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# Aspects of the Insanity Defence in South Africa and New Zealand: The Case of Lauren Dickason

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## ABSTRACT

This article examines the insanity defence in South Africa and New Zealand through the lens of the widely publicised case of R v Dickason. In September 2021, Mrs Lauren Dickason killed her three daughters in Christchurch, New Zealand, and raised a plea of insanity, which was rejected, leading to her conviction for murder. Against this factual backdrop, the article explores the concept of mental illness from both a clinical and legal perspective, tracing its definitions, diagnostic classifications, and relevance for criminal responsibility. The discussion highlights similarities and differences in the development and application of the insanity defence in the two jurisdictions, with reference to leading statutory provisions and case law. By situating the Dickason case within these frameworks, the article illustrates the challenges courts face in reconciling psychiatric evidence with legal standards of culpability and responsibility and reflects on the limits of criminal law in addressing offences committed under conditions of severe mental illness.

## 1. Introduction

Burchell[1] explains that mental illness may deprive persons of the capacity to appreciate the unlawfulness of their conduct. It may also deprive them of the capacity to control their conduct. A person who suffers from a mental illness that has such an effect is said - in legal terms - to be 'insane'. The mentally ill, however, are a distinct subgroup within the penal system.[2] The underlying premise of the insanity defence is that 'insane persons' are the victims of an affliction that causes them to behave in an abnormal manner, which is beyond their control. To be fair they cannot be blamed for their conduct while afflicted by the illness. The test for capacity is entirely subjective,[3] for example, relating to the capacity of the particular accused person who is alleged to be 'insane'.[4]

The scope and purpose of this article is to discuss certain aspects of the insanity defence in South Africa and New Zealand with reference to the case of Mrs Lauren Dickason. Further reference is made to the classification of mental illness, the concepts of mental illness in a legal and clinical context and a discussion of the Lauren Dickason case. Due to the fact that it is an article of limited scope, only certain aspects are touched upon. For a more detailed discussion, see the sources referred to in endnote 4 and more sources referred to throughout this article.

The following research methodologies are employed: A literature study of the Constitution, statutes, and case law as primary sources of law is followed. In addition, textbooks and writings of authors as secondary sources of law are utilised. Other sources include the internet and electronic databases.

## 2. The facts of the Dickason case

On 16 September 2021, the unthinkable happened. Lauren Anne Dickason, a South African immigrant, murdered her three daughters, 6-year-old Liané, and 2-year-old twins Maya and Karla at her home in Timaru, New Zealand.[5] After admitting to killing her children, she went under trial, denying that it was murder, but instead pleaded insanity or infanticide. She was found guilty of murdering her three children on 16 August 2023 and was sentenced on 26 June 2024 to 18 years in prison with the possibility of parole within six years.[6] She will first be transferred to a mental institution due to her ill mental condition. Lauren's husband, Graham Dickason, is an orthopaedic surgeon and Lauren was a part-time surgeon assistant to him after her first baby died. Lauren experienced multiple fertility struggles; to have her children, she had IVF done seventeen times and needed donor eggs in the end.[7] In 2013, she had her first child, named Sarah, who had to be born after 18 weeks of pregnancy.[8] She died shortly after. Lauren was diagnosed with a 'major depression order with underlying anxiety' in 2015, that was linked to postpartum depression caused by the loss of Sarah. She reportedly experienced flashbacks of the loss of her child, sleep difficulties, crying, suicidal thoughts, panic attacks, restlessness, detached feelings, and intrusive thoughts.[9]

In May 2019, Lauren saw a psychiatrist after experiencing homicidal thoughts towards her children. This episode had been triggered after she and her nanny struggled with putting her twins to bed. Lauren has spoken about Karla being a difficult child, saying that Karla lashed out often, slapped and bit her.[10] Without consulting her doctor, Lauren stopped taking her antidepressant medication in March 2021 but subsequently resumed her medication regime in August 2021. Lauren experienced thoughts about harming and killing her children. She confided in her husband Graham, who reacted with anger and convinced her to resume her antidepressant medication. She continued to experience homicidal thoughts following a foot surgery but did not disclose them since she feared it would affect their immigration plans.[11]

In August 2021, Lauren experienced thoughts about using cable ties to asphyxiate her children after witnessing her husband and the girls playing with cable ties in the family garage. The incident occurred two weeks before the family emigrated to New Zealand. Lauren became withdrawn and

communicated less and cried frequently.[12] During testimony, her mother Wendy recalled that her mental condition deteriorated during that period, and she had experienced significant weight loss. Following two weeks in managed isolation, the Dickason family arrived in Timaru on 11 September 2021, five days before the children died. Lauren was unhappy during her time in Timaru, taking issue with the appearance of the town's residents and describing local rental accommodation as 'small, disgusting and creepy'. These issues led her to regret emigrating to New Zealand.[13] According to defence experts, she became fixated on these issues to the point that they became delusions reinforced by her depression. The night of the murders Graham went out with colleagues, leaving Lauren alone with the children. After gathering the children in a bedroom, she told them they were going to make necklaces with cable ties and tricked them into wearing the ties around their necks. Lauren then asphyxiated the children, starting with Kayla and then Liané and Maya. Dickason told police officers that Kayla had been 'really horrible' to her recently and that Liané had fought back.[14]

Since the children were still breathing, Lauren then smothered them with a towel and their blankets. Afterwards, she tried to commit suicide with a knife and by taking pills. The children's bodies were discovered in their beds by Graham after coming back home from the work event. On 18 September, Lauren appeared in the Timaru District Court and was later remanded to a forensic psychiatric ward at Christchurch's Hillmorton Hospital. She was later placed in a hospital psychiatric unit. At Hillmorton Hospital, she was interviewed by five forensic psychiatrists and psychologists for 53 hours.[15] Three of them, Hatters-Friedman, Barry-Walsh and Metoui, believed she was severely mentally unwell and could claim a defence based on insanity. The two others, Monasterio and McLeavey believed that she killed her children out of anger and control, including not wanting to let another woman parent her children if she either died and Graham remarried.[16]

The question was if Mrs Dickason could plead insanity and whether such defence could succeed. Before continuing with her case, the concept of the defence of insanity in South Africa and New-Zealand is now discussed to serve as a background to her circumstances.

## 3. The concept of mental illness

### 3.1 MENTAL ILLNESS IN A CLINICAL AND LEGAL CONTEXT

Mental illness in a clinical context is defined as: [17]

> … a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (for example a painful symptom) or disability (for example impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (for example, political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual …

Mental illness is a disorder (or a disease) of the mind that is judged by experts to interfere substantially with a person's ability to cope with the demands of life on a daily basis. It can profoundly disrupt a person's thinking, feeling, moods and ability to relate to others. Mental illness is manifested in behaviour that deviates notably from normal conduct. The landmark analysis of mental illness by the United States surgeon general states that it is "the term that refers collectively to all diagnosable mental disorders". However, according to Bartol the word "illness" encourages us to look for etiology, symptoms and

cures and to rely heavily on the medical profession both to diagnose and to treat. It further encourages us to excuse the behaviour of persons plagued with the "illness". The term mental disorder need not imply that a person is sick, to be pitied, or even necessarily less responsible for his or her actions.

Mental illness in a legal context is defined as:[18]

> … a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health practitioner authorised to make such diagnosis.[19]

3.2 CLINICAL ASPECTS OF MENTAL ILLNESS

Mental or psychiatric illness is a vast subject, however, one which is of great importance in legal matters, particularly those with regard to medical law, criminal law and the law of delict. The various conditions range from a mild anxiety state to which we are all prone - the full blown-picture of insanity. Compartmentalising of mental illness is difficult but can be explained under the headings of anxiety disorders; psychoneurosis and psychosis, which is divided into functional psychosis (including bipolar disorder and schizophrenia) and the organic types of psychosis. In addition to frank psychiatric illness, one must also consider personality disorders, for example antisocial personality disorder. These disorders are disorders of the mind that interfere substantially with a person's ability to cope with life on a daily basis.

Forensic psychiatry operates at the interface of two disparate disciplines, namely law and psychiatry. Although most cases in forensic psychiatric practice produce little conflict, functioning at the interface of these two disciplines can lead to confusion and ethical dilemmas. Forensic psychiatry can be defined as follows:

Forensic psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters; forensic psychiatry should be practiced in accordance with guidelines and ethical principles enunciated by the profession of psychiatry.

Most forensic psychiatrists do not see themselves as functioning outside of their medical and psychiatric roles. They see themselves (and probably generally are perceived) as utilising their medical and psychiatric skills and techniques. Controversy exists regarding to whom the forensic psychiatrist owes a duty. This problem is part due to the fact that a standard doctor-patient relationship does not apply. Stone believes that psychiatry enters an ethical morass when it leaves the clinical situation as in the case of forensic psychiatry.

## 4. System of classification of mental illness

Diagnosis and classifications in psychiatry have undergone tremendous changes in the last 40 years. Before the 1950's, diagnoses were not only unreliable but even had meanings that varied considerably across the world. By the end of that decade, 'anti-psychiatrists', including Laing,[20] and Szasz[21] had started to suggest that diagnoses and classifications in psychiatry should be abandoned, together with the concept of mental illness.[22] In the 1960's, the World Health Organization instigated a world-wide programme aimed at improving diagnosis and classification of mental disorders, fostering research into the reliability of diagnosis and classification. The mental health section of the *International Classification of Diseases* is currently in its 11th edition (ICD-11). The American Psychiatric Association developed its own classificatory system, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM); the current classification, DSM-5-TR,[23] was published in 2000.[24]

An examination of a person with psychiatric or psychological problems begins with the attempt to recognise the individual pattern of symptoms and experiences that leads to the establishment of a specific psychiatric diagnosis. This diagnosis should be expressed in a particular nomenclature according to a recognised classification system. The fundamental purpose of diagnosis and classification in medicine is to define a group of discrete disease entities, each of which is characterised by a distinct pathophysiology and / or aetiology. However, for most psychiatric

diseases the approach is based more on phenomenology than pathophysiology or aetiology.[25]

The two main current systems of classification in South Africa are the ICD-11 and the DSM-5.[26] It is important to note that there are textual differences between ICD-11 and DSM-5, but according to treaties between the United States of America and the World Health Organization, the diagnostic code numbers must be identical to ensure uniform reporting of national and international psychiatric statistics.[27] ICD-11 is a uniaxial system, which attempts to standardise by using descriptive definitions of the syndromes and operational criteria, as well as producing directives on differential diagnosis. DSM-5 is a multiaxial system, which relies on operational criteria, rather than descriptive definitions. It states which symptoms need to be present (often quantifying their number and requiring a specific length of time for symptoms to be present) as well as exclusion criteria.[28]

A multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome.[29] The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psycho-social and environmental problems as well as the level of functioning that might be overlooked if the focus were on assessing a single presenting problem.[30]

## 5. The insanity defence in South Africa

### 5.1 THE HISTORY OF THE INSANITY DEFENCE

The exemption of the mentally ill person from full criminal punishment dates back to at least the Code of Hammurabi.[31] Children, because of the innocence of their intentions, and the mentally ill, because of the nature of their misfortune, were excused from punishment under the *Lex Cornelia*. In the matter of legal responsibility or culpability for wrongdoing, the Roman law followed a principle stated in one of the opinions of Paulus, namely that a mentally ill person, like an infant, was incapable of malicious intent and the will to insult. Accordingly, he was considered immune from any action for damages.[32]

The modern insanity defence was born in 1843. The M'Naghten Rules (also spelled McNaughton) were the first serious attempt to codify and rationalise the attitude of criminal law toward a mentally ill accused. These rules arose from the attempted assassination of the British Prime Minister, Robert Peel, in 1843 by Daniel M'Naghten. M'Naghten shot Minister Peel's secretary, Edward Drummond, who died five days later. The medical evidence was in substance this: That persons of otherwise sound mind, might be affected by morbid delusions: that the prisoner was in that condition: that a person so labouring under a morbid delusion, might have a moral perception of right and wrong, but that in the case of the prisoner it was a delusion which carried him away beyond the power of his own control, and left him no such perception; and that he was not capable of exercising any control over acts which had a connection with his delusion: that it was of the nature of the disease with which the prisoner was affected, to go on gradually until it had reached a climax, when it burst forth with irresistible intensity: that a man might go on for years quietly, though at the same time under its influence, but would all at once break out into the most extravagant and violent paroxysms. Hereafter, the House of Lords instructed a panel of judges, presided over by Sir Nicolas Conyngham Tindal, Chief Justice of the Common Pleas, to set down guidance for juries in considering cases where an accused pleads insanity. The rules formulated as M'Naghten's Case 1843 10 C & F 200 have been a standard test for criminal liability in relation to mentally ill defendants in common law jurisdictions ever since, with some minor adjustments. When the tests set out by the Rules are satisfied, the accused may be adjudged 'not guilty by reason of insanity' and the sentence may be a mandatory or discretionary (but usually indeterminate) period of treatment in a secure hospital facility, or otherwise at the discretion of the court (depending on the country

and the offence charged) instead of a punitive disposal. The M'Naghten rules are sometimes referred to as the 'right and wrong test'.[33]

## 5.2 THE INSANITY DEFENCE IN SOUTH AFRICA[34]

### 5.2.1 *Fitness to stand trial*

Since 1977 the defence of insanity has been governed by statute.[35] In terms of section 77 of the Criminal Procedure Act, an accused who suffers from mental illness or defect may as a result not be fit to stand trial.[36] The enquiry into the capacity of the accused to understand the nature of the trial process is seen as a preliminary issue that has to be finalised before the issue of criminal responsibility for the conduct is examined. Burchell[37] argues that this approach can severely prejudice an accused who has a defence to the charge or where the State has a weak case against him or her. The Criminal Matters Amendment Act[38] addressed this problem. Section 3(b) of this Act provides that the court may order that such evidence be placed before the court so as to determine whether the accused committed the act. This enquiry can be initiated by the prosecution, the defence or by the court of its own accord. The court usually relies on medical evidence and must be satisfied that there is a reasonable suspicion that the accused lacks the capacity to appreciate the nature of the trial proceedings or to conduct a proper defence.[39] Such capacity to understand can be challenged at any stage of the proceedings.[40]

### 5.2.2 *The test to determine criminal responsibility*

If the defence of insanity is raised, the test to determine the accused's criminal responsibility must be applied. This test is set out in section 78(1) of the Criminal Procedure Act.[41] Section 78(1) reads as follows:

A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or intellectual disability which makes him or her incapable—

(a) Of appreciating the wrongfulness of his or her act or omission; or

(b) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission, shall not be criminally responsible for such act or omission.

It is clear from the content of section 78(1) that the words 'an act which constitutes an offence' do not refer to an offence for which the accused is liable, but only to an act which corresponds to the definitional elements of the relevant crime.

It is important to note that since the decision of the court depends on the facts and the medical evidence of each case, Rumpff JA stated in *S v Mahlinza*[42] that it is impossible and dangerous to attempt to lay down any general symptom by which a mental illness could be recognised as a mental 'disease' or 'defect'. Therefore, for the purposes of the insanity defence in South Africa, there is no formal definition of mental illness. However, the court held in *S v Stellmacher*[43] that in order to constitute a mental illness or defect it must at least consist in: '[A] pathological disturbance of the accused's mental capacity and not a mere temporary mental confusion which is not attributable to a mental abnormality but rather to external stimuli such as alcohol, drugs or provocation.'[44] Furthermore, every person is presumed not to suffer from a mental illness or mental defect so as not to be criminally responsible in terms of section 78(1), until the contrary is proved on a balance of probabilities.[45] Whenever the criminal responsibility of an accused with reference to the commission of an act or an omission which constitutes an offence is in issue, the burden of proof with reference to the criminal responsibility of the accused shall be on the party who raises the issue.[46]

In terms of section 78(2), if it is alleged at criminal proceedings that the accused is by reason of mental illness or mental defect or for any other reason not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court must in the case of an allegation or appearance of mental illness or mental defect, and may, in any other case, direct that the matter

be enquired into and be reported on in accordance with the provisions of section 79.[47]

In the case of S v Kavin,[48] Kavin was charged on three counts of murder. He took a gun one evening and shot his wife and two children. When his sister asked him what was going on, he replied that it was only a car backfiring. His defence was one of insanity. An inquiry in terms of section 78 of the Criminal Procedure Act was held. Kavin suffered from severe reactive depression super-imposed on a type of personality disorder displaying immature and unreflective behaviour. In the opinion of Dr Shubitz and Dr Garb it produced a state of dissociation. Both these psychiatrists as well as Prof Bodemer agreed that Kavin could not act in accordance with an appreciation of the unlawfulness of his act. They based their opinion on the basis of progressive depression. He was therefore not regarded as being criminally responsible for the acts in question. He was thereafter admitted in a psychiatric clinic in terms of section 78(6) of the Criminal Procedure Act.

#### 5.2.3 *Panel for purposes of enquiry and report under sections 77 and 78*

In terms of section 79 of the Criminal Procedure Act, the court can refer an accused at any stage of the trial for a psychiatric or psychological assessment of his or her mental state with reference to either section 77 or 78 of the Criminal Procedure Act. The Act distinguishes between offences that involve serious violence and those that are non-violent.[49] The accused is usually admitted to a state psychiatric hospital under a warrant for a period of observation for 30 days. Effectively the court must appoint a panel of two or three psychiatrists if the alleged offence involved serious violence. The court has the discretion to appoint a clinical psychologist as well. The court may, for the purposes of the relevant enquiry, commit the accused to a psychiatric hospital or to any other place designated by the court, for such periods not exceeding thirty days at a time, as the court may from time to time determine, and where an accused is in custody when he is so committed, he shall, while he is so committed, be deemed to be in the lawful custody of the person or the authority in whose custody he was at the time of such committal.[50] When the period of committal is for the first time extended under paragraph (a), such extension may be granted in the absence of the accused unless the accused or his legal representative requests otherwise.[51]

According to Kaliski,[52] it is important to note that the critical first stage in any assessment is to determine whether the accused is suffering from a mental illness or whether there are other psychological or psychiatric factors that are associated with the terms of referral. The Criminal Procedure Act requires that mental illness or defect must be present before the question of whether the accused is fit to stand trial or criminally responsible can be examined. However, the courts will demand a variety of deeper insights into the accused and his or her behaviour. Consequently, it is good practice to conduct complete clinical examinations and to learn how to anticipate the court's requirements.

## 6. The mentally ill offender: Lauren Dickason

The relationship between disorder and crime varies from case to case and a failure to consider the alternatives sometimes leads to erroneous conclusions. Although not uniform, the relationship between mental illness and crime is not so variable as to be unique to each case. According to Dietz,[53] certain patterns occur with sufficient frequency that should be considered in every case. He describes the five patterns frequently observed among mentally ill offenders (according to the relationship between the mental illness and the criminality) as:

**Pattern 1:** *Crime in response to psychotic symptoms:* Crimes committed in obedience to command hallucinations or in accordance with other psychotic perceptions sometimes meet cognitive tests of insanity, but it is less clear whether they ever meet volitional tests of insanity, which prove for exculpation of offenders who acted under an irresistible impulse or whose capacity to conform their conduct to the requirements of law was impaired substantially by mental disease at the time of the offence.[54]

**Pattern 2:** *Crime to gratify compulsive desire:* In these cases, mental illness provides the motive for the crime but does not impair the offender's knowledge of what he or she is doing or that it is wrong. Examples are crimes motivated by sexual sadism; crimes committed by kleptomaniacs and illegal gambling by compulsive gamblers.

**Pattern 3:** *Crime reflecting personality disorder:* Many mentally ill offenders are pattern three offenders, most often antisocial adults or conduct-disordered youngsters. Some of these defendants have other conditions as well that provide an arguable, though sometimes unsuccessful basis for presenting an insanity defence or for mitigation at sentencing, for example, post-traumatic stress disorder.

**Pattern 4:** *Coincidental crime and mental illness:* In this pattern there occurs to be a crime committed, which is unrelated to and not a result of the person's mental illness. It illustrates the coincidental occurrence of mental illness and criminality in a single individual.[55]

**Pattern 5:** *True or feigned mental illness in response to crime:* This pattern refers to the offender developing symptoms of mental illness that were not present before or during committing the crime. Such cases often pose a difficult diagnostic challenge, particularly because there are usually no pre-offence psychiatric records. Perhaps the most diagnostically challenging of all cases are talented and well-trained malingerers,[56] such as those who have succeeded in malingering mental illness for so long that they have learned all the symptomatic nuances from fellow patients or those who have been trained to enact the role of multiple personality disorder by therapists and examiners who specialise in the condition.[57]

Dietz[58] explains that pattern 1 offenders do meet legal criteria for insanity, depending on the facts of each case and the applicable legal standards. It is arguable whether or not pattern 2 offenders ever meet legal criteria of insanity. Offenders evidencing only patterns 3, 4, or 5 are not candidates for an insanity defence.[59]

## 7. The insanity defence in New Zealand[60]

The insanity defence, also known as the mental disorder defence, is an affirmative defence by excuse in a criminal case, arguing that the defendant is not responsible for their actions due to a psychiatric disease at the time of the criminal act. Section 23 of the Crimes Act[61], which defines the insanity defence, provides that: (1) Everyone shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.

According to section 23(2) No person shall be convicted of an offence by reason of an act done or omitted by him or her when labouring under natural disease of the mind to such an extent as to render him or her incapable-

(a) of understanding the nature and quality of the act or omission; or

(b) of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

According to section 23(3) insanity before or after the time when he or she did or omitted the act, and insane delusions, though only partial, may be evidence that the offender was, at the time when he or she did or omitted the act, in such a condition of mind as to render him or her irresponsible for the act or omission and according to section 23(4) the fact that by virtue of this section any person has not been or is not liable to be convicted of an offence shall not affect the question whether any other person who is alleged to be a party to that offence is guilty of that offence. In *Cameron v R* [62] the defence depended on a presumption of sanity, imposing a legal burden on the defendant to make out the defence on the civil standard of balance of probabilities. Framing the defence according to a 'two limb' model of assessing responsibility, section 23(2)(a) applies whereas a result of 'disease of the mind' the defendant was 'incapable' of 'understanding the nature and quality of the act or omission'. This is a focus on the physical act or omission, a requirement in effect that the

defendant did 'not know what he was doing'. The limb applies where the defence is automatism attributable to a disease of the mind or a case where a delusion renders the accused unaware of the character of the act.

The second limb in section23(2)(b)[63] applies where, as result of disease of the mind, the defendant is incapable of 'knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong'. The Court of Appeal describes the 'paradigm case' as where a delusional defendant acted intentionally while believing the act was justified. However, the Court of Appeal has held that the incapacity standard relative to both limbs is not an objective standard but depends simply on whether the defendant understood the nature and quality of their acts or knew the acts were wrong. The consequences for people acquitted on account of insanity are serious. They are likely to be detained for some years in a mental health facility, for periods that correlate with the time they would have served in jail if found guilty of the offence. It is not a legal loophole to avoid punishment.[64]

## 8. An analysis of the Lauren Dickason case

Now that aspects of the insanity defence in South Africa and New-Zealand were discussed, a discussion of the case of Lauren Dickason continues. On 15 October 2021, Beaton (Lauren's lawyer) told a court hearing in Christchurch that Dickason would plead not guilty to the three charges of murder although she never denied killing her children. A trial date for March 2023 was set in Timaru. The trial of Lauren Dickason commenced on 17 July 2023 at the Christchurch High Court. While the Crown has argued that Lauren murdered her children because she resented the impact they had on her marriage, she has not pleaded guilty to murder due to insanity or infanticide.[65] Infanticide means where a woman causes the death of any child of hers under the age of ten years in a manner that amounts to culpable homicide, and where at the time of the offence the balance of her mind was disturbed, by reason of her not having fully recovered from the effect of giving birth to that or any other child. The jail sentence cannot exceed three years.[66]

She told doctors that she was not 'hearing' commands to kill her children, and that the decisions were made on her own. Graham testified that he found three sets of cable ties inside a wardrobe after returning to the Dickason family home in South Africa. The Crown also played Graham's police interview where he claimed that Lauren was not a nurturing mother and the children particularly the twins preferred being around him. He also testified that Lauren suffered from stress and depression while living in South Africa due to her fertility troubles and safety issues.

He further testified that his wife had confided her thoughts about killing their children on at least three occasions. Davies, a teacher from Timaru's Christian School testified that Lauren had confided that she was struggling inside despite appearing calm. Detective Mitchell also submitted hundreds of text messages from Lauren's phone to friends and her husband between 2016 and 16 September 2021. Several of the text messages discussed her relationship problems and her struggles with depression, anxiety, self- harm, and raising twins. On 26 July, the Crown rested its case. Lauren's defence lawyer Anne Toohey delivered her opening address to the jury, arguing that the defendant's decision to kill her children was 'spontaneous' because Lauren believed that her and the children's lives were not worth living and 'that they were all better off dead'. It was argued that Lauren was mentally unwell, due to post-partum depression. Another relative testified that Lauren never recovered from the death of her first child Sarah.[67]

On 27 July, the defence's first expert witness Dr Hatters-Friedman, a forensic and reproductive psychiatrist was introduced. Hatters-Friedman spent four days interviewing Lauren and testified that she frequently had 'thoughts and images' about killing her children. Hatters-Friedman testified that Lauren - on the night of the children's murder - told them

that she was ill and going to die, and that she killed them because she believed that nobody was going to look after them. She also reiterated the defence's case that the Lauren was suffering from post-partum depression when she killed her children.[68] On 31 July, the forensic psychiatrist and Canterbury District Health Board clinical director Dr Erik Monasterio, who was summoned by the Crown as an expert witness, testified that Dickason had trouble bonding with her three children. Monasterio testified that Lauren told him that she made sacrifices to ensure that Graham could go hunting and work, which increased her frustrations with her children. On 1 August, Monasterio claimed that Lauren killed her children out of anger rather than insanity or postpartum depression, citing evidence from her fourth interview in April 2022.[69]

On 2 August, the defence accused Dr Monasterio of being biased due to his alleged dislike for Lauren. On 3 August, Dr McLeavey, a consultant psychiatrist at Hillmorton Hospital and the first psychiatrist to interview Lauren following her children's deaths, testified that she "had the capacity to engage meaningfully" and discussed her previous engagement with South African mental health specialists due to her history of depression, anxiety, and feelings of being a 'bad parent'. McLeavey also told the Court that Dickason told her she killed her children and attempted suicide to "end the suffering."

On 7 August, during cross-examination, forensic psychiatrist Dr McLeavey claimed that Lauren was not experiencing psychosis during the killings, saying that 'it would be exceptional for psychosis not to be detected if in fact, it was present,' and that Lauren was suffering from depression and grievances instead.[70] On 8 August, the Court heard testimony from forensic psychiatrist Dr Barry-Walsh, who interviewed Lauren on two occasions. Barry-Walsh testified that she linked the killing of her children to an 'out of body experience' and initially thought that she was free of her troubles during her interview on 10 October 2021. On 9 August, the Court heard testimony from forensic psychologist Metoui, who interviewed Lauren on nine occasions, totalling 20 hours.[71] Based on a report into her psychiatric history, Metoui argued that the deaths of her children were motivated by 'insanity' and 'infanticide' rather than murder. Metoui told the Court that Lauren experienced her first violent ideation towards her children in May 2019 when her twin daughters were six months old. Justice Mander, in his summary to the jury, said that there were no disputes in Lauren causing the deaths of the children and that the question was whether it was murder, infanticide or insanity due to the undisputed unbalance of Lauren's mind at the time.

On 16 August 2023, Lauren was found guilty of murdering her children in the Christchurch High Court. Following 15 hours of deliberation, the jury reached a majority verdict (11-1) to convict her of three counts of murder. The majority jurors rejected her partial defence of infanticide and defence of insanity and accepted the Crown's argument that Dickason 'acted purposefully and even clinically out of anger and control' when she killed her three children. Justice Mander remanded her to Hillmorton Hospital until her sentencing date, stating that she was under a compulsory treatment order that made prison inappropriate.

The Sentencing Act presumes that murder would result in life imprisonment unless it would be 'manifestly unjust to do so'.[72] The sentence was scheduled for 26 June, and it had to be determined whether Lauren should serve her sentence in prison or be detained as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Until 26 June, she stayed in Hillmorton Hospital. She was sentenced on 26 June 2024 to 18 years in prison, as three concurrent determinate sentences of 18 years. She was not given a minimum term of imprisonment and will be kept in a mental health hospital until she is deemed mentally fit for prison.[73] When the sentence was delivered, Lauren was allegedly silent and had no reaction.

## 9. Conclusion

Mental illness may deprive persons of the capacity to appreciate the unlawfulness of their conduct. It may also deprive them of the capacity to control their conduct. The underlying premise of the insanity defence is that "insane persons" are the victims of an affliction that causes them to behave in an abnormal manner, which is beyond their control. To be fair they cannot be blamed for their conduct while afflicted by the illness and will be acquitted of the crime but admitted to a psychiatric facility. In the sad case of Lauren Dickason her defence of insanity could not succeed, and she is held accountable for the murders of her children. The outcome of the appeal is not available yet as the appeal has not been finalized. In many cases though the defence of insanity succeeded as discussed above.

## References:


1. J Burchell *Principles of Criminal Law* 5ed (2016) 370.

2. BA Arrigo *Punishing the mentally ill: a critical analysis of law and psychiatry* (2002) 105.

3. See J Burchell 'A provocative response to subjectivity in the criminal law' (2013) *Acta Juridica* 23-47.

4. This endnote is merely to provide background on sources relevant to the insanity defence to show from how early there has been written about it. Several authors have conducted research on it, for example, C Badenhorst Criminal capacity of children PhD (Unisa) (2006); M Blackbeard 'Epilepsy and criminal liability' (1996) 9 *South African Journal of Criminal Justice* 2 191-210; J Burchell 'Non-pathological incapacity: Evaluation of psychiatric testimony' (1995) 8 *South African Journal for Criminal Justice* 137-42; FJW Calitz 'Evaluering van die geestestoestand van 'n beskuldigde wat van 'n misdryf aangekla is: 'n Multiprofessionele benadering' (1993) 18 *Tydskrif vir Regswetenskap* 1 31-40; PA Carstens 'The defense of non-pathological incapacity with reference to the battered wife who kills her abusive husband' (2000) 13 *South African Journal for Criminal Justice* 2 180-189; F Cassim 'The accused person's competency to stand trial: a comparative perspective' (2004) 45 *Codicillus* 17-27; CA Gagiano 'Unnecessary committals for forensic observation' (1991) 108 *South African Law Journal* 4 714-718; JW Jonck 'Noodsaaklikheid van toestemming deur 'n beskuldigde by 'n ondersoek kragtens artikel 79 van die Strafproseswet' (1997) 22 *Tydskrif vir Regswetenskap* 2 196-203; L Jordaan 'General principles of liability: Sane automatism' (1999) 40 *Codicillus* 2 83-84; S Kaliski Sensation seeking, impulsivity and violence in schizophrenics found unfit to stand trial (1993); A Kruger 'JC de Wet se bydrae tot die leerstuk van toerekeningsvatbaarheid by geestesongesteldheid (1991) 4 *South African Journal for Criminal Justice* 2 145-147; A Kruger 'The insanity defence raised by the state, minister's decision, patients and a Bill of Rights' (1993) 6 *South African Journal for Criminal Justice* 2 148-154; J Le Roux 'Strafregtelike aanspreeklikheid en die verweer van nie-patologiese oftewel gesonde outomatisme' (2000) 33 *De Jure* 1 190-193; J Le Roux 'Strafregtelike aanspreeklikheid en die verweer van tydelike nie-patologiese ontoerekeningsvatbaarheid' (2002) 65 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* 3 478-481; H Oosthuizen & T Verschoor 'Verwysing van onverhoorbare beskuldigdes en die daarstelling van 'n verhoorbaarheidvasstellingseenheid' (1993) 6 *South African Journal for Criminal Justice* 2 155-164; CR Snyman 'Die verweer van nie-patologiese ontoerekeningsvatbaarheid in die strafreg' (1989) 14 *Tydskrif vir Regswetenskap* 1 1-15; SA Strauss 'Nie-patalogiese ontoerekenbaarheid as verweer in die strafreg' (1995) 16 *South African Practice Management* 4 14-34; FFW Van Oosten 'The insanity defence: Its place and role in criminal law' (1990) 3 *South African Journal for Criminal Justice* 1 1-9; I Verster 'Mental disorders in patients referred for psychiatric observation after committing homicide' (1999) 24 *Tydskrif vir Regswetenskap* 1: 58-66.

5. Because this case is a fairly recent case there has not been much written about it and therefore the author relies mostly on internet sources. See R Davis 'SA Killer Mum' Lauren Dickason's New Zealand murder trial is a chillingly strange, sad and complex affair' Daily Maverick, 5 August 2023, available at https://www.dailymaverick.co.za/article/2023-08-05-south-africa-killer-mum-lauren-dickason-new-zealand-murder-trial/ accessed on 7 January 2025.

6. Davis op cit (n 5).

7. N McCain 'Convicted murderer Lauren Dickason served with deportation order – reports' News 24, 23 October 2024, available at https://www.news24.com/news24/southafrica/news/convicted-murderer-lauren-dickason-served-with-deportation-order-reports-20241023 accessed on 7 January 2025.

8. Davis op cit (n 5).

9. N Chittock 'Lauren Dickason trial: Jury finds mother guilty of murdering her three daughters' New Zealand / Court, 16 August 2023, available at https://www.rnz.co.nz/news/national/495916/lauren-dickason-trial-jury-finds-mother-guilty-of-

murdering-her-three-daughters accessed on 6 January 2025.

10. Chittock op cit (n 9).

11. A Leask 'Lauren Dickason trial: alleged child murderer stopped taking antidepressants 'for immigration purposes' The New Zealand Herald, 9 August 2023, available at https://www.nzherald.co.nz/nz/lauren-dickason-trial-alleged-child-murderer-stopped-taking-antidepressants-for-immigration-purposes/IM6OBGE2VVFLRLXUTCL2XSVXAA/ accessed on 7 January 2025.

12. A Leask 'Lauren Dickason trial: Psych expert reveals killer's last words to daughters' The New Zealand Herald, 27 July 2023, available at https://www.nzherald.co.nz/nz/lauren-dickason-trial-world-expert-on-reproductive-psychiatry-and-women-who-kill-their-children-to-give-evidence-supporting- accessed 6 January 2025.

13. Leask op cit (n 12).

14. Leask op cit (n 12).

15. L Davies 'Psychiatrist recounts Dickason's comments about day she killed girls' Crime and Justice, 3 August 2023, available at https://www.1news.co.nz/2023/08/03/psychiatrist-recounts-dickasons-comments-about-day-she-killed-girls/ accessed on 7 January 2025.

16. Davis op cit (n 5).

17. According to the American Psychiatric Association the term 'mental disorder' unfortunately implies a distinction between 'mental disorders' and 'physical disorders', which is a reductionistic anachronism of mind / body dualism. A compelling literature documents that there is much 'physical' in 'mental disorders' and much 'mental' in 'physical disorders'. However, the problem raised by the term mental disorder has been much clearer than its solution, and the term will have to persist until an appropriate substitute is found. See American Psychiatric Association DSM-5 xxi. See the definition of mental disorder according to ICD-11: 'a mental disorder is a clinically recognisable collection of symptoms or behaviour associated in most cases with distress or interference with personal functions. A deviant pattern of behaviour, whether political, religious, or sexual, or a conflict between an individual and society, is not a mental disorder unless it is symptomatic of a dysfunction in the individual'.

18. Section 1 of the Mental Health Care Act 17 of 2002.

19. See also the definition of 'severe or profound intellectual disability': 'means a range of intellectual functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self-care and requiring constant aid and supervision, to severely restricted sensory and motor functioning and requiring nursing care'. See s 1 of the Mental Health Care Act 17 of 2002.

20. (1927-1989.) Ronald David Laing was a Scottish psychiatrist who wrote extensively on mental illness – in particular, the experience of psychosis. Laing's views on the causes and treatment of serious mental dysfunction (greatly influenced by existential philosophy) ran counter to the psychiatric orthodoxy of the day by taking the expressed feelings of the individual patient or client as valid descriptions of lived experience rather than simply as symptoms of some separate or underlying disorder. Often associated with the anti-psychiatry movement, he himself rejected the label as such, as did certain others critical of conventional psychiatry at the time. See G Miller RD Laing (2015) 7, 19.

21. (1920-.) Thomas Stephen Szasz is a Professor Emeritus of Psychiatry at the State University of New York Health Science Center in Syracuse, New York. He is a prominent figure in the anti-psychiatry movement, a well-known social critic of the moral and scientific foundations of psychiatry, and of the social control aims of medicine in modern society, as well as of scientism. He is well known for his books: *The myth of mental illness* (1960); and *The manufacture of madness: A comparative study of the inquisition and the mental health movement*, which set out some of the arguments with which he is most associated. See AL Slade A bibliography of works by and about Thomas Stephen Szasz MD, 1947-1975 (1976) 1 and onwards.

22. The term anti-psychiatry usually refers to a movement that emerged in the 1960's, which is hostile to most of the fundamental assumptions and common practices of psychiatry. The term anti-psychiatry was first used by the South African psychiatrist David Cooper in 1967. Two central contentions of the anti-psychiatry movement are that: (1) The specific definitions of, or criteria for, hundreds of current psychiatric diagnoses or disorders are vague and arbitrary, leaving too much room for opinions and interpretations to meet basic scientific standards; and (2) prevailing psychiatric treatments are ultimately far more damaging than helpful to patients. See RA Baker Mind games: Are we obsessed with therapy? (1996) 1and onwards. See also RD Laing 'Violence and psychiatry' 14-33 in *Psychiatry and Anti-Psychiatry* ((ed) D Cooper D) (1967) 14 and onwards.

23. TR stands for "text revision".

24. C Katona & M Robertson Psychiatry at a glance (2005) 10.

25. H Pretorius 'Classification' 7-13 in J Burns & L Roos *Textbook of psychiatry for Southern Africa* 2nd ed (2016) 7-8.

26. A Allan 'Psychiatric diagnosis in legal settings' (2005) 11 *South African Journal of Psychiatry* 2 55.

27. Katona & Robertson op cit (n 24) 10.

28. Katona & Robertson op cit (n 24) 11.

29. See American Psychiatric Association *DSM-5* 25.

30. A multiaxial system further provides a convenient format for organising and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis. In addition, this system promotes the application of the bio-psychosocial model in clinical, educational and research settings. See American Psychiatric Association *DSM-5* 25.

31. Hammurabi's activity as king of Babylonia dates from the middle of the 23rd century BC. From a legal point of view, there is much fundamental value to be found in the Code of Hammurabi. According to Price, the legal fraternity will find that Roman law has its roots in Babylonia, Egypt, and Persia, and that the ancient world was so admirably organised as to furnish better protection, in some respects, to its subjects than does our boasted civilisation of this day. The epilogue too is a remarkable document, which describes the benefits accruing to the subjects of Hammurabi from observance of these righteous laws and calls down the wrath of the gods upon the transgressor. Like the Roman *Ius civile*, the Hammurabi Code is divided into three sections: *Ius actionum*, *Ius rerum* and *Ius personarum* (this is usually found in reversed order in Roman law). See IM Price 'The stele of Hammurabi' (1904) 24 *Biblical World* 468, 469, 472.

32. BL Diamond & JM Quen *The psychiatrist in the courtroom: Selected papers of Bernard L Diamond* (1994) 39 and onwards.

33. See M'Naghten's Case 1843 10 C & F 200; C Elliott *The rules of insanity: Moral responsibility and the mentally ill offender* (1996) 10-13; J Hall *General principles of criminal law* (2008) 472 and onwards.

34. For a recent discussion of the insanity defence see L Roos, and C Kotze 'Examining the Mr Tsafendas enquiry trial: Current insights on forensic psychiatric assessment and ethics' (2024) 17 *The South African Journal of Bioethics and Law* 1 available at https://doi.org/10.7196/sajbl.2024.v17i1.1600 accessed 7 January 2025.

35. Ss 77-79 of the Criminal Procedure Act 51 of 77. See also the Report of the Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters RP 69/1967 (also called the Rumpff Report).

36. S 77(1): "(1) If it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of section 79."

37. Burchell op cit (n 1) 372.

38. The Criminal Matters Amendment Act 68 of 1998.

39. The question of fitness to stand trial is determined by a psychiatric examination and report. A person who is found not be fit to stand trial is detained in a mental hospital or prison until they become fit to be tried. See sections 77(6) and 77(7). See also *S v Leeuw* 1987 (3) SA 97 (A) 17. In this case two psychiatrists, Prof WH Wessels and Dr PJ Gouse, reported in par [4] as follows: 'Hy is weens verstandelike vertraging nie in staat om hofverrigtinge dermate te begryp dat hy sy verdediging na behore kan voer nie. … Hy was weens verstandelike vertraging ten tyde van die betrokke handeling nie in staat om die ongeoorloofdheid daarvan te besef of om ooreenkomstig 'n besef van die ongeoorloofdheid van die betrokke handeling op te tree nie. Hy is dus nie strafregtelik toerekenbaar nie.'

40. Burchell op cit (n 1) 372.

41. CR Snyman *Strafreg* 6ed (2017) 164.

42. *S v Mahlinza* 1967 (1) SA 408 (A) at 417.

43. *S v Stellmacher* 1983 (2) SA 181 (SWA) at 187. In this case the accused had been on a strict weight-loss diet for a period of weeks and also performed strenuous physical labour on the day in question. He consumed at least half a bottle of brandy the evening. According to him there was in the bar a strong reflection of the setting of the sun in his eyes which shone through an empty bottle. As a result, he lapsed into an automatistic state, during which he began shooting at people in the bar, killing one person. The question was whether the accused had suffered from a mental illness as contemplated in s 78 of the Criminal Procedure Act. The state did not prove beyond reasonable doubt that the conduct of the accused was indicative of a pathological disorder which is not due to a temporary clouding of the mind not attributable to a mental abnormality. A foundation was laid in the evidence for a reliance on lack of criminal responsibility not caused by mental illness. Bearing in mind the reasonable doubt which exists regarding the cause of his lack of criminal responsibility, the accused had to be given the benefit of the doubt. He was found not guilty and discharged.

44. It is important to note that the defence of insanity should not be confused with the defence of non-pathological criminal incapacity. The defence of non-pathological criminal incapacity is not set out in any statutory provision, but forms part of the common law. Criminal incapacity is not the result of a specific cause; it may have any cause, for example, emotional collapse, fear, provocation or intoxication. If this defence succeeds, the accused leaves the court a free person and is not sent to a psychiatric hospital or prison. See Snyman op cit (n 41) 161 and onwards. See also *S v Chretien* 1981 (1) SA 1097 (A). In this case, the accused, after driving away from a party at which he had been drinking, drove into a crowd of people, killing one and injuring five others. He was acquitted on the basis of his lack of intention due to his level of intoxication. The court, however, accepted that there were degrees of intoxication and depending to what extent an individual was intoxicated, his or her intoxication could impair either his or her intention, criminal capacity or the voluntariness of the conduct. Due to tremendous criticism the legislature enacted a special offence in the Criminal Law Amendment Act 1 of 1988 that made it a criminal offence while intoxicated if the level of the accused's intoxication was such that he or she lacked capacity.

45. Section 78(1A) of the Criminal Procedure Act 51 of 1977.

46. Section 78(1B) of the Criminal Procedure Act 51 of 1977.

47. See also section 78(3)-(8): " (3) If the finding contained in the relevant report is the unanimous finding of the persons who under section 79 enquired into the relevant mental condition of the accused, and the finding is not disputed by the prosecutor or the accused, the court may determine the matter on such report without hearing further evidence. (4) If the said finding is not unanimous or, if unanimous, is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence, and the prosecutor and the accused may to that end present evidence to the court, including the evidence of any person who under section 79 enquired into the mental condition of the accused. (5) Where the said finding is disputed, the party

 

disputing the finding may subpoena and cross-examine any person who under section 79 enquired into the mental condition of the accused. (6) If the court finds that the accused committed the act in question and that he or she at the time of such commission was by reason of mental illness or mental defect not criminally responsible for such act - (*a*) the court shall find the accused not guilty; or (*b*) if the court so finds after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside and find the accused not guilty, by reason of mental illness or mental defect, as the case may be, and direct - (i) in a case where the accused is charged with murder or culpable homicide or rape or another charge involving serious violence, or if the court considers it to be necessary in the public interest that the accused be - (*aa*) detained in a psychiatric hospital or a prison pending the decision of a judge in chambers in terms of section 29(1)(*a*) of the Mental Health Act 18 of 1973; (*bb*) admitted to, detained and treated in an institution stated in the order in terms of Chapter 3 of the Mental Health Act, 1973 (Act No. 18 of 1973), pending discharge by a hospital board in terms of section 29(4A)(*a*) of that Act; (*cc*) treated as an outpatient in terms of section 7 of that Act pending the certification by the superintendent of that institution stating that he or she need no longer be treated as such; (*dd*) released subject to such conditions as the court considers appropriate; or (*ee*) released unconditionally; (ii) in any other case than a case contemplated in subparagraph (i), that the accused - (*aa*) be admitted to, detained and treated in an institution stated in the order in terms of Chapter 3 of the Mental Health Act, 1973 (Act 18 of 1973), pending discharge by a hospital board in terms of section 29(4A)(*a*) of that Act; (*bb*) be treated as an out-patient in terms of section 7 of that Act pending the certification by the superintendent of that institution stating that he or she need no longer be treated as such; (*cc*) be released subject to such conditions as the court considers appropriate; or (*dd*) be released unconditionally. (7) If the court finds that the accused at the time of the commission of the act in question was criminally responsible for the act but that his capacity to appreciate the wrongfulness of the act or to act in accordance with an appreciation of the wrongfulness of the act was diminished by reason of mental illness or mental defect, the court may take the fact of such diminished responsibility into account when sentencing the accused. (8) (*a*) An accused against whom a finding is made under subsection (6) may appeal against such finding if the finding is not made in consequence of an allegation by the accused under subsection (2). (*b*) Such an appeal shall be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence. (9) Where an appeal against a finding under subsection (6) is allowed, the court of appeal shall set aside the finding and the direction under that subsection and remit the case to the court which made the finding, hereupon the relevant proceedings shall be continued in the ordinary course."

48. *S v Kavin* 1978 (2) SA 731 (W).

49. See section 79(1)(a)(b): '78 - (1) Where a court issues a direction under section 77 (1) or 78 (2), the relevant enquiry shall be conducted and be reported on - (*a*) where the accused is charged with an offence other than one referred to in paragraph (*b*), by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court; or (*b*) where the accused is charged with murder or culpable homicide or rape or another charge involving serious violence, or if the court considers it to be necessary in the public interest, or where the court in any particular case so directs - (i) by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court; (ii) by a psychiatrist appointed by the court and who is not in the full-time service of the State; (iii) by a psychiatrist appointed for the accused by the court; and (iv) by a clinical psychologist where the court so directs.'

50. Section 79(2)(a) of the Criminal Procedure Act 51 of 1977.

51. Section 79(2)(b) of the Criminal Procedure Act 51 of 1977.

52. S Kaliski 'The criminal defendant' 93-111 in S Kaliski *Psycholegal assessment in South Africa* (2006) 97, 110-111.

53. PE Dietz 'Mentally disordered offenders: Patterns in the relationship between mental disorder and crime' (2009) *Psychiatric Clinics of North America* 540, 544, 546, 547, 549.

54. CR Hollin *Criminal behaviour: A psychological approach to explanation and prevention* (2022) 105 and onwards.

55. HJ Eysenck & GH Gudjonsson *The causes and cures of criminality* (2017) 217.

56. Malingering is the intentional feigning or exaggeration of physical or psychological symptoms, motivated by external incentives such as avoidance of work or military service, receipt of financial compensation, evasion of criminal prosecution or procurement of prescription drugs. See M Dunn *et al* 'Detecting neuropsychological malingering: effects of coaching and information' (2003) 18 *Archives of Clinical Neuropsychology* 121-134.

57. See also Prins HA *Offenders, deviants, or patients: An introduction to the study of socio-forensic problems* (2020) 41ff.

58. PE Dietz 'Mentally disordered offenders: Patterns in the relationship between mental disorder and crime' (2002) *Psychiatric Clinics of Northern America* 540-541.

59. M Swanepoel 'Legal Aspects with Regard to Mentally Ill Offenders in South Africa' (2015) 18 *Potchefstroom Electronic Review* 1 3238-3259.

60. See R Mackay & W Brookbanks *The Insanity Defence: Conflict and Reform in New Zealand* 2022 144-169.

61. The Crimes Act 1961.

62. *Cameron v R* [2017] NZSC 89.

63. The Crimes Act 1961.

64. W Brookbanks 'The insanity defence: Is it still fit for purpose?' (2023) 54 *Victoria University of Wellington Law Review* 101-126.

65. Davis op cit (n5).

66. PJ Dean 'Child homicide and Infanticide in New Zealand' (2004) 27 *International Journal of Law and Psychiatry* 4 339-348; D Wilson 'The offence/partial defence of infanticide in New Zealand law: past, current and future use' (2022) 17 *Otago Law Review* 335.

67. Chittock op cit (n 9).

68. Davis op cit (n 5).

69. Chittock op cit (n 9).

70. Chittock op cit (n 10).

71. Davis op cit (n 5).

72. Davis op cit (n 5).

73. Chittock op cit (n 9).