CRIM APP 430/01

KAITANO MACHONA
versus
THE STATE

HIGH COURT OF ZIMBABWE
CHINHENGO and GUVAVA JJ
HARARE 10 and 23 January 2002

Mr *J.J. Callow,* for the appellant
Mrs*.. Gurure,* for the respondent

CHINHENGO J: This is an appeal from the decision of the Regional Court sitting at Harare in terms of which the appellant was convicted of attempted murder and sentenced to 10 months imprisonment of which 5 months were suspended for five years on the usual condition of good behaviour.

The facts on which the conviction and sentence were based are not in contention. They were accepted by the appellant at the trial. On those facts however the appellant submitted in this appeal, as he did in the court *a quo,* that he should not have been convicted but acquitted. He based this submission on s 29(2) of the Mental Health Act 1996 (Act No. 15 of 1996) in terms of which if his submission is sustainable, he would be entitled to a special verdict.

The facts of this matter which, as I have said, are not contested are the following. On 22 July 1997 the appellant was found in his house bleeding profusely from a cut on his throat.

It was not nor has it since been established how the appellant sustained that injury. The evidence seems to indicate that the injury was self-inflicted. The doctors who later examined the appellant to establish the state of his mind at the time of committing the offence of which he was convicted accepted that the appellant had, for some unknown reasons, cut himself. The appellant was taken to a hospital at Norton. Dr Shamu attended to him. He sutured the appellant's wound under an anaesthetic. After completing this procedure, the Doctor turned away from the appellant and walked towards the door of the operation theatre to hung up his apron. The appellant got up, picked up a scissors from the trolley and struck the doctor with it. The scissors broke and its blades remained embedded in the doctor's head. The doctor fell to the ground and became unconscious. The appellant however continued to assault him with a drip stand, an iron rod, and a bottle of medicine which broke in the process. The doctor sustained a broken skull. He was severely bruised and bled profusely. He suffered damage to a part of his brain the result of which is that after treatment, he remained permanently disabled. His speech function was severely weakened. His sight, memory and mental faculties were seriously impaired. He cannot practice as a medical doctor again. He was permanently disabled. An affidavit tendered in court on the injuries which the doctor sustained describes the injuries as "compound depression fracture of the skull with severe brain damage".

There is no doubt at all that the attack on the doctor was severe

and devasting and it brought to an end the professional life of a very useful member of society. It was a misfortune which quite certainly was most painful to him and to members of his family and indeed to the community at large.

The facts I have narrated were contained in the State outline. Though admitting them, the appellant pleaded not guilty to the charge of attempted murder. His defence was encapsulated in the words "I do not know anything about what transpired". Before the State closed its case certain medical reports were, with the consent of the defence counsel submitted in evidence:- the report by Dr Auhthour on the injuries sustained by Dr Shamu; the reports by Dr Madhombiro and Dr Muzamhindo on the mental condition of the appellant. Dr Madhombiro reported that the appellant may have suffered a mental disorder because of post anaesthetic effects. He was not categoric. Dr Muzamhindo's report was not helpful. He seemed to have learnt of the appellant's mental condition from some other doctor. He could not give any reason for that condition. He simply noted that "the factors which caused the mental disorder or defect are unknown".

The medical reports by Doctors Madhombiro and Muzamhindo are important in that they accept that the appellant suffered from a mental disorder. These two doctors are employed at Harare Remand Prison and Chikurubi Hospital respectively. They also reported that the appellant did not receive any treatment. This is an important disclosure because the

appellant did not display any mental defect at his trial nor at any time after the commission of the offence. He was normal.

The question for the court's decision was whether the appellant was suffering from a mental disorder or defect at the time that he committed the offence with which he was charged and consequently whether s 29(2) of the Mental Health Act 1996 should be applied in the case.

The appellant himself gave evidence at the trial. He called two psychiatrists in his defence and his wife also. The appellant's evidence was that before he slit his throat and committed the present offence, he had had a number of misfortunes. He father had died, then his brother. His rented house and movable property therein were destroyed in a fire. He lost $18 000 which was all his life's saving and with which he intended to pay a deposit for the purchase of a house. His daughter was impregnated and gave birth to twins which died soon after their birth. All these misfortunes occurred one after the other. He was particularly disturbed by the death of his father and only brother and sibling. He told the court that there was some history of epileptic attacks in his family. He had heard that his mother had suffered an epileptic attack before he was born. Her maintained that he did not remember attacking Dr Shamu but said that he could not dispute that he had done so. As regards Dr Shamu he stated that he would have had no reason at all to attack and injure him. He had not known him before and there would have been no reason to attack a doctor who had

treated him of the injuries to his throat.

The appellant was quite extensively cross-examined by the prosecutor. Nothing of any significance emerged from that cross examination. His testimony was not contradicted by any other evidence.

The evidence of Dr Chikara, a government psychiatrist, was that the appellant suffered a brief reactive psychosis which was not likely to recur "unless one was to recreate … (the) traumatic events leading up to his behaviour". He was of the view that the appellant had recovered his mental equilibrium and that there would be no purpose in detaining him in a special or mental institution. Dr Chikara did not think that the appellant had suffered an epileptic fit even though there was some history of epileptic fits in his family. He said that the probability of him having inherited this illness from his mother was 50% but there was no evidence to suggest that the appellant had suffered from this illness. Dr Chikara was asked in cross-examination to explain what he meant by reactive psychosis. He said:

> "It's a psychosis where there is a stressor. A stressor which would elicit some confusion or a mental illness or depression in a number of people. If we look at the way these events were unfolding – that's what I am looking at as the stressor."

He was asked if the appellant lost control of his mental faculties at the time of the commission of the offence. His answer which appears at – 23-24 of the record of the proceedings was that –

> "At the time of the alleged offence my opinion is that he

didn't have control."
Later on in his evidence he again stated his opinion that there was no likelihood that the reactive psychosis would recur.

The appellant's wife gave evidence that she was called home from work to find that the appellant had slit his throat and that he was bleeding profusely. She took the appellant first to the police station and then to the hospital. She did not witness the attack on Dr Shamu but was informed about it. She gave information to Doctors Chikara and Nhiwatiwa when they examined the appellant. She told the court that the events that had preceded the attack on Doctor Shamu, i.e. the death of appellant's father and brother and the destruction of their home in a fire, had so severely affected the appellant that he had shown signs of illness. In particular he had began to talk to himself inaudibly and incoherently. She was cross-examined but nothing of any significance emerged from her cross-examination. She also stated that there had been no suggestion that the appellant's throat injury may have been caused by any other person other than the appellant himself. She had accepted that the injury had been self inflicted.

The appellant then called his employer Mr Paul Fisher who gave confirmatory evidence as to the misfortunes that the appellant had suffered. He said that the appellant had been adversely affected by those events and had become hesitant in his work attitude. He said that after the attack on Dr Shamu the appellant was "quite upset" and he (the employer) and

appellant's workmates had to constantly give the appellant reassurances and had to relieve him of any pressures at work. He said that the appellant had now fully recovered and was performing his tasks normally.

Dr Nhiwatiwa's evidence which was given very well, in my view, confirmed that of Dr Chikara. She stated that the appellant was in a "psychotic episode" when he committed the offence. At p 37 of the record she stated that:

> "You have to take the events into context because usual people try to, I mean, he cannot remember why he cut his throat but in our experience people who try to inflict harm on themselves are actually suicidal which may mean that he may actually have been psychotically depressed at the time."

At p 38 of the record Dr Nhiwatiwa stated that the psychotic episode which the appellant suffered was in fact a mental disorder which was the same condition described by Dr Chikara as a "brief reactive psychosis". Dr Nhiwatiwa also stated that a brief reactive psychosis is usually a "once-off thing" and unlikely to recur. She said that in her opinion she did not think that the appellant should be placed in a mental institution. Under cross-examination she was again asked why the appellant should not be placed in a mental institution and she said, at p 40 of the record, that –

"He had a brief psychotic episode. Now he is okay. So mental institutions are for people who are actively psychotic."

Dr Nhiwatiwa also stated that from the information given to her by the appellant wife the appellant was mentally disturbed

at the time that he caused the injury to his throat.

The evidence led in the court *a quo* can be summarised as follows. On the morning of 22 July 1997, the appellant injured himself by slitting his throat and bled profusely from that wound. His children became aware of this and called their mother. The mother took the appellant first to the police station and then to the hospital. At the hospital the appellant was treated by Dr Shamu who sutured the wound on his throat under anaesthetic. After Dr Shamu completed this procedure, the appellant, without any apparent cause, attacked Dr Shamu and caused serious injuries to him which have resulted in Dr Shamu being permanently disabled such that he can no longer practice his profession. The appellant suffered a brief psychotic episode and lost control of himself and of his mental faculties. The evidence of both Dr Chikara, a government psychiatrist of sixteen years standing and Dr Nhiwatiwa also a psychiatrist of fifteen years standing was to the effect that the appellant suffered a brief reactive psychotic episode and that he was not responsible for his actions at the time that he attacked Dr Shamu.

In her judgment the magistrate analysed the evidence led in court and identified the question for determination as being "whether the accused was suffering from diminished responsibility or mental disorder in terms of the Mental Health Act 1996".

It seems to me that the magistrate was led astray in her reasoning when she thought that Dr Chikara's opinion that diminished responsibility was the same thing as a mental disorder was correct. She lurched at that statement and drifted from the correct path. To clearly understand what Dr Chikara said in this regard I refer to p 22 of the record where he was being cross-examined. He was asked the question –

> "So Doctor, how do you arrive at the conclusion that at the time he committed the offence he (the appellant) had diminished responsibility?"

He answered:

> "Yes. If you look at the whole thing in context, I mentioned at the end to say if he had committed the alleged offence first and then tried to cut his throat regretting or fearing the consequences, to me, in my view, it would have made sense. So first he cut his throat for what reason …"

And at p 23 –

> "If he was depressed after all these events he would need to be a very strong person indeed. Then you put together the question of diminished responsibility, it's a British concept which we have taken into our legal system that he did not have full responsibility. At the same time probably having no responsibility at all but the responsibility is reduced."

It will be clear on perusal of Dr Chikara's evidence as a whole that his professional assessment was that the appellant suffered a "brief reactive psychosis" which was the same diagnosis made by Dr Nhiwatiwa. The two doctors clearly stated that this was a form of mental disorder which was brief in nature but which, when it occurs, the person concerned loses the control of his

mental faculties. Dr Chikara does not seem to have clearly understood the legal concept of diminished responsibility and his understanding of it should not have been relied upon by the court. The magistrate conceived that Dr Chikara's evidence was in substance to the effect that the appellant was in a state of diminished responsibility. She then relied on *State v Stephen* 1992 (1) ZLR 15 and in particular on a statement by a specialist witness who stated that a special verdict was no longer automatically returnable in such cases. The magistrate in my view also misconstrued Dr Nhiwatiwa's evidence when she stated at p 4 of her judgment that –

> "Doctor Nhiwatiwa's report was also not conclusive. She stated that at the time Mr Machona (appellant) could have been mentally disturbed before being attended to by Doctor Shamu. The doctor's reports, therefore contradicted each other and they were not conclusive on what accused's state of mind at the relevant time was."

I must confess that I find no contradiction at all in the evidence of Dr Chikara and Dr Nhiwatiwa. Both of them were agreed that the appellant suffered a brief reactive psychosis or a psychotic episode. Both were agreed that he lost his self-control. They were thus agreed that the appellant suffered from a mental disorder at the time that he attacked Dr Shamu. It is clear from their evidence that they were of the opinion that the psychotic episode may have commenced at the time that the appellant slit his own throat through to the time that he attacked Dr Shamu. It is rather surprising that against this clear evidence given by Dr Chikara and Dr Nhiwatiwa the magistrate came to the conclusion that –

> "… there was no evidence to show that the accused was suffering from a diseased mind. There was also no evidence to show that the accused though suffering from diminished responsibility, lost total control of himself."

With all due respect to the magistrate I find that her appreciation of the evidence and its effect was quite erroneous. The evidence, as I have endeavoured to show, clearly established that the appellant was mentally disordered at the time that he attacked and severely injured Dr Shamu and that he had lost control of his mental faculties. This failure to appreciate the effect and nature of the evidence before her led the trial magistrate to the conclusion that the evidence did not show that the appellant lost total control or that his mind was diseased at the time of the offence. With this finding and relying on *Petros Chief Sibanda v The State* SC 137/93 and *State v Gambanga* 1997 (2) ZLR 1, she decided that "diminished responsibility only affects the accused's moral and not legal blameworthiness" and she refused to return the special verdict and instead found the appellant guilty on the charge.

It seems to me that in deciding that the appellant suffered not from a mental decease but from diminished responsibility the magistrate failed to appreciate what in law constitutes diminished responsibility and what constitutes insanity. Burchell and Hunt in *South African Criminal Law and Procedure* Vol 1, 1970 ed at p 2134 state that –

> "Diminished responsibility is usually a finding where the accused is a psychopath and in cases of epilepsy and mental deficiency which do not amount to legal insanity.

> Whether the mental abnormality in question does justify diminished responsibility and if so, whether, in a case of murder, the death penalty should not be imposed, are questions to be determined in the circumstances of the particular case."

The same authors at p 198-199 say the following about insanity:

> "The meaning of insanity for the purpose of the defence to criminal liability is wider than that under the Mental Disorders Act (No. 38 of 1916). It maters not how temporary the disease of the mind is, nor is its cause relevant. The latter point arose crisply for decision in *R v Kemp* ([1957] 1 QB 399; [1956] 3 All ER 249). The accused made a motiveless and irrational attack with a hammer upon his wife. He suffered from arteriosclerosis (hardening of the arteries) which caused a congestion of blood in the brain and resulted in a temporary unconsciousness at the time of the attack. It was contended on behalf of the accused (i) that his defect of reason resulted, not from a mental disease, but from a physical one, and (ii) that arteriosclerosis only became a mental disease when it caused degeneration of the brain which had not yet occurred. In rejecting these contentions and holding that the accused was suffering from a disease of the mind, DEVLIN J said:
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> > "The distinction between the two categories (diseases of the mind which are physical in origin and those that are mental in origin) is irrelevant for the purposes of the law, which is not concerned with the origin of the disease or the cause of it but simply with the mental condition which has brought about the act. It does not matter, for the purposes of the law, whether the defect is due to a degeneration of the brain or to some other form of mental derangement. That may be a matter of importance medically, but it is of no importance to the law … [The law] is not in any way concerned with the brain but with the mind, in the sense that the term is ordinarily used when speaking of the mental faculties or reasoning, memory and

> understanding … If one read for "disease of the mind" "disease of the brain" it would follow in many cases pleas of insanity would not be established because it would not be established that the brain had been affected either by degeneration of the cells or in any other way. In my judgment the condition of the brain is irrelevant."

The important point to note from the above statement is that the law is concerned with what has happened with the accused's mind as distinguished from his brain. The law is therefore concerned only with whether "the mental disease has prevented the accused from knowing the nature and quality of his act or that it is wrong or gives rise to an irresistible impulse" (Burchell and Hunt *op cit* at p 299-200).

The appellant's plea in the court *a quo* was in substance one of insanity. That plea is supported by all the evidence led at the trial. I am satisfied that the court *a quo* arrived at a wrong determination that the accused suffered from diminished responsibility.

Section 29(2)(c) of the Mental Health Act provides that –

> "(2) If a judge or magistrate presiding over a criminal trial is satisfied from the evidence, including medical evidence, given at the trial that the accused person did the act constituting the offence charged or when he did the act he was mentally disordered or intellectually handicapped so as not to be responsible for the act, the judge or magistrate shall return a special verdict that the accused person is not guilty because of insanity, and may –
>
> (a) …
> (b) …

(c) if the judge or magistrate is satisfied that the accused person is no longer mentally disordered or intellectually handicapped or is otherwise fit to be discharged, order his discharge and, where appropriate, his release from custody."

I have determined that the appellant did the act and that when he did it he was mentally disordered so as not to be responsible for the act, that is to say, the appellant was insane at the time he did the act. The obvious verdict which the court below should have returned is that the appellant was not guilty because of insanity, which verdict, is in the Mental Health Act, referred to as a special verdict. A special verdict is, in terms of the proviso to s 10 of the Mental Health Act, regarded as an acquittal except for the purposes of any appeal or reservation of a question of law when it is regarded as a conviction in which case ss 34 to 41 and 44 of the High Court Act [*Chapter ….*] and ss 9 to 17 of the Supreme Court Act [*Chapter ….*] shall *mutates mutandis* apply to the proceedings concerned.

It is important to make a general observation about the Mental Health Act at this point. Most of its provisions are concerned with a person who is mentally disordered or intellectually handicapped and such a person is defined in s 2 of the Act thus –

> "in relation to any person, means that the person <u>is</u> suffering from a mental illness, arrested or incomplete development of the mind, psychopathic disorder or any other disorder or disability of the mind." (the emphasis is mine)

The definition, as is apparent, does not include within its ambit a

person who is not suffering from a mental disorder at the time that he is appearing in court, that is to say a person who has fully recovered, such as the appellant was - *vide* the use of the word "is" in the definition. Section 29(2)(c) of the Act is therefore concerned with a person who lost his mind and became mentally disordered at the time that he committed the offence. Section 29(2)(a) and (b) on the contrary are concerned with a person who is mentally disordered as defined and has done an act constituting the offence charged but when he did it he was and continues to be mentally disordered such that he can not be held responsible for his actions hence he may be returned to prison for transfer to an institution for examination or treatment or he may be ordered to submit himself for examination or treatment or his guardian, spouse or close relative may be ordered to apply for him to be received for examination or treatment at any institution in terms of the Act.

The acquittal of both categories of mentally disordered persons referred to in s 29 of the Act is in recognition of the fact that that person lacked the necessary *mens rea* when he committed the offence of which he was charged. Before its repeal and replacement with Act No. 15 of 1996, the Mental Health Act [*Chapter 15:06*] did not provide that on returning a special verdict the accused shall be regarded as having been acquitted. The special verdict in terms of s 28 of the repealed Mental Health Act merely meant that the accused was guilty of the act or omission but was mental disordered at the time when he did the act and the judge or magistrate was then required to order

in every case that person's return to prison for transfer to an institution for examination.

In view of the new provisions of the Mental Health Act 1996, if a persons committed an offence during a moment of insanity and he is, to the satisfaction of the court no longer mentally disordered, that person is entitled not only to an acquittal but also to be released from custody. In this case the State conceded that the proper verdict was an acquittal. It further conceded during oral submissions that appellant did no have to be further detained at a mental institution. This concession was proper because the appellant not only had he not been treated at all for the illness but he had fully recovered at the time that he was arraigned before the court.

The appeal therefore succeeds. The conviction is quashed and the sentence is set aside.

Guvava J, I agree.

Stumbles & Rowe, appellants' legal practitioners.
The Attorney General, respondent's legal practitioners.