BioCore
Exploring Scientific Community

International Journal of Criminal and Forensic Science

Case Report
ISSN 2576-3563

Crime but no Punishment: Guilty but Mentally Sick in Transkei Region of South Africa. A Case Report

Banwari Meel*

Department of Forensic Medicine, Walter Sisulu University, Mthatha, P/Bag X1, Mthatha 5117, South Africa

Abstract

There is high crime and mental disorders in the Transkei region of South Africa. Many of them are guilty but mentally sick. The mentally sick may be perpetrator of crime or vice versa. The mental sickness may not used as a defence. If it is used, then confined to serious offences such as murder. This is because it is not very well known among public as well as in custodian of law enforcement, result in serious consequences. This case report was a young male who was suffering from epilepsy, and beaten his mother and a neighbour inadvertently. He was charge for his crime and taken into prison. He was devoid of anti-epileptic treatment in the prison, and resulted into coma. He was treated successfully in Umtata General Hospital, and then referred to prison hospital. Again, there was lack of care, ended into status epilepticus, and death. The history of the case along with its management and lack of care has described. The rule of diminished responsibility was not exercised is discussed

Keywords: Crime, Epilepsy, Insanity, Prisoner, Law Enforcement

Corresponding author: Banwari Meel

Department of Forensic Medicine, Walter Sisulu University, Mthatha, P/Bag X1, Mthatha 5117, South Africa. **Tel:** 047 502 2963, 047 502 2963, **Fax:** 047-502 2107, **Cell:** 0822007460,

E-mail: meelbanwari@yahoo.com

Citation: Banwari Meel (2018), Crime but no Punishment: Guilty but Mentally Sick in Transkei Region of South Africa. A case report. Int J Cri & For Sci. 2:2, 60-61

Received: March 29, 2018
Accepted: April 04, 2018
Published: May 30, 2018

Introduction:

Epilepsy directly affects 50 million people worldwide.[1] Human neurocysticercosis is recognised as an important cause of epilepsy in regions where the parasite occurs. However, it is largely underreported and there is a lack of data about the disease burden. [2] We surveyed the clinical records kept at the outpatient psychiatric clinic at the Umtata Hospital, Transkei.The four commonest psychiatric disorders diagnosed at the clinic were schizophrenia, depression, epilepsy, and anxiety states. Other diagnoses included alcoholism, hysteria, confusional states and organic brain syndromes.[3]

One hundred and fifty-eight epileptic patients belonging to the Nguni tribe in Transkei were interviewed and examined; electro encephalograms (EEGs) were recorded in 104. Partial epilepsy with secondary generalized seizures were diagnosed in 59%. Headtrauma appeared to be the main etiological factor in 18%. Thirty-five percent of the EEGs taken showed epileptiform activity.[4] Aggressive behaviour in epileptics may have many Causes, which are connected more or less closely with epilepsy.[5]

Courts have accepted that epileptics sometimes commit unlawful acts as a result of an epileptic seizure. Reason for this unlawful behaviour may be found in the interictal, ictal and post-ictal phases of the seizure.6 Ictal aspects include the specific part of the brain from which the seizure Originates, the loss of integration of incoming sensorial stimuli with motor-emotional output, the loss of higher control associated with a reversion to primitive automatic behaviour and the emergence of repressed feelings and aggressive instincts.[6]

How many of them are guilty but mentally sick? Insanity as a defence is actually not raised very often. The insanity defence is raised in less than 1% of cases in United States, and is successful only in a fraction of those. The vast majority of those that are successful, are the result of plea agreement in which the prosecution and the defence agree to a not guilty by reason of insanity.[7] The purpose of this case report is to highlight the problem of insanity and crime.

Case history:

ND, a 23-year-old, known male epileptic had beaten his mother and a neighbour in their location. On charges of assault, he was taken to prison on magisterial orders. Although he had passed standard 10, he remained unemployed. He did odd jobs for an income and smoked cigarettes, cannabis and consumed alcohol. The reason for the assault had been the mother's boyfriend. He had lost his father when young due to an illness he contracted whilst working in the mines.

He has been on antiepileptic treatment but had not disclosed to prison authorities about it. He was found unconscious in the cell and was brought to Umtata General Hospital. He regained consciousness after 2 days and later discharged. On discharge, he was admitted to the prison hospital. After a week there, he had developed continuous fits, then lapsed into a coma and died.

Discussion:

The lack of literature on epilepsy and related violence, but a few observations indicate that there is a heavy burden of epileptic patients in this region. A study carried out in 2004 showed that the overall prevalence of cysticercoids in South Africa is about 10%, but in Transkei, it is about 20%. There is also a high (30 to 40%) prevalence of epilepsy between 20 and 40 years of age groups. HIV/AIDS has complicated the picture, as both co-infections are not uncommon.[8] This is because of the fact that that people in this region eats poorly cooked pork meat. A possible relationship between epilepsy and violence could be assumed by sudden murder without provocation, and motive. There is a high crime rate and psychiatric disorders in the Transkei region of South Africa. It is not sure, whether high psychiatric disorders are the cause or effect of this crime. The annual incidence of violent and/or traumatic deaths in the Transkei region of South Africa is 162 per 100,000 populations. Firearm-related deaths, at 43 per 100,000 of the population per year, have contributed substantially to this high incidence.[9]

There is increasing use of the 'diminished legal responsibility' and 'insanity' defences in cases where a person is suffering from epileptic fits in United States, but this is not true in Africa. In this case, ND was taken to police custody, and shifted to prison by the order of magistrate. Neither the police nor the judiciary were aware of the law related with diminished responsibility in an epileptic person who commits crime. There are few studies showed that epilepsy is the underlying cause of violence. A study conducted by Devinsky (2008) described that after a series of fits, an attack of mental disturbance may come on which lasts for several days. It is simply demented state, or there may be hallucinations, with irritability and even violence.[10] There is two-to fourfold increase in prevalence of epilepsy in prisoners compared with normal population. Many of these studies had suggested a high prevalence of epilepsy in young violent offenders. A prisoners study carried out by Gunn and Bonn (1971) showed that the prevalence rate of epilepsy among prisoners 8.8 per 1000. Seventeen percent of epileptic has committed an act of violence compared with 11% of non-epileptic sentenced.[11]

ND has committed crime of beating her mother as well as a neighbour. He is a guilty of crime, and treated in similar fashion as non-epileptic. It is surprising that despite of the fact that ND was treated in Mthatha General Hospital, and taken back to prison hospital; the family physician fail to advise the prisoners authorities the problem of epilepsy. It is not sure that how many of prisoners were treated in similar fashion. The prisoner's authorities must provide necessary medical care for persons in their legal custody, and the practitioners of family medicine must know the legal aspect of medical practice.

References:

1.Bandstra NF, Camfield CS, Camfield PR. Stigma of epilepsy. Can J Neurol Sci. 2008; 35(4):436-40.

2.Praet N, Speybroeck N, Manzanedo R, Berkvens D, Nsame Nforninwe D, Zoli A, Quet F, Preux PM, Carabin H, Geerts S. The disease burden of Taenia Solium Cysticercosis in Cameroon. PLos Negi Trop Dis. 2009; 3(3):e406.

3.Gijana EW, Louw J. Psychiatric disorders in a developing community as reflected by archival material. S Afr Med J. 1981; 59(27):988-91.

4.Newton CR, Gero BT. The epilepsies among rural blacks. S Afr Med J. 1984; 66(1):21-3.

5.Steinert T, Froscher W. Differential diagnosis of aggressive behaviour in epilepsy. Psychiatr. Prax. 1995; 22(1):15-8.

6.van Rensburg PH, Gagiano CA, Verschoor T. Possible reasons why certain epileptics commit unlawful acts during or directly after seizures. Med. Law. 1994; 13(3-4):373-9.

7.Perlin M. The jurisprudence of the Insanity Defense, Carolina Academic Press, 1994.

8.Awotedu AA, Foyaca-Sibat H. Human cysticercosis in Eastern and Southern Africa. Cysticercosis Working Group for Eastern and Southern Africa. A conference held at University of Transkei, Eastern Cape Province, Mthatha, 7-11 June, 2004.

9.Meel BL. Incidence and patterns of violent and/or traumatic deaths between 1993 and 1999 in the Transkei region of South Africa. J. Trauma 2004; 57(1):125-9.

10.Devinsky O. Post-ictal psychosis: common, dangerous, and treatable. Epilepsy Curr. 2008;8(2):31-4.

11.Gunn J, Bonn J. Criminality and violence in epileptic prisoners. The British J. Psychiatry, 1971; 118:337-343.