STATE
versus
WZ

HIGH COURT OF ZIMBABWE
TSANGA J
HARARE, 28 NOVEMBER, 9 & 31 DECEMBER 2019

Criminal trial

S.W. Munyoro, for the State
S. Maminine, for the accused

TSANGA J: The accused WZ was charged with murder. She pleaded not guilty due to insanity at the time that she committed the offence. The agreed facts were that on the 28th of May 2018, at around 0300 hours, she sneaked out of the room where she was sleeping with her mother. She took her four year old child with her, and proceeded to Hunyani river, which is about 400 metres from her homestead. There she threw herself together with the child into the river in an attempt to kill herself and the child. The child drowned, whilst she, on the other hand, became unconscious and was washed to the river bank. She was picked up by passers-by whilst her deceased child was retrieved down steam. A post mortem done on the child by Doctors Iglesias Capetillo and Aissa Serrano Gomez concluded that death was due to mechanical asphyxia and liquid penetration of the respiratory tract due to river drowning. The post mortem report was produced as Exhibit No 1.

From the statement of agreed facts, the accused was mentally ill at the time the offence was committed. The psychiatrist report by Dr MFS Mazhandu was produced as Exhibit No 2. It detailed that she had become mentally ill in 2017. She would wander away from home. She also had reduced self-care in that she was not bathing. She was violent and aggressive towards others. She would hear voices that were not there and would equally also see things that were not there. She was taken to faith healers but did not get better. The report concluded that the above symptoms at the time of the alleged offence would have prevented her from fully comprehending the wrongfulness of her actions. Since admission to Chikurubi Psychiatric Unit she was said to be now mentally stable. She was also said to have guilt and

remorse for her actions and was taking haloperidol, a medication for mental disorder. She was declared fit to stand trial.

Against the backdrop of the facts and the psychiatric report, the matter was dealt with in terms of the Mental Health Act [*Chapter 15:12*]. Section 29 (2) of this Act provides in essence, that if a person pleads insanity and there is evidence in support of that, including medical evidence, the court shall enter a special verdict of not guilty because of insanity. Thus although the death of the minor child was indeed intentionally caused by the accused, the court's verdict was that the accused is not guilty because of insanity.

Regarding her recovery, the report before the court had been carried out in June 2019. Her family members were present and her brother in particular put himself forward as being in a position to take care of her were she to be released. Section 29 (2) (c) provides that

> ..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.

Inevitably there is concern about releasing a person back into society if they have already exhibited that they are a danger to others. Thus in making use of this section the courts are guided by professional medical assessment of the patient's suitability for release following their assessment of fitness to stand trial. This court therefore ordered that she be re-examined by the Psychiatris, this time for assessment of her suitability for release into the custody of her brother Chamunorwa Zhuwao.

On the 5th of December 2019 an updated psychiatric report was availed recommending that she was suitable for release into the custody of her brother. Accordingly, on the 9th of December the court ordered that having been found not guilty because of insanity, she should be released into the custody of Chamunorwa Zhuwao as per psychiatrist's second report.

Whilst one of the duties of the court is to deal with such homicides in accordance with the Mental Health Act, still, courts are not oblivious of the mental health care issues that are being surfaced by the cases that come before the court. Suffice it to observe that cases such as these continually bring to the fore the vulnerability of family members, children in particular, to loss of life at the hands of the mentally ill. It is apparent from some of the cases that often by the time the patient is placed in an institution for assessment and treatment, it is because a homicide will already have been committed. In other words, damage which could possibility

have been averted with timely medical intervention in particular, will already have been done. A few examples of such cases will suffice.

In *S* v *M* CRB 20 /19, the accused was charged with three counts of murder in that on 15 October 2015, at Mushpark farm in Karoi, he set fire to a hut in which his now three deceased three grandchildren were sleeping with some adults. The three children were aged nine, five and three. The adults had managed to escape but the three children all perished. He pleaded not guilty because of insanity. According to the psychiatrist's report he had has been suffering from a mental disorder since 1992. He would exhibit paranoid delusions (excessive suspiciousness) and disorganised behaviour. Medical reports done at the time of his arrest showed that he was experiencing auditory hallucinations (hearing voices which not there), symptoms of mental disorder. Also, according to the report, whilst admitted at Chikurubi he had paranoid delusions. The doctor concluded that at the time of the offence, he was suffering from a mental disorder. He was said to have stabilised on chlorpromazine. The court found him not guilty because of insanity.

In *S* v *CM* CRB 93/19, the accused was charged with murder of her three year old son, by grabbing him and throwing him into a well thereby drowning him. She was mentally examined by a psychiatrist in Harare. The report captured that she started showing symptoms of mental illness in 2003 when she would exhibit disorganised behaviour such as removing her clothes in public, shouting and beating other people. According to the report, medical examinations done at the time of her arrest for this crime, showed that she had visual and auditory hallucinations and grandiose delusions. Whilst admitted at Chikurubi female prison she would also experience hallucinations and suicidal ideation. The psychiatrist's conclusion was that at the time of committing the offence, CM was mentally disordered and this prevented her from appreciating the wrongfulness of her actions. In the report, she was said to have stabilised on haloperidol, a medication for mental disorder.

Somewhere along the way, the health system appears to fail mental health sufferers in turn presenting frail and vulnerable family members to danger at the hands of such persons. In *S v K* CRB 84/19 the accused was a known mental patient who killed his 74 year father after he refused to give him money to buy beer. The accused became annoyed and picked a metre long wooden pestle which he used to strike the deceased several times on the head and several times all over the body until the deceased fell from the chair he was seated. He sustained a cut at the back of his head and multiple injuries all over his body as result of the assault. He was ferried to Parirenyatwa hospital where he died. The psychiatric report stated

that he had started showing symptoms of mental disorder in 2013 when he would talk to himself, refuse to eat and exhibited disorganised behaviour which included hitting his head against the wall. Medical reports done at the time also showed that he had auditory hallucinations. According to the report, whilst at Chikurubi he had continued to experience hallucinations. Her conclusion was thus that at the time of the offence he was mentally disordered. He had stabilised on haloperidol, a medication for medical disorder.

These cases raise issues such as whether the families and communities have adequate awareness, if any, of the law and the steps that they can take in terms of committing a mentally ill person to an institution before the commission of an offence. The Mental Health Act [*Chapter 15:12*] defines mentally disordered as follows:

> "mentally disordered or intellectually handicapped", in relation to any person, means that the person is suffering from mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of the mind;

It also has a definition for psychopathic disorder as follows:

> "psychopathic disorder" means a persistent disorder or disability of the mind, whether or not subnormality of intelligence is present, which—
> (*a*) has existed or is believed to have existed in the patient since before he was eighteen years old; And
> (*b*) results in abnormally aggressive or seriously irresponsible conduct on the part of the patient;

In terms of s 4 of the Act, relatives in particular, or any person over the age of 18, can make an application to a magistrate for a reception order for a mentally ill person to be received into an appropriate institution or for single care at home whilst being visited by a doctor. (See sections 4 to 10 of the Act for the process and procedure involved). The application for a reception order needs to be supported by medical recommendation from two doctors or one doctor and a psychiatric nurse or other named appropriate professional.

The reception order granted by a magistrate under ordinary circumstances is for a period of six weeks during which a person presumably gets treatment at the institution or whilst in single care. There are also procedures to be followed in emergency situations in terms of s11 of the Act.

Whether people are aware of the procedures is a crucial issue as is whether the critical institutions are as accessible to people in the rural areas. The willingness of relatives to use the law is also another core consideration. A proper understanding of these issues informed by research is evidently required. In this case of WZ, for example, the family resorted to faith

healers in a bid to seek help. One can surmise that prophets, faith healers, traditional healers and the like may be viewed as providing ready, easier and more accessible treatment alternatives compared to following the procedure laid out in the Mental Health Act for having a person admitted to an institution. The thrust of the existing Act particularly in part one, is designed to ensure that clearly articulated procedures are followed in admitting a person to a mental institution. Section 3 of the Act states as much that no person is to be received or detained in any institution except in accordance with the Act. Its thrust is to protect the civil liberties of mentally ill persons in terms of how they are to be detained as well as how long they can be kept and thereafter.

Protection of others, whether in public or in private is key. The factual circumstances of the cases outlined seem to point to shortcomings when it comes to early intervention. As such, the overall critical issue raised by the cases outlined is fundamentally that of the right to treatment for mental illness as a legal right for which the state should assume greater responsibility. What this right should practically entail in our context and environment is an urgent issue for wider engagement across relevant disciplines.

National Prosecuting Authority: State's Legal Practitioners
Uriri Attorney's at Law: Accused's Legal Practitioners