The Impact of the Mental Health Act No. 18 of 1973 and Related Legislation on Sentencing Practices at the Cape Town Supreme Court, 1964-1980

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Abstract

This study will empirically analyse whether the Mental Health Act of 1973 had an impact on sentencing practices for murder and murder related crimes at the Cape Supreme Court from 1964-1980. It contextualises the various discussions and debates that were taking place in the judiciary and mental health fields, and demonstrates that the said Act had little significant impact on sentencing practices after 1975, when the Act was finally ascended into law. Furthermore, analysis of the courtroom testimony not only reveals how debates on criminology, psychiatry, psychology and politics unfolded during the period under investigation, but it is argued that these very debates, rather than any legislation, had a more significant impact on the sentencing practices for the crime of murder in the Cape Supreme Court.

Key words: Mental Health Act of 1973, Criminal Procedure Act of 1977, murder, sentencing practices, 20th century South Africa.

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Opsomming

Hierdie studie sal op ŉ empiriese wyse die Wet op Geestesgesondheid van 1973 analiseer om te bepaal of die wetgewing van 1973 wel ŉ impak gehad het op vonnisopleggingspraktyke vir moord en moord verwante misdade by the Hooggeregshof in Kaapstad tussen 1964-1980. Dit sal die verskeie gesprekke en debatte wat plaasgevind het onder lede van die regbank, en in geestesgesondheidsvelde kontekstualiseer, en addisioneel sal hierdie studie demonstreer hoe die wetgeweing van 1973 eintlik ŉ minimale impak gehad het op vonnisopleggingspraktyke na 1975, toe die wetgewing uiteindelik as wet aanvaar was. Verdere analise van getuienisse van die hof wys nie net hoe debatte in Kriminologie, Psigiatrie, Sielkunde en in die politici ontvou het nie, maar dat die einste debatte ŉ meer beduidende invloed gehad het op vonnisopleggingspraktyke as enige ander wetgewing op moord en moord verwante misdade by die Hooggeregshof in Kaapstad.

Sleutelwoorde: Wet op Geestesgesondheid van 1973, Strafproseswet van 1977, Moord, Vonnisopleggingspraktyke, Suid-Afrika in die 20ste eeu.

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Chapter 1

Introduction

On 6 September 1966, Prime Minister Hendrik Frensch Verwoerd was stabbed four times in the neck and chest by Dimitri Tsafendas.[1] This sent shock waves throughout South Africa and prompted a variety of commissions of enquiry into the murder. Of particular importance was the debate around creating greater cohesion between psychiatrists, psychologists and jurists in criminal cases where the accused was considered insane. In the wake of Verwoerd's assassination, the government decided to review the outdated 1916 Mental Disorders Act, effectively changing how those deemed mentally defective would be considered and punished within the formal judiciary. The 1973 Mental Health Act was eventually implemented in 1975. However, changes needed to be made to the Criminal Procedure Act of 1955 to ensure that those deemed mentally unfit would be sentenced accordingly. The Criminal Procedure Act was changed in 1977, two years after the Mental Health Act was implemented. It is within this period of debate and legislative transition that this study is located.

Through a systematic investigation of the court records from the Cape Supreme Court from 1964-1976, and a review of the law reports from 1977-1980, this dissertation investigated the sentencing practices of those who appeared before the courts on the charge of murder and related offences. In so doing, courtroom discussions and professional testimonies reflected the evolving debates on criminology, psychiatry, psychology and politics during the period under investigation. Questions arise as to whether sentencing practices changed over time, if so under what conditions and essentially whether this was due to the changes in the abovementioned legislation or some other criteria.

1.1 Literature Review

Effectively assessing the impact of the Mental Health Act of 1973 on sentencing practices at the Cape Supreme Court requires the intricate analysis of a variety of different, but related, fields: the judicial, the legislative and mental health arms. The state of crime in

[1] H. Laurenson & S. Swartz: "The Professionalization of Psychology within the Apartheid State 1948-1978," *History of Psychology*, (14), (3), 2011, p. 250.

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the Cape, notions on criminology in the 1960s to 1980s, sentencing practices in the courts, judges' proclivities, the assassination of Hendrik Verwoerd in 1966 and the ensuing debates on how to amalgamate a variety of different approaches to effectively consider mental illness in the sentencing practices is a necessity. This requires contemplating mental health strategies in the country as well as the inherent racism attached to mental health debates. These debates also had to negotiate growing resistance to mental health reforms, particularly from the Church of Scientology. In negotiating these domains, effective change could be implemented within mental health legislation, as was seen in 1975.

For a study such as this, it is important to contemplate the level of crime, especially murder, in South Africa. Medical doctor and scholar of crime, Louis Franklin Freed's dissertation "Crime in South Africa" explains the complex nature of crime in the 1950s. According to Freed, a criminal is a:

> Frustrated person emerging in society as a product of disorganizing forces variously arising from his psycho-somatic personality or his multiform social environment, and conducing finally to a form of maladjustive behaviour which threatens the safety, security, and the happiness of other persons in the community.[2]

This already gives a sense that a criminal is a product of both nature and nurture. This proves instrumental in subsequent debates about mental health and the criminal during the period in question.

Freed's study included an analysis of crime in the city of Cape Town. Cape Town, as a subject, is unique due to the predominantly Coloured[3] population which he argues was largely responsible for the high incidence of crime in the city. He argues that in almost every Coloured district of the Cape Peninsula, knife attacks, robbery, murder, rape, car-stealing, soliciting, pimping, and other illicit activities are the "order of the day". He quotes South African writer Hugh MacKinnon:

> The "skollies"[4] of today are the roughest, toughest, juvenile thugs in the world. Primed with Brandy and dagga, and armed with revolvers, strap-slung automatics, bayonets, home-made daggers, bicycle 'pepper bombs,' they terrorize Europeans, wealthy Malays, prosperous Indians, and Natives alike. These adolescent killers are no longer the ragged hoodlums that they used to be, for today they have taken to wearing smarter clothes, and they are affecting a sort

[2] L. F. Freed: *Crime in South Africa: an integralist approach*. p. 3.
[3] The formal racial categories of the time have been maintained within this dissertation as they were pivotal to the discussions around changing legislations and perceived notions of criminality in South Africa during this period.
[4] Translation: Thugs.

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> of tough-guy American slang borrowed from the films. Violence is the only code they know. They go all out for money, and to get it they strike in the dark with everything they have got. They have no respect for life, and no respect for age, sex, race, colour, or creed.[5]

He argues that this level of gangsterism was the result of two centuries of hatred, bitterness, and inferiority in the face of all other races. He also attributes much of this criminal behaviour to environmental factors such as poor parenting, inadequate housing, poverty and the abuse of substances such as cannabis and alcohol.[6] Many of these were considered mitigating circumstances during sentencing in the period under investigation.

Of particular importance to these environmental factors is the Group Areas Act. The Group Areas Act's origin lies within the white population's growing fear of the black and Coloured urban working class. This, together with the Nationalist government's commitment to apartheid, formed part of the government's reasoning for the act. Additionally, the white trader's fears of competition, falling inner city property values, ghetto overcrowding, and deteriorating housing conditions can also be attributed to the reasoning for the Act. It has been argued that the sanitation syndrome was simply a ruse by the authorities to segregate and remove certain races from urban spaces. As a consequence, these forced removals contributed to rising crime statistics in the Cape.[7]

After the 1948 election won political power for Afrikaner workers, farmers, and entrepreneurs, it was deemed that the physical removal of all non-white people from the cities would serve their interests well. It began with the tightening of the Pass Laws and an inquiry into the 'Ghetto'[8] Act. This resulted in a parliamentary report in which the framework for spatial apartheid were demarcated in the final two chapters of the report.[9]

According to Don Pinnock, given the political, economic and ideological framework within which the removals took place in Cape Town, social disaster was inevitable. As the familiar social landmarks in the close-knit communities of the old city were ripped apart it resulted in a whole culture disintegrating. These removals forced individual people to the Cape Flats, but not whole neighbourhoods. These close knit neighbourhoods were ripped apart during the forced removals. These changes brought with them psychological difficulties and skewed coping behaviour. Notably, these removals also had an impact on

[5] L. F. Freed: *Crime in South Africa: an integralist approach*, p. 138.
[6] *Ibid.*, pp. 139-142.
[7] D. Davis & M. Slabbert (ed.): *Crime and Power in South Africa: Critical studies in criminology*, pp. 22-23.
[8] Asiatic Land Tenure Act of 1946. This act provided for the racial segregation of Indian business and residence.
[9] D. Davis & M. Slabbert (ed.): *Crime and Power in South Africa: Critical studies in criminology*, pp. 22-23.

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marital relations. The divorce and marital desertion rates rose. Parent-child relationships also became problematic – often because of the father's sense of inadequacy in his new environment. Accompanying this was a rise in promiscuity, alcohol abuse, and drug trafficking. More children were on the streets with nothing to do.[10]

Whereas Don Pinnock and Louis Franklin Freed focused their criminological studies on the environment which breeds criminality, legal scholar Martin Chanock focused on South African legal culture, and the various discourses about law and how they relate to each other.[11] Some of these discourses include crime, criminals, criminality and penology. Understanding legal culture depends on how these various discourses about law relate to each other. According to Chanock, how we frame them is pivotal. This entails an analysis of scientific and practical areas of knowledge and activities which depend on a structured imagination of selves and others. This is of interest in understanding excessive adherence to the law, or legalism, in a society influenced by colonial thinking in which criminal justice can be influenced by racial, or indeed class, discriminations.[12]

Chanock argues that at the beginning of the 20th century in South Africa, it appeared that legal preoccupations, discourses, methods, and techniques were separated from debates on criminology and penology. The institution of white rule in South Africa had an impact on the criminological and penological agenda. In essence, this was a grab for power based on racial doctrine. While both ideology and institutions were developed within the context of the struggle by the new white state to control blacks during urbanization, the specific debates about crime had to draw upon other international discourses which were more liberal and egalitarian, in principle.[13] It is in this ideological transition that certain features become apparent.

As in many British colonies, the framework of criminology in South Africa was imported from criminological ideas in Britain, Europe, and North America. These imported external discourses prescribed how law should unravel in local contexts. Within criminology in South Africa, there existed a constant battle between these imported discourses, local needs and the realities of legal precedence, or deviation from prescribed law, as seen in jurisprudence. The framework, concepts and procedures of law were imported from English

[10] D. Davis & M. Slabbert (ed.): *Crime and Power in South Africa: Critical studies in criminology*, pp. 29-30.
[11] M. Chanock: *The Making of a South African Legal Culture 1902-1936: Fear, Favour and Prejudice*. Cambridge University Press, Cambridge, 2001.
[12] *Ibid.*, p. 61.
[13] *Ibid.*, pp. 61-62.

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law, Roman law and Roman-Dutch law.[14] It is here that criminology was adapted to suit local needs.

Legislation, however, did not go unchallenged and unchanged over time. This is clearly reflected in both the changes to the mental health acts as well as criminal procedure. These changes have a long and complicated history. Chanock draws on examples of the first adaptions of "scientific" criminology in South Africa and to its connections with anthropological thought on race at the turn of the 20th century. Criminologists in South Africa did not attempt to understand the black criminal, but attempted to construct an essentialist picture of the black criminal. In essence, the construction was intrinsically linked to racial separateness.[15] This dictated how the purported criminal should be punished.

Internationally, the aim of criminology was to offer a scientific understanding of crime. In the local context of South Africa, however, it justified a form of covert oppression closely related to the political context of racial preoccupation. However, the profession was also concerned with understanding criminals and "deviancy" of individuals. Initially this was contemplated in a pathological framework. Deviancy was initially explained in terms of brain defect. The categories which also permeated in legal procedures – such as moral imbecile, moral insanity, degeneracy and feeble-mindedness – were adopted from psychiatry and become basic components in criminology. These categories overlapped with contemporary anthropological debates, preoccupied with clearly identifying varying levels of intelligence between the various races. It became increasingly difficult to separate inherent criminality from the fundamental physical, mental and cultural characteristics attached to notions of savagery and blackness: if all criminals were like savages then all savages were criminals. Much criminological writing found it hard to consider black criminals as individual actors responding to situations as a consequence of their environments or history, as suggested by Pinnock and Freed above.[16] This posed problems for a criminal law organized around the notion of "guilty intention" in relation to specific acts. This was a necessity in passing the appropriate sentence.[17]

[14] M. Chanock: *The Making of a South African Legal Culture 1902-1936: Fear, Favour and Prejudice,* p. 63.
[15] *Ibid.,* pp. 63-64.
[16] L. F. Freed: *Crime in South Africa: an integralist approach*, 1963 & D. Pinnock: "Breaking the Web: gangs and family structure in Cape Town" in D. Davis & M. Slabbert (ed.): *Crime and Power in South Africa: Critical studies in criminology*, pp. 29-30.
[17] M. Chanock: *The Making of a South African Legal Culture 1902-1936*, pp. 64-65.

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Typically, criminologists in South Africa argued that white offenders were "weak" or "defective", but they could be rescued from their situation, particularly if they could be separated from blacks; as if criminality was infectious, it could spread like a disease up the racial hierarchy. Conversely, arguments were made that the reverse process was also a possibility. These notions were based on the stereotype of the easily corruptible, gullible, mystified "tribal innocent" who came to the city in search of work. Naturally these arguments were promoted to justify separation of the races during this period.

According to criminologist and scholar Dirk van Zyl Smit, early South African criminologists developed an intellectual basis for their work during the course of their practice, but they too were products of their environment. Two of the most notable criminologists of the 1930s, for example, Geoff Cronjé and W. A. Willemse, both had prolific careers, but both had attachments to the growing Afrikaner intellectual circles as nationalism grew in the country. Additionally, both had studied in Europe during a period when Nationalism was on the rise and returned to South Africa where they became notable and influential academics in the field.[18]

Both Cronjé and Willemse supported Afrikaner Nationalism throughout their academic careers.[19] With his involvement in the *Volkskongress,*[20] Cronjé only approached problems of crime through this lens. His assessment of cultural and sociological factors served as a foundation for his sociological justification of apartheid.[21] Willemse's major contribution to the field on criminology came with the publication of *Kriminologie*[22] in 1933, with C.I. Rademeyer. It was the first South African text on criminology. *Kriminologie* was to a large extent a summary of Willemse's earlier work on abnormal psychology. It explained in the earlier chapters a strong hereditary theory of criminal behaviour. A chapter on "Social Crime Problems of the Union of South Africa" set the tone for the future of South African criminology in the 1930s until its heyday in the 1980s.[23] It is, therefore, through the lens of

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[18] D. van Zyl Smit: "Adopting and Adapting criminological ideas: Criminology and Afrikaner Nationalism in South Africa", *Contemporary Crises*, (13), 1989, pp. 229-232.
[19] For additional reading on what van Zyl Smit refers to as "Afrikaner Criminology" see D. van Zyl Smit: "Criminological Ideas and the South African transition", *The British Journal of Criminology*, (39), (2), 1999, pp. 198-215.
[20] In 1934 he attended the *Volkskongres* in Kimberly. The aim of this congress was to discuss the Carnegie report on the poor white problem in South Africa. This congress was of great significance to Afrikaner Nationalism, and for the emergence of a specific unit to deal with Afrikaner social work and criminology.
[21] D. van Zyl Smit: "Adopting and Adapting criminological ideas: Criminology and Afrikaner Nationalism in South Africa", *Contemporary Crises*, (13), 1989, p. 233.
[22] Translation: criminology.
[23] *Ibid.*, p. 232.

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growing Afrikaner nationalism that much of the criminological debates of the 1940s and 1950s proliferated.[24]

According to Chanock, the discussions around criminology fed into the insecurities of white society which sought the best "science" to justify its policies. His chapter on "Prisons and Penology"[25] gives a clear and concise view of sentencing during the early formation of South Africa's legal culture when, in essence, punishment was in the form of retribution rather than rehabilitation. To illustrate the difference in sentencing practices in South Africa, Chanock uses the once prevalent sentence of lashing as an example. During the period of 1911-1914 about 4 000 people per year received a sentence of either cuts or lashes. The average cut or lash per person was about nine. The former British colonies of the Cape and Natal[26] relied heavily on the use of corporal punishment in the early period of their existence. This is not surprising as common thoughts at the time suggested that the non-white races, in particular, would only learn from their mistakes when corporal punishment was administered. White offenders would rarely receive lashes and when they did, they received far fewer in comparison.[27]

The fluid nature of sentencing is also reflected in a 1914 petition by the prison Board of Visitors of the Transvaal who complained that prison sentences, especially in what the Board referred to as the "very numerous cases of culpable homicide among Africans", was being arbitrarily passed down. The next year the same Board of Visitors drew attention to the disparities between judges in sentencing of cases involving violence against white women and children by Africans. They noticed that the sentence for rape was the severest in Natal which used the longest prison sentence and lashes, with the Free State coming in second. However, it was the lowest in the Cape. The Board of Visitors of the Transvaal had received complaints from men in prison where some had been more severely punished for the same crime as their fellow convicts.[28] Here the independent workings of the different courts throughout the country, the freedom of judges to deviate from prescribed sentences as well as the more lenient reputation of the Cape courts is illuminated. Albie Sachs suggests that the courts of all four provinces deliberately rejected dominant racial attitudes. Cape

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[24] D. van Zyl Smit: "Adopting and Adapting criminological ideas: Criminology and Afrikaner Nationalism in South Africa", *Contemporary Crises, (13), 1989, p.* 239.
[25] M. Chanock: "Prisons and Penology" in *The Making of South African Legal Culture 1902-1930: Fear, Favour and Prejudice*.
[26] In 1918, the Director of Prisons dubbed the province, the 'lashing province.'
[27] M. Chanock: *The Making of South African Legal Culture 1902-1930: Fear, Favour and Prejudice*, p. 104.
[28] *Ibid.,* p. 105.

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liberal politics, however, led to comparatively more liberal Cape court. In order to effectively gauge the impact of mental health legislation on sentencing practices thus necessitated a detailed investigation in a judicial system less influenced by racial rhetoric.[29]

While Chanock illuminates the fluid nature of sentencing and how judges can deviate from prescribed norms in sentencing, historian Robert Turrell in his book *White Mercy* focused on the most severe of sentence, the death penalty. The argument that Turrell makes regarding the death penalty concerns racial equality: black men charged with the crime of murder were more likely to be sentenced to death than their white counterparts. This was particularly evident if they committed a crime against a white person. Turrell quotes Joe Slovo, the Minister of Housing in the first post-apartheid government. Slovo refers to his experience as an advocate in the 1950s:

> Jerry Maritz rarely pronounced the death penalty, because as Judge President he saw to it that the bulk of the trials that came before him involved a black accused and a black victim.[30]

Justice Maritz once interrupted Slovo in the flow of his argument to suggest that if his client's plea was changed to culpable homicide, he would not go to jail. Slovo made it clear that Maritz's attitude did not stem from the belief in the abolition of the death penalty, but rather in his relaxed and casual attitude towards violence if it did not involve the white community.[31] The arguments made by Slovo on race-of-victim and racial indifference to intra-black homicide have provided essential grist to the interpretation mills of the few South African scholars who have considered the question of race and the death penalty.

Pioneer scholar in the field, Jack Simons, found a way of combining the two. For the first handbook of the Institute of Race Relations published in 1949, Simons published an extensive survey on the criminal justice system where he illustrated three arguments to show how the white judicial system placed a higher value on the lives of whites than blacks. Firstly, Simons showed there was indeed a greater probability of conviction in murder cases where the victim was white. The marked differences in the ratios of prosecutions to convictions indicate that race bias had an effect upon the courts' decisions. It was rare for whites to be convicted of murder when the victim was non-white. The accused was either acquitted or found guilty of culpable homicide or assault. Therefore, there was a reluctance to execute

[29] M. Chanock: *The Making of South African Legal Culture 1902-1936: Fear, Favour and Prejudice*, pp. 104-109.
[30] R. Turrell: *White Mercy: a Study of the Death Penalty in South Africa*, p. 8.
[31] *Ibid.*

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white offenders.[32] Secondly, Simons noticed that the courts were casual about the verdict and lenient about the sentence when both the victim and the perpetrator were black. To quote Simons: "not only is less value placed upon the life of a non-European, but non-Europeans as a group are assumed to observe low standards of morality and self-restraint."[33] Thirdly, Simons pointed out that the Governor-General and the cabinet reprieved whites more easily and readily than non-whites after the mandatory death sentence for murder was abolished in 1935. The statistical evidence for this belief lay in the fact that only four whites were executed between 1935 and 1946.[34]

There is some similarity between the argument made by Simons and that made by Gunnar Myrdal in *An American Dilemma*, published in 1944. However, it is unknown whether Myrdal directly influenced Simons. He is not mentioned in Simon's notes, but Ellison Kahn, who is a leading South African legal academic monitoring the death penalty, feared that in the late 1960s South Africa's death penalty system was attracting harmful allegations of racial prejudice by sociologists using Myrdal's analysis. According to Kahn, whites who controlled the justice system took a benevolent view of intra-racial crimes of Coloureds and "Bantus"[35], due to the fundamentally racialistic view that they were prone to violence and had low levels of morality and self-restraint. Therefore, whites were to be treated more strictly because they were expected to maintain higher standards of behaviour and have greater control over their aggressive instincts.[36] These points, made by Simons and Myrdal, are reflected in the criminal cases at the Cape Supreme Court. The coming chapters will grapple with this by discussing the criminal cases and the sentences accompanying them.

Additionally, Turrell focused on the mercy reports[37] and what they reflected, and according to him, a strong sense of essential racial difference could be derived from dominant white ideological discourse that marked all the reports. The "natives" were simply seen as different from whites. All of them were considered "primitive". The essential characteristics of primitive men were that they were quick to anger and thoughtless in the excessive violent act they committed in a rage. Another characteristic attributed to them was that native men and women were more jealous than their white counterparts. A further

[32] R. Turrell: *White Mercy: a Study of the Death Penalty in South Africa*, pp. 8-9.
[33] *Ibid.,* p. 9.
[34] *Ibid.*
[35] Term used for its historical relevance.
[36] *Ibid.*
[37] Documents outlining the application of the condemned for mercy and the discussion whether mercy should be granted.

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stereotype in the mercy reports was that of "the drunken coloured man". The Cape Attorney-General, E. W. Douglas, once told the jury that "they as men of the world, and knowing the habits of these coloured people, could, if they, on all facts, had any doubts whether he, when he killed the woman, actually intended to do so, find a verdict of guilty of culpable homicide."[38]

Therefore, the mercy reports reflected that white convicts were more likely to receive mercy and have their death sentence commuted to a lengthy prison sentence. The unsuccessful convicts were either hanged for deliberate or determined murder. Deliberate murder is the calmly contemplated, cold-blooded murder of an individual, and determined murder is the persistent and dangerous assault of an individual. On the one hand malice is something that must be considered: Did the accused make preparations, use threats, or say something before the assault to reveal their intention to kill? On the other hand, was malice implied according to how the victim was assaulted: where on the body the victim was struck, and what kind of weapon was used, and how many times was the victim struck, are all factors taken into consideration. According to Turrell, Coloureds, Indians and whites were condemned for deliberate murders, while blacks were condemned for determined murders.[39] The impact that the law had on sentencing practices is profound and, therefore, warrants this dissertation to discuss when moments of transition occur.

To discuss sentencing practices without considering the key influence of trial judges in these cases would be an enormous oversight. Legal scholar David Dyzenhaus discusses the Judiciary's complicity during apartheid and their reluctance to acknowledge that by refusing to properly participate in the Truth and Reconciliation Commission of the post-apartheid era. Dyzenhaus discusses three important factors such as the rule of law, judicial independence and legislative intent. He looks at Judges specifically and how they used and interpreted the law to uphold the legal order of apartheid through means such as legislative intent and the rule of law. Dyzenhaus attempts to illustrate how the judges simultaneously enjoyed judicial freedom from the state to interpret the law, and were bound to the rule of law. Apartheid laws made judges complicit in perpetuating apartheid and abandoning their freedom of interpretation of the law.

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[38] R. Turrell: White Mercy: *a Study of the Death Penalty in South Africa*, p. 36.
[39] *Ibid.*, pp. 39-40.

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In his book *Judging the Judges, Judging ourselves: Truth, Reconciliation, and the Apartheid legal order*, Dyzenhaus references an important South African jurist, Arthur Chaskalson's work as important to his own. Chaskalson's opinion on the rule of law was considered controversial, because many judges resist the idea that their own personal morals should have an impact on the interpretation of the law. According to judges, their duty as judges is to interpret the law as it was intended by legislators to be interpreted. According to Dyzenhaus the apartheid government had unchecked limits on its legislative power. Statutes had to comply with numerous official steps before it was signed by the head of state, in order to be recognized as valid. These statutes had no substantial limits on the legislation of the contents thereof. Therefore, the judges appeared to be under a duty to interpret the legislation as it was clearly expressed, and as the legislature indicated it should be interpreted, regardless of how morally offensive they themselves found the legislation.[40]

According to Chaskalson, this created an "almost Schizophrenic approach by courts"[41] in interpreting apartheid law. This was because the judges' Common Law tradition required them to interpret statute law, as much as they could, in the light of the principles developed by judges in their decisions which "deny all forms of discrimination and which seek to protect fundamental rights and freedoms".[42] Essentially, judges were asked to uphold and give effect to equitable Common Law principles, despite the fact that they were upholding discriminatory laws. South African law is part of the common law heritage, which means the decisions judges make on the interpretation of the law lay down precedents for the future. Therefore, Chaskalson claimed that it was the duty of judges to resort to common law in a legal order where the government was determined to use the law to uphold and implement apartheid ideology.[43]

However, Chaskalson did acknowledge that the problem was that the statute law reigned supreme over Common Law. Additionally, even if judges were able to use such presumptions when they could, their interpretations would always be subjected to statutory understanding, which was a likely outcome if the government was sufficiently determined to realize its policy unchecked by these presumptions.[44]

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[40] D. Dyzenhaus: *Judging the Judges, Judging ourselves: Truth, reconciliation and the Apartheid legal order*, pp. 14-15.
[41] *Ibid.*, p. 15.
[42] *Ibid.*
[43] *Ibid.*
[44] *Ibid.*, pp. 16-17.

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Judges knew that any judicial decisions that would weaken the agenda of the ruling government or enact legal restrictions on the enactment of apartheid would be overruled by legislative amendments to make the government's intention clear. Therefore, in cases where statutory provisions seemed vague, the judges argued that their duty as a judge compelled them to clear up the vagueness, not by referencing a common law presumption, but by referencing how the legislature would have wanted the statute to be interpreted. That understanding of their duty was entrenched in a particular notion of the rule of law. The notion has it that the role of judges in maintaining the rule of law largely involves judges seeing to it that those who implement a statute does it in agreement with the law as it was, intended to be implemented.[45]

It has been an unspoken rule of South African judicial practice that judges must not look to the parliamentary record, to see what has been said in the debates, for indication of legislative intent. The rule of law requires an independent judiciary shielded from political pressure and influence. The idea of the rule of law as removed from politics is worth protecting, especially during a transitional period when a nation is moving away from a regime that used the law as a tool of domination, thus unavoidably politicizing the role of judges. This means that the rule of law should be regarded as impartially as possible in order for the judges to be seen as to stand above the political fray of a transition, accountable only to the law. The idea that the rule of law can be considered as removed from politics can then be thrown into question, because the choice of conceptions of the rule of law for South African judges during apartheid was clearly a political one.[46] In addition, certain aspects such as politics, public debates, misconceptions, and preconceived notions, all entered the narrative in the courtroom when witnesses, complainants, accused and experts were called to testify. Therefore, analysis of the actual court procedure allows one to adequately investigate the extent these discussions affected the reasoning of judges. How they interpreted this, has motivated this study.

This chapter thus far has given context to this study by referring to discussions in criminology, sentencing practices, and the proclivities of trial judges. However, the assassination of former Prime Minister Hendrik Verwoerd was the catalyst for the ensuing debates, commissions of enquiry, and discussion in the judicial and mental health fields. In

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[45] D. Dyzenhaus: *Judging the Judges, Judging ourselves: Truth, reconciliation and the Apartheid legal order*, p. 17.

[46] *Ibid.,* pp. 18-22.

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the aftermath of the assassination of former Prime Minister Hendrik Verwoerd in 1966, both the Prime Minister Verwoerd and Dimitri Tsafendas were sent to Groote Schuur Hospital. Verwoerd was declared dead on arrival, and Tsafendas was interviewed by the acting head of the Department of Psychiatry, Dr Isaac Sakinofsky. When asked why he had killed the Prime Minister, Tsafendas vaguely answered that the Prime Minister was against the "English way of life," against the "Cape to Cairo movement" and supported what he, Tsafendas, saw as an unjust Immorality Act that banned sexual relations between members of different population groups.[47] This case brought issues of "madness" to the forefront of South African society. The media and politicians struggled with a case they referred to as a mindless killing. The media's coverage of Tsafendas as a "crank" and "madman" became increasingly popular in the weeks after Verwoerd's death. The government's explanations for Tsafenda's actions revolved around notions of insanity. This sparked many debates.[48]

In her article "The Assassination of Hendrik Verwoerd: The Spectre of Apartheid's Corpse", Deborah Posel states that she is interested in "the fluctuating ways in which the Apartheid regime made sense of Tsafendas's life and motives in the aftermath of the assassination, in its efforts to redeem a sacrificial meaning of Verwoerd's death."[49] In the case of Verwoerd, the meaning and impact of what Tsafendas had done was inseparable from the cultural politics of leadership within the Afrikaner *volk*. The political culture of Afrikaner nationalism strongly subscribed to a patriarchal form of leadership. This type of leadership was an expression of strength, courage and protectiveness of the father of the *volk*. Expectations of his authority were amplified by the belief that his rise to power was a calling from God. No one embodied this version of the national leader more than Verwoerd.[50]

The first efforts to make sense of the assassination were sensationalized and rife with conspiracy. There were certain elements that portrayed Tsafendas as a smart and malevolent antagonist, and this portrayal of him immediately captured the public's imagination. White members of the public, desired for a story that crucified Tsafendas. According to Posel stories that Tsafendas was an expertly trained assassin were very popular. The Afrikaans newspaper *Die Beeld* even published a story that made reference to a secret file that the

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[47] T. F. Jones: *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, pp. 86-87.
[48] *Ibid.,* p. 87. See also Z. Adams: "Demetrios Tsafendas: Race, Madness and the Archive", unpublished PhD diss, University of the Western Cape, 2011. Zuleiga Adams probes the significance of the murder to debates on mental health in her thesis.
[49] D. Posel: "The Assassination of Hendrik Verwoerd: The Spectre of Apartheid's Corpse, "*African Studies*," (68), (3), 2009, pp. 333.
[50] *Ibid.*

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security police had on Tsafendas. During this chaos political leaders called for "fact and certitude". On 23 September 1966 the government announced in the Government Gazette that it would launch an enquiry into the death of the Prime Minister. The aim of the inquiry was to "probe into all aspects relating to the death of Hendrik Frensch Verwoerd which the Commission deems to be in the public interest".[51] This commission was the first spark that led to the Rumpff Commission of 1967, which in turn recommended the Commission of Enquiry of 1972 to reappraise the existing Mental Disorders Act of 1916.[52]

In the aftermath of Verwoerd's assassination, a substantial change in the discourse of mental health can be seen. South Africa saw numerous official publications deal with the topic of mental health eventually culminating in a new Mental Health Act of 1973,[53] the first significant change in legislation since the 1916 Mental Disorders Act. Training for psychiatrists and psychologists was instituted, and psychologists began working in psychiatric institutions in increasing numbers and were now required by law to register with a professional board. At first glance it may seem that these changes were only repercussions of the aftermath of Verwoerd's assassination. However, other countries such as America and the United Kingdom had also experienced a growth in the professionalization of both psychiatry and psychology after the Second World War, prompting needed reform in South Africa.[54]

According to psychiatrist Dr M. Minde the state of psychiatric knowledge in South Africa went through different stages. The first stage being the settlement of the Cape Colony in 1652. This stage was referred to as the "demonic" stage due to the belief that insanity was caused by demonic possession. This belief had weakened by the second half of the 18th century. The second stage of psychiatric knowledge spanned the entire 19th century and lasted to the middle of the 1930s. This stage is also referred to as the custodial stage. During this period the preferred treatment was containing the patient to an asylum as other treatment options were limited. The rationale was to keep the patient safe, but also to protect the community. By the 1930s, physical treatments such as the use of insulin comas to treat

[51] D. Posel: "The Assassination of Hendrik Verwoerd: The Spectre of Apartheid's Corpse, "*African Studies,"* (68), (3), 2009, p. 333.
[52] The 1972 Commission of Enquiry into the Mental Disorders Act is also referred to as the Second van Wyk Commission of 1972.
[53] For additional reading on the Mental Health Act 18 of 1973 see N. Haysom et al: "The Mad Mrs. Rochester Revisited: The involuntary confinement of the mentally ill in South Africa," *South African Journal on Human Rights*, (314), (1990), pp. 341-362.
[54] H. Laurenson & S. Swartz: "The professionalization of Psychology within the Apartheid state 1948-1978," *History of Psychology*, (14), (3), 2011, pp. 249-250.

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patients became popular. The treatment was favoured for schizophrenics, and cardiozol and electroshock for manic depressive psychoses and schizophrenia. Another form of treatment was the prefrontal leucotomy, which is now obsolete.[55]

According to Robert Kaplan the period between the First and Second World Wars was considered a difficult time for psychiatry. The medications that were available – such as opiates, chloral hydrate, paraldehyde, barbiturates and bromides – were not curative but treated the symptoms of psychiatric patients. Paraldehyde, for example, was considered to be a good sedative and barbiturates had anti-anxiety properties and was useful for sedation and to restrain patients. However, the side-effects and possible addiction to these medications could be lethal to patients. By the late 1930s, new biological treatments became popular in Europe. A new treatment, Malariotheraphy presented hope that new additional biological treatments would be made available. Insulin-coma therapy, developed by Manfred Sakel after he observed a depressed patient recover after going into a hypoglycaemic coma, had become a popular treatment method.[56] According to historian Julie Parle, who has written about the early treatments for psychiatric conditions, the use of insulin-comas in psychiatric institutions was common in South Africa.[57]

South Africa's mental health professionals and those in England had always enjoyed a close link with one another. New developments in Britain were often quickly reproduced in South Africa with no regard for the difference in context. Most of South Africa's mental health professionals received their training in Britain and followed the progress of psychiatry in the Northern Hemisphere when they returned. Professionals would often visit medical institutions in places such as Europe, America and Britain. Britain is of particular interest as South Africa adopted their mental health legislation.[58]

By 1948 with the establishment of the National Health System in the United Kingdom, psychiatric hospitals acquired the same status as general hospitals. At the time nearly half of all beds in hospitals were allocated to mental patients. Hospitals were the domain of superintendents who primarily trained on the job. The psychiatric qualification

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[55] M. Minde: "History of Mental Health Services in South Africa-Part XVI. Psychiatric Education," *South African Medical Journal*, (51), 1977, p. 210. See also L. S. Gillis: "Education for Appropriate Psychiatry," *South African Medical Journal*, (49), 1975, pp. 112-116.
[56] R. Kaplan: "A History of Insulin Coma Therapy in Australia," *Australasian Psychiatry*, (21), (6), 2013, p. 587.
[57] See J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s-2018," *Oxford Research Encyclopedia, African History*, 2019, pp. 1-25.
[58] H. Laurenson & S. Swartz: "The professionalization of Psychology within the Apartheid state 1948-1978," *History of Psychology*, (14), (3), 2011, p. 252.

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was a diploma that lacked the status of other medical fields. Luckily the establishment of the National Health System gave more funding for facilities, and expansion of staff members. It was the National Health System that made clinical psychologists a standard part of the health service by establishing a career structure and salary scales.[59]

According to psychiatrist and scholar Dr Gillis, psychiatry in South Africa, was still in its infancy at his point. In the past, all psychiatric training had been done at the mental hospitals, by the hospital superintendent. There had been no formal training course before the first university diploma course. The first training course, based on the British model, was set up at Johannesburg's Tara Hospital in 1948. Tara Hospital was a psychiatric institution linked to the University of the Witwatersrand. Dr Gillis recalls that while Tara Hospital was breaking new ground the majority of South Africa's mental institutions still functioned on the old custodial method. These institutions were overpopulated, and the staff suffered poor professional specialization.[60]

The physical stage of the physical treatment period lasted to the mid-1950s and was followed by the fourth stage of the development of psychiatric knowledge which was marked by the rise of psychotropic drugs.[61] The discovery of psychoactive drugs resulted in deinstitutionalization that changed the professions of psychology and psychiatry internationally by reducing the number of chronically ill psychotic patients that were institutionalized and, therefore, changing the landscape of psychiatric institutions. Neuroleptics in 1952, imipramine in 1956, and the inhibitors of monoamine oxidase in 1958, for example, had a prolonged effect on psychotic symptoms in patients that had been previously unresponsive. Methods such as physical restraint were no longer necessary. The use of treatments such as an insulin coma, Metrazol shock treatment, and ECT[62] could now be minimized or eliminated completely. It now became possible to treat patients in an out-patient setting. Due to deinstitutionalization, the function of asylums shifted from custodial to curative. This is important, because patients that would respond favourably to these treatments could be send home. During this period South Africa was not the only country

[59] H. Laurenson & S. Swartz: "The professionalization of Psychology within the Apartheid state 1948-1978," *History of Psychology,* (14), (3), 2011, p. 252.
[60] *Ibid.,* p. 253.
[61] M. Minde: "History of Mental Health Services in South Africa-Part XVI. Psychiatric Education," *South African Medical Journal*, (51), 1977, p. 210.
[62] Electroconvulsive therapy.

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updating its outdated mental health legislation. Ireland and Norway updated their laws in 1945 and 1961 respectively.[63]

Helen Laurenson and Sally Swartz, in their article "The Professionalization of Psychology within the Apartheid State 1948-1978", have stated that with the development of psychoactive drug treatments such as insulin-coma therapies fell out of fashion. Therefore, with the psychoactive drugs becoming available, psychiatric institutions moved towards a curative approach instead of being custodial.[64]

During the apartheid era, the medical profession in South Africa had been complicit in abuses. The psychiatric profession's reputation had taken a considerable knock. The abuse of homosexual conscripts, male and female, in the South African Defence Force comes to mind. According to Robert Kaplan's article "The Aversion Project-Psychiatric abuses in the South African Defence Force during the Apartheid era",[65] for over a period of two decades, conscripts were systematically removed from the Defence Force and subjected to aversion therapy and sex reassignment surgery. The doctor behind these abuses was a psychiatrist, Dr Aubrey Levin, a former Colonel in the Defence Force. He was in charge of Ward 22 at One Military Hospital were most of these conscripts were "treated".[66] This is but one example of many where medical practitioners, inside and outside of the field of psychiatry, had abused patients.[67]

Kaplan focuses his work on the individuals in the medical field who commit medical abuses. In his article "The Clinicide Phenomenon: an exploration of medical murder", he focuses on individuals who commit such acts.[68] The article identifies three categories of Clinicide; namely (1) medical serial killers; (2) treatment killers; and (3) political mass murderers. Medical serial killers are those who use their medical training and knowledge to murder mass numbers of patients predominantly through administering lethal doses of medication, while treatment killers have no apparent motive. They do not kill on the same

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[63] H. Laurenson & S. Swartz: "The professionalization of Psychology within the Apartheid state 1948-1978," *History of Psychology*, (14), (3), 2011, pp. 250-252.
[64] See H. Laurenson & S. Swartz: "The professionalization of psychology within the Apartheid state 1948-1978," *History of Psychology*, (14), (3), 2011, pp. 249-263.
[65] R. Kaplan: "The Aversion Project-Psychiatric abuses in the South African Defence Force during the Apartheid Era," *South African Medical Journal*, (91), (1), 2001, pp. 1-3.
[66] *Ibid.*
[67] See also R. Kaplan: "Dr Radovan Karadzic: psychiatrist, Poet, soccer coach and genocidal leader," *Australasian Psychiatry*, (11), (1), 2003, pp. 74-78.
[68] For example Dr Harold Shipman, who in 2000 was found guilty of murdering 15 people with lethal overdoses of heroin, and Dr Swango who killed 60 patients in Zambia, Zimbabwe and several states in America.

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scale as medical serial killers, but death in increasing numbers usually accompanies their treatment. Lastly, political mass murderers are the accomplices in state brutality, repression and genocide. They use their training to commit abuses in the name of nationalism or some other form of ideology.[69]

Due to the focus of this dissertation being the impact of mental health legislation on sentencing practices it is therefore necessary to discuss the basis of South Africa's mental health legislation. Early Mental Health legislation dates back to Roman Law and Roman-Dutch Law. In his book *Mental Health Law* in South Africa, A. Kruger begins his discussion on mental health legislation in South Africa by referring to the history of mental health law with particular reference to Roman law and Roman-Dutch law. In Roman law the care for mentally ill individuals falls on family members because the family unit in Rome was a close-knit one. According to Roman law the mentally ill person should be taken into custody of his nearest family member, not only for the sufferer's care, but as a curator of their estate. This law becomes applicable when mental retrogression is setting in.[70]

Roman law did not distinguish, in so many words, the different classes of insane persons. Lunacy was always considered curable. The insane person would have freedom when s/he lapsed into periods of sanity. Therefore, s/he would no longer be under the direction and control of his curator. When the insane person relapsed back into insanity s/he would once again be under the direction and control of the same curator. The insane person would have no legal capacity, except for moments when s/he was sane. Curatorship would only end completely when the insane person became well again, permanently, or if the insane person died. Roman law did not concern itself with the rights of the patient, but with protecting the family heritage. The interests of the family and the community had to be protected.[71]

Roman-Dutch law, as the name suggests, was built upon the principles of Roman law. Roman-Dutch writers examined and developed the principles of Roman law, especially relating to the mentally ill. They had adopted the relevant principles of Roman law and adapted it according to their needs and their context. An important development in Roman-Dutch law was that the curator was no longer automatically appointed. The curators were

[69] R. Kaplan: "The Clinicide Phenomenon: an exploration of medical murder," *Australasian Psychiatry*, (15), (4), 2007, pp. 299-302.
[70] A. Kruger: *Mental Health Law in South Africa*, pp. 1-3.
[71] *Ibid.*, p. 4.

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appointed either by the provincial court of Holland or by the ordinary magistrates, depending upon which court the relatives of the patient approached. Additionally, curatorship did not automatically end with the recovery of the patient. An application had to be made to the court that ordered the curatorship, and only then could the court remove that curatorship.[72]

In Roman-Dutch, law the patient could now also apply to the court for an annulment of the order placing a curatorship over them if they felt aggrieved by the order. The right to confinement could also be granted by the court. In earlier times this right was granted to the family and friends of the patients. It would appear that mentally ill patients were treated much better in Roman-Dutch law than in Roman law. However, in Roman-Dutch law there was no control over how the patient was detained, or how the patient was treated. The detention of the patient was rather informal than official. Roman-Dutch law had legitimized the incarceration of the mentally ill, yet no mental hospital or even a reasonable treatment plan existed.[73]

As English Law had an impact on the South African legal system, it is important to refer to the 'M'Naghten' rule in English Law.[74] The "law" came to be in 1843 when the private secretary, Edward Drummond, of the Prime Minister of England, Sir Robert Peel, was murdered by Daniel M'Naghten. During the trial it became clear that M'Naghten had been suffering from delusions that he was being prosecuted by the Prime Minister and other members of parliament. The jury found him "not guilty, on the ground of insanity." The M'Naghten trial had received some notoriety in England because of the verdict. However, the nature and extent of the unsoundness of mind that would "excuse" such a crime became the point of departure in discussion of the case in the House of Lords.[75]

In the same year as the court case took place, the House of Lords began to develop the M'Naghten Rules. The judges were tasked with setting out the proper test for insanity. Here follows their rule:

> To establish a defence on the grounds of insanity, it must be conclusively proved that, at the time of the committing of the act, the party accused was labouring

[72] A. Kruger: *Mental Health Law in South Africa*, pp. 4-5.
[73] *Ibid.,* pp. 6-7.
[74] For additional reading see S. E. Sobeloff: "Insanity and the Criminal Law: From McNaghten to Durham, and Beyond," *American Bar Association Journal*, (41), (9), 1955. pp. 793-796. America also used the McNaghten rules. However the 1954 case *Durham* v. *United States* in the District of Colombia provided the 'Durham Rule' until that was abandoned in the case *Brawner* v. *United States* in 1972. See also J. Hall: "The M'Naghten Rules and Proposed Alternatives," *American Bar Association Journal*, (49), (10), 1963, pp. 960-964.
[75] E. R. Keedy: "Irresistible Impulse as a Defence in the Criminal Law," *University of Pennsylvania Law Review*, (100), (7), 1952, pp. 958-959.

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> under such defect of reason, from a disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know what he was doing was wrong.[76]

Within the next century the rule was adopted in South Africa and followed until the assassination of Verwoerd when the ensuing commissions of enquiry concluded that the legislation was not satisfactory, or effective. Therefore, the M'Naghten rules were extended to include a "test" based on whether a mentally disordered person had committed an offense under an irresistible impulse, even though he had the capacity to understand the nature of the act and appreciate the wrongfulness of the act.[77]

Not only has legislation impacted the mental health field in South Africa, ideologies about race such as eugenics influenced how mental health was conceptualized for the different races. According to Saul Dubow, race is viewed as a scientific construct and, therefore, it becomes easy for white supremacists to use "scientific" evidence as proof for white superiority. It also influences the imagery and representation of non-whites in European minds.[78] Therefore this "scientific" justification for racism plays an important role in creating and maintaining white supremacy.[79] According to psychologists C. Van Ommen and D. Painter in their edited volume *Interiors: A History of Psychology in South Africa* psychiatry and psychology developed racialized processes of knowledge production.[80] This meant that the fields of psychology and psychiatry had been influenced by early theories on race.

The study of human difference can be traced back to the mid-eighteenth century. It was with the development of European enlightenment that the main racial divisions of the world were firmly established. One of the great paradoxes of the enlightenment is that it implied not only the advanced scientific forms of reasoning, but also "the rationalization of old prejudices".[81] A significant development was the association of race as type. Carl Linnaeus distinguished between European man, Asiatic man, African man and American

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[76] E. R. Keedy: "Irresistible Impulse as a Defence in the Criminal Law," *University of Pennsylvania Law Review,* (100), (7), 1952, pp. 958-959.

[77] L. Möller: "The Constitutionality of the Onus of Proof in cases where Mental Illness is averred," Masters diss, University of Pretoria Law Faculty: Department of Public Law, 2011. p. 4. & F. F. W. van Oosten: "The Insanity defence: its place and role in the Criminal Law," *South African Computer Journal*, (1), 1990, pp. 1-9.

[78] S. Dubow: *Illicit Union: Scientific racism in Modern South Africa*. Witwatersrand University Press, Johannesburg, 1995.

[79] For further reading on white supremacy in South Africa refer to C. Bloomberg & S. Dubow (ed): *Christian-Nationalism and the Rise of the Afrikaner Broederbond, in South Africa, 1918-1948*. MacMillan, Basingstoke, 1990.

[80] C. Van Ommen & D. Painter (ed.): *Interiors: A History of Psychology in South Africa*. UNISA Press, South Africa, 2008.

[81] S. Dubow: *Illicit Union: Scientific racism in Modern South Africa*, p. 25.

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man. The Europeans were civil, governed by law and ingenious. Africans were lazy, careless and governed by the arbitrary will of their masters. Johan-Friederich Blumenbach, who is often referred to as the father of physical anthropology, first named three fundamental races: Caucasian, Mongolian, and Ethiopian. Later American and Malayan were added. The profiling of racial types or sub-types was well underway.[82]

The institutionalization of physical anthropology in Europe strengthened the conception of race as a type. Robert Knox published his book, *The Races of Men in Britain* in 1850. He sought to establish a link between anatomical differences and national character. Knox was one of the most important scientific racists of his time. His ideas became very influential as mid-Victorian society became increasingly susceptible to the ideology of racial determinism. Moreover, Knox was also a forerunner of anthropometrical studies in South Africa. He developed an interest in comparative anatomy when working as a field surgeon in the Eastern-Cape. He was one of the first people to refer to the Khoisan people as the "yellow-skinned race of Southern Africa". He also claimed responsibility for sending the first "Kaffir Crania" to Europe. Many of Knox's statements on the mental and physical characteristics of the "Bosjeman", the "Hottentot" and the "Caffre", as well as the questions he posed about their racial origins, were still taken seriously by scientists some 50 years after the publication of *The Races of Men* in 1850.[83]

The classification of people according to their physical attributes involved many different criteria. Criteria included the analysis of skin colour, hair texture, bodily stature, head shape, and facial proportions. As comparative anatomy emerged, these forms of measurements became more technically advanced. Moreover, Blumenbach initiated the study of the human crania. While his classification of the world's peoples into distinctive types relied on physical criteria, it continued to reflect an older biblical paradigm which took monogenesis for granted. Therefore, he regarded the various forms of mankind as having "degenerated" form a single "Caucasian" type. Monogenetic forms remained powerful in a pre-Darwinian world because it agreed with European religious and philosophical orthodoxies.[84]

The origins of eugenics dates back to the 1860s when Francis Galton explored the inheritance of natural ability. It overlapped with the rising intensity of imperialist feeling

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[82] S. Dubow: *Illicit Union: Scientific racism in Modern South Africa*, pp. 25-26.
[83] *Ibid.,* pp. 27-28.
[84] *Ibid.,* p. 28.

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from the 1880s helping to fan nationalist fervour and provided a convenient justification for the colonial subjugation of non-Europeans. The rise of the eugenics movement was responsible for the explicit expression of racist conceptions. It offered important reinforcement to those who continued to seek scientific justification for their prejudices. Chief measures started to move away from relying exclusively on physical anthropology to an emphasis on intelligence testing, since this also offered a path to the same invalid goal of ranking groups by mental worth. By translating the insights of evolutionary biology into a popular idiom with a recognizable social programme, eugenics gave Social Darwinism a decisive impetus and a distinct political resonance.[85]

On the one hand eugenics reflected the confidence in the superiority of the Anglo-Saxon race. This was supported by the application of evolutionist ideas to society in such a way as to normalize divisions based on social class, gender and race. However, eugenics also reflected a deep vulnerability and fear among the Victorian middle class.[86] These biological conceptions of race informed Christian-National theory, both implicitly and explicitly. However, these had to be reconciled with theological and cultural explanations of human difference. In constructing a coherent argument for apartheid, Christian-National ideologues frequently chose to suggest biological theories of racial superiority, rather than to assert these openly.[87]

It is within these various contexts, that the issue of mental health and the law is situated. While the manner in which this developed during the period under investigation is further discussed in the content chapters, it is important to note that resistance to change has historically been consistent. One such example can be seen in the resistance to changes in mental health legislation during the period under investigation.

While researching the parliamentary debates, the house of assembly mentioned the Church of Scientology during their discussion of the proposed Mental Health Act. It became clear that the organization had been involved in anti-psychiatry activities not just abroad, but in South Africa. Due to the nature of Scientology's anti-psychiatry activities in South Africa this dissertation will focus on the harmful practices of Scientology and its attacks on psychiatry, and what the implications were of their activities. Historian Tiffany Fawn Jones's chapter "Critics of the system? The Church of Scientology and the International Vilification

[85] S. Dubow: *Illicit Union: Scientific racism in Modern South Africa*, p. 120.
[86] *Ibid.,* p. 121.
[87] *Ibid.,* p. 246.

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of Psychiatry" in her book *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*[88] provides an in-depth look at Scientology in South Africa and their critique of South African psychiatry.

The Church of Scientology[89] and its subsidiary, the Citizens Commission of Human Rights (CCHR)[90] had not always positioned itself against the apartheid state. The organization tried to ally itself with the National Party claiming that the true enemies of the state were psychiatrists.[91] The CCHR had their own self-serving agenda for attacking psychiatry. Scientology rejects psychiatry completely, in favour of their own dogma, as a means to obtain mental clarity. However, the organization never managed to form a relationship with the National Party government. Instead, due to their rejection by the Apartheid state, they began to publicize the overall conditions in hospitals and began a series of investigations that would culminate in the international community ostracizing the South African government and those working within its constraints. The attacks on psychiatry perpetrated by the organization revealed how close the relationship between the government and psychiatrists were. The relationship was close enough for the government to set up a Commission of inquiry into the organization in 1969.[92]

The theory of Dianetics, on which Scientology is based, is inherently racist. In Hubbard's *Dianetics: The Modern Science of Mental Health* he argues that "primitive societies, being subject to much mauling by the elements, have many more occasions for injury than civilized societies". According to Hubbard, these societies have a very limited level of medicinal and mental health knowledge and practice. Notably, Hubbard made it clear that Africans were of too low intelligence for them to become effective members of the organization. However, despite his initial racist rhetoric and the organization's continued

[88] T. F. Jones: "Critics of the system? The Church of Scientology and the International Vilification of Psychiatry" in *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, Chapter 5.
[89] The Hubbard Association of Scientologists International (HASI) opened offices in 1957 in Johannesburg and Durban. By 1961 another office opened in Cape Town followed by an office in Port Elizabeth in 1962. Notably, in 1962 Hubbard sent out a letter to all the branches that Scientology was to slowly transition from business to church status. HASI would eventually incorporate its South African branches under the name of the Hubbard Scientology Organization in South Africa (Propriety) Limited. He would make his wife Mary Sue Hubbard and Marilyn Routsong and himself directors. Ironically the mandate of the South African offices read as if the organization wanted to partake in psychological research. Their aim was to partake in a sort of pseudo-psychiatry to ultimately eclipse the work of psychiatrists.
[90] The CCHR was meant to be an independent body, regardless of its affiliation to the Church of Scientology, set up to investigate human rights violations in the psychiatric field.
[91] T. F. Jones: *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, p. 156.
[92] *Ibid.*, pp. 156-157.

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reassurance to the National Party government that it supported their mandate, Scientology was never able to win the support of government officials.[93]

In 1969 an investigation into the organization began, because of their attacks against psychiatry and prominent psychiatrists who were aligned with the state. Since opening their branches in South Africa, they began targeting psychiatrists who headed up large mental health organizations or had political connections. Some of their targets included T. J. Stander, the director of the South African National Council for Mental Health, and his 1966 replacement Jan J. Robbertze. They also targeted prominent United Party members which included Dr. E. L. Fisher, and Dr. A. Radford; both of whom practiced in the field of psychiatry. Both had been outspoken advocates for the improvement of mental health care.[94]

In 1972 the government published the commission of inquiry into Scientology detailing as much information about Scientology as possible, particularly the organization's activities in South Africa. The document consists of 15 chapters containing all the information the government could gather about the organization, its founder and their activities in South Africa. Although Scientology did not appear to be a threat to the hegemony of the Apartheid state, it did however assist in denting the international reputation of South African psychiatrists. Therefore, it is important to include the findings of the Commission of enquiry into Scientology in this dissertation.

1. 2. Methodology

The archival research in this study is primarily focused on criminal cases from the Cape Town Supreme court for the period of 1964-1976. This is two years before the assassination of former Prime Minister Hendrik Verwoerd in 1966. This entailed a systematic perusal of over 2000 boxes of criminal case files from the Cape Town Supreme Court for the period 1964-1976 housed at the Cape Town Archives and Records Services.[95] The Supreme Court archives are the most comprehensive and systematically maintained archival source base from which relevant statistical analysis and contextualization within the broader debates could be conducted. Due to the sheer volume of case files, this dissertation

[93] T. F. Jones: *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, pp.159-160.
[94] *Ibid.*, p. 160.
[95] KAB CSC 1/1/1/580-2714 Cape Supreme Court Records.

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will only discuss cases brought before the courts for murder, culpable homicide and murder-related cases. These cases had to be rewritten based on the various and conflicting information sheets bound within what can only be described as an incoherent folder. The statistics have been tabulated and presented in Chapter Two. Unfortunately, the Western Cape Archives only houses criminal case files until 1976. Therefore, trends between 1977 and 1980 had to be gleaned from case law from the legal journals. These do not provide contextual information but do provide some indication of deviations from the prescribed minimum and maximum sentences in cases of murder, and the conditions under which such deviations occurred.

It should be noted that given the nature of the study which focusses on mental health and sentencing practices for murder, in which the testimony of expert testimony provided invaluable information surrounding the various debates unfolding in the country, specific focus has been kept on the main Supreme courthouse in Cape Town. Vastly different trends may be found within the rural circuit courts, which also fell under the Cape Town Supreme Court. Similarly, the formal mental state of the victim as per the categories under the DSM classification system, falls beyond the scope of this dissertation. It should also be noted that this study does not attempt to evaluate the moral implications bound by the act of murder, but rather questions the way in which various considerations unfolded during the judicial process.

Parliamentary debates, commissions of enquiry, [96] including those on the mental health act, and the proposed criminal procedure bill from the National Library in Cape Town were also consulted.[97] The study could have been elevated if access to the Valkenberg assessment files was granted. However, the discussions which arose in the actual court proceedings have provided sufficient evidence of the complex ways in which these debates were contemplated and negotiated within the legal system.

Due to the timeframe investigated, consideration was given to the subjects of this study. The author has opted to use the initials of those brought before the courts to avoid any undue harm that the study could have on survivors or members of their family.

[96] For example, the Rumpff Commission (1967), the Botha Commission (1971) and the Van Wyk Commission of 1972.
[97] These include the parliamentary debates from 1972-1977.

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1. 3. Dissertation Outline

Chapter Two will provide a statistical analysis of the prosecution and conviction rate compared to the criminal cases where mental illness was averred. This chapter will also discuss legal and medical terminology, such as the legal definitions of murder and culpable homicide. Additionally, attention will be given to mitigating factors taken into consideration in the sentencing of parties found guilty for murder. This includes intoxication,[98] degree of provocation, and related mental considerations, such as intelligence tests, as well as more pathology-based discussions such as epilepsy and head injuries.[99] The reflection on the proclivities of court judges is also discussed in this chapter. The psychological and psychiatric considerations in these trials are fleshed out within the remaining content chapters.

Chapter Three will discuss the legislation prior to the 1916 Mental Disorders Act to give context on what the outdated mental health legislation was based on, particularly the English M'Naghten rules. Additionally, the criminal cases which appeared before the Cape Supreme Court, two years prior to the assassination of Verwoerd will be discussed, outlining some of the discussions that went into the sentencing of those found guilty. This chapter, therefore, provides context to what unfolds in the various debates on psychiatry, psychology and the judiciary after the assassination and subsequent debates and commission on mental health and the legal profession. This chapter will also look at the Rumpff Commission of 1967, instigated by the first van Wyk Commission in 1966, that recommended that a Commission of Enquiry be called into the Mental Disorders Act of 1916.

Chapter Four will focus on mental health in the courts, as discussed in the parliamentary debates, and as reflected in the new proposed acts of parliament. Additionally, this chapter will discuss criminal cases at the Cape Town Supreme Court between the years 1968-1971 to gauge how these cases unfolded in the aftermath of Verwoerd's assassination. The Commission of Enquiry in the Criminal Procedure and Evidence legislation of 1955 will also be discussed due to the report of the commission recommending that a new Criminal Procedure Bill be drafted to replace the outdated 1955 Criminal Procedure Act, which was largely based on English and Roman-Dutch law and did not adequately reflect the new issues and concerns of South African society at this point. The second van Wyk Commission of 1972 also published its findings that made influential recommendations to parliament concerning mental health legislation.

[98] Marijuana and alcohol use.
[99] For example, the courts would contemplate the effects of brain damage or epilepsy during deliberations.

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Additionally, the parliamentary debates concerning these proposed changes will be discussed, namely the Mental Health Act No. 18 of 1973 that only became law in 1975 and the Criminal Procedure Bill of 1973 that lapsed only to become law in 1977.

Chapter Five will predominantly be a discussion of criminal cases before the Cape Supreme Court from 1974-1980 to gauge what trends had become apparent after all of these legislative debates and changes. Interestingly, the previously discussed Acts were not yet reflecting in the legislation, however, they do appear in the criminal case discussions. Due to cases for 1977-1990 not being available in the archives, this study will make use of the law reports for 1977-1980. Additionally, the government statistics will be used, as this is the only statistical analysis available for 1977-1980.

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Chapter 2

Sentencing Practices for Murder and Culpable Homicide at the Cape Supreme Court, 1964-1976

This chapter serves as an important foundation from which the developing trends in mental health and the judiciary develop in the coming chapters of this dissertation. The chapter will begin by expanding on the complex and somewhat nuanced terminology of murder in South Africa during the 1960s and 70s. Attention will be shifted to a detailed presentation of the prosecution and conviction rates tabulated by the author for cases appearing in the Cape Town Supreme court between 1964 and 1976. This will be followed by a discussion on the most prolific trends of this court. This will include a brief introduction to the preference of judges, the passing of the death sentence and the most prevalent extenuating circumstances seen in the court proceedings. The chapter ends with the locating of cases in which mental illness is considered a mitigating factor. It is argued that many of the extenuating circumstances share similarities with the existing secondary literature but through the discussions and reflections on mental illness in the judiciary, components of more complex and unfolding debates begin to unravel.

2. 1. Note on Categories of Murder Charges

When an accused was charged, s/he appeared before a magistrate and was formally charged for an offence as determined by the Attorney-General. In cases where multiple offences had occurred, the more severe and/or the one for which a conviction was more likely, became the formal charge. In some instances, as will be shown later, compound offences were also presented on the charge sheet.

The focus of this study is on cases brought before the courts for murder and culpable homicide. According to legal scholar T.B. Barlow, murder was considered the wrongful killing of a human by another with the intent to kill. In order to find the accused guilty of murder they must have intended the death of their victim. This involves either deliberate purpose to kill or causing some kind of injury the accused knew was likely to cause the death of the victim regardless of the consequence

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If found guilty, the maximum sentence that could be passed was death by hanging. This was mandatory prior to 1935 after which, it was at the discretion of the presiding judge.[1]

Culpable homicide was a lesser charge compared to murder with a lower range of sentences. In order for the accused to be guilty of culpable homicide they had to cause the death of another human, without the intent to kill. The death could be a negligent performance of some legal act, or the negligent failure to perform some legal duty. It is clear that the distinguishing factor between murder and culpable homicide is the absence of intent to kill. The death is a result of the failure of the accused to foresee the possibility of harm and not paying enough attention to the possibility of harm resulting from their action. It is important to note that there is a clear distinction between the performance of an illegal act and the negligent performance of a legal one.

During the trial, the accused was asked to plead either guilty or not guilty. It was here that one could also accept guilt on a lower charge. This could also be on the advice of the judge. One such example can be seen in the case of the State *v*. D., in 1970. The accused in this case, D. was charged with murder of a young Coloured man by stabbing him to death. D. pleaded guilty to culpable homicide and on the 16th of March 1970 Justice van Zyl found him guilty of culpable homicide and sentenced the accused to six years in jail. Both the accused and the deceased were residents of the farm Onverwag where they were both employed, including the woman central to this case, Sanna Ewerts Voe. On the 9th of September 1969 the deceased, J. N., went to visit the witness Sanna as they were lovers. According to the witness testimony of Sanna Ewerts Voe the deceased was her 'vryer'[2]. Sanna and the deceased left to go to the home of Marie Jacobs, who also lived on the farm Onverwag, where they spent the night. Early the next morning the deceased left to go to work, and by midday the deceased and a man named Douglas, a tenant of Marie Jacobs, met up with Sanna at the crossroad at Onverwag.[3]

She could tell that both of them had something to drink, however they were not drunk. The three of them went back to the home of Marie Jacobs where they were joined by her husband Karel. At the house they had about a gallon of wine amongst them. A little while later the accused showed up at Marie Jacobs's house. He walked over to the kitchen door and called the deceased to come with him. The deceased obliged. According to Sanna the

[1] T. B. Barlow: *Digest of the Law of Murder and Culpable Homicide*, pp. 1-2.
[2] Translation: Lover.
[3] KAB CSC 1/1/1/1345, Cape Supreme Court Records, Case no. 33 of 1970. State *v*. D.

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deceased walked to the kitchen door where he faced the accused. They did not speak to each other, and suddenly they started fighting. The battle continued outside. Sanna later found the deceased with blood on his chest. According to her she did not see what happened or what happened next as she bolted to get the police. When she returned J. N. was dead.[4]

If no evidence was proven against the accused, the charges were dismissed and the accused was discharged. If found guilty, however, a variety of factors were taken into consideration. These include extenuating circumstances such as having temporary loss of faculties. This could include alcohol and substance abuse at the time of the murder. It could also include provocation, a history of violence as well as a previous conviction. This would determine whether the death sentence would be passed or whether a lighter sentence was warranted. This was made explicit during sentencing.

The presiding judge could either find the defendant guilty of murder, guilty of murder without extenuating circumstances, guilty of murder with extenuating circumstances or guilty of culpable homicide. In some instances the sentence might even be lowered to the level of assault. The punishment would therefore vary from the death penalty, imprisonment, being declared a State patient or a fine. It could also be suspended.

In the case of S. N., for example, the accused and the deceased, were jovially chatting. During their interaction the accused wanted to give his female cousin a fright and he pulled out a dagger. He jokingly made stab movements towards his cousin, accidentally stabbing her in the process. The court believed that neither of the parties were intoxicated and that the accused genuinely tried to help his cousin after he had accidentally stabbed her. The accused also had no previous convictions. Justice van Zyl found him guilty of culpable homicide and sentenced him to 18 months imprisonment suspended for 18 months.[5] While he did not receive a prison sentence, this judgment would remain on his record for life.

Suspended sentences, or portions thereof, even appeared in quite gruesome cases of baby killing. In the State *v*. J. J in 1972, the accused was charged with the murder of a three-month old baby. The accused was severely intoxicated. According to the deceased's mother, he was unable to stand upright and he was stumbling. The accused had arrived home in this state and proceeded to pick up his baby. Due to his intoxicated state the mother demanded that he give the child to her. The deceased then proceeded to throw the baby to the mother

[4] KAB CSC 1/1/1/1345, Cape Supreme Court Records, Case no. 33 of 1970, State *v*. D.
[5] KAB CSC 1/1/1/1766, Cape Supreme Court Records, Case no. 100 of 1972, State *v*. S. N.

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and he fell on the cement floor. According to the mother the deceased fell hard. Sadly the child died later due to the fall. The trial judge, Justice Steyn found the accused guilty of culpable homicide and sentenced him to 18 months imprisonment suspended for three years.[6]

Some sentences are quite hard to fathom. In contrast to the case above, T. P. was charged with murder after he assaulted the deceased during a fight that resulted in the death of the deceased. The confrontation occurred outside a local store in Cape Town. It was unclear to passers-by what the accused and the deceased were arguing about. According to some they seemed heavily intoxicated. It was determined that the deceased was quite intoxicated, however it is not clear how intoxicated the accused was. The fight ended when the accused took a broken bottle that was lying outside the store and proceeded to stab the deceased in the chest with it. The deceased died before he could be taken to hospital for medical assistance. Justice Beyers found the accused guilty of murder with extenuating circumstances, and although the accused had no previous convictions, especially for assault indicating aggressive behaviour, he was sentenced to a hefty 15 years imprisonment.[7]

In murder cases the highest degree of *mens rea* or intention is an important element and unless the prosecution can discharge the onus of proving the presence of this intention, it cannot get a conviction for murder. It is essential to distinguish between the intent to kill and the desire to cause the death of the deceased. An example of this may be that a man may not want to kill a woman but may nevertheless be prepared to assist her in committing suicide. The intent to kill covers knowledge that the act of the accused is dangerous enough that it is likely to cause death, coupled with recklessness where death results.[8]

Mens rea is defined as a blameworthiness state of mind with which the perpetrator acts. In cases where the *mens rea* of a perpetrator is an issue, two factors may arise which have to be dealt with separately. The first is whether the perpetrator can be held responsible, that is, whether his mental state is of such a nature as to render him accountable for his act under the law. When the perpetrator is responsible, the second factor arises. This factor asks in what blameworthy state of mind the perpetrator acted, that is, did he kill someone with the intention to kill, or was his intention merely to frighten the deceased and was he negligent

[6] KAB CSC 1/1/1/1765, Cape Supreme Court Records, Case no. 96 of 1972, State *v*. J. J.
[7] KAB CSC 1/1/1/1751, Cape Supreme Court Records, Case no. 60 of 1972, State *v*. T. P.
[8] T. B. Barlow: *Digest of the Law of Murder and Culpable Homicide*, pp. 5-6.

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in his actions? That second factor is of importance when the question of diminished responsibility is raised.[9]

It is here that the divergence between criminal law and mental health becomes apparent. Criminal law adopts the point of view which accepts that man can direct his will in respect of his actions. Criminal law does not allege that disposition, character and environment have no influence in shaping the human will, but holds all mentally sound persons accountable for punishable action, irrespective of the extent of influence of the factors mentioned in shaping the will. When the jurist associates the term 'insanity' with responsibility, he introduces a medical concept, although psychiatry does not use the term. To the jurist it means the mental condition of a person which, as a result of morbid disorder, may be regarded in law as abnormal. The jurist cannot use the methods of jurisprudence to establish the effects of morbid disorder on a person's mental condition. Therefore, psychiatry and psychology have to be called in to solve the problem of responsibility on a case by case basis.[10] It is here that expert testimony becomes visible in the court proceedings and it is here that one can ascertain how debates on mental health permeate into the judicial space.

To further enhance this theory, attention will first be given to the statistics of the Cape Town Supreme Court followed by a presentation of cases on some of the overarching extenuating circumstances that led to a deviation in sentencing for the convictions of murder and culpable homicide.

2. 2 Prosecution and Conviction Rates, 1964-1976

In this section, the tabulated statistics from the Cape Town Supreme court will be contextualized within the government's available national statistics on murder and culpable homicide prosecution and conviction rates. Unfortunately, for the years 1969-70, 1971-72, 1973-74, and 1975-76 only the national conviction rates for murder and culpable homicide were published. Therefore, the tabulated statistics for the prosecution rates from the archival research for 1969-70, 1971-72, 1973-74, and 1975-76 provide much needed context.[11]

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[9] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 6.
[10] *Ibid.,* p. 6.
[11] For the tabulated national government statistics see Appendix A.

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There is a steady increase in the murder prosecution rate from 1963-64 until 1967-68. Unfortunately, the prosecution rates are not available for 1969-70 to 1975-76[12] therefore it is not possible to ascertain if the rates steadily increased or declined. The national conviction rate for murder remains relatively high for the period of 1963-1976. However, the national conviction rate for murder in 1963-64 was the lowest for this period with only 970 murder convictions. It is evident from the national statistics for culpable homicide that the charge rate for culpable homicide is relatively high, whereas the charge rate for culpable homicide tabulated from the archival research for 1964-1976 shows the opposite trend.

Nationally the conviction rate for culpable homicide is high, as is the conviction rate at the Cape Supreme Court. Unfortunately the statistics of the national prosecution rate for culpable homicide is not available for the years 1969-70 to 1975-76. Yet, from the prosecution rates of 1977-78 and 1979-80[13] the trend of high culpable homicide rates continues. Therefore, it is possible that the unavailable prosecution rates for 1969-1976 will indicate that the national prosecution rate for culpable homicide had remained high compared to the prosecution rates at the Cape Supreme Court.

The national prosecution and conviction rates based on the race of offenders indicates that 'Bantu' males have the highest prosecution and conviction rates for murder and culpable homicide followed by Coloured males. At the Cape Supreme Court it can be ascertained that the majority of criminal cases were Coloured offenders, due to the uniquely high Coloured population in the Cape. Nationally, Coloured males had the second highest prosecution and conviction rate, whereas at the Cape the inverse would be true. It is not possible to determine if this is a national trend throughout the years of 1964-76 due to the change in how the government statistics were tabulated. This trend is only visible in the national statistics from 1963-64, 1965-66, and 1967-68. From 1969-70 only the conviction rates were available and not the prosecution and conviction rate by gender and race. The gaps in the official statistics are therefore filled by this study.

The following figures are the prosecution and conviction rate of murder, culpable homicide, murder with extenuating circumstances and murder without extenuating circumstances for the period 1964-1976. It is important to compare these rates with each other, because the prosecution rate indicates the initial charge, where conviction rate details

[12] Appendix A, Tables 18-25, pp. 182-185.
[13] See Chapter Five for the discussion regarding the national statistics for murder and culpable homicide, 1977-78 and 1979-80.

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the final charge on which the defendant is found guilty or is discharged. This allows for analysis on the circumstances under which the charge was lowered. Mitigating or extenuating circumstances are also reflected when the accused is found not guilty or when the charge is downgraded. The most significant statistic for this study is that for those accused of murder and sent for a psychiatric evaluation.

For 1964, the prosecution rate for murder and culpable homicide is 202 and 8, respectively. The conviction rate differs quite dramatically – 27 and 144, respectively (see Table 1 below). Out of the total 210 cases prosecuted, four cases were dismissed. According to Table 1, there is a strong indication that there was an increase in the number of criminal cases for murder and murder related crimes in 1965 and 1966 compared to 1964. The discharge rate for 1966 is higher than 1964. In 1965 and 1966 there is a high prosecution[14] rate for murder whereas the rate for culpable homicide is quite low. However, the conviction rate for culpable homicide in both figures is quite high compared to the conviction rate for murder. This can be attributed to criminal cases where the murder charge was mitigated to a lesser charge of culpable homicide. The conviction rate for murder with extenuating circumstances, in 1965 and 1966, is higher than the prosecution rate. Therefore, the defendants in these cases avoided the death penalty but received lengthy prison sentences. These cases are considered too severe to be convicted as culpable homicide, but there are certain factors present that mitigate a lesser charge of murder.

1967 has the highest amount of murder and murder related criminal cases for the period 1967-1971. The same trend in culpable homicide convictions can be seen between 1967 and 1971 as seen in 1965 and 1966. The conviction rate for culpable homicide is much higher than the prosecution rate. This is due to murder charges being either reduced to culpable homicide charges or the defendants being found guilty of the lesser charge of culpable homicide. The culpable homicide conviction rate is higher than the murder conviction rate. In 1967 and 1968, the amount of convictions for murder with extenuating circumstances are significant. In 1969 the culpable homicide rate is higher than the rest, but not as high as in 1965 and 1966.

The amount of murder and murder related criminal cases are very high for the years 1972-1976. The years 1975-1976 have relatively fewer murder and murder related cases with both under 200 cases per year. The same trend in culpable homicide prosecution and

[14] Also referred to as the charge rate.

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conviction rates can be seen for the years 1972-1976 as in 1964-1966 and 1967-1971. The murder charge rate is high but the conviction rate for culpable homicide is higher which indicates that murder charges were mitigated to lesser a lesser charge of culpable homicide. The conviction rate for murder with extenuating circumstances in the years 1972-1974, are also relatively higher. The conviction rate differs each year, and there is no clear pattern that emerges for the conviction rate for murder with extenuating circumstances.

Table 1: Statistical Analysis of the Prosecution and Conviction Rates, 1964-1976[15]

	Charge: Murder	Charge: Culpabale Homicide	Conviction: Murder	Conviction: Culpabale Homicie	Conviction: Murder With Extenuating Circumstances	Conviction: Murder Without Extenuating Circumstances	Conviction Rate	Discharged	Discharge Rate
1964	202	8	27	144	28	7	98,1%	4	1,90%
1965	216	11	11	150	40	7	91,6%	19	8,40%
1966	202	8	27	144	28	7	93,6%	14	6,4%
1967	254	15	14	182	43	5	90,7%	25	9,3%
1968	189	24	10	148	41	2	94,4%	12	5,6%
1969	194	2	9	137	23	2	87,2%	25	12,8%
1970	185	7	10	138	35	1	95,8%	8	4,2%
1971	207	5	12	151	29	3	92,0%	17	8,0%
1972	219	3	14	154	39	0	93,2%	15	6,8%
1973	298	2	16	223	36	0	91,7%	25	8,3%
1974	279	0	9	190	43	2	87,5%	35	12,5%
1975	140	4	17	92	28	0	95,1%	7	4,9%
1976	122	1	15	84	17	1	95,1%	6	4,9%

The section regarding the conviction rate of murder *without* extenuating circumstances should be viewed with the conviction rate of murder. The concept of extenuating circumstances was to mitigate the harshness of the death penalty. That is, the accused would still be guilty of murder, however if the accused could prove the existence of a factor that would mitigate the death penalty as a sentence, the trial judge may at their own discretion impose a lengthy sentence instead of the death penalty.[16] Therefore, a guilty conviction for murder can still get an accused the death penalty, with or without extenuating circumstances. In other words, no definable patterns could be gathered from the actual

[15] Tabulated from court files KAB CSC 1/1/1/580-2714, Cape Supreme Court Records.
[16] Please refer to the section in this chapter where extenuating circumstances is discussed at length.

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murder and murder without extenuating circumstances cases in this study, suggestive of the arbitrary way in which the crime was punished within the formal judiciary.

Table 2: Statistical Analysis of Mentally Disordered Cases, 1964-1976[17]

	Accused Sent for Evaluation	Percentage Sent for Evaluation	Declared Mentally Ill	Percentage Declared Mentally Ill After Evaluation	Percentage Declared Mentally Ill in Comparison to Total Charges for Murder and Culpable Homicide
1964	**1**	**0,48%**	**0**	**0%**	**0%**
1965	**1**	**0,44%**	**1**	**100%**	**0,44%**
1966	**1**	**0,45%**	**1**	**100%**	**0,45%**
1967	**1**	**0,37%**	**1**	**100%**	**0,37%**
1968	**2**	**0,94%**	**1**	**50%**	**0,53%**
1969	**0**	**0**	**0**	**0**	**0**
1970	**1**	**0,52%**	**0**	**0%**	**0%**
1971	**2**	**0,94%**	**0**	**0%**	**0%**
1972	**0**	**0**	**0**	**0**	**0**
1973	**7**	**2,33%**	**1**	**14%**	**0,33%**
1974	**6**	**2,1%**	**1**	**17%**	**0,36%**
1975	**2**	**1,4%**	**0**	**0%**	**0%**
1976	**8**	**6,5%**	**0**	**0%**	**0%**

The rate of defendants being declared mentally disordered according to the relevant Acts are considerably lower than those sent for mental health evaluation. This is especially true by 1973 where there is a spike in cases and a gradual decrease in 1974 (Table 2 above). Interestingly, there was only one case in 1975, which is the year the new Mental Health Act became law in March of that year. There is a spike again in 1976 in the number of defendants sent for observation. From the sporadic spikes in cases from 1973 it can be assumed that this is due to an increase in awareness of mental illnesses among the defendants in criminal cases. In the cases from 1973 to 1976 there were discussions taking place regarding the new mental health act before it became law. These discussions were primarily concerned with psychopathy, and what provisions will be made under the proposed legislation. These discussions will be dealt with in more detail in the relevant chapters. The number of defendants declared mentally disordered and deemed a State President's decision patient is

[17] Tabulated from court files KAB CSC 1/1/1/580-2714, Cape Supreme Court Records.

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extremely low with only one deemed mentally disordered and declared a State President's patient every other year. The increase in cases from 1964 can be attributed to the assassination of Hendrik Verwoerd when issues of mental illness became prominent to the judiciary. The content of these cases will be thoroughly discussed in subsequent chapters.

In the murder charge rate there appears to be four periods that coincide with the events discussed in this study, around which the content chapters have been periodized. In the first period from 1964-1967 the murder charge rate is over 200 cases per year. In 1967, which is the year after Verwoerd's assassination in September of 1966, there is a spike in cases from 202 case for 1966 to 254 cases for 1967. Additionally, in 1967 the findings of the Rumpff Commission was published which recommended another Commission of Enquiry in the Mental Disorders Act of 1916. This marked increase in cases could be attributed to the nervous climate regarding defendants and their mental state. However, with regards to the rate of defendants sent for mental health evaluation (see Table 2), there was no increase in the number of defendants sent for mental health evaluation in the immediate aftermath of Verwoerd's assassination. From 1965 to 1967 there had been one defendant sent for evaluation and each of those defendants had been declared a State President's patient. The exception being in 1964 where there was one defendant sent for evaluation, however they were not declared a State President's patient. This is rather telling, one would expect an increase in patients sent for evaluation as the number of murder charges increased after Verwoerd's assassination and the subsequent commissions of enquiry.

In the second period of 1968 to 1970 the murder charge rate decreases. Interestingly, during this period there were no Commissions of Enquiry, therefore there were no findings that could be influencing the discussions that the judiciary were having. However, in 1968 there were two defendants sent for mental health evaluation and one was declared a State President's patient. This is a noticeable increase in the percentage of defendants sent for evaluation: 0,94% for 1968 compared to the 0,37% for 1967, which was the year after Verwoerd's assassination. The year 1969 also has the highest number of murder charges for the period of 1968-1970, yet there were no defendants sent for mental health evaluation in that year.

For the third period of 1971-1974 there is an increase again in murder charges back to over 200 cases per year with 1973 having a staggering 298 murder charges for that year.

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By looking at the conviction rate percentage[18] for 1973 it is only 91, 7% compared to the conviction rate for 1968 which is 94, 4%. Although 1973 had the most murder charges, it also had a discharge rate of 8, 3% whereas 1968 had a discharge rate of 5, 6%. Notably, during this period the findings of the Second van Wyk Commission was published in 1972 and the Botha Commission also published its findings in 1971. Additionally, during this period the House of Assembly began its debates regarding the then proposed Mental Health Act of 1973 and the proposed Criminal Procedure Bill of 1973. These acts were considered landmark changes in dealing with the mentally ill in general and in criminal cases, in particular. During this period the discussion surrounding the proposed changes to legislation started to appear in criminal cases in this period. The amount of defendants sent for evaluation during this period distinctly increased. In 1971 two had been sent for evaluation, however none were declared. Notably, for 1973 there were seven defendants sent for evaluation, compared to the zero sent in 1972. However, of that seven sent only one was declared a State President's patient. Similarly, in 1975 only two were sent for evaluation and none of the two were declared a State President's patient.

Lastly, for the period of 1975 to 1976 there is a marked decrease, again, in murder charges. During this period the Mental Health Act of 1973 became law in 1975. However, the Criminal Procedure Bill of 1973 lapsed and only became law in 1977. In this period the amount of defendants sent for mental health evaluation increases considerably from only two in 1975 to eight in 1976. However, neither in 1975 nor 1976 were defendant's declared State President's patients. The increase in cases sent for evaluation is indicative of an increase in awareness of the mental state of defendants. It is clear from the criminal cases that the judiciary began to participate in the changing discussions regarding mental health. Although the number of murder charges decreased, the percentage of those sent for evaluation jumps from 1,4% in 1975, when the Mental Health Act became law, to 6,5% in 1976. This is much higher compared to the percentage of those sent for evaluation in the years 1964-1975, considering the low amount of murder charges for the period of 1975-1976.

As discussed above, the murder charge rate varied each year. By only referring to the charge rate it is clear that a fair amount of defendants had been charged with murder. However, the conviction rate is telling in the sense that although the charge rate for murder is considered high, the conviction rate is low. The defendants were convicted of a lesser

[18] See Table 1.

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charge of culpable homicide instead of murder. In his book, *White Mercy: a study of the death penalty in South Africa*, Robert Turrell provided an explanation which could explain how defendants charged with murder were convicted on a lesser charge such as culpable homicide. As discussed in chapter 1, if the defendant and the deceased are both non-white the sentence would often be less severe compared to if the deceased was white. Due to the majority of the criminal cases from the Cape Supreme Court involving non-white deceased and accused individuals, this could explain why the culpable homicide conviction rate is higher that the murder conviction rate throughout 1964-1976.

These statistics are also indicative of trends which reflect a correlation with unfolding debates and discussions around the same period. It is here that the actual testimony of the court proceedings needs to be discussed in order to ascertain whether these debates did indeed seep into the judicial considerations, despite the various mental health and criminal law acts only being enacted much later. It is therefore from this statistical analysis that attention must be given to the case files in the remaining content chapters of this dissertation.

2. 3. General Trends in Cases Tried for Murder, 1964-1976

According to law Professor Andrew Novak, the concept of extenuating circumstances was introduced in 1935 to reduce the severity of the mandatory death penalty for murder. The trial judge was permitted to give a lesser sentence if the accused had proved the existence of a mitigating factor in these cases. This has led the way to judicial sentencing discretion, which has taken two norms. According to the first norm, the trial judge has to determine a certain aggravating factor that places a crime into a special category for seriousness. This would usually merit the death penalty. The trial judge is able to review evidence and pass a sentence that is tailored to the crime. However, this originated in America and India. The other norm required the trial judge to articulate a mitigating factor that would be considered an extenuating circumstance, therefore the judge does not have to, at their discretion, implement the death penalty.[19]

[19] A. Novak: "Capital Sentencing discretion in Southern Africa: a human rights perspective on the doctrine of extenuating circumstances in death penalty cases," *African Human Rights Law*, (14), (1), 2014, p. 25.

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2. 3. 1. The Trial Judge's Preference

During a trial the judge would take into account certain factors, or reject them, which can result in a case being reduced from murder to culpable homicide, for example. Understanding judges, or Justices as they were formerly known, is important for the interpretation of the sentences they handed down and therefore our understanding what legislation had an impact on said sentencing process. In the past the law had been used as a tool of apartheid. Under the new regime, the constitution requires that statutes be aligned with constitutional values. However, the Parliament of Apartheid South Africa were unchecked by any constraints on its legislative powers. It was taken for granted that there were no substantive limits on legislation and the content of statutes. Hence, the judges appeared to be under the duty to interpret the clearly expressed legislation as the legislature had intended for it to be interpreted regardless of how morally bankrupt the judges might find the legislation.[20]

The trial judge could at their own discretion decide whether mitigating factors are valid. In cases where the death penalty has been handed down the trial judge has the discretion whether there are extenuating circumstances present that would result in a lengthy sentence instead. However, if there were extenuating circumstances present, the trial judge could still, at their discretion, hand down the death penalty. It would become clear in the following chapters when this dissertation begins to discuss these criminal cases at length that the trial judge wielded considerable power over the defendant and what sentence they would receive. Attention will now be drawn to the most extreme form of punishment, the passing of the death sentence, as a way to reflect on the power of the judges.

2. 3. 2. The Passing of the Death Penalty

In the case of the State v. A. A., the death sentence was passed because no extenuating circumstances could be found. It should also be noted that the convicted felon was a Coloured male and he had killed a white male.

On the 19th of March 1964 the deceased's wife was busy in the kitchen when she noticed the accused, A. A., in the garden. She confronted him. He left and the deceased

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[20] D. Dyzenhaus: *Judging the Judges, Judging Ourselves: Truth, Reconciliation and the Apartheid legal order*, pp. 14-15

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followed A. A. Mr M. returned to the house and collapsed on the pavement. He had been stabbed. He was bundled into the car of a neighbour and rushed to hospital. On the way, they had a car accident and Mr M. passed away.

On the day of the murder, the accused was in town at the Sea-Breeze hotel and bar with two friends. They spent the day drinking. Unfortunately, there were problems with the accused's testimony, especially since he was the only one that could testify to what happened when the murder took place. He left out the part where the deceased allegedly strangled him, and only told the Magistrate that the deceased had hit him. According to the testimony of a 15-year-old boy named Nelson Stempe, the accused told him that he stabbed the white man after he felt him touching his shoulder. He told Nelson the exact same story of the events of the day that he told the court, except he left out the part where the deceased had choked and hit him twice in the face. Additionally, he told a woman, Asa Salie, that he stabbed someone who was chasing after him. Justice Banks believed that Nelson Stempe was a reliable witness, especially because of the believable manner in which he delivered his testimony in court. However, Justice Banks stated that maybe it would not be right to attach too much value on the testimony of Nelson Stempe and Asa Salie as it was possible that they did not tell the court everything. However, it was remarkable that the accused did not tell either of them about the deceased choking and hitting him.

The Court, however, believed that the accused had stabbed the deceased when he touched his shoulder, yet acknowledged that the deceased could have hit the accused. The Court found that the accused was breaking the law by trespassing on property that did not belong to him and therefore, the deceased was entitled under article 24 (3) of the Criminal Procedure Act no. 56 (1955) to detain the accused. The Court further stated that he was entitled to use a bit of force to do so.[21]

In the end Justice Banks rejected all arguments that could have mitigated a lighter sentence than the death penalty and the accused was found guilty of murder without extenuating circumstances. Justice Banks said the following:

> Dit blyk uit die beskuldigde se getuienis dat hy goed geweet het wat hy gedoen het. Die beskuldigde het verder gesê dat hy nie bedoel het om die oorledene dood te maak nie- maar die hof verwerp sy getuienis. Hy het die oorledene in n gevaarlike plek met n mes gesteek, n mes met n skerp punt, en met geweld. Hy

[21] KAB CSC 1/1/1/599, Cape Supreme Court Records, Case no. 263 of 1964, State *v*. A. A.

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> het wel bedoel om die oorledene daar te steek. Die hof bevind om hierdie redes dat hy wel bedoel het om die oorledene dood te maak.[22]

On 8 September 1964 the accused was sentenced to death, despite not having any serious previous convictions that could indicate a history of violent behaviour. However, the accused did appeal his case. His appeal was not against the death penalty, but the verdict that there were no mitigating factors present during his ordeal. His appeal was denied on 29 September and the accused was executed shortly thereafter.[23]

The death sentence was also much more easily passed when the victim was considered vulnerable. In the State *v.* J. D. in 1967, the accused was charged with murdering an 80-year-old woman who lived by herself in a caravan in Stanfordsbaai.[24] On the night of her murder the deceased was on her way back to her caravan. It was on her return that the deceased ran into the accused along the road. According to the accused he fell off his bicycle and the woman offered assistance. The court believes that it was under this pretence that the accused wanted to rob the deceased. Justice Beyers was not concerned with what the motive was for the robbery, but he was concerned whether the accused aimed to murder the deceased or if it was an assault that eventually lead to the deceased’s death.

According to the autopsy report the deceased died as a result of multiple injuries. At one point she was strangled, there were cuts and bruises over her body, and one of her ribs were broken. All of these injuries coupled with her age made it unlikely that the deceased would have survived. The accused told the magistrate that he had hit her with his fist.

Justice Beyers found the accused guilty of murder. He rejected the accused’s argument that he had consumed too much alcohol on the night in question. Therefore, he found no extenuating circumstances and sentenced the accused to death.

In the case of State v. G. N., the accused was charged with murder and found guilty of murder without extenuating circumstances.[25] The trial judge, Justice Tebbutt gave the accused the death sentence for his crime. The accused had stabbed a constable of the police force that resulted in that officer’s death. G. N. was a member of the anti-apartheid movement

[22] Translation: It would appear from the accused's testimony that he knew what he did. The accused also said that he did not intend to kill the deceased-but the court rejected his testimony. He stabbed the deceased in a dangerous place with a knife, a knife with a sharp point, and violently. The accused intended to stab the deceased where he did. The court found for these reasons that he did intend to kill the deceased.
[23] KAB CSC 1/1/1/599, Cape Supreme Court Records, Case no. 263 of 1964, State *v.* A. A.
[24] KAB CSC 1/1/1/ 980, Cape Supreme Court Records, Case no. 214 of 1967, State *v.* J. D.
[25] KAB CSC 1/1/1/962, Cape Supreme Court Records, Case no. 162 of 1967, State *v.* G. N.

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Poqo.[26] It was during one of the group's activities that G. N. came into contact with the deceased and, due to a confrontation, stabbed the police officer. Two witnesses testified that they saw the accused stabbing the deceased.[27]

Justice Tebbutt called the crime brutal and frightful. He stated that the accused killed the deceased mercilessly and in doing so left his wife a widow and his children without a father. The accused had an opportunity to put forth any arguments for extenuating circumstances, however G. N. declined. The accused did however state that he only joined *Poqo* under duress. Due to the testimony of two witnesses Justice Tebbutt argued that this was proof of his willingness to participate in the armed struggle. In this case no mitigating circumstances were found. The killing of a white man by a black man was already considered repulsive at the time, but the killing of a policeman by an anti-apartheid activist, abhorrent.

The case of the State v. I. B. in 1971 is an example of when multiple charges are prosecuted. On 12 October 1971 the deceased, a nine-year-old girl was walking to the store when she encountered the accused, I. B. He requested from the girl that she buy him a sandwich, but she cursed at him and continued on her way. Later she returned from the store and made her way back to her aunt's house. The deceased again walked past the accused, but this time he grabbed the girl, pulled her into his house where he proceeded to rape and strangle her with a belt.[28]

According to the pathologist's report the cause of death was strangulation. The pathologist also noted that the shock caused by the injuries of the rape could have contributed to her death. The cuts and bruises on her throat indicated that she was strangled from behind with a belt. The marks did not cover her entire neck, which indicates he stood behind her as he strangled her. There was substantial damage caused by the rape. The rape caused a substantial posterior tear of the vagina. Additionally, there were tears on the anterior of the vulva and the vagina. According to the pathologist, these injuries occurred while the deceased was still alive. The markings on her back indicated that she most likely struggled to get away from the accused. The pathologist also noticed cuts on her left temple, her back, and her left shoulder.

[26] *Poqo*, or the Azanian People's Liberation Army, was the armed wing of the Pan Africanist Congress.
[27] KAB CSC 1/1/1/962, Cape Supreme Court Records, Case no. 162 of 1967, State *v*. G. N.
[28] KAB CSC 1/1/1/1592, Cape Supreme Court Records, Case no. 171 of 1971, State *v*. I. B.

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The accused did not deny that he had raped and strangled the nine-year-old girl, however, his defence was that he only did what he did because he was drunk. He further stated that after the rape and murder he fell asleep and when he woke up, he saw the body lying there beside him. He could not remember much of the incident and he could not remember that he raped her. The accused stated that a few years ago he was in a motorcycle accident and since then there was "something wrong with his head".

It also became known that the accused had a habit of drinking too much and when he did, he became a "difficult man". He also smoked marijuana while he drank, and this allegedly made him dangerous. The trial judge, Justice Rabie found him guilty of murder and sentenced him to death. The accused did apply for leave to appeal. The accused did not deny that he committed the crime, however he maintained that the state could not prove that he had the intent to kill the nine-year-old girl. Justice Rabie rejected this and the death sentence was upheld, and the accused was executed.

These cases highlight how the death sentence was passed in cases where no extenuating circumstances warranted a deviation from the passing of the death sentence. It also shows how the discretion of the judge could also play a role in accepting whether extenuating circumstances would be accepted into testimony. Even if these mitigating circumstances were acknowledged, the weight given to them had to be assessed. This is most aptly shown in the case of the State *v*. N. B. in 1975.

N. B. had broken up with his wife as he suspected she was cheating on him. She moved into her mother's house where the accused jumped through the window and stabbed her to death.[29]

During the trial, the man suspected of sleeping with the accused's wife testified against N. B. The court not only believed that the murder was premeditated but also believed that the accused was a menace to society. The accused was described as a possessive type and was no doubt angered by the state of affairs. Justice Broeksma also noted that in crimes committed on Fridays and Saturdays, there "is always a certain amount of alcohol involved". He concluded that the accused was only mildly under the influence of alcohol on the day in question and was therefore deemed in control of his faculties. N. B. was found guilty of murder with extenuating circumstances. According to Justice Broeksma the crime

[29] KAB CSC 1/1/1/2320, Cape Supreme Court Records, Case no. 5 of 1975, State *v*. N. B.

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committed was particularly savage. The accused's previous conviction record also weighed against him. He had five previous convictions for assault, conviction for possession of a deadly weapon and housebreaking. The court could not find factors in the accused's favour. He was declared a danger to the community with no regard for the rights of others. Justice Broeksma passed the death sentence.

What is particularly interesting in this case is the way in which Justice Broeksma explains murder without extenuating circumstances during this period. The presence of extenuating circumstances meant that the court had the discretion not to pass the death penalty. In deliberating on the appropriate sentence for a crime, he suggests that three factors must be considered: (a) the nature of the crime; (b) the person of the accused; and (c) the interest of the community. In factor (c) the court also had to look at (a) to what extent would the punishment serve as a deterrent for members of the community who want to commit the same crime; and (b) will the punishment serve to protect the community. It is here that a clearer understanding of the differences between these categories are further explained, as applied in the court procedure by a judge of the time.

Previous convictions, it should also be argued, did not necessarily warrant the passing of the death sentence – even under dire circumstances and in contrast to the reflections made above by Justice Broeksma. For example, in the State *v*. G. V., in 1969, G. V. was charged with the murder of a non-white man and with the assault of a non-white female with a pickaxe. [30] G. V. was found guilty of culpable homicide on the first charge and guilty of assault with the intent to cause bodily harm. G. V.'s sentence was largely determined by his previous convictions. He had committed a similar crime, murdering two people, for which he was sentenced to a mere six years. He was paroled after three. Justice Beyers blamed the parole board for releasing a danger into society and believed that they were partially responsible for the crimes presented before him. No extenuating circumstances were apparent in this case and the judge may well have passed the death sentence. However, G. V. was sentenced to 15 years imprisonment.

These cases also provide a variety of other extenuating circumstances prevalent in the court cases during this timeframe, and quite commensurate with secondary literature on mitigating circumstances.

[30] KAB CSC 1/1/1/1307, Cape Supreme Court Records, Case no. 281 of 1969, State *v*. G. V.

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2. 3. 3. Most Prevalent Extenuating Circumstances in Court Cases, 1964-1976

This section will provide some insight into how the law was applied and how deviations from prescribed sentences depended on the severity of the crime as well as extenuating circumstances. Cases which involved some element of mental disease will be discussed in subsequent chapters. There is little doubt that the most prevalent and consistent mitigating factor in sentencing practices over time is intoxication at the time of the murder.

On the 6th of June 1964 the accused, along with a few of his friends, attended a dance party in Elsiesrivier at the house of a friend, Aggie.[31] Later in the evening a fight broke out between the accused, the deceased, and the deceased's brother. The exact circumstances of the fight are unclear, but the Court accepted that words were exchanged, and as a result, the deceased made a move that seemed like a hacking movement in the direction of the accused. It is not clear whether the accused was hit. There is no evidence to support this, such as an injury or damage to his clothing. A witness testified that the deceased and his brother decided to leave Aggie's house to return home. The accused and four of his friends followed them home. When they arrived at the property where the deceased lived, they encountered the owner of the property at the gate, Ms. Swarts. She tried to refuse them entrance as the accused made it clear to her that he intended to fight with the deceased. He forced himself through the gate and past Ms. Swarts. When the deceased heard the accused outside of his home, he proceeded to jump out of the window. According to witnesses inside the house he feared that the house would be set on fire. When they later encountered the deceased again, as he re-entered the house, he had serious stab wounds in his chest. He was bleeding profusely and died shortly thereafter. According to the autopsy report the deceased died due to his aorta being cut, resulting in massive blood loss.[32]

The debate between the state and the prosecution was whether in this case the accused was the man who stabbed the deceased, or if it was possible that someone else could have stabbed the deceased. According to the accused, when he left the property, he heard the deceased shout for him to come outside. When the occupants of the house said that he was not there, the accused left. Additionally, as he walked away, he saw one of his friends, who had accompanied him, standing outside a window with a knife in his hands. However, the

[31] KAB CSC 1/1/1/610, Cape Supreme Court Records, Case no. 299 of 1964, State *v*. C. K.
[32] *Ibid.*

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accused's friend gave the same story as the accused, that when he walked away, he saw him with a knife and added that the accused told him that "hy het hom klaargemaak".[33]

Justice Corbett found that it was the accused who stabbed the deceased to death. According to Justice Corbett this was a crime of murder, however, he concedes that there were two circumstances that were mitigating. The first would be the state of drunkenness of the accused on the night of the murder. He was not intoxicated to the extent that he did not know what he was doing, but he had consumed a considerable amount of liquor that night. The second circumstance would be the provocation that resulted from the deceased's behaviour. Justice Corbett therefore found the accused guilty of murder with extenuating circumstances. On 16 September 1964 he was sentenced to eight years in prison for his crime.

In contrast, and reflecting on the differences between murder and culpable homicide, on 28 October the accused, C. L.,[34] pleaded not guilty to the charge of culpable homicide, however, before the sentencing hearing he changed his plea to guilty. Justice Corbett accepted that in the accused's case there was a mitigating factor. The accused was attacked, without provocation, by the deceased who proceeded to twice hit him over the head with a whip.[35]

The accused reacted by stabbing him with a knife he had in his hand for work purposes. Justice Corbett scolded him for using the knife so quickly, yet he took the testimony of his character into consideration. C. L.'s defence asked for a suspended sentence, and the attorney for the state, Mr Kahn supported this claim. However, Justice Corbett felt that the sentence of this case should not send the message that this was the typical sentence for such a crime. The circumstances of this case were unique as the accused acted in self-defence. For this reason, Justice Corbett sentenced him to 18 months in prison suspended for three years.[36]

Another common mitigating factor that arises in these criminal cases is intoxication and provocation. So too is a previous conviction. However, a factor in favour of the convicted was also his or her role within the community.

[33] Meaning he killed/stabbed him.
[34] KAB CSC 1/1/1/822, Cape Supreme Court Records, Case no. 321 of 1966, State *v*. C. L.
[35] *Ibid.*
[36] *Ibid.*

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L. M., for example, was charged with culpable homicide on 2 June, 1965.[37] The accused murdered her husband during a drunken brawl. Both parties were intoxicated during the encounter. The Court also considers that her husband had assaulted her with a piece of iron. She pleaded that the death was an accident. The Court rejected this but took into account that the accused and the deceased had four children. However, because of a previous conviction for a similar crime and that it is apparent that the accused had "not learnt her lesson", the court was reluctant to show mercy. L. M. pleaded guilty and was found guilty to the charge of culpable homicide, and sentenced to three years in prison of which 18 months were suspended for three years.[38]

At the sentencing hearing Justice Steyn said the following:

> Dit is nie maklik vir die hof om jou te straf nie. Die hof neem in aanmerking dat jy en jou man albei dronk was, dat jou man jou aangerand het, dat julle mekaar geslaan het. Die hof is selfs bereid om te aanvaar dat jou man n wapen gehad het, dat hy jou met n yster geslaan het. Die hof aanvaar egter nie dat dit n ongelik was, soos jy gesê het nie. Dit is heeltmal duidelik op die getuienis wat gegee is by die voorondersoek dat jy, nadat jy jou man gesteek het, weer probeer het om hom by te kom met die mes en moes gekeer word, anders het jy hom weer gesteek. Die hof is bewus van die feit dat daar nou vier kinders is en dat daar niemand is om vir hulle te sorg nie. Daar sal gereël word deur die Departement van Volkswelsyn dat jou kinders versorg word terwyl jy in die tronk is. Jy moet tronk toe gaan. Jy was al tevore in die tronk vir dieselfde ding en jy het nie jou les geleer nie. Mense wat nie hulle les leer nie en steeds n mes teen ander gebruik kan nie verwag dat die hof hulle met genade moet behandel nie.[39]

Justice Theron shares a similar sentiment. On 9 November 1966 Justice Theron found the accused P. D. guilty of culpable homicide, and sentenced him to three years imprisonment, suspended for two years .[40] The accused, initially pleaded not guilty to a charge of culpable homicide, yet changed his plea on the 9 November 1966, the day he was to be sentenced.[41]

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[37] KAB CSC 1/1/1/645, Cape Supreme Court Records, Case no. 199 of 1965, State *v*. L. M.

[38] *Ibid.*

[39] Translation: It is not easy for the court to punish you. The court takes into account that both you and your husband were drunk, and that your husband assaulted you, that you assaulted each other. The court is even prepared to accept that your husband had a weapon and that he hit you with a piece of iron. However, the court does not accept that it was an accident, as you said. It is clear based on the testimony given during the preliminary examination that you stabbed your husband, and tried to stab him again and had to be retained or else you would have stabbed him again. The court is also aware that there are now four children without someone to take care of them while you are in prison. You have to go to prison. You've been there before for the same charge and you did not learn your lesson. People that are incapable of learning their lesson and still use a knife against other people can't expect the court to treat them with mercy.

[40] KAB CSC 1/1/1/841, Cape Supreme Court Records, Case no. 342 of 1966, State *v*. P. D.

[41] *Ibid.*

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According to the presiding Judge, Justice Theron, it appeared to him that the events of the night were more of an accident than anything else. The accused killed his wife during yet another fight that the two had while intoxicated. According to Justice Theron it was clear that it was the deceased who had started the fight. She pulled the intoxicated accused from the bench he was sitting on and proceeded to slap him. However, according to Justice Theron it seemed that the accused was someone who all too often lost his temper. A much more lenient sentence was passed because they had children:

> Ek lê die besondere vonnis op in hierdie geval omdat jy vier jong kinders het wat nou deur ander mense onderhou word. Jou suster lyk vir my 'n persoon van goeie karakter, sy sal vir jou help met die kinders en jy moet werk vir die kinders. Dit lyk vir my dat jy jou werk sal terug kry as ek jou kan vertrou om jou te gedra.[42]

Another compelling circumstance was the notion of respectability of both accused and deceased. On 6 January 1969 J. d. P., a white male, assaulted a white female by kicking her and stepping on her. [43] He also proceeded to hit her and pushed her around on the ground. In doing this he caused her serious injuries that eventually resulted in her death. He was charged with culpable homicide and found guilty of assault, and fined a mere R20 for his actions.[44]

Justice Diemont gave the accused such a light sentence due to the reputation of the woman. He thinks that she was the one who "caused the trouble" due to her reputation as a "difficult woman" who tended to get into confrontations, especially when she had been drinking. Justice Diemont chastised the accused for hitting her as hard as he did but justified his sentence by saying, "Ek het jou baie lig gestraf omdat ek dink jy was n bietjie ongelukkig gewees".[45] Here, not only are the possible racial biases of judges revealed but so too is their patriarchal notions on how a woman should behave.

In contrast, the reputation of the accused was considered in the case against J. H.[46] He was accused of murdering his stepson with the intent of stabbing him to death. The trial court found him guilty of the lesser sentence of culpable homicide. Contrary to the state's

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[42] Translation: I give you this specific sentence because of the four young children that you are responsible for are dependent on someone else to support them. It appears that your sister is someone of good character, she is willing to help you with the children and you need to work for these children. It would seem that you can have your job back if I can rely on you to behave yourself.
KAB CSC 1/1/1/841, Cape Supreme Court Records, Case no. 342 of 1966, State *v*. P. D.
[43] KAB CSC 1/1/1/ 1212, Cape Supreme Court Record, Case no. 180 of 1969, State *v*. J. D. P.
[44] *Ibid.*
[45] Translation: I sentenced you very lightly because I think you were a bit unhappy.
[46] KAB CSC 1/1/1/1326, Cape Supreme Court Records, Case no. 376 of 1969, State *v*. J. H.

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assertion, the trial court determined that the accused did not intend to kill the deceased. The circumstances in which the crime was committed is not completely clear to the court, however, there existed longstanding animosity between the accused and the deceased. In the past it even required intervention from the police, which was brought to light during the trial.[47]

On the day of the murder there was another explosive altercation between the accused and the deceased. Justice Steyn said he did not know how much provocation was present or if, and how much, fear the accused felt during this altercation considering that the accused's arm had been amputated from the shoulder. The deceased was under the influence of alcohol during the altercation, therefore the accused used a knife to defend himself. Justice Steyn deemed the age of the accused as well as the above mentioned as factors that he considered when deciding on the sentence. In addition it was made clear that the accused had no previous convictions.

Justice Steyn sentenced the accused to two-years' imprisonment, suspended for three years. The accused made a favourable impression on the court because he was a 50-year-old man that have never before been convicted of a crime and because he was regularly employed and, all things considered, "a responsible citizen".

It is clear from these cases that much of the sentencing practices were determined in large part by the interpretation of law by the judges and the extent to which they took into consideration the extenuating factors.

In murder cases the accused could avoid the death penalty if the judge was of the opinion that there were extenuating circumstances present. Therefore, the judge could, at his discretion, pass a lengthy sentence instead of the death penalty. This differs from mitigating factors, because the defence for the defendant could argue in any case for mitigation of sentence. What this means is that the accused could receive a lesser sentence due to certain factors being present. Extenuating circumstances morally, but not legally, affected the degree of the accused's guilt. An essential factor in cases involving extenuating circumstances is the effect of the surrounding circumstances on the mind. There had to exist compelling forces that produced a mental abnormality. However, hatred, bias or prejudice towards the deceased was not necessarily taken into consideration. A mental disorder less than "insanity" would

[47] KAB CSC 1/1/1/1326, Cape Supreme Court Records, Case no. 376 of 1969, State *v*. J. H.

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constitute extenuating circumstances. Clouding of the mind by stress was extenuating and the court could also consider the mental ability of the accused, especially if the IQ was deemed below average. This benchmark was largely subjective but played an enormous role in calculating the moral blameworthiness of the accused.[48] So too was due consideration given to the age of the accused. It is important to note that extenuating circumstances were not a factor of the crime, but merely a basis for reducing the punishment.[49]

In Table 1, a majority of the murder cases had been reduced to culpable homicide. This is due to mitigating factors such as intoxication, the degree of provocation and other medical and mental health concerns.

Intoxication was not a defence in a charge of murder unless the intoxication was involuntary or accidental, but (1) were not brought about with the deliberate intention of committing a crime; and (2) if the degree of intoxication was to such an extent to render the accused incapable of forming the intention to kill. These factors reduced the crime of murder to culpable homicide. However, it did not excuse the behaviour. The argument upheld was where one indulges in alcohol, one should be held accountable for his/her actions. However, the rule differed if the intoxication was brought on by the fraud, artifice or contrivance of a third person. The same principles applied to involuntary drug use.[50]

The use of dagga featured in the criminal cases discussed in this dissertation. In these cases it was often used by defence attorneys as a mitigating factor due to the influence it had on the behaviour of those who consume it.[51] According to The Cape Coloured Commission *dagga* was harmful, especially when used simultaneously with alcoholic intoxicants, and the resulting mental state was argued to be the main cause of crimes of violence. The Commission advised that the evidence given by Magistrates and the police had to be scientifically supported. This was in response to the 1935 Department of Public Health report which argued that people were being senselessly prosecuted for smoking "a harmless substance". This led to several discussions on the use of *dagga.* In 1935 a Medical Congress urged the Minister of the Interior to conduct an investigation into the relationship of dagga use and the "ultimate production of mental degeneration". Experiments were later conducted

[48] T. B. Barlow: *Digest of the Law of Murder and Culpable Homicide*, p. 37.
[49] *Ibid.*, p. 38.
[50] T. B. Barlow: *Digest of the Law of Murder and Culpable Homicide*, p. 10.
[51] See M. Chanock: *The Making of a South African legal Culture 1902-1936: Fear, Favour and Prejudice*, pp. 92-94 for additional reading on Dagga in relation to the law.

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at the Pretoria Mental Hospital. During observations it was noted that there was a universal "dulling of the mental faculties" and in some cases "wild motor excitement".[52]

Dagga produced different responses in different individuals. According to Bourhill this is where the danger lay. It is from here that the broader implications were discussed at length within the medical profession. The underlying personality of the smoker was called into question. Additionally, Bourhill noted that an "intelligent person" under the influence of *dagga* might have varied and brilliant hallucinations, but a person of "baser type" might have savage reactions. Therefore the danger was that violent crime would result from the use of dagga by those with "criminal traits and tendencies". The discussion around alcohol focused on blacks and poor whites, dagga was centered on Indians and the Coloured population. The majority of complaints made by law enforcement officials during this period were waged against the coloured communities of the Western Cape.[53] The nature of these debates and the essentialist categories created seeped into the judicial discourse.

In some cases, provocation was a mitigating factor in a murder charge. The murder was reduced to culpable homicide if the accused had been so provoked by the action of the deceased as to be temporarily deprived of self-control. In order for this to be valid (1) the killing must have taken place upon receiving the provocation; and (2) only under the most extreme circumstances would words amount to sufficient provocation to reduce the nature of the crime. An overwhelming anger, originating from some internal emotion, such as jealousy was not in itself sufficient grounds for a plea of provocation. The court paid attention to the circumstances which gave rise to the anger, not the anger itself. Provocation was only a defence if it robbed the accused of his self-control and mastery of his actions. The action of the deceased had to deprive malice from the act, as there could be no provocation where the killing was deliberate. The murder also had to occur directly after the provocation. Any delay suggested a desire for revenge. Lastly, less provocation was accepted as a mitigating circumstance in the case of intoxication because of the weakening state of the mind during alcohol consumption.[54]

[52] M. Chanock: *The Making of a South African legal Culture 1902-1936: Fear, Favour and Prejudice*, p. 95.
[53] *Ibid.*
[54] T. B. Barlow: *Digest of the Law of Murder and Culpable Homicide*, pp. 10-11.

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2. 4. Mental Illness as a Mitigating Factor

Insanity, or mental illness as it was later referred to, is considered an important mitigating factor in murder cases. According to legal scholar T. B. Barlow: "No person is guilty of murder or culpable homicide if he was insane at the time he killed the deceased".[55] Insanity, in this context, is defined as a mental disease resulting in the accused's inability to distinguish between right and wrong, not knowing what the accused did was wrong, and being subjected to an irresistible impulse which made it impossible for them to control their actions. Additionally, an insane person was to be dealt with under the outdated Mental Disorders Act of 1916.

Insanity must be distinguished from mental deficiency such as "nervous tension" and a "clouded mentality of a lesser type", which may affect the actions of the accused and make him more liable to give way to impulse. T.B. Barlow defined mental deficiency as factors that have an impact on the defendant's mental state at the time of the alleged offence whereas insanity is a mental disease, that is psychopathy or schizophrenia.[56]

According to the statistical analysis in Section 2.2 above, there is a fluctuating pattern in criminal cases where mental illness was a considered factor. Most notable is the number of defendants sent to Valkenberg for observation which differs from the number of cases where the defendant was declared a state president's patient and sent to an institution. This increase, which is at its highest in 1973 and 1976, shows an increased preoccupation with determining the defendant's mental state.[57]

Moreover, the number of defendants sent for psychiatric observation are higher in some years, compared to defendants deemed mentally disordered in the same year. However, when mental health is concerned, factors such as traumatic brain injury or epilepsy are a factor on whether the defendant is deemed mentally disordered or not. Yet in some cases, the defendant might exhibit observable abnormal behaviour but does not necessarily meet

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[55] T. B. Barlow: *Digest of the Law of Murder and Culpable Homicide*, p. 8.
[56] *Ibid.*, p. 9
[57] See cases KAB CSC 1/1/1/1948. Case no. 63 of 1973. State *v*. P. L., KAB CSC 1/1/1/1951. Case no. 70 of 1973. State *v*. B. M., KAB CSC 1/1/1/1991. Case no. 172 of 1973. State *v*. K. S., KAB CSC 1/1/1/2019. Case no. 194 of 1973. State *v*. D. M., KAB CSC 1/1/1/2025. Case no. 204 of 1973. State *v*. G. d. P., KAB CSC 1/1/1/2035. Case no. 229. State *v*. W. l. R., KAB CSC 1/1/1/2083. Case no. 295 of 1973. State *v*. L. B., KAB CSC 1/1/1/2540. Case no. 34 of 1976. State *v*. B. H. H., KAB CSC 1/1/1/2586. Case no. 115 of 1976. State *v*. A. D. *v*. E., KAB CSC 1/1/1/2586. Case no. 117 of 1976. State *v*. M. T. S., KAB CSC 1/1/1/2588. Case no. 125 of 1976. State *v*. K. E., KAB CSC 1/1/1/2589. Case no. 142 of 1976. State *v*. W. O., KAB CSC 1/1/1/2592. Case no. 160 of 1976. State *v*. D. M & others, KAB CSC 2602-2603. Case no. 187 of 1976. State *v*. C. L & A. P., KAB CSC 1/1/1/2614. Case no. 216 of 1976. State *v*. P. E. C.

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the criteria to be considered mentally disordered according to the outdated Mental Disorders Act of 1916.[58] The nuances of mental health laws and its impact on murder cases at the sentencing level will be discussed in the forthcoming chapters.

In cases where mental illness is averred there are certain medical factors that need to be considered. From the archival research it is clear that the dominant factors are epilepsy, injuries to the brain and mental deficits. In cases of epilepsy, the degree of epilepsy varies in severity and chronicity. Some epileptics, in severe cases, are institutionalized where they can receive the proper treatment they need, whereas some are out-patients. The reason for institutionalization in severe cases are associated with mental deficits and dementia, or frequent seizures that result in severe confusion or personality changes.[59] Epilepsy is one of the most important conditions in the psychiatric field for a number of reasons. Abnormal mental symptoms and disturbed behaviour may either accompany or follow an epileptic seizure. In some cases, it may be so prolonged and severe that the label epileptic psychosis is merited.[60]

Epilepsy is also associated with defects in consciousness, which may only be transient, or may be associated with partial recall and frequently have a mixed quality encompassing cognitive disturbances. Some of these cognitive disturbances may include depersonalization with emotional hallucinations. Additionally, amnesia is a characteristic of epilepsy that often appears, even though the patient may not appear unconscious; the alternation in consciousness may be severe or light. Due to the effect that epilepsy has on the mental state in criminal cases it is considered a mitigating factor, especially in cases where mental illness is averred.

Additionally, head trauma or traumatic brain injuries could also alter the behaviour of defendants in these criminal cases. It has been established that for those who survive moderate and severe head trauma, the long-term mental consequences, such as cognitive, behavioural, and emotional problems outweigh the physical consequences as the primary cause for the difficulties encountered by these individuals in their vocational, personal and social adjustment. The subtle and enduring cognitive and personality changes secondary to

[58] As an example, in KAB CSC 1/1/1/1701C case no. 364 of 1971. State *v*. G. J. P. the Valkenberg Superintendent deemed that G. J. P had a personality disorder, yet it was not enough to deem him mentally disordered in terms of the Mental Disorders Act of 1916.
[59] A. B. Daneel: "Tegretol in Institutionalized Epileptics," *South African Medical Journal*, 1967, p. 774.
[60] E. Wolpowitz: "The use of Thioridazine (Melleril) in cases of Epileptic Psychosis," *South African Medical Journal*, 1966, p. 143.

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brain injury are frequently undetected until the person who suffers deteriorates from acute care to a chronic state of existence. The most common cause of brain injury is a rapid acceleration and deceleration, such as a car accident and trauma caused in falls or blows to the head caused by a weapon.[61]

In patients with traumatic brain injuries there is often a marked social change in their behaviour. The person may experience an impaired capacity for social perceptiveness, an impaired capacity for control and self-regulation, stimulus-bound behaviour, and apathy and changes in emotions, including irritability, silliness, and hyper- or hyposexual behaviour. Conditions also include a decreased general ability or complete inability to capture experiences. These factors do not occur in isolation but often overlap with one another. The changes in someone who suffered a traumatic brain injury is often so subtle that it is only recognized after the person re-enters society.

The medical field may differ in their views of what makes up cognitive, behavioural, or psychosocial changes, but the message is the same. The cognitive deficits, such as impaired recent memory and decreased intelligence, contribute more than the physical problems to the residual disability of moderately to severely disabled people.[62] Therefore, due to the impact that head injuries have on the emotions and behaviour of those impacted by it, it was considered a major mitigating factor in criminal cases.

2. 5. Chapter Conclusion

The abovementioned cases are just a small sample of the most prevalent mitigating circumstances taken into consideration throughout the period under investigation. Sentencing has undoubtedly varied according to the proclivities of the judges as well as the extenuating circumstances they deemed to be of importance. This was largely framed around perceptions on race and class, levels of intoxication at the time of the crime of murder and notions of what constituted respectability. These trends are however, not unusual nor are they restricted to cases brought before the Cape Town Supreme Court, nor are they restricted to the offence of murder. They have a long historical trajectory which transcends geographical location and time, as reflected within secondary literature. It is, however, the

[61] S. G: Tollman: "Behavioural changes after closed head injury," *South African Medical Journal*, (74), 1988, p. 22

[62] *Ibid.*

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consideration of, and discussions on, mental health and the law which unfold within the court records, however scant they may be in statistical terms, which prove to be specific to the context in which they unfold.

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Chapter 3

Mental Health, the Law and Cases of the Mentally Disordered, 1964-1967

The assassination of former Prime Minister Hendrik Verwoerd in 1966 by Dimitri Tsafendas was a major shock to many South Africans sparking a variety of questions and debates, especially around the intricate link between murder and mental health.[1] His death also sparked a long overdue overhaul of the country's mental health legislation. Tsafendas was found to be mentally unstable by attending psychiatrists and he was therefore not sentenced to death. In the aftermath of the assassination, there were multiple commissions of inquiry that would begin the process of revising the outdated Mental Disorders Act No. 38 of 1916. The first commission of inquiry in 1966, referred to as the First Van Wyk Commission, dealt with the matters relating to the Prime Minister's death deemed to be of public interest. This commission was followed by the Rumpff Commission in 1967 that aired judicial, professional, and public doubts about criminality and mental illness. This commission recommended another commission of inquiry into the efficacy of the Mental Disorders Act. The Second van Wyk Commission followed in 1972 and this commission concluded that the Mental Disorders Act was indeed ineffective and needed to be revised and repealed.[2]

In this chapter context is provided on the mental health legislation prior to 1916. This will be followed by a discussion on the role of the British M'Naghten rules in the courts of law. This provides a context for a discussion on the law and mental health from 1964 to 1967. Three of the criminal cases which were sent for psychiatric evaluations during this period provide a foundation from which to discuss five important points of reflection as seen in the judicial process: the role of intelligence tests, the Mental Disorders Act of 1916, the psychopath, the state of psychiatry and psychology in South Africa as well as mental institutions. It is from these points of departure that more attention is given to the assassination of Verwoerd and the subsequent commissions of enquiry into his death, the state of mental health in the country and rising discussion on the need to transform criminal procedures within South Africa. The importance of microanalysis of court cases is clearly

[1] See also D. Posel: "The Assassination of Hendrik Verwoerd: The Spectre of Apartheid's corpse," *African Studies*, (68), (3), 2009, pp. 332-350. For further reading on Tsafendas see Z. Adams: "Demetrios Tsafendas: Race, Madness and the Archive." PhD Diss. University of the Western Cape, 2011. The Report of the Commission of Enquiry into the Circumstances of the death of the Late Dr. the Honourable Hendrik Frensch Verwoerd is available for perusal at the Stellenbosch University Library, (SP-(RP-A)).

[2] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, p. 12.

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foregrounded in this chapter as being illuminating to the complex debates that arose around aligning the medical and judicial professions.

3. 1. Mental Disorders Legislation Prior to the Act of 1916

In Roman-Dutch law there is no explicit provisions for the detention of the mentally ill. In 1866 the Cape Colonial Office instructed the resident magistrates regarding the procedures necessary for the detention of "lunatic" patients, with further legal requirements outlined in 1875. The template used for much of the mental health legislation enacted in the region was The Colony of Natal's Custody of Lunatics Act (Number 1 of 1868). This law was driven by two factors at the time. Firstly, the economic depression across much of South Africa in the 1860s revealed that the socially and mentally vulnerable were being disregarded. The need for a public asylum to incarcerate the so-called mentally ill arose. Secondly, the law was promoted by the Lieutenant Governor Robert W. Keate. He was previously the governor of Trinidad. These factors encouraged the Colonial Office to audit relevant facilities across the British empire. Additionally, this also led to legislative reforms reflective of the 19th century humanitarianism, universalism, and liberalism. The underlying thrust was that all men were equal before God and the law, and should therefore be treated in humane ways. However, the reality proved vastly different.[3]

The Natal Custody of Lunatics Act determined a number of important principles. The act provided for the "safe custody of, and the prevention of crimes being committed by, persons dangerously insane, and also for the care and maintenance of persons who were insane, but not dangerously so."[4] The act also stated that "persons appearing mentally deranged or who attempted suicide"[5] should be brought before a resident magistrate. The magistrate required that two medical practitioners swear an oath that the person was a "dangerous lunatic or dangerous idiot."[6] The magistrate could certify detention until discharge was authorized by the Supreme Court, or the lieutenant governor ordered a transfer to a public lunatic asylum. According to the act, relatives or guardians could also initiate certification of the insane. Other responsible persons such as magistrates could also make

[3] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, p. 6.
[4] *Ibid.*
[5] *Ibid.*
[6] *Ibid.*

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the application. The Act did not attempt to define lunacy or insanity. The Act also did not make provision for treatment, instead it emphasized the custodial nature of restraint.[7]

The Cape Lunacy Act No. 20 of 1879 was very similar to the Natal Custody of Lunatic Act of 1868. In 1891 the new lunacy act was more directly linked to the English Lunacy Act of 1890. This act acknowledged the local realities of a small population spread over great distances and permitted examination and certification of alleged lunatics by one medical practitioner. By 1897 there was an amendment made to the Act for the provision of voluntary patients.[8] Lunacy, mental health and its implications in legal proceedings were also influenced by debates emanating from abroad.

3. 2. The M'Naghten Rules in South African Law

The common law rules of South Africa in regard to the application of the principle of responsibility in connection with insanity originated in England. The M'Naghten rules had been followed since 1843. The criteria laid down in the M'Naghten rules came in for criticism from psychiatrists and also certain jurists from the onset. The criticism of the rules was based on two points. Firstly, that the criteria did not make adequate provision for persons who were in fact insane and therefore could not be held responsible. Secondly, that the application of the clauses remained vast.[9]

In application of the M'Naghten rules, the English court of Appeal ruled that the words "the nature and quality of the act" referred solely to the "physical character" of the act, making no distinction between the physical and the moral aspects, and that "wrong" meant punishable by law. With regards to the onus of proof, the courts ruled that the state of mind "must be clearly proved" but that the onus resting upon an accused was not the same as that of the state.[10] It is clear that during the deliberations on reforming the laws in South Africa, English jurists were also debating the validity of their mental health law and reflected upon how pressing it was that the laws be updated and improved.

[7] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, p. 6.
[8] *Ibid.,* p. 7.
[9] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 9.
[10] *Ibid.*

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3. 3. South African Law and Mental Illness

In South Africa the judges turned to English law instead of continuing to build on pure Roman-Dutch Law, thus saddling South Africa with the M'Naghten rules which England and even the United States of America were using. Prior to 1953 the law of South Africa had taken over the essence of the M'Naghten rules with the addition of the concept of "irresistible impulse." It was in 1953 that the Appeal Court formulated the law as follows in R. V. Koortz 1953 (1) SA (a) 371:

> Section 29 of the Mental Disorders Act prescribes the verdict when it has been found that the accused person is "mentally disordered or defective" so as to not be responsible according to law for the act or omission charged, and the law as to freedom from responsibility for conduct, on the ground of mental defect, is stated in Gardiner and Landsdown as follows: A person is not punishable for conduct which would in ordinary circumstances have been criminal if, at the time, through disease of the mind or mental defect (a) prevented from knowing the nature and quality of the conduct, or that it was wrong, or (b) that he was the subject of an irresistible impulse which prevented him from controlling such conduct.[11]

Although the M'Naghten rules had been a feature of South African law, the appeals court challenged the rules in 1953. In the 1953 court case the M'Naghten rules were changed by adding the irresistible impulse concept.

It is within this context that attention will now turn to cases that appeared before the Cape Town Supreme Court, prior to the assassination of Verwoerd and in the context of the then existing rules of how mental illness was to be assessed within the judicial system.

3. 4. Criminal Cases of the Mentally Disordered, 1964-1966

The statistical analysis on court cases discussed in Chapter 2, identified the only three cases in which the accused was sent for psychiatric evaluation during the period 1964-1966. The following criminal cases are the only cases from the Cape Supreme Court, for this period, where mental illness was considered. It is important to discuss these cases as they appeared before the court before mental health reforms began to take shape, in order to adequately gauge the effects of the subsequent debates and changes to legislation in cases of mental illness from 1967.

[11] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 12.

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3. 4. 1. State *v*. R. A., 1964[12]

The accused in this case had been charged with the murder of his common law wife by pouring paraffin over her and setting her on fire. She died on the 16th of March 1964. The accused was committed on the 24th of September to Valkenberg for observation to determine whether or not he was mentally disordered. On the 19th of November, Mr Hartford who appeared on behalf of the state, submitted a certificate from the Physician Superintendent of Valkenberg that declared that the accused was not mentally disordered in terms of the Mental Disorders Act of 1916. Mr Ryneveld who appeared on behalf of the accused, at the request of the court, did not argue in anyway against the evidence of the state concerning the manner in which the deceased met her fate. Additionally, he did not urge the court to accept the accused's version that he did not pour the paraffin on his wife and set her alight.

The court had relied mainly on the evidence provided by the deceased's child, Fanie Fortuin. He was the child of the deceased, but not the accused. His testimony was corroborated by witnesses Daniels, and Freddie Jafta. According to Fortuin, on the evening in question, the deceased was under the influence of alcohol. She was castigated by the accused and the two retired to the bedroom, where he assaulted her. He slapped her across the face and attacked her with a scissors. The accused left the bedroom to fetch the paraffin that they kept in the kitchen and brought it to the bedroom. He then proceeded to pour the paraffin on her. He then took a candle and held it to the hem of her dress in an attempt to set her alight. This attempt failed. The accused went to the kitchen to fetch another candle, and on this occasion he was successful.

As the flames flared up the accused attempted to pull the burning clothes off her. In doing so he himself sustained first and second degree burns on his hands and to one of his arms. He made further attempts to quench the flames by taking a blanket and wrapping her in it.

As far as provocation is concerned, the Court accepted that there was a history of strife and disagreement concerning the deceased's habitual drunkenness. The Court also accepted that her behaviour had been the subject of heated discussions, and even

[12] KAB CSC 1/1/1/614, Cape Supreme Court Records, Case no. 372 of 1964, State *v*. R. A.

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chastisement by the accused. Justice Steyn therefore found the accused guilty of murder with extenuating circumstances and sentenced him to 20 years in prison.

The extenuating circumstances presented here echo many of the court cases presented in the preceding chapter. However, the brutality and calculated manner in which the accused killed his wife, necessitated a psychiatric evaluation in order for the court to find him accountable for his actions.

3. 4. 2. State *v*. F. G., 1965[13]

In the State *v*. F. G., the accused, a 21-year-old Coloured male, murdered a 53-year-old elderly lady, M. C. F. on the 25th of June 1965. The court documents stated that he killed her by kicking her face into a pulp with a booted foot. The autopsy report stated that during the assault he had fractured almost all the bones in her face and skull. Unfortunately, because of her level of intoxication it made it easier for the accused to kill her in such a manner because she offered little visible signs of resistance. According to the court documents she was "helplessly, even paralytically drunk."

On the night of the murder the accused was not alone. He was in the company of his friend Joseph 'Josie' Escorse. Justice Beyers was not completely convinced that the accused was the sole assailant in this case. According to the evidence given by the accused, Josie had intercourse with the deceased. He does remember kicking the deceased once. He further stated that he could not remember the details of the events.

Escorse himself gave evidence for the state. According to Justice Beyers he was an "unsatisfactory, unlovely character" and as a witness his impression upon the court was extremely bad. Notably, in the case of the accused there was almost a pathetic loyalty towards Escorse, and an attempt to save his friend from any undue trouble. The impression Justice Beyers got from Escorse was the complete opposite. To quote Justice Beyers:

> I was quite convinced that he was not beyond putting all the blame upon the accused. His evidence is, as I have said, unreliable, and I shall not refer to him again hereafter, because nothing can, in my view, be built upon his evidence.

Clearly this was a more complicated case in which the key witness had a much stronger psychological control over the accused. Sadly, the accused in this case also had a

[13] KAB CSC 1/1/1/707, Cape Supreme Court Records, Case no. 363 of 1965, State *v*. F. G.

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long history of mental illness. He had been checked in to hospitals since the age of nine. He had since that early age shown aggressive tendencies warranting his mother to seek advice.

The accused reportedly had a seizure after he was born, and as he got older it became apparent that something was "wrong". According to his mother, as a child he would often stare into space and begin to scream at nothing. Concern turned to panic when he aggressively attacked his younger brother.

In 1952 the accused's mother took him to a Dr M. Russell Clarke. He was eight years old at the time of his first meeting with a mental health care professional. According to Dr Clarke the accused's I.Q. was in the 80s as determined by an Individual Standardized Intelligence Test. This meant that his I.Q. was of a "dull normal" classification. His aggressive behaviour was, at this stage, interpreted as probably being a secondary result of his intellectual inadequacy, and other "psychogenic" factors. He was placed in a special class, and his parents and family were more sympathetic to his aggressive and explosive behaviour. Dr Clarke would have recommended a neurological examination, more specifically an Electro Encephalograph. However, Dr Clarke lost contact with the accused's case.

Interestingly, Dr Clarke was the same doctor to examine the accused while he was in Valkenberg. Dr Clarke visited him on the 1st and 2nd of December 1965 at Valkenberg, and during two testing sessions, covering a total of 2 hours and 45 minutes, Dr Clarke administered the South African version of the Wechsler Bellevue Adult Intelligence Test. He found his verbal I.Q. to be 80, his performance I.Q. to be 88, and his full I.Q. to be 82. The advantage of this test is that it not only provided and overall I.Q. score, but also allowed for an etiological diagnosis to be made.

According to Dr Clarke's report:

> It has been found by many investigators that certain abilities remain fairly constant in the face of organic change such as organic brain damage. These abilities are measured by the "Hold" subtests. Other abilities, more especially those covering memory, new learning, spatial concepts and design, are known to be adversely affected by organic brain damage. These abilities are measured by the "Don't hold" subtests. By applying a standardized formula comparing scores on the constant "Hold" subtests, with those on the adversely affected "Don't Hold" subtests, it is possible to calculate an Index of Deterioration or Organic loss.

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By applying this formula to the accused's test performance, he was shown to have a net organic loss index (indicating brain damage) of 30%. A net loss greater than 10% is indicative of possible organic brain damage.

As a young child the Nazareth home[14] refused to accept the accused because he was unable to learn like other children. According to his mother he would just stare into space at times or scream for no apparent reason. He would frequently attack and hurt other children without provocation. The social worker found out that the mother, who was Portuguese, only married the accused's father, a heavy drinker, to obtain South African citizenship. She also admitted to the social worker that she hated the accused for being like his father and attacking her younger child, Julian, whom both she and her husband preferred over the accused. The social worker made a note on the very unhappy background from which he came. In one of his files it is also reported that he felt unwanted by his parents and that he knew that they preferred his brother.

It appears in the accused's story that he was vulnerable to even small amounts of alcohol. It is reported that he often suffered "blackouts" when he consumed small amounts of alcohol. He denied, however, that he had suffered actual attacks of unconsciousness, suggestive of epileptiform attacks, but admitted, on questioning, that he had experienced momentary lapses of memory at times when he could not recall what he had just said or what somebody had just said. He also admitted to rare occasions where he would feel dizzy and a bit peculiar for a few seconds at a time. He complained mainly about suffering frequently from short attacks of severe depression and restlessness when he thought of his unhappy experiences in childhood and the fact that his mother never seemed to care for him and didn't want him.

During the court proceedings the psychiatrist, who had examined the accused, determined that he did indeed suffer from organic brain damage which could have influenced his memory and behaviour. The psychiatric report concluded:

> The results of the electro-encephalograms confirm, in my opinion, the probability that the accused is a brain damaged individual from birth who has an epileptic dysrhythmia from birth. In other words, he has a brain that can be caused to produce an abnormality of behaviour such as impulsive, aggressive violence, or carrying out a impulse which he is incapable of resisting, or automatic uncontrollable behaviour, providing certain exciting or aggravating factors or conditions exist which then would tend to produce an attack. These condition have been proved to have been present prior to and during the time of the

[14] Nazareth House Cape Town provides care and protection for orphans and other vulnerable children.

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> accused's act of violence. These include excessive fluid intake, in all probability resulting in fluid retention due to alcoholic over-indulgence, carbohydrate deficiency (lack of food) over a period of 10 hours and the influence of dagga intoxication (the association of dagga with alcohol is known to cause seizures in even non-epileptics). There is also the possibility that hyperventilation occurred, i.e. excessive deep breathing due to excitement or abnormal emotion which is one of the methods of producing abnormal brain waves in an epileptic and even attacks in some individuals. I consider it probable, therefore, that at the time the accused killed this woman he was not responsible, in a psychiatric sense, for his actions. For, to be responsible, a person must be in full possession of his consciousness and so be able to pass judgment and control his actions. I am of the opinion that the accused probably suffered from a minor epileptic attack at the time of the crime which caused his brain to function abnormally, the abnormality of such as to impair his judgment and render him unable to fully appreciate the nature of his act.

According to the report, the accused was an epileptic since birth which could cause abnormal behaviour such as impulsivity, aggression, and violence. Due to this he could not be held responsible for killing the deceased.

During the trial the accused gave evidence in his own defence and during the course of that evidence doubt arose as to his *animus occidendi.*[15] A doubt also arose in the mind of the court as to whether the person before the court was mentally stable enough to form an intention to kill and for that reason the court thought it fit to refer the accused to Valkenberg for investigation of his mental condition. In due course a report was received from the Superintendent of the Valkenberg Hospital, which details certain observations and inquiries conducted by the staff of that institution and in which the medical Superintendent comes to the conclusion: "In view of the aforegoing findings I must come to the conclusion that in my opinion no reason exist on psychiatric grounds for diminished responsibility".

The report from Valkenberg only deals with certain interviews between the accused and members of the mental institution and the conclusion to which Justice Beyers makes reference is based entirely on those interviews together with a study of the evidence given by the accused at the trial. The defence, however, was able to consult a private psychiatrist, and one whom the accused had met with in 1952, Dr M. Russell Clarke.

It would appear the morning after the murder the accused was unaware of the fact that he had killed this woman. He even went to his work with his boots and his trousers stained by blood; and it was only after lunch on the Saturday when his attention was drawn to a newspaper report referring to the death of the deceased, that he realized that he must have been responsible for this woman's death.

[15] Latin for "the intention to kill".

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If one approaches his evidence the first matter that must be decided is whether he is worthy of credence. Neither of the psychiatrists suggested at any stage that the accused was malingering, nor did the defence of lesser mental responsibility really come from the defence. According to Justice Beyers and his two assessors it seemed to them that the accused was really trying to be truthful. While on the stand the accused admitted that he went to the deceased to have intercourse with her after his friend Escorse had intercourse with the deceased. Instead, he kicked her to death. It was clear that the accused struggled to remember the events, despite his best efforts.

The presiding Judge, Justice Beyers was satisfied that the accused met the conditions set forth in the Mental Disorders Act in section 29 (2) and on the 24th of February 1966 the presiding judge ordered that he be kept in custody pending signification of the State President's decision.

In cases where the mental state of the accused is concerned there are also various themes, or factors that become apparent. According to the cases discussed here, factors such as IQ, epilepsy, and family history are important. In the case of F. G. we see these themes very clearly. It was determined that he was of low IQ and had probably suffered from epileptic like seizures that could have had an influence on his behaviour and impacted his memory.

The State v. F. G. is a more serious case involving psychiatric pathology. This was proven and resulted in the accused being declared a State President's patient – in other words, incarcerated in a mental health facility.

3. 4. 3. State *v*. S. S. & S. N., 1966[16]

The only other case during this period where the defendant's mental health was considered was in the case of the State *v*. S. S. & S. N. Both had been charged with murder of a Coloured male. The accused S.S. had been found guilty of assault with the intent to cause harm. The co-accused in this case, S. N., was detained at an institution pending the State President's decision according to the terms of the Mental Disorders Act. Unfortunately, regarding the mental state of S. N. insufficient information was made available in the

[16] KAB CSCS 1/1/1/, Cape Supreme Court Records, Case no. 307 of 1966, State *v*. S. S & S. N.

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archival file. The only documents available are those that prove that he had been sent to Valkenberg, but no additional documentation on his diagnosis could be found.

Both of the accused assaulted the deceased, however, Justice Steyn noted that either one could have dealt the lethal stab to the back of the deceased's head. Due to this and reasonable provocation by the deceased, S. S. had been found guilty of the lesser charge of assault and was given 18 months suspended for three years.

Attention will now be given to some of the components taken into consideration during these trials.

3. 5. General Trends on Mental Health Considerations in the Cape Town Supreme Courts, 1964-1966

In this section the general trends considered in murder and murder related cases at the Cape Supreme Court will be discussed. These trends include intelligence quotient testing, how the mentally disordered or defective were defined in the Mental Disorders Act, psychopaths, early psychiatric treatments and institutions, the State President's Patient, and finally the position of clinical psychologists.

3. 5. 1. Intelligence Quotient Testing

According to psychologists, S. Laher and K. Cockcroft the medium of psychological testing came to South Africa via Britain. In South Africa tests were developed in the context of unequal distribution of resources as dictated by Apartheid policies. These psychological assessment practices were used to validate the exploration of black labour and to deny black South Africans equal access to education. Additionally, these tests also decided who gained access to economic and educational opportunities in South Africa. During Apartheid certain jobs were reserved for white individuals only. Psychometric testing and psychological assessment were abused to support the practice of job reservation for white individuals.[17]

In South Africa, the first assessment used was the Leipoldt-Moll Scale. This scale was an initial adaption of the Binet-Simon scale created by Theodore Simon and Alfred Binet between the years of 1904-1905. This scale was commissioned by the Parisian Ministry of

[17] K. Cockcroft & S. Laher (ed): *Psychological Assessment in South Africa: Research and Applications*, p. 2.

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Public Instruction to assist in identifying special needs school children. In 1973 Carl Brigham caused controversy surrounding cognitive assessment when he used the Army Alpha and Beta test to investigate the differences of intelligence between racial groups in the United States. In South Africa psychologist M. L. Fick commissioned a similar study and also used the Army Alpha and Beta tests as well as his own Fick Scale to measure the differences in intelligence between black and white students. According to the results of Fick's study there was a significant discrepancy between the intelligence of black and white students, the black students scoring lower. Fick proposed cultural, educational, and social reasons for this discrepancy whereas Carl Brigham did not. Fick later changed his view and in his book, *Educability of the South African Native* published in 1939, where he argued that the differences between racial groups was because of inherent and not external factors. This would eventually have lasting implications for psychological testing in South Africa.[18] Separate tests would be used to assess different races and the outcome would serve as a means of assessing intellectual ability and explaining "normal" behaviour.

The National Bureau for Educational and Social Research developed and adapted a number of psychological assessments between the 1960s and 1990s. Some of these tests included the South African Wechsler Adult Intelligence Scale, General Scholastic Aptitude Test, and the Ability, Processing of Information, and Learning Battery. The South African Wechsler Adult Intelligence Scale was released in 1969. This Scale was based on the Wechsler-Bellevue Intelligence Scale that was released internationally in 1955.[19]

The history of what to do with those deemed mentally defective dates back to 1929 when there was an interdepartmental Committee called on Mental Deficiency. The report of this committee was published by the Union Education Department and had an important part in the development of "facilities for defectives". The mandate of the Committee was to "enquire into the position in the Union with regard to the mentally retarded, mentally defective."[20] The terms of reference for the committee was wide and covered all aspect of mental deficiency, backwardness in schoolchildren, legislation with regards to mental deficiency, and the problems of the socially unfit. According to the findings and

[18] http://histories.jvrpsychometrics.co.za/history-of-psychometric-testing-south-africa/ (3 November 2019).
[19] *Ibid.*
[20] M. Minde: "History of Mental Health Services in South Africa-Part IX. The Protection and Care of the Feebleminded," *South African Medical Journal*, (49), 1975, p. 1719.

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recommendations of the Committee, the position of the mentally defective persons in the Union was unsatisfactory and required State action.[21]

By 1967 there was another report of the Commission of Enquiry into the Care of Mentally Deficient persons. According to Minde the recommendations of this Commission was unobjectionable – the was a need to build more asylums. However, they were considered too expensive. Unfortunately, this report also exclusively focused on the white population, although the terms of reference made no mention that the focus should be solely on the white population. It was argued that there was a lack of adequate facilities for psychiatric patients, especially for non-white "defectives". The only exception was Westlake for Coloureds. The Commission based their findings and recommendations on the examples set in Denmark, Great Britain, Holland and Germany. It was argued that if their recommendations were implemented, it would greatly improve the treatment of mental health in South Africa.[22] Needless to say, there was a shortage of facilities for those deemed mentally unstable, let alone facilities for those who committed murder and sentenced to incarceration. Another issue that arose was who could be deemed medically insane. It is here that one should outline what constituted mental deficiency in terms of the legislation in place at the time of these court trials.

3. 5. 2. Mentally Disordered or Defective as Defined in the Mental Disorders Act of 1916

The Mental Disorders Act 1916 was largely based on the old British Mental Deficiency Act of 1913 and the pre-Union laws of the provinces. Prior to 1910 each province in South Africa had their own laws relating to the mentally ill. The Cape Province, for example, had the Lunacy Act of 1897. In 1914, Parliament enacted the Lunacy and Leprosy Laws Amendment Act no. 14 which changed some of these provincial laws.[23] It was accepted at the time that no treatment could cure or improve the "mentally disordered or defective". It is for this reason that mental institutions were hardly a priority for the state. It was only since 1944 that the Department of Health was placed in charge of mental institutions; before that time they were the responsibility of the Department of the Interior.[24]

[21] M. Minde: "History of Mental Health Services in South Africa-Part IX. The Protection and Care of the Feebleminded," *South African Medical Journal*, (49), 1975, pp. 1719-1720.
[22] *Ibid.*, p. 1720.
[23] See J. Parle: "Mental illness, Psychiatry, and the South African State, 1800s-2018," *Oxford Research Encyclopedia, African History*, 2019, pp. 1-25.
[24] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 5.

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The Rumpff Commission noted that since 1916, the field of psychiatry and psychology, particularly in the prior 20 years, had made ever-increasing progress in the field of mental health yet the custodial care attitude, prevalent at the time of the enactment of the Mental Disorders Act of 1916, persisted. Relatively isolated mental hospitals were built or developed; sometimes in old and disused buildings. Improvements were attempted, however, the stigma of these institutions persisted. When people are removed from their families and communities this lead to the chronicity of illness and often rejection from families. The Rumpff Commission recommended that the public be taught to understand mental health problems, and the assistance of mass media such as the press, radio and television was to be invoked to augment the efforts made by existing voluntary associations and public authorities.[25]

Section 3 of the Mental Disorders Act of 1916 classified mentally disordered or defective persons into the following classes:

> Class I: A person suffering from mental disorder, that is to say a person who, owning to some form of mental disorder, is incapable of managing himself or his affairs; Class II: A person mentally infirm, that is to say, a person who through mental infirmity arising from age or the decay of his faculties, is incapable of managing himself or his affairs; Class III: An idiot, that is to say, a person so deeply defective in mind from birth, or from an early age, as to be unable to guard himself against common physical dangers; Class IV: An imbecile, that is to say, a person in whose case there exists from birth or from an early age mental defectiveness not amounting to idiocy and who, although capable of guarding himself against common dangers, is incapable of managing himself or his affairs, if he is a child, of being taught to do so; Class V: a feeble-minded person, that is to say, a person in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility so that he is incapable of competing on equal terms with his normal fellows or of managing himself and his affairs with ordinary prudence and who requires care, supervision and control for his own protection or for the protection of others or if he is a child, appears by reason of such defectiveness to be permanently incapable of receiving proper benefit from the education and training in a special school as defined in section 20 of the vocational education and special schools act, 1928 or in any ordinary school etc.; Class VII: an epileptic, that is to say, a person suffering from epilepsy who is a danger to himself or others or is incapable of managing himself or his affairs.

By the 1970s, these classifications were considered obsolete, however adequate changes could only be effected once a new act was passed.[26] While these categories of mental illnesses continued to simmer, the judiciary, in particular, was concerned with eradicating society from a much more sinister and pathologically "predisposed beast". This lay heavily

[25] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act,* pp. 9-11.
[26] *Ibid.*, pp. 35-36.

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on a broader confusion over distinguishing between those deemed mentally ill and not accountable for his/her actions and those able to fool the system: the psychopath.

3. 5. 3. Psychopaths

Various investigations unfolded to discuss the problems of psychopathy. This included various facets: the definition of psychopathy, aetiology of psychopathy, diagnostic criteria, and incidence in the community, in mental hospitals and in prisons. The part played by the different disciplines in the handling of the psychopath, the part played by state departments, medico-legal aspects, the principle of diminished responsibility, the amendment of the law, prevention, the influence of psychopathy on married life and family life, and many other matters in connection with psychopathy considered important. Of particular interest was how prosecutable a psychopath could be.

Initially, psychopaths were classified under the deleted Class VI of section 3 of the Act of 1916, "a moral imbecile, a person who from early age displays some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect".[27] Often legislation would be amended without completely revising and replacing it. In the case of the Mental Disorders Act there were amendments made to the Act, particularly regarding definitions. In 1944 such an adaption was made by Section 2 (b) of Act 7 of 1944:

> A socially defective person, that is to say, a person who suffers from mental abnormality associated with anti-social conduct, and who by reason of such abnormality and conduct requires care, supervision and control for his own protection or in the public interest.[28]

In 1957 there was another amendment made to the Mental Disorders Act. Section 1 of act 37 of 1957 repealed the above mentioned provision and nothing was inserted in its place:

> Psychopathic disorder is a form of mental illness and it seems that the original Class VI as well as the provisions substituted in 1944 applied to person's suffering from such illness. The existing act, however, compels a court to send an accused who is found to be certifiable to an institution and such a person cannot be tried. Generally psychopaths are both responsible and capable of understanding the proceedings against them and of defending themselves, and such persons ought to be tried if accused of a crime, and sentenced if found guilty. It is apparently because psychopaths could not be tried under the existing act that the provisions included in Class VI were repealed in 1957. If effect is given to

[27] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 38.
[28] *Ibid.*

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> the recommendations of the Rumpff Commission, the criminal procedure act will draw a clear distinction between responsibility, trialability and certifiability. As soon as this has been done there will no longer be any reason for this excluding 'psychopathic disorders' as defined herein from the definition of mental illness.[29]

Confusion continued to reign:

> There has been, and still is, considerable disagreement and confusion surrounding this term and its application. In North America the term 'sociopath' is more frequently used today. This refers more particularly to the individual's inability to form and to maintain mature and reciprocal social relationships and to his general failure in adjusting to society.[30]

Many definitions of psychopaths are so general and vague that they have little value as a diagnostic device. The English legal definition of psychopathy presented in Britain's Mental Health Act of 1959 is an example. It describes psychopathy as: "a persistent disorder or disability of mind (whether or not including sub normality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to, medical treatment."[31] Of concern was what to do with people deemed psychopathic.

3. 5. 4. Early Psychiatric Treatments

By the end of the First World War psychiatry became more of a respected profession, due to the prominence of shell shock among men and the public recognition of the trauma caused by war. By the 1920s psychiatry became an academic discipline at South African universities, although not well subscribed or supported. The discipline of psychiatry often reflected state ideological and economic priorities. Psychiatric thought and practice in South Africa, although deeply prejudiced and discriminatory, did not boost extreme measures like in places such as Nazi Germany. The financial support of asylums had still not become a priority for the government and the needs of white men continued to be given preference.[32]

The aetiology of mental illnesses continued to be influenced by ideologies of race and gender. Psychiatrists and other specialists from other fields such as anthropology and psychology emphasized factors such as "genetic heritage" and "predisposition" often associated with other races. There were others that stressed factors such as social conditions

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[29] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, pp. 38-39.
[30] *Ibid.,* p. 39.
[31] *Ibid.,* p. 40.
[32] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, p. 8.

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such as poverty, place and upbringing. The beliefs of the 19th century, and earlier, regarding the abilities, attitudes, emotions, and psychological strength of individuals suffering from mental illness remained largely influential. In cases of black patients, they would most often receive a diagnosis of schizophrenia and white patients, depression or neurosis. However, even when determined that they are suffering from the same condition, different racially specific causes and inclinations were attributed as the cause.[33]

Black patients were often described as being incapable of experiencing guilt or depression and therefore seldom suicidal. If suicide was attempted it was explained as the consequence of anger. White professionals wrote of urbanization as especially stressful for Africans. Therefore, they argued, this was the cause of a psychopathological state of mind. These views underpinned segregationist and apartheid policies, even when not directly cited by governments. Internationally, there were a mixture of new treatment methods tested. Many of these methods became controversial or were replaced by more effective treatments. From the 1930s treatment included convulsive therapies for manic depression and injections of camphor and cardiozol for schizophrenic patients. Hypothermia was used as a treatment for syphilitic patients. Electroconvulsive therapy and insulin-induced comas were also popular treatment methods.[34]

An amendment to the Mental Disorders Act of 1916 reoriented psychiatric discourse away from disease and disorders and towards the treatment and recovery of patients. Patients who were suffering were encouraged to voluntary treatment and legal certification was no longer required. As part of the move away from custodial care, there were efforts made to deinstitutionalize patients. Mental health societies were established across the country to assist local services such as specialist schools and rehabilitation or occupational centres for the "mentally handicapped." Additionally, general hospitals established inpatient treatment units for psychiatric patients, and treatment for alcoholism.[35]

From the 1950s and 1960s drugs such as chlorpromazine, lithium, and imipramine became popular for effectively treating mental illnesses. The medications would not necessarily cure patients, but managed extreme symptoms and behaviours. Sedatives and hypnotics also became more widely prescribed by general practitioners.

[33] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, p. 10.
[34] *Ibid.*, p. 11.
[35] *Ibid.*

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Deinstitutionalization following the discovery of psychoactive drugs in the 1950s changed the profession of psychiatry and psychology internationally by reducing the number of chronically psychotic patients and in doing so changing the profile of psychiatric hospital populations.[36]

The 1950s saw an era of new therapies in psychiatry becoming available to patients. In 1952 the neuroleptics, imipramine in 1956, and the inhibitors of monoamine oxidase in 1958. These drugs had a prolonged and positive effect on psychotic symptoms that had been previously unresponsive to treatment methods. Therefore, physical restraint was no longer necessary, and the use of treatments such as insulin comas, and shock treatment could be minimized, or eliminated completely. As outpatient treatment became possible, the function of an asylum could now shift from custodial to curative care. This resulted in a dramatic drop in patients' numbers in asylums.[37]

Not only did new psychoactive drugs become popular in treating patients, but in the 1950s and 1960s behaviour therapy also became popular. This method became popular with psychologists, whose function was different than that of a psychiatrist. With behaviour therapy there was an opportunity to become involved in an "approach to treatment" whose general intellectual justification was firmly rooted in psychology rather than psychiatry. We see psychologists begin to work independently and develop their own models.[38]

The 1960s saw a move towards a move progressive psychiatry. An example of this would be inter-disciplinary approaches, academic specialties, and the inclusion of psychiatry into general nurse training. There were arguments highlighting the pressing need for black psychiatrists. The idea was that they will serve their own communities, therefore freeing white psychiatrists to assist white patients. The influence that these new drugs had and the changes they permitted did not escape the attention of parliament. A member of parliament had pointed out as early as 1959 that the psychiatric system in the country needed to shift from custodial to curative care. Notably, there was no corresponding policy change, and it was only in 1961 that the Minister of Health stated that the new drugs and treatments offered

[36] H. Laurenson & S. Swartz: "The professionalization of psychology within the Apartheid state 1948-1978," *History of psychology*, (14), (3), 2011, p. 250.
[37] *Ibid.*, p. 252.
[38] *Ibid.*

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the hope of cure and emphasized early intervention as to avoid detention at a mental facility, and that this was to be the rule.[39]

The annual reports to the Minister of Health by the Commissioner for Mental Health clearly reflected the impact of these new antipsychotic drugs. In 1960 the report of the Commissioner noted a rise in admissions and discharges for South African asylums, along with voluntary admission, improved treatments, and a change in attitude from communities. According to the Commissioner, psychotic patients had benefitted the most from the change in regime.[40]

3. 5. 5. Early Psychiatric Institutions

The treatment and care for mental illness existed since the earliest occupation of Southern Africa. According to historian Julie Parle treatment was sought across all communities from indigenous healers through local medicines, religious or spiritual guides, and rituals. Sustainable care and control of those deemed mentally ill have only been formalized since the 1800s. Sadly, before then the only option was to restrain those deemed mentally ill in jails. The detained were not treated differently than the other criminals in the jails. Spaces were eventually made available in hospitals or annexes.[41]

The first hospital to offer some care for the mentally ill was the Somerset Hospital established in 1818. The facilities were woefully inadequate. In 1846 the colonial government converted the Robben Island prison into a facility for lepers, chronically ill and mentally ill patients. Geographically it was cut off from the mainland and reserved for disruptive patients. According to Parle the situation at Robben Island was often described as dire and there was evidence of abuse of patients. Medical treatments favoured at the time included hypnotics, bromides, and calomel, all of which had serious side effects. Records also show that alcohol, chloral hydrate, laudanum, tincture of opium, cannabis indica, and hemlock juice were administered to patients. After 1891 white patients had a segregated

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[39] H. Laurenson & S. Swartz: "The professionalization of psychology within the Apartheid state 1948-1978," *History of psychology*, (14), (3), 2011, pp. 254-255.
[40] *Ibid.,* p. 255.
[41] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, p. 2.

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mental hospital at Valkenberg Hospital. Only after 1916 were black patients accommodated at separate buildings on the same estate.[42]

In 1892, Valkenberg, situated on the outskirts of Cape Town, was the first hospital in the Cape designed to specifically cater for the mentally ill. The Valkenberg hospital's focus continued to be on severely psychotic disorders. In these hospitals, services were largely custodial. Custodial care meant containing those suffering from mental illnesses in asylums. This was due to the lack of adequate treatments available at the time.[43] The favoured treatment for black patients was manual labour. Mechanical restraints were eventually phased out, yet straitjackets and seclusion remained a way to control and subdue unruly or suicidal patients. For white men the most common explanations for insanity were alcohol abuse, epilepsy, mania, dementia praecox,[44] and "general paralysis of the insane", which was the tertiary stage of syphilis.[45]

During this period little was known about the causes of mental illness among the "Coloured, Native, or Asiatic" inmates.[46] Additionally, in most cases, the asylum staff rarely spoke African languages and made little effort to understand their diagnoses. The main cause given for illnesses among black men included *insangu*[47] smoking. Paperwork demanded detailed information yet "unknown" was the most common term noted for the cause of mental illness for black patients.[48]

During the Apartheid government's tenure most of the state's psychiatric institutions remained centrally administered by the national government's Department of Health. After 1944, when the management of mental health services shifted to the Department of Public Health from a separate division known as the Department of the Interior, mental health policy remained the same until 1973. There were only two legislative changes during that period. In 1957 an amendment transferred the cost of a non-South African migrant to the patient's home country. Additionally, the amendment changed the name of the Commissioner for

[42] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, p. 2.
[43] L. Gillis et al: "No Health without Mental Health: Establishing Psychiatry as a major discipline in an African Faculty of Health Sciences," *South African Medical Journal*, (102), (5), 2012, p. 449.
[44] Dementia Praecox was later renamed schizophrenia.
[45] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, pp. 4-5.
[46] Terms maintained due to its historical significance.
[47] Cannabis.
[48] J. Parle: "Mental Illness, Psychiatry, and the South African State, 1800s to 2018," *Oxford Research Encyclopedia, African History*, 2019, p. 5.

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Mental Disorder to the Commissioner for Mental Hygiene. The second amendment came in 1961 which extended free treatment to voluntary patients who could not afford care. The procedures for the management of mentally ill patients remained as set out in the 1916 Mental Disorders Act, with only minor amendments, as discussed above.[49]

It is within this climate that a convicted felon suffering from a mental illness could be declared a State President's Patient or be sent for psychological help.

3. 5. 6. The State President's Patient

Convicted felons declared as State President patients were initially incarcerated indefinitely in mental institutions. With changes within the disciplines of psychiatry and the emergence of psychology and social work as related and emerging disciplines, new ways of treating these patients appeared. State president's patients were discharged provisionally. It was recommended that they be placed under the supervision of social workers only if it appeared that they would benefit from the intervention. The services of social workers was to be utilized merely for the purposes of ensuring some measure of control.[50] In cases where the defendant was declared mentally disordered, s/he was deemed a State President's patient decision. Therefore, s/he was subject to the mercy of the State President. Due to the lack of special institutions and existing institution's ability to handle and care for the criminally insane, these patients would often spend their time in the hospital section of prisons or in the few institutions that could accommodate them. It was also in this context that the role of psychologists, and clinical psychologists in particular, was considered important.

3. 5. 7. The Position of Clinical Psychologists

Compared with the services in some western countries, clinical psychological services were relatively underdeveloped in the republic:

> Clinical psychologists may register with the SA medical and dental council, the latter regards them as paramedical (as is the case with physiotherapists, radiographers, etc.) with the result that they do not enjoy professional recognition or status. Many medical aid funds refuse to accept liability for the accounts of clinical psychologists. This state of affairs exists despite the fact that a clinical

[49] T. F. Jones: *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, p. 48.
[50] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 18.

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> psychologist's course lasts six years including 12 months as an intern at an approved psychiatric hospital.[51]

Government notice R. 1727 of 30 October 1964 states that a clinical psychologist may examine and treat patients only if he is a member of a team of which at least one member is a medical practitioner. Because of this lack of status medical practitioners were reluctant to refer patients to a clinical psychologist. Their salaries were relatively unattractive, with the result that very few students were attracted to the occupation. Furthermore, very few posts were available for clinical psychologists.[52]

Many psychiatrists and medical practitioners' felt that psychologists were not qualified to enter the field of psychotherapy and were therefore to be confined to tasks such as psychological testing and research. This period was marked by vast improvements in accepting psychology and psychologists as instrumental to the welfare of convicted felons enhancing the status of clinical psychologists as part of a multi-disciplinary team.[53]

It was in the aftermath of the assassination of Verwoerd that the disciplines of psychiatry, psychology and jurists were brought closer together.

3. 6. The Death of Hendrik Verwoerd and the Beginning of the End for the Mental Disorders Act No. 38 of 1916

The Commission of enquiry into the assassination of Verwoerd was essentially a detailed investigation into the life of Tsafendas. Tsafendas was the illegitimate child of a non-white Mozambican mother and a white Greek father. According to South Africa's racial classification he was considered a Coloured. Since his early days his life was one of transience and marginality, with little sense of family or home. He lived his adult life as a nomad. Travelling from one destination to another. Notably, Tsafendas was, during his many travels, often detained in psychiatric institutions. Repeatedly he was diagnosed with various serious psychiatric illnesses. In 1946 he was classified as a "schizophrenic with deterioration, prone to assaultiveness and agitation, smearing the walls with his faeces, experiencing hallucinations."[54] In 1952, he was diagnosed with "manic depressive psychosis" and this

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[51] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 23.
[52] *Ibid.,* pp. 23-24.
[53] *Ibid.,* p. 24.
[54] D. Posel: "The Assassination of Hendrik Verwoerd: The Spectre of Apartheid's Corpse," *African Studies*, (68), (3), 2009, p. 339.

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diagnosis came with reference to the tapeworm that Tsafendas said had been bothering him since 1937. During the periods that Tsafendas experienced mental stability, he spent his time at sea.[55]

Another concern for the Commission was how Tsafendas was able to obtain employment in parliament as a messenger. By the mid-1960s the National Party government had implemented aggressive affirmative action policies for whites in the public sector. Work such as the one Tsafendas had received in parliament was reserved for those in the lower levels of civil service, particularly for loyal supporters of the National Party. The work he had obtained in parliament was therefore reserved for a white person and preferably an Afrikaner Nationalist. Considering that Tsafendas was a "half-caste", and someone with alleged communist leanings, it was spectacular that he had gained employment in parliament. The Commission was told that Tsafendas was only appointed because of the desperation of the state which was reduced to employing "incompetents". This was a consequence of the labour shortages caused by its affirmative action policy. The parliamentary official responsible for Tsafendas's appointment told the Commission that "he was the best of the loose spineless applicants" making themselves available for such employment. There had been no effort made to do a background check on Tsafendas before he was employed. "In short, in rendering Tsafendas's personal biography, the commission established a version of Verwoerd's assassin as a 'half-caste,' illegitimate, ill-educated, psychotic man, roaming aimlessly, without a stable family – a man without an identity, without a home, without any attachments, and without any coherent version of a cause".[56]

The report of the Commission of Enquiry into the death of Verwoerd, or the First van Wyk Commission as it is also known, recommended that another commission of enquiry be set up to look into the matter of the mentally deranged. This became known as the Rumpff Commission of 1967. This in turn led to another commission of enquiry, the Second van Wyk Commission. Although the First van Wyk Commission was not a focus point of discussion in this study due to the abundance of literature already available on the subject, it is nevertheless important due to the other Commissions of Enquiry that stemmed from it.

[55] D. Posel: "The Assassination of Hendrik Verwoerd: The Spectre of Apartheid's Corpse," *African Studies*, (68), (3), 2009, p. 339.
[56] *Ibid.*, p. 337.

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3. 6. 1. The Rumpff Commission of 1967

In the aftermath of Verwoerd's assassination a one man commission of inquiry was appointed, headed by Justice J. T. van Wyk. This commission is referred to as the first van Wyk Commission. That commission found that "it is probable that a large number of assassinations, if not the majority are committed by mentally disordered persons. They are pre-eminently the ones who could be used to commit a murder."[57] The first Van Wyk Commission recommended that the "advisability be investigated of compelling all medical practitioners-including all psychiatrists to submit to the Commissioner the names of all patients who are mentally disordered and who, in their opinion, are likely to become a danger to others at some time in the future."[58]

In 1967, the Rumpff Commission was appointed to "inquire into and report on the efficacy or otherwise of existing statutory provisions and legal rules regarding (a) The adjudication of criminal cases involving persons alleged to be suffering from some form of mental derangement; (b) the responsibility and the criminal liability of such persons; and (c) the prevention of acts by such persons which are dangerous to others".[59] The Rumpff Commission also had to make recommendations concerning any law reform considered necessary and pragmatic in the interests of such persons and in the public interest. The commission produced its report in 1967.[60] The Rumpff Commission concluded that a commission of inquiry be appointed to inquire and revise the Mental Disorders Act No. 38 of 1916. That commission was appointed in 1972 and referred to as the Second van Wyk Commission.[61]

The Rumpff Commission highlighted a problem that had been persisting in South Africa before Verwoerd's assassination. It was clear that in cases where the accused's mental health is a factor, the law and psychiatry did not work with each other. This is highlighted in the memorandum submitted by the National Council for Mental Health to the Rumpff Commission. In this memorandum Dr. R. W. S. Cheetham stated:

> I would like to respectfully plead with the Commission that, where possible, the points of contact between psychiatry and law be expanded and, where possible the points of difference be minimized. On behalf of the South African National

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[57] A. Kruger: *Mental Health Law in South Africa*, p. 24.
[58] *Ibid.,* pp. 24-25.
[59] *Ibid.*, p. 25.
[60] J. H. van Rooyen: "The Psychopath in South African Criminal and Mental Health Law," *The Comparative and International Law Journal of Southern Africa*, (9), (1), 1976, p. 4.
[61] A. Kruger: *Mental Health Law in South Africa*, p. 25.

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> Council for Mental Health and also another member of the executive committee of the Society of Neurologists and Psychiatrists, I beg to disagree, in principle, with the current concept that the aim of Law is to 'protect' society and that psychiatry attempts to 'protect' the individual, at the expense and to the danger of society.[62]

According to Dr. Cheetham the differences could be bridged in time, provided that the jurist and the psychiatrist each discharged their task in a responsible manner and, in practicing their profession, especially in the trial of criminal cases, look beyond their own interests, remembering that the interests of society was at stake.[63]

Ironically, the gap had been bridged when psychiatrists were called to act as expert witnesses. In effect, what the recommendation implied was an alignment of the goals of each of these professions within the judicial system.

3. 6. 2. Psychiatrists in the Dock: Psychiatrists as Expert Witnesses

The Rumpff Commission discussed impressions of the existing legal system that dated back to 1924 with a specific focus on a report published in the *South African Law Journal*. It is a report from a symposium held by representatives of the local Bar and the medical profession on mental disease and criminal liability. According to Dr. C. C. Elliot who was in attendance at the symposium, the discussions were summarized as follows: (a) the necessity for a skilled psychiatrist being available to the courts for advice to the assessors, or in a consultative capacity; (b) the absurdity of both the prosecution and the defence calling medical witnesses, when there could be an impartial board of experts to examine the case and report to the court; (c) that it was undesirable to, as a jury, decide whether a person is insane or mentally deficient; (d) that it is necessary for lawyers to be better acquainted with the subject of mental deficiency; (e) the advisability of punishments being graded according to the degree of responsibility present; and finally (f) the superiority of South African law to English law in regard to the subject of mental deficiency.[64]

According to Dr. E. Swift, the then Physician Superintendent of Valkenberg, English law only recognized disorder of the cognitive and intellectual faculties that affected responsibility, whereas conduct and responsibility were largely influenced by disorder of

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[62] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 5.
[63] *Ibid.*
[64] *Ibid.*, p. 23.

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other faculties of the mind such as emotions, instinct and will. Dr. Swift defined mental disorder as a morbid condition of the whole organism and argued that it should be recognized that the normal restraining influences may be compromised in a way not particularly associated with the intellect or will. With reference to the M'Naghten rules, Dr. Swift also supported the idea that a rigid test for responsibility should be abolished and that it should be recognized that there are degrees of responsibility.[65]

Dr. R. A. Foster, the Physician Superintendent at the Alexander Hospital also considered that the M'Naghten rules should be abolished. According to him the question of ascribing criminal responsibility was quite impossible for the majority of psychiatrists, especially considering the way the M'Naghten rules were governed. He contends that "the rules intended to apply to the herd, can only be applied to a few individuals".[66]

The commission received various representations concerning the criteria of responsibility and the application of the M'Naghten rules. The then Attorney-General of the Transvaal was of the opinion that the M'Naghten rules, as such, did not constitute part of the law, although they were used by some judges. He recommended that since it is impossible to draw up rules which would cover the circumstance of every possible case, the question of whether a person was insane or not should be decided in each case on the evidence. The various jurists across the country had mixed opinion of the M'Naghten rules. Some believed that it should be done away completely, others believed that it was common sense legislation and should therefore stay, and lastly there were those who felt that the M'Naghten rules needed to be expanded upon and modified, but not done away with completely.[67]

It is this very dissention, difference of opinion and clearly different applications of the various laws throughout the country, and how they are applied to specific cases that require studies such as this to ascertain the impact of legislation on particular types of offences. It also necessitates an investigation on how the criminal procedure was to be implemented to somehow formalize what was clearly a fractured medical and judicial system.

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[65] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters,* p. 23.
[66] *Ibid.*
[67] *Ibid.*, p. 27.

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3. 6. 3. The Trial of Individuals Suffering from a Mental Disorder

The first part of the *Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters* deals with the technical aspects of the law such as *mens rea* and the M'Naghten rules. It is the second part of the report that is arguably more important to this study. As a starting point it is important to refer to section 182 of the Criminal Procedure Act of 1955 which reads as follows:

> If at any time after the commencement of any trial it is alleged or appears, that the accused is not sound of mind, or if on such a trial the defence is set up that the accused was not criminally responsible, on the ground of insanity, for the act or omission alleged to constitute the offence with which he is charged, he shall be dealt with in manner provided by the law relating to mental disorders.[68]

Additionally, section 164 of the Criminal Procedure Act of 1955 which deals with the fitness to stand trial, reads as follows:

> If, when, (a) the accused is called upon to plead to a charge, it appears to be uncertain for any reason whether he is capable of understanding the proceedings at the trial, so as to be able to make a proper defence, the procedure described in section 28 of the Mental Disorders Act of 1916 shall be followed. If the jury or the court, as the case may be, find that he is capable, the trial shall proceed as in other cases; (b) if he is found to be not capable, the accused shall be dealt with in accordance with the provisions of section 28 of the Mental Disorders Act of 1916; and (c) if a person is found to be incapable of understanding the proceedings at the trial may thereafter be again indicted or charged and tried for the offence at any time when he is so capable; and lastly (d) the provisions of this section shall be read as being additional to and not in substitution for the provisions of section 28 of the Mental Disorders Act of 1916.[69]

The abovementioned sections of the Criminal Procedure Act of 1955 are the provisions for dealing with accused persons who are perceived to be mentally disordered, and incapable of understanding the trial process or the charges made against them. This section is not concerned with criminal responsibility. It is a procedural provision in terms of which an inquiry has to be made into the mental condition of the accused at the time of his alleged offence. These provisions are necessary because the accused has to be present at his trial, has the right to cross examine the opposing witnesses, and to give evidence himself. Therefore, it was necessary that he be mentally capable. However, it was argued that this did not only pertain to those suffering from mental disorders. "Deaf mutes" were also found unfit to stand trial. The accused had to understand the proceedings in order to make a proper

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[68] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 52.
[69] *Ibid.*

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defence.[70] When the court was in doubt, they have to follow the procedure set out in section 28 of the Mental Disorders Act of 1916.

In the Mental Disorders Act there are classifications of the different types of classes of mentally disordered states that could afflict the accused. For this study, it is important to refer to Class VI. This class had originally made provision for those with anti-social behaviour, which is a feature of psychopathy. That class was deleted from the Mental Disorders Act of 1916 in 1957. This class read as follows:

> A socially defective person, that is, to say, a person who suffers from mental abnormality associated with anti-social conduct, and who by reason of such abnormality and conduct requires care, supervision and control for his own protection or in the public interest.[71]

The commission made inquiries as to why this part of the Act was deleted, considering the then current events and how psychopathy had come to the fore. According to the Department of Health it was desirable to delete this passage because it was redundant:

> Section 3 of the Act is a classification of section 2 (1) in which a mentally disordered or defective person is defined, This implies that the mental abnormality referred to in Class VI must amount to abnormality which falls within the definition; Section 2 (1) of the Act. As this is so, any person whose conduct is anti-social by reason of mental abnormality-if the abnormality is a mental disorder or defect within the meaning of Section (2)-can be classified under the Classes I, II, III, IV, V or VII. Since class VI was inserted in the Act in 1944, when the Act was amended, it had given rise to a great deal of confusion in the courts of law. Advocates for the defence had on numerous occasions raised the plea that the accused was a socially defective person as described under Class VI of the Act and had tried to prove that he was a psychopath and therefore mentally abnormal and that as the abnormality was associated with anti-social conduct he was not responsible for his criminal acts. It was difficult for the psychiatrist called by the state to get the magistrates or judges to accept the fact that the mental abnormality must amount to an abnormality which fell within the definition (Section 2 (1) of the Act). Usually the psychiatrists called by the state were psychiatrists in the mental hospital service and they succeeded in clarifying the position-but there were occasions when they did not and on occasions when a psychiatrist, who was not in the service, was called to give evidence for the state the plea by the defence almost invariably succeeded. A great deal of time was wasted in the courts when his plea was advanced by the defence.[72]

In light of this explanation from the Department of Health it is clear that in practice, confusion arose concerning the concept of non-responsibility and the concept of certifiability under the act. The Act did not define when a person is regarded mentally disordered nor did it define a permanent mental disorder. Additionally, it was not possible to infer a definition

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[70] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 52.
[71] *Ibid.,* pp. 52-53.
[72] *Ibid.,* p. 53.

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of mental disorder or mental defectiveness from the classification given in section 3. The Act did not define responsibility and was only referred to in passing in section 29 of the Act. That section only provided that when an accused at trial is found to be not responsible on account of mental disorder or permanent mental defect, a special verdict had to be returned that stated that s/he was guilty of the act but was mentally disordered or defective.[73]

Sections 27, 28, and 29 of the Mental Disorders Act are the most important sections of that legislation relating to this study. In section 27 the provision was made for a person under detention for the purposes of their preparatory examination or trial sentence. If the Attorney-General concerned, or prison officer was of the opinion that the accused was mentally disordered or defective, the magistrate had to be advised accordingly as to what steps could be taken in terms of the Mental Disorders Act. According to section 28 when the accused was found to be mentally disordered or defective before or during his trial, and whose trial is stayed, his condition must be inquired into. If the court is satisfied that the accused meets the criteria, he is declared a State President's patient. If the court was in doubt, the accused was to be detained for observation and the Physician Superintendent had to submit a report. Lastly, section 29 stated that if an accused was actually capable of standing trial and in the trial there was an inquiry as to whether the accused was mentally disordered or defective at the time of the act, he was not to be considered responsible according to the law. If the accused was found to be not responsible, a special verdict was to be returned that the accused was guilty of the act but was mentally disordered or defective.[74] These sections were to be revised and included in Chapter 13 of the proposed Criminal Procedure Bill that had lapsed in 1973, which will be discussed in greater length in the next chapter. Therefore, these sections were retained and unrevised in the new Mental Health Act of 1973.

The inclusion in the Mental Disorders Act No. 38 of 1916 of provisions relating to criminal procedure and the provision in section 182 of the Criminal Procedure Act of 1955 gave rise to a host of problems and misconceptions. The Mental Disorders Act had its own purpose which essentially had little to do with responsibility or fitness to stand trial. That was the purpose of the criminal procedure act. It was to regulate the procedural problems arising from those concepts. The commission was of the opinion that it could never have been the legislature's intention that every person who may have been deemed to be mentally

[73] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 53.
[74] *Ibid.*

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disordered or defective under the Mental Disorders Act of 1916, would be found unfit to stand trial. Psychiatry did not deny that there were in fact cases, even though they were the exception, where a person may be deemed to be mentally discorded or defective within the meaning of the Act while they may be nevertheless capable of standing trial.[75] It is here that one is reminded of the statistics from Chapter Two which support this observation.

The provision of section 28 of the Mental Disorders Act of 1916 and the provision of section 161 of the previous Criminal Procedure Act no 31 of 1917 created an impression that when the accused was deemed under section 28 to be certifiable under the act, s/he must be declared a State President's patient without any necessity of going into the question of whether he is fit to stand trial. There were steps taken which confirmed that impression as the correct one and this was done by the addition by Act 29 of 1955, of sub-section (5) to section 161 of Act 31 of 1917 and its retention in the successor to the Act of 1917-Act 56 of 1955.[76]

There were persons who made representations about the above-mentioned legislative problems. It was suggested to the commission that the procedural provisions regarding the examination and trial of accused persons should be removed from Act 38 of 1916 and be incorporated in the Criminal Procedures Act with the necessary amendments so that the distinction between non-responsibility, unfitness to stand trial and administrative certifiability was not obscured. The head of some mental hospitals argued that even if an accused were incapable of understanding proceedings against him, the trial against him should proceed and the court should arrive at a decision whether he was guilty of the act he was charged with. The commission firmly disagreed with this.[77] The role of the psychiatrist in these court cases, and through the findings of this commission, seriously questioned the weight that had been placed on psychiatrist's testimony during trials of this nature.

According to the commission two possibilities arose during the trial of persons alleged to be insane. In the first scenario, the accused would admit his act, but would allege that he was insane at the time of committing the offence. In the second scenario, the accused would deny that he committed the act, but plea in the alternative that if it be found that he committed the act, he was insane at the time of the offence. In the first scenario the

[75] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 54.
[76] *Ibid.*, p. 56.
[77] *Ibid.*

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circumstances of the admitted act would be used as evidence in support of the plea of insanity. In the second scenario, if the accused was found unfit to stand trial and the plea was advanced on his behalf that he did not commit the act, something which seldom happened in practice (if the statistics are anything to go by), it would be impossible for the court to arrive at a decision as to whether the accused did indeed commit the offence. If the court were to proceed to decide whether the accused did commit the act, not only would the rights of the accused be disregarded, but the trial could be by no means effective. The results might be, in the words of the commission, grotesque.[78]

The heads of these hospitals also recommended that Class VI, which was deleted in 1957 from section 3, be reinstated. According to the commission, if the law was amended as they recommended, the reason for Class VI's deletion would disappear. In fact, the commission considered that in the event of their recommended amendment of the law in regard to responsibility were to be accepted, it would be desirable to revise the entire section three to bring it into line with contemporary trends and ways of thinking in the disciplines of psychology and psychiatry.[79]

3. 6. 4. The Feasibility of Preventing Dangerous Acts Committed by Mentally Disordered Individuals

The final discussion of the Rumpff Commission centred around the efficacy of existing statutory provisions and legal rules regarding the prevention of acts by mentally deranged persons. Due to the often unpredictable behaviour of the mentally disordered person, they were often regarded with fear. After the assassination of the Prime Minister there was a tendency to assume that there were a number of potentially dangerous mentally disordered persons at large in the country. According to the commission, it was with contemporary knowledge and diagnostic methods, that many potentially dangerous mentally disordered persons could be detected before they committed potentially dangerous acts.[80]

According to the Commission, a mentally disordered person, whether obviously disordered or not, who talked about murdering and expressed intense aggressive drives and

[78] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 56.
[79] *Ibid.*
[80] *Ibid.*, p. 66.

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impulses against a particular person, usually a relation, or people in general, could be summarily placed in safe custody by the proper authorities. Other concerns were raised: (a) how to deal with mentally disordered persons who for some reason or another had not been certified; (b) detention facilities for those certified as dangerous mentally disordered; (c) after-care of the certified patient on his discharge from hospital; (d) escaped certified mentally disordered persons-even those who had not yet shown signs of being dangerous.[81]

3. 6. 5. Mentally Disordered Persons Not Yet Certified

Here two concepts are diametrically opposed to each other. Firstly, the welfare of the community and secondly, the freedom that every citizen of a democratic country regards as a fundamental right. However, the commission believed that the welfare of the community must take precedence over individual rights. The solution that they provided is twofold. All dangerously mentally disordered persons should be kept in hospitals and must be accepted and carried as a community risk. The other extreme is that all mentally disordered persons must be detained in mental institutions.[82]

Even if it were possible to test all persons suffering from some form of mental disorder it would have been impossible to make any kind of accurate assumption regarding their potential danger. Due to this there existed no simple and reliable method of eliminating the potential danger of mentally disordered persons. Although there was admittedly no simple way of screening potentially dangerous mentally disordered persons, it still appears that there were deficiencies in the existing lawful preventive measures against such persons that had to be remedied. There existed a variety of potentially dangerous categories. The National Council for Mental Health of South Africa submitted the following categories: (a) the aggressive psychopathic personality; (b) the anti-social high-grade defective; (c) the pre-psychotic paranoidal individual with unrestricted use of, for example, firearms; (d) alcoholics, drug addicts, and hallucinogenic drug users.[83]

The necessity for an institution for the detention of convicted psychopaths was stressed, among others, by the National Council of the Social Services Association of South

[81] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters,* p. 66.
[82] *Ibid.*
[83] *Ibid.*

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Africa. This council considered individuals with the following markers as dangerous: (a) their behaviour is threatening and aggressive; (b) they have been repeatedly convicted of violent crimes; (c) a psychiatrist has diagnosed them as being psychopathic or suffering from a mental condition that makes them incapable of controlling their behaviour; (d) they cannot be detained in mental hospitals because they are not certifiable in terms of the Mental Disorders Act. Category (b) contains potentially dangerous persons, some of whom are often sent after committing a crime to a mental hospital where there is no provision for proper attention, treatment and rehabilitation. Regarding category (c) there was a request made that their firearms be removed and that they not be able to gain legal access to firearms in the future.[84]

Regarding the reporting of mentally deranged individuals, Justice A. J. Smit proposed that a legal requirement be made of medical practitioners to report to a magistrate every case of suspected mental disorder, upon which the magistrate was to take steps for the case to be certified. There was a recommendation made to the commission for the creation of a central register that was advocated by some, and strongly opposed by others. The Department of Justice suggested that the Commissioner for Mental Health should have at his disposal a Central Bureau for mentally disordered persons to which medical practitioners could submit reports. The Department of Justice acknowledged that this approach would have its problems. It was also doubtful whether it would afford an effective means of preventing serious crimes by mentally disordered persons. The persons reported to this Central Bureau would be examined by a panel of psychiatrists with a view to treatment. There was another suggestion made to keep track of patients who were psychopathic - placing them in an institution for psychopaths where they could be treated and controlled.[85]

The First Van Wyk Commission recommended that particulars of all persons who were receiving or had received treatment for mental defects in any hospital or similar institution should be sent to the Commissioner for Mental Health who would compile a list of such persons, and that any psychiatrist or psychologist consulted by the Security Police in connection with a security investigation, would be entitled to ascertain from the Commissioner whether the name of the person concerned appeared on the list. Additionally the First Van Wyk Commission also recommended that an inquest be conducted on the

[84] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 67.
[85] *Ibid.,* p. 68.

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viability of compelling all medical practitioners, including psychiatrists, to submit to the Commissioner the names of all patients who were mentally disordered but not in an institution and who were in their opinion, likely to become a danger to others at some time in the future.[86] It is here that one can see an attempt to draw psychiatrists into the oppressive state arm of the police under the apartheid government.

Those who were strongly against that recommendation stated that it would be an encroachment upon the liberty of the individual and that medical ethics did not permit it as it would undermine the trust between doctor and patient. Additionally, it was impossible, as stated before, to predict who was potentially dangerous. The recommendation was also not practical due to the extensive administrative machinery that would be required. It was also a concern that this register could lead to malpractices since malicious persons could submit the names of their enemies to the registry. After consideration of the advantages and disadvantage of such a measure it was determined that the disadvantages outweigh the possible advantages and that the institution of such a register would be impracticable and undesirable.[87]

The dangerous certified mentally disordered persons, both white and non-white, were scattered all over the country in all the existing mental hospitals. This state of affairs was deemed unsatisfactory because: (1) None of the existing hospitals, except in Bloemfontein, had effective "maximum security" wards to prevent escapes; (2) there was a world of indifference to the planning, design, architecture, and administration of a "maximum security unit" hospital and the facilities required for neurotic and harmless psychotic patients; (3) the modern permissive approach which was being applied and developed in mental hospitals was not suitable for dangerous mentally disordered cases. It precluded the maintenance on the same premises as the rest of the hospital of a maximum security unit, which would moreover aggravate the stigma attached to these hospitals. (4) The staff at a maximum security hospital were to be specifically selected and trained to be able to control inmates; and, (5) at the time, malingerers sometimes reported themselves in order to try to evade imprisonment.[88]

[86] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 69.
[87] *Ibid.*
[88] *Ibid.*

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The commission also set out the requirements for such a place. These requirements were: (1) In the planning, provision was to be made for the compartmentalization of different diagnostic entities; (2) Although security was to be the main objective, the treatment, whatever nature or form, was not to be neglected. It was suggested that (a) inmates would receive physical as well as psychological care and treatment and (b), an active program of rehabilitation in preparation for ultimate return to the community was to be worked out and applied. Lastly, (3) strategies had to be implemented to address the lack of therapeutic facilities which was said to be harbouring mutual resentment between inmates and the staff.[89]

3. 7. Chapter Conclusion

Following the assassination of Verwoerd, it could be argued that the climate of excessive concern, bordering on a witchhunt for possible mentally deranged individuals in the country, could be considered a type of moral panic of the late 1960s and early 1970s. However, out of the proverbial madness came significant and long-overdue debates and discussions which ultimately led to a closer formal working relationship between the mental health and legal professionals over the treatment of the mentally unstable who appeared before the judiciary, much in the same vein as the volunteers of the Cape Mental Health Society, which will be discussed in the next Chapter. It is clear that legislation alone could not compensate for poor psychiatric services provided by the state, and therefore adequate and satisfactory treatment facilities were considered a priority. According to the recommendations submitted to the commission, it was clear that the Mental Disorders Act of 1916 was out of date. Additionally, the problems with the prevention, detention, proper and adequate accommodation and treatment, discharge, and the need of integrating psychiatric and psychological services, made the urgent revision of the outdated Mental Disorders Act essential. The Rumpff Commission concluded by suggesting that another commission of enquiry should be appointed to revise the Mental Disorders Act No. 38 of 1916 and to investigate the possibility of restructuring the administrative control of mental hospitals.[90]

[89] RP 69/1967, *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*, p. 69.
[90] *Ibid.,* p. 71.

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The investigation of the case files proved useful as it already highlighted some of the issues prevalent in subsequent discussions during the commissions of enquiry. In the next chapter, criminal cases that were sent for evaluation during these discussions will be presented in order to assess if and how these contentious issues were negotiated by the judicial system during this interim phase. Attention will also be given to the recommendation to reappraise the outdated Criminal Procedure Act of 1955.

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Chapter 4

Mental Health in the Courts, Parliamentary Debates and New Acts of Parliament, 1967-1973

During the commission of enquiry into the death of Hendrik Verwoerd and the subsequent Rumpff Commission of 1967 which led to discussions on reforming the mental health system in place in South Africa, cases continued to be tried for murder at the Cape Town Supreme court. In five of the cases which appeared before the court, in 1968, 1970 and 1971, the suspects were sent for mental evaluations. During this period, debates unfolded on the need to institute a new Mental Health act as well as reform criminal procedure to deal with cases that involved those deemed mentally ill. Of significance was the Botha commission of 1971. By 1973, a new mental health act was passed. Although this was only enacted it 1975, it did require adjustments to what was perceived to be an ineffective Criminal Procedure Act of 1955. This led to the second Van Wyk Commission of 1972 as well as an enquiry into the biggest oppositional voice to changes in mental health in South Africa, the Scientologists. The 1972 report on the Commission of Enquiry into Scientology also provides some context to the debates around changing mental health legislation. By 1973, all foundational discussions had been concluded and the results of this are evaluated in Chapter Five.

This chapter will begin by reviewing the five cases which were sent for mental evaluations. Attention will then be given to the Botha Commission, the second Van Wyk Commission of 1972, the Commission of Enquiry into Scientology and the unfolding debates of parliament around the Criminal Procedure Bill of 1973.

It is argued that elements of the 1960s discussions and debates, as presented in Chapter Three, are visible in the cases brought before the courts in 1968, 1970 and 1971. These dates correlate with these debates and discussions. Interestingly, no cases appeared in 1967, 1969 and 1972 – one year after Verwoerd's assassination in 1966 and one year after the Botha Commission of 1971, neither in the years during the second Van Wyk Commission of 1972 nor the Commission of Enquiry into Scientology of 1972. The latter commissions already predetermine some of the shortcomings of the legislation to be implemented in 1973 and 1977.

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4. 1. Mental Health Evaluations in the Cape Town Supreme Court, 1968-1971

The murder and murder related cases, in the period after Verwoerd's assassination will be discussed, as well as the cases where mental illness was averred. This will provide context as to how the courts dealt with defendants in the immediate aftermath of Verwoerd's death and ascertain whether the broader discussions presented in the previous chapter were in any shape or form reflected in the court proceedings.

4. 1. 1. State *v*. J. O., 1968[91]

On the 8th of March 1968 J. O. was charged with the crime of rape and murder. The accused was a young Coloured male who raped his sister-in-law while she was asleep. According to her, this was the second time he had done this. On the night in question, he got on top of her and pinned her arms to her side. Before she realized it, he proceeded to have sex with her. The deceased was a neighbour who was alerted by the commotion after the accused's sister-in-law had pushed him off her and a scuffle had broken out. The deceased slapped the accused twice in the face and the accused retaliated by stabbing him in the chest. According to the report from Valkenberg, the accused was certified on the 12th of March 1968. The report said:

> A history obtained about the familial background has revealed that his father suffered from involuntary movements and died at a relatively early age. The patient under observation has shown to have myoclonic contractions as well as fits of Grand Mal epilepsy which are followed by very prolonged and profound confusion lasting from 12-20 hours which may very well have influenced his actions at the time of alleged offence, provided that there was a history of a preceding seizure. His intellectual development is that of the dull normal group and he must be regarded as mentally disordered in terms of the Mental Disorders Act, for which he needs care, supervision and treatment.

According to the testimony of C. S. the accused lived on the farm Wolwekloof with his mother. She stated that he had suffered from "vallende Siekte".[92] She had witnessed his epileptic fits when he had them. He used medication infrequently, but when he took his medication he had no attacks. The accused had stayed with them from the Friday until Sunday morning. She stated that she did not witness him having an attack when he was at their house. On the Saturday, she and the accused and her husband along with others went to town. They bought half a "gelling" wine and took it home with them. According to her

[91] KAB CSC 1/1/1/983, Cape Supreme Court Records, Case no. 5 of 1968, State *v*. J. O.
[92] Epilepsy or grand mal epilepsy.

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everybody had a bit to drink, but they were not drunk. Her husband and the accused later left to do some work on the farm. When they returned, both were visibly drunk. She clearly states that she was sober. Later, both passed out outside and she pulled her husband into the house and left him by the table in the kitchen.

She left the accused in the doorway where he was sleeping. She and her three kids went to bed. Later that night she felt someone on top of her and she realized this person was having "relations" with her. She stated that his "privates were inside her" and she first thought it was her husband. It was dark. She realized the voice belonged to the accused and said "J. O, is dit alweer jy, dit is nou die tweede keer wat jy dit aan my doen."[93] He held his arms around her body. He said nothing. She started to struggle and pushed her one hand in front of accused's chest and the other hand onto the bed. Eventually, she managed to get out from under him. She moved into the kitchen but he followed her. He pulled her on her skirt. She noticed a bottle of wine and used that to hit him on the head. She woke her husband. Her husband's stepfather, "Kaffer"[94] Erasmus, and the deceased arrived. She told them what the accused had done to her. The accused then came back in to the house and sat down on the couch. The deceased tried to convince C. S. to lay a complaint against the accused at the police station. The accused then said to the deceased "jou moer."[95] The deceased then slapped him twice. After the deceased slapped him, he took the knife that was on the table and went outside. When she and the deceased walked outside, the accused stabbed him in the chest.

The deceased went into his house and C. S.'s husband, J. S., confiscated the knife from J. O. The deceased went to lay on his bed but was bleeding profusely from a wound in his chest. He died a little while later.

The accused did not plead to any of the crimes he was charged with. For his sentence he was ordered in terms of sec. 28(4) of Act 38 of 1916 to be kept in custody in an appropriate institution pending the outcome of the State President's deliberation. On the 30th of May the commissioner for mental health, P. Naudé issued a warrant for his detention as a State President's Patient.

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[93] Translation: J. O, this is the second time you are doing this to me.
[94] Either a real name or a nickname, however that was the name used in the case file.
[95] Afrikaans equivalent of saying "screw you".

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4. 1. 2. State *v*. H. B. & B. M., 1968[96]

Both accused where charged with the crime of murder on the 9th of May 1968. Both parties pleaded not guilty to the charges. Both were also found guilty of murder. However, H. B. was found guilty of murder with extenuating circumstances. B. M. was found guilty of murder without extenuating circumstances. H. B. was sent to a reform school and B. M. received the death sentence. B. M. was sentenced on the 30th of May 1968 and H. B. was sentenced on the 9th of August 1968. The delay was due to a pending report from the parole officer.

The deceased and her friend walked to Paarl from the farm where they lived, on the morning of 25 September 1967. In Paarl, they visited a bottle store and a bar. There they met two female Coloured persons, Anna Marthinus and Siena Barnes. They returned to Anna's home. She later laid down on her bed as she had recently suffered an injury. The deceased and her friend Francis sat in the kitchen and that was when one of the accused entered and sat down. Shortly after, the deceased and Francis left to go back to Agterdam, the farm where they lived. The two accused then followed them to steal their wine. They robbed them and, in the process, assaulted them. The deceased turned back to report the incident in Paarl and her friend Francis made her way back to the farm where they lived. Her body was found on the 27th of September 1967 about 700 yards away from the point where the deceased had turned around back to Paarl. Apparently, the accused encountered her on her way back to Paarl and B. M. told her to go home, but she refused. He proceeded to hit her with a stick. This did not deter her, and he threatened to stab her to death if she did not return. This also did not deter her, and he stabbed her in the right side of her neck.

Both of the accused admitted that on the day of the murder they followed the deceased and her friend, Francis Pienaar. They did admit that both of them had something to drink on the day of the crime. During the questioning of H. B., his lawyer, Mr Immerman, asked them if they were smoking something when they were following the women. He admitted that they were smoking *dagga*. According to H. B., during cross-examination, B. M. told him to hold the feet of the deceased during the attack. When asked why he did so, he admitted that he was scared that B. M. would also cut him with the knife. Apparently, two years before the murder, B. M. had literally stabbed him in the back. He also says that it was B. M. that tried to severe her head, not him. While he was holding the feet of the deceased,

[96] KAB CSC 1/1/1/982, Cape Supreme Court Records, Case no. 3 of 1968, State *v*. H. B and B. M.

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B. M. kneeled on her chest and proceeded to cut her head off. It was this action that led to the psychiatric evaluation.

According to the Department of Social Welfare and Pensions report for H. B. he received no schooling. His previous convictions include crimes such as theft and assault with a piece of iron. He never knew his mother and his father died 12 years before. According to the report all his family members were mentally and physically normal, except his great aunt who was an epileptic. He was raised by his 'grootouers.'[97] They had a tight bond and he deemed them to be his true parents. According to the report he had made friends with the wrong people as he got older, especially with his grandparents' one son, the accused B. M. It appears that he had a strong hold over H. B. and was an extremely negative influence on him as well. He realized that his regular alcohol use as well as B. M.'s hold over him was the reason he found himself in his present predicament at the tender age of 16 years old.

Unfortunately, there is no Valkenberg report included or any other document that detailed his time at Valkenberg. The only information was Dr Simons from Valkenberg's opinion that although the accused had demonstrated a certain degree of intellectual backwardness, he was not considered certifiable in terms of the Mental Disorders Act.

4. 1. 3. State *v*. D., 1970[98]

The case of the State *v*. D. v. D is unique due to the pathology of the accused's mental difficulties being psychological, and not physical. The accused was a young white male who strangled a 13-year old white female, after which he allegedly attempted to have intercourse with her corpse. Here is an account of what had happened according to the accused:

> Dit was Woensdagaand the 25ste Maart 1970- kwart oor agt het ek na die waenhuis toe gestap. Toe het die oorledene op haar fiets verby gery. Sy het toe gestop en gevra of ek plate het om vir haar te leen. Ek het ja gesê. Sy het saam met my in die huis ingestap. Ek weet toe nie wat gebeur het nie maar toe ek my kom kry het ek haar verwurg. Dit was in ons huis. Ek het haar fiets verder in Townsendstraat opgevat en het dit in n oop erf ingestoot. Ek het toe weer terug geloop huis toe. Omtrent half elf dieselfde aand het ek haar in die pad uitgesleep. Toe het ek weer huis toe gekom.[99]

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[97] Translation: Grandparents.

[98] KAB CSC 1/1/1/1379, Cape Supreme Court Records, Case no. 158 of 1970, State *v*. D.

[99] Translation: It was a Wednesday evening the 25th March 1970- a quarter past eight, I walked to the barn. Then the deceased drove past on her bicycle. She then stopped and asked if I had vinyls to lend her. I said yes. She walked with me into the house. I did not know what had happened but next thing I knew, I strangled her. It was

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On the 18th of June 1970 the accused was found guilty of culpable homicide. The court was of the opinion that the accused did not intend on killing the deceased. There were an ample number of witnesses to testify that the accused had shown to be an intelligent and hardworking school boy. However, there was some undeniable evidence that the accused was psychiatrically or emotionally disturbed although he was not certifiable in terms of the mental health law. Prof Van Wyk, deputy-commissioner of mental health testified that it would be best for the accused to be institutionalized for an extended period in order to conduct further investigations on his condition.

A report on the accused's condition was filed on the 30th of July 1970 by the clinical psychologist J. C Maritz who had worked with the accused while he was at Stikland Hospital. According to the report he was accepted on the 8th of July 1970 as a willing patient at the Neuroclinic with the aim to receive treatment for certain aspects of his personality which had not developed fully during the process of becoming and adult (puberty). These aspects of his personality included a lack of proper socializing, reduced affect-response that led to isolated behavioural problems, and an over-inhibited personality that resulted from the first two problems. Over a period of three years, the accused had received treatment from various doctors that included a Dr Roux that had built a relationship of trust with the accused. Dr Geyser focused on behavioural therapy, and Dr Wait took over the case after Dr Geyser's death in 1971. He not only focused on die behavioural conditioning process, but also paid attention to the psychodynamic aspects. Mr J. C. Maritz, the clinical psychologist focused on reinforcing the positive behavioural patterns that the accused had learned, helping him find inner control instead of external control, helping him to develop and reinforce good morals and principles. Lastly, the accused had also received speech therapy at the Tygerberg medical campus for his speech difficulties.

The defence in the accused's case included a specialist psychiatrist, Dr A. A. Zabow who also testified at his trial. He saw the accused on the 5th of April 1970 at his private practice. He conducted an examination under methedrene and amatyl. What this meant was that Dr Zabow was not satisfied with the initial information he had received about the accused from the accused and his mother. He decided to do an examination using a combination of drugs – methedrene which was a stimulant and sodium amatyl which was a central nervous sedative used to get rid of a maximum amount of inhibition. Dr Zabow and

in our house. I took her bike further up into Townsend Street and I pushed it into an open field. I then ran back home. About half past ten that night I dragged her out onto the road. Then I came home again.

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the doctor wanted to better understand his inner feelings. Additionally, he also wanted to see if there were any factors which were either being suppressed or repressed, that the accused was either consciously withholding or dissociating at an unconscious level.

According to further testimony by Dr Zabow he viewed the crime committed by the accused as a sexual offence. He had this encounter with this young girl, as he told Dr Zabow, because she had invited him to have sex with her. He already knew her, or thought he knew her to be a girl of easy virtue and the circumstance of their being alone in an empty house had already aroused him sexually. When the deceased allegedly made this invitation to him, very clumsily and without any experience at all, he grabbed for her. The deceased's reaction to him grabbing her was such that she started to struggle and being sexually aroused at the time, frustrated and perhaps aggressive at being rebuffed, the accused seemed to have lost sight of what was happening. The accused's aim was to go through with the sexual act. To have her sexually. When, as a result of this initial struggle in which he put his arm around the neck of the deceased, she collapsed to the ground, there were still these sexual emotions, frustration and aggression, but this was now accompanied by a further emotion of panic over what he had done. A terrible fear that when she regains consciousness, she would tell someone what had happened. In this state of this mixture of emotions and sexual arousal, frustration, aggression and panic for fear of being shamed, he then went on to make use of the toilet brush and broom to cover his tracks. According to Dr Zabow, when the act was completed it was as if he had come back to reality, realizing what he had done. That is when the accused decided to cover his tracks by using the broom and the toilet brush to clean up. He then took a suitcase from his mother's room and used it to help pull the body outside to hide it. However, before he had dragged the deceased's body outside, she was still lying in the passageway of the house. He opened her brassiere, pulled down her pants, touched her breast, interfered with her genitals, bit her thigh and then also, attempted some form of sexual penetration with her corpse.

Dr Zabow was asked if he thought that this was a lust-murder. According to him it did not fall into the category of a lust murder, in that the accused had not gotten any sexual pleasure out of any sadistic attack. Dr Zabow had also told the court that the accused had told him that he never ejaculated during the event. He had told the doctor that the attempt was to have sex with her and this resulted in her death.

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According to the doctor the accused's father was an absent parent and he never had a warm relationship with his mother. Therefore, there was no opportunity to form a significant and warm relationship with an adult during his formative years. He therefore never learned how to deal with certain feelings and emotions, especially feelings of love, aggression, frustration, and sexual feelings. It was also noted that the accused did not have a circle of emotionally matured friends who could have been a positive influence in his life.

According to further testimony of Dr Zabow, one of the major inhibited areas in his development was that of sexuality. Sex for him was associated with something which one does not talk about, one does not show one's feelings about it and one tries as far as possible not to acknowledge its existence. Except that it does exist and biologically it was there. The court asked Dr Zabow whether or not the accused was mentally ill and according to him he was not. According to Dr Zabow the accused was not mentally ill in terms of the contemporary understanding of mental disorder or mental illness.

The next question the court asked Dr Zabow was whether or not the accused was a psychopath. The doctor did not believe that the accused was a psychopath. Dr Zabow elaborated on this point and said the following:

> There are writers who describe this sort of offence as being the act of a sexual psychopath. I have up until now used the term 'sexual offender' or spoken of a sexual offence for this reason. There is some confusion about the meaning of the word 'psychopath.' In fact, recently in the world classification it has been changed to the term sociopath so that one knows more or less what one is talking about, a person who is inclined to outbursts of aggressive, impulsive behaviour: who is not able to benefit from experience; who shows no anxiety, guilt or remorse and whose acts tend to be anti-social. And who, in their developed mental history indicates evidence of persistent anti-social behaviour. Now, on the other hand the word 'sexual psychopath' has been used by some writers merely to indicate not psychopath or sociopath in the terms I have just described them, but rather that the committal of an offence associated with sexual behaviour in which the other party is harmed.[100]

Dr Zabow suggested to the court that the accused could be classified as an introverted schizoid. Such a person would be unable to form adequate relationships and they tended to withdraw from relationships, such as the accused did in this case. However, Dr Zabow agreed that he would respond to treatment and would be able to better himself.

Justice Steyn, however, was not satisfied that the accused was not mentally disordered, because psychiatric testimony concluded that he was not mentally disordered or

[100] KAB CSC 1/1/1/1379, Cape Supreme Court Records, Case no. 158 of 1970, State *v*. D.

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defective because of a physical defect such as epilepsy, but psychiatrically disordered. The accused had experienced problems with his sexual development, which manifested in abnormal behaviour which resulted in the death of the deceased female. Therefore, Justice Steyn found the accused guilty of culpable homicide, however, he agreed that the accused did suffer from some psychological ailment and was in need of psychiatric assistance. His sentence was therefore suspended for three years on the condition that he submit himself as a voluntary patient at Stikland Hospital for treatment during those three years.

4. 1 .4. State *v*. G. J. P., 1971[101]

G. J. P., a white 16-year-old male was found guilty of murder with extenuating circumstances after he had strangled a 59 year old white male to death. The man the accused murdered was a guard from the industrial school, Die Built. The deceased was supposed to accompany the accused on a train ride back to Die Built School in George from which he had escaped. However, the deceased wanted to escape from the train and therefore he strangled the deceased with the chain that connected his handcuffs. The accused had shown throughout his life certain behavioural problems, particularly fits of rage. However, he did not commit this act in a fit of rage like his previous indiscretions. He admitted that he committed this act in an attempt to escape. The accused had been known to revolt under circumstances of restraint.

The welfare report document presented to the court dated back to 1968. It was a record of his problems. In 1968 the accused saw a psychiatrist for his behavioural problems. The psychiatrist who saw him recommended that he be sent to Boys Town Kinderhuis[102] in the Transvaal. Whether this had occurred was not known, because it was not in the record. According to the testimony from an officer of the welfare department, the accused’s mother accused him of being uncontrollable. According to his mother, the accused had violent fits of rage and refused to go to school. When he did go to school, he did not put in any effort into his schooling.

His parents were immigrants from the Netherlands. They managed to maintain a South African standard of living and they were accepted as such. His dad was a relatively sick man and his mother was a homemaker. She used to work but had to stop due to the

[101] KAB CSC 1/1/1/1701, Cape Supreme Court Records, Case no. 364 of 1971, State *v*. G. J. P.
[102] Translation: Orphanage.

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accused's behavioural problems. The father earned R160 per month and was the sole breadwinner in the house. They had to move to a new area due to the problems caused by the accused at their previous residence. According to the officer they had lived above their means. The family's relationships with each other were extremely tense due to the behavioural problems of the accused. The officer noted that there was nothing wrong with the intelligence of the accused.

His untrustworthiness resulted from his serious fits of rage. The intensity of his fits increased whenever he was contradicted or constrained. Whenever he did something wrong his mother usually punished him by not giving him food until he apologized. On one occasion he had put a knife to the neck of his younger brother and threatened to cut his throat if his requests were not adhered to. He had a tendency to break the neighbour's windows and he would climb onto roofs and refuse to come down. During a visit to the district surgeon for an evaluation he had gotten into a fight with the doctor and the police had to be called. During another visit to a psychiatrist at the Karl Bremer hospital in Bellville he tried to hit his mother over the head with a chair, in the presence of the psychiatrist. He had received treatment at the Karl Bremer hospital. They had performed EKG[103] tests at the Jan Kriel School for epilepsy in Kuilsrivier, and at Karl Bremer hospital. According to these tests there was a light cerebral dysrhythmia present that got worse whenever he was at home. However, there was no definitive epileptic symptoms present.

He had also spent time at Tenderden in Wynberg. It was a type of safe house. His fits of rage actually improved when he was discharged from Tenderden. The accused was also obsessed with gaining weight. He was afraid of being small and delicate like his father whom had shown no real interest in the accused. The accused however longed to find a friend in his father to talk to about the things boys and men are interested in, but his father did not reciprocate. His mother was overprotective and treated him like he was a small child. He acted out against this treatment. He refused to be associated with anything small, because it made him feel small, powerless, and worthless.

The fact that he felt humiliated and hurt by his father's lack of interest and by his mother's overprotective behaviour only seemed to fuel his fits of rage. It is during these fits that he could validate his feelings and he got some satisfaction from the idea that other people feared him. According to the principal at Tenderden, the accused was a capable, honest and

[103] Electrocardiography.

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hardworking man that could have achieved many things if he was treated right and understood. The report concluded that the accused should not be returned to the custody of his parents until they adjusted their conduct towards the accused.

Before Justice Steyn made a decision about the fate of G. J. P, he asked Dr Zabow, the psychiatrist who testified at the trial and treated the accused, some important questions. According to Dr Zabow the accused suffered from a severe form of personality disorder best described as psychopathy which was exhibited from an early age. He was prone to aggressive, explosive outbursts of violence, usually when provoked. He also exhibited other hallmarks of psychopathy such as truancy. He admitted to lying at times and he had shown a complete indifference to the feelings of other people and how his behaviour had affected other people.

Dr Zabow states, however that he made this observation on the basis of the records, before the events of the crime were revealed during the actual trial. This was not a *post hoc* diagnosis, but based a diagnosis on his record up until the time he was fetched from his home in Bellville and taken to the train. The diagnosis was not dependent on the accused's crime but on his previous personality and previous record and his crime confirms that, although in this instance he was not provoked in the same way as the instances previously related to the court, there was once again the impulsive behaviour to conquer with no consideration of the consequences.

Justice Steyn wanted to know what the cause of the psychiatric disorder could be. This was difficult to answer. What was known about the accused was that he was the second born child of five children. He was from an immigrant family that were experiencing economic difficulties. The accused also had a very poor relationship with his mother and father. His mother had experienced a prolonged and difficult birth. He was at one stage dropped on his head, and was dazed and lost his breath for a while. Therefore, these were all possible interacting factors between physical and constitutional aspects of psychopathy and the more familiar aspects in which very often there was a history of early poor relationships with parental figures.

Dr Zabow viewed him as a potential threat to society. Justice Steyn wanted to know from Dr Zabow what the course of treatment should be for the accused. In South Africa there was little experience of this and this was one of the reasons why the Van Wyk Commission was appointed. However, according to Dr Zabow there had been work done overseas. Dr

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Zabow mentioned the US, Great Britain, and Denmark as countries that had shown that psychopathic personalities are best treated in specialized mental institutions which were neither mental hospitals nor conventional prisons. They were institutions under the direction of, or at least the guidance of, psychiatric personnel, with the assistance of psychologists, and social workers. The aim of this type of institution was to achieve a degree of social maturity.

Justice Steyn found the accused guilty of murder with extenuating circumstances and sentenced him to 12 years imprisonment. Additionally, Justice Steyn determined that the accused should be committed to what was referred to as a young adult first offender's prison in Kroonstad, with a further recommendation that the accused be transferred to Weskoppies Psychiatric Hospital in Pretoria at the earliest opportunity. The court indicated that the 12-year sentence was imposed for the protection of the public. Justice Steyn stated that should the accused respond favourably to treatment, the authorities could, in the court's view, review his sentence.

The accused did apply for leave to appeal against the verdict. According to Justice Steyn it was reasonably possible that another court would have come to a different conclusion, that is, that the accused should have been convicted of culpable homicide. Therefore, leave to appeal was granted.

This was not a case where the degree of moral guilt of the accused was a dominant factor in the determination of penalty. It was the undisputed view of a psychiatrist called by the defence that the accused, by reason of a severe personality disorder, was someone against whom the public required protection. His recommendation was that the accused should be isolated from the public for an undetermined period. No such authority vests in the court under the provision of the criminal code and it was obligated to determine detention for an arbitrary period, which the court coupled with certain recommendations in an attempt to safeguard the interests of the accused in the event of his responding favourably to treatment.

In the Supreme Court of South Africa appellate division in front of the Honourable Justices Homes, Potgieter, and Trollip the conviction of murder with extenuating circumstances was set aside and substituted with a verdict of guilty of culpable homicide. The sentence of 12-years' imprisonment was also set aside and substituted with a sentence of eight years' imprisonment. It is here that one not only notices how the contemporary

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debates on mental health appear within the court proceedings but also how the law can be interpreted in such a vastly different manner, especially if the accused was white.

4. 1. 5. State *v*. M. B., 1971[104]

The accused in this case was charged with murder after stabbing a man in the chest resulting in his death. He and a friend were on their way to a club for a night out. On their way there they ran into the deceased and two of his friends. The friend of the accused and the deceased were familiar with each other and started a conversation. The accused overheard the deceased say "is die mental sonny ook saam jou?"[105] This comment deeply offended the accused. He proceeded to slap the deceased and then a fight broke out between the deceased and the accused. According to the testimony of the friends present, they fled the scene when they saw something resembling a knife. It was during this altercation that the accused must have stabbed the deceased.

Due to his paranoid tendencies he was sent to Valkenberg to see a psychiatrist. According to an officer from the Department of Coloured Affairs the accused had been diagnosed as mentally retarded. According to the Superintendent at Valkenberg there was a life pattern, starting in early childhood, of behavioural disturbance which was so severe as to require medication in an attempt to control it. During his observation period at Valkenberg there was no evidence found of mental defect, and he gave a clinical impression of someone with an IQ of 81. In the ward, he had not been placed on medication and did not exhibit signs of impulsivity, for which he had been previously treated. His mood and state had been "appropriate" to his situation and his thought processes was deemed clear. There was no evidence, objective or subjective, of hallucinations and he did not express delusions or psychotic behaviour. The psychiatrists deemed him not mentally disordered in terms of the Mental Disorders Act.

In light of these factors, Justice Steyn stated that the court determined that he did not have the intention to kill the deceased. The accused was found guilty of culpable homicide, and not murder. Justice Steyn sentenced the accused according to the terms of article 352 (1) (a) of the criminal procedure act of 1955. His sentence was to be suspended for a period of three years and the accused was to be released on the condition that he subjected himself to

[104] KAB CSC 1/1/1/1615, Cape Supreme Court Records, Case no. 214 of 1971, State *v*. M. B.
[105] Translation: Is mental Sonny with you?

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the training, treatment, supervision and control of the Cape Mental Health Society located in Observatory. The court had also requested that the Cape Mental Health Society submit reports to the court every six months on the accused's progress.

4. 2. Sentencing Trends, 1967-1971

For some accused where their mental health was brought into question, their previous observation period in mental institutions was an extenuating factor in the sentencing process. In the cases State *v*. P. d. S of 1967, State *v*. D. of 1970, State *v*. M. B of 1971, and the State *v*. G. J. P of 1971 their previous observation periods in mental institutions were considered a factor for the trial judge to consider because it showed a history of mental illness. In the case of State *v*. P. d. S[106] there was a possibility that the accused had been wrongly treated for gonorrhoea or that he might have already contracted syphilis the first time he was sent to Valkenberg. Syphilis does have an effect on the mental condition of the person afflicted and therefore the accused's mental state could have been afflicted for a while before he committed his crime. He did have a history of grandiose delusions-symptomatic of syphilis according to the psychiatrists at Valkenberg; however, he was treated for gonorrhoea and given penicillin. His delusions dissipated and he was released from Valkenberg, possibly suffering from syphilis.

Epilepsy was a factor in these cases that features more prominently than other conditions. The effects of epilepsy can include confusion, affected mood, and in some cases cause issues with memory recall. The IQ of the accused was often discussed in these cases considering certain behavioural problems that sometimes accompanied these individuals. This could have an impact on their ability to either understand the court proceedings or to be able to make a proper defence. The effects of *dagga* and alcohol also feature heavily in these cases. In some cases, the accused admitted to using both, usually chronically, or before they committed the act they were accused of.[107]

In the cases of the State *v*. D. of 1970 and Stave *v*. G. J. P of 1971, the discussions around their mental health became more interesting because their behaviour could not have been blamed, essentially, on conditions such as epilepsy, or *dagga* and alcohol abuse. The

[106] KAB CSC 1/1/1/934, Cape Supreme Court Records, Case no. 188 of 1967, State *v*. P. d. S.
[107] See cases KAB CSC 1/1/1/982, Cape Supreme Court Records, Case no. 3 of 1968, State *v*. H. B. and B. M., KAB CSC 1/1/1/1592, Cape Supreme Court Records, Case no. 171 of 1971, State *v*. I. B.

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accused D. was a young white male guilty of strangling a white 13-year-old female. The psychiatrist that testified at his trial was of the opinion that he was not mentally disordered and that he was not mentally disordered at the time of the act he committed. According to the psychiatrist D. was not a psychopath, but someone with a Schizoid personality type.[108] In his case his personality never fully developed during puberty, and he had an inhibited attitude towards sexuality. This meant that to him sex was something not to be talked about or to be acknowledged. His relationship with his mother and father was also an important factor considered by the courts. He had an absentee father and he never had a warm relationship with his mother. Additionally, he had no friendship group from which to learn how to deal with certain feelings, or friends to help and support him for that matter.

In the case of the State *v*. G. J. P. of 1971, much like D., his mental illness was not caused by organic factors such as epilepsy. He had displayed behavioural problems early in life, usually in the forms of extreme fits of rage. His poor behaviour was likely aggravated by his poor family life based on the history of his mentally disordered behaviour. G. J. P. did not have a meaningful relationship with his parents. His father had shown no real interest in him and his mother was overprotective of him. The way she had treated him made him feel inferior and worthless. He longed for a meaningful relationship with his father, but this was never reciprocated. His behavioural history was important in the case, because he did not commit his crime in a fit of rage, which he was prone to, but it does explain from what place his actions could have come from.

In the cases where mental illness was not a factor, as discussed in Chapter Two, there were other mitigating factors to be considered on a case by case basis. Death penalty cases are interesting because the point of mitigating factors is to lessen a charge or to avoid the death penalty. In the case of the State *v*. J. D. of 1967 the accused stabbed a police Constable to death. This was a capital offence. For the accused there were no extenuating circumstances and the accused was sentenced to death. The fact that he was a member of the group *Poqo* probably did not help his chances. However, it was not clear whether the death penalty was politically motivated, it was clear that the trial judge was disgusted with the accused that he had caused the death of a police officer. Rape was also a capital offence and whether the

[108] This type of person is unable to form adequate relationships and maintain them.

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death penalty was handed down depended on who the victim was. In the State *v*. I. B. the accused raped a nine year old girl for which he received the death penalty.[109]

In the cases where mental illness was not a factor, the accused would have to rely on other mitigating factors. In the State *v*. J. H., the accused received only a suspended sentence. He was perceived favourably by the trial judge because in his 50 years he had never been convicted of a crime. Additionally, he had his one arm amputated from the shoulder, therefore, when the altercation with the deceased escalated he was at a considerable disadvantage and it 'made sense' that he would use a knife to defend himself.

In certain cases, it can be argued that being white was a mitigating factor. There was a tendency to give white offenders the lesser sentence in criminal cases, depending on the severity of the crime, type if crime, and the type of victim. In the State *v*. J. D. P. the accused killed a woman by assaulting her. He was found guilty of culpable homicide and only fined R20 for his crime. The trial judge insinuated that the deceased had started the trouble, because she had a reputation as being a difficult woman, especially when she drank.

For some accused persons their previous convictions counted against them. In the State *v*. G. V. the accused had been convicted of culpable homicide, twice. According to the trial judge there was certainly provocation present but this was his third murder. The judge deemed him a dangerous man and gave him a lengthy sentence.

Of significance, is the way in which mental health and the changes in how psychiatry was developing in the country started to enter the courts. To accommodate these changes, and to ensure that these new definitions could serve as extenuating circumstances within sentencing practices, required a re-evaluation of the Criminal Procedure Act. It is here that the commissions of enquiry and parliamentary debates become important.

4. 3. The Commission of Enquiry into the Criminal Procedure Act of 1955 – The Botha Commission of 1971

In 1970 a commission of inquiry into criminal procedure and evidence was called. This commission was headed by Justice D. H. Botha. The commission had to inquire into

[109] See R. Turrell: *White Mercy: A study of the Death Penalty in South Africa*. Praeger publishers, United States of America, 2004.

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and report on various aspects of criminal procedure and evidence. This commission published its report in 1971.[110]

The object of substantive criminal law is to protect society as well as the offender themselves, against harmful and dangerous conduct. The law of criminal procedure and the law of evidence prescribe the procedure to be followed for the proper enforcement of the substantive criminal law. The ideal criminal procedure and evidence act would ensure that the guilty offender is never acquitted, and that the innocent person is never condemned. Sadly, such an ideal can never be achieved due to human failings and because of the presumption of innocence. Every system of criminal procedure should be so designed as to ensure, as far as possible, but with the observations of fairness, the conviction of the guilty without creating any danger of the condemnation of the innocent.[111]

A recommendation was made to the commission regarding the onus of extenuating circumstances in murder cases. According to existing legislation, a sentence of death was to be imposed in terms of section 330 of the criminal procedure act on a person convicted by a superior court of murder. Where the court found that there were extenuating circumstances, this could be waivered. The onus to prove the existence of extenuating circumstances on a balance of probabilities, rested upon the accused. That is in accordance with the generally accepted principle that with reference to any sentence the onus rests upon the accused to prove the existence of circumstance which he alleges had an extenuating effect. The General Council of the Bar of South Africa suggested that the onus of proving the absence of extenuating circumstances be shifted to the state. The result of this would be that if any evidence of extenuating circumstances is given to the court, the court would be able to impose any sentence other than the death penalty unless the state proves, either beyond a reasonable doubt or on a balance of probabilities, the absence of such circumstances. According to Justice Botha no reasons had been given for this suggestion, and the reason for the change is not self-evident.[112] Where the legislation states that the trial court may impose a sentence other than the death penalty, this is where the trial judge's preference can exert influence.

[110] J.H van Rooyen: "The Psychopath in South African Criminal and Mental Health Law," *The Comparative and International Law Journal of Southern Africa*, (9), (1), 1976, p. 5.
[111] RP 78/1971, *Report of the Commission of Enquiry into the Criminal Procedure and Evidence*, p. 3.
[112] *Ibid.*, p. 39.

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In the Criminal Procedure Act extenuating circumstances are not defined for the purposes of section 330, but there are circumstances which can be considered such as the accused's mental capacity or emotions on the day of the alleged offence. This determines blameworthiness. The trial court is required, therefore, to determine in a particular case whether there were circumstances present which would have affected the mental capacity or emotions of the accused, whether such circumstances did in fact influence the accused, and whether the influence was, according to the final view of the court, of such a nature that it reduces the reprehensible nature of the accused's crime. This inquiry is purely a subjective one. No one knows better about the accused's mental capacity and emotions than the accused themselves, and no one better could testify on their behalf than themselves. If the accused knows how to prove it, he ought to be given the chance to do so. How the state is to prove the absence of such influences is not clear. An accused's belief falls peculiarly within his own knowledge, and it is almost self-evident that the existence thereof should be proved by him, and that it cannot be expected of the state to prove the absence thereof.[113]

It is not contended that because the onus of proving the presence of extenuating circumstances rests upon the accused, that this could result in an injustice. It is conceded that the courts do not in practice require a high degree of proof of the existence of extenuating circumstances from the accused, and that where there is any doubt with regard to the existence, or not, of such circumstances the executive usually commutes the sentence. However, it is difficult to foresee the practical effect in all possible cases of the proposed shifting of the onus to the state, but it could have the effect of placing the imposition of the death sentence within the complete discretion of the trial court in a considerably larger number of murder cases. This recommendation which could have such an effect fell outside of the commission's terms of reference. Therefore, according to Justice Botha the proposal could not be supported, and no recommendation was made.[114] Although this recommendation was not accepted, it is interesting to see that this type of change was suggested, especially considering that it could have impacted a considerable number of murder cases where the death penalty could have been passed.

In view of what is alleged to be the considerable number of executions in South Africa, and the alleged doubtful value as deterrent, in all circumstances, of the death sentence, a suggestion was submitted to the Commission on behalf of the Institute for the

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[113] RP 78/1971, *Report of the Commission of Enquiry into the Criminal Procedure and Evidence*, p. 39.
[114] *Ibid.*

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Prevention of Crime and the Rehabilitation of Offenders to consider the possible abolition of the death sentence, except in the following circumstances: (a) treason; (b) murder with premeditation; (c) murder on a policeman or prison official in the course of his duties; (d) murder committed in perpetrating the crime of rape, robbery, housebreaking or theft.[115]

The institute also submitted to the commission, for its information and for a recommendation, a memorandum on penal reform and punishment in general. According to Justice Botha penal reform or punishment clearly did not fall within any of the commission's specific terms of reference. Neither was it an aspect of "criminal procedure and evidence" in the general mandate to the commission. Additionally, it was apparently also so understood by the legal profession and the general public, because no other memoranda or representations were received by the commission on this difficult matter with regards to which sharp differences of opinion existed especially amongst experts in the field. Therefore, Justice Botha declined an invitation to consider the suggestion and make a recommendation thereof.[116]

The commission concluded that a new Bill on criminal procedure and evidence should be drafted. The new Bill was prepared in consultation with this commission. The alterations which are not mentioned in the report are not alterations of principle and are not contentious, and for the most part are purely textual alterations. Interestingly, Justice Botha did not think it was necessary or possible to mention and to deal with all those alterations in this report. The commission did mention a few examples to illustrate what kind of alterations they were referring to. For example Section 243 of the Criminal Procedure Act made it possible for the state to cause the evidence given by a witness at a preparatory examination to be handed in at the trial where the witness concerned was dead, or could not be found or could not for some reason or another, be called to give evidence. It was recommended that this section be amended to enable an accused to also have the evidence of the witness, who at the preparatory examination gave evidence for the accused or testified in his favour, handed in at the trial.[117] Therefore, it is clear that the Botha commission did not contain information that is pressing to this study, other than showing that there were interesting recommendations made concerning the onus of extenuating circumstances in murder cases, and capital cases. How this affected cases in which the accused was deemed to be suffering

[115] RP 78/1971, *Report of the Commission of Enquiry into the Criminal Procedure and Evidence*, p. 39.
[116] *Ibid.*
[117] *Ibid.*

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from a mental illness is more clearly discernible in the subsequent commission of enquiry of 1972.

4. 4. The Commission of Enquiry into the Mental Disorders Act No. 38 of 1916 – The Second Van Wyk Commission of 1972

This commission was appointed as a result of the recommendations made by the Rumpff Commission of 1967. It recommended that a commission of enquiry should be appointed to "revise Act 38 of 1916 in the light of the problems today, and to investigate the desirability of reorganizing the administrative control of mental hospitals."[118]

It should be emphasized that this commission was not concerned with the procedural provisions regarding the examination and trial of persons alleged to be suffering from mental illness. The provisions in the existing act relating to these matters, namely section 27-29 *bis*, were not included in the new Act, but were dealt with in the revised criminal procedure act. These two acts were to come into operation simultaneously, otherwise complicated provision would be necessary. For example, if the new proposed act was enacted before the aforementioned sections were incorporated in the criminal procedure act, the repeal of the existing act by the new proposed act was not to include these sections.[119] It is here that reference was made to the changes occurring within the mental health system. A most pertinent question raised was how does one define a psychopath and what should the courts do with one defined as such?

4. 4. 1. The South African National Council for Mental Health

The Commission mentioned a large number of registered voluntary welfare organizations which, as part of their family-welfare services, attended to the mentally ill and their families. There was however, one organization, namely the South African National Council for Mental Health, to which the commission made reference. As a registered welfare organization, under the National Welfare Act of 1965, it enjoyed special recognition as a national welfare organization which coordinated the mental health services of voluntary welfare agencies. This council operated largely under the control of a director who was in

[118] A. Kruger: *Mental Health Law in South Africa*, p. 25.
[119] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 3.

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turn under the control of the executive committee. This was a multi-disciplinary body, composed of psychiatrists, clinical psychologists, registered psychiatric nurses, social welfare officers, ministers of religion and lay representatives of the societies, all of whom provided invaluable services on a voluntary basis. The council endeavoured to enlist the co-operation of all organizations or bodies concerned with mental health and not only to promote the prevention of mental illness, but also to undertake treatment and care, including after-care. One of its major tasks was the education of the general public and the cultivation of a well-informed public opinion. It can truly be said that this council advanced mental health on a broad front.[120] It also provided a model on cooperation between professional bodies.

Several day-centres and homes for the "mentally retarded" were affiliated to the council. Because the psychiatric services rendered by the public authorities in the community were considered inadequate owing to a shortage of staff, these societies had concentrated on the psychiatric treatment of mentally ill persons. This was done by means of psychiatric clinics staffed by state psychiatrists, on a sessional basis, assisted by social workers. The national council controlled 15 psychiatric clinics. The Department of Health provided the services of the state psychiatrists and psychiatric nurses as well as drugs. Motor transport was provided by the department of transport and accommodation and furnishings by the Department of Public Works.[121]

The South African National Council for Mental Health and its societies played an important role in the country's mental health services. By reason of their composition and activities they were very closely associated with the community, and this enabled them to play a major role in a multi-disciplinary community orientated mental health service. According to the evidence many patients had to wait from one month to four months for an interview with a psychiatrist. On account of the large number of patients, psychiatrists often found it impossible to devote more than five to fifteen minutes per consultation. The inevitable result was that the clinics could not provide satisfactory psychiatric services.[122] This therefore called into question the ability of expert witnesses to testify in trails where the accused was said to be suffering from a mental illness. Essentially, the argument being made was that the country did not have adequate facilities and trained staff to accommodate the

[120] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 19.
[121] *Ibid.,* pp. 19-20.
[122] *Ibid.*, p. 20.

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enormous number of people who were suffering from what was now being considered a mental illness nor were they in a position to recommend that those deemed dangerous to society, such as psychopaths, should be incarcerated in a medical facility.

4. 4. 2. Recommended Definition for Psychopathy

With regards to the definition of "psychopathic disorder" in the British Mental Health Act, the Commission were of the opinion that it was not desirable that the definition of psychopath should include a provision for the recommendation of medical treatment. According to the Commission it was doubtful whether most psychopaths could really benefit from medical treatment. It was preferred that a person whom from an early age, before or during puberty, had suffered from a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which resulted in abnormally aggressive or seriously irresponsible conduct, should be considered a psychopath.[123]

Therefore, psychopathic disorder was defined as a persistent disorder or disability of mind (whether or not including subnormality of age) which existed from an age prior to that of 18 years and which resulted in abnormally aggressive or seriously irresponsible conduct on the part of the patient. Psychopaths as defined were to be considered mentally ill irrespective of whether the disorder required, or was susceptible to, medical treatment.[124]

Psychopaths who were able to respond to medical treatment were to be dealt with differently from "lost causes". This is not to suggest that no medical efforts were to be made to treat the latter. The danger, as the Commission saw it, was that if the definition of psychopath stipulated that the disorder should require or be susceptible to medical treatment, cases for which there was as yet no effective treatment would be excluded (Section 2 (b) of the new act). The Commission deemed psychopaths as a disruptive influence in South Africa's prisons. They constantly violated rules and regulation, formed gangs, organized fights and caused the authorities endless trouble. Little could be done to prevent these people from committing these acts. Ideally, so it was argued, they were to be removed to a hospital prison for psychopaths.[125] However, in the context of scarce resources and undertrained staff, a different recommendation had to be made.

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[123] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 40.
[124] *Ibid.*
[125] *Ibid.*, pp. 40-41.

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4. 4. 3. Recommendations Made by the Commission on Psychopaths

The commission concluded that certified psychopaths under sentence of death may, notwithstanding any provision in the act, be executed. For the protection of the public, provision was also to be made by legislation for the establishment of a hospital-prison for psychopaths where psychopaths who were a danger to the public could be detained for long periods and where they could be treated.[126]

The Commission recommended that section 10 be amended and that it should compel a psychologist, medical practitioner, or a psychiatrist, to notify a magistrate if they deemed an individual to be particularly dangerous. Furthermore, a maximum security hospital that catered only for state president's patients was deemed an urgent necessity. Class VI of defined mental illnesses which was deleted in 1957 was to be reinstated. But the whole of section three was to be revised and brought in line with accepted modern concepts of psychology and psychiatry. Lastly, the procedural provisions regarding the examination and the trial of persons alleged to be suffering from a form of morbid mental disorder was to be removed from Act 38 of 1916. The said provisions belonged in the criminal procedure act and was to clearly distinguish between those deemed by law to be not responsible for their actions, unfit to stand trial and certifiable under the Mental Disorders Act.[127] These procedural provisions were sections 27-29 of the Mental Disorders Act and they, according to the Commission, were to be included in Chapter 13 in the proposed Criminal Procedure Bill of 1973.

4. 4. 4. Sections 27-29 of the Mental Disorders Act of 1916

Sections 27 dealt with the procedure if an accused person is found mentally disordered or defective prior to arraignment or sentence, section 28 with the procedure if an accused person was found mentally disordered or defective on arraignment or during trial, section 29 with accused persons found to be mentally disordered or defective at the time of committing an act or omission that would, but for his mental condition, have constituted a criminal act, and section 29 *bis* safeguarded the powers of prosecuting authorities to

[126] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 58.
[127] *Ibid.*, p. 2.

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withdraw charges in respect of certain persons referred to in sections 28 and 29. As already indicated, these matters were now to be dealt with in the criminal procedure act.[128]

This final decision helped resolve the issues of aligning new definitions of mental illness with judicial practices. This is not to suggest that the process was smooth. One rather vigorous campaign against the new law reforms on mental health can be seen in the Commission of Enquiry into Scientology in 1972. Subsequent debates in parliament around the proposed Bills also reflect some of the shortcomings of the legislation which was to be implemented in 1973 and 1977.

4. 5. The 1972 Commission of Enquiry into Scientology

The anti-psychiatry activities of Scientology in South Africa are of interest to this dissertation due to their campaign against psychiatric practice in South Africa. The Church of Scientology[129] and its subsidiary, the Citizens Commission of Human Rights (CCHR)[130] had not always positioned itself against the apartheid state. The organization tried to ally itself with the National Party claiming that the true enemies of the state were psychiatrists. The CCHR had their own self-serving agenda for attacking psychiatry. Scientology rejects psychiatry completely in favour of its own dogma as a means to obtain mental clarity. The organization never managed to form a relationship with the National Party government. Instead they played a role in publicizing the overall conditions in hospitals and began a series of investigations that would culminate in the international community ostracizing the South African government and those working within its constraints.[131]

Ironically, it might have been Hubbard's attempts to contact Prime Minister Verwoerd that intensified the police investigation into the organization. In the aftermath of Verwoerd's assassination, Hubbard publically insinuated that the assassination of the Prime

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[128] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*, p. 52.

[129]The Hubbard Association of Scientologists International (HASI) opened offices in 1957 in Johannesburg and Durban. By 1961 another office opened in Cape Town followed by an office in Port Elizabeth in 1962. Notably, in 1962 Hubbard sent out a letter to all the branches that Scientology was to slowly transition from business to church status. HASI would eventually incorporate its South African branches under the name of the Hubbard Scientology Organization in South Africa (Propriety) Limited. He would make his wife Mary Sue Hubbard and Marilyn Routsong and himself directors. Ironically the mandate of the South African offices read as if the organization wanted to partake in psychological research. Their aim was to partake in a sort of pseudo-psychiatry to ultimately eclipse the work of psychiatrists.

[130] The CCHR was meant to be an independent body, regardless of its affiliation to the Church of Scientology, set up to investigate human rights violations in the psychiatric field.

[131] T. F. Jones: *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, pp. 156-157.

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Minister was a plot by the psychiatric profession to overthrow the government. He elaborated:

> In 1966 I wrote to Dr. Verwoerd the South African Prime Minister a letter that I had information that a dangerous situation might exist in his vicinity. He wrote back thanking me. I was suddenly made persona non grata in Southern Africa. Shortly afterwards Dr. Verwoerd was assassinated by a psychiatric patient.[132]

It became clear to the Church of Scientology that the government had no interest in paying any attention to them and their cause. The organization published multiple attack articles in the media, often accompanied by pictures depicting the evils of psychiatry. One such picture depicted the grim reaper straddling the Republic of South Africa holding a scythe inscribed with the word psychiatry. Another article insinuated that there were incidents of "psychiatric patients involved in political assassination". This comment echoes statements made by Hubbard that Tsafendas was a tool used by psychiatry to assassinate Prime Minister Verwoerd as part of their communist plot. Yet, the article once again, declared loyalty to the South African government. In this specific article the organization also made a few suggestions for what the government should do to address this problem within its borders. Notably, majority of these recommendations suggested that the government investigate the allegations made by the organization against the discipline of psychiatry.[133]

The organization also began to distribute bulletins defaming prominent psychiatrists. For example, in 1968, they sent out an information letter to all the members of parliament defaming Dr. E. L. Fischer. In this letter the organization claimed that Dr. Fisher was a secret communist. Interestingly, Dr. Fisher was a trained psychiatrist and member of parliament who was pushing for a commission of inquiry into Scientology. Due to their attacks on psychiatric practices worldwide, they began to receive pushback from the media and governments abroad. The English newspapers in South Africa published a few negative articles about the organization and in response the organization sued the South African Associated Newspapers Limited for slander, however they later withdrew their case. This was only the beginning of a series of lawsuits launched by the organization.[134]

In 1969 the organization sued T. J. Stander from the South African National Council for Mental Health (SANCMH). However, by 1977 they withdrew their case. During the same

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[132] T. F. Jones: *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, p. 160.
[133] *Ibid.*, p. 162.
[134] *Ibid.*, pp. 162-163.

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period, they also sued Jan Hendrik du Plessis, the former South African police Captain, who promised them a meeting with B. J. Vorster and other members of parliament and never followed through. Members of the organization began to write letters to the Minister of Health claiming that Scientology was being distorted and that the organization remained completely loyal to the country. However, during their attempts to align themselves with the Apartheid government, they underestimated the close relationship between some psychiatric practitioners, mental health associations, and government members. Interestingly, not only were some members of the government mental health practitioners, former Prime Minister Verwoerd also trained in the field of psychology.[135]

Pushed by mental health practitioners, the government set up the Commission of Inquiry into Scientology in 1969 which reported their findings in 1972. The commission dealt the organization some great blows. The commission recommended to extend legislation that would control the use of psychotherapy, which they thought that Scientology was attempting to do. It was also recommended that any security checking and intelligence actions by independent organizations such as Scientology be outlawed. Moreover, the commission also suggested that any "inaccurate, untruthful and harmful information in regard to psychiatry and the field of mental health in general", be prohibited. Additionally, the Apartheid government denied all allegations made by the organization and argued that the organization was simply engaging in a vendetta against psychiatrists. The government insisted that many of the allegations of abuse were simply unwarranted and argued that many patients in private institutions chose sub-standard conditions themselves.[136]

However, the Church of Scientology and their subsidiary the Citizens Commission of Human Rights (CCHR) did not cease their attacks on the actions of psychiatrists. Disillusioned by their failure to ally themselves with government officials against psychiatrists, they began to attack the Apartheid government. The organization began to exploit the burgeoning international concerns about racial discrimination that existed in South Africa. During the 1970s the organization sent press reports to various news outlets that highlighted the atrocious conditions within mental institutions. They purposely ignored the legislation and continued with their attacks against psychiatry, sometimes brazenly sending information to government officials. Their persistence and damaging publications about the conditions in mental institutions sparked both domestic and international outrage

[135] T. F. Jones: *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, p. 163.
[136] *Ibid.,* p. 164.

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at the abusive treatment of psychiatric patients. Perhaps their best act of defiance happened in 1979 during the annual Convention of Psychiatry held at the University of Cape Town. The international participants arrived to find a publication in their hotel rooms from the Church of Scientology repeating many of their accusations of human rights abuse. At the conference some of the international participants, much to the dismay of the Minister of Health, suggested contracting the Church of Scientology to gain further information regarding conditions in institutions. The actions of the Church Scientology resulted in an international awareness of the injustices of Apartheid.[137]

The government published the commission report in 1972 detailing as much information about Scientology as possible, particularly the organization's activities in South Africa. The document consists of 15 chapters containing all the information the government could gather about the organization, its founder and their activities in South Africa. The organization was very intolerant of criticism or opposition, whether it came from the outside or within their own ranks. According to their terminology, a source of trouble, from inside or outside the organization, was referred to as a suppressive person or group. The suppressive person or group is "one who actively seeks to suppress or damage Scientology or Scientologists by suppressive acts." Additionally, suppressive acts were defined as "actions or omissions undertaken knowingly to suppress, reduce or impede Scientology or Scientologists."[138]

The founder of Scientology, L. Ron Hubbard provided a lengthy list of what constituted an attack on Scientology for Scientologists. The list contains 22 points. This list reflects their fear of legislation curtailing their freedom and those who could possibly testify to the acts of the organization or undermine the authority of the organization. The concern over former members speaking publically about the organization was also condemned. So too were its members who refused to disconnect from the suppressive person or group.[139] Its enemies were considered fair game and could be persecuted.

The harshness of this fair game policy and the willingness to deceive and destroy was demonstrated in the case of Dr. Fisher, a member of parliament. Dr. Fisher was the elected MP of Rosettenville, Johannesburg. In that capacity, and as a medical practitioner, Dr. Fisher received complaints from members of the public with regards to the practice of Scientology.

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[137] T. F. Jones: *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*, pp. 165-166.
[138] RP 55/1973, *Report of the Commission of Enquiry into Scientology for 1972*, p. 114.
[139] *Ibid.*

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He raised the issue in parliament on several occasions and requested a commission of enquiry into Scientology. This conduct on the part of Dr. Fisher was seen as an attack on Scientology and resulted in him being deemed as a suppressive person and therefore fair game. As news of Dr. Fisher's comments about the organization reached Hubbard, he insinuated that during an investigation into Dr. Fisher, the organization had found evidence of embezzled funds, moral lapses, and "a thirst for young boys".[140]

The commission concluded that although members of the organization promoted the claim that Scientology is a religion and a church, however, it cannot be considered as a religion or a church in South Africa. Additionally, the commission recommended that the government, with regard to the principle of freedom of religion, might consider it useful to define the minimum standards required before an organization can be registered as a Church, in terms of the Companies Act or other relevant legislation. Due to the claim from the organization that Scientology was beneficial and vital to monitoring mental health, the commission recommended that legislation should be enacted to provide for the registration and control of psycho-therapists and persons practicing psychology and for the prohibition, subject to prescribed exceptions, of the application of psycho-therapy and the practice of psychology. The practice of disconnection, public investigation and fair game law was to be declared illegal by appropriate legislation. Notably, the commission recommended that the distribution of incorrect, dishonest, and damaging information regarding psychiatry and the field of mental health in general, was to be prohibited in terms of legislation. This recommendation came due to concerns that the conditions in mental institutions would be made public.[141] This is suggestive of the deplorable conditions at state-run mental health facilities.

Despite the controversy around this Commission of Enquiry and a clear indication of a particular religious agenda coming to the fore, one can read into the criticisms lodged against the state into the poor handling of psychiatric services in the country as well as the use of psychiatry in Apartheid's racialized politics. It is within this unstable climate and opposition to psychiatric services in South Africa that the government had to set about making requisite changes to the legislation, as recommended by the various commissions of enquiry. This too was no easy feat and these debates also reflected on what was to become the sustained shortcomings of dealing with psychiatric patients after they were deemed

[140] RP 55/1973, *Report of the Commission of Enquiry into Scientology for 1972*, p. 117.
[141] *Ibid.,* pp. 231-232.

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mentally ill and convicted in a court of law. The debates had to also become more inclusive and were subsequently tabled in parliament.

4. 6. Parliamentary Debates: The Mental Health Act of 1973 and the Criminal Procedure Bill of 1973

The Parliamentary debates on the Mental Health Act and the Criminal Procedure Bill are important to this study due to the information that it provides regarding those acts. The debates provide insight in to the importance of changing the mental health legislation, the need to amend the criminal procedure and reasons as to why the Bill of 1973, lapsed. They also lay a foundation from which to analyse the challenges faced in the cases tried during the interim period, as discussed in the next chapter.

4. 6. 1. The New Mental Health Act of 1973

Parliament had its first reading of the proposed Mental Health Act of 1973 on the 7th of February 1973. The Bill was only read at this sitting. The draft Bill of the new Act had been sent to approximately 32 different organizations for perusal and comments. It received constructive criticism that had been incorporated into the Bill. However, it excluded the criticisms of the Scientologists.[142]

On the 1st of March 1973 at the second reading the new Act was debated. Again Parliament mentioned the Rumpff and both Van Wyk commissions and gave reasons for why those commissions where necessary. Parliament constructed the new Act in accordance with the recommendations made by these commissions. The Minister of Health emphasized that the Bill did not include the procedural provisions regarding the examination and trial of persons alleged to suffer from mental illness. These provisions in the present Mental Disorders Act – sections 27-29 *bis* would be dealt with in the proposed revision of the then existing Criminal Procedure Act of 1955.[143]

The post of Commissioner for Mental Health was created following the Union of South Africa when health was the function of the Department of the Interior. Due to the

[142] *Hansard*, Vol, 42, 1973, p. 1791.
[143] *Ibid.*, p. 1785.

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changes happening in legislation the Bill proposed that the reference to Commissioner for Mental Health be omitted and replaced with Secretary for Health, and that the secretary be entrusted with the responsibilities of the commissioner. This change would bring the Act in line with modern organizational practices. Parliament acknowledged that psychiatric services had changed enormously over the past decade. In South Africa there was a great shortage of psychiatrists, especially those working for the state. Therefore, optimum utilization of existing psychiatrists was the main goal.[144]

The government made an important decision regarding the psychiatric services rendered by the state and in the provinces. In the provisions of the new Act, the Van Wyk Commission recommended that provincial administrations were to render psychiatric services to acute psychiatric patients in provincial hospitals, and the Department of Health was to be responsible for community psychiatric services in state hospitals. Additionally, the Van Wyk Commission recommended that sterilization and abortion should not form part of the legislation.[145]

The debate shifted to clinical psychologists. The commission stated quite clearly that compared to some Western countries, clinical psychological services were underdeveloped in the Republic. The commission recommended that greater recognition be given to the profession in regard to the clinical psychologist's role as a psychotherapist, especially with regards to psychopaths. However, the Minister of Health disagreed with the commission's recommendation that psychologists be empowered to certify people as mentally ill. He argued that mental illness often varied and might be physiological and not only psychological, thus falling outside of the expertise of a clinical psychologist. According to the debates, the clinical psychologist was not trained to diagnose physiological or somatic diseases and defects. Therefore, in cases of that nature it could happen that a person could be certified as mentally ill when their illness could have been cured by a surgical, or other procedure. In South Africa medical practitioners received comprehensive training and it was therefore argued that they were better equipped to make a correct diagnoses. Therefore, parliament concluded that it was in the interest of the public to retain the *status quo* in empowering only medical practitioners to certify patients.[146]

[144] *Hansard*, Vol, 42, 1973, p. 1786.
[145] *Ibid.*
[146] *Ibid.*, p. 1787.

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Regarding Chapter One of the new Act, the Minister of Health made some observations regarding some of the definitions. Regarding the definition of mental illness, the commission pointed out that the definition of a mentally disordered or defective person in the Mental Disorders Act defined such a person in terms of practical effects. It seemed to the commission that practical effects should be as far as possible be excluded from the definition, but should be taken into account when detention, care or treatment were considered to be incomplete.[147]

The Commission, therefore, recommended that the term "mentally ill" should be used in the place of mentally disordered or defective and that this definition should be broad enough to include *inter alia* all possible classes of mentally disordered and defective persons. Also, to avoid possible misinterpretations, it was advised that psychopaths should be expressly included and that an indication should be given as to what this entailed. The term patient was considered adequate to define a patient as a mentally ill person, or person suspected of, or alleged to be, mentally ill. The patient, however, was to be deemed mentally ill to such a degree that they need to be detained, supervised, controlled or treated.[148]

The Bill of the new Act was based on the principles of the existing Act, which, according to parliament, had proven effective over the previous 57 years. The draft legislation recommended by the commission, however, was of considerable assistance. The Bill of the new Act made enough provisions for the protection of not only the public, but of the rights of the individual. This Bill created the opportunity to consolidate the existing legislation and modernize the existing Act. In the light of the then existing psychiatric knowledge, provision was made in the regulations for (a) the establishment of maximum security hospitals for dangerous patients; (b) establishment of institutions for psychopaths; (c) the establishment of institutions for the State President's decision patient; (d) establishment of child guidance clinics and child psychiatric units; (e) observation and treatment of alcoholics and drug dependents who were mentally ill; and (f) provision of community psychiatric services after-care and follow up services.[149]

It should be noted that some of the above mentioned recommendations had already been implemented: (a) alcoholics and drug dependents had been admitted and treated in state mental hospitals; (b) child guidance clinics and child psychiatric units were established in

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[147] *Hansard*, Vol, 42, 1973, p. 1787.
[148] *Ibid.,* p. 1788.
[149] *Ibid.*, p. 1790.

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various centres by mental health societies and other bodies; sections (c) and (f) had already been established; and (d), a maximum security ward in Weskoppies hospital[150] had been erected to accommodate 100 white male patients.

Dr. Fisher praised the Bill as being well investigated and thorough. He also echoed the comments made by the Minister of Health about the acute shortage of trained personnel. He believed that the government had been able to give adequate service until then but that this needed to be upgraded. According to him South Africa had been able to cheaply treat mental illness however, mental institutions were under-financed and poorly managed. He suggested that money be spent to modernize Valkenberg Hospital, instead of building another state psychiatric facility in Cape Town. He was shocked when he saw the difficulties the staff were confronted with and the poor conditions under which some of the patients had to be accommodated. Whether the new hospital at Stikland was going to be a relief for this position, he was unsure.[151] Despite the religiously motivated protests made by the Scientologists, there was some consensus over the poor conditions at mental institutions in the country.

Fischer suggested that new institutions be built in the cities and even the Bantu homelands and that hiding the mentally ill should be a thing of the past. Of great significance was the call to treat those with mental illness with compassion. He was also perturbed by the poor number of psychiatrists in the country and even suggested that Bantu doctors be given facilities to enable them to become specialist psychiatrists. In fact much of the unfolding discussion was about the poor number of psychiatrists who could deal with the different races in the country. This also developed into a heated discussion on how to improve facilities for the racially segregated mental patients. These reflections would suggest a much more compassionate and racially inclusive consideration of mental health issues on the part of Fischer. It is worth noting that he was often called to testify in trials at the Cape Supreme Court. This would further suggest that his analysis of those sent for evaluation would be focussed on the mental state of the patient rather than reflecting an explicitly racist undertone.

Another member of parliament, Dr. Viljoen, who was also a psychiatrist, brought up the issue of preventative measures concerning children. Psychiatrists agreed that the origin

[150] For additional reading on the history of Weskoppies Hospital see C. Plug & J. L. Roos: "Weskoppies Hospital, founded 1892-the early years," *South African Medical Journal,* (81), 1992, pp. 218-221.
[151] *Hansard*, Vol. 42, 1973, pp. 1792-1793.

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of mental illness could virtually always be traced back to an incident in a patient's childhood. Therefore, although it mainly appeared to be discussed in court trials as a social problem, he argued that the social condition was inherently connected to psychiatric condition. The Bill also made no attempt to prescribe any arrangements with regard to preventative measures. Dr Viljoen was adamant that this needed to be discussed. He believed that this was mainly an educational problem, concerning children, particularly with regard to special education.[152] Here, the importance of evaluating intelligence and educational performance, as was prevalent in courtroom trials, is made explicit. It also indicates that this approach was far from being formalised in law, despite its prevalence in legal trials.

Despite some reservations, the Mental Health Act of 1973 was passed into law. The dissonance between mental health considerations and legal procedure, however, was discussed in relation to the amendment of the Criminal Procedure Act of 1955. The new Mental Health Act could not be ascended to unless vital changes were made to the Criminal Procedure Act.

4. 6. 2. The Criminal Procedure Bill of 1973

The first discussion of the new criminal procedure act, hereafter referred to as the Criminal Procedure Bill, was first debated in parliament on the 10th of April 1973. According to the Minister of Justice, the criminal procedure had to change due to points of friction that had arisen over the years. The Minister of Justice described it as a "manpower" shortage in the country and that cumbersome procedures served no purpose and was no longer sustainable. New aids had been developed to enhance the efficiency of the courts. However, outdated ideas and methods had proven to be a handicap. Therefore, change was necessary because the pattern of crime had changed. Rules that were originally designed for the protection of ignorant accused persons were being manipulated by the outdated system.[153]

The Minister believed that it was necessary to adjust the 1955 Act, as was being reviewed in countries such as England at the time. He confirmed that all interested stakeholders had been involved in the process and that no objections had been raised about the stipulations of the new proposed Act. One would therefore have expected an expedient

[152] *Hansard*, Vol. 44, 1973, p. 1921.
[153] *Ibid.*, pp. 4453-4454.

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outcome. While the Minister of Justice emphasized that the criminal procedure was a document that was above politics and above self-interest, in his closing remarks he stated that the existing criminal procedure act was for the large part being retained.[154] This was despite the earlier observation that the existing Act was redundant. Nevertheless, the amendments made to the proposed Mental Health Act were actively enmeshed within the new procedural Bill.

The proposed Bill stated that if an accused by reason of a mental illness or mental defect does not have the capacity to appreciate the wrongfulness of his act, or of acting in accordance with that appreciation, he should not be held criminally responsible. In such a case he should be found "not guilty by reason of mental illness" and declared a State President's decision patient. Similarly, an accused who was not capable of understanding the proceedings so as to make a proper defence, should also be declared a State President's decision patient. To assist the court with this inquiry, the accused needed to be examined by a panel of psychiatrists.[155]

The proposed Bill also provided for two new procedures. Firstly, there was a provision whereby a petition for mercy by a condemned person, based upon evidence relating to such a person's conviction, or the death sentence imposed upon them, and which was discovered after all the recognized legal procedures had been exhausted, or were no longer available, could be referred by the State President to a court to hear such further evidence and all other evidence. The court to which the petition had been referred to was to hear the matter and submit its report thereafter to the State President. Another provision provided that whenever the Minister of Justice is in doubt as to the correctness of the conviction of a person who has been sentenced to death, and the convicted person does not appeal against his conviction, he could refer the matter to the Appeal Court.[156]

The first Member of Parliament to comment on this Bill was Dr. E. L. Fisher. He admitted that he approached the Bill as layman, but he wanted to talk about Chapter 13 which dealt primarily with the issue of sick people. This chapter dealt with special circumstances which could occur when a person who is accused of a crime appears to be mentally ill. Mental illness and mental defects were not defined in the Bill, but rather in the Mental Health Act, which was recently passed by the House. According to Dr Fisher's definition, mental illness

[154] *Hansard*, Vol. 43, 1973, 1973, pp. 4559-4560.
[155] *Ibid.*, p. 4474.
[156] *Ibid.*

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was any disorder or disability of the mind, and included any mental disease, any arrested or incomplete development of the mind, and any psychopathic disorder.[157]

According to this definition mental illness therefore included a congenital disease, or a mental disease acquired through some inflammation or growth or accident, and it also included all stages of mental disease. By extension, this would include maniacs (which could lead to even more crimes being committed), schizophrenics, paranoias or simple phobias. All these were included in the definition of mental illness. Some diseases, he argued, were chronic and incurable, while some were acute. Some lasted for short durations, and others longer. His concern was around how a non-medical professional would determine the severity of the mental illness as well as accountability of the accused at the time of committing the crime. His argument lay in the fact that psychiatrists would be called to testify in a case after having little exposure to the patient.[158] It is here that one is confronted with a state that wants to change its legislation to align with other western societies but without the capacity to effectively ensure that the procedure was adequately followed.

He mentions these facts to demonstrate how vast the field of mental illness is, how carefully one has to be in making a diagnosis, how convinced one has to be in making the correct diagnosis, the tricky proceedings in court and the final decisions which the magistrates or judges would have to make based on the testimony of the medical practitioner. For that reason Dr. Fisher argued that the provisions which were made in the Bill should provide for the report of a psychiatrist to be made under better conditions.[159]

Essentially, the psychiatrist determined whether the accused was fit to stand trial. He could save the man from the death penalty, but he could also be responsible for sending a man to a mental hospital for the rest of his life. That man, who goes to a mental hospital for the rest of his life, could possibly, be kept in a security section of a mental hospital for the rest of his life. This is based on the report of the psychiatrist in cases where the man may not be responsible for a violent crime but may be suffering from a mental disease.[160]

Dr. Fisher wanted to further probe clause 79 of the Bill, and what he thought were certain deficiencies in the Bill. In clause 79 of the Bill, the procedures to be taken concerning the examination of the accused were set out. According to him they were divided into two

[157] *Hansard*, Vol. 43, 1973, p. 4561.
[158] *Ibid.*, p. 4562.
[159] *Ibid.*
[160] *Ibid.*,, p. 4563.

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categories. These included the procedures stipulated where the death penalty is, or could be involved, or not. The accused was to be examined by the Superintendent, and at the request of the court, a psychiatrist not in service of the government. If the accused wished he could be examined by a psychiatrist appointed by himself. Therefore, the minimum number of psychiatrists that could examine the person were two. In cases where the death penalty was not being considered, the Bill was only suggesting that the accused be seen by one psychiatrist.[161]According to Dr. Fisher this was discrimination and unwarranted. He felt that the severity of the disease and the severity of the offence should be taken into consideration.[162]

The discussion continued on the 12th of April 1973. Although nothing concerning mental health legislation was discussed, the United Party did make it clear that they rejected the Bill *in toto*.[163] The Bill moved to a committee stage on Friday the 13th of 1973. Again, no discussion regarding mental health took place. According to the debates the Bill was read again on the 20th of February 1974. There was a second reading of the Bill on the 25th of February. However, there were points made about the section of the Bill dealing with fines, but the Bill was not discussed. In 1975, on the 6th of March the Bill was read again.[164] The delays were the result of an intermediary Commission of Inquiry launched in 1974.

In 1974 the Viljoen Commission inquired into the penal code, or penalty system of South Africa. Therefore, the decision was made to wait until the Viljoen's commissions report was available.[165] The Viljoen commission did make recommendations that have an immediate bearing on this study, especially the declaration of offenders as habitual criminals. Parliament thought it was important enough to discuss. The goal of the commission was to make recommendations to improve the penal code, not to revise it. It is important to note that the mandate of the commission did not include the question of whether the death penalty should be kept or not. The report of this commission had to be completed before 1977 sitting of parliament and submitted to the relevant authorities.[166]

The Viljoen commission did recommend that the compulsory sentence for corrective imprisonment for the prevention of crime should be scrapped. The commission determined

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[161] *Hansard*, Vol. 43, 1973, p. 4563.
[162] *Ibid.*, p. 4564.
[163] As a whole.
[164] *Hansard*, Vol. 55, 1975, pp. 2031-2032.
[165] *Hansard*, Vol. 66, 1977, p. 416.
[166] *Ibid.*, p. 421.

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that there were certain offenders who will simply continue to commit certain offences. The commission agreed that the sentence and declaration of a habitual criminal should therefore stay, but that only a superior court could hand down such a sentence. However, the Minister of Justice believed that would be a strain on the Supreme courts, and after consultation with members of the legal profession, they recommended that magistrates too be allowed to hand down such a sentence.[167] By 1977, after a lengthy period of discussion and debate, the Criminal Procedure Act of 1977 was ascended.

4. 7. Chapter Conclusions

This chapter discussed the criminal cases that appeared before the Cape court in the immediate aftermath of Verwoerd's death. Notably in this period the findings of the Rumpff commission was published. The most important recommendation made by that commission was that a Commission of Enquiry into the Mental Disorders Act of 1916 be set up. Additionally, the Botha Commission also published its findings that recommended that the Criminal Procedure Act of 1955 be revised and improved upon. In this period interesting discussion unfolded in the criminal cases regarding the mental state of defendants brought before the court. Notably, these discussion were already prevalent in the criminal cases, before they were enacted in legislation that is in the cases of the State v. G. J. P, 1971 and the State *v*. D., 1970.

The unfolding debates and discussions also show how the difficulties in defining a mentally ill criminal in terms of health and law can lead to undue pressure on the medical profession and confusion within the judiciary when legislation is not aligned. These debates clearly point to contention and deep reflection and are adequately delineated in the next chapter when attention is drawn to how cases were tried during this transitional period. What does become apparent is the level of intervention and relative importance of state psychiatrist in determining the outcome of death sentence cases during this period. It could therefore be argued that while judge's proclivities need to be considered when reflecting on sentencing practices, here, the vision and personal proclivities of the medical professionals called to testify in murder cases share an equal role in the outcome of said sentence, even in a state of legislative and medical confusion.

[167] *Hansard*, Vol. 66, 1977, pp. 421-422.

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Chapter 5

Mental Health and Sentencing in the Courts, 1974-80

This chapter investigates the twenty-three cases which appeared before the Cape Town Supreme Court during the period, 1974-1980. The Mental Health Act of 1973 was only ascended in 1975, and the necessary changes to the Criminal Procedure act of 1955 only became law in 1977. However, as will be shown, during this period the proposed legislation was already being applied in the criminal case discussions. By 1976, eight of the accused were sent for psychiatric evaluation. This is in contrast to the two sent in 1975, after the Mental Health Act of 1973 was implemented. Prior to this, in 1973 and 1974, already seven and six cases, respectively, were referred. This suggests a lack of cohesion and correlation between the passing of the act and judicial procedure.

It would have been useful to assess these trends between 1977 and 1980 to gauge if indeed these acts had been formally implemented within the judicial system. However, cases after 1976 could not be accessed. The study had to rely on the clearly deficient governmental statistics on murder and culpable homicide and law reports which only record how the new Mental Health Act of 1973 were adapted in subsequent years. While hugely deficient, this does show the importance of the archived court case in contrast to the selective law reports normally found in the public domain.

5. 1. Criminal Cases for Murder, 1973-1976

The criminal cases for this period are pivotal to this dissertation due to the discussions surrounding the new legislation that unfold within the trials. Additionally, the cases also focus on the concept of psychopathy and the institutions that can accommodate them, an area of major concern for the medical and legal professionals.

5 .1. 1. State *v*. P. L., 1973[1]

In the State *v*. P. L., the accused had been charged with murder. He had stabbed a 13 month old child to death. He was sent to Valkenberg for observation before the trial commenced. According to the report from the psychiatrist, the accused was well behaved

[1] KAB CSC 1/1/1/1948, Cape Supreme Court Records, Case no. 63 of 1973, State *v*. P. L.

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and co-operative, with the appropriate mood during his observation period. The accused also exhibited a clear and coherent thought process. The accused denied that he experienced hallucinations. P. L. was considered to not be deluded and on clinical assessment the accused was deemed intellectually intact. The accused agreed with the psychiatrist that he was mentally normal during his observation period, however he said that since 1967 he had suffered "episodes" lasting two days to two weeks during which he became mentally deranged.

These episodes would start with insomnia and then he would begin to hear voices. According to the accused, these voices would start to discuss him in the third person, and the content of what they were discussing was threatening. According to the accused, he would become intensely afraid when this happened. The accused was told that during his episodes he would start to talk nonsense. Previously he sought the help of witch doctors. These episodes would occur at variable intervals, being a few months to a year apart and persisted after the accused had been alcohol free for a year. Additionally, the accused had stopped using *dagga* for many years.

According to the psychiatrist, the details of the accused's feelings and experiences during these periods were strongly suggestive of a schizophrenic illness and were of such a sophisticated nature that it seems very unlikely that they could have been simulated by a man of his background. The psychiatrist testified to the trial court:

> I am of opinion that this man in all probability suffered psychotic episodes and if his story is accepted, may well have been psychotic at the time of the alleged crime. He is however, not mentally disordered in terms of the Mental Disorders Act, at present.

Justice Beyers found the accused guilty, and sent him to jail in terms of section 29 (1) and (2).

5. 1. 2. State *v*. B. M., 1973[2]

The case of B. M. centred on the jealousy and possessiveness the accused felt towards the deceased, his wife. The accused and the deceased had experienced problems in their marriage due to his abusive behaviour towards her. She had left him and he tried to convince her to come back to him, but she refused. Due to her rejection the accused took an overdose of pills in an attempt to kill himself. After his suicide attempt she arranged for him to see a

[2] KAB CSC 1/1/1/1951, Cape Supreme Court Records, Case no. 70 of 1973, State *v*. B. M.

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psychiatrist. After the first suicide attempt he began to plead his case and asked the deceased to come back to him, and again she refused. When the deceased rejected the accused again, he tried to commit suicide by throwing himself in front of a truck.

However, before the accused tried to commit suicide he assaulted his wife after she had refused, yet again, to get back together with him. The deceased went to the hospital to visit the accused after his second suicide attempt where he proceeded to threaten her that he would kill her if she did not come back to him. According to a witness, her alleged lover, he saw how the accused had tried to assault the deceased. He and the accused had gotten into a confrontation about the deceased and the accused proceeded to stab him four times, luckily not fatally. In light of these facts the accused was sent to Valkenberg for observation due to his two suicide attempts.

According to the assistant superintendent at Valkenberg, Dr. Pascoe, the accused was a person of normal intelligence, but someone who suffered from a personality disorder, displaying hysterical, dependent and psychopathic features. Dr. Pascoe stated that there was a long-standing pattern of maladjustment in society. The accused was a selfish type of person who wanted his wife back, probably not so much because he had loved her, but because he felt humiliated that she had left him. It was his pride and self-esteem more than anything else that was affected. Dr. Pascoe concluded his report by stating that the accused had a low frustration tolerance which would have affected his reactions under extreme conditions of stress.

Dr. Pascoe certified him as not mentally disordered in terms of the Mental Disorders Act. This was enough for Justice Banks who sentenced him to 20 years in prison for stabbing his wife to death.

5. 1. 3. State *v*. D. M., 1973[3]

In the State *v*. D. M the accused shot a white female with a pistol. He was sent to Valkenberg for observation. According to the report from Valkenberg, the accused had a history of chronic alcohol addiction for which he was hospitalized twice in 1961. Physically the accused showed signs of mild chronic bronchitis in the region where he had a previous chest operation. He showed no sign of neurological or electroencephalographic abnormality.

[3] KAB CSCS 1/1/1/2019, Cape Supreme Court Records, Case no. 194 of 1973, State *v*. D. M.

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During his observation period he had shown no lapses in consciousness, thought disorder, delusions or hallucinations. The accused had suffered no amnesia, except for a circumscribed short spell at the time of his alleged crime.

However, the accused's memory of the other events of that day was good. His amnesia was of the dissociative type with an onset after a distressing event. The mood of the accused had been appropriate and at times he had been tense and tearful, with slight impairment of his concentration. Clinically his intelligence was within normal limits, but psychometric tests had proved invalid due to his failure to co-operate. The report concluded that although he was addicted to alcohol, he was not mentally disordered in terms of the Mental Disorders Act and therefore he was fit to stand trial.

Justice Theron found him guilty of murder with extenuating circumstances and sentenced him to 12 years in prison. He could well have received the death penalty and despite being declared mentally fit according to the Mental Disorders Act, the extenuating circumstances of his affliction resulted in a lower sentence.

5. 1. 4. State *v*. W. l. R., 1973[4]

In the case of the State *v*. W. l. R. the accused had stabbed the deceased which resulted in his death. He was charged with murder and sent to Valkenberg for observation. The court wanted to assess his mental condition because the accused had a history of convulsions in childhood since the age of eight years. Subsequently, no fits occurred during his observation period and he was never treated for epilepsy, nor was he regarded as an epileptic. According to the accused he had amnesia for a period extending from the commencement of the alleged incident until he found himself in his bedroom after the murder.

The psychiatrist at Valkenberg determined that his amnesia was not consistent. The accused was helpful, friendly and co-operative during the period of his observation. He had no hallucinations or delusions either and his intelligence was considered satisfactory and his judgment was unimpaired. Therefore he was not mentally disordered in terms of the Mental

[4] KAB CSC 1/1/1/2035, Cape Supreme Court Records, Case no. 229 of 1973, State *v*. W. l. R.

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Disorders Act. Justice Banks found him guilty of culpable homicide and sentenced him to one year imprisonment suspended for three years.

5. 1. 5. State *v*. L. B., 1973[5]

L. B. was charged with the crime of raping and murdering a non-white woman. Due to the crimes he was charged with, the accused was sent to Valkenberg for observation where it was determined that he was not mentally disordered in terms of the Mental Disorders Act. However, he was a heavy drinker and a regular dagga user. He did have one syncopal[6]attack once, however he never had any other epileptic seizures during his life. Justice Watermeyer found him guilty of culpable homicide and sentenced him to seven years imprisonment of which two years were suspended for three years.

5. 1. 6. State *v*. G. d. P., 1973[7]

The accused stabbed a man in the chest while he was out on parole, resulting in the man's death. After his arrest his lawyer arranged that he be transferred from Polsmoor prison to Valkenberg for observation. Unfortunately there was no report from Valkenberg included in the case file. However, the case file noted that he was found not mentally disordered and sent back to Polsmoor for the duration of the trial due to the accused's bail being revoked when he was sent for observation at Valkenberg. Justice Beyers found him guilty of murder and sentenced him to death. However, the State President commuted his death sentence to 12 years imprisonment.

5. 1. 7. State *v*. K. S., 1973[8]

Unfortunately this case was one of the incomplete case files. There was a note made on the cover of the case file that the accused was sent to Valkenberg for observation, however no report was included in the case file. The accused in this case was charged with murder, however the case against them was dropped by the state. The case file did note that he was

[5] KAB CSC 1/1/1/2083, Cape Supreme Court Records, Case no. 295 of 1973, State *v*. L. B.
[6] Fainting or a sudden temporary loss of consciousness.
[7] KAB CSC 1/1/1/2025, Cape Supreme Court Records, Case no. 204 of 1973, State *v*. G. d. P.
[8] KAB CSC 1/1/1/1991, Cape Supreme Court Records, Case no. 172 of 1973, State *v*. K. S.

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declared "kranksinnig"[9]and declared a State President's patient by the trial judge, Justice van Heerden.

5. 1. 8. State *v*. J. M., 1974[10]

In the State *v*. J. M. the accused was charged with several charges, namely murder, rape, and two counts of housebreaking and theft. Additionally, 18 months before he was arrested the accused was convicted of rape. Due to the missing documents in the case file it is not clear what the exact nature of each crime was, however it is possible to piece together the details of his observation period at Valkenberg.

Before the trial commenced the accused was incarcerated at Polsmoor prison. His lawyer proceeded to request that the accused be transferred from Polsmoor to Valkenberg hospital because he allegedly had an epileptic seizure. When the guards came to his cell he was lying extremely still and when stirred he seemed confused and did not know what was going on around him. They suspected that he was suffering from epilepsy and therefore there could have been brain damage which would have made him not responsible for the alleged crime. According to the accused's father he would always foam at the mouth during convulsions, he would soil himself, and he would bite his tongue. His father also said that for the last two years the accused had been using alcohol which could have aggravated brain damage that was already present.

At Valkenberg Dr. Pascoe examined the accused. According to Dr. Pascoe he was well-behaved and was somewhat simple and childish. The state of his mood was appropriate and there was no thought disorder. There was no objective or subjective evidence of hallucinations or delusions. His memory was intact, except for the period of amnesia covering the alleged crime. The accused's intelligence was also low. There was a history of epilepsy obtained from his father. His EEG[11] showed a mild abnormality which supported this. Serological examination showed that he suffered from cerebral syphilis and that his judgment was impaired. According to Dr Pascoe he was certifiable in terms of the Mental Disorders Act and was in need of care and treatment.

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[9] Translation: Insane.
[10] KAB CSC 1/1/1/2197, Cape Supreme Court Records, Case no. 69 of 1974, State v. J. M.
[11] Electroencephalogram.

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At the trial the presiding judge, Justice van Heerden asked Dr. Pascoe some questions regarding the accused before he made his decision. The Justice wanted to know if the accused should be kept in an institution or a jail. According to Dr. Pascoe the accused was considered dangerous and would have been a danger to the community. The security at Valkenberg was lax and the accused could escape. Dr. Pascoe felt that from what he knew of this case, that it would be better for the accused to be kept in a prison or prison hospital where he could receive the necessary treatment.

In response to Dr. Pascoe's answer, Justice van Heerden wanted to know what type of mental jail was available, or jail hospital. He was aware of one in Bloemfontein. Dr. Pascoe informed Justice van Heerden that at that time there really wasn't such a place. There was a high security section being built at Valkenberg that would house Coloured males when completed, but there wasn't another one in the country. He suggested that the accused be held in the hospital section of Polsmoor prison. Justice van Heerden was satisfied with Dr. Pascoe's answer and proceeded to inquire about the syphilis diagnosis. In this particular case there were three combinations of factors: (a) his innate low intelligence; (b) his epilepsy; and (c) positive tests for cerebral syphilis. This suggested that there might have been some brain damage that needed to be considered. Dr. Pascoe told Justice van Heerden that he regarded this damage as permanent. The treatment for cerebral syphilis would almost certainly arrest the progression of the illness, but it would not repair the existing damage. The accused would remain an epileptic of low intelligence. Therefore the accused needed care and control of a permanent nature.

Justice van Heerden deemed that the accused was a person in need of care and treatment in terms of the Mental Disorders Act. The accused was accordingly committed to the hospital sector of the Polsmoor prison at the pleasure of the State President.

5. 1. 9. State *v*. G. C., 1974[12]

The accused was arrested on 15 different charges. The charges were two counts of housebreaking, three counts of robbery, seven counts of assault with intent to commit murder, and three counts of murder. The massive amount of charges were accompanied with a report from the Department of Coloured affairs stating that the accused had a history of

[12] KAB CSC 1/1/1/2274, Cape Supreme Court Records, Case no. 232 of 1974, State *v*. G. C.

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poor behaviour and that his parents struggled to control him. The kind of friends that he had made also aggravated the situation. During his crime spree the accused stole multiple firearms each time he broke into someone's house, and oddly, milk. He also committed three murders, and shot a woman in the leg.

The accused's lawyer did make a compelling case for mitigating factors. He was only 18 years old at the time of the crime and under the influence of *dagga* and alcohol. Most importantly, the lawyer argued that his client was a psychopath. During one of the murders the accused had drank about one litre of wine and was probably 'gedagga.'[13] The intention of this murder could have possibly been *dolus eventualis*.[14]

In the murder of the second person his lawyer argued that he was more intoxicated than the previous murder. This was a circumstance of *dolus directus*,[15] but there were factors present that could be considered limited mitigating factors. Again, the lawyer argued that the accused's alcohol and dagga use, and that the accused was 18 years old and a psychopath, was a mitigating factor. Regarding the murder of the third person, of which the accused was only found guilty of assault with the intent to commit harm, his lawyer argued that he was slightly intoxicated and under the influence of *dagga*. There was provocation from the deceased, therefore there was reduced moral blameworthiness. According to the deceased's lawyer these factors, cumulatively, reduced his moral blameworthiness and therefore there were mitigating circumstances present in this case.

What made this case particularly interesting was the discussion about the new Mental Health Act, which would soon to become law in 1975. The defence for the accused argued that the court, when dealing with a psychopath, must be realistic and should refer to the new Act which would soon become law. However, according to Justice Vos the court had to apply the law as it currently was, and not as it will be. Nevertheless, he continued to entertain the discussion on what the new law said about psychopaths. The commission of inquiry into the Mental Disorders Act defined three concepts that is important when dealing with the mentally disordered. Namely, trialability, certifiability, and responsibility.

Therefore, before the new Mental Health Act No. 18 of 1973 could be properly interpreted, all the other relevant legislation needed to become law first. Based on the new

[13] The lawyer argues that he was likely under the influence of dagga.
[14] Under the principle of *dolus eventualis*, in South African law, a person can be convicted of murder if they foresaw the possibility of their actions resulting in the death of someone but continued regardless.
[15] When an accused is taken to have objectively foreseen the consequences of their act.

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proposed act, section 30 would have provided a provision for people given the death penalty. Sub-article one said that if it seemed to the Minister of Health that an incarcerated inmate appeared to be psychopathic, he then can take certain steps, but it specifically excluded the person be given the death penalty. Sub-article two said the same. It laid out what the officer in charge of inmates at a jail should do when he finds out that one of his inmates is a psychopath. However, it excluded inmates that are psychopaths. Sub-article seven states that such persons that are psychopaths, could still be given the death penalty and executed. Therefore, the interpretation of these provisions was that one was compelled by sub-article one, two, and seven of section 30 of this new law, as the lawmakers intended for it to be interpreted, to give the psychopath the death penalty, if deemed applicable.

This interpretation was supported by a paragraph in the report of the committee into the Mental Disorders Act that said, “Soos alreeds hierbo vermeld, moet n bepaling bygevoeg word dat gesertifiseerde psigopate wat die doodsvonnis opgelê is, nieteenstaande enige bepaling van die Wet, tereggestel kan word”.[16]

According to this, Justice Vos therefore did not agree with the accused’s lawyer that the new act now meant that a psychopath cannot be given the death penalty, or if it happened that they were given the death penalty before the new act they could not be executed. Justice Vos gave the accused the death penalty for the first two murders, he considered the circumstances around the death of the third person to be less serious and therefore he did not pass the death sentence for this murder.

The accused was sent to Valkenberg where Dr. Pascoe examined him. According to Dr. Pascoe the accused was a danger to the community, and to property. He gave the court a definition of a psychopath. “Although he can distinguish between right and wrong he has no forethought, he is heedless of consequences, and he loses control of himself”.

Justice Vos wanted to know if the psychopath has a conscience, and he wanted Dr. Pascoe to give his definition of a psychopath. According to Dr. Pascoe he was not aware of a satisfactory definition, but he did have a list of particular properties of this type of individual. According to Dr. Pascoe’s list the psychopath could be considered as:

> One that is not psychotic and that the facts of character that one sees are not a result of a psychosis. Then one would find a pattern of dishonesty, untruthfulness, a lack of remorse, a lack of shame at what he has done, an apparent inability to learn from this. His pattern of life would be egocentric, that is, with little thought

[16] Translation: A certified psychopath that has already been given the death penalty can be executed.

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> or feeling for other people. A much diminished capacity for forming warm emotional relationships with other people.

Again, Justice Vos wanted to know if the accused had a conscience, and Dr. Pascoe determined that conscience would fall under a lack of remorse or shame. Therefore, one could have said that the psychopath has a lack of conscience, or a very badly developed one. Quite often there was abuse of alcohol and drugs associated with this particular unbecoming and anti-social behaviour while under the influence of drugs and quite often a sexual pattern that shows the lack of feeling for any particular partner and that this may be diffused in more than one outlet.

What Dr. Pascoe meant by this is that they may be homosexual as well as heterosexual and possibly have other "sexual perversities in the pattern". These, according to him, are the major features and one expects to find these not in isolation, in isolated instances only, but very much as a life pattern. This type of person, he concluded, lacks any forethought and does not foresee the consequences of his actions, and is frequently impulsive. Justice Vos however, passed the sentence of death, despite the protracted discussions and references to the upcoming Mental Health Act.

5. 1. 10. State *v*. G. M., 1974[17]

In the State *v*. G. M., the accused was charged with the rape and murder of a ten year old girl. He was sent to Valkenberg for observation because the accused had suffered from depression, and to ensure that he was ready for his trial. However, according to Dr. Pascoe it can be disregarded that the accused had suffered from any form of depression during the committal of the rape and murder. Dr. Pascoe based this on the fact that the accused had a very strong sex drive and that this could not be reconciled with any serious depressive state. Additionally, the accused's behaviour after he committed the crime and during the rest of the day was also not that which is associated with someone suffering from some form of depression.

Dr. Pascoe also pointed out that the accused was looking for company that day and spent time with people, even participating in a soccer game. However, it was known that the accused had tried to commit suicide in May of 1973. According to Dr. Pascoe this indicated

[17] KAB CSC 1/1/1/2181, Cape Supreme Court Records, Case no. 35 of 1974, State *v*. G. M.

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that there was some form of emotional instability. He was not found to be mentally disordered in terms of the Mental Disorders Act. Justice Steyn was thoroughly disgusted with the details of the case though. He called the crime that the accused committed, "Gruwelik, wreed, n seksmisdaad van n brutale aard, en dies meer".[18]

Justice Steyn was right to be disgusted. According to the autopsy report the deceased's hymen was torn. Additionally, there was also blood present, not just by her genitals but from the mons pubis to the anus. Justice Steyn found no extenuating circumstances present and the accused was found guilty of murder and guilty of contravening article 14 (b) No. 23/1957. The accused was sentenced to death.

5. 1. 11. State *v*. E. A., 1974[19]

In this case the accused was charged with the murder of a 12 year old non-white girl. He stabbed her in the chest which resulted in her death. E. A. was also charged with the rape of an eight year old girl. He had committed both these crimes on the same day. The accused had no previous convictions. He was sent to Valkenberg for observation. The report from Valkenberg stated that the accused was just your average man. There was nothing wrong with him. There was no psychiatric reason for diminished responsibility or diminished blameworthiness.

Regarding the rape of the eight year old girl, her injuries were horrific. According to the medical examination, "Daar is inderdaad aansienlike geweld aan haar privaatdele toegedien en soos ek gese het, is dit geskeur".[20]

Due to the nature of these crimes committed against two female children, Justice Vos passed the death penalty.

5. 1. 12. *v*. N. F., 1974[21]

In the case of the State *v*. N. F. the accused was charged with murder after he killed the deceased by stabbing the deceased various times over various parts of the body. N. F.

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[18] Translation: horrific, cruel, a sex crime of a brutal nature, and some more.
[19] KAB CSC 1/1/1/2206, Cape Supreme Court Records, Case no. 90 of 1974, State *v*. E. A.
[20] "Indeed there had been considerable damage done to her private parts, and, as I've said, it had been torn".
[21] KAB CSC 1/1/1/2194, Cape Supreme Court Records, Case no. 60 of 1974, State *v*. N. F.

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and three of his friends were sitting on the stairs at a flat complex smoking marijuana when they saw the deceased and another person coming their way. They decided to rob the deceased and the person accompanying them. The court requested that the accused be removed from Polsmoor prison and be taken to Valkenberg in order for the superintendent to determine whether his epilepsy had any impact on his moral blameworthiness.

According to the report from the superintendent at Valkenberg the accused was alert, well-behaved, and co-operative during interviews. He expressed himself fluently and spontaneously without thought disorder or evidence of retarded cerebration. The accused denied having hallucinations or evidence of any sort except in immediate association with a fit. Neither did he express delusions and was fully oriented in all spheres. His intelligence was assessed as being within limits and his memory for both remote and recent memory was intact, including his memory of the events of the alleged crime. He was capable of giving a clear and detailed account of himself and was in touch with reality.

According to the accused he had been suffering from grand mal epilepsy since the age of six years with brief auras of dizziness and a headache that followed a fit. After a fit he experienced periods of confusion lasting about 90 minutes. He consistently gave this description. However, he did give an inconsistent story of hearing noise, either just before or just after a fit. He had received, and benefitted, from anti-epileptic medication. His EEG[22] showed a mild abnormality, which was consistent with an inter-ictal[23] record. The accused denied having a fit on the day of the alleged crime. The superintendent was of the opinion that the accused was not mentally disordered in terms of the Mental Disorders Act and could find no evidence to suggest that his epilepsy had a bearing on his moral blameworthiness. Justice Vos found him guilty of murder as charged and sentenced him to 20 years imprisonment.

5. 1. 13. State *v*. P. K., 1974[24]

The accused in this case was a female who stabbed a non-white male with a screwdriver resulting in his death. Unfortunately this case was not complete, however it was

[22] Electroencephalogram.
[23] Ictal period refers to a physiological state or event such as a seizure, stroke, or headache.
[24] KAB CSCS 1/1/1/226, Cape Supreme Court Records, Case no. 210 of 1974, State *v*. P. K.

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possible to ascertain that the magistrate had sent the accused to Valkenberg. Justice van Wyk found the accused guilty of culpable homicide and gave her seven years imprisonment.

5. 1. 14. State *v*. A. B., 1975[25]

In the State *v*. A. B., the accused assaulted a non-white male resulting in his death. The case was postponed in order for the accused to be sent to Valkenberg for observation. The court requested that the Department of Coloured Affairs also submit a report on the background of the accused. According to the report both of the accused's parents were farm labourers and had no formal schooling. There was no history of mental illness in the accused's family. There was only a family history of asthma from the father's side. The family relationship was a tight one and they seemed to all get along with each other.

According to the report, after the crime the accused would frequently talk to himself. He told his family that the deceased talked to him and that he also regularly walked around with him. He occasionally went back to the scene of the crime and sat there for a while. The report concluded that the accused's alcohol use could have possibly had an effect on his mental condition. It appeared that the accused was disorientated and that he experienced hallucinations and delusions. The accused seemed to show remorse, however he did not have any understanding of the implication of his actions.

According to the report from Valkenberg, Dr. Pascoe felt that the accused was polite and co-operative. His mood state was appropriate to this situation and his thought processes were rational and relevant. There was no evidence of hallucinations and delusions. His memory for remote and recent events was intact and his intelligence on psychometric testing was assessed as being in the borderline category. Taking his ward behaviour into consideration, Dr. Pascoe was of the opinion that the accused was not certifiably defective or psychotic in terms of the Mental Health Act. Justice van Winsen found the accused guilty of culpable homicide and sentenced him to three years imprisonment suspended for three years.

[25] KAB CSC 1/1/1/2389, Cape Supreme Court Records, Case no. 165 of 1975, State *v*. A. B.

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5. 1. 15. State *v*. N. K., 1975[26]

In the State *v*. N. K. the accused assaulted a non-white woman and killed her in the process. He threw a glass bottle at her face. The accused then proceeded to hit her in the face with the bottle. The case was postponed so that the accused could be sent to Valkenberg for observation. According to the report from Valkenberg the accused gave a consistent and exculpatory account of the alleged crime. However, he gave a vague and longitudinal account of his life in general. His behaviour was at times mannerist and bizarre, and he was preoccupied and appeared to be talking and mumbling to himself. In the ward he was a helpful patient who mixed well with other patients. At other times he became withdrawn, asocial and preoccupied. He expressed ideas of passivity and influence. It appeared that there was something in his head trying to interfere with his thoughts. He admitted to having auditory hallucinations that would tease him and try to influence him, but he was not able to explain this further. His mood was inappropriate and at times rather fatuous. The accused was of low normal intelligence and his EEG[27] exam was normal. According to the psychiatrist who examined him, his judgment and insight were both defective. He was deemed mentally disordered in terms of the Mental Disorders Act and therefore unfit to plead. Unfortunately this case did not contain information about whether the accused was declared a State President's patient, or any other information regarding the case for that matter.

5. 1. 16. State *v*. B. H. H., 1976[28]

As in the State *v*. G. C., the discussion in this case was also regarding whether the accused was a psychopath, or had any psychopathic features. The deceased in this case was a non-white woman that the accused assaulted with a knife causing her death. The accused had two previous convictions against him for assault. The accused was a white male from a poor family background. His father was a heavy drinker and he would frequently assault his wife. The father was a man that was easily excitable and prone to fits of rage. The accused's mother died in March of 1975 and was very close with the accused. She frequently tried to shield him from his father's animosity. The father accused his wife of sheltering and

[26] KAB CSC 1/1/1/2320, Cape Supreme Court Records, Case no. 9 of 1975, State *v*. N. K.
[27] Electroencephalogram.
[28] KAB CSC 1/1/1/2540, Cape Supreme Court Records, Case no. 34 of 1976, State *v*. B. H. H.

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overprotecting the accused. She was a soft-hearted woman who was completely dominated by her husband whom she feared.

During his formative years the accused made no progress in school. He had a sub-normal intelligence and was difficult to control in a class situation. He left school before he could obtain any certification. The father of the accused blamed the school. In his opinion he did not get a proper education because the school did not discipline him. His father stated that for the accused, the only thing that worked was a belting. The father went as far as to report the principle of the accused's school to the Department of Education, and he would frequently go to the school and cause a scene in the principal's office. The principle, Mr. Venter had felt extremely sympathetic towards the accused and there developed a relationship between them. According to Mr. Venter he would often see the accused bruised and covered in blood. The accused told him that he lived in fear of his father. Mr. Venter never reported this to the police, because he was afraid that the accused would suffer repercussions and stop confiding in him.

According to the report from Valkenberg the accused was co-operative during interviews and his behaviour was appropriate for the situation he was in. There had been no spontaneous show of remorse except when asked direct questions. His thought process was clear and logical and he was able to give a coherent account of himself. There was no evidence, objectively or subjectively, of hallucinations or delusions, and his remote and recent memory were intact except for periods when he had been intoxicated. He could recall the period immediately prior and after the alleged crime, but claimed amnesia for the events of the murder.

The accused was fully orientated in all spheres, and maintained normal conversation throughout a lengthy interview. Testing by a clinical psychologist placed his IQ at 89. He was assessed as falling within the dull-normal range of intelligence and no indication of brain damage could be elicited. Additionally, his EEG[29] also fell within normal limits. It was felt that his poor functioning at school was the result of emotional difficulties and poor adjustment, rather than a reflection of a low intelligence or brain damage. According to the psychiatrist the factors that might have indicated psychopathy included egocentricity, impulsivity, a life without set goals, repeated and persistent anti-social acts which were at times of an aggressive nature, and a failure to profit in a socially acceptable sense of past

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[29] Electroencephalogram.

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experiences. This was complicated by an abuse of alcohol and various drugs leading to a diminution of already precarious self-control.

For the purposes of assessing the diagnoses of psychopathy, the psychiatrist was of the opinion that it was necessary to assess the degree to which he persistently reacts impulsively, without planning or apparent hope of gain and that if a persistent pattern such as this was present other features of psychopathy must have been present. After consideration and consultation with colleagues, the accused was certifiable as a psychopath in terms of the Mental Health Act, but was not psychotic, brain damaged or defective in terms of that Act.

The accused was charged with murder, but Justice Grosskopf found him guilty of culpable homicide and sentenced him to eight years imprisonment. Additionally, he recommended that the accused be treated in terms of Section 30 of the Mental Health Act.

5. 1. 17. State *v*. P. E. C., 1976[30]

The case of the State *v*. P. E. C. is unique because the accused was not disordered due to some pathology, or psychological issue. The accused was charged with murder. He was a 21 year old white male. The medical report from Valkenberg stated that he was in good health, except for an old injury to his leg and knee. According to the welfare report he came from a home where his father's influence was a bad one. His mother was meek and uneducated, and his older siblings were also not a good influence. The accused expressed behavioural problems since his school days. It was clear that the accused was not suffering from mental illness. There was nothing to indicate that he had ever behaved in an abnormally aggressive way. He was at Die Built industrial school and spent time in the army during which "he had shown no homosexual tendencies".[31] He was of bright normal intelligence according to his behaviour in the interview. The accused's behaviour had been appropriate considering his situation.

The accused had expressed remorse for his crime. There were also no evidence of hallucinations or delusions or other psychotic phenomena present. The accused said he had

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[30] KAB CSC 1/1/1/2614, Cape Supreme Court Records, Case no. 216 of 1976, State *v*. P. E. C.

[31] For additional reading on psychiatric abuses in the South African Defence Force with regards to homosexuality see R. Kaplan: "The Aversion Project-Psychiatric abuses in the South African Defence Force during the Apartheid Era," *South African Medical Journal*, (91), (1), 2001, pp. 1-3 & T. F. Jones: "Averting White Male (Ab)normality: Psychiatric Representations and Treatment of 'Homosexuality' in 1960s South Africa," *Journal of Southern African Studies*, (34), (2), 2008, pp. 397-410.

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no memory of the crime due to his intoxication. When the crime was discussed the accused would become tense, blushed and looked distressed, and this emotional reaction was particularly marked when the sexual aspects of the case were discussed. It is acknowledged that the accused was under provocation and according to the medical report he was provoked by something that would not provoke a normal person. The provocation that the report refers to was the possibility of whether the deceased had intercourse with the accused against his will. According to the accused that was the case. The deceased tried to seduce him and told him "come on [redacted], have some of daddy." This provoked the accused and he assaulted the deceased resulting in his death.

There were clinical features of personality disorder present, but these features were not of a degree or persistence to warrant a diagnosis of psychopathy in terms of the Mental Health Act. He was therefore mentally fit to stand trial. Justice Theron found the accused guilty of culpable homicide and sentenced him to three years imprisonment of which two and a half were suspended for three years. Additionally, Justice Theron recommended that he see a prison psychologist.

5. 1. 18. State *v*. D. M. & Others, 1976[32]

The crime in the State *v*. D. M. & Others took place while the defendants were incarcerated. All of the accused were found guilty of murder and each received lengthy sentences. The first three offenders were given the death penalty, including the accused, which is the focus of this case. He was sent to Valkenberg for observation. He, and his fellow eight offenders were charged with murdering a fellow inmate by stabbing him 49 times. The reason D. M. was referred to Valkenberg was because his lawyer was of the opinion that he was a socio-or psychopath. He wanted to determine whether this was true or not.

According to a Dr. Stock called by the accused's lawyer, the accused lost both his parents before he was ten years old. He only stayed in school until standard six. By the age of twelve the accused was in and out of institutions and later prisons. The impression he gave was that he was of a poor personality type and easily influenced by others. He was also unstable and displayed anti-social behaviour. In the opinion of Dr. Stock he would classify him as a sociopathic personality or a psychopathic personality. However, the accused did

[32] KAB CSC 1/1/1/2592, Cape Supreme Court Records, Case no. 160 of 1976, State *v*. D. M & Others.

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have insight into his actions. He was aware of what was wrong and what was right. He rationalized that where he had done something wrong, others were to blame.

Dr. Stock was called to examine the accused to determine whether further examination by a psychiatrist at Valkenberg was necessary. The court agreed and the accused was examined by Dr. Pascoe at Valkenberg. According to Dr. Pascoe the accused was in good physical health and a routine examination revealed a faintly positive blood test for syphilis. Cerebrospinal fluid was positive, however, other tests were negative. The accused could not be considered as brain damaged due to infection. It is clear that some features of psychopathy were present, but the accused remained loyal to his group within the prison and was in turn accepted by that group. This was probably not abnormal in terms of standards of the sub-culture in which he had recently been active in the prison.

The reason for the debate on whether the accused was a psychopath was due to certain features of psychopathy that were present. He showed little remorse for the act of which he was accused. The accused seemed to regard himself as belonging to a culture that was against society.[33] This is common among those in prison or had been in prison. He did not speak with warmth about his family. According to Dr. Pascoe a person can act like a psychopath, but that does not make them one. One needed to look for mental abnormality or instability. Therefore, the accused's social factors and history was the reason that he was in this problem, not psychopathy.

Dr. Pascoe had formed the opinion that the accused was not a psychopath in terms of the Mental Health Act. There was no evidence, objective or subjective, of psychosis and his intelligence was in the average range. He was fit to stand trial and was not ill in terms of the Mental Health Act. Justice Broeksma gave the accused, including the other two guilty of murder the death penalty. The three who were given the death penalty appealed against the sentence. The trial judge granted leave to appeal for the accused against the verdict and the sentence. For the other two he granted leave to appeal the guilty verdict. The appeal judge, Justice Rabie denied their appeal. He determined that the trial court did not err in its decision. All three men were executed.

[33] The accused was a member of the 26 gang in prison.

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5. 1. 19. State *v*. C. L. & A. P., 1976[34]

In the State *v*. C. L. & A. P., the accused murdered a 79 year old white man in Rondebosch. They were working in his garden and decided to steal things from the house. According to one of the accused, A. P. and C. L. went to look for work in Rondebosch and this was where they encountered the deceased. The deceased gave them work to do in his garden. C. L. asked the accused for water and A. P. followed him and the deceased to the back door. C. L. took a rake with him and he hit the deceased with it. He then entered the house and proceeded to take things. According to the testimony of A. P. he was upset with what C. L. had done and was shocked. They left the premises.

The accused, A. P. was born on a farm and illiterate. Psychometric testing placed the accused's intelligence on the borderline group, but not certifiability defective. There was no evidence of hallucinations, delusions or other psychotic features. Dr. Pascoe added that the accused's handicap did not significantly reduce his moral blameworthiness. According to the Valkenberg report of A. P. his left eye was severely damaged. He had no vision in that eye. The injury was caused by a ball when he was 13 years old. The injury had likely been frequently infected. Dr. Pascoe concluded that the accused was not suffering from a mental illness and he was not mentally ill in terms of the Mental Health Act.

According to the Valkenberg report for C. L. he had a bone deficit on the parietal bone on the right side of his skull. According to the Tygerberg hospital records he was admitted because he had a depressed fracture of the skull, and paralysis on his left side. He recovered after they operated on his skull. The reflexes on his right side had still not completely recovered. Although the recovery of strength of movement was almost complete, some clumsiness of the affected limbs persisted. The accused had occasional attacks of grand mal epilepsy. He was given medication at the Tygerberg hospital to control his epilepsy. His EEG[35] exam showed mild slowing at times and was reported as a possible mild abnormality.

C. L. received a disability grant because of his physical disability. An x-ray exam showed that there was no cranial or intracranial disease. The neurosurgeon's examination revealed no abnormality of the nervous system. Unfortunately for the accused he had friends of the anti-social type. He smoked dagga since he was 17 years old and regularly drank wine. The accused was tested by a clinical psychologist and no valid results could be obtained. It

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[34] KAB CSC 1/1/1/2602-2603, Cape Supreme Court Records, Case no. 187 of 1976. State *v*. C. L & A. P.
[35] Electroencephalogram.

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seemed likely to the psychologist that he was purposely malingering. He expressed behaviour and emotion appropriate to his situation and the accused expressed no hallucinations or delusions.

Dr. Pascoe concluded that he had a head injury that resulted in physical disability and epilepsy. The alleged crime did not occur in relation to a fit. He was not certifiably brain damaged. He was not a psychotic, although there were features of psychopathy. In the opinion of Dr. Pascoe, the accused was not psychopathic in terms of the Mental Disorders Act. He was fit to stand trial and not mentally ill in terms of the Mental Health Act of 1973.

According to Justice Baker one or the other of the two accused hit the deceased on the head with a rake and the other one, in all probability, stood by and punched the deceased in the face according to the injuries on the deceased's face. Both of the accused wanted to shift the blame onto one another. Each one of the accused said the other one was the ring leader. The deceased was hit so hard that there was a laceration on his brain and it was severely bruised. The lawyer for the state argued that although, due to the medical reports on the accused, there were extenuating circumstances present, he argued that the offenders treated the old man in an animalistic and barbaric manner. Justice Baker agreed with him and stated that he had the discretion, even in cases where there were extenuating circumstances, to impose the death penalty. Which he subsequently did. They appealed the death penalty, but Justice Baker had denied their leave to appeal and they were executed.

5. 1. 20. State *v*. A. D. v. E., 1976[36]

This details of this case resembled that of of the State *v*. P. E. C. The accused, an 18 year old white male, killed the deceased, a Coloured male by beating him with a piece of iron. He was charged with murder and the court requested a welfare report on the accused. According to the report his mother was a psychotic schizophrenic with lesbian tendencies. She was permanently certified and a patient at Valkenberg. His father was an unemployed man with a sub-normal intelligence. The accused's father and mother had six children in total. One had died and the other four were in foster care.

The mother had allegedly interfered, sexually, with one of her daughters. The family lived in a mixed area in 1962. The accused's behaviour was difficult, especially for his father

[36] KAB CSC 1/1/1/2586, Cape Supreme Court Records, Case no. 115 of 1976, State *v*. A. D. v. E.

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who struggled to control him. His behaviour at school was not any better. In 1974 the accused was arrested for assault and sent to Valkenberg for psychiatric observation. He managed to escape in November of that year, but was caught and brought back to Valkenberg where he stayed until January of 1975. The psychiatrist determined that he was fit to stand trial and was found guilty of common assault and given eight lashes. The psychiatrist referred to him as a pathological liar who denied being involved in the assault, contrary to the evidence.

Regarding the current case, the accused seemed to have no vestige of a conscience regarding the crime he committed. He maintains that he was under the influence of liquor and that the deceased endeavoured to assault him sexually. However, the court could not take him at his word. In his mind the cumulative effect of these factors exonerated him from any possible moral guilt. The court found that the accused was a psychopath in terms of the Mental Health Act of 1973. Justice Theron found him guilty of murder with extenuating circumstances and sentenced him to 10 years imprisonment. He recommended that the accused be treated in terms of section 30 of the Mental Health Act.

5. 1. 21. State *v*. K. E., 1976[37]

The accused, a white male, assaulted a work colleague after he had hit him over the head. The assault led to the deceased's death. According to the accused he had no breakfast on the day and was physically exhausted as a result of very hard manual labour over a period of hours. He had received two painful blows on his head, and that he reacted to this situation with emotions of intense fear and anger.

According to the report from Valkenberg the accused was in good physical health, except that he suffered from epilepsy. He complained of pain and tenderness over an area to the left of the midline of his head. He was a known epileptic. He first received treatment as an out-patient at Valkenberg at the request of his employer. There was no other evidence of mental illness. He was prescribed medication for his epilepsy. He started to have epileptic fits again when he went off his medication. According to the EEG[38] his fits were consistent with grand mal epilepsy. There was no violence that accompanied his fits. The accused had a fit on the day before the murder and on the day of the murder.

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[37] KAB CSC 1/1/1/2588, Cape Supreme Court Records, Case no. 125 of 1976, State *v*. K. E.
[38] Electroencephalogram.

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The accused did not suffer from delusions, his memory was intact, and his IQ was low, however not certifiably low. He was able to understand the proceedings of the court and instruct his defence. The report concluded that he was not mentally ill in terms of the Mental Health Act. Justice Diemont found him guilty of murder with extenuating circumstances and sentenced him to eight years imprisonment of which four years were suspended for three years.

5. 1. 22. State *v*. W. O., 1976[39]

W. O. assaulted a man by throwing rocks at him and by jumping on him resulting in that man's death. He was referred to Valkenberg for 28 days for observation. The reason for his referral was due to a head injury he received two years prior to the alleged crime. The injury caused him headaches. When this occurred he did not receive medical treatment and the wound later became septic. Afterwards a piece of bone came out of the wound and the wound healed. The accused still did not seek medical assistance. The examination confirmed that there was a scar on his head and a bone deficit where the wound was.

According to the report of Dr. Pascoe the accused appeared to have been involved in three previous cases where he was involved in acts of violence. Two cases in 1969 and one in 1974. Dr. Pascoe noticed the gap from 1969-1972 during which the accused was not in trouble. He accepted financial responsibility for his child and had been self-sufficient. His IQ was on the average range. This does not indicate impairment of functionality due to brain injury. During interviews the accused was quiet and co-operative, his mood was "appropriate", and he appeared to be anxious and depressed. He also showed remorse for what he had done. He expressed himself clearly without thought disorder and there was no evidence of hallucinations or delusions.

According to Dr. Pascoe he was not mentally ill in terms of the Mental Disorders Act, the relevant sections retained in the Mental Health Act. Justice Schoek found him guilty of murder with extenuating circumstances and sentenced him to seven years imprisonment.

[39] KAB CSC 1/1/1/2589, Cape Supreme Court Records, Case no. 142 of 1976, State *v*. W. O.

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5. 1. 23. State *v.* M. T. S., 1976[40]

The accused was sent to Valkenberg for examination after he allegedly stabbed a person with a sharp object resulting in their death. He pleaded not guilty and the court found him not guilty and discharged the accused. The accused in this case did not plead, because he was not aware of the deceased's death. The lawyer for the defence motioned that the case against the accused be withdrawn and Justice Baker agreed. It did not appear that the accused was involved in the murder of the deceased. However, it was interesting to refer to this case, because the accused was sent to Valkenberg where it was determined that he might have had possible brain damage. The accused was in a motorcycle accident in his youth which resulted in a head injury. He complained that he suffered periodic headaches, drowsiness, and suffered from sleepiness on occasion. Although the accused was sent to Valkenberg in terms of the Mental Health Act. The court still refers to section 28 (3) of the Mental Disorders Act of 1916.

5. 2. General Trends in the Court, 1973-1976

The criminal cases for this period is dominated by cases where mental illness features quite often. From 1973 we see more cases where mental illness is a factor. The commission of inquiry into the Mental Disorders Act published their report in the previous year, and parliament had been discussing the proposed Bill of the new Act, and discussing the revision of the Criminal procedure Act of 1955. Therefore, it would be accurate to say that issues of mental health and how they relate to crime were of concern to legal professionals and mental health care practitioners.

In the cases from 1973 the old Mental Disorders Act was still being used, particularly sections 27-29 that deals with the procedure to be followed when the accused's mental state comes into question, including the special order declaring an accused a State President's patient. In the case of the State v. J. M.[41] the accused was found to be mentally defective in terms of section 28 of the act. The psychiatrist at Valkenberg deemed him certifiable and the trial judge agreed and he was sent to the hospital section of Polsmoor prison.

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[40] KAB CSC 1/1/1/2586, Cape Supreme Court Records, Case no. 117 of 1976, State *v*. M. T. S.
[41] KAB CSC 1/1/1/2197, Cape Supreme Court Records, Case no. 69 of 1974, State *v*. J. M.

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In the case of G. C.[42], his lawyer argued that he is a psychopath and that the court needed to consider the new legislation that would soon become law. However, the trial judge, Justice Vos, argued that the court must apply the law as it currently is, and not as it will soon be. The commission of inquiry into the Mental Disorders Act defined three concepts that is important when dealing with the mentally disordered. Namely, trialability, certifiability, and responsibility. According to the new proposed act a psychopath could be certified, but according to the new proposed legislation it also appears that the psychopathy could be a factor that would later be handled in the new Criminal Procedure Act, even though the court was unsure when it would be ascended to. Justice Vos made an important point that should be kept in mind when discussing the impact of legislation, especially criminal cases. By interpreting the law as it is Justice Vos maintains that the job of a judge is to interpret the legislation as the legislature indicated it should be interpreted. Therefore it is clear to see what the legislature had intended with the Mental Disorders Act No. 38 of 1916. Additionally, sections 27-29 that had bearing on this case was to be handled in the new Criminal Procedure Act, and according to Justice Vos it was not clear when that would become law. If Justice Vos had considered the new legislation he would have set a precedence in the superior courts that could have had far-reaching consequences. This reasoning on the part of judges, clearly changes during the 1974-1976 period.

The new Mental Health Act became law in 1975. The last case for that year that referred to the old Act was the State v. N. K.[43] in which the accused was deemed mentally disordered because he was considered unfit to plead, and therefore instruct his defence. The first case that used the new Mental Health Act was in the State v. A. B.[44] that deemed the accused not certifiably defective or psychotic in terms of the Mental Health Act. In the case of the State v. B. H. H. of 1976[45] the accused was sent to receive treatment under section 30 of the new Mental Health Act. This section provided the Superior court judge, or the magistrate, with the power to have the convicted accused sent for treatment, or inquire into their mental state. The accused in that case was convicted of culpable homicide.

In the case files from 1976 the Valkenberg reports refer to both the Mental Health Act and the old Mental Disorders Act. This is due to sections 27-29 of the old act being

[42] KAB CSC 1/1/1/2274, Cape Supreme Court Records, Case no. 232 of 1974, State *v*. G. C.
[43] KAB CSC 1/1/1/2320, Cape Supreme Court Records, Case no. 9 of 1975, State *v*. N. K.
[44] KAB CSC 1/1/1/2389, Cape Supreme Court Records, Case no. 165 of 1975, State *v*. A. B.
[45] KAB CSC 1/1/1/2540, Cape Supreme Court Records, Case no. 34 of 1976, State *v*. B. H. H.

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retained in the new act. In the case of the State v. M. T. S.[46] the report says that they were referred to Valkenberg in terms of section 28 of the Mental Disorders Act. In the case of the State v. W. O.[47] the accused is deemed not mentally ill in terms of the Mental Disorders Act, the relevant section retained in the Mental Health Act. The new Mental Health Act is especially concerned with patients who could possibly be psychopaths. Dr Pascoe, the superintendent at Valkenberg reminded the court in the State v. D. M. & Others[48] that a person can act like a psychopath, but that does not make them one.

The increase in cases for 1976, the year after the Mental Health Act was ascended to, can be attributed to an increased awareness of mental health, and mental illness among those accused in criminal cases. However, the full impact of the legislation cannot be seen due to the revised Criminal Procedure Act lapsing and only becoming law in 1977. To be able to evaluate the full scope of the impact if this legislative change, one would have to assess the criminal cases for 1977 to at least 1980. Nevertheless, the details of the courtroom trials presented clearly indicate how debates on procedure and mental health permeated the court room because the very protagonists involved in the debates, were party to the criminal procedure during the trials. In the face of uncertainty, new and old Acts were referred to. Judges, as has already been established in the secondary literature, mentioned in Chapter One, deviated from law if they felt inclined. These court records also suggest that the psychiatrists in turn, deviated from agreed definitions of mental illness and their reflections further contributed to the final decision made by judges on appropriate punishment. The process was therefore guided more by personal considerations rather than legislated certainty.

5. 3. Statistic of Offences 1977-1980[49]

Due to criminal cases for 1977-1980 not being available in the archives, this dissertation will refer to the national statistics for murder and culpable homicide prosecution[50] and conviction rates. Similar to the trend at the Cape Supreme Court the prosecution rate for murder was nationally high with a corresponding lower conviction rate.

[46] KAB CSC 1/1/1/2586, Cape Supreme Court Records, Case no. 117 of 1976, State *v*. M. T. S.
[47] KAB CSC 1/1/1/2589, Cape Supreme Court Records, Case no. 142 of 1976, State *v*. W. O.
[48] KAB CSC 1/1/1/2592, Cape Supreme Court Records, Case no. 160 of 1976, State *v*. D. M & Others.
[49] See Appendix A for the explanation of what each code stands for.
[50] Also referred to as the charge rate.

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The statistics compiled from the archives for 1964-1976[51] show that there is a lower prosecution rate for culpable homicide, nationally the prosecution rate for culpable homicide was comparatively much higher than at the Cape Supreme Court. One would expect that the trend would be the same nationally, considering that culpable homicide was a lesser charge than murder and due to Attorney-General's usually pursuing the maximum charge of murder.

Table 3:Tabulated from the Report of the Statistics of Offences and Penal Institutions, 1977-78[52]

Table of Statistics of Offences and of Penal Institutions						
C1 Murder Statistics for persons over the age of 7						
	Prosecutions			Convictions		
1977-78	TOTAL	Male	Female	TOTAL	Male	Female
Code 148	48	22	26	33	13	20
Code 149	64	60	4	41	40	1
Code 150	17	15	2	11	10	1
Code 151	82	77	5	66	61	5
Code 152	17	17	0	10	10	0
Code 153	28	27	1	12	11	1
Code 154	3 990	3 706	284	1 752	1 626	126
Total C1	4,246	3,924	322	1,925	1,771	154

Table 4: Tabulated from the Report of the Statistics of Offences and Penal Institutions, 1977-78[53]

Table of Statistics of Offences and of Penal Institutions						
C1 Culpabale Homicide Statistics for persons over the age of 7						
	Prosecutions			Convictions		
1977-78	TOTAL	Male	Female	TOTAL	Male	Female
Code 143	1 937	1 846	91	1 186	1 130	56
Code 144	59	54	51	38	35	3
Code 145	111	110	1	65	64	1
Code 146	106	93	13	84	77	7
Code 147	2 134	1 939	195	1 884	1 707	177
Total C1	4,347	4,042	351	3,257	3,013	244

[51] Refer to Chapter 2 for the statistical analysis of criminal cases for murder and murder related crimes, 1964-1976.
[52] Report No. 08-01-10, Statistics of Offences 1968-1969 to 1978-1979.
[53] *Ibid.*

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Table 5: Tabulated from the Report of Statistics of Offences and Penal Institutions, 1979-80[54]

Table of Statistics of Offences and of Penal Institutions **C1 Murder Statistics for persons over the age of 7**						
	Prosecutions			**Convictions**		
1979-80	**TOTAL**	**Male**	**Female**	**TOTAL**	**Male**	**Female**
Code 148	**62**	47	15	**36**	25	11
Code 149	**36**	34	2	**22**	22	0
Code 150	**41**	38	3	**31**	28	3
Code 151	**64**	53	11	**48**	41	7
Code 152	**5**	5	0	**0**	0	0
Code 153	**43**	42	1	**24**	24	0
Code 154	**1 409**	1 326	83	**606**	563	43
Code 155	**46**	42	4	**26**	24	2
Code 156	**40**	39	1	**33**	32	1
Code 157	**107**	89	18	**89**	74	15
Code 158	**4**	4	0	**3**	3	0
Code 159	**48**	47	1	**16**	16	0
Code 160	**2 657**	2 513	144	**1 128**	1 065	63
Total C1	**4,562**	**4,279**	**283**	**2,062**	**1,917**	**145**

Table of Statistics of Offences and of Penal Institutions **C1 Culpable Homicide Statistics for persons over the age of 7**						
	Prosecutions			**Convictions**		
1979-80	**TOTAL**	**Male**	**Female**	**TOTAL**	**Male**	**Female**
Code 143	**1 832**	1 734	98	**1 043**	984	59
Code 144	**55**	51	4	**40**	37	3
Code 145	**69**	67	2	**47**	46	1
Code 146	**94**	85	9	**59**	51	8
Code 147	**2 418**	2 165	253	**2 089**	1 885	204
Total C1	**4,468**	**4,102**	**366**	**3,278**	**3,003**	**275**

[54] Report No. 08-01-11, Statistics of Offences, 1979-1980.

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From the government statistics it can be ascertained that nationally there was a slight increase in murder prosecutions from 4, 246 in 1977-88 to 4, 562 in 1978-80. Correspondingly, the conviction rate for murder increased in 1979-80 from 1, 925 to 2, 062, but as a percentage of the prosecution rate there was a slight decrease from 1977/88 to 1979/80. Similarly with the Culpable homicide prosecution and murder rates there were marginal increases. Interestingly, as in the case with murder, there was a slight decrease of prosecutions for culpable homicide from 1977/88-1979/80. Additionally, how the government would tabulate the statistics changed. Notably, the classifications of White, Coloured, Bantu, and Asiatic were removed, as can be seen from tables 18 to 25.[55] However, the codes were still tabulated according to race, and from 1979-80 there were further classification codes added to the murder section of the government statistics.

These statistics, unlike those tabulated in Chapter Two, do not reflect how mental health was actually considered in the courts. Similarly, the trends and nuances discussed in the various case studies presented throughout this dissertation, are not reflected in the official reports presented by the legal profession. Legal discussions only reflect in case law when that trial deviates from legislated laws and practices. They are reflect on cases sent for Appeal. These are not the original documents of the trial but rather an interpretation of what was most relevant to case law. Focus is therefore placed on what actually deviated from the law compared to how this evolved and if any traces of those eventual changes were present in other trials not necessarily presented as case studies in the legal reports. Three particular reports foreground this observation.

5. 4. Law Reports, 1976-1978

5. 4. 1. State *v*. De Bruyn. 1976[56]

The accused was a 30 year old white male found guilty of three charges of planned and brutal murders. Before he committed the crimes he was convicted of, he was unemployed for a very long time. During that time he met a white woman, Johanna van Jaarsveld, with whom he started a relationship. By day, the pair would roam the streets of Johannesburg begging, telling people false stories of their hardship. They would use the money they got from begging for alcohol. They had no home and would sleep wherever they

[55] See Appendix A for the tabulation of the codes.
[56] S *v*. De Bruyn 1976 (1) SA 496 (A).

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can. There was also another way the appellant and Johanna made money. Johanna would become very friendly with male suitors. She would then accompany these men, whom were under the impression they will be having sex with Johanna, to a room where the appellant would rob or blackmail the victim.

The accused appealed against the death penalty that had been imposed at the Witwatersrand provincial division. The trial court found that there were no extenuating circumstances and imposed the death penalty. In the appeal court it is claimed that the following factors made out a case for extenuating circumstances: (a) according to the respondent his abuse of alcohol over a long period of time, especially his abuse on the days the three murders were committed (b) that he suffered from epilepsy from an early age (c) that he has shown remarkable psychopathic tendencies, coupled with emotional immaturity, and hysterical tendencies.

Every single one of the three victim were lured to a room where they were killed. Two of the victims were killed in November of 1973 and the third in March of 1974 in Port Elizabeth. On the 5th of March 1974 the appellant and Johanna were arrested in Humansdorp. Afterwards the appellant and Johanna appeared at a provincial trial. Based on medical inquiries Johanna was referred to the Sterkfontein Hospital as a State President's patient. Thus, the appellant was the only defendant at the trial. At the trial he denied being the murderer and tried to put all the blame on his accomplice, Johanna. At the trial only two people testified for the appellant. A social worker, Ms Tollman and the superintendent of Weskoppies Hospital, Dr Phyllis Morgan. According to her he did not suffer from any mental illness or defect as described in the Mental Disorders Act of 1916. On the issue of whether he suffered from epilepsy her testimony was as follow:

> There was a history which strongly suggested epilepsy and during his period of observation at Weskoppies three electroencephalograph readings were done. The first two which were done with the accused fasting, which is usual, fasting may bring out more G abnormalities than otherwise, showed some non-specific abnormalities but were still essentially within normal limits. The third one which was done, both fasting and with eight ounces of alcohol given half an hour prior to the test, showed an excess of bi-temporal slow-wave activity. This is a type of recording found frequently in individuals who have a personality disorder and particularly those with aggressive tendencies. Not any of the three E.E.G.'s showed evidence of epilepsy. But this in itself does not exclude the diagnosis of epilepsy. The accused himself, during the period I saw him showed, was never observed in any epileptic seizures or any confusion or episode.

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However, during the examination it was discovered that the appellant did show noticeable psychopathic tendencies. Primarily, he was aggressive and had no shame or showed no remorse for his actions.

According to Dr Coetzee, a clinical psychologist at Weskoppies Hospital who performed certain tests on the appellant, the appellant's intelligence was above average. This was the following summary of his testimony concerning the appellant:" As a whole, it seems to be an emotional, immature personality structure with psychopathic, and to a lesser extent, hysterical tendency".

The appellate division came to the conclusion that any other reasonable court would have come to the same conclusion as the initial conviction. His alcohol abuse was not considered a mitigating factor because he was very much in control of his actions. The court acknowledged that he suffered from epilepsy when he was young, but as an adult the disease did not manifest again. He once lost consciousness when he was transported from Port Elizabeth to Johannesburg, but other than that there are no other clear epileptic fits to go on or a concise history of his epileptic fits.

Lastly, the appellant did not cave under his emotional, immature, psychopathic personality during the murders. His crimes were premeditated. The Appeal Court held in response to the accused's factors that made a case for extenuating circumstances that (a) that he could not have been much affected by the liquor; (b) that the epilepsy had not again shown itself.; and (c) that it had only been established that the appellant had psychopathic tendencies, combined with emotional immaturity and hysterical tendencies, to which the trial Court had given proper consideration. The Court could not find that no reasonable Court could come to any other conclusion than that extenuating circumstances were present, that there was no ground for intervention in the trial Court's sentence. Based on all of the facts discussed, the appeal's court could not find a reason to overturn the original sentence.

5. 4. 2. State *v*. Mnyanda, 1976[57]

This appeal was against a death sentence in the Cape Provincial Division in front of trial judge Justice R. Steyn. The case is concerned with the intention of the legislature that the definition of "mental illness" in Act 18 of 1973 would only come into operation when a

[57] State *v*. Mnyanda 1976 (2) SA 751 (A).

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new Criminal Procedure Act was introduced and when "psychopathy" could be regarded as an extenuating circumstance. The legislature did not intend to insert more into the definition of "psychopathic disorder" in section 1 of the Mental Health Act, 18 of 1973, such as that "abnormally aggressive or seriously irresponsible conduct must be shown to occur in a way which was not deliberately chosen or planned, but was only minimally subject to willed control, and that this type of reaction to situations has been persistent, thus demonstrating that it results from a "persistent disorder or disability of mind", and that other feature of psychopathy must also be present". The legislature also did not intend to impose a tacit limitation on the clinical concept of psychopathy.

The legislature had left this naturally difficult diagnosis to expert medical opinion, with due consideration of the general picture of each particular case, and, in Act 18 of 1973, did not wish to interfere more with the expert medical opinion than was required by the definition of "psychopathic disorder". If acceptable expert evidence showed that a person suffered from a "psychopathic disorder" as defined in the Act, and could be regarded as a patient as defined in section one, then it appears that it was the legislature's intention that he should be dealt with according to the Act. In the absence of any exceptional symptom, a complete psychopath was criminally responsible. As the result of an amendment in 1957[58] the Mental Disorders Act, 38 of 1916, no longer defined a psychopath as a mentally disordered person.

Where a court finds that an accused suffers from a "mental illness" or "mental disability" according to Act 18 of 1973 it must act in terms of sections *28 to 29 bis* inclusive of the Mental Disorders Act, 38 of 1916, as Act 18 of 1973 does not provide for what must be done with the accused in such a case, but has left sections *28 to 29 bis* inclusive in operation. It is clear that section 28 of Act 38 of 1916 concerns the mental condition of the person at the time of trial and not to the mental condition of a person at the time of the committing of the alleged offence, which is dealt with in section 29. It follows, therefore, that section 28 did not deal with the question of responsibility at the time of the commission of the offence, a concept which is specifically mentioned in section 29. In the application of section 28 the question whether the accused must necessarily be placed in a prison or institution pending the decision of the State President must be answered. The legislature intended in Act 18 of 1973 that, for the adjudication of (the responsibility of) a person, the

[58] Deletion of Class VI, as discussed in the Rumpff commission.

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definition of "mental illness" in the Act would only come into operation when the new Criminal Procedure Act, to which reference is made in Act 18 of 1973, was introduced.

The Pro-deo lawyer for the appellant, C. J. de Klerk argued that the trial court had failed to find that the appellant was not a psychopath in terms of the Mental Health Act, 18 of 1973. If the appellant was a psychopath in terms of the definition contained in Act 18 of 1973, he should have been dealt with in terms of section 28 of Act 38 of 1916 and section 27 to 29a of the latter Act, which was not repealed by Act 18 of 1973 and therefore remained in place. Because the definition of the section of Act 38 of 1916 was recalled, section 28 of that act should have been viewed either *in vacuo*[59] or in the light of act 18 of 1973, and thus not to the repealed wording of the first mentioned Act.

This means that appellant should have been treated in terms of section 28 of Act 38 of 1916. It appears from Act 18 of 1973 that the legislature wanted to change the position to also provide for psychopaths. The argument that the legislature did not want to change the position since section 29 of Act 18 of 1973 refers to a non-existent Criminal Procedure Act of 1974[60] in terms of which section 27 to 29 *bis* of Act 38 of 1916 would be repealed by Chapter 13 of the said non-existent Act, is illogical and does not end, as this Criminal Procedure Act does not exist and therefore still has to be looked into. In order to give due consideration to a non-existent act, only reference is made to speculation, and it could possibly even appear that the legislature meant section 28 of Act 38 of 1916 would apply to psychopaths. Alternatively, the court failed to prove that there were no mitigating circumstances after Act 18 of 1973. *Dolus Eventualis*[61] or the absence of *dolus directus*[62] may act alone or in conjunction with other circumstances as a mitigating circumstance.

H. G. Klem for the State argued that the trial court was correct in its ruling that the appellant was not suffering from a psychopathic disturbance as described in section one of act 18 of 1973. The onus rested on the appellant, and he did not indicate in all probability that he was suffering from a psychopathic disturbance as section one of act 18 of 1973. In the alternative, even if the Court of Appeal found evidence that the appellant suffered from a psychopathic disorder, he could not be declared a State President's patient in terms of the

[59] Definition: "Away from or without the normal context or environment".
[60] Only became law in 1977.
[61] Definition: "Foresaw the possibility of their actions resulting in the death of someone but continued regardless".
[62] Definition: "Intent in the form of *dolus eventualis* or legal intention, which is present when the perpetrator objectively foresees the possibility of his act causing death and persists regardless of the consequences, suffices to find someone guilty of murder".

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provisions of section 28 (a) of Act 38 of 1916. Section 27 to 29a of Act 38 of 1916 remained in force and would remain in force until revoked by the new Criminal Procedure Act, which did not yet exist at the time. Section 28 (2) must be read with section two and three of Act 38 of 1916 and not with the wording contained in section one of Act 18 of 1973. A definition is part of the provision in which a defined expression appears as if incorporated into the provision. In order to explain the remaining provisions of a law, which has been partially repealed, a court should have considered the purpose of the Act in its original form and not the purpose of the Act in its cut-off form, except where the partial revocation is apparently intended to change the meaning of the remaining provisions. However, until the new Criminal Procedure Act becomes effective, section 28 (2) of the old act in the light of its own wording remained in effect.

According to the Appeal judge, Justice Rumpff, the factors considered by the trial court for mitigation, as well as the age of the appellant, did not constitute separately or cumulatively, mitigating circumstances. Mitigating circumstances must be considered and weighed within the factual complex of the particular crime.

5. 4. 3. State *v*. Swart, 1978[63]

When the Mental Health Act, 18 of 1973, came into force on 27 March 1975, section 8 of that Act superseded section 5 of the Mental Disorders Act, 38 of 1916, and its operation was not postponed or suspended by reason of the fact that, until the Criminal Procedure Act, 51 of 1977, came into force on 22 July 1977, sections 27, 28, 29 and 29 *bis* of the 1916 Act remained in force. Consequently, where the mental condition of the accused became an issue during the hearing of a criminal charge in a magistrate's court before the Criminal Procedure Act, 51 of 1977, came into force, it was competent for the magistrate either to enquire then and there into the accused's mental condition (under section 28 of the 1916 Act) or to postpone the hearing to enable a magistrate, sitting in a capacity other than that of a criminal judicial officer, to consider whether a reception order should be made under section eight of Act 18 of 1973, committing the accused to an institution as defined in that Act. The appeal argued that when an accused is a chronic alcoholic and appears to have brain damage caused

[63] State *v*. Swart 1978 (1) SA 503 (c).

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by excessive consumption of alcohol, he is *prima facie*[64] in need of treatment in an institution rather than imprisonment.

This appeal was against an order in a magistrate's court refusing a postponement to enable application to be made for a reception order under sec. 8 of Act 18 of 1973 and against sentence. The facts appear from the reasons for judgment. S. Baker argued for the state that on 20 April 1977 and at Bredasdorp the appellant was convicted of drunken driving. On 29 June 1977 he was sentenced to two years' imprisonment and was declared unfit to possess a driving license for an indefinite period. The licence had on or about 7 April 1977 been withdrawn in terms of sec. 75 (2) of the Road Traffic Ordinance, 21 of 1966 (C). The Appellant had two previous convictions for drunken driving and one for driving without a licence. His conviction was in order, and there is no appeal against that. On 19 July 1977 he lodged an appeal against the sentence on the ground that it was inappropriate and excessive. This was superseded by an amended notice lodged on 15 August 1977 and reading as follows:

> Dat die landdros fouteer het deur die aansoek namens appellant om die uitstel van die strafsaak, hangende die oorweging van 'n aansoek om 'n opnemingsbevel kragtens art. 8 van die Wet op Geestesgesondheid, 18 van 1973, van die hand te wys. Dat die opgelegde vonnis buitensporig is in die lig van al die omstandighede van die misdryf en die persoonlike omstandighede van die appellant.[65]

After conviction on 20 April 1977 the case was adjourned to 25 May 1977 for the previous convictions to be proved. They were duly produced and admitted. At this stage the attorney for the accused asked that the proceedings be stayed and that the court should hold an inquiry in terms of sec. 30 of Act 41 of 1971 (an ordinary inquiry involving someone who appears to be an alcoholic, *inter alios*).[66]

The application purported to be made under sec. 341 (1) of Act 56 of 1955 as substituted by sec. 62 of Act 41 of 1971. This section (341) makes the consent of the public prosecutor (given after consultation with a social welfare officer) a prerequisite to the holding of the inquiry. The attorney said his client was such a one as was contemplated in sec. 29 of Act 41 of 1971. The public prosecutor made no objection to the request. The case was therefore postponed so that he could consult the social welfare officer. On resumption

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[64] Definition: “Based on the first impression; accepted as correct until; proved otherwise”.

[65] Translation: That the magistrate has went through the application on behalf of the appellant for the postponement of the criminal case, pending consideration of an application for a notice of institutionalization under section. 8 of the Mental Health Act, 18 of 1973.

[66] Definition: “That the imposed sentence is excessive in the light of all the circumstances of the offense and the personal circumstances of the appellant”.

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(29 June 1977) the public prosecutor said that, after consulting with the social welfare officer, he would not consent to the G conversion (under sec. 341 of Act 56 of 1955) of the proceedings into a rehabilitation inquiry under sec. 30 of Act 41 of 1971.

The public prosecutor explained that he had been informed by Mrs. Volschenk (a social welfare officer) that the accused would not, in her view, benefit by treatment in a rehabilitation centre. She had read a letter written by a psychiatrist at Stikland Hospital, Dr. Hans Rompel and, according to this, the appellant had been five and a half months in Stikland and was discharged upon his own insistence. He was regarded by Rompel as an incurable drinker. Therefore the public prosecutor refused his consent. The attorney agreed that he could not press this application.

The accused's attorney then asked the court to postpone the case until an application already brought before the magistrate in terms of sec. 8 of the Mental Health Act, 18 of 1973, was disposed of. The magistrate would hear this application in a different capacity from that in which he was currently acting. Sec. 8 of Act 18 of 1973 provides that a "reception order" may be made in respect of a person believed to be suffering from mental illness to such a degree that he should be committed to an institution. Certain facts have to be laid before the magistrate requested to make the order.

The court told the attorney that secs. 27 - 29 of the "Wet op kriminele sake" were applicable (he meant the old Mental Disorders Act, 38 of 1916). Secs. 27 - 29 of the 1916 Mental Disorders Act deal with the situation where someone is found to be mentally disordered or defective prior to arraignment or sentence (sec. 27); or mentally disordered or defective on arraignment or during trial (sec. 28); or mentally disordered or defective at the time of the offence (sec. 29). They do not, *prima facie*, appear to have any application to a chronic alcoholic who has been found to be such, or is believed to be such, at the stage when he has already been convicted of drunken driving and now awaits sentence. “Mental illness" in sec. 8 of Act 18 of 1973 is defined in sec. 1 of the Act as being "any disorder or disability of the mind, and includes any mental disease, any arrested or incomplete development of the mind, and any psychopathic disorder...". This definition seems to me to be wider than the concepts of "mental disorder" or "mental defect" contained in the 1916 Mental Disorders Act. It may be, therefore, that chronic alcoholism falls within the concept of "mental illness" contemplated by the 1973 Mental Disorders Act. The attorney for the appellant argued that secs. 27 - 29 of the 1916 Mental Disorders Act did not apply to his client's case, but that sec.

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8 of the 1973 Mental Health Act did. He contended that his client was "mentally ill" in terms of the 1973 Act, and referred to affidavits by Drs Rompel and Van Heerden and accused's son to substantiate this submission.

Dr. Rompel said in his affidavit that accused had brain damage; so did Dr. Van Heerden; and so did Johannes J. Swart, the son. All these affidavits were originally filed in an application to the Supreme Court brought by the son to have his father declared unfit to manage his own affairs, and for the appointment of a *curator bonis*.[67] The attorney's contention was that "brain damage" amounted to “mental illness.” The order which this Court made at this stage is that the sentence of two years' imprisonment was set aside; the refusal of the postponement was set aside; the matter was remitted to the magistrate to reconsider the application for a postponement in order to enable the applicant to bring an application under sec. 8 of Act 18 of 1973, bearing in mind the views expressed by the Court in this judgment. It was not, in this circumstance, found necessary to deal with the second ground of appeal argued by counsel.

5. 5. Chapter Conclusion

In the period of 1974-1980 the majority of the important changes occurred in mental health legislation. The Mental Health Act of 1973 passed in Parliament and became law in 1975. However, the Criminal Procedure Bill of 1973 lapsed and only became law in 1977. Due to the criminal cases in the archive for 1977 not being available, the law reports for 1977-1980 were consulted. The law reports show that there were discussions surrounding mental health legislation taking place in other courts throughout the country. Additionally, the statistics for this period also show an increase in defendants being sent for mental health evaluation, however there was not a corresponding increase in defendants being declared mentally ill in terms of the Mental Health Act of 1973. According to the national statistics for the murder and culpable homicide rates there was nationally a high culpable homicide charge rate, whereas the opposite was the case according to the statistics compiled from archival research for 1964-1976. This indicated that the murder charge was favoured over a charge of culpable homicide. Yet, the conviction rate indicated that culpable homicide was favoured over a murder conviction.

[67] Definition: “A legal representative appointed by the court to manage the finance, property, or estate of another person unable to do so because of mental or physical incapacity”.

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Essentially, this chapter has also shown how despite new Acts being passed, there was a tendency to draw on aspects of previously defunct Acts within court cases and appeals and that even prior to an act being implemented, discussions around those changes became part of the judicial proceedings during expert testimony. It cannot be concluded that this had a direct impact on sentencing practices but during the delivery of the sentence, judges would often draw references to what motivated their sentence. In the cases presented before the Cape Town Supreme court, it is clear that the debates and around mental health, changing fields of psychiatry and psychology and the various commissions of enquiry following the assassination of Verwoerd featured in the court proceedings despite the fact that there were alarming lapses in time between the discussions, Bills and eventual Acts which would change how mental health would be considered in a court of law. The instigators of these considerations were the psychiatrists who in large part therefore had a profound impact on the sentence passed in the event of a guilty verdict being passed. More importantly, it is clear that the debates and eventual resolution to change both mental health and criminal procedural laws allowed a space for greater cohesion between the legal and medical fraternity who took these debates from parliament to the courts. Ironically, the actions of a "madman" who assassinated H. Verwoerd in 1966, led to an overhaul of two major arms of the political landscape in South Africa.

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Conclusion

Chapter Two provided a statistical analysis of murder charges and sentencing practices at the Cape Supreme Court from 1964 to 1976. The most prevalent mitigating circumstances taken into consideration throughout the period under investigation were foreground. Sentencing practices were influence by these extenuating and mitigating circumstances as well as personal eccentricities of the judge. Race, class and notions of respectability were of importance and of course, so too was the severity of the crime. These observations were hardly restricted to the Cape nor were they restricted by the offence under investigation.

Following the assassination of Verwoerd, Chapter Three showed that an inordinate amount of energy was spent on understanding the link between the diseased mind, social upbringing and criminality. Inherent were nature/nurture debates on what made the criminal mind and how best to treat it, if at all. Penology and discussions around prisons, rehabilitation centres, mental institutions or simply eradicating the "beast" were infused in rigorous debates on the state of psychiatry, psychology and the law in what almost appeared to be a moral panic in the mid-1960s and early 1970s. This marked the beginning of a working relationship between these professions as well as produced unlikely forms of support and resistance from organisations such as the Scientologists. It is at this stage that a variety of commissions of inquiry led to major reforms culminating in the amendment to the outdated 1916 Medical Disorders Act in 1973. However, it was only in 1975 that this was ascended to as a major overhaul of the Criminal Procedure Act of 1955 was necessitated to accommodate the changes proposed by the 1973 Mental Health Act. It is the impact of this transition on sentencing practices that becomes the basis for Chapter Four.

Between 1968 and 1971, five cases of murder in which the mental health of the accused is taken into account are delineated. Large portions of the sentencing trends correlated with broader extenuating circumstances and mental health concerns. As the commissions of inquiry into the criminal procedure unfolded some of the issues prevalent in subsequent discussions during the commissions of enquiry lead to serious delay in accepting the Criminal Procedure Bill of 1973. This only occurred in 1977. Chapter Five therefore reflects on twenty-three cases of murder in which mental health was rigorously discussed between 1973 and 1976. This period of the great transition, reflected a much greater understanding of mental health as well as showed more deviations from prescribed sentences

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despite the fact that formally, the criminal procedure was still under review. Here, however, the nuances and debates around mental health and the law, as discussed openly in the courts of law, further provides a glimpse into the nuances attached to the implications of these two Acts of parliament, one still to be implemented at the time. The chapter ends by briefly discussing legal reports which very scantily address three cases in which mental health and criminal procedure are discussed.

The statistics provided by government publications on murder and murder related crimes were limited due to missing information from these statistics. For some of the years only the conviction rates were available. Nationally, they did not reflect the changing discussions that took place. However, the statistical analysis provided in Chapter Two better reflect changes in the charge rates that correspond with contemporary discussions such as the Rumpff Commission, both Van Wyk Commissions, and parliamentary debates. The analysis of the criminal cases at the Cape Supreme Court show that these discussion had been considered by the judiciary well before becoming legislated. The tabulated statistics in Chapter Two indicate that mental illness was given more attention, particularly in the period when the Mental Health Act was still being discussed in parliament, and notably after it became law in 1975, despite the fact that the Criminal Procedure Bill of 1973 was still being debated. The judiciary turned to mental health care practitioners to assist the courts with such cases and as such, it is argued that their personal considerations, thoughts and compassion allowed for verdicts and sentences which deviated from legislated guidelines. Secondary literature has argued that much of the sentencing practices was based on judge's proclivities. This dissertation argues that it relied on the proclivities of both judges and psychiatrists, two professions brought together to discuss pivotal national concerns around redundant mental health and criminal procedure after the assassination of Verwoerd.

The debates from parliament sheds light on the legislative process and logistical nightmare regarding the Mental Health Act of 1973 and the Criminal Procedure Bill of 1973. The Mental Health Act passed rather quickly through parliament, with some members of parliament showing concern over the speed with which such a complex and changing field could be adapted into legislation. Members of parliament appeared to be more in agreement with each other regarding the Act. The recommendations by the commissions of inquiry were amended where necessary and included in the Act. The necessity of a revised mental health law was apparent to all members of the legislature and the psychiatric discipline, therefore the Act passed quickly compared to the Criminal Procedure Bill of 1973. The Criminal Procedure

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Bill of 1973 did not enjoy the same universal approval as the Mental Health Act. Other factors also hindered the bill passing simultaneously with the Mental Health Act, such as the Viljoen Commission and the election year preventing the bill from being reintroduced again. This resulted in sections 27-29 of the old Mental Disorders Act being retained in the new Act. The Commissions of enquiry and debates that were concerned with issues of mental health in South Africa reflected a change from relying on external English laws and remnants of Roman-Dutch law to a more local and context based understanding of mental illness. Additionally, these changes were also in line with modern and international trends.

The secondary literature as discussed in Chapter One highlights the different discussions in sentencing practices during Apartheid. Additionally, Chapter One covered secondary literature that added additional context to the points of discussion in this study. Some of these factors regarding sentencing practices included the race and/or class of the defendant in criminal cases. The cases reflect these assertions although no definable trend could be ascertained in this particular court of law. Historically, black and coloured individuals were seen as intellectually inferior,[1] and lived in deplorable conditions. Therefore, these individuals were more susceptible to psychological and psychiatric problems compared to white individuals. From the commissions of enquiry and the parliamentary debates it can be ascertained that there was a growing appreciation for psychological factors as the cause of mental illness and not strictly pathological causes as proposed by psychiatry. However, in the courts, preference was still given to pathological causes of mental illnesses, however there seemed to be a willingness to accept psychological causes in the case of white defendants.

There were cases where the pathology of mental illness in the accused is considered to have a psychological origin and not a physical one such as brain damage, syphilis, or epilepsy. In the case of the State v. D.[2] the specialist psychiatrist, Dr. Zabow testified that the accused was not mentally disordered due to physical disease such as epilepsy or brain damage, but that he was psychiatrically disordered. The accused's behaviour can be attributed due to his lack of sexual development which caused him to experience problems which manifested in abnormal behaviour. In D.'s case the trial judge was not satisfied that the accused was not mentally disordered, because psychiatric testimony concluded that he was not mentally disordered or defective because of a physical defect such as epilepsy, but psychiatrically disordered. He did

[1] See Chapter 2 for discussion on IQ.

[2] See also the State *v.* G. J. P, 1971. The case is similar to that of D. in the sense that the mental problems experienced by the accused was due to other psychological problems, however only a light cerebral dysrhythmia is present in G. J. P.'s case that deteriorated whenever he was home.

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however concede that the accused was suffering from some psychiatric ailment. This indicates that whereas psychiatrist are well versed in mental illnesses, physical or psychological, the judiciary still considered pathology a more acceptable explanation for crime. This is but one example of the divergence between mental health professionals and the judiciary.

In the criminal cases of this dissertation the most important aspect of mental health which created much confusion for both the mental health and legal professionals is that of psychopathy.[3] The Second Van Wyk Commission[4] was arguably more concerned with the concept of psychopathy than the Rumpff Commission[5] of 1967 that made reference to the deletion of Class VI in the Mental Disorders Act that referred to anti-social behaviour. The Commission noted that this class seemed important considering the importance of psychopathy.

The legislature also did not intend to impose a tacit limitation on the clinical concept of psychopathy. The legislature had left this difficult diagnosis to expert medical opinion, with due consideration of the general picture of each particular case, and, in Act 18 of 1973, did not wish to interfere with the expert medical opinion than was required by the definition of "psychopathic disorder". If acceptable expert evidence showed that a person suffered from a "psychopathic disorder", as defined in the Act, and could be regarded as a "patient" as defined in section one, then it appears that it was the legislature's intention that he should be dealt with according to the Act. In the absence of any exceptional symptom, a complete psychopath was criminally responsible.

These debates were clearly visible in the court trial records. These, in stark contrast to the legal reports, allow a much clearer understanding of the intricate and nuanced manner in which these patchworks of "confusion" were practically negotiated. They also reflect the prevalence of cases in which mental health was actually a point for consideration. In contrast, the legal reports only reflect on three cases where mental illness was a factor for the criminal proceedings. These cases were from the appeals court, and there is one that dealt with the Mental Health Act of 1973 and the proposed Criminal Procedure Bill of 1973. In the State *v.* Myanda[6] the appellant's lawyer argued that the trial court failed to prove that the appellant was

[3] In cases the State *v*. G. J. P, 1971, the State *v*. G. C, 1974, the State *v*. D. M & others, 1976 psychopathy was discussed.
[4] RP 180/1972, *Report of the Commission of Enquiry into the Mental Disorders Act*.
[5] RP 69/1967, *Report of the Commission of Enquiry into the responsibility of mentally deranged persons and related matters*.
[6] State *v*. Mnyanda 1976 (2) SA 751 (A).

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not a psychopath in terms of the Mental Health Act of 1973. Therefore, the trial court did not consider psychopathy as an extenuating circumstance. The case was concerned with the intention of the legislature that the definition of "mental illness" in Act 18 of 1973 would only become law when the new Criminal Procedure Act became law, and when "psychopathy" could be regarded as an extenuating circumstance. The legislature did not intend to insert anything more into the definition of "psychopathic disorder" in section one of the Mental Health Act, 18 of 1973.

The focus of this study was on the legislative changes, such as the Mental Health Act of 1973 and other related legislation, that took place in the aftermath of Verwoerd's assassination in 1966. These changes included the Mental Health Act of 1973 that only became law in 1975 and in addition to this there was the Criminal Procedure Bill of 1973 that was supposed to pass in the house of assembly in tandem with the Mental Health Act of 1973. The Criminal Procedure Act became law in 1977 and there should have been visible change in the sentencing practices of offenders where their mental illness became an extenuating factor. Existing secondary literature has argued that the Mental Health Act of 1973 could only become effective after the changes of Criminal Procedure in 1977. This dissertation argues differently. Analysis of the archival records suggest that the debates surrounding these two major Acts of parliament played a central role in the sentencing of condemned murderers in the courts of law because the very members of parliament, professionals and even organisations asked to contribute to national debates on reform, were the very people asked to provide expert testimony in court. Their reflections affected the outcome of both verdict and trial. Therefore, this dissertation argues that the sentencing practices were rather dependent on the people involved in the trial process rather than on the actual legislative changes which took place during this investigation and this had a direct impact on both verdicts and sentences presented in this dissertation.

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Appendix A

Tabulated Government Statistics of Murder and Culpable Homicide Prosecution and Conviction Rates, 1964-1976

1963-64

Table 6: Government Published Statistics for the Murder Prosecution Rate, 1963-64[7]

Table of Statistics of Offences and of Penal Institutions
C1 Murder Statistics for persons over the age of 7

1963-64	Prosecutions TOTAL	White Male	White Female	Coloured Male	Coloured Female	Bantu Male	Bantu Female	Asian Male	Asian Female
Code 148	**63**	0	2	3	2	14	41	0	0
Code 149	**45**	37	8	0	0	0	0	0	0
Code 150	**29**	0	0	17	2	0	0	9	1
Code 151	**92**	0	0	0	0	87	5	0	0
Code 152	**7**	6	1	0	0	0	0	0	0
Code 153	**14**	14	0	0	0	0	0	0	0
Code 154	**2 933**	0	0	217	25	2 461	205	19	6
Total C1	**3 183**	**57**	**11**	**237**	**29**	**2 562**	**251**	**28**	**7**

Table 7: Government Published Statistics for the Murder Conviction Rate, 1963-64[8]

Table of Statistics of Offences and of Penal Institutions
C1 Murder Statistics for persons over the age of 7

1963-64	Convictions TOTAL	White Male	White Female	Coloured Male	Coloured Female	Bantu Male	Bantu Female	Asian Male	Asian Female
Code 148	**41**	0	0	1	1	9	29	0	0
Code 149	**20**	19	1	0	0	0	0	0	0
Code 150	**15**	0	0	9	2	0	0	4	0
Code 151	**45**	0	0	0	0	42	3	0	0
Code 152	**2**	2	0	0	0	0	0	0	0
Code 153	**3**	3	0	0	0	0	0	0	0
Code 154	**844**	0	0	65	5	707	59	5	3
Total C1	**970**	**24**	**1**	**75**	**8**	**758**	**91**	**9**	**3**

[7] Tabulated from the Statistics of Offences and Penal Institutions, 1963-64.
[8] *Ibid.*

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Table 8: Government Published Statistics for the Culpable Homicide Prosecution Rate, 1963-64[9]

Table of Statistics of Offences and of Penal Institutions C1 Culpable Homicide Statistics for persons over the age of 7									
	Prosecutions	**White**	**White**	**Coloured**	**Coloured**	**Bantu**	**Bantu**	**Asian**	**Asian**
1963-64	**TOTAL**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Code 143	**1 237**	606	33	88	2	453	6	48	1
Code 144	**55**	45	10	0	0	0	0	0	0
Code 145	**72**	71	1	0	0	0	0	0	0
Code 146	**19**	0	0	2	0	14	2	1	0
Code 147	**1 770**	0	0	190	20	1 434	121	5	0
Total C1	**3,153**	**722**	**44**	**280**	**22**	**1,901**	**129**	**54**	**1**

Table 9: Government Published Statistics for the Culpable Homicide Conviction Rate, 1963-64[10]

Table of Statistics of Offences and of Penal Institutions C1 Culpable Homicide Statistics for persons over the age of 7									
	Convictions	**White**	**White**	**Coloured**	**Coloured**	**Bantu**	**Bantu**	**Asian**	**Asian**
1963-64	**TOTAL**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Code 143	**563**	240	12	42	2	248	3	16	0
Code 144	**19**	13	6	0	0	0	0	0	0
Code 145	**27**	27	0	0	0	0	0	0	0
Code 146	**13**	0	0	2	0	10	1	0	0
Code 147	**1 391**	0	0	171	18	1 108	91	3	0
Total C1	**2,013**	**280**	**18**	**215**	**20**	**1,366**	**95**	**19**	**0**

[9] Tabulated from the Statistics of Offences and Penal Institutions, 1963-64.
[10] *Ibid.*

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1965-66

Table 10: Government Published Statistics for the Murder Prosecution Rate, 1965-66[11]

Table of Statistics of Offences and of Penal Institutions
C1 Murder Statistics for persons over the age of 7

1965-66	Prosecutions TOTAL	White Male	White Female	Coloured Male	Coloured Female	Bantu Male	Bantu Female	Asian Male	Asian Female
Code 148	**46**	1	0	1	6	17	21	0	0
Code 149	**41**	38	3	0	0	0	0	0	0
Code 150	**30**	0	0	21	2	0	0	6	1
Code 151	**59**	0	0	0	0	56	3	0	0
Code 152	**5**	5	0	0	0	0	0	0	0
Code 153	**20**	20	0	0	0	0	0	0	0
Code 154	**4 339**	5	0	442	42	3 549	279	25	2
Total C1	**4 540**	**69**	**3**	**464**	**50**	**3 622**	**303**	**31**	**3**

Table 11: Government Published Statistics for the Murder Conviction Rate, 1965-66[12]

Table of Statistics of Offences and of Penal Institutions
C1 Murder Statistics for persons over the age of 7

1965-66	Convictions TOTAL	White Male	White Female	Coloured Male	Coloured Female	Bantu Male	Bantu Female	Asian Male	Asian Female
Code 148	**28**	0	0	0	3	9	16	0	0
Code 149	**14**	13	1	0	0	0	0	0	0
Code 150	**22**	0	0	16	2	0	0	4	0
Code 151	**22**	0	0	0	0	21	1	0	0
Code 152	**2**	2	0	0	0	0	0	0	0
Code 153	**5**	5	0	0	0	0	0	0	0
Code 154	**1 375**	0	0	139	10	1 144	75	7	0
Total C1	**1 468**	**20**	**1**	**155**	**15**	**1 174**	**92**	**11**	**0**

[11] Tabulated from the Statistics of Offences and Penal Institutions, 1965-66.
[12] *Ibid.*

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Table 12: Government Published Statistics for the Culpable Homicide Prosecution Rate, 1965-66[13]

Table of Statistics of Offences and of Penal Institutions **C1 Culpable Homicide Statistics for persons over the age of 7**									
	Prosecutions	**White**	**White**	**Coloured**	**Coloured**	**Bantu**	**Bantu**	**Asian**	**Asian**
1965-66	**TOTAL**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Code 143	**178**	849	37	150	0	646	15	83	1
Code 144	**64**	61	3	0	0	0	0	0	0
Code 145	**48**	47	1	0	0	0	0	0	0
Code 146		0	0		0	34	4		0
Code 147	**2 140**	0	0	214	24	1 776	115	11	0
Total C1	**2 460**	**957**	**41**	**364**	**24**	**2 456**	**134**	**94**	**1**

Table 13: Government Published Statistics for the Culpable Homicide Conviction Rate, 1965-66[14]

Table of Statistics of Offences and of Penal Institutions **C1 Culpable Homicide Statistics for persons over the age of 7**									
	Convictions	**White**	**White**	**Coloured**	**Coloured**	**Bantu**	**Bantu**	**Asian**	**Asian**
1965-66	**TOTAL**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Code 143	**706**	264	2	67	0	327	9	26	0
Code 144	**32**	30	0	0	0	0	0	0	0
Code 145	**16**	16	0	0	0	0	0	0	0
Code 146	**43**	0	0	11	0	31	1	0	0
Code 147	**1 582**	0	0	198	20	1 262	96	6	0
Total C1	**2,379**	**310**	**2**	**276**	**20**	**1,620**	**106**	**32**	**0**

[13] Tabulated from the Statistics of Offences and Penal Institutions, 1965-66.
[14] *Ibid.*

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1967-68

Table 14: Government Published Statistics for the Murder Prosecution Rate, 1967-68[15]

Table of Statistics of Offences and of Penal Institutions C1 Murder Statistics for persons over the age of 7									
1967-68	**Prosecutions TOTAL**	**White Male**	**White Female**	**Coloured Male**	**Coloured Female**	**Bantu Male**	**Bantu Female**	**Asian Male**	**Asian Female**
Code 148	**75**	1	2	1	5	31	33	1	1
Code 149	**60**	52	8	0	0	0	0	0	0
Code 150	**37**	0	0	30	2	0	0	5	0
Code 151	**99**	0	0	0	0	96	3	0	0
Code 152	**3**	3	0	0	0	0	0	0	0
Code 153	**18**	17	1	0	0	0	0	0	0
Code 154	**4,751**	0	0	447	41	3,886	343	30	4
Total C1	**5,043**	**73**	**11**	**478**	**48**	**4,013**	**379**	**36**	**5**

Table 15: Government Published Statistics for the Murder Conviction Rate, 1967-68[16]

Table of Statistics of Offences and of Penal Institutions C1 Murder Statistics for persons over the age of 7									
1967-68	**Convictions TOTAL**	**White Male**	**White Female**	**Coloured Male**	**Coloured Female**	**Bantu Male**	**Bantu Female**	**Asian Male**	**Asian Female**
Code 148	**34**	0	1	0	2	9	21	0	1
Code 149	**20**	18	2	0	0	0	0	0	0
Code 150	**18**	0	0	15	0	0	0	3	0
Code 151	**59**	0	0	0	0	58	1	0	0
Code 152	**1**	1	0	0	0	0	0	0	0
Code 153	**9**	9	0	0	0	0	0	0	0
Code 154	**1,456**	0	0	144	7	1,261	120	12	2
Total C1	**1,597**	**28**	**3**	**159**	**9**	**1,328**	**142**	**15**	**3**

[15] Tabulated from the Statistics of Offences and Penal Institutions, 1967-68.
[16] *Ibid.*

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Table 16: Government Published Statistics for the Culpable Homicide Prosecution Rate, 1967-68[17]

Table of Statistics of Offences and of Penal Institutions C1 Culpable Homicide Statistics for persons over the age of 7									
	Prosecutions	**White**	**White**	**Coloured**	**Coloured**	**Bantu**	**Bantu**	**Asian**	**Asian**
1967-68	**TOTAL**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Code 143	**2,245**	1,052	47	167	3	814	16	644	75
Code 144	**36**	33	3	0	0	0	0	8	0
Code 145	**64**	62	2	0	0	0	0	146	0
Code 146	**35**	0	0	10	0	23	1	0	0
Code 147	**2,398**	0	0	264	35	1,911	178	0	0
Total C1	**4,778**	**1,147**	**52**	**441**	**38**	**2,748**	**195**	**798**	**75**

Table 17: Government Published Statistics for the Culpable Homicide Conviction Rate, 1967-68[18]

Table of Statistics of Offences and of Penal Institutions C1 Culpable Homicide Statistics for persons over the age of 7									
	Convictions	**White**	**White**	**Coloured**	**Coloured**	**Bantu**	**Bantu**	**Asian**	**Asian**
1967-68	**TOTAL**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Code 143	**934**	362	16	88	3	402	11	52	0
Code 144	**21**	19	2	0	0	0	0	0	0
Code 145	**23**	23	0	0	0	0	0	0	0
Code 146	**23**	0	0	8	0	14	1	0	0
Code 147	**1 800**	0	0	235	29	1,387	146	3	0
Total C1	**2,801**	**404**	**18**	**331**	**32**	**1,803**	**158**	**55**	**0**

[17] Tabulated from the Statistics of Offences and Penal Institutions, 1967-68.
[18] *Ibid.*

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1969-70

Table 18: Government Published Statistics of the Murder Conviction Rate, 1969-70[19]

Table of Statistics of Offences and of Penal Institutions C1 Murder Statistics for persons over the age of 7	
	Convictions
1969-70	**TOTAL**
Code 148	40
Code 149	11
Code 150	6
Code 151	29
Code 152	0
Code 153	5
Code 154	1,209
Total C1	**1,300**

Table 19: Government Published Statistics of the Culpable Homicide Conviction Rate, 1969-70[20]

Table of Statistics of Offences and of Penal Institutions C1 Culpable Homicide Statistics for persons over the age of 7	
	Convictions
1969-70	**TOTAL**
Code 143	801
Code 144	23
Code 145	31
Code 146	6
Code 147	1,573
Total C1	**2,434**

[19] Tabulated from the Statistics of Offences, 1968-1969 to 1978-1979.
[20] *Ibid.*

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1971-72

Table 20: Government Published Statistics of the Murder Conviction Rate, 1971-72[21]

Table of Statistics of Offences and of Penal Institutions C1 Murder Statistics for persons over the age of 7	
	Convictions
1971-72	**TOTAL**
Code 148	20
Code 149	24
Code 150	3
Code 151	31
Code 152	3
Code 153	7
Code 154	1,065
Total C1	**1,153**

Table 21: Government Published Statistics of the Culpable Homicide Conviction Rate, 1971-72[22]

Table of Statistics of Offences and of Penal Institutions C1 Culpable Homicide Statistics for persons over the age of 7	
	Convictions
1969-70	**TOTAL**
Code 143	1,150
Code 144	26
Code 145	36
Code 146	25
Code 147	2,422
Total C1	**3,659**

[21] Tabulated from the Statistics of Offences, 1968-1969 to 1978-1979.
[22] *Ibid.*

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1973-74

Table 22: Government Published Statistics of the Murder Conviction Rate, 1973-74[23]

Table of Statistics of Offences and of Penal Institutions C1 Murder Statistics for persons over the age of 7	
	Convictions
1973-74	**TOTAL**
Code 148	29
Code 149	23
Code 150	4
Code 151	27
Code 152	1
Code 153	12
Code 154	1,367
Total C1	**1,463**

Table 23: Government Published Statistics of the Culpable Homicide Conviction Rate, 1973-74[24]

Table of Statistics of Offences and of Penal Institutions C1 Culpable Homicide Statistics for persons over the age of 7	
	Convictions
1969-70	**TOTAL**
Code 143	1,060
Code 144	27
Code 145	40
Code 146	36
Code 147	2,430
Total C1	**3,593**

[23] Tabulated from the Statistics of Offences, 1968-1969 to 1978-1979.
[24] *Ibid.*

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1975-76

Table 24: Government Published Statistics of the Murder Conviction Rate, 7975-76[25]

Table of Statistics of Offences and of Penal Institutions C1 Murder Statistics for persons over the age of 7	
	Convictions
1975-76	**TOTAL**
Code 148	22
Code 149	18
Code 150	16
Code 151	56
Code 152	1
Code 153	12
Code 154	1,655
Total C1	**1,780**

Table 25: Government Published Statistics of the Culpable Homicide Conviction Rate, 1975-76[26]

Table of Statistics of Offences and of Penal Institutions C1 Culpable Homicide Statistics for persons over the age of 7	
	Convictions
1969-70	**TOTAL**
Code 143	1,304
Code 144	34
Code 145	54
Code 146	83
Code 147	2,632
Total C1	**4,107**

[25] Tabulated from the Statistics of Offences, 1968-1969 to 1978-1979.
[26] *Ibid.*

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Codes

1964-1980

Code:	**Explanation:**
143	Culpable homicide as a result of driving a vehicle
144	Culpable homicide: White by White
145	Culpable homicide: Non-white by White
146	Culpable homicide: White by Non-white
147	Culpable Homicide: Non-white by Non-white
From 1979-80 Murder With a Firearm:	
148	Murder as a result of Infanticide
149	Murder: White by White
150	Murder: White by Coloured or Asiatic
151	Murder: White by Bantu
152	Murder: Murder: Coloured by Asiatic or White
153	Murder: Bantu by White
154	Murder: Non-white by Non-white
From 1979-80	Murder with another weapon:
155	White by White
156	White by Coloured or Asian
157	White by Black
158	Coloured or Asian by White
159	Black by White
160	Non-white by Non-White

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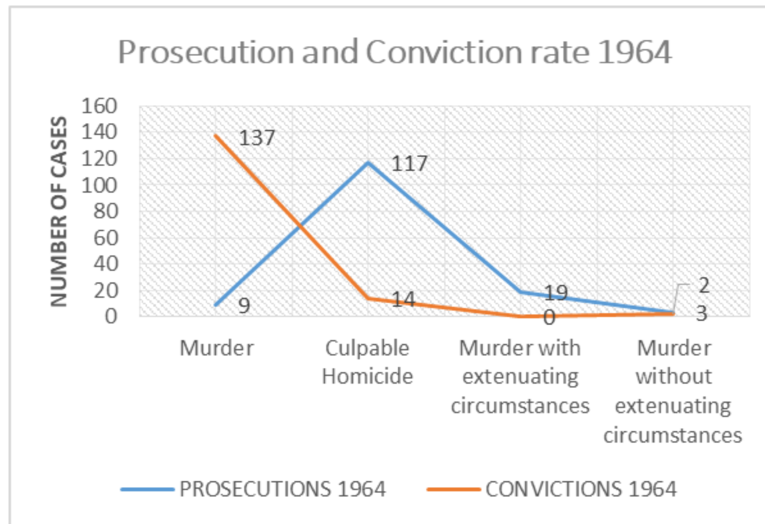
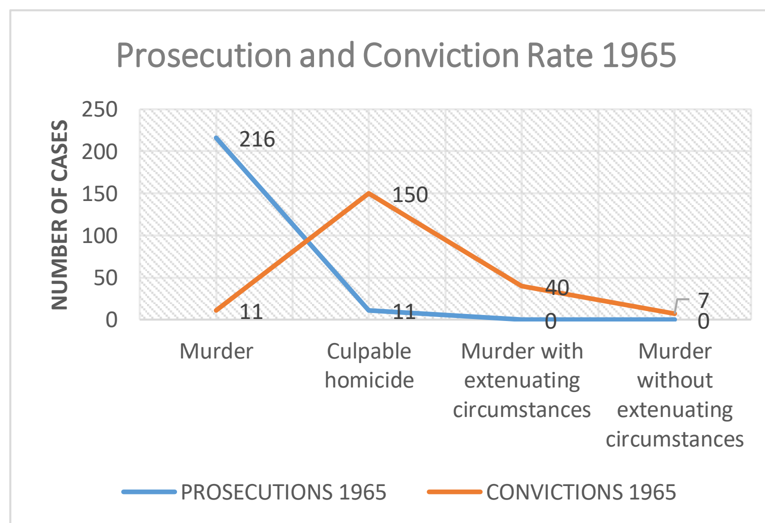
Appendix B

Graphs of the Prosecution and Conviction rate of Murder and Murder related cases for 1964-1976

Graph 1: Prosecution and Conviction rate, 1964[27]



Graph 2: Prosecution and Conviction rate, 1965[28]



[27] Tabulated from KAB CSC 1/1/1/581-627, Cape Supreme Court Records, 1964.
[28] Tabulated from KAB CSC 1/1/1/628-730, Cape Supreme Court Records, 1965.

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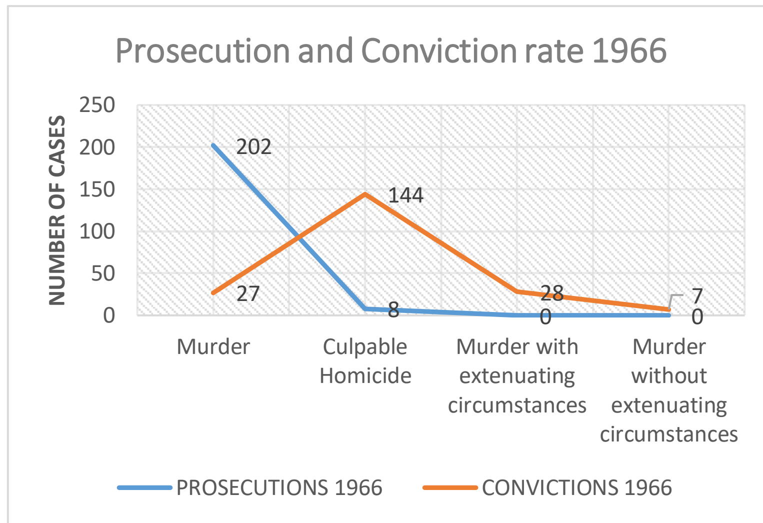
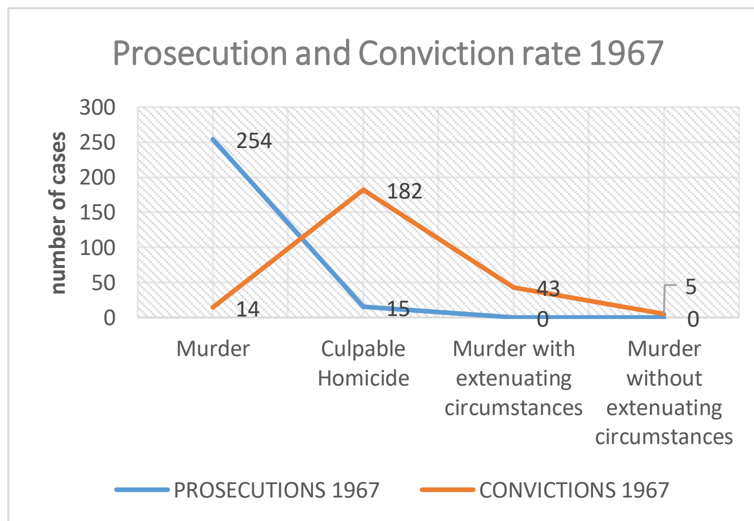
Graph 3: Prosecution and Conviction rate, 1966[29]



Graph 4: Prosecution and Conviction rate, 1967[30]



[29] Tabulated from KAB CSC 1/1/1/731-856, Cape Supreme Court Records, 1966.
[30] Tabulated from KAB CSC 1/1/1/857-981, Cape Supreme Court Records, 1967.

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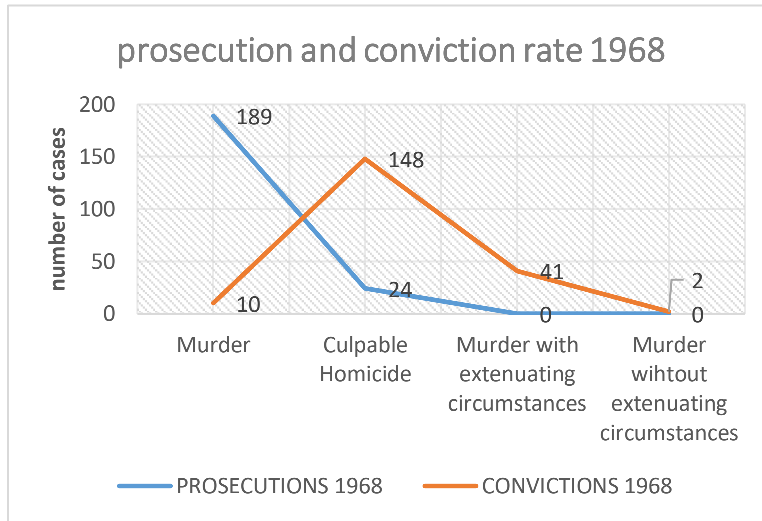
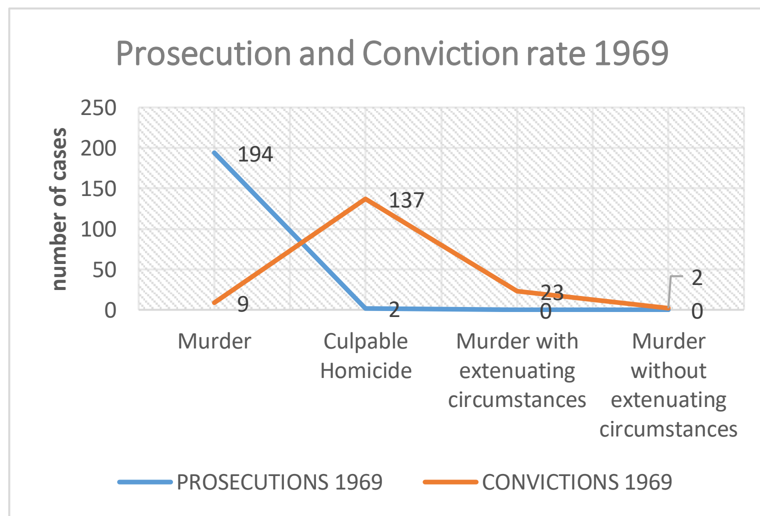
Graph 5: Prosecution and Conviction rate, 1968[31]



Graph 6: Prosecution and Conviction rate, 1969[32]



[31] Tabulated from KAB CSC 1/1/1/982-1152, Cape Supreme Court Records, 1968.
[32] Tabulated from KAB CSC 1/1/1/1153-1327, Cape Supreme Court Records, 1969.

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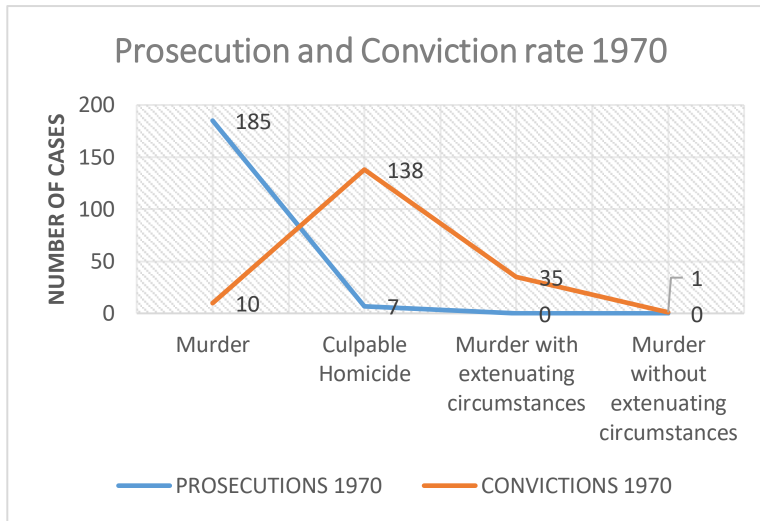
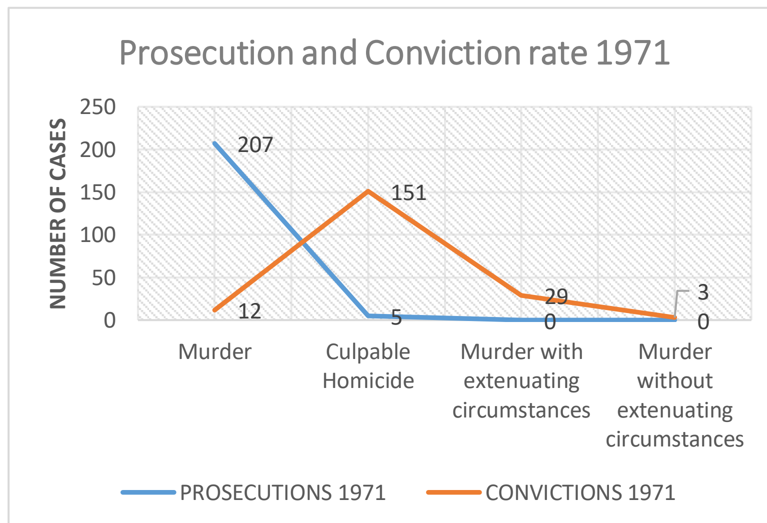
Graph 7: Prosecution and Conviction rate, 1970[33]



Graph 8: Prosecution and Conviction rate, 1971[34]



[33] Tabulated from KAB CSC 1/1/1/1328-1511, Cape Supreme Court Records, 1970.
[34] Tabulated from KAB CSC 1/1/1/1512-1713, Cape Supreme Court Records, 1971.

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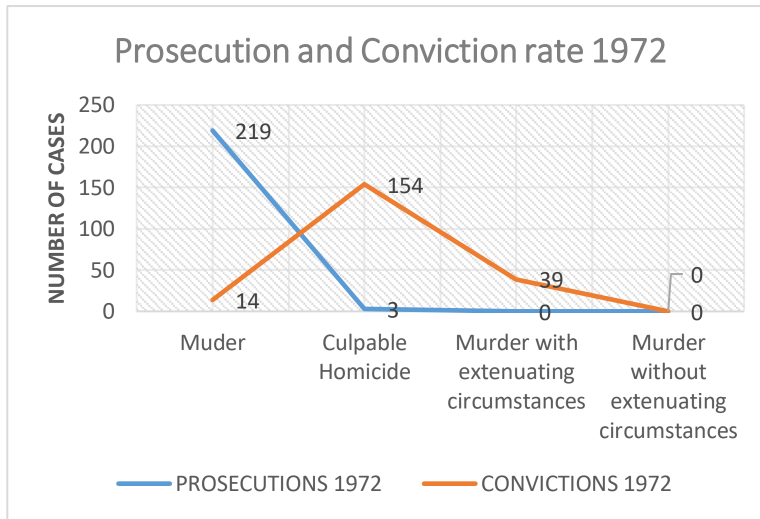
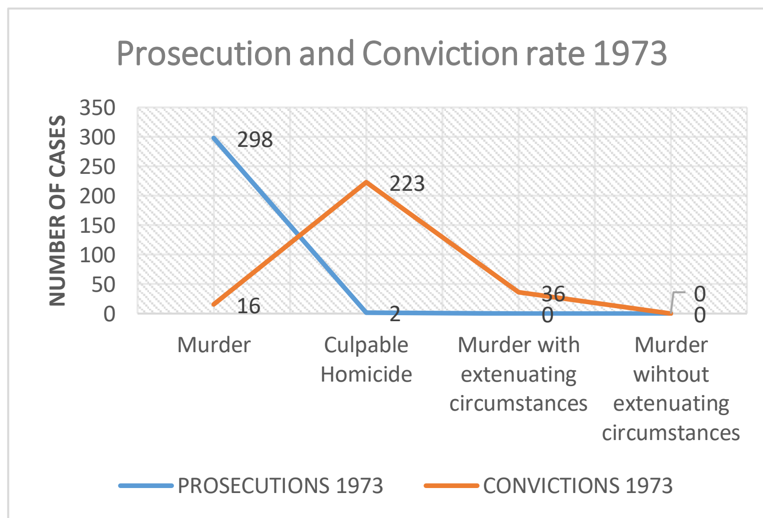
Graph 9: Prosecution and Conviction rate, 1972[35]



Graph 10: Prosecution and Conviction rate, 1973[36]



[35] Tabulated from KAB CSC 1/1/1/1714-1910, Cape Supreme Court Records, 1972.
[36] Tabulated from KAB CSC 1/1/1/1911-2165, Cape Supreme Court Records, 1973.

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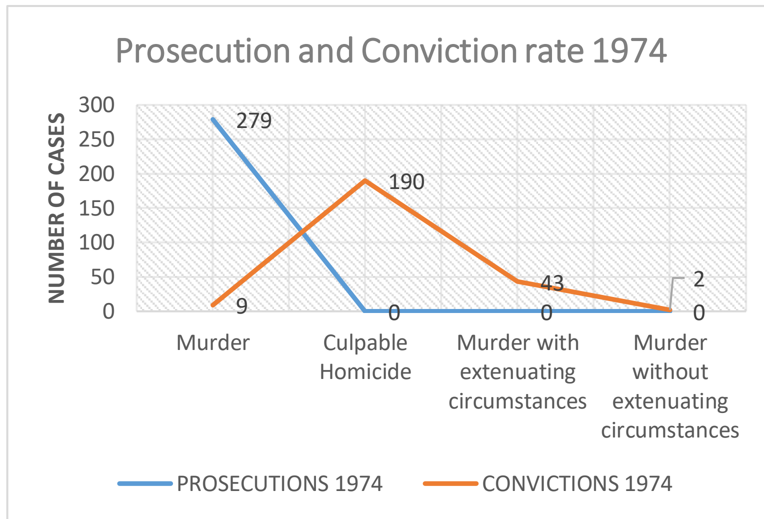
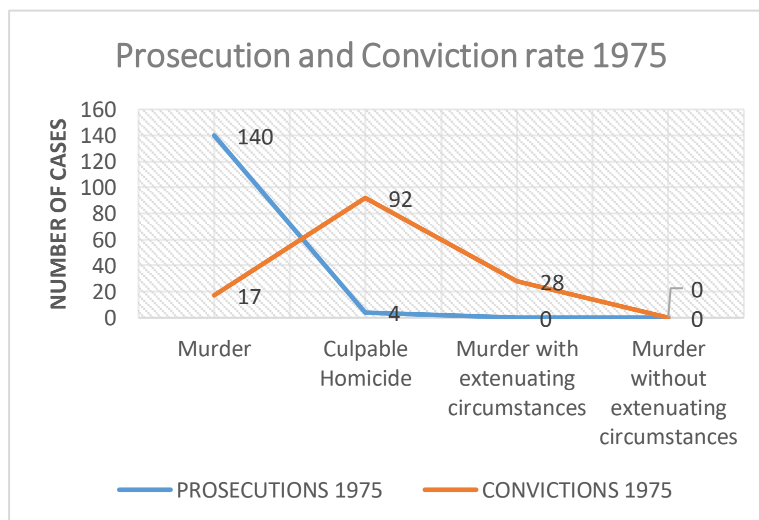
Graph 11: Prosecution and Conviction rate, 1974[37]



Graph 12: Prosecution and Conviction rate, 1975[38]



[37] Tabulated from KAB CSC 1/1/1/2166-2319, Cape Supreme Court Records, 1974.
[38] Tabulated from KAB CSC 1/1/1/2320-2579, Cape Supreme Court Records, 1975.

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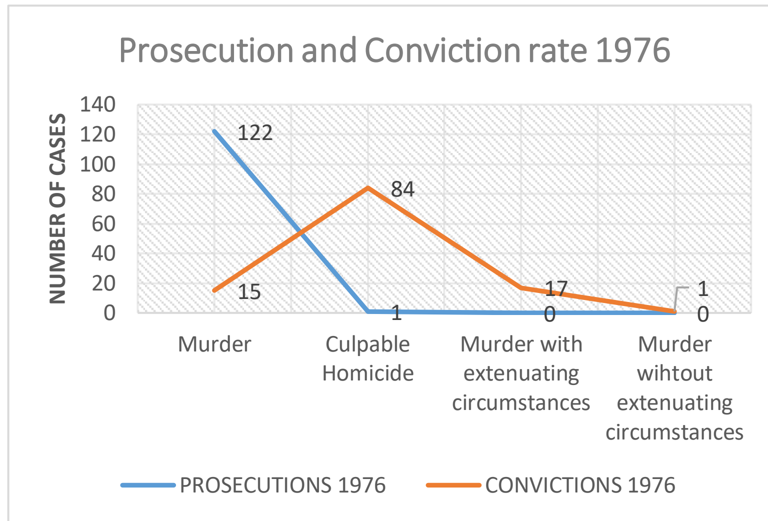
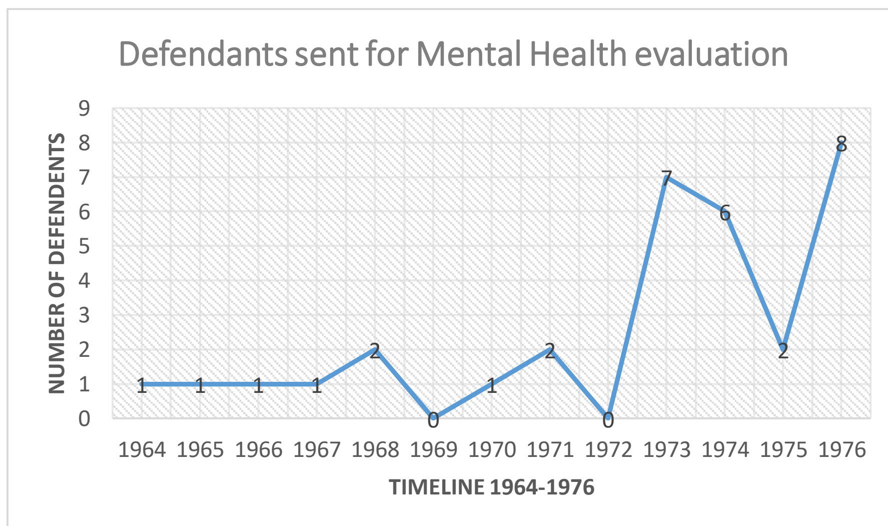
Graph 13: Prosecution and Conviction rate, 1976[39]



Defendants sent for Mental Health Evaluation, 1964-1976[40]



[39] Tabulated from KAB CSC 1/1/1/2580-2714, Cape Supreme Court Records, 1976.
[40] Tabulated from KAB CSC 1/1/1/581-2714, Cape Supreme Court Records, 1964-1976.