacity' is ill-defined, maps inadequately onto the structural features of negligence and poses significant evidential challenges. It therefore advances this paper's core claim, viz. that the insanity defence is beset by such a formidable conceptual challenge that it is implausible and unworkable in negligence cases. Section 5 recalibrates the normative problem by positing that a minor doctrinal modification would ensure that tort law is fair to mentally-disordered defendants.

It argues that a proper understanding of the role of the Mental Health Act (MHA) 1983 and a fuller appreciation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD)¹⁴ would render redundant the normative case for an insanity defence.

2. Defining our Terms

According to the Oxford English Dictionary, the word 'insanity' dates from the sixteenth century and means 'the condition of being insane; unsoundness of mind as a consequence of brain-disease; madness, lunacy'.¹⁵ Few would dispute that it is a hopelessly outmoded term. These days we commonly employ terms like 'mental disorder' instead of 'insanity'.¹⁶ For example, the MHA, which governs the compulsory care and treatment of people with mental health problems, uses 'mental disorder' and defines it as 'any disorder or disability of the mind'.¹⁷ This formulation demonstrates that disorders or disabilities of the mind are diagnosed and treated according to clinical judgment. Yet 'insanity' retains a strange currency in criminal law. In *M'Naghten's Case*, Tindal CJ said that to establish insanity, it must be proved that at the material time the accused was under such a defect of reason from a disease of the mind that he did not know (i) the nature and quality of the act he was doing, or (ii) that what he was doing was wrong.¹⁸ 'Insanity' is therefore a legalistic umbrella term that applies to any mental disorder whose effects might justify the 'special verdict'; that is, a finding that an accused is 'not guilty by reason of insanity'.¹⁹ Beyond the confines of the criminal law, 'insanity' has no psychiatric significance.

It is not clear whether those who support the introduction of an insanity defence in English tort law define 'insanity' along the same lines as *M'Naghten's Case*. Two themes emerge from the literature. First, tortious liability is considered contingent on a defendant's *mental capacity*. Second, the insane

lack, or can lack, that capacity. Those who support the introduction of an insanity defence in tort law therefore do not specifically define ‘insanity’. Instead, they define it by logical regression; that is, they define ‘insanity’ with reference to another concept, ‘capacity’. This tactic has a long heritage. Hornblower claimed in 1905 that there is ‘no logical reason’ why a person of ‘absolute mental incapacity’ should be held liable in tort.²⁰ Ames thought that English courts should apply the ‘ethical principle’ of ‘no liability without fault’ where ‘lunatics’ are concerned.²¹ Cook wrote that ‘a lunatic has no capacity for acting as a prudent man’ and therefore he ‘would not seem to be liable for actionable negligence’.²² Bohlen thought that ‘mental deficiency’ can destroy a person’s ‘capacity for fault’.²³ Ague echoed this view, drawing a link between insanity, which renders someone ‘devoid of the power to understand and to reason’, and the absence of capacity ‘to realise the risk of injury to another person’.²⁴ More recently, Bromberger has written that if medical professionals can make judgments about the ‘general nature and capacity’ of mentally ill people, then there is no reason why these generalisations cannot form the basis of an attenuated standard of care in negligence.²⁵ Elsewhere, Goudkamp has argued that insanity ‘destroys or at least severely diminishes a person’s capacity for self-determination’.²⁶ He claims that, in the absence of an insanity defence, tort law ‘does not adhere faithfully to the paradigm of free will’.²⁷ Goudkamp concludes that the case for an ‘affirmative defence’ of insanity in tort law is overwhelming.²⁸

Those who support the introduction of an insanity defence typically locate the concept of capacity at the core of their arguments. It is the incapacity that may be occasioned by mental illness that warrants the excusal from liability of mentally-disordered defendants who occasion injury, loss or damage to others. In this way, ‘insanity’ does not describe a specific mental disorder; rather, it refers to a particular *manifestation* of mental

illness. This formulation is not so much a definition of ‘insanity’ but rather a moral justification for the introduction of a defence, be it an ‘affirmative’ one²⁹ or an ‘absent-element’ defence.³⁰

By defining ‘insanity’ in this way, the proponents of the defence rely on some questionable assumptions. For example, when referring to ‘capacity’, they appear to assume that it is a familiar concept in tort law. This paper will show that this is not the case. The claim that insanity destroys or diminishes a person’s capacity is question-begging and may be based on doubtful assumptions about mental illness. It is not necessarily true that ‘insanity’ and ‘incapacity’ are interchangeable concepts;³¹ if they were, then *anyone* with a mental illness of *any kind* might have an answer to a claim in negligence. Nor is it clear whether ‘capacity’ for the purposes of tort law should be taken to be the same thing as decision-making capacity under the Mental Capacity Act (MCA) 2005. While a person’s depressive disorder may lead her to experience symptoms such as low self-esteem, low mood and feelings of hopelessness, it does not follow that her ‘capacity’ to take decisions is in any way diminished. According to [section 2](#) of the MCA, a person lacks capacity if he is unable to make a decision for himself in relation to the relevant matter ‘because of an impairment of, or a disturbance in the functioning of, the mind or brain’. A person is deemed ‘unable to make a decision’ if he cannot (a) understand the information relevant to the decision, (b) retain that information, (c) use or weigh it as part of the decision-making process or (d) communicate his decision.³² We will see later that these provisions do not readily map onto negligence, suggesting that ‘capacity’ must have a unique meaning in tort law if it is to serve as a framework concept for the insanity defence. It is also not clear why mental illnesses occasioning ‘insanity’ deserve to be singled out for special treatment. If what matters is ‘capacity’, then surely *anything* mentally incapacitating – sleep, drunkenness, drug

intoxication, high fevers and so on – might provide an occasion on which to excuse a defendant's liability in tort. Some readers may welcome the excusal of liability for these incapacities, yet a stubborn focus on 'insanity' raises a tricky question about what is so special about mental illness. We will see that these points raise difficult problems which the proponents of the insanity defence may not have considered. It may not have been their intention to frame the insanity defence so generously, but without defining 'capacity' it is hard to discern where the limits lie. To claim that insanity has such a negative impact on a person's 'capacity' without defining what that means is to risk invoking simplistic (and potentially stigmatising) assumptions about mental disorders. In any case, all this assumes that there is such a thing as 'capacity to commit negligence' and that insanity, in particular, has such a destructive or inhibiting effect on it that the law should afford the mentally ill a defence. This paper will challenge these assumptions.

3. Insanity, Negligence and Corrective Justice

Imagine that A has bipolar disorder. During a manic episode, A drives the wrong way down a dual carriageway and collides with B. Therefore, B is injured owing to A's failure to exercise reasonable care. Yet A's mental disorder may have affected her behaviour. Because there is no insanity defence, A would be liable in negligence for the injuries she has caused B. Why does English law not excuse the carelessness of 'insane' defendants like A?

Corrective justice theory may offer an explanation. The author hastens to add that readers should not take this as an argument for a corrective justice interpretation of tort law more broadly. That theory's explanatory power is highly contestable and the author wishes to avoid embracing universal theoretical interpretations of tort law.³³ This paper instead takes the view that corrective justice

may explain why 'insanity' is no answer to a claim in negligence, and why the standard of care takes no account of defendants' mental health. Whichever theoretical framework one prefers, it is in any event likely that mental capacity will remain a problematic concept with which to justify an insanity defence in this context.

According to Owen, 'fault' is tort law's 'basic cement', providing 'definition and justification for the great majority of rules governing private responsibility for causing harm'.³⁴ Without fault, a claimant's claim will usually fail.³⁵ 'Fault' is therefore an essential ingredient of negligence. Yet 'fault' does not necessarily equate with *moral* culpability. It is impossible to assert that liability depends on personal wrongdoing 'without many explanations, qualifications, and exceptions'.³⁶ In many cases, the courts have imposed liability 'without proof of wrongdoing in the ordinary sense of blameworthy conduct'.³⁷ Jules Coleman says that 'fault liability' is really a form of liability *without* fault because it relates to 'fault in the doing, not in the doer'.³⁸ A's driving the wrong way down a dual carriageway and crashing into B therefore constitutes 'fault in the doing'. That A has a mental disorder may indicate that there is no 'fault in the doer' but this is immaterial. It is therefore possible to refer to 'fault' in a way that connotes no *moral fault* on the part of the actor but that indicates her *legal responsibility* for injury.³⁹ Negligence neither implies nor requires a moral failing on the defendant's part.⁴⁰ Questions of 'culpability' simply matter less for tort liability than they do in the criminal law.⁴¹

This distinction between moral and legal fault raises an important theoretical point. Weinrib argues that private law relationships are 'bipolar' and must therefore be viewed through the lens of corrective justice, correlating a defendant's gain with the claimant's loss.⁴² Corrective justice provides, in Weinrib's view, the only coherent explanatory model for the way tort law constructs and resolves disputes.⁴³ The upshot of

corrective justice is that, if a defendant carelessly causes injury, then he should compensate the claimant, *even where no moral blame can be imputed to him*. What matters is 'objective Right rather than subjective virtue'.⁴⁴ This theory may therefore explain *why* English tort law does not exempt the morally-blameless mentally ill defendant from liability. A duty-bearer must attain the objective standard of the 'reasonable person'.⁴⁵ It makes no difference that a defendant's carelessness might be attributable to inexperience, clumsiness or some other idiosyncrasy: if he falls below the standard of care, he will be liable for the consequences of his negligence.⁴⁶ According to Beever, this objective standard 'is an instantiation of corrective justice' in that it 'sets the rights and duties of the parties' by reference to a 'hypothetical person who embodies a standard universalisable across the community as a whole'.⁴⁷ The fact that A's bipolar disorder might lead her to take unreasonable risks (such as driving the wrong way down a dual carriageway) will not therefore preclude a court from finding her in breach of her duty to B, whom she has injured.⁴⁸

In *Dunnage v Randall*,⁴⁹ the defendant injured his nephew whilst acting under the delusions he suffered due to undiagnosed paranoid schizophrenia. The claimant, Mr Dunnage, suffered burns to his body after Mr Randall, the defendant, set fire to himself. Randall had arrived at the claimant's house in an agitated state. He accused Dunnage of being involved in a conspiracy. Randall poured petrol over himself and threatened to set himself alight unless Dunnage told him 'the truth'. A struggle ensued during which Randall set himself on fire. Randall died at the scene. In a claim for personal injury which he brought against Randall's estate, Dunnage argued that the defendant had owed him a duty of care and that mental illness was no bar to recovery. The Court of Appeal agreed: Vos LJ said there is no principle in English law that 'requires the law to excuse from liability in

negligence a defendant who fails to meet the normal standard of care partly because of a medical problem'.⁵⁰ Arden LJ echoed this sentiment:

The standard to be expected of [Mr Randall] is purely objective. It is the standard of a reasonable person, not a person having [Mr Randall's] disabilities. It does not therefore matter whether the person was in fact drunk or had some disability. The only question is whether he failed to act as a reasonable person would have done.⁵¹

This is a sound restatement of the doctrine and entirely consistent with corrective justice theory. Randall's moral blamelessness was not relevant to his liability in negligence. It is arguable, of course, that Randall *was* morally at fault. He must have known he was taking risks that might harm the claimant; that was, after all, the very point of his actions. In any case it makes no difference: Randall was liable for the injuries he caused because he failed to comply with the 'reasonable person' standard.

Goudkamp and Ihuoma contend that *Dunnage* is in 'obvious and significant conflict'⁵² with *Mansfield v Weetabix Ltd.*⁵³ That case concerned a lorry driver who had malignant insulinoma, a rare condition that can cause hypoglycaemia. During the course of a 40-mile journey, the driver experienced low blood sugar and crashed into the plaintiff's shop. The plaintiff sued the lorry driver's employer. The lorry driver had not been aware at the material time that he was suffering from insulinoma. The Court of Appeal held that the defendant was not liable: the standard of care which the lorry driver had to meet was that of a reasonably competent driver 'unaware that he is or may be suffering from a condition that impairs his ability to drive'.⁵⁴ Since he was unaware that he had any such condition, the lorry driver was not to blame for what happened. If correct, *Mansfield* suggests that a defendant will not be liable for injury that results from 'involuntary' actions.⁵⁵

Mansfield does not easily lend itself to a corrective justice analysis. The Court of Appeal's decision turned on the absence of 'fault in the doer': the defendant did not know that he had a rare medical condition that could impair his ability to drive; therefore, he was not in breach of duty. Yet, on the facts, he had driven too fast into a bend in the road and had lost control of his lorry. Corrective justice would seem to invite the opposite conclusion: the defendant should have been liable because there was 'fault in the doing'. *Mansfield* undermines the corrective justice theory's explanatory power. The case does suggest, however, that there may be circumstances in which a court will displace what might be called negligence's 'corrective function'. This function ordinarily presumes that where A carelessly causes injury to B, A shall compensate B. In *Mansfield*, it was the defendant's lack of awareness of his condition that provided the occasion on which to displace that corrective function. *Dunnage* suggests that a defendant's undiagnosed paranoid schizophrenia is not another such occasion.

Goudkamp and Ihuoma argue that the Court of Appeal's decisions in *Dunnage* and *Mansfield* are inconsistent and describe this as 'puzzling'.⁵⁶ It is true that the two cases sit uneasily alongside each other. Following *Dunnage*, if A has a manic episode of her undiagnosed bipolar disorder whilst driving and crashes into B, it is likely that she will be liable in negligence. By contrast, if C, with no prior diagnosis of heart disease, has a sudden heart attack, with the result that he crashes into D's house, *Mansfield* suggests that C would *not* be liable in negligence. At first blush, this hardly appears to be coherent: sudden and unexpected 'incapacitation' either pre-empts negligence's corrective mechanism or it does not. In appearing to recognise a distinction between mental and physical disorders, the Court of Appeal has failed to afford them 'parity of esteem'.⁵⁷ Yet it is arguable that there *is* a distinction between *Mansfield* and *Dunnage* which made the displacement

of negligence's corrective function impossible to justify in the latter case. In *Dunnage*, Vos LJ said that only those defendants whose 'medical incapacity' has had 'the effect of entirely eliminating any fault or responsibility for the injury can be excused'.⁵⁸ The distinction between *Mansfield* and *Dunnage* lies in this binary capacity/incapacity interpretation. Whereas in *Mansfield* there was a clear basis on which to conclude that the defendant had been 'incapacitated' (in that his undiagnosed medical condition destroyed his physical ability to control the lorry), in *Dunnage*, Mr Randall had not been 'incapacitated' in the same way. Randall had arrived at the right address. He had brought petrol and a lighter with him. He correctly identified and confronted Mr Dunnage. Randall took out the petrol can and lighter when Dunnage's answers failed to satisfy him. On spilling the petrol, Randall knew that a naked flame would ignite the fuel. Although he was labouring under a paranoid delusion, Randall was clearly capable of acting in a way which he must have foreseen carried the risk of injury to others. If there was any incapacity here, it was certainly not total. Consequently, the justification for effectively excusing the defendant in *Dunnage* is much less compelling than it was in *Mansfield*. The distinction between the two cases therefore derives from the very different *capacities* that the defendants exhibited; while the defendant in *Mansfield* was no longer physically capable of acting, the defendant in *Dunnage* certainly was. The proponents of the insanity defence argue that a mentally ill defendant's perceived incapacity should excuse him from liability, leaving the injured claimant without a remedy.⁵⁹ Yet 'capacity' is an uncertain conceptual basis on which to justify such excusal. It is to this issue that we now turn.

4. The Trouble with Capacity

There are four reasons why capacity is no basis on which to displace negligence's corrective presumption in cases involving

mentally-disordered defendants: (a) the mental element problem, (b) the definition problem, (c) the problem with reasoning from analogy and (d) the evidential burden problem. This section will demonstrate that 'capacity' offers little conceptual solidity to the insanity defence, rendering it implausible and unworkable for the purposes of negligence. There are many arguments against the insanity defence.⁶⁰ While this paper joins that sceptical chorus, what follows is a compelling conceptual basis on which to challenge the case for an insanity defence.

(a) *The Mental Element Problem*

In criminal law, establishing that the accused possessed the requisite *mens rea* is an essential ingredient of liability.⁶¹ If a jury is not sure that the accused had the relevant 'guilty mind' at the material time, then it must acquit him. In negligence, by contrast, it has long been recognised that 'negligence is conduct, not a state of mind'.⁶² A claimant therefore does not have to prove that the defendant possessed a 'negligent *mens rea*' in order to win damages.⁶³ It follows a fortiori that the defendant's *mental capacity* is not germane to his liability. As Goudkamp correctly states, 'sanity on the part of the defendant is not a component of any tort'.⁶⁴ References to mental capacity in negligence are therefore instantly problematic: in most cases, the defendant's mental capacity is entirely incidental.

It is important not to overstate this point. First, torts such as trespass *do* feature a mental element. Where they are concerned, we may be on safer ground when invoking 'mental capacity'.⁶⁵ Mental elements that must be satisfied as a prerequisite for liability are therefore not alien to tort law. It is conceivable that the courts *could* imply a 'negligent *mens rea*' into the duty of care in order to get around this mental element problem and do justice to mentally ill defendants. Yet this would seem an inelegant solution in which the tail of the insanity problem would wag the dog of tort doctrine. We will see in

Section 5 that the normative case for an insanity defence is weaker than some of its proponents suggest and therefore such reinvention of the doctrinal wheel is probably unnecessary. Secondly, the absence of a 'mental element' does not strip the goings-on in a defendant's mind of their *explanatory* potential. So, while the tort of negligence lacks a structural mental element, the defendant's state of mind may explain *why* she behaved the way she did. In any event, this is merely incidental: it is not necessary for a claimant to prove the defendant's mental state as part of his negligence claim.

(b) *The Definition Problem*

Defining 'capacity' as a concept in negligence is likely to be a quixotic endeavour. Oliver Wendell Holmes said that the common law 'presumes or requires a man to possess ordinary capacity to avoid harming his neighbours, unless a clear and manifest incapacity be shown'.⁶⁶ He therefore saw capacity as a fundamental ingredient of liability. In the criminal law context, Hart took a similar view, arguing that there is *more than one type* of capacity; that is, the capacity to understand, to reason and to control one's conduct.⁶⁷ Hart further argued that these capacities may be 'diminished', 'impaired' or 'altogether absent', implying that 'capacity' is also a *divisible* concept.⁶⁸ Moore and Hurd make a similar point by distinguishing a person's capacity to do something 'over some stretch of time' from his 'ability to do that thing on some particular occasion'.⁶⁹ Elsewhere, Cane has written that possessing a minimum standard of capacity is a 'precondition' of legal liability.⁷⁰ Where a person cannot satisfy that minimum standard, the moral and legal basis for liability presumably evaporates. An assertion of incapacity therefore entails an implicit claim that the relevant person is 'unfit to be held legally accountable ... for her actions'.⁷¹ Yet Cane argues that the threshold for capacity in tort law is low.⁷² Moreover, a person's *moral*

agency is contingent on it.⁷³ Cane refers to the 'traditional humanistic approach' to argue that only human beings can have moral personhood.⁷⁴ It is human beings' capacity for 'purposive' action that justifies the law's imposition of moral responsibility on them.⁷⁵ Beaver would almost certainly endorse this interpretation: he sees a person's ability to manifest his 'will in action' as the cornerstone of liability.⁷⁶ Capacity is therefore a core component of being human. To say that a person *lacks* capacity implicitly casts doubt on his moral personhood.

This creates two intractable problems for the insanity defence. First, if the threshold for 'capacity' is low, something *particularly* incapacitating is required before a defendant will lack capacity. It may be safe to assume, for example, that those who are asleep, in a coma or manifesting unresponsive wakefulness syndrome will fall below the threshold because they are, at least temporarily, physically incapable of purposive action. By contrast, it is in no way obvious that mental disorders such as clinical depression, schizophrenia, bipolar disorder and so on render those who suffer from them incapable of purposive action. Moreover, the link between 'capacity' and 'moral personhood' carries unfortunate connotations. If mentally ill defendants are deemed to lack capacity in tort, this implies that they may also lack moral personhood. They are, in other words, *morally irresponsible by definition*. Conclusions such as this are inherently tricky in an era concerned about the stigmatisation of mental illness. Secondly, if there is no single concept of 'capacity', then any reference to it in the abstract borders on meaningless. References to 'capacity' may relate to a person's understanding, reasoning, decision-making ability and so on. Any or all of these or none at all could be relevant to the conduct in question.

This all casts doubt on there being a natural meaning of 'capacity' with which we might frame an insanity defence. Is it possible to select one? First, at its most basic, we

might interpret 'capacity' as a synonym for 'ability'; that is, the *physical* ability to commit negligence. On this interpretation, anyone who is not physically *able* to commit negligence might escape liability for it. The problem is that anyone who is *physically able to act* is able to commit negligence. Such a generous interpretation would mean that even children have full capacity to commit negligence and should therefore be judged by the objective standard.⁷⁷ While this definition would exclude people who are unable to act, such as those who are asleep, in a coma or in minimally-conscious states, most people with mental disorders will retain the physical capacity for carelessness. It therefore offers no help to the insane: there is nothing to suggest that mental illness inevitably has a bearing on a person's physical ability to commit negligence. It *might* apply to the mentally ill if it can be said that a defendant's insanity had a physically-disabling effect, but such a manifestation would seem unlikely.

Another way to define 'capacity' might be to interpret it as 'capacity for fault'. Here, much depends on how one defines 'fault'. There is, of course, an obvious circularity in defining 'capacity' as the 'capacity for fault'. In any case, as we have seen, liability in negligence may flow from 'fault in the doing' as well as, or separately from, 'fault in the doer'. If 'fault' means 'fault in the doing', then A's driving the wrong way down a dual carriage-way can be faulty conduct irrespective of her mental health. A therefore had 'capacity for fault' because she was physically able to steer her car the wrong way along a road. Once again, anyone who is capable of purposive action would likely be deemed to have 'capacity for fault', and therefore this definition is unhelpful.

A third way to define 'capacity' is to understand it to mean 'capacity to realise (or foresee) risk'. According to Ague, a 'lunatic' should not be responsible in negligence where he lacks the capacity 'to realise the risk of injury to another person which his act may involve'.⁷⁸ Goudkamp and Ihuoma echo

this sentiment in their contention that persons who are ‘sufficiently’ mentally disordered lack the ability to ‘weigh up pros and cons of given courses of conduct’.⁷⁹ It is true that the capacity to realise risk is undoubtedly an implicit trait of the ‘reasonable man’.⁸⁰ Yet this definition is also unsatisfactory.

In the Canadian case *Attorney-General of Canada v Connolly*,⁸¹ the defendant had driven off whilst the plaintiff’s arm was caught in his car window. The plaintiff sued the defendant in negligence. According to expert evidence, the defendant had a history of mental illness and probably could not have foreseen the harm that resulted from his deliberate actions. Paris J said that persons with severe mental illnesses ‘have their capacity for ... foresight severely impaired’. Consequently, if a defendant is not capable of foreseeing that his act involves a ‘significant risk of harm’, then one can say that ‘there was not sufficient awareness or consciousness of the nature of his act to make it a true voluntarily negligent act’.⁸² The problem here is that to require a defendant to realise the risks involved in his actions implies that there is something that resembles a *mens rea* in negligence. This would constitute a radical departure from established doctrine in that it would require an examination of a defendant’s subjective state of mind.

The interpretation of ‘capacity’ as ‘capacity to act differently’ has enjoyed scholarly and judicial support. Korrell incorporated this interpretation into his ‘test’ for excusing an insane person’s liability in tort law.⁸³ Perry also claimed that a person’s capacity ‘to avoid the result ... is what gives rise to moral responsibility for harm’.⁸⁴ Horder has argued that the ability (even if unexercised) to evaluate one’s conduct against one’s moral character gives capacity its full meaning.⁸⁵ Honoré also placed the notion of the capacity ‘to act otherwise’ at the heart of his general theory of outcome responsibility. He said that the ‘capacity to act otherwise’ referred to a ‘general ability to perform the sort of action that would in the instant case have led to a different outcome’.⁸⁶

In *Corr v IBC Vehicles Ltd*,⁸⁷ the deceased had suffered a serious head injury whilst working for the defendant-employer in 1996. He had had no history of mental illness but shortly after the accident he began to suffer from post-traumatic stress disorder. In May 2002, the deceased was diagnosed with severe anxiety and depression and subsequently killed himself. The claimant, the deceased’s wife, brought a claim against the defendant-employer, who pleaded that the deceased had been guilty of contributory negligence. The House of Lords held that the deceased’s mental illness had been a direct and foreseeable consequence of the defendant’s negligence and that his suicide had been a deliberate and conscious act. The defendant was therefore liable for the deceased’s death. According to Lord Bingham, the deceased had been suffering from a disabling mental illness ‘which impaired his capacity to make reasoned and informed judgments about his future’.⁸⁸ In other words, the deceased had lost the capacity to act differently.

Framing ‘capacity’ as ‘capacity to act differently (or otherwise)’ is imperfect. It requires the court to evaluate counterfactual questions that are difficult to answer.⁸⁹ Since two people can suffer from the same mental disorder and yet manifest different symptoms, it may be difficult to prove, even using medical evidence, that a person’s insanity has suspended her capacity to act differently. Determining whether a person had capacity to act otherwise would therefore require guesswork. In any case, it would require the court to consider the *subjective* state of mind of the defendant, thereby departing from the objective standard around which negligence is organised. Furthermore, to say that a person lacks the capacity to act differently is to imply that a person’s mental illness somehow rendered the injury inevitable or unavoidable. This would seem a very high threshold to meet, reducing any insanity defence to a residual role.

Another possible definition of ‘capacity’ says that a person has capacity when he

'understands and appreciates' the duty of care. This formulation has found favour in Canada and in the United States. In *Buckley v Smith Transport Ltd*,⁹⁰ the defendant's employee lost control of a tractor and crashed into a streetcar. The defendant claimed that its employee had suddenly and without warning become insane and was labouring under the delusion that his vehicle was being operated remotely. According to medical evidence, the defendant's employee had syphilis of the brain. In the Ontario Court of Appeal, Roach JA said that where 'understanding and appreciation exist in the mind of the individual ... he is liable for the breach of that duty'.⁹¹ The Court of Appeal of Alberta refined this test in *Fiala v MacDonald*.⁹² Here, Wittman J said that a defendant will be relieved of tort liability when he is 'afflicted suddenly and without warning with a mental illness' that leaves him with 'no capacity to understand or appreciate the duty of care owed at the relevant time'.⁹³ The Supreme Court of Wisconsin ruled along the same lines in *Breunig v American Family Insurance Co*.⁹⁴ In this case, the plaintiff had crashed her car. Immediately prior to the collision, she had experienced a series of delusions: she believed that God had taken control of her car and that the vehicle could fly. The defendant insurance company argued that the plaintiff had not been negligent because she had had no knowledge or warning that she might be subject to delusions that would cause her to lose control of her car. Hallows CJ said that to excuse the defendant from liability, the mental illness 'must be such as to affect the person's ability to understand and appreciate the duty which rests upon him'.⁹⁵ This 'understand and appreciate' test is a curious contrivance because the courts have invoked it in cases in which a defendant has suddenly and without warning exhibited symptoms of mental illness. In this way, the test might be construed as the North American equivalent of *Mansfield*. Moreover, whether a defendant understands and appreciates his duty of care is

immaterial.⁹⁶ The notion that a person's *capacity* to do so should matter at all is therefore quite incongruous.

In a paper ahead of its time, Curran correctly stated that most 'capacity' tests would find even a 'manic psychotic person' capable of committing all varieties of torts. To overcome this problem, he suggested that a person's 'capacity to commit' should rest on a 'control' or 'irresistible impulse' test.⁹⁷ Cane also links a person's 'basic control' to his 'capacity'.⁹⁸ Mindful of Cane's view that most people capable of purposive action have capacity, we might infer that the threshold for discharging a 'control' test is rather high. It is also difficult to imagine circumstances outside of *Mansfield*-style sudden incapacitation in which 'loss of control' or 'irresistible impulse' would be applicable.

What becomes clear is that 'capacity' is afflicted by a crippling lack of certainty. For those who construct the case for an insanity defence using the concept, this poses a significant problem. It is difficult (if not impossible) to select a definition of 'capacity' that will be clear, certain and achieve the relevant objectives; that is, provide a basis for excusing the mentally ill from liability that does not undermine the corrective function of the tort of negligence.

(c) *The Reasoning from Analogy Problem*

According to Korrell, 'courts regularly determine a party's capacity to understand and approve the terms of a contract or a will, manage financial affairs and make medical treatment decisions'.⁹⁹ Why, he asks, can we not simply reason from analogy and interpret 'capacity' in tort law in the same way?

Korrell's is a false analogy. The capacity that a person must possess in order to enter a contractual relationship, consent to medical treatment, dispose of her finances and so on differs from the 'capacity' that might preface liability in negligence. Korrell's examples require a particular *relational* decision-making capacity of the sort that characterises and

underpins bilateral relationships. We have already seen that section 3(1) of the MCA makes a person's decision-making capacity contingent on his ability to understand the information relevant to the decision, retain it, use or weigh it and communicate his decision. Decision-making capacity therefore functions according to a reciprocal dynamic. It is principally concerned with the *communication* of one party's decision taken in respect of information that another party has conveyed to him. The ingredients of decision-making capacity that appear in the MCA do not map onto the structural features of negligence. For example, A suffers from schizophrenia and experiences persecutory delusions. He wrongly believes that he is the victim of a conspiracy and decides to flee in his car. He drives at speed, fails to stop at a traffic signal and eventually crashes into B. B suffers personal injury and sues A in negligence. Let us imagine that A says that his mental illness meant that he lacked capacity and that the test for incapacity that the court will use is that which appears in the MCA.¹⁰⁰ To what extent are the criteria under section 3(1) helpful? First, there is the obvious point that there is nothing in this example that suggests that A was *unable to make a decision for himself*, or that this is in any way relevant to his liability in negligence. Admittedly, his interpretation of his situation was wrong, but it does not necessarily follow that his *ability to make decisions* was in any way impaired. Secondly, it is not at all clear what constitutes the relevant 'information' that A needed to have understood, retained, used and weighed. There is no 'information' here that is even remotely analogous to the sort of information that a patient considering whether to consent to medical treatment will possess, for example. Thirdly, what constitutes 'understanding' in this context? *Misunderstanding* one's situation is not necessarily the same thing as being *unable* to understand it. Finally, there was no 'communication' here. We might say that A's driving his car was a form of communication; if so, then A was able to

'communicate' his decision through his actions. In any case, it is doubtful whether negligence occasioning personal injury requires anything that even closely resembles communication. For these reasons, the section 3(1) criteria are of little use in A's case; he probably still had decision-making capacity for the purposes of the MCA.¹⁰¹ Most mentally ill defendants are likely to retain their *decision-making capacity*; predicating an insanity defence on 'incapacity' for the purposes of the MCA is therefore pointless. The closest tort law gets to the decision-making dynamic reflected in the 2005 Act – and implied by Korrell's examples – is in relation to economic loss occasioned by negligent misstatement.¹⁰² The heightened degree of proximity required in this context arguably fits the criteria in the 2005 Act. In these circumstances, however, it seems more likely that it would be the *claimant's* mental health at issue, not the defendant's.

This raises a deeper conceptual problem: 'insanity' is not the same thing as 'incapacity'.¹⁰³ The notion of the 'permanently insane of yesteryear' is obsolete: the label 'mental disorder' applies to a range of conditions like dementia, depression and bipolar disorder, not all of which have a bearing on a person's decision-making capacity.¹⁰⁴ A person's mental health may fluctuate, meaning that old-fashioned binary constructions no longer apply. Furthermore, the MCA Code of Practice says that a person's ability to make decisions may be affected by 'temporary factors', such as acute illness, severe pain and shock.¹⁰⁵ Splane rightly stresses that the mentally ill are not *by definition* incapable of conforming to the standard of the reasonable person.¹⁰⁶ The link between mental illness and incapacity therefore lacks a clinical or legal basis. Although there may be a correlation between mental disorder and incapacity for the purposes of the MCA, it is not true that the link is a causal one. Lord Bingham explicitly recognised this in *Corr*. His Lordship pointed out that the deceased had had 'the capacity to manage his

own affairs' *despite* having 'a disabling mental condition'.¹⁰⁷ A person can therefore have a serious mental disorder and yet still retain his decision-making capacity.¹⁰⁸ Logically, if insanity and incapacity do not necessarily go hand-in-hand, it follows that anyone else who lacks the capacity to commit negligence should also have the benefit of a defence, *even if that incapacity is in no way related to a mental illness*. If this follows, then English tort law surely warrants a defence of *incapacity* rather than insanity. If this does not follow, then the onus is on the proponents of the insanity defence to explain what it is about mental disorder that warrants special treatment. It is doubtful whether any principled basis for such a distinction exists; there is no magic in the 'insanity' label per se. A defendant who injures a claimant whilst in the throes of a high fever that has caused her to hallucinate might claim that she lacked capacity and should be excused liability too. So might a defendant who was intoxicated at the time of committing negligence. It is true that intoxication is typically voluntary; mental illnesses are not. Yet a distinction based on voluntariness is rickety. What about the long-term cannabis user who now suffers from mental health problems? Or the person who has abused alcohol for years and has developed Korsakoff's syndrome?¹⁰⁹ Or the man who has voluntarily put himself under inordinate strain and suffered a nervous breakdown? The proponents of the insanity defence say nothing about such non-insane incapacities.¹¹⁰ Hart wrote that it was likely that 'exemption by medical category rather than by individualised findings of absent or diminished capacity will be more likely to lead in practice to satisfactory results'.¹¹¹ It is difficult to see how that could possibly be true. The present author shares Hardisty's scepticism about the use of insanity as the basis on which legal responses to incapacities must turn. He wrote that 'if a person does not have the ability to understand what he is doing, it does not serve any obvious legal purpose to make his legal position turn on

whether "mental illness" caused the incapacity'.¹¹² Although he was not writing about English tort law, there is no reason why his analysis cannot be applied for present purposes. This is not to say that incapacity *should* be a defence in negligence; the difficulties of defining 'capacity' even then would pose intractable problems. Rather, it is to say that it would seem to be a more *principled* approach to excuse a person from liability in negligence because he lacked 'capacity' in some way or other; limiting the ambit of the defence to insanity alone lacks any apparent justification.

(d) *The Evidential Burden Problem*

Goudkamp says that an argument against the insanity defence that claims that evidence of mental illness is 'unsatisfactory' is 'totally without merit'.¹¹³ He points out that 'evidence of insanity' is 'relevant to various other issues inside tort law and in numerous other legal contexts'; why then should it pose a unique challenge to the insanity defence?¹¹⁴ Alas, the situation is not as straightforward as Goudkamp implies. It is true that there is no reason why a defendant in a negligence case could not rely on the same sort of expert evidence from a psychiatrist which the courts will accept elsewhere to prove that he was suffering from, say, schizophrenia at the material time. Yet establishing the extent to which a defendant's insanity has *affected his capacity to commit negligence* is a distinct and altogether more challenging inquiry. Unless the insanity defence follows the *diagnosis* of mental illness rather than its alleged *incapacitating effects*, then arguments concerning evidential difficulties are more meritorious than Goudkamp suggests.

First, capacity thresholds are likely to shift depending on the claim in question. This means that the evidential burden required to establish a defendant's incapacity in, say, a personal injury case is likely to be more exacting than it would be in an economic loss case. For example, if A has a mental disorder

that prevents him making coherent representations to B, then it might be easy to adduce evidence that he did not have the capacity to commit a negligent misstatement. It may be much harder to prove that A's mental disorder vitiated his capacity carelessly to cause personal injury to B. Although such varying standards occur in criminal law, 'capacity' seems a less problematic construct where mental elements form core ingredients of liability. Secondly, to what extent must a defendant's insanity affect his capacity? A person's capacity can be merely impaired, or it may be totally absent. There is also the added complication of 'fluctuating' capacity. These different thresholds pose profound evidential challenges. In *Dunnage*, Vos LJ distinguished capacity that is merely impaired from total incapacity. That the courts are prepared to treat mental capacity as a *divisible* concept in this way when it lacks a definition to begin with further diminishes its utility. It is difficult to know whether a person is totally mentally incapacitated for the purposes of determining his liability in negligence when one cannot state with any certainty what 'mental capacity' means in the first place.

In light of the foregoing, it is clear that 'capacity' does not provide a compelling conceptual justification for displacing the corrective function of negligence where 'insane' defendants are concerned. As a matter of principle, considerations of a defendant's mental capacity are alien to the tort of negligence. The duty of care does not comprise a structural mental element and therefore any pleadings submitted on the basis that the defendant's capacity was in some way impaired would raise issues that are ordinarily immaterial. Even if it were possible to overcome the problems of principle, 'capacity' raises a number of practical challenges. It is undefined, poses evidential challenges, and has an uncertain relationship with 'insanity'. These problems of principle and practice mean that capacity fails as a framework concept and provides weak foundations

on which to frame the case for the insanity defence.

5. Recalibrating the Normative Problem

The 'insanity problem' that the proponents of the defence seek to solve may be overblown. There are three reasons for this. First, a defendant who falls into *Mansfield*-style circumstances should not be in breach of his duty of care to the claimant where his mental disorder suddenly and without warning *totally incapacitated him from performing a voluntary act*. For example, if a defendant suddenly and unexpectedly succumbs to a totally incapacitating undiagnosed mental disorder whilst driving his car and crashes into a pedestrian, the fact that he was no longer acting voluntarily should excuse him from liability. Although these circumstances still necessarily require some reference to 'capacity', it is likely to be much easier to establish what the *immediate* consequences of a particular mental disorder were for a person totally blindsided by it. As *Mansfield* demonstrates, sudden and unexpected physical incapacitation provides an objectively-justifiable basis on which to displace negligence's corrective mechanism. There is no reason why this same displacement should not occur where a defendant could not reasonably have foreseen the risk of sudden 'insanity'. Consequently, the spurious distinction between physical and mental disorders that separates the Court of Appeal's decisions in *Mansfield* and *Dunnage* should collapse. There is no need, therefore, for a standalone insanity defence where a minor adjustment to an existing principle would achieve the same result.

It is true that there are problems with this approach. Sudden and unforeseeable *physical* incapacity is easy to identify. For example, medical evidence can show that a defendant has had a heart attack or stroke. By contrast, it may be much harder to establish sudden and unforeseeable total *mental* incapacity. Furthermore, sudden and unforeseeable

incapacitation of any variety is rare. There is scope therefore for disagreement (and litigation) about whether there was sudden and unforeseeable mental incapacity and whether the degree of that incapacity was sufficient to breach a duty of care or not. However, a defendant who is suddenly and unforeseeably incapacitated by a mental illness should be treated as a matter of principle in the same way as one who is suddenly and unforeseeably incapacitated by a physical illness. To hold otherwise requires one to maintain a distinction between physical and mental disorders, for which there is no justification. In any case, this extension of *Mansfield* to cover mentally-disordered defendants would not, quite rightly, have availed the defendant in *Dunnage*, who, as we have seen, was not totally incapacitated.

Second, we must consider the case of defendants who know, or ought reasonably to know, that they are suffering from a mental illness. Such defendants will know, or ought reasonably to know, that their ability to comport with the standard of the reasonable person *may* be impaired in some way. It is submitted that the courts should continue to measure the conduct of these defendants against the yardstick of the objective standard of care. There is nothing about mental illnesses per se that renders those suffering from them incapable of discharging the standard of care. In any event, it would flout the very purpose of the tort of negligence if defendants who know that their ability to comply with the reasonable standard of care is impaired can nevertheless escape liability for the injury, loss or damage that follows from their decision to proceed with the relevant activity regardless. In the same way that the law would not excuse a defendant from liability who, for example, knows that the medication he is taking may adversely affect his ability to drive and yet still gets behind the wheel of a car and runs over a pedestrian, mental illness should not offer an occasion on which to excuse unreasonable behaviour. Even where a defendant has not been

formally diagnosed with a mental disorder, he may be aware of symptoms which would prompt a reasonable person to reconsider taking any risks.

Although at first blush this argument may seem harsh on mentally-disordered defendants, it is important to set the tort of negligence in context. The Mental Health Act (MHA) 1983 provides the legal basis for the compulsory admission to hospital of people suffering from mental disorders of the requisite nature or degree.¹¹⁵ Those committed under the Act's compulsory powers can be detained in hospital for a relevant period for assessment or treatment. Importantly, *risk* is the fulcrum on which the Act's compulsory powers turn: a person with a mental disorder can only be detained under the MHA *when he poses a risk to his health or safety or to other people*.¹¹⁶ Landes and Posner were the first to link the objective standard of care in negligence and civil commitment. They argued that because people 'whose insanity is severe enough to affect their ability to avoid physical injury to themselves and others are generally kept under restraint', one can assume that anyone *not* subject to such compulsion can exercise reasonable care.¹¹⁷ Writing from a United States perspective, Goldstein argued that Landes and Posner had wrongly assumed that 'mere proclivity to commit torts' was enough to justify civil commitment.¹¹⁸ This is because the civil commitment legislation in many places employs a 'dangerousness' standard that sets the bar for compulsory admission too high to be effective in the way that Landes and Posner suggested.¹¹⁹ Goldstein therefore thought that their argument was unconvincing. In England, however, a person with a mental disorder need not be 'dangerous' before he can be compulsorily admitted.¹²⁰ The MHA's 'risk formula' comprises a broader formulation than 'dangerousness' and therefore extends the remit of the compulsory powers to include the very same risks that might be relevant to the tort of negligence. A person who is diagnosed with a mental disorder severe enough

to render him unable reasonably to avoid the risk of injury to other people falls within the remit of the compulsory powers. By implication, if that person's clinical team decides *not* to deprive him of his liberty, then we can infer that he is capable of functioning in accordance with the reasonable person standard.¹²¹ Other legal mechanisms exist in the same conceptual space that the insanity defence would occupy, thereby rendering the case for one in respect of negligence redundant. People diagnosed with mental disorders serious enough to pose a risk of harm will be subject to the MHA's compulsory powers and therefore incapable of committing torts. Those who, like Mr Randall, have carelessly injured someone but have not been diagnosed with a mental disorder should not enjoy a defence because there is no conceptual basis on which to excuse their tortious conduct. Others who have been diagnosed with mental disorders will know, or ought to know, that their disorders may have a bearing on their behaviour and should modify their actions accordingly. To afford such people a defence would run counter to the very essence of the tort of negligence.

Third, we must consider the relevance of the Convention on the Rights of Persons with Disabilities (CRPD), which the UK ratified in 2009. The purpose of the CRPD is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities', including those with long-term mental, intellectual or sensory impairments.¹²² Article 4 subjects all States Parties to a general obligation to 'take all appropriate measures ... to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities'.¹²³ According to Peter Bartlett, the CRPD adopted a 'bold new vision' in which 'non-discrimination is a core value',¹²⁴ a fact evident under article 5(2), for example, which prohibits all discrimination on the basis of disability. Yet Bartlett also acknowledges that the Convention's effect on English law

could be 'profound', not least because it would appear to require the abolition of laws whose operation relies in whole or in part on mental disability.¹²⁵ Amongst other things, this raises a question about the compatibility of the insanity defence in criminal law with the CRPD. Bartlett points out that this issue arises from article 12, which requires States Parties to recognise that persons with disabilities are equal before the law.¹²⁶ Although it makes no explicit reference to the insanity defence, Bartlett cites the UN High Commissioner for Human Rights, who stated that article 12 requires that defences 'based on the negation of criminal responsibility because of the existence of a mental or intellectual disability' be abolished.¹²⁷ Neither the CRPD nor the High Commissioner refers to the insanity defence as it might pertain in civil law. It is, however, reasonable to assume that any insanity defence that might excuse liability in negligence would similarly contravene the spirit, if not the letter, of the CRPD. Any defence that might excuse a mentally-disordered defendant from liability in negligence would necessarily depend on concepts such as disability or incapacity in order to operate. It would therefore embed in the common law a discriminatory mechanism that violates the CRPD, thereby bringing the United Kingdom into conflict with its obligations under international law. More by accident than design, the standard of care in the English tort of negligence complies with the CRPD because it measures all defendants against the same (disability-neutral) objective standard. Arguments in favour of a standalone defence of insanity (or a modified standard of care) in negligence pull in the opposite direction from these prevailing policy trends.

It is difficult to escape the conclusion that the normative case for the introduction of an insanity defence that would excuse a mentally ill defendant from liability in negligence is unpersuasive. A minor modification to tort doctrine would achieve a more rational body of rules with 'parity of esteem' between physical and mental disorders. Beyond that, the

‘problem’ which some scholars have used to justify the case for a defence of insanity in tort law is overstated.

6. Conclusions

In English law, a defendant with a mental disorder who carelessly injures another person cannot use his or her mental illness as an excuse for negligence. The absence of any defence of insanity may be explicable by corrective justice theory, which presumes that where A carelessly injures B, A should compensate him. The objective standard of care facilitates this corrective function by rendering the defendant’s subjective state of mind immaterial to the negligence enquiry. In *Dunage*, the Court of Appeal confirmed that English law will not excuse a defendant from liability in negligence because of a mental health problem; all that matters is whether he or she acted reasonably or not. Yet it is possible to displace the corrective function of negligence. In *Mansfield*, for example, the fact that the defendant was not aware he had a physical disorder that totally incapacitated him provided a basis to excuse him from liability. This article has explored whether ‘insanity’ should provide another basis on which to displace the corrective function of negligence. It has concluded that it should not.

The case for the introduction of an insanity defence rests on mental capacity. It is the impaired capacity that mental illnesses may occasion that the proponents of the insanity defence argue warrants the displacement of negligence’s corrective function. This paper has shown that ‘mental capacity’ fails as a framework concept for reasons of principle and practice. The tort of negligence does not require a defendant to have *mental* capacity as a prerequisite of liability. To frame a defence using a concept that does not underpin the duty of care produces a doctrinal mismatch. In practical terms, ‘capacity’ is poorly defined, raises considerations alien to the negligence enquiry, and is beset by evidential

challenges. References to it in relation to mental disorders imply that insanity and (in) capacity are two sides of the same coin. They are not. Therefore, if the argument is that defendants who lack capacity should be excused liability, then why should reform only go as far as ‘insanity’? An insanity defence framed using the concept of mental capacity would have unintended consequences: at best, it would play such a marginal role as to be virtually pointless; at worst, it would systematically produce injustice for injured claimants. The conceptual foundations of, and normative justifications for, the insanity defence are therefore so weak that it is implausible and unworkable. The English tort of negligence is better off without it.

Notes

1. The author reluctantly employs ‘insanity’ for the sake of expediency. Readers should interpret references to ‘mental disorder’ in accordance with the definition given by the Mental Health Act 1983 (UK), s 1(2); that is, ‘any disorder or disability of the mind’.
2. The author adopts Duarte d’Almeida’s definition of ‘defence’ in this article: ‘Defence’ refers to considerations that are ‘merits-relative [and] liability-defeating’ and that place a burden of proof on the defendant. L Duarte d’Almeida, ‘Defining Defences’ in A Dyson et al (eds), *Defences in Tort* (Hart, Oxford 2015) 50.
3. *Weaver v Ward* (1616) Hobart 134.
4. *Re Farnham (A Lunatic)* [1895] 2 Ch 799; *Morriss v Marsden* [1952] 1 All ER 925 (QB); *Williams v Williams* [1964] AC 698 (HL).
5. [2015] EWCA Civ 673.
6. *M’Naghten’s Case* (1843) 10 C&F 200 (HL).
7. Eg, WB Hornblower, ‘Insanity and the Law of Negligence’ (1905) 5 Columbia L Rev 278; WGH Cook, ‘Mental Deficiency in Relation to Tort’ (1921) 21 Columbia L Rev 333; J Goudkamp, ‘Insanity as a Tort Defence’ (2011) 31(4) OJLS 727; N Bromberger, ‘Negligence and Inherent Unreasonableness’ (2010) 32 Sydney L Rev 411.
8. Eg, DE Seidelson, ‘Reasonable Expectations and Subjective Standards in

- Negligence Law: The Minor, the Mentally Impaired, and the Mentally Incompetent' (1981) 50 Geo Wash L Rev 17; SL Splane, 'Tort Liability of the Mentally Ill in Negligence Actions' (1983) 93 Yale LJ 153; P Kelley, 'Infancy, Insanity and Infirmary in the Law of Torts' (2003) 40 Am J Juris 179.
9. P Cane, 'Mens Rea in Tort Law' (2000) 20 (4) OJLS 533, 536.
10. Eg, trespass requires proof of intention (*Fagan v Metropolitan Police Commissioner* [1969] 1 QB 439; *Williams v Humphrey*, The Times, 20 February 1975; *Collins v Wilcock* [1984] 1 WLR 1172 (QB)), deceit requires fraud (*Derry v Peek* (1889) 14 App Cas 337 (HL)), and malicious prosecution requires evidence of the defendant's improper motive (*Stevens v Midland Counties Railway* (1854) 10 Ex 352. See also *Clarke v Molyneux* [1877] 3 QBD 247; *Christie v Davey* [1893] 1 Ch D 316; *Hollywood Silver Fox Farm Ltd v Emmett* [1936] 2 KB 468)).
11. Eg, product liability (Consumer Protection Act 1987), the rule in *Rylands v Fletcher* (1868) LR 3 HL 330, and private nuisance cases (*Rapier v London Tramways Co* [1893] 2 Ch 588 (CA); cf *Cambridge Water Co v Eastern Counties Leather PLC* [1994] 2 AC 264 (HL)) are all species of strict liability wherein the defendant's mental capacity has no bearing on his liability.
12. Cane, 'Mens Rea' (n 9) 553.
13. [1998] 1 WLR 1263 (CA).
14. UN General Assembly, *Convention on the Rights of Persons with Disabilities: Resolution / Adopted by the General Assembly*, 24 January 2007, A/RES/61/106.
15. 'insanity, n.'. OED Online, OUP September 2016 <<http://www.oed.com/view/Entry/96612?redirectedFrom=insanity>> accessed 22 September 2016. More recently, 'insanity' has evolved also to refer to 'extreme folly or want of sound sense', or an instance thereof.
16. Eg, MIND, *Understanding Mental Health Problems*, London 2016. <<https://www.mind.org.uk/media/3244655/understanding-mental-health-problems-2016.pdf>> accessed 22 September 2016. See also Rethink Mental Illness, 'Conditions' <<https://www.rethink.org/diagnosis-treatment/conditions>> accessed 22 September 2016.
17. MHA 1983, s 1(2).
18. *M'Naghten's Case* (n 6) 210 (Tindal CJ).
19. Trial of Lunatics Act 1883, s 2; Criminal Procedure (Insanity) Act 1964, s 1.
20. WB Hornblower, 'Insanity and the Law of Negligence' (1905) 5 Columbia L Rev 278, 283. Hornblower referred to *Williams v Hays* 143 NY 442, 1894 in which the Court of Appeals of the State of New York held that insanity is no defence to negligence. In that case, Earl J referred to 'capacity' and affirmed at [454] that the 'standard man' is an 'abstract or ideal man of ordinary mental and physical capacity and ordinary prudence'.
21. JB Ames, 'Law and Morals' (1908) 22 Harvard L Rev 97, 99–100.
22. WGH Cook, 'Mental Deficiency in Relation to Tort' (1921) 21 Columbia L Rev 333, 344.
23. FH Bohlen, 'Liability in Tort of Infants and Insane Persons' (1924) 23 Michigan L Rev 9, 28, 31–33.
24. RM Ague, 'The Liability of Insane Persons in Tort Actions' (1955–56) 60 Dickinson L Rev 211, 221.
25. N Bromberger, 'Negligence and Inherent Unreasonableness' (2010) 32 Sydney L Rev 411, 435. Bromberger suggests elsewhere that the law's differential treatment of mentally-disordered defendants is a form of discrimination which is structurally embedded in the law: N Bromberger, 'Capacity and the Law of Negligence: Ignorance and Prejudice Guiding the Way' (published paper from the 62nd Annual Conference of the Australian Law Teachers' Association (ALTA) 2007) 16–17, 21.
26. Goudkamp (n 7) 751.
27. Goudkamp (n 7) 751.
28. Goudkamp (n 7) 752.
29. See also An Coimisiún Um Athchoiriú An Dlí, 'Report on the Liability in Tort of Mentally Disabled Persons' LRC 18, 1985.
30. See also HJF Korrell, 'The Liability of Mentally Disabled Tort Defendants' (1995) 19 L & Psych Rev 1; OC Dark, 'Tort Liability and the "Unquiet Mind": A Proposal to Incorporate Mental Disabilities Into the Standard of Care' (2004) 30 T Marshall L Rev 169.
31. The courts have long recognised that a person can suffer from a mental disorder and yet retain decision-making capacity: eg, *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290; *St George's Healthcare NHS Trust v S* [1999]; Fam 26; *R (on the application of B) v S* [2006] EWCA Civ 28; *Re MM (An Adult)* [2007] EWHC 2003 (Fam); *Re C* [2009] UKHL 42; *Heart of England NHS*

- Foundation Trust v JB* [2014] EWHC 342 (COP).
32. MCA 2005, s 3(1).
33. For an excellent discussion of this topic, see J Goudkamp and J Murphy, 'The Failure of Universal Theories of Tort Law' (2016) 22 LT 1.
34. DG Owen, 'Philosophical Foundations of Fault in Tort Law' in DG Owen (ed), *Philosophical Foundations of Tort Law* (Clarendon Press, Oxford 1995) 201.
35. *Waugh v James K Allan Ltd* 1964 SC (HL) 102; *Jones v Dennison* [1971] RTR 174 (CA); *Snelling v Whitehead* [1998] RTR 385 (HL).
36. S Waddams, *Dimensions of Private Law: Categories and Concepts of Anglo-American Legal Reasoning* (CUP, Cambridge 2003) 80.
37. Waddams (n 36). Eg, in *Nettleship v Weston* [1971] 2 QB 691 (CA), Lord Denning MR said (at [699]–[700]) that a learner driver who carelessly caused injury to another road user may have been doing her best, 'but her incompetent best is not good enough ... Morally the learner driver is not at fault; but legally she is liable'.
38. J Coleman, *Risks and Wrongs* (OUP, Oxford 1992) 219.
39. RW Wright, 'The Standard of Care in Negligence Law' in DG Owen (ed), *Philosophical Foundations of Tort Law* (Clarendon Press, Oxford 1995) 258.
40. This is not to say that tort law is amoral: there is undoubtedly a moral sentiment underlying the neighbour principle in *Donoghue v Stevenson* [1932] AC 562 (HL), 580 (Lord Atkin). See also *Smith New Court Securities Ltd v Citibank NA* [1997] AC 254 (HL), 280 (Lord Steyn).
41. JCP Goldberg, 'Tort Law's Missing Excuses' in A Dyson et al (eds), *Defences in Tort* (Hart, Oxford 2015) 58.
42. EJ Weinrib, *The Idea of Private Law* (OUP, Oxford 2013) 64, 74.
43. There would certainly be some dispute about this: eg, P Cane, 'Distributive Justice and Tort Law' (2001) 4 NZ L Rev 401; P Cane, 'Rights in Private Law' in D Nolan and A Robertson (eds), *Rights and Private Law* (Hart, Oxford 2012). On distributive justice, see *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455 (HL), 510–11 (Lord Hoffman); *McFarlane v Tayside Health Board* [2000] 2 AC 59 (HL), 82 (Lord Steyn).
44. Wright (n 39).
45. *Vaughan v Menlove* (1837) 3 Bing NC 486; *Blyth v Birmingham Waterworks Co* (1856) 11 Exch 781.
46. *Glasgow Corporation v Muir* [1943] AC 448 (HL); *Nettleship v Weston* [1971] 2 QB 691 (CA).
47. A Beever, *Rediscovering the Law of Negligence* (Hart, Oxford 2007) 96.
48. Courts elsewhere have explicitly measured insane defendants against the objective standard; eg, New York (*Williams v Hays* 143 NY 442, 1894; *Sforza v Green Bus Lines Inc* 268 NYS 446, 1934); Wisconsin (*Breunig v American Family Insurance Co* 173 NW 2d 619 (1970)); and Australia (*Adamson v Motor Vehicle Insurance Trust* (1957) 58 WALR 56; *Carrier v Bonham* [2002] 1 Qd R 474).
49. [2015] EWCA Civ 673.
50. *Dunnage* (n 49) at [130] (Vos LJ).
51. *Dunnage* (n 49) at [149] (Arden LJ).
52. J Goudkamp and M Ihuoma, 'A Tour of the Action in Negligence' (2015) <<http://www.jamesgoudkamp.com/#!draft-papers/c12ja>> accessed 27 November 2015.
53. [1998] 1 WLR 1263 (CA).
54. *Mansfield* (n 53) 1268 (Leggatt LJ).
55. The author doubts that *Mansfield* truly involved 'involuntariness'. On the facts, the lorry driver behaved 'voluntarily': he opted to continue driving despite being involved in several minor incidents before the crash. 'Involuntariness' more accurately describes circumstances involving a sudden and unexpected loss of consciousness (*Roberts v Ramsbottom* [1980] 1 WLR 823, 832 (Neill J)), an epileptic seizure (*Hill v Baxter* [1957] 1 QB 277, 283 (Goddard CJ)) or an attack by a swarm of bees (*Kay v Butterworth* (1945) 61 TLR 452).
56. Goudkamp and Ihuoma (n 52).
57. NHS England, *Valuing Mental Health Equally with Physical Health or 'Parity of Esteem'*, <<https://www.england.nhs.uk/mentalhealth/parity/>> accessed 27 January 2016.
58. *Dunnage* (n 49) per Vos LJ at [131].
59. It is true, of course, that if we move beyond Weinribian bipolarity, then justice for an insane defendant does not necessarily have to correlate with injustice for an injured claimant. If, for example, a government-run social insurance scheme replaced fault-based liability, then it is conceivable that this would more effectively 'balance the rights and needs of the insane, the victim, and society' (see P Picher, 'The Tortious

- Liability of the Insane in Canada: With a Comparative Look at the United States and Civil Law Jurisdictions and a Suggestion for an Alternative' (1975) 13(1) Osgoode Hall L J 193, 194–95), thereby sidestepping the conceptual problems that this present paper discusses. Some readers may feel that this paper focuses too narrowly on the corrective function of a fault-based tort of negligence and therefore excludes the possibility of more elegant or ambitious solutions to the 'insanity problem' outside the current paradigm of the English common law. The author makes no apology for the narrow focus that this paper adopts. Many of the arguments for the introduction of an insanity defence in tort law proceed on the basis that such a defence is required to ameliorate the perceived harshness of existing doctrine. The implicit assumption that underlies these arguments is that an insanity defence is entirely compatible with the corrective function of the tort of negligence and that there is no need to reinvent the doctrinal wheel, so to speak. For the reasons he sets out in Section 4 of this paper, the present author disagrees that an insanity defence could resolve matters so neatly. This is not to say that an entirely different doctrinal framework could not overcome the problems that this paper discusses. Whether such radical structural reform would ever be forthcoming in English law seems open to doubt.
60. See Kelley (n 8) ('the objective standard is a social co-ordinating norm'); Splane (n 8) ('deinstitutionalisation demands an objective standard of care'); GJ Alexander and TS Szasz, 'Mental Illness as an Excuse for Civil Wrongs' (1967) 43 Notre Dame L Rev 24 ('it is unthinkable that a group of defendants should be licensed to commit torts'); Seidelson (n 8) ('objective standard protects the claimant's "reasonable expectations"'); DW Shuman, 'Therapeutic Jurisprudence and Tort Law: A Limited Subjective Standard of Care' (1992) 46 SMU L Rev 409 ('objective standard is a "therapeutic agent"'); RA Epstein, 'Defences and Subsequent Pleas in a System of Strict Liability' (1974) JLS 165 (where a defendant causes harm to a claimant that alone 'states a good *prima facie* case'); JCP Goldberg and BC Zipursky, 'Tort Law and Moral Luck' (2007) 92 Cornell L Rev 1123 ('tort law is about redressing wrongs, not punishment'); T Honoré, *Responsibility and Fault* (Hart, Oxford 1999) 24–25; 26–27 ('objective standard controls for good and bad luck'); WM Landes and RA Posner, *The Economic Structure of Tort Law* (Harvard, Cambridge Massachusetts 1987) ('objective standard reduces information costs contingent on establishing whether a defendant is insane').
 61. Eg, intention (*R v Woollin* [1999] 1 AC 82 (HL)); recklessness (*R v G* [2003] UKHL 50); dishonesty (*R v Ghosh* [1982] QB 1053 (CA)). *Nullum crimen sine culpa* ('There can be no criminal liability without fault'); see G Hallevy, *The Matrix of Insanity in Modern Criminal Law* (Springer, New York 2015).
 62. HT Terry, 'Negligence' (1915) 29 Harv L Rev 40.
 63. On negligence as *mens rea* in the criminal law context, see MS Moore and HM Hurd, 'The Culpability of Negligence' in R Cruft et al (eds), *Crime, Punishment and Responsibility: The Jurisprudence of Antony Duff* (OUP, Oxford 2011) 311.
 64. Goudkamp (n 7) 730.
 65. Eg, *Morriss v Marsden* [1952] 1 All ER 925 (QB).
 66. OW Holmes, *The Common Law* (Little Brown, Boston 1881) 110.
 67. HLA Hart, 'Postscript: Responsibility and Retribution' in HLA Hart and J Gardner (eds), *Punishment and Responsibility: Essays in the Philosophy of Law* (OUP, Oxford 2008) 227–28.
 68. Hart (n 67).
 69. Moore and Hurd (n 63) 321–22.
 70. P Cane, *Responsibility in Law and Morality* (Hart, Oxford 2002) 65, 72.
 71. Goldberg (n 41) 53.
 72. P Cane, 'Retribution, Proportionality and Moral Luck in Tort Law' in P Cane and J Stapleton (eds), *The Law of Obligations: Essays in Celebration of John Fleming* (Clarendon, Oxford 1998) 149, 156.
 73. Cane, 'Retribution' (n 72).
 74. Cane, 'Retribution' (n 72) 144–45. On 'personhood', see P Singer, *Rethinking Life and Death: The Collapse of Traditional Ethics* (OUP, Oxford 1995); J Harris, 'The Concept of the Person and the Value of Life' (1999) 9(4) Kennedy Inst Ethic J 293; J Harris, 'Four Legs Good, Personhood Better!' (1998) 4(1) Res Publica 51; M Tooley, 'Personhood' in H Kuhse and P Singer (eds), *A Companion on Bioethics* (2nd edn, John Wiley, New York 2009).

75. Cane, 'Retribution' (n 72) 144–45.
76. Beever (n 47) 74.
77. The courts have customarily granted an exception to the objective standard where children are concerned; see, eg, *McHale v Watson* (1966) 115 CLR 199; *Mullin v Richards* [1998] 1 All ER 920 (CA); *Orchard v Lee* [2009] EWCA Civ 295.
78. Ague (n 24) 221.
79. Goudkamp and Ihuoma (n 52) 7.
80. *Roe v Ministry of Health* [1954] 2 QB 66 (CA).
81. 64 DLR (4th) 84, 1990.
82. 64 DLR (4th) 84, 1990.
83. Korrell (n 30) 49.
84. SR Perry, 'Risk, Harm and Responsibility' in DG Owen (ed), *Philosophical Foundations of Tort Law* (Clarendon, Oxford 1995) 341.
85. J Horder, 'Pleading Involuntary Lack of Capacity' (1993) 52 CLJ 298, 302; see also V Tadros, 'Insanity and the Capacity for Criminal Responsibility' (2001) 5 Edin LR 325.
86. Honoré (n 60) 37.
87. [2008] UKHL 13.
88. *Corr* (n 87) [5] (Lord Bingham).
89. It is true that establishing whether a defendant is in breach of duty necessarily entails the consideration of counterfactuals by the court; see, eg, *Bolton v Stone* [1951] AC 850 (HL); *Paris v Stepney BC* [1951] AC 367 (HL); *Latimer v AEC Ltd* [1953] AC 643 (HL).
90. [1946] 4 DLR 721.
91. *Buckley* (n 90) [16] (Roach JA).
92. (2001) 201 DLR (4th) 680.
93. *Fiala* (n 92) at [14]–[16] (Wittman J).
94. 173 NW 2d 619 (1970).
95. *Breunig* (n 94) 541 (Hallows CJ).
96. It would be interesting to know, for example, how many motorists drive carefully, not because they understand that they owe a duty of care to other road users and appreciate that that requires them to take reasonable care, but because they are motivated by selfish impulses to preserve their own health and property. If A labours under such a motive and crashes into B's car, he would not be excused liability because he had misunderstood or failed to appreciate the duty of care.
97. WJ Curran, 'Tort Liability of the Mentally Ill and Mentally Deficient' (1960) 21 Ohio St L J 52 69.
98. Cane, *Responsibility* (n 70) 65.
99. Korrell (n 30) 38.
100. The 2005 Act codified the existing case law on capacity; eg, *Re C* (n 31); *Re MB (Cae-sarean Section)* [1997] 2 FLR 426 (CA); *Re W (Adult: Refusal of Medical Treatment)* [2002] EWHC 901 (Fam).
101. MCA 2005, s 1(2).
102. *Hedley Byrne and Co Ltd v Heller and Partners Ltd* [1964] AC 465 (HL).
103. *Re C* (n 31).
104. Dark (n 30) 200.
105. HM Government, *MCA 2005 Code of Practice* (TSO 2007) at [4.26].
106. Splane (n 60), 168. Cf WR Castro, 'The Tort Liability of Insane Persons for Negligence: A Critique' (1971–72) 39 Tenn L Rev 705, 716.
107. *Corr* (n 87) at [5] (Lord Bingham).
108. MHA 1983, ss 2 and 3.
109. Bohlen (n 23) 28–29. Korsakoff's syndrome is a mental illness that results from chronic alcoholism.
110. Horder also cites pre-menstrual tension, severe allergic reactions and delirium (n 85) 317.
111. Hart (n 67) 229.
112. JH Hardisty, 'Mental Illness: A Legal Fiction' (1973) 48 Wash L Rev 735, 744.
113. Goudkamp (n 7) 741.
114. Goudkamp (n 7) 741.
115. MHA 1983, pt II.
116. MHA 1983, ss 2(2) and 3(2)(c).
117. WM Landes and RA Posner, *The Economic Structure of Tort Law* (Harvard, Cambridge Massachusetts 1987) 127–28.
118. EJ Goldstein, 'Asking the Impossible: The Negligence Liability of the Mentally Ill' (1995–96) J Contemp Health L & Pol'y 67, 86.
119. Goldstein (n 118) 86.
120. B Hale, *Mental Health Law* (5th edn, Sweet & Maxwell, London 2010) 58. See, eg, MHA 1983, ss 2(2)(b) and 3(2)(c); cf MHA 1983, s 25(1).
121. If the clinical team is negligent in assessing the relevant risks, then an injured claimant may have a claim against the relevant hospital trust in negligence; eg, *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 (HL); *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2.
122. CRPD (n 14) art 1.
123. CRPD (n 14) art 4(1)(b).
124. P Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75(5) MLR 752, 753. See also CRPD (n 14) art 3.

- 125. Bartlett (n 124).
- 126. Bartlett (n 124) 775.
- 127. Bartlett (n 124) 776. See UN General Assembly, *Annual Report of the United Nations High Commission for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General*, 26 January 2009, A/HRC/10/48 at [47].

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Declaration

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