

THE STATE
versus
TSITSI FOMBE

HIGH COURT OF ZIMBABWE
HUNGWE J
MUTARE, 29 October 2013, 1 and 5 November 2013

ASSESSORS: 1. Mr Magorogosho
 2. Mr Chagonda

Trial

Ms *C. Sungai*, for the state
Mrs *V. Zviuya*, for the accused

HUNGWE J: The accused pleaded not guilty to murder as defined in s 47(1) of the Criminal Law Codification and Reform Act, [*Cap 9:23*] where it is alleged that on 22 November 2013 at Kurimakwakanaka Village, Chief Saunyama, Nyanga, she unlawfully and with intent to kill or realising that there is a real risk or possibility that death may result from her conduct orally administered termaron pesticide to Remba Gorekore thereby causing his death.

Most of the facts in this case were not in serious dispute. As a result the evidence of most state witnesses was admitted on the record by way of admission in terms of s 314 of the Criminal Procedure and Evidence Act, [*Cap 9:07*].

In essence this evidence comprised the formal evidence of the two police details who investigated the crime and the medical practitioner who carried out a post mortem report Exh 3.

The accused gave a warned and cautioned statement which is Exh 4 which was confirmed. In it the accused admits administering poison on her child but claims that she did not know what had come over her. She realised that she had done after the act when the child was dying.

The police sketch plan was also produced showing the outlay of the homestead where this occurred.

In summary the evidence against the accused is that on the day in question the accused was with her 18 month old baby. She decided to administer poison. She picked a bottle of termaron where her brother Tendai Fombe had left it at her grandmother's place.

She administered enough quantity which resulted in the baby dying a short while thereafter.

She had taken the baby to her grandmother when the baby was in the throes of death. Her grandmother advised her to seek medical attention. Baby dies before this was achieved.

Accused's grandmother gave a background of how the accused had been orphaned at an early age. She had raised her but when her elder sister was old enough to look after her siblings she had decided that they fend for themselves.

Accused was then 12 years old. Her sister was 16 or so. Accused endured the usual hardships associated with rural orphans that is having to survive by carrying out manual tasks while looking after other younger siblings. She was the head of a child headed family.

This witness would help her out if approached. She never had to refer the case to the headman who, in her experience, would have helped her.

The accused pleaded temporary insanity brought about by acute emotional stress.

In the trial that followed the question for decision became whether, at the time the accused poisoned her son to death she suffered from diminished responsibility such as would incapacitate her from appreciating the nature of his or her conduct or that his or her conduct was unlawful or to act in accordance with such an appreciation of the kind referred to above. Section 218 of the Criminal Law (Codification and Reform) Act, [*Cap 9:23*].

The State called a psychiatric nurse, one Petty Gwizo. She is a registered Mental Health Nurse.

She examined the accused during this circuit specifically on 31 October 2013.

She made three findings relevant to the issue in question.

The first finding was that at the time of examination, the accused had no mental illness afflicting her.

The second important finding, in our view, was that she never suffered from any mental illness of any kind in the past.

Thirdly she established that there was no history of mental illness in her family.

In her psychometric assessment, she did not detect any abnormalities although the accused exhibited poor defence mechanisms and poor support systems.

In conclusion she advised the court that the accused suffers from Reactive Depression due to circumstances which arose during the peuperium period as well as after wards. Which are exacerbated by her social background. She recommended individual therapy to strengthen her coping mechanisms so as to avoid the recurrence of the event in issue. Her report is Exh 6.

The defence called the evidence of another psychiatric Nurse Wilbert Chitupa.

He is the designated psychiatric nurse practitioner at the same institution as the State witness. The evidence was basically similar regarding the psychometric assessment as he also detected nothing abnormal.

The point of departure appears to be Chitupa's conclusion that the accused was mentally unwell due to psychological changes involved in peuperium. He concluded that accused suffered from puperal psychosis of reactive depression type.

In his report at p 2 he states:

“This was supported by the element of infanticidal aspect which is the key feature in the diagnostic criteria of Reactive Depression in Puperal Psychosis. She had some internalised anger which she later displaced to the infant hence poisoning the child.”

It is this conclusive point of departure which needs to be dealt with because both evidence of the psychiatric nurses cannot be correct as they came to different conclusions regarding the same subject.

If I understood the evidence of Petty Gwizo well, she diagnosed the accused as at present and concluded that she suffers from Reactive Depression. She did not speak of puperal psychosis as being the trigger of her behaviour when she killed her son. About this delicate post natal period I understood her to say that the accused suffered from mental instability which manufactured itself in reactive depression at the time of examination. Her social upbringing which encompasses loss of both parents at 9 years; the tough financial position that she endured which was exacerbated by an unwanted pregnancy, were all stresses which induced reactive depression on the accused whose coping mechanisms were weak due to the absence of both maternal and paternal support at the crucial stages of her growth and development.

In my attempt to understand the nurse evidence I surfed the internet and discovered the following.

Reactive depression is and adjustment disorder that is also called situational depression. It is a transient depression that is triggered by some external event or trauma.

Generally, the diagnosis of this disorder is based on the presentation of symptoms that do not easily fit into other categories of depression. The symptoms of reactive depression normally disappear within a months period after removal of the stressful stimuli.

With reactive depression the individual is reacting to something like death of a loved one. If a person has the symptoms of a major depression, even if his depression appears to be the result of a traumatic personal event, he will generally be diagnosed with major depression. In a sense well-defined depression trumps the less well defined adjustment disorders.

As to the causes it is well known that reactive depression is caused by sudden change in the environment or circumstances of a person, or sometimes, the chronic presence of a stressor. Examples of causes of reactive depression include loss of a loved one, sudden suicide of a friend, a break-up in a close relationship, financial hardship e.g sudden loss of a job, or a problem such as an injury or disease.

The feature of these causes that associates them with reactive depression is that the stressor can often be removed and the reactive depression symptoms will ease.

The experts at Psychology Information suggest that the symptoms of reactive depression may include some or all of the following; persistent headaches, stomach aches, pain that does not respond to treatment, sadness, memory problems, thoughts of death, difficulties in making decisions, excessive crying, changes in sleep patterns, changes in weight, persistent feelings of hopelessness and anxiety symptoms; feeling guilty; pessimistic, hopelessness helplessness etc.

Most importantly, reactive depression is not believed to have any underlying biological cause or process. It is associated with environmental conditions. There is an important caveat. All depression diagnosis must be made by certified psychological experts.

On the other hand a web search for puerperal psychosis revealed the following to me.

Puerperal psychosis is usually referred to as postpartum psychosis. It is a rare and serious mental illness that can affect new mothers. It usually starts within a few days or weeks of giving birth and can develop suddenly within just a few hours.

Its common symptoms include hearing voices and seeing things that are not there (i.e. hallucinating) rapid extreme mood swings, maniac behaviour like cleaning the house in the middle of the night; feeling disconnected from reality, feeling confused, perhaps not recognising family or friends, having delusions or believing things that are untrue or illogical.

Other people will notice that such a person is not well before that person realises it.

It is rare and affects one mother in a thousand.

Postpartum psychosis is a severe form of mental illness amounting to a psychiatric emergency.

Between the two nurses' evidence and reports we prefer the evidence and report given by Petty Gwizo over that given by Wilbert Chitupa for the following reasons.

There is nothing in the Psychology Information that is termed puerperal psychosis of a reactive depression type. Puerperal psychosis or postpartum psychosis is a severe mental disorder which is obvious to the ordinary person. There is no evidence that the accused ever suffered from it. Her history, as confirmed by both nurses, speaks to this. In short Chitupa's evidence is replete with contradiction which render it less than credible for the court's purposes.

Further he claimed to be in a position to venture an opinion regarding the mental state of the accused at the time she committed this offence without the privilege of the background information upon which he could have ventured this opinion.

The same can be said of Gwizo's opinion regarding accused's state of mind but her opinion is well - measured and, although liable to the same criticism, she does not proffer the hyperbolic opinion offered by Chitupa.

She expresses her view about the present state of mental health of the accused and suggests what factors may have contributed to the commission of the offence. In our view it is the better evidence as it was on qualified expression of opinion.

The fundamental characteristic of expert evidence is that it is opinion evidence. To be truly of assistance to the court expert evidence must also provide as much detail as is necessary to convince the court that the expert's opinions are well founded. In order for it to be so expert evidence will often include factual evidence obtained by the witness which requires expertise in its interpretation and presentation; factual evidence which, while it may not require expertise for its comprehension, is inextricably linked to the evidence that does; explanation of technical terms or topics; hearsay evidence of a specialist nature e.g as to the consensus of medical opinion on the causation of particular symptoms or conditions as well as opinions based on facts adduced in the case.

Expert evidence will be sought out obviously in disputes requiring detailed scientific or technical knowledge. The Civil Evidence Act, [Cap 8:01] does not prevent the expert

from being called on any factual issue in dispute that is deemed to be outside the knowledge or experience of the court, that is, that the court deems admissible.

In the present case it is important to determine what weight to give to the witnesses that is, whether they qualify to be called as experts.

They do not profess to be so. Their qualifications and experience, however, put them in a category which is that of experts. In other words their evidence must be treated as at their level of qualification and experience. As I pointed out above, all depression diagnosis is better certified by psychological experts.

The onus is on the defence, when relying on the plea of temporary insanity, to prove, on a balance of probabilities, that the accused was insane at the time she committed the offence. In other words the defence must lead evidence to show that the accused was mentally irresponsible at the time she committed the crime.

As I have tried to show above, the evidence led from Mr Chitupa did not advert properly to the time of the commission of the offence nor was opinion offered as to what might have contributed to the commission of the crime.

In the result we are satisfied that the accused was not mentally irresponsible when she committed the crime. There is evidence on the record that she was by then pregnant again whilst the deceased was still breast feeding.

Portia speculated that the reason why this offence was committed may have been to win the sympathy if the elders of the deceased only fell ill; so that she wears him off the breast without realising that he could die of the poisoning.

Whilst this is just an opinion, it provides cogent proof that the accused rationalised her actions. She was in control of her faculties and cannot be said to have behaved as irrationally as to call into question her mental capacity. In the same vain, she may have believe that she needed to clear herself of the existing burden of the deceased so that she is married without him.

But as I said, this is mere speculation. The important observation is that her mental capacity was such that, although she was enduring social pressures arising from several endogenic factors, she was in no way prevented from appreciating the wrongfulness of her conduct.

We are satisfied that she must, on that basis, be found guilty of murder with constructive intent.

National Prosecuting Authority, state's legal practitioners
Legal Resources Foundation, accused's legal practitioners