IN THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

Case Number: CC122/2016

DELETE WHICHEVER IS NOT APPLICABLE

(1) REPORTABLE: YES/NO.

(2) OF INTEREST TO OTHER JUDGES: YES/NO.

(3) REVISED.

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DATE SIGNATURE

In the matter between:

THE STATE

And

R. M. **ACCUSED**

JUDGMENT

Fabricius J,

1.

The accused is charged with two counts of murder and two counts in terms of the ***Fire Arms Control Act 60 of 2000***, namely unlawful possession of a fire arm and unlawful possession of ammunition. It is alleged that on 17 April 2015 and at or near Plot 2, Impala, Waterval, in the District of Hammanskraal the accused unlawfully and intentionally killed her two sons aged six and two. She was married to Dr M. M., a psychiatrist in Pretoria.

2.

The summary of substantial facts in terms of ***Section 144 (3) (a) of the Criminal Procedure Act 51 of 1977*** as amended, states the following:

2.1 "The accused is the biological mother of the deceased referred to in counts 1 and 2 of the indictment;

2.2 On 17 April 2015, the accused shot and killed both the deceased in a vehicle where she parked it;

2.3 Shortly after the incident, the accused ran to a nearby house where she informed one Mrs Van Rooyen of the shooting;

2.4 The accused was later arrested on the scene of the crime;

2.5 Dr K. Y. Kgoete indicates the cause of death of the deceased referred to in count 1 of the indictment, A. M., as being:

"PERFORATING GUNSHOT OF THE HEAD".

2.6 Dr M. du Plessis indicates the cause of the death of the deceased referred to in count 2 of the indictment K. M. as being:

"GUNSHOT WOUND OF THE HEAD"."

3.

The accused pleaded not guilty to all the charges and tendered a written Plea Explanation in terms of ***Section 115 (2) of the Criminal Procedure Act ("CPA")***. This explanation reads as follows:

2.

"I am a 34 year old female and a South African citizen of [...] G. Avenue, East Clyff, Arcadia.

3.

3.1 I confirm that the two deceased referred to in the indictment were my biological children, born from my marital relationship with Dr M. M..

3.2 I am happily married to my husband and love my deceased children dearly.

3.3 My husband has two children from a previous marital relationship who also resided with us at the time of the incident.

3.4 On [...] January 2017 I gave birth to a baby girl named M..

4.

I state that I am not guilty of the charges levelled against me.

5.

My defence to the charges is as follows:

5.1 I deny that during the commission of the crimes I was able to appreciate the wrongfulness of my actions and/or act accordingly.

5.2 I specifically plead that my defence to the charges is one of sane automatism due to a short-lasting psychotic depressive episode with prominent suicidal trends, as a result of a combination of side-effects of medication and substance intake.

5.3 I specifically plead that the side-effects of the medication and/or substances were unknown to me prior to the commission of the offence.

5.4 I state that the combination of the side-effects to the medication and/or substances caused a short-lasting but severe substance induced psychotic depressive episode with prominent destructive and suicidal trends.

5.5 I state that the combination of the side-effects of the medication and/or substances had the following effects on me with feelings of melancholia, suicidal thoughts, temporary memory loss and impaired judgment.

5.6 I have partial memory loss of the events leading up to the shooting incident and thereafter.

5.7 I have no recollection of the shooting incident itself.

6.

I confirm that the medication and/or substances consumed by me were consumed separately, intermittently and/or in combination prior to and on the day of the fatal shooting of the two deceased. These were as follows:

6.1 Symbicort Turbuhaler (Budesonide/Formoterol);

6.2 Mypaid Forte (Ibuprofen, Paracetamol);

6.3 K-Fenak (Diclofenac potassium);

6.4 Migril (Ergotamine, cyclizine, caffeine);

6.5 Empacod tablets (Acctominophen/Paracetamol, Codeine Phosphate);

6.6 Alcohol (one glass of red wine);

6.7 Red Bull energy drink;

6.8 Sports supplements to wit:

6.8.1 BCAA capsules;

6.8.2 Protein shake – Biogen Iso-Whey Premium;

6.8.3 Muscle building supplements – USN Creatine;

6.8.4 Caltrate Plus;

6.8.5 Cranberry tablets.

7.

7.1 I am unable to state accurately the quantity of the medication and/or substances I consumed separately, intermittently and/or in combination on the day of the incident.

7.2 I state that approximately two days before and on the date of the incident I suffered from severe headaches. I used pain medication to alleviate the symptoms. I felt extreme emotions of loneliness, tension and suicidal thoughts. I also experienced tightness of my chest and used the Symbicort Turbuhaler to alleviate the symptoms.

7.3 I suffer from severe migrainous headaches and have been using Migril medication for a very long time.

7.4 These headaches are associated with symptoms such as dizziness, nausea and occasional vomiting, and blurred vision.

7.5 I consumed the medication listed in paragraph 6 prior to and on the day of the incident in order to alleviate the various symptoms that I experienced.

8.

On the day of the incident I did not eat breakfast. I consumed a glass of red wine and a sandwich for lunch. I also drank a Red Bull energy drink and consumed an energy bar which I thought would help with my low energy levels.

9.

9.1 I confirm that I was also experiencing my menstrual cycle and suffered from period pains and body pains as a result.

9.2 I consumed various medications to alleviate the symptoms that I experienced.

10.

I would never intentionally hurt my beloved children, and even when I experienced extreme suicidal thoughts, I did not ever consider to harm or kill them."

4.

Certain admissions were also made in terms of Sections 220 of the ***Criminal Procedure Act***, in main relating to the identity of the deceased, the relevant post-mortem examinations, the fact that the husband of the accused was the registered owner of .38 special calibre Rossi revolver, and that this revolver was kept by him in a safe with a pin code that had to be entered to gain access the safe at their residential address. A photo album was handed in and the relevant admissions were made in regard thereto. During pre-trial proceedings, presided over by myself, it was agreed that the State would lead the initial evidence and that the trial would then be postponed to an agreed-upon date. The accused and certain experts would then give evidence, and an expert appointed by the State would then have the opportunity to reply to that evidence. Defendant's case is by-and-large set out in the Plea Explanation, and the relevant experts would obviously be in Court when the accused gave evidence.

5.

Mrs R. van Rooyen testified that on 17 April 2015, she was at home and identified the relevant building on photo 1 of the album Exhibit H. She saw accused standing in front of her window asking for assistance. It was her opinion that she had had to climb through the fence, because the gates had been locked. She opened her window, whereupon the accused told her that she was looking for a bullet. She told her that she had no bullets and asked her where her fire-arm was as she could not see one in her possession. She was then asked for a knife so that she could kill herself. They were speaking in English. The accused was then told that she would not be given a knife, whereupon she stated that she would kill herself on the highway which is indicated on photos 7 and 8 of Exhibit H, as being behind the wall that appears thereon. She then phoned the Hammanskraal Police whilst the accused was running towards this wall. Mrs Van Rooyen pulled her off this wall and walked with her back to the house. She spoke to her to calm her down and asked her what the problem was. The accused said that she had shot her two children, but did not have enough bullets to shoot herself. She asked her what the reason was, and was

then told that her husband was busy with another woman and that he would give her children to this particular woman (my translation from Afrikaans). She was then asked where the vehicle was with the children, and was told that it was on the plot. Mrs Van Rooyen then phoned Mr Dorfling of the Community Policing Service, and asked the accused whether she was sure that the children were dead. She answered in the affirmative, and said that she had shot the youngest with one shot and the oldest with two shots. That was the reason why she then asked for another bullet for herself. The police then arrived and Mr Dorfling was also on the scene. She was then told that the vehicle had been discovered.

The accused phoned her mother after having been asked to use her cell phone. She used the word “mum” and then spoke in her language. When asked about the condition of the accused, she said that it was difficult to say. There appeared to be some foam on her mouth and she was out of breath. The conversation was however rational and accused did not even cry. Her clothes were clean.

After the incident, she made a statement in Afrikaans which was however written in English.

6.

When the accused ran towards the highway, she realized that something was amiss. Accused told her that she wanted to jump in front of a motor vehicle and thus kill herself. She was busy climbing over the wall when she pulled her back. She said that she wanted to kill herself before her husband arrived. She asked her why she had killed her children so as to calm her, and was told that her husband would leave her and take the children to another woman. She did not expand on that topic. Shortly thereafter the police arrived. She noticed that when she spoke to her mother over the phone, it was without emotion. That also appeared strange to her inasmuch as she expected emotion.

The contents of paragraph 5 of the Plea Explanation was then put to her for comment. Obviously the witness could not express a view thereon, and Adv Leonard SC on behalf of the State accepted that the accused's version had been put to the witness.

The accused's version as contained in the Plea Explanation was also put in detail to Captain Mokgapa, who obviously also said that she could not comment. The debate

followed in Court about the necessity to put a detailed version of the accused to a witness who was obviously not in a position to comment thereon. Mr Pistorius repeatedly insisted that he was obliged to put the whole of the accused's version to a witness, irrespective of whether that witness could have any knowledge of what was put to him or her. For instance, and with reference to the contents of paragraph 6 of the Plea Explanation, it must be asked: how could this witness or any member of the police present possibly sensibly comment on what medication the accused had taken on the day of the fatal shooting of the two children? Ms Leonard therefore quite sensibly accepted that paragraph 6 had been put to this witness. Whilst it is undoubtedly so that an Advocate is obliged to put his or her client's version to an opposing witness, this rule is certainly not inflexible and is not intended to be a mechanical and senseless exercise irrespective of the context and contents.

In ***Smal v Smith 1954 (3) SA 434 (SWA)***, Claassen J said the following at 438 D to E: "It is, in my opinion elementary in standard practice for a party to put to each opposing witness so much of his case or defence as concerns that witness (I underline)..." In ***R v M 1946 AD 1023 at 1028***, the following was quoted from

Phipson on Evidence: "As a rule a party should put to each of his opponent's witnesses in turn so much of his own case as concerns that particular witness (I underline) or in which he had a share..."

These two decisions were also referred to with approval in ***S v Van As 1991 (2) SACR 74 (W) at 108***.

In ***S v Abader 2008 (1) SACR 347***, it was held at 356 that the duty to put an accused's version to a witness is not an inflexible axiomatic rule cast in stone. The rationale of this rule and the duty is that, if it is intended to argue that the evidence of the witness should be rejected, he should be cross-examined so as to afford him an opportunity of answering points supposedly unfavourable to him. The rule does therefore not demand or even imply that a version must be put to a witness who in the nature of things would be unable to comment thereon, because it is obviously outside his field of knowledge.

In ***President of the Republic of South Africa and Others v South African Rugby and Football Union and Others 2000(1) SA 1 (CC) at 36J - 38C par. 61***, the judgment of the Court reads as follows: "(61) The institution of cross-examination

not only constitutes a right, it also poses certain obligations. As a general rule it is essential, when it is intended to suggest that a witness is not speaking the truth on a particular point, to direct the witness' attention to the fact by questions put in cross-examination showing that the imputation is intended to be made and to afford the witness an opportunity, while still in the witness box, of giving any explanation open to the witness and of defending his or her character. If a point in dispute is left unchallenged in cross-examination, the party calling the witness is entitled to assume that the unchallenged witness' testimony is accepted as correct". In paragraph 65 the following was said: "These rules relating to the duty to cross-examine must obviously not be applied in a mechanical way, but always with due regard to all the facts and circumstances of each case..."

It should therefore be clear that an accused's Counsel is not obliged to mechanically put the whole of the accused's version to a witness who would have no knowledge thereof whatsoever, and whose testimony is in any event not intended to be challenged by putting such version. Any mechanical application of this rule must therefore not result in an absurdity.

7.

In the present context, this absurdity became abundantly clear when the contents of paragraph 7.2 of the Plea Explanation was put to this witness. Similarly, the absurdity of the mechanical application of this rule became abundantly clear when the proposed evidence of Prof C. Brink was put to this witness, namely what the effects of a combination of medication was on the accused on the day of the incident. Mrs Van Rooyen, when confronted with that proposed evidence, said that the conversation had been normal, and that the accused had realized what she required and why. Mr Pistorius then put on record, with the concurrence of Ms Leonard SC, that it had been agreed in any event not to put the comprehensive instructions of the accused or the experts' reports to the witnesses, but that the conclusion of experts would suffice. One of the witnesses' statements dated 25 September 2015, was shown to her (Exhibit K) and she stated that it was not the same statement that she had in her possession. The witness stated that she remembered the incident well, even if regard is had to the passage of time, and stated that the accused had not screamed when she spoke to her mother, but had

merely spoken louder. She had given her version in Afrikaans and the statement had been written in English. The police must have misunderstood her, because the accused did not scream when speaking to her mother. The witness then also stated unsurprisingly that she had no knowledge of which medicine the accused had bought on any particular day prior to the incident. In re-examination she indicated with reference to photo 2 where the accused had stood when she said that her husband would kill her. At that stage the accused spoke normally and was aware of her surroundings, and that she had shot her children. She also mentioned that one child was shot with one bullet, and the other with two. At that stage she then also said that her husband would leave her and take the children to another woman. She did not want this to happen.

8.

The evidence of Mr Dorfling:

Mr Dorfling lived in Wallmansthal and was a member of the Community Policing Service, an organisation which voluntarily co-operated with the police. Mrs Van

Rooyen phoned him on that particular day and asked for support. He arrived at her home and noticed the accused and Mrs Van Rooyen near her. He was told that the accused had shot her children. He spoke to the accused and was then also told that she had shot her two sons. She was concerned that her husband would kill her. They spoke in English. He tried to find out where this incident had occurred and asked for directions, but the accused was not sure and merely indicated the south-east direction. He conveyed this information to other members of the community, and the blue BMW was then discovered. According to him this was about between 16h15 and 16h30. The police then arrived on the scene. He was asked about the accused's state of mind and said that she had looked disturbed. Under cross-examination, he remembered that she had mentioned killing herself. He was asked exactly what the accused had told him, and he replied that she had said "I killed my boys", whilst holding her face in her hands. She did not cry at that time. She also said that her husband would kill her. His interaction with the accused was of very short duration. He also made a statement to the South African Police on 18 April 2015. It was put to him that the accused would say that she could not remember

speaking to him. The witness could not comment thereon. It was also put to him that the accused would say that she did not know how she had arrived at the plot of Mrs Van Rooyen, and also that she could not remember saying how she had shot the children. The side effects of certain medications were then also put to this witness, who obviously was not in a position to give any meaningful answer.

9.

Dr K. Y. Kgoete:

He is from the Forensic Pathology Services at Garankua, and gave evidence with reference to Exhibit C. He confirmed his findings and read the cause of death in each particular case into the record.

10.

Captain B. E. Mokgapa:

In 2015 she had been employed by the South African Police Service for 27 years, and her rank was Captain at the time. She left the Service during February 2016. At

that time she was stationed at Hammanskraal, and on 17 April 2015 at about 16h45, she was on duty and in full uniform. She received a call and went to the relevant scene in her police car with Warrant Officer Mashabo. They found members of the community at the scene and the previous witness, Mr Dorfling. They saw the accused on the scene running around and crying. She told her "I killed my kids, I want to kill myself, please kill me also, I want to rest". She was speaking Tswana and the witness was conversant in Tswana. She also hugged the witness. She asked her where the children were, and she pointed in the particular direction where she later found the dead children. She had also warned the accused that she was a police Captain and that anything she said could be used as evidence against her in Court. She locked the accused in the vehicle. She was told by Mr Dorfling that he knew where the scene was and that she could follow them. They did so and found the particular blue BMW which was facing north. On its right side they found the son aged six lying in a pool of blood. In the car they found the younger son on the left front seat, with the safety belt still on and a wound in the head. With reference to the photo album, Exhibit G, she identified photos 1 to 6. The BMW was found where

indicated as A. She was not sure how far this vehicle was from the house of Mrs Van Rooyen. According to Exhibit H, photo 13, the distance is however indicated as being 4.5km. The witness also identified photos 24 and 25, part of Exhibit F, which shows the child lying on the ground, on the right side of the BMW. She also identified photos 17 and 18, being the position of the younger son. Inside the vehicle was a fire-arm, and on the driver's seat a cell phone, and on the left seat mat was a laptop. The fire-arm on the driver's seat was a .38 revolver and the cell phone was next to this fire-arm. She did not touch it and did not know whether it was still loaded. After the visit to the scene, she spoke to the accused again and asked her whether the child lying on the ground was hers, and similarly whether the child in the front seat was hers. She answered in the affirmative. She again admitted having killed them and when asked why, she said that she had struggled for 12 years in her marriage. She was then arrested on two counts of murder and her constitutional rights were relayed to her. She was also told that she had a right to a lawyer or the right to state assistance in that regard. Later on at the police station, she gave the accused the particular document and again told her about her right to remain silent.

When asked whether the accused was either upset, angry or normal, she replied that she was not happy, crying at the scene, but otherwise normal. Accused told her what had happened, and she knew what she had done.

11.

Under cross-examination she admitted that the accused had looked upset at the scene. She confirmed that she had been told that the accused wished to commit suicide. She again confirmed that when she had asked the accused why she had done the deed, she was told that she had struggled for 12 years in her marriage. Her husband arrived at the scene and spoke to the accused. They spoke privately and she could not hear what was said. She handed over the scene to the Crime Scene Management Team. The accused's husband, Dr M., took the vehicle the next morning whilst it was still full of blood. When it was put to her that the vehicle was not forensically examined at the scene or at the station at all, the witness replied that she had handed the scene and the vehicle over to the relevant detectives. It was put to her that the accused could not dispute, nor admit, saying to her that she

shot the children and wanted to rest, because of a 12 year problematic marriage. The witness again confirmed that that was what she had been told. It was also put to her that accused had been confused, distressed, and suffering from “snapshot amnesia” prior to, during and after the incident. The witness replied that her conversation was fine, although the accused had been crying. She was not told by the accused that she had to relieve herself in the police vehicle, or that she had vomited. She did not question the accused regarding the sequence of the shooting, nor did she ask her any detail.

The events contained in the Plea Explanation were then substantially put to the witness, although she was obviously in no position to comment thereon. It was put to her that on the date of the incident the accused had suicidal thoughts and the witness replied that the accused had wanted her to kill her. She said that at the house of Mrs Van Rooyen. The full version of the accused was then put to this witness, which is mainly contained in the plea explanation, but as I have said, the witness was for obvious reasons not in a position to make any comment. The

witness also denied that during May 2015 she met the accused with her husband at the police station and allegedly told her that “you will not recognize me”.

12.

Captain S. K. Modisane:

He gave evidence in the context of an affidavit he had made in terms of Section 212 of the ***Criminal Procedure Act***, which was Exhibit N. His qualifications and experience were not in issue, and he confirmed what was shown in paragraph 5 of this Exhibit, which by-and-large consists of photographs with the relevant explanations. He also confirmed his findings and conclusions which are contained in paragraphs 10 and 11 of this Exhibit. He also explained what he meant that the elder child was most probably in the defensive position when shot in the arm. He demonstrated in Court how this would have occurred according to his opinion. He also explained that the elder child had been lying outside in a pool of blood and that there had been no blood where he had been seated. The younger child was in his opinion shot from the outside of the vehicle from the left hand position and the elder

child was first shot on the fore arm and then in the head. He confirmed his affidavit as being correct. He confirmed that the relevant fire-arm used was a .38 revolver. It did not have a safety catch and had place for five cartridges. The trigger therefore had to be pulled five times for it to be fully discharged.

13.

Mrs M.: the accused:

Mrs M. was 35 years old when she testified on 31 July 2017. She had matriculated in 2000. In 2006 she obtained a National Diploma in engineering computer systems. In 2015 she obtained a Bachelors degree in Information and Systems also from the Tshwane University of Technology.

She married Dr M. in 2011 and had known him since 2003. She was in a relationship with him for 12 years. He had previously been married and his two daughters from that marriage lived with them.

She had a happy marriage.

She suffered from migraine since her primary school days. This would usually involve severe pain in the head, and often nausea. These attacks were often coupled with her menstrual cycle. It would typically last for three to four hours, but the longest one was for two days. She took Migril tablets then: one tablet initially and then either another half or a whole tablet.

Her menstrual cycle was accompanied by mood changes where she would feel “a bit blue”. In general she was a healthy person. There was no history of depression and she had never taken any medication that would have affected her mental well-being. There was no physical or mental abuse in her marriage. At the time of her evidence she was still married and in fact they decided to have another child, a daughter who was born in January 2017. Her husband supported her throughout this case, but was not part of her defence team.

She lived a healthy life, did a lot of exercise and even had a personal trainer who visited her home. Her husband was in private practice and she assisted him with the administration. At the time of the incident, they were busy building a new home and she regarded herself as the project manager.

14.

I will deal with her activities on three separate days.

Wednesday 15 April 2015:

As on any other normal day she would take the three children, S. (Dr M.'s daughter), and her two sons K. and A. and drop them off at school. S. was 16 years old and attended Christian Brothers College in Silverton at the time. Her eldest son K. attended Loreto School in Queenswood. Her youngest son attended a crèche in the CSIR Campus also in Pretoria East. Loreto School was about 8km from their home near the Union Buildings. The estimated distance to the crèche was about 3km.

After dropping off the children she would come home, make breakfast for herself and her husband, and then start with her exercise regime as her personal trainer attended to her on Wednesdays.

On Wednesday 15 April she had menstrual pains and as she started exercising felt tightness in the chest. The training session was then stopped. After her trainer had left she took "a few puffs" of the Symbicort inhaler that had been prescribed by her

husband for her younger son who was suffering from asthma. According to her this would have alleviated the tight chest. This had been explained to her by her husband. She could not tell how many “pumps” she had taken but it could have been three or four.

On that particular day she did not have any mood changes but felt tired and did have abdominal pains. For that she took Mypaid Forte which had been prescribed by her gynaecologist. The purpose thereof was to alleviate menstrual pain.

Those were the only physical problems she experienced on Wednesday.

As the day went on she still had a tight feeling in her chest and used the inhaler again with “several pumps”.

On that afternoon as on any other Wednesday, she took her eldest son to a soccer school which was also at the CSIR. Whilst he was playing she would normally run around that field but that afternoon was unable to do so. She felt tired and had the tight chest feeling again and used Symbicort. She took Mypaid Forte for the menstrual pain but could not say how many tablets she had taken. She could not particularly remember whether she slept well that night.

Thursday 16 April 2015:

She woke up feeling very tired and still had a headache. She took Mypaid Forte and as she still had a tight chest took some of the Symbicort as well. She had mentioned to her husband that she had a tight chest and general menstrual pains. Thursday she also followed the same routine with taking the children to school.

After dropping the youngest child at the crèche she felt very down and sad and as she was driving home she had thoughts of suicide. She never had these thoughts before. She could not attribute them to any particular cause. She felt lonely and sad. She did not phone her husband and tell him about her feeling. In the morning she again used Symbicort and Mypaid Forte. Later that day she felt exhausted and horrible. Her headache became worse. She took Migril tablets but could not say when.

She collected the children from school and normally on Thursdays she has her swimming lesson together with her eldest son K. at the swimming school in Colbyn which was about 7 – 8km from their home. She did not take her swimming lesson

that day. The tightness in the chest was still there and she took a few puffs of the inhaler.

15.

On Thursday night she had a discussion with her husband and told him about how she felt physically. He suggested that she should perhaps consult a general practitioner. She told him that she was suffering from a migraine attack. She also mentioned that she had been using the inhaler and that it was helping her. There was no discussion about the quantity of the medicine that she had taken or should take. On Thursday evening she felt worse and took Migril and Mypaid Forte. She could not remember in which quantity she had taken these tablets. During the night she again took a few puffs of Symbicort. She did not sleep well that night, but was very restless. She also had thoughts of suicide again, but could not attribute this feeling to any particular cause. She assumed that it was linked to her menstrual cycle and just felt depressed. She did not want to tell her husband about those thoughts.

16.

Friday 17 April 2015:

She felt very miserable that morning and her whole body was in pain. She had a migraine headache and took Mypaid Forte and Migril tablets. She could not say how many pills she had taken. She did not have any breakfast and then dropped the children off at school. She again took a few pumps of the Symbicort. When she returned home her husband was not there and she called him to find out where he was. She did not tell her husband that she felt very alone as she had thought that it was just the sadness that accompanied the menstrual cycle and that it would pass. The Mypaid Forte and the Migril tablets did not help and the pain persisted. She tried to exercise, but felt too tired. She did speak to her husband a few times during that morning. They spoke mainly about the building and the variations that were intended.

During the day she felt very sad and suicidal thoughts coming and going. Those thoughts were only directed towards herself and no one else.

During the noon period she had one slice of a sandwich and poured herself a glass of wine. There was tension around her shoulder and the neck and the migraine was still there. During that morning she had also taken a few pumps of the Symbicort but in fact could not specifically recall that.

17.

She had an overwhelming feeling of suicide at the time and fetched her husband's gun from the safe in the bedroom. She was not familiar with firearms, had never fired a shot and had not done any training. She then went to sit in her car which was in front of the garage. She cried and then decided that she needed to distract herself. She then decided to drive to Pick n Pay in Silverton. She could not say why she had wanted to commit suicide. She could also not say whether she had ever put the firearm against her head or any part of her body. She also had not checked whether there were any bullets in the revolver.

18.

At Pick n Pay in Silverton she bought a number of items which were indicated on Exhibits J1 and J2. The time indicated on this pay-receipt is 12:15. Items included baby nappies for the youngest son.

Thereafter she went to Dischem in Glen Fair which might have been a distance of 5km, and at that pharmacy explained to the pharmacist at the counter that her pain was not improving and that she had already taken Migril, Mypaid Forte and Symbicort. She described the symptoms to the pharmacist and especially the body pains, the menstrual pains and the migraine headache. Exhibit J1 indicates which medication was bought, and this included K-Fenak and Migril tablets as well as Empacod. She also bought a can of Red Bull. When she left Dischem she took Migril immediately with a sip of Red Bull. She cannot say how many Migril tablets she had taken. She then drove to CSIR which was closest to the particular Dischem pharmacy to fetch her youngest son.

19.

She recalled that as she walked into his class he was still sleeping and she lay down next to him. They then left and she went home to pay one of her housekeepers. She would have fetched the youngest child at about 14h00. Upon returning home she took K-Fenak, Empacod and Migril but could not say how much she had taken or whether individually or jointly. She took these tablets together with the Red Bull that she had bought earlier. She and A. then drove to pick up K. at the Loreto School which was about 10km away. Upon her arrival at Loreto School, she had “an image of myself on the field looking at K.”. She then recalled getting into the car, strapping both children into their car seats as she normally did. She remembers getting into her vehicle and her next recollection was her waking up lying on the gravel with K. lying in a pool of blood. I must point out at this stage that this was not the version put to Captain Mokgapa. She called out his name and he was not responding. She also recalled calling A.’s name and he was not in his car seat. She found him in the front seat. She remembers taking the gun, pointing it against her head and pulling the trigger. The gun was next to her when she awoke on the

ground. She does not know how it got there. When she pulled the trigger she heard clicking sounds. She then recalls running around the field and finding a beer bottle which she wanted to break to stab herself with it. This bottle however broke into small pieces.

20.

She did not contemplate there at the scene that she would hurt her children and did not think about it. She found herself at the plot of Mrs Van Rooyen but could not say how long it had taken her to get there. At Mrs Van Rooyen's house she could not remember the sequence of events though she did recall asking for help to kill herself. She recalls a woman being there and also other gentlemen. She cannot recall speaking to Mr Dorfling. She also recalled someone pulling her down from the fence and instructing her to sit down. She thought that the police would help her kill herself. She could not recall the conversation that she had with Mrs Van Rooyen and where she said that her husband would leave her for another woman and take the children with him. There was in any event no reason why she would have said

that. She recalled speaking to her mother. She cannot recall speaking to Captain Mokgapa. She also cannot recall that she said that she was tired of 12 years of abuse in the marriage. There was no reason why she would have said that in any event. She could remember seeing her husband through the window of the police vehicle. She recalled vomiting in the back of the vehicle. She still had a headache and felt very cold. She cannot recall that she offered any explanation for her conduct. She could not recall shooting the children. She could not explain why she had shot the children or tendered any reason for doing so.

21.

She was examined by the psychiatrists at Weskoppies Hospital. She confirmed that she was seen by various experts including Prof Pretorius, Dr du Plessis and also a social worker. She was physically examined and also informed the physicians that she had taken certain medicine. She also told them that she had used Symbicort and that she had been a migraine sufferer. There was however no in-depth discussions with regard to the therapeutic effects of the medication used. She had

been “instructed” by her legal representatives to make notes of her consultations with the various experts whilst in the Weskoppies Hospital, but did not do so. Dr Savov was appointed as well as Prof Brink, because “that there is a very strong possibility, that you suffered from severe adverse complications of the various substances or medications that you have consumed in the day, and days leading up to the incident…” as it was put by her Counsel.

22.

She did not discuss her defence with her husband. Her reply was: “I did not consult him as *per se*, but once I heard the defence, I told him what the defence is and he said to me, that we would rather not discuss it, because he does not want to get involved at that level”.

23.

She did consult Prof Brink and Dr Savov who treated her for depression.

24.

During her evidence the relevant distances between the various places that were mentioned were put on record and the distance from Pick ‘n Pay to Glen Fair Mall was 14km and from Glen Fair to the home it was 14.2km. From the home to the Loreto School was 8.5km, and from Glen Fair to Wallmansthal was 20.8km. From where the vehicle was found to the home of Mrs Van Rooyen was by road 4km and by the “crow route” about 2km.

25.

Cross-examination of Mrs M.:

She confirmed that she consulted Dr Kariuki. She was referred to a part of his report where he stated that “she has good memory with deficits only around the incident for which she is charged”. She confirmed that she explained to him what she could remember at the time. She was reluctant to say whether that was the same as the time that she was giving evidence. It was put to her that there was no mention of any snapshot images. In her evidence she also made no mention that her son

wanted to go to MacDonald's after school and that from thereafter, she had no memory. Mrs M. replied that she does not remember telling the doctor about all those details, but did describe the details of her lying on the gravel with her children lying in blood next to her. She did explain all her pains to Dr Kariuki and could not explain why there was no reference of Migril being taken prior to her visit to Dischem. According to the report she also experienced the sudden feeling of loneliness only on Friday and not on the Thursday.

26.

She could also not recall speaking to anyone while she was waiting for her son to finish the cricket game on that Friday.

27.

Returning to the specific days that I have mentioned, she confirmed that she could not say exactly how many puffs of Symbicort she took on Wednesday. She did remember however that she used it a few times. She confirmed that it was

Symbicort prescribed by her husband for the youngest child. She did not read the package insert, but remembered her husband telling her to give her son one or two puffs. From that instruction she concluded that she could take more, but could not say how much more. It could have been three however. The end result however was that she could not say how many Symbicort puffs she took on Wednesday. The same applied to Thursday and Friday, and one could only guess at best. She could not say whether she took three or four puffs at a time. She also could not remember how many Mypaid Forte she took on Wednesday, Thursday and Friday. The last Mypaid Forte taken was on Friday morning. As far as Migril was concerned she normally used it as per the prescription. On Friday after Dischem she could have taken two or three however. She also could not remember what instruction the pharmacist at Dischem had given her. She did not read the package inserts. She did however take two or three types of medication on Friday before she had to fetch the children. She could however not say how many tablets were taken. She also could not give the time at which the medication was taken, nor the intervals in between.

28.

She could not explain why she did not commit suicide after taking the gun from the safe. She could also not remember what she did with the gun when she got into her car and whether she put it against her head. She can just remember driving out. She did not take it back into the house and by way of deduction probably put it in the boot, but also could not remember this conclusively. She did not know that the gun was loaded.

29.

Regarding her comments made about her marriage to Mrs Van Rooyen, she said there were difficulties in the relationship before they got married, but there was never any abuse. She sought the protection order “out of anger and fear but not out of a history of abuse”. She did not mention the protection order before because she had not been given an opportunity to mention it. She also could not explain why she said to Mrs Van Rooyen that her husband will leave her and take the children with him.

She did however recall phoning her mother. She had no explanation why she told Captain Mokgapa that she had struggled for 12 years in her marriage.

30.

On Friday she picked up K. at Loreto School at about 15h00. She could not remember where she went then. After strapping the children in, she could not remember anything. She had never been to Wallmansthal before and could not say why she drove there. She would however accept the description of the route that she must have taken. She remembered running and finally arriving at the home of Mrs Van Rooyen and also finding a meshed fence there. She remembered clicking sounds when she tried to shoot herself at the scene.

31.

She never considered shooting her children.

32.

She repeated that on the Friday, whilst at Dischem she immediately took Migril with Red Bull. She then went home and took the other medication together with a sip of Red Bull.

33.

She could not dispute that she had told Captain Mokgapa that she was afraid her husband would kill her. She confirmed again that she could not say how many tablets she had taken on Friday and when. It was put to her that this whole version of extra medication was “thumb-sucked”. It was not mentioned in the consultations with Dr Kariuki and if it had been mentioned it would have been stated by him. The accused had no comment to make on this point. It was also put to her that she wanted to kill the children, because she suspected her husband of having had an affair and that he would take the children with him to another woman. She denied that this was so. There was also no argument over the phone with her husband as

Dr Kariuki had said. It was simply a disagreement about the variations to the home that she had in mind.

34.

Towards the end of her evidence I asked her about details relating to the protection order that she had sought. She testified that she had said therein that he had a history of abuse and had abused her before. She thought that she did say that he had assaulted her. She did exaggerate however in that regard “to prove a point”. The point was “that he should not even try. He should not even mess with me”.

Her husband however did not ever assault her. As far as the birth of the daughter in January was concerned, she testified that they had discussed the incident and decided to have another child.

35.

Prof C. Brink:

Prof Brink holds a Ph.D. degree in pharmacology and is a full Professor in pharmacology at the University of North-West since 2009. Regarding his “fields of expertise”, the following was said in Exhibit R1, which contained his Curriculum Vitae and details of professional experience as well as his expert report. Under the heading “Education” it is said that it is “Technology-based learning. The pharmacology of cardiovascular drugs and drugs sexual health”. He teaches the pharmacology of drugs employed in the treatment respiratory diseases, amongst others.

36.

His report dated 19 July 2017, was addressed to Adv Pistorius, and was prepared at his request. He consulted with the accused and obtained certain information from her as well as from textbooks and literature from the internet. Exhibit A was also given to him which contains details of the medication allegedly taken by the accused prior to the shooting, and on the day of the shooting. He did however not investigate

or evaluate the sports-supplements referred to therein. Exhibit R2 contains details of the literature that he referred to.

37.

With reference to his expertise, he stated in his report that this involves translational pharmacology, describing the relationship and interplay between basic pharmacological principles and the clinical implications thereof. He is a qualified pharmacist, has post-graduate training and experience as a pre-clinical pharmacologist. He said in his report that he could provide a sound evaluation of the "potential role of medicines used by the accused, from a broader pharmacological perspective, as explained in scientific literature and interpreted in the context of this specific case".

Under the heading of "CASE BACK-GROUND INFORMATION PROVIDED", he said the following: "Mrs M. shot and killed her two biological children in her car after picking them up from school on 17 April 2015. She has no re-collection of the shooting incident itself, but remembers only to a certain extent of what happened

prior to and after the incident. She also experienced melancholia, in particular an overwhelming feeling to commit suicide, the morning before the incident. However, there is no history of psychiatric disorder or drug abuse, and no psychiatric diagnosis following mental observation after the incident, and she reportedly presented a sound mental judgment when assessed during the weeks following the incident".

38.

Under the heading "Important for this report", the following was said:

"Important for this report, Ms M. claims to have taken a number of prescription drugs, over-the-counter medicines (with proof of possession from cash slips) and other substances on the day of the incident, however she is unable to state with precision the exact quantity of the medication and/or substances consumed separately, intermittently and/or in combination on the day of the incident. She claims that a vast quantity of medication was consumed.

Firstly, the prescription drugs (medicines) consumed on the day of the incident include:

- Symbicort® turbuhaler (budesonide 160 µg + formoterol fumarate 4.5 µg per inhalation) for the treatment of asthma;
- Mypaid Forte® (ibuprofen 400 mg + paracetamol 325 mg per tablet) for the treatment of pain and inflammation;
- K-Fenak® (diclofenac potassium 50 mg per tablet) for the treatment of pain and inflammation;
- Migril® (ergotamine tartrate 2 mg + cyclizine hydrochloride 50 mg + caffeine 100 mg per tablet) for the treatment of specifically migraine-associated pain.

Secondly, she has also been taking the following medicines on the morning of the incident:

- Empacod® tablets (paracetamol 500 mg + codeine phosphate 20 mg per tablet) for the treatment of pain;
- Alcoholic red wine (12% ethanol (EtOH) › estimate: 1 glass = 3 units = 24 g EtOH);

- Red Bull® (caffeine 80 mg per 250 ml can, as well as taurine, B-group vitamins and sugars)".

39.

The objective of his report was to investigate whether medication used by Mrs M. could explain her erratic behaviour to kill her children without any recollection thereof. The mandate was to look at the reasonable likelihood (either theoretically or as from clinical reports) of any relevant drug (medicine) effects or side-effects or interactions that may likely to have occurred (or not), and that may provide a reasonable explanation (or not) for her behaviour.

40.

In his evidence, and with reference to his report, he then described the purpose and effect of the various medicines that the accused said she took before the day of the incident. I will accordingly deal with the crux of his comments on each of these substances:

1. Budesonide (Symbicort Turbuhaler): Budesonide is a corticosteroid, typically administered per inhalation to reduce chronic bronchial inflammation, underlying the pathology of bronchial asthma. A prescription is needed for this substance. In his report he referred to effects after administration of higher doses of corticosteroids which could amongst others cause hyperglycaemia and may also have acute psychotropic effects.

   In the treatment of asthma, budesonide is administered via inhalation thus minimizing systemic effects associated with oral or parenteral administration of corticosteroids. He described the effects of higher inhaled doses and that the psychotropic effects would result within about half an hour, lasting a few hours.

2. Caffeine (Migril and Red Bull): Caffeine is a central nervous system stimulant and its typical effects in the brain include enhanced alertness and ability to concentrate, but sometimes also increased irritability and insomnia. It also bolsters the analgesic effects of several pain-alleviating medications, so that it is often combined for that purpose. Caffeine toxicity can be

associated with anxiety or even panic, disorientation, disinhibition (leading to inappropriate behaviour) or even psychosis. With reference to literature he stated that fast and slow metabolisers have been prescribed depending on individual, physiological and environmental conditions. It readily crosses the blood-brain barrier, giving rise to effects in the central nervous system. This implies that maximal effect may potentially be seen within an hour, and could last for several hours.

3. Codeine (Empacod): Codeine is an opioid drug. It may also promote histamine release, and although not common, it may cause nausea and vomiting. Codeine is converted to morphine typically in one hour, although the quantity produced is dependent on whether the individual is a poor, intermediate, extensive or ultra-rapid metabolizer. He agreed that there was no evidence into which category the accused fell.

4. Cyclizine (Migril): It was put to him that it was common cause in these proceedings that the accused had used Migril since about the age of 16. It is an older generation anti-histamine, and is commonly used for the treatment

of nausea and motion-sickness and also to treat allergies. It also exerts a mild analgesic effect. A common side-effect is drowsiness. The accused used this medication for migraine, but he stated that it did not address the migraine pain, but addressed the nausea.

5. Diclofenac (K-Fenak): This is an over-the-counter medicine and is a non-steroidal anti-inflammatory drug. It is used for inflammation, pain and temperature control. It may also exacerbate asthma in sensitive individuals. It may also cause dizziness.

6. Ergotamine (Migril): This is a potent vasoconstrictor used for the treatment of acute migraine attack. He stated that "Central side-effects are mostly associated with agonism at D_2 receptors and, although usually not severe, few cases of significant altered mental status, confusion, combative behaviour and sensory hallucinations have been reported". The absorption and metabolism of Ergotamine is known to be erratic. It has a rapid onset of action so that it is removed from the plasma within hours.

7. Ethanol (Alcohol in red wine): The accused's evidence was that she had one glass of red wine at lunchtime.

8. Formoterol (Symbicort Turbuhaler): This relaxes the bronchial smooth muscles in the lungs and is used as inhalant for the treatment of chronic bronchial asthma.

9. Ibuprofen (Mypaid Forte): This is similar to the Diclofenac referred to above. It is a prescription drug, although it can be obtained in small doses over the counter.

10. Paracetamol (Mypaid Forte and Empacod): Tablets are commonly used to treat mild to moderate pain and fever. It is often combined with other classes of analgesics to enhance pain relief. Safety is strictly limited to therapeutic doses.

41.

In the context of drug interactions, Prof Brink stated that Migril taken when the accused had her menstrual cycle "could" have played a role. I asked him whether

this would depend on facts of each individual case and the doses of each drug, and he replied in the affirmative. The leaflets contained in each drug container described all possible side-effects. Drug interactions described how drugs influence one another. One drug can influence the good or unwanted effect of another. It can also influence absorption, distribution, metabolism and excretion of another drug. In his opinion, these interactions were at play with the medicines that the accused took. Different individuals respond differently and the same individual may respond differently on different occasions. This implies *inter alia* that not all people will experience the same side-effects from the same medicine, and that the same person may experience different side-effects from one day to another. These differences are determined by a host of factors, including genetic make-up, weight, age, sex, hormonal changes, disease, metabolic status, food intake, and other medicines or substances used, as well as psychological status, all of which may be different between individuals and also different for one person between different days. All medicines have anticipated/potential therapeutic benefits and

anticipated/potential risks. Risks may be small or large, but there are no medicines without any risks.

Time to maximal blood levels and duration of effect is determined by drug properties, food or substance intake, and other factors relating to the gastro-intestinal tract. The time from oral consumption of medicine to therapeutic or toxic, can be estimated within a rough range. He said that “from typical pharmacokinetic parameters of the drugs taken by accused, it could be estimated that near maximal to maximal effects would have presented roughly between 30 minutes and four hours after consumption, and that effects would thereafter have worn off during the remainder of the day. Concomitant ingestion of alcohol may enhance solubility and absorption. The maximal dose of drugs without unacceptable side-effects may be dependent on drug and substance interactions, intra- and inter-individual differences, therapeutic index, tolerance and pharmacokinetics of absorption. Although there are those ranges that would normally be considered safe, this may not be a simple one-size-fits-all calculation. The complexity of factors at the time of medicine consumption and then the incident in the M. case, may render exact

calculations of doses needed for toxic effects, almost impossible. He then said the following in his report: “The combination of medicine and substance use, pathophysiological and hormonal-physiological status, as well as psychological status of Ms M. on the day of the incident was very complex with a significant degree of uncertainty about the intensity and extent. It will be virtually impossible to recreate the exact scenario of complexity to verify her biological, mental and psychological status at the time of the incident. Any such attempts may give rise to false positive and/or false negative results, and will in no way be conclusive”.

42.

As far as the information and warning in leaflets was concerned, he said that such information was extensive, but did not describe the combination of drugs in all cases. It was impossible to reconstruct possible side-effects and the exact set of side-effects in her complex scenario that she was allegedly in.

43.

Under the heading of “FINDINGS AND DISCUSSION”, he said the following amongst others:

1. Of all the medicines and supplements used, Migril “immediately” struck him as containing the drug ergotamine, with a side-effect profile that includes compromised mental and emotional well-being. There seems to be a significant inter-individual variation and potentially even intra-individual variation in pharmacological response, as well as interaction with other substances to explain idiosyncratic effects;
2. The metabolism of ergotamine leaves the potential for many drug-drug interactions, and even a significant interaction with grape juice, and potentially also with caffeine (Migril and Red Bull);
3. “To expand on the aforementioned possibility of ergotamine toxicity, the dose of ergotamine (Migril 4mg in two tablets), together with interacting drugs such as budesonide (Symbicort) and high-dose caffeine (Migril and Red

Bull), may have resulted in unexpected elevation in ergotamine levels and hence more side-effects, which may have included central effects".

4. Codeine is known to cause nausea and vomiting, and it would be difficult to distinguish such side-effects from side-effects of migraine;

5. Budesonide (Symbicort) may potentially have supported any euphoria, confusion or even psychosis by other drugs, such as ergotamine, ethanol and codeine;

6. Diclofenac (K-Fenak), has been associated with dizziness and nervousness, and less frequently with irritability, anxiety, memory disturbance and even psychotic reactions;

7. Symbicort could lead to confusion if used in excessive doses. Although there was no background information to suggest that this was likely to have played a significant role, its potential contributory role could not be ruled out. As will be seen, this is contrary to the opinion of Dr Savov, who attributed a major role to Symbicort.

44.

The following summary appears in the report of the witness: “In summary, taken the erratic nature of ergotamine absorption and the co-administration of budesonide and high doses of caffeine, it is conceivable that ergotamine blood levels could have reached toxic levels in Mrs M., different from previous times she took this medication. Central toxic effects could then potentially include melancholia or mania, psychosis, memory loss and impaired judgment. Furthermore, it is conceivable that codeine, particularly in combination with alcohol, and budesonide may have contributed significantly to central side-effects, including confusion. One should not forget that severe forms of migraine have also been associated with altered cerebral blood flow, as well as impaired cognitions and effect, which could have further contributed to a complexly altered psychological and mental status”. With reference to the “erratic nature of ergotamine absorption” he said that such absorption cannot be predicted. His reference to “conceivable” meant that rational argument could be made out for that conclusion. He was asked which facts he was given regarding the intake of medicine and stated that he was referred to the medicines listed in Exhibit

A, which were taken in unknown quantities on the particular day, some minimum quantities during the previous days and at unknown intervals. I asked him what he then accepted as the basis for his report with reference to the facts. His reply was that the medicines were taken as per the plea explanation in unknown quantities and at unknown intervals. Further unknown factors were her exact physiological status, details of her menstrual phase, and exact content of her stomach.

45.

Under the heading of “FINAL CONCLUSION AND RECOMMENDATIONS”, he said the following in his report: “In conclusion it is conceivable (reasonably possible, he added), that Mrs M. could have experienced toxic side-effects of ergotamine, including melancholia and suicidal thoughts, loss of memory and impaired judgment. Such side-effects could be potentiated by the central side-effects and/or metabolic effects of codeine, budesonide and alcohol. In particular, a severe migraine attack associated with altered cerebral blood flow plus the co-administration of the aforementioned medicines could collectively have increased the likelihood of such

catastrophic side-effects". He added the following: "The information provided in this report is NOT conclusive to prove (confirm) that Mrs M. indeed experienced the said toxic effects. However, it does suggest that there is a reasonable possibility that this may potentially explain her erratic behaviour and loss of memory".

46.

He was asked whether his view of the adverse side-effects was farfetched, remote or precise, and replied that they were farfetched in the context of any individual medicine, but in this particular case the combination of the drugs meant that the likely outcome was that she experienced psychological side-effects. By that he meant a "clouded mind", an "altered mood" the exact extent of which he could not state. There was a reasonable possibility that she knew nothing about the children's shooting.

47.

The witness then also referred to aspects of the leaflets which accompany every medicine referred to in this case, and of which he made a copy in a separate Exhibit Bundle. He dealt with the general side-effects of each of such substance in his main report and in his evidence, and I have referred to the summary of that evidence.

48.

Cross-examination of Prof Brink:

Upfront he readily conceded that if information given to him was lacking, or there was additional information, or if the accused had not been truthful, this would have a bearing on his conclusion. The actual shooting incident had not been discussed with him and he was given only details of the medication taken. He also did not study the case record. The medicine could cause confusion and memory loss, and he said that this was likely that it had occurred. When details of the accused's evidence were put to him plus the common cause facts relating to the shooting, and what she had conveyed to the persons near the scene of the incident, he stated that these

were new facts to him, but that someone in a psychotic state would still have automatic brain function, and could for instance drive a motor vehicle. He agreed that driving for a distance of some 20km, going through a toll gate and deciding which route to take at a T-junction was not an automatic behaviour. Psychosis was a possibility, but this did not imply that there would be no memory, as it is a lack of contact with reality. The loss of memory could be explained by the side-effects of the medicine, but he could not say whether there would be no memory or partial memory. No definite answer could be given, but there could well be partial memory. He was not aware that the accused had stated that she had snap-shot images of her actions of that day. He would expect no recollection of the whole incident. He was not aware that she had a snap-shot image of children strapped into the car seat, and also awakening whilst lying on gravel and seeing the children lying in blood. He had also not read the report of the psychiatrist, Dr Kariuki. In that report mention was only made of the inhaler and Mypaid Forte (of which he was not aware), and he stated that if only that medicine had been taken, he would not have expected any memory loss. He had no conclusive facts relating to doses and

intervals at which medication was taken, and therefore could not make a definite conclusion, except for saying that there was a reasonable possibility that she had no recollection of the incident in the light of what was provided to him. He provided his opinion on the basis that she had taken five pumps of the inhaler on Friday, two Mypaid Forte, two K-Fenak as always, and two Empacod as always. He agreed that if information given to him was incorrect, his conclusion would be wrong. He agreed that severe side-effects of the use of Symbicort would occur if this inhaler was used for longer than five days. This was however dependent on whether or not high doses were taken and if 1000 mg were inhaled. About seven pumps would achieve this dosage. On the accused's version, she used the inhaler for two and a half days at most, and he agreed that on its own it would not have caused the symptoms relied upon. In aerosol form, the dosage inhaled was in fact low.

49.

As far as codeine was concerned, he was unable to present a final dosage. As far as Migril was concerned, it was put to him that the accused had not been able to

say what dosage was taken and at which intervals, and he was asked whether this would have an impact on his opinion. He answered in the affirmative. One did not know what dosage she took and he said that on its own, it was highly unlikely that Migril contributed to automatism. Small doses of Migril would indeed affect his finding. It was put to him that it was noteworthy that the accused had made no mention to Dr Kiriuki of Migril. As far as his reference to “significant altered mental status” was concerned, he said that this meant that thought processes were interrupted, that a person was slower in thought, and portrayed less accurate reasoning. One would pick this up if having an in-depth discussion with such person. No single drug would have caused the condition relied upon by the accused in this trial, but it was possible that it occurred when the mentioned drugs were taken in combination. He agreed that the proviso to this was that one needed to know the doses and the intervals at which the medication was taken.

As far as Mypaid Forte or Empacod was concerned, it was put to him that the accused could not explain how many she had taken or at which intervals. The therapeutic doses of Forte, according to the pamphlet relating to it, were two tablets

every four hours. He had no personal knowledge of what was contained in any such pamphlet and his evidence was based merely on what was contained therein. No serious side-effects were expected from the use of these tablets.

Ergotamine would cause toxicity, but only if taken in higher dosage. In the context of his “findings and discussion” contained in his report, I asked him whether he had expert knowledge of the topics contained therein, and replied that he had obtained his knowledge from relevant literature, but had no personal knowledge thereof. He agreed that the effect of medicine was different in different persons at different times. He agreed that there was no evidence that she had suffered from hypoglycaemia. He was asked as to what toxic side-effects were present in this case, and replied that side-effects explained erratic behaviour which could be psychosis and memory impairment. It was not within his area of expertise to say that the amnesia could have resulted from the fact that a brain protects itself against trauma. He could not recall whether the literature that he relied on referred to any suicidal thoughts resulting from medication. Ergotamine would only have side-effects if taken in large doses or with other drug interaction. He agreed that it was

impossible to reconstruct the exact side-effects on that particular day and when then asked why, he said that it was a reasonable possibility that drugs had caused the particular behaviour, and that side-effects and the interaction of drugs were all documented. He however agreed that if one did not know the doses of drugs taken, or the intervals at which they were taken, one could not give conclusive evidence, but only what possibly could have happened. He did not think that any individual drug caused the relevant effects, but a combination of all could possibly have been the cause.

50.

Dr M.:

Dr M. is a specialist psychiatrist in private practice in Pretoria with branches in Bloemfontein, Polokwane and Mahikeng. He met the accused early in 2000, whilst he was still married. They had a relationship at the time, he divorced his wife and married her in 2011. It was therefore correct to say that they had been in an on-going relationship for some 12 years. He had two children from the previous

marriage, aged 21 and 17 at the time, who lived with them. This was done by agreement with his previous wife. They were happily married and there were no major issues in their relationship. There were certainly no abuse issues emanating from him, be it physical or mental.

He admitted that in 2011 an interim protection order had been issued against him at the request of the accused. They were not married at the time and he was in the process of divorcing his wife. Those were difficult times, and with hindsight he could say that he did not give her enough attention as he was suffering from stress. He received this order with a return date, but it was withdrawn by her before that. Her root complaint was that she had felt threatened, because during an argument she had apparently never seen him that angry, though he never threatened her physically.

51.

From then onwards they had a good relationship and were also the best of friends. He was not aware that there was any substance abuse in their household. He did

not drink alcohol, but his wife a glass or two of wine when they went out. Her relationship with his children was also good and they all got along well. She loved her own children.

52.

During her menstrual cycle she was moody and irritable and also sometimes depressed. This was however not every month and it did not bother him. He also did not act as her physician and did not treat her for any illnesses. She had her own general practitioner and a gynaecologist.

He was aware that she had a longstanding migraine problem and had seen a neurologist in that regard. She had mentioned to him that she had received medication from one of her doctors. During such migraine she complained of severe pain on the one side of her head which also affected her vision. She then felt nauseous and very irritable.

53.

At the time they were building a new home and his wife was overseeing the project and for all practical purposes was the project manager. She was also the administrator in his practice which for the last 10 years mainly consisted of a compilation of medico-legal reports for the Road Accident Fund litigation.

54.

The accused was very health conscious. He described her as a “physical fanatic” and she even had a personal trainer at home. At home they were also assisted by two employees for the general household.

55.

He himself had prescribed Symbicort for the young child A.. Beyond that, he did not readily treat his own children and referred them to a paediatrician when they were ill. An asthma pump had also been previously prescribed for the child by a paediatrician, and the accused had administered it.

56.

Before the incident, she did complain about a tight chest and she cancelled the session with the personal trainer at home. She also had her menstrual cycle at the time. Asked to describe her general well-being, he said that she felt “low”, but was not sick and just felt unwell. Asked whether he had noticed anything out of the ordinary regarding her mental state, he said that she was just ”down”, which he took as normal in her menstrual cycle. She was sad, but not clinically depressed: simply not her normal jovial self.

She told him that she had used the inhaler and that she did obtain some relief. He did not guide her regarding the dosages.

On the Thursday preceding the incident, he was busy with the construction project and saw her only in the evening. She complained that she was not feeling very well, but he just dismissed this and asked her to see her doctor. There was no in-depth discussion about that topic. He could not recall any particular complaint, but remembered that she felt nauseous and had a headache.

57.

On the Friday morning she left before him to take the children to school. During the day there were telephonic exchanges when they spoke about the construction project. There was no quarrel, but they did disagree on aspects of the construction, namely the size of the future bathroom.

58.

He never told her, or even suggested to her, that he would leave her for another woman. There were no infidelity issues in their marriage at all. There were no threats of divorce from either side.

59.

On Friday he was at the building site when he missed a call between about 14h00 and 15h00, but he could not recall the exact time. He returned this call after 30 minutes and a lady answered. He was told that she was with a woman who alleged to be his wife and had said that she had shot the children. He was shocked and

could not believe it and then terminated the call. After a while, he called again and asked her what vehicle was on the scene. She then described their vehicle and told him that she would meet them at the particular off-ramp, which she did.

On the scene, he met the female police officer who did not allow him to go the actual site of the shooting. His wife was in the police vehicle, and after a while was given a minute to see her. It was very brief. She appeared dirty, had stains on her face, and her glasses were smudged. She “mumbled incomprehensible things” without any particular logic. He did not ask her what had happened. There was something obviously wrong with her and she was not her usual self. A strong stench also emanated from the police van. He stayed at the scene until the crime scene investigation unit arrived. The crime scene was about 100 to 150m away from him and he could see the BMW. His mother also arrived at the scene later.

60.

The next day he spoke to her at the police cells. She was crying and looked dazed. She was not herself and again he did not ask her what had happened. This was a

conscious decision. Other family members were there as well and he wanted a private moment. A few days later he was taken to the Central Prison in Pretoria and he visited her there. She still looked sad and when he asked her what had happened, she said that she did not know. He did not probe this reply.

61.

The fire-arm that was used was a .38 special which was kept in a safe. The chamber took five bullets and he normally did insert these five bullets into the chamber. The ammunition was .38 ammunition and he did not have any 9mm ammunition referred to in the charge-sheet before amendment. The safe was locked and required a four digit pin code. His wife had never used this fire-arm, had never handled it and she also did not see him use it.

62.

He arranged Dr Kariuki, a psychiatrist, to see her as they were working in the same building. He was not present when she was seen by him. She was also sent for

observation to Weskoppies for a 30 day period. The relevant panel of doctors did not contact him in that regard.

The accused's Counsel put to him that it was difficult to understand why he still supported his wife. He replied that the children were their children, and not only his. She had been a loving mother and it was out of character for her to have done the deed.

Asked what her condition was like at the present, he said that she was often sad and depressed. Another child was born in January 2017, and this had been a conscious decision. He did not assist the accused in formulating a defence and neither did he guide her in that regard. He had suggested that she see Dr Savov, a psychiatrist. He was asked whether he had been aware of any emotional instability before the incident and he replied in the negative. She only suffered from migraines and was moody and sad during her menstrual period, but all was normal. Since the incident, she still uses pain medication for headaches, but he was not over-seeing any treatment.

63.

He was cross-examined about details of the protection order, but could not provide such.

She still suffered from migraine which has no cure. She was taking pain medication for that condition, which was prescribed by her gynaecologist. He could not give details. The contents of the record of the bail application was put to him, where he had said that he had not been aware that his wife had suffered from shortness of breath. On the day before the incident, she did complain however. She never suffered from shortness of breath until a few days before the incident, and as a result cancelled the session with the personal trainer.

In the context of the relevant exhibit reflecting the route to Wallmansthal and the tollgate, he said that he was not consciously aware of the fact that he had used this particular tollgate. When he was on the scene that afternoon, it was not yet dark, but getting dark. When the accused spoke to him, she used words he could not understand and was not sure whether his reference to “mumbling” was correct. He could simply not comprehend her. She said that she did not know what happened

and could not remember. At the Pretoria Central Prison she told him she remembered nothing. He does not know what drove her to do the deed.

It was easy to shoot with the particular fire-arm. There was no safety pin and there was no kick-back.

He was still happily married. The accused did not tell him about suicidal thoughts before the incident. A while afterwards she did mention this however. He did not know why this condition had not been shared with him. He also did not notice that condition, she simply looked “down”. He denied that he had ever told her that he would leave her for another woman.

64.

I deemed it necessary to ask the witness certain questions pertaining to the contents of Exhibit A, the Plea Explanation. He said that the accused does not use the inhaler, because she was breastfeeding. She still uses pain medication, but could give no details. She also did not complain about a tight chest anymore. In the last year she had not been treated for depression.

I asked him what had changed since the incident regarding the intake of medicine. He replied that she no longer complains about a tight chest. She does not use alcohol, because of the breastfeeding. He could not comment on the exact compounds that she uses for pain. The tightness of the chest in fact disappeared since the incident. He was asked whether he was not afraid that a similar incident would happen again and replied that he could not – not be afraid, but that it was out of character. Asked whether there were any safeguards in place in that context, he replied that he had pleaded with her to talk to him when she was depressed. He did have a discussion with her about the usage of medicine and their side-effects. This was a discussion only as him being a husband and not a doctor.

65.

Dr R. Savov:

Dr Savov is a specialist psychiatrist in full time practice. He obtained his Ph.D. in psychiatry at the Medical University of Varna, Bulgaria in 1986. He handed up his Curriculum Vitae as an exhibit. A note at the end thereof states that he has 36

years of psychiatric experience, 11 of which were gained in Bulgaria and 25 in South Africa. Fifteen years of this experience has been clinical work at teaching at university hospitals and this includes the positions Junior Lecturer to Associated Professor/Chief Specialist and Head of University Department of Psychiatry. The main areas of his many publications include anxiety disorders, psychopharmacology in treatment of mental disorders, community psychiatry, psychosomatic medicine and methods of assessment and psychiatric research and forensic psychiatry.

66.

He handed up a “Psychiatric Forensic Report” dated 28 July 2017. The accused was referred to him by her Attorney and he first saw her on 30 September 2015. The reason for referral was to assess her mental state during the commission of the deed on the afternoon of 17 April 2015. Collateral information was obtained from her husband as well as from the psychiatric report of Dr F. Kariuki, and additional statements by the accused. Information regarding the safety of certain medications

was obtained from medical and specialized psychiatric books as well as from review of their safety records. He would refer to these “exhibits” in his report.

67.

His first consultation with her lasted about three hours and then he also hospitalized her in Witbank from 29 February 2016 to 4 March 2016. As far as her medical history was concerned, he noted that she had a long-lasting history of migraine which dated back to her teenage years. She took pain medication and non-steroid anti-inflammatories on occasional basis. She also reported short-lasting episodes of de-realization when things were appearing smaller than that they really were.

She also suffers from pain of explosive character and also of pain in the back of her neck and head lasting a few minutes. She further reported mood changes during her menstruation when she became tearful and withdrawn. She also reported episodes of mild asthmatic attacks which were provoked by exercising and which manifested with difficulties in breathing and “tight chest”.

68.

Under the heading of “Past Psychiatric History”, he said that there was no previous history of psychiatric problems, including suicidal behaviour prior to the incident. She had never taken psychiatric medication prior to this date. There was no history of severe stressful life events in the year preceding the offence. At the time of the incident, they were building a new family home and she was managing this project herself. She was also busy with her B.Tech. in System Management Studies during that time. There was no history of psychiatric illness in her family.

69.

He continued his evidence with reference to his report and the heading “History and Events on the Day Preceding the Incident”:

“On the morning of the day of the offence she dropped her children off at school and crèche and returned home. She took various pain medication and Migril for extreme migraine attack. She also used an asthma pump to relieve tightening of her chest as she had done for the last two days. She had telephonic discussion with her husband

around the building of their home including offloading container with tiles and fixtures.

After returning home she found her husband not there but already at the building site. She remembers above provoked deep feeling of loneliness. She recalls phoning him to find out where he was and he told her that he was at building site. She also remembers having later a telephonic discussion with him over different options in the building constructions.

Above conversation deepened her feelings of sadness. She remembers that an overwhelming suicidal feeling came over her and that she went to her bedroom took out the firearm of her husband from the safe, went back to her car and wanted to kill herself.

She recalls going to Pick n Pay to buy nappies and other items for her youngest son (according to till slip at 12h50pm). On the way to school she bought numerous items from Dischem which includes flu medication for her son, pain tablets, Migril, toothpaste, hand wash, etc. and she paid at the counter at 13h31 pm (29 items bought). She took some more pain tablets thereafter.

She remembers escalating despair and overwhelming feelings to commit suicide after she fetched her eldest son from school.

It is at this point to emphasize that at no time even around her suicidal ideation she thought of killing her own children.

As from that time she only has vague recollections of sitting at the steering wheel and driving to an unknown destination with both her children strapped in the car. She has no recollection of shooting her own children. She has snapshot memories of trying to shoot herself with a gun that would not fire after realizing that she shot her own children. She vaguely recalls running around and asking people to call the police.

She has recollections of being detained and put in a police van and as well as being overwhelmed with feelings of severe guilt, despair, shock and remorse around her husband. She also recalls feeling cold and nauseous."

70.

At present, he said that her immediate, short - and long term memory is intact. However, she has amnesia (loss of memory) of the events surrounding the incident which starts off from the time she collected her eldest son until the moment she woke up and realized she had shot her own children. In his opinion, this memory loss was consistent with the features of dissociative amnesia which was triggered off by extreme shock and facilitated by side-effects of medication. Dissociated amnesia is a well-known diagnostic category and it occurs in cases of severe trauma and stressful life events which are unacceptable to the particular person. As far as "snap-shot memories" were concerned, these are highlights of recollection and not full amnesia.

71.

It is convenient for purposes of this judgment that I quote his discussion of the evidence as he had it, and his opinion on the events as contained in his written report:

“Until the day of the incident Mrs M. was apparently a healthy young woman without any history of mental illness.

Two days prior to the incident she suffered severe migraine attacks, menstrual pain and tightness of chest with difficulty breathing. She took several pumps of Symbicort asthma pump (combination Budesonide and Formoterol) together with several tablets of Mypaid Forte (combination of Ibuprofen and Paracetamol). During the next day she took again several pumps of the asthma pump, Mypaid Forte (combination of Codeine, Paracetamol and Ibuprofen) and Migril tablets.

On the day of the incident, Friday 17/04/2015, she took unknown quantity of more pumps in a period of 7-8 hours together with Migril tablets (Ergotamine, Cyclizine and Caffeine), Mypaid Forte and K-Fenak (Diclofenac and Potassium). Around midday the same day she had a glass of wine and made herself a sandwich. She did not eat the whole sandwich.

Despite the pain and her tight chest on the morning of 17/04/2015 there was nothing to suggest that her behaviour was out of her daily routine including discussions with her husband around the building of their new home.

Two to three hours prior to the incident she went to Pick n Pay to buy nappies for her youngest son and other supplies. She paid at the teller at 12h50 pm. She thereafter went to Dischem to get more supplies and medication for him as he was suffering from mild flu. She also bought pain medication for herself and took additional K-Fenak, Migril tablets together with Empacod that she had purchased. She paid her bill at 13h31. She took the medication with red bull.

She picked up her youngest son from crèche. She took additional medication which she had bought from Dischem. Half an hour later around 14h30 she drove together with her younger son to pick up her eldest son. She strapped both children in the vehicle and drove off.

Mrs M. recalls that on the morning of the same day she woke up early and after she prepared them and dropped them off at school she came back home and found her husband not at home. She remembers having a short telephonic discussion with her husband over some variations of the building construction. She experienced for the first time a sudden and deep feeling of loneliness. She recalls going up to the

bedroom, taking the firearm from the safe and want to commit suicide with it whilst seated in her car.

Above feeling escalated again into feelings of despair and overwhelming feelings to commit suicide soon after she picked up eldest son from school at around 14h30 on the same day. She remembers strapping both children into the car and herself sitting at the steering wheel.

As from that time she only has snap shots of driving with both her children to an unknown destination. She does not remember, stopping at a completely unknown place, taking and firing the gun and killing her children.

She only has vague memories of trying to shoot herself with a gun which would not fire, realizing that she had shot her children. She recalls running around and begging unknown people to help her kill herself and asking them to call the police.

She remembers being detained and put in the police van completely broken down with feelings of remorse, despair, guilt and failure and trying to imagine the reaction and shock of her husband. She also wet herself in the van.

I am of the opinion that Mrs M. developed a short lasting severe Medication Induced Psychotic Depressive Episode characterized by escalating feelings of sadness, despair, loneliness, failure and overwhelming self-destructive trends.

Above episode can be directly related to combination of side effects of medications which are well known with their ability to provoke suicidal ideation.

I would consider Symbicort and Migril as most important in this regard.

It is of note that both ingredients of Symbicort (Budesoniden and Formoterol) can induce suicidal ideation (see exhibit about safety record).

In this regard the additional interaction with Cyclizine, Ergotamine, Codeine and together with small amounts alcohol aggravated the above short lasting psychotic depression with severe suicidal trends.

It is also of note that suicide inducing reactions to Symbicort are much more common in female users with non or only short lasting previous exposure to above medication as in the case of the accused.

In this regard it is also of note the FDA safety update on asthma medication from 03/10/2015 (see exhibit).

I am of the opinion that her actions of shooting her own children dead and trying to shoot herself thereafter can be accommodated into so called “extended suicide” (also known as “mercy killing”, “altruistic suicide” or filicide). Above is a hallmark of severe depression when mothers want to kill themselves but don’t want to leave their children suffering without their protection and therefore take their lives “to spare them from suffering” and then kill themselves or attempt suicide.

This category is well known in Clinical and Forensic Psychiatry. (Oxford Textbook of Psychiatry) (See exhibit).

From medico-legal point of view her behaviour during the commission of the offence meets the criteria of the so called “temporary non-pathological incapacity” as a form of “sane automatism”. The above refers to offenders who are not suffering from any pre-existing mental illness but had concussion, hypoglycaemia, sleep walking, involuntary intoxication or severe psychological blow. In this case the behaviour of the accused was as a result of so called “involuntary intoxication”.

The signs of above automatism as a full defence are summarized in the so called Fenwick criteria which are met in this case and namely:

1. Actions are completely out of character.

2. No evidence of pre-meditation.

3. No attempt to conceal actions.

4. No recollections of the events around the incident with amnesia of so called dissociative type so called Psychogenic or Dissociative Amnesia (see exhibit).

I am therefore convinced that in terms of Section 78 of the ***Criminal Procedure Act*** during the commission of the offence on 17/04/2015 the accused due to her mental illness was not able to appreciate the wrongfulness of her actions and to act accordingly.

Above discussed side effects of medications caused short lasting but severe Medication Induced Psychotic Depressive Episode with prominent destructive and suicidal trends.

The side effects can be regarded as idiosyncratic reaction. As already mentioned above medications are known to cause above side effects and specifically suicidal behaviour.

In a medico-legal terms, above condition therefore meets the criteria of “sane automatism” and non-pathological incapacity.

At the time of my forensic assessment nearly one year after the commission of the offence I found her fit to attend Court proceedings and to offer a proper defence.

In this regard she is triable in terms of Section 77 of the ***Criminal Procedure Act***”.

72.

The witness then arrived at his conclusion which reads as follows as it is conveniently described in his written report:

“At the time of the commission of the offence she developed short lasting but severe Psychotic Depressive Episode with prominent suicidal trends.

Above episode was directly related with idiosyncratic reaction to medications which are known to cause such self-destructive trends.

Her mental state at the time of shooting dead her own children and her attempts to kill herself thereafter can be accommodated within the so called “extended suicide” actions which is regarded as a hallmark of severe depression.

In medico-legal terms her behaviour covers the criteria of “sane automatism” caused by involuntary intoxication.

Her loss of memory is proof of partially clouded sensorium and Dissociative Amnesia due to tragic realization that she had shot both her children and facilitated by side-effects of medication taken by her.

I am therefore of the opinion that in terms of Section 78 of the ***Criminal Procedure Act***, at the time of commission of the offence and due to above described mental illness the accused was not able to appreciate the wrongfulness of her actions and act accordingly.

In terms of Section 77 of the ***Criminal Procedure Act*** the accused is capable of understanding the Court procedures and to offer a proper defence”.

73.

His reference to “Symbicort and suicide attempt - from FDA reports” consisted of two separate exhibits (S3 and S4) which according to him indicated that the use of Symbicort lead to suicidal tendencies. It is however clear from those documents

themselves, and especially having regard to the “Summary” that this extract refers to people who have attempted suicide after taking Symbicort, and who are female and aged 60+, and who have taken the drug for longer than one month, as well as the drug “Crestor”, and who have had depression. The relevance of this extract is therefore difficult to accept. Furthermore, it is clear that this is not a finding from the actual FDA reports, but is a purported extract by a support group for people who have taken Symbicort and have attempted suicide. It is stated that some 45 000 people have reported to have had side-effects when taking Symbicort and from these some 74 people (0.16%) have attempted suicide. It is also not clear what relevance this “statistic” has to homicide or even “extended suicide” which implies the presence of *mens rea* and appreciation of wrongfulness.

After argument I ruled that these purported reports were not admissible. They are not relevant on the one hand, taking into account the “Summary” that appears on each of these extracts, and furthermore taking into account that the extracts were drafted by a support group and/or an individual member of such support group. These extracts are clearly of a hear-say nature as well and, contrary to Mr Pistorius’

argument, ought in my view not be accepted as evidence under the mantle of the interests of justice in the context of provisions of s. 3 of the ***Law of Evidence Amendment Act 45 of 1988***.

74.

In the context of his reference to “extended suicide”, he stated that this occurs when a mother decides to kill herself and also the children so that they would not suffer. It was put to him by accused’s Counsel that in this case the evidence was that one child had been shot once and another more than once. He replied that in such a case the parent wants to kill the children and not injure them. It was a delusional way of thinking. In that context he gave a number of examples of horrifying incidents which occurred in the United States of America and resulted in particularly cruel deaths of children. At that stage it was my opinion and decision that I deemed such examples to be irrelevant in the context of the facts of the case as I had them at the time of him giving evidence. It was also put to him that it was undisputed that the accused was able to drive for some distance on the freeway, proceed through a

tollgate and then take an off-ramp with a T-junction. His explanation was that people with severe depression could drive. He said that whilst driving, buying medicine and collecting the children, the depression would have become more severe. No reason was given for this conclusion.

The accused's Counsel also put the evidence of Mrs Van Rooyen to him for comment. His view was that automatism was a very short depression which lasted for a few hours due to medication. In his view, the Symbicort together with medication caused a severe major depression. This condition would have started at about 14h55, but was short-lasting and probably for a few minutes only. Her behaviour in the context of what Mrs Van Rooyen noted was appropriate to depression. He said this in the context of that her husband would leave her and that the children would suffer. This was an aspect of the extended suicide that he had referred to. Being referred to Mrs Van Rooyen's evidence that she thought that she saw foam on the accused's mouth, his opinion was that this was of exceptional significance as it could not be produced voluntarily, and was either a sign of epilepsy or toxicity due to her high dose of medicine. There was however no evidence of any

seizure, and therefore he regarded this as a sign of toxicity. He regarded the extract (although it is clearly not such), from the Federal Drug Administration of the United States of America as being particularly relevant. In his view, she suffered from severe depression and this was therefore its relevance. The accused's Counsel's comment at the time was that it was not the case of the accused that the use of Symbicort caused the incident, and not even the other individual medicines, but the combination thereof. Dr Savov was of the view that the use of Symbicort was to a great extent the leading cause of the incident. He did concede that he did not know the intervals at which the pumps were used, nor the volume on the day of the incident. He insisted that she had suffered from psychotic depression because of the medicine taken.

75.

Cross-examination of Dr Savov:

He is not registered as a forensic psychiatrist in the sub-speciality of forensic psychiatry. He had eight consultations with the accused during which time the whole

situation, as he put it, was discussed. Facts were discussed as well as new facts. He saw the accused for the first time in September, and during that time he had to decide whether to be “part of the defence or not”. He had sight of the report of a Dr Kariuki. He considered that report to be very relevant. He did not immediately agree with it, but had to do further research. He also obtained information from the accused’s husband, Dr M.. He asked her about her prior behaviour and he had to determine whether she had depression, and whether Dr M. had seen any signs of such, say some 10 days prior to the incident. He also had to consider the accused’s version and it was not possible that he could be misled, or that she was exaggerating something. With reference to his report he confirmed that the accused had taken various medications and Migril after dropping off her children at school. He was asked what medication she did in fact take, and replied that one would not know what medications she took exactly, at what time, in which doses and whether she took one or two pumps of Symbicort. She also took the Mypaid Forte tablet. He then added that she took unknown Symbicort pumps in the period of seven, eight hours together with Migril tablets. Details appeared at page 6 of his report. It was

put to him by Ms Leonard SC that there was no clear indication of what she took, when she took it and what dosages she took. It was put to him that she had given various versions to various witnesses and also gave evidence in Court, and as a result one was left with a distinct impression she was very vague about what she took and when she took it. It must be remembered that the accused herself said so in par. 7.1 of the Plea Explanation.

He was asked when the depression started that mention was made of, and replied that on the morning of the incident she started to feel low, suicidal and down. Returning to the debate about the medication taken he said that “the amount of the medications, is not of crucial importance whether she took four, or she took six, or seven, because we are not claiming that she overdosed herself to toxicity, where they are saying the combination and idiosyncratic reaction you know to medication”. The fact that she had foam on the mouth at the scene of the incident, that she had wet herself, and “kept vomiting” was indicative to him of the substantial amount of medication she took. The accused would not have known how many tablets she had

taken. There is no evidence that the accused “kept vomiting”, but there is evidence that migraine and Migril may result in nausea.

He was asked to explain why the accused gave different versions as to what she took, when she took it and how many she took. His explanation was that it was impossible for her to remember exactly how many tablets she had taken and most people would not remember a few months later what they had taken. It was also put to him that there were discrepancies as to when she took K-Fenak tablets, which were bought at Dischem. It was put to him that the accused’s credibility on this topic would be challenged and also in the context that she made mention of only two substances to Dr Kariuki namely Symbicort and Mypaid Forte. When she spoke to other witnesses, more medication was added which would make her versions suspect. It was put to this witness that the State would argue that the accused was not truthful.

Returning to the topic of Dr Kariuki’s report, Dr Savov surmised that he did not ask her sufficiently about the details of medication taken. It was clear that she went to

Pick n Pay and Dischem, and bought other medications there as well which was clear from the receipts.

76.

He was asked when the accused actually decided to kill her children and replied that she did not decide to kill her children at all prior to the incident. She had depression developing, and he then referred to the concept of “extended suicides” and “sane automatism” and during that time she shot the children. This was a short-lasting episode which was super-imposed on the major depression.

She made the decision probably within a minute or two, prior to the actual deed. At no time did she have the idea to kill her children, because it would then not have made sense that she would have bought the particular medication for them.

He was asked in the context of the concept of “extended suicide” when a mother is depressed and then decides to kill their children to protect them, as he had previously explained, when would that decision have been made? It was his view that that decision was made just prior to the actual shooting. The reason was that

her behaviour before that did not fit in. He was asked what the reason for the depression was, and in his view it was because of the combination of medication. The most likely severe depression and severe psychotic problems occur within five days from the onset of medication. In his view corticosteroids could cause severe depression. He was therefore convinced that this was probably the most important part in combination with other medications. Other medications could also have an idiosyncratic reaction. In his view, this was a unique combination of pain medication, corticosteroids, a small amount of alcohol and the question of depression.

77.

Returning to his report, he was asked when she started experiencing suicidal ideas and in his view, it was on the Friday. That had been explained to him by the accused. It was put to him that her husband, who was also a specialist psychiatrist, had not noticed this. He replied that on the previous day her husband had not noticed this and everything looked normal. It was put to him that her version had been that she had experienced depression already on the Thursday. His reply was

that one does not diagnose one's self, and on the Thursday she already had been taking medication and had negative feelings of pain and hopelessness. The fact that the accused had given different explanations did not mean she was not truthful about what had happened, because the patients do not diagnose themselves, and on Thursday there was an overlapping of pain and depression. The depression on Thursday was however not as severe as that on Friday, and she continued to take medication including corticosteroids which develop side-effects within five days. She however had not been suffering from a major or severe depressive order. Even at the time that she saw Dr Kariuki she had not been in a state of a major depressive disorder. He would agree that at least a period of two weeks was necessary for certain symptoms to manifest themselves before one could say that a particular person had major depressive disorder.

78.

Dr Savov averred that he was aware of the facts, and when it was put to him what the accused had said to Mrs Van Rooyen, his answer was that those allegations

were indicative of a depressive syndrome coupled with toxicity. The foam on her mouth was a sign of toxicity. It was also his view that the accused had expressed feelings of hopelessness and his reply was: “Ja because she is, you know that in depression you are worth nothing you know, that your husband is going to abandon you he will find a better wife you know as well”. He added that the fact that she was afraid that her husband was going to leave her for another wife was a typical proof to him that she had depression before the commission of the offence. The accused however testified that she had been in a happy marriage and was therefore asked where this depression emanated from? Dr Savov then referred to a predisposition to develop depression, because many patients take medications with alcohol and asthma pumps, but they do not then suffer from depression. The accused’s statements to the police at the scene that she had a problem in her marriage were not a plausible explanation of why she had committed the offence. His view was that they had a happy marriage and still have a happy marriage, despite the death of the children. He did not believe that she shot the children from some type of motive of revenge, because she then would not have asked for a bullet to kill herself, and

would not have tried to jump from the fence onto the highway. All of her behaviour after the commission of the offence fitted well into somebody who had realized that she had shot her children and had not wanted to do that. In this particular case there had been no history of any personality disorder. He was aware of the fact that before they had been married, the accused had applied for a domestic violence order against Dr M.. He explained that this occurred because of relationship problems.

He was then asked: if the accused suspected her husband of infidelity, and the possibility that he might divorce her and take the children with him, did this not tie in with the fact that she had previously wanted to teach him a lesson and to show him not even “to mess” with her? Dr Savov was of the view that this was not a significant factor inasmuch as the facts indicated that this was very improbable, because there was no history of any type of jealousy or any type of extra-marital affairs.

79.

The concept of dissociative amnesia was then dealt with him and he agreed that this was as a result of the shootings. In this context he was referred to the diagnostic criteria in the DSM IV (Diagnostic and Statistical Manual of Mental Disorders).

With reference to those criteria he was asked why, in his opinion, the accused had dissociative amnesia? In his view it was acute stress resulting from shooting both of her children and it was facilitated by medication. It was put to him that according to the criteria for diagnosis they would not apply if there was a possibility of substance abuse. He did not agree with that, because he was not using that particular test. She did have amnesia because of the unusual event of shooting her children. Loss of memory in this instance was due to the fact of the intoxication and the realization that she had shot both of her children. He was then referred to DSM V under the heading “DISSOCIATIVE AMNESIA”. This confirmed what was stated in DSM IV, namely that one could not use a diagnosis if the particular disturbance was caused by substances. In his view, in real psychiatry, there was often an overlap of the various categories. He was aware of the diagnostic codes in DSM V and he

accepted that both DSM IV and DSM V were relevant referenced manuals used widely. He did consider the DSM V to be authoritative on mental disorders. He agreed that it was a general occurrence or common phenomenon for that patient's claim not to remember when faced with particularly stressful circumstances. In his view that however was not the case here. He at no stage thought that the accused had been malingering.

80.

With reference to the snapshot images that the accused claimed to have had, he was asked when this amnesia started. It was his view that it started when she commenced driving. It was put to him that her versions were different in this context and why would she not be consistent about exactly when this memory loss started? He said snapshot memories were more common than not in dissociative amnesia. He was also asked how long this amnesia would last and whether it could be expected of her to have more of her memory now. In his view it was possible that she might have more snapshots now than she had before. It was put to him that she

remembered shooting the youngest child and the second child twice. She also made sure that they were dead. He was asked whether this was not indicative of the fact that she did not have amnesia and she did know what she did? In his view it was not, because at the moment when she started shooting her memory started coming back. It was also put to him that taken into account the explanation that she gave to Mrs Van Rooyen, this was indicative that she knew what she did. In his view she does have amnesia and she also has snapshots because of these extreme events. It was put to him that she did not have amnesia during the shootings, because she could explain what had happened. It was his opinion that when she fired the first shot her memories returned, and this all fitted well into the extended suicide theory and the major depression. Sane automatism takes minutes, in his view.

81.

He was familiar with Prof S. Kaliski, Head of the Forensic Psychiatric Unit at the Valkenberg Hospital, and Associate Professor at the Department of Psychiatry at the University of Cape Town. He was also familiar with the book written by him namely

Psycho Legal Assessment. In the context of his evidence that the accused acted in a state of sane automatism, he was asked to explain what automatic behaviour in practice meant? Dr Kaliski also suggested criteria that could be used for the assessment of automatism, and there seems to be agreement between those criteria and those of Fenwick. He was referred to these criteria, the first one being that there should be a clear case for the automatism. The witness agreed. The third criteria was that the behaviour should be consistent with clinical descriptions of automatism. The witness agreed. The fourth criteria was that there should not be any evidence of premeditation, as automatism was a spontaneous phenomenon. The witness also agreed. Criteria five was that the behaviour during the automatism must have been out of character, mostly inappropriate to the circumstances and an exceptional event. The sixth criteria was that afterwards the person should have been bewildered and make little attempt to escape or avoid detection, because he should not have realized what he had done. The seventh criteria was that the person should have amnesia for the whole period of the automatism, because the brain was not working. That was also one of the Fenwick criteria.

In the context of these criteria he was asked what the cause for the automatism was in this case. In his view it was an idiosyncratic reaction to medication. Dr Savov was then referred to Dr Kaliski's book where he said (p. 106), that amnesia must only be regarded as supportive evidence that an automatism occurred and not as an excuse in itself. The witness agreed. He also agreed with the statement that it was easy to malinger amnesia which allowed an accused to avoid having to describe his thoughts, feelings and actions at the time. He also agreed with the statement that the facts of the case are paramount in determining whether automatism occurred and that this was one of the rare occasions that the experts may have to examine physical evidence provided in Court documentation closely. He agreed that this was common sense. Having regard to the fact that the behaviour should be consistent with clinical descriptions of automatism, he was asked what he would have expected? He replied that she must not have been in touch with reality according to the witness, her behaviour was completely out of touch with the internal factors, and having had a stable marriage. Dr Savov was then of the opinion that the thought that the children would be left without any protection, that there would be abuse later,

was in the whole picture of the severe nature of the depressive psychosis. In his view the incident was a short-lasting organic reaction in the context of a completely normal woman in a stable marriage. That was the internal factor, the external factor was the idiosyncratic reaction from medications. He was again referred to the evidence of Mrs Van Rooyen that the accused explained to her what she had done and why she had done it. He was asked whether this was not indicative of the fact that there was no automatism. Dr Savov was of the view that this was after the automatism. It was his view that the automatism had subsided then, and she gave clear signs of severe major depression. One did not ask for bullets, nor could one fake the toxicity and the fact that she said that her husband was going to leave her and that the children would go to someone else was completely out of touch with reality of having a stable family life. The fact that she went shopping with the children, buying medication and nappies for them, was very important to him, because one could not then explain why she would shoot her children then thereafter. I may add at this stage that Dr Savov was not aware of the later evidence of Dr Pooe, who had been told by the accused that her husband had made a remark

over the telephone on Friday morning that he would “build this house and leave you with the children”.

81.

He was referred to a further comment by Dr Kaliski (p. 107), where the following appeared: “During automatism, awareness of the surroundings is impaired therefore there is always amnesia afterwards. Accordingly his actions cannot be overtly purposeful, although they may superficially appear to be so and he would not be able to plan and execute behaviour not previously rehearsed”. Dr Savov agreed with this statement. There was a further statement by Prof Kaliski namely that: “During such automatism, an accused should not be able to find a pistol, loaded, take it off the safety catch, cock it and shoot accurately”. He was asked whether he was in agreement with that statement. The witness was of the view that that statement did not refer to the present case, because she had the gun with her, and she did not need to cock it. He was asked how the condition could have been automatism where the children were shot with a purpose and the eldest son in fact, twice. Dr

Savov's explanation was that shooting one's own children was completely out of character and her judgment was grossly impaired. It was put to him that according to the police evidence, the eldest child had been shot through the arm which would indicate that he was trying to defend himself and that this would have happened outside the car, whilst the first child was shot in the front seat. In that context he was asked whether these types of actions, with reference to Prof Kaliski's views, did not indicate automatism? His answer was partly the following: "But this is a case of sane automatism and then and she shot her children with a lot of cruelty as I have said it the previous time but she wanted to make sure you know that this is going to be dead and not remain disabled as I am saying. And this is completely in line with the extended suicides you know, psychosis and severe depression". In his view the judgement was severely impaired, although coordination might be there. He was given an example unrelated to the facts of this matter, namely if a person decides to commit suicide and to kill her children, she would have to decide how she is going to do it as a first step? He agreed. And if that person did not want to be detected one would have to go to a place where no one could see what one is doing. He

agreed with that to some extent in general. It was put to him that this was planning or premeditation. In his view it was not premeditation, because at no stage did it come to cross her mind that she was going to kill the children. The witness said that in his view this did not show premeditation, because … "even is some premeditation you know, in that is in the last moment, where she decided to probably kill herself and then she, then it came to the whole … idea, that … very selfish you know to leave her children you know, her life have injured and that is why she did it but in that sense is that psychotic premeditation in psychiatry is a straight forward thing, like … rules you that, you know implicates all those cases, you got premeditation but psychotic premeditation". It was put to him that it would be argued that there was planning and premeditation and his reply was that the planning was within seconds before she shot the children.

Dr Savov repeated that when the accused spoke to Mrs Van Rooyen, she was not in a state of automatism. He was asked again that in order to rule out any misunderstanding, to state over which period the automatism occurred? His answer was that it covered the period when she stopped the car and started to shoot the

children and that this would have lasted for a minute or two. Counsel for the State then asked him how this could be so if she could explain how many times she had shot the children? His view was that she would have realized what she did after the first shot was fired. He was asked to be more concise when she was out of the state of automatism and stated that after the first shot snapshots would have arisen. He was then asked why she was not suffering from automatism until when she shot the second child? His reply was that one could not pinpoint the exact moment. After she shot the first child her judgment was still grossly impaired: “She did, to me she did not, her memory you know, she got, her judgement was still grossly impaired, because if she produced a shot and she realized, she simply stop shooting, but she was still you know, in there, with the automatism … way and of … idea that she is going to shoot herself you know she does not deserve to live anymore, she needs to kill the children as well. So that is that, that was the time you know, of the super-imposed automatism on the major depression with extended suicide you know with her altruistic suicide. She, for her it is a nightmare that she is going to, you know, kill herself and then going to leave the children without any protection, that was the,

that was you know, the whole, the core symptoms of the filicide, which we have discussed before. … but I will say that is the time you know that when she started to producing the shots you know that is the time she was starting to get out of the automatism as well".

I then asked him to be more specific in the light of the fact that with the first shot there would have been a loud noise, and his previous evidence that she would then have come out of the automatism. His reply was: "No, I think that she started, she started but she did not come out completely, because we do not get, you know we have certain bewilderedness, which is well described, has also got mentioned by S. Kaliski, so it does not go like, you know, immediately but that was a time which, you know, obviously that she does have those snapshots you know of these two shots, and then, especially that the fact that she is trying to kill herself, I think probably that was the time when she get a much more clear picture of what has happened".

82.

Ms Leonard, with reference to the witness' repeated referral to extended suicide, said that she had some difficulty to understand why she would embark on extended suicide, whilst in a state of sane automatism if she kept on informing the Court that she never considered her children, why would she do that when there is a state of automatism? Dr Savov replied that prior to the moment when she got out of the car, she did not have any idea to kill her children.

Dr Savov also repeated that the prior shopping episode did not fit into the picture inasmuch as … "to me, is like she just had a severe suicidal idealizing, like many patients with very severe depression who have, it is overwhelming at … the moment she decides to kill herself, then she realize, she realize at that moment that her kids you know, are going to suffer thereafter and this is why she shoots them as well. And that was the moment of planning that was the only moment when she planned not prior to that because it simply does not make any sense, it is much reasonable ways of killing your children as well, but then their behaviour, her behaviour prior to that you know, would completely not fit you know …".

83.

It was put to him that when the accused went to Dischem to buy further medication, she already had the gun in her car, because she had testified that she wanted to commit suicide on that Friday. He was asked why she then did not do so? He agreed that that indicated planning and that she did plan to kill herself. She did not then have the strength to kill herself and she asked herself when I have everything why should I do so?

84.

He agreed that the medication played a very important role and said the following, “it was the main reason for her to get depressed, you know and to get depression, and when patients get severe depression, they also get suicidal … as well, so that we know that the medications which can cause severe depression and it can cause within the most common is some of the narcotic … within five days you know, not like two, three weeks or five weeks, … so it a, in that sense, that I am absolutely convinced, because you cannot develop such a severe depressive psychosis just

within one, two or three days, just out of … you know, you usually have, you know, symptoms before, that you have some social withdrawal … you know different, loss of interest and so on. She is an active woman you know, she has been known as very active, doing sports as well and very well integrated, doing very well, stable marriage. So this is why I am saying that the external factor, the intoxication and reaction to medications you know". In his view, after the use of corticosteroids depression would come within five days most commonly. In some cases it could be within one day, two days or three days. He then however said that in his view it would have occurred within five days.

85.

It was also put to him by Counsel for the State that he had no basis for saying that Prednizone in tablet form was the cause of depression with reference to a textbook statement that he had referred to, because one was dealing with budesonide which was inhaled. It was also therefore a fraction of the amount that was contained in tablet form. He did agree with that. The view of Dr Muller, the original founder of the

Toxicology Centre at the Tygerberg Hospital was put to him, namely that the amounts of budesonide contained in the Symbicord that were inhaled and described, was of so little value that it could not give rise to what he stated that it almost would have had no effect. He agreed with the fact that a small dose was contained in the inhaler, but mentioned that she had used it repeatedly. It was also pointed out that the particular Symbicort had been prescribed by Dr M. for his younger son. Dr Savov simply repeated his view that she had used the pumps a number of times and that one could expect idiosyncratic reaction in combination with other medication. He was referred to the Symbicort pamphlet relating to the inhaler at a dosage of 160, which seemed to suggest that one could use it up to eight inhalations per day. Dr Savov repeated that in his view the idiosyncratic reactions were of relevance, because one was not speaking about overdosing on certain medications. The debate was not about a toxic dose, but about an idiosyncratic reaction. He could in fact not say which medication would have caused the idiosyncratic reaction, but that it was the unique combination of medications which caused depression and the particular kind of psychosis and that was the only

explanation why those events unfolded. The psychotic feature in this context was: "Psychotic features is a delusion of failure, delusion of … that you must kill your own children you know that you not let them suffering you know so that, this is like out of touch with reality, because your marriage is not falling apart, he is not abusive, you achieved so much, you are doing very well, you have two children, you have a stable marriage, you are rich, you make money, so everything is fine you know so why should you … so this reality testing problem you know, is, those are the psychotic features. The psychotic features he obtained from the evidence and also from the evidence of Mrs Van Rooyen.

86.

In re-examination, Dr Savov admitted that he had considered the question of fabrication or malingering at the beginning, but during his examination realized that this was not the case. He confirmed that after his discussions with Dr M., he was of the view that there was no evidence of any marriage difficulties and when he made enquiries everybody confirmed that they were a good family. He was also of the

view that the accused did not fabricate genuine bereavement. He confirmed his previous evidence that after the first shot with the extreme noise and the emotional shock that would probably be the starting point of “getting out” of automatism. Automatism does not go away just like that.

87.

I asked him about his discussions with Dr M. and he said that he verified the information given to him concerning marital problems, amongst others. He had spoken to colleagues about that and hospital staff. He was told that the M.s had a reputation of being a very good family. I referred him to his report where it was stated that on the Friday morning she had a deep feeling of loneliness and an overwhelming suicidal feeling. I referred him to the evidence of Dr M. who had testified that there was nothing unusual about their life, they were busy building a new home and she was also assisting in his practice. He was therefore asked what the cause of this sudden overwhelming feeling of depression and loneliness had emanated from that Friday morning and whether it was simply because he was not

at home. His view was that “this is absolutely so”. His view was that the reaction to the medication would then have arisen on the third day after the intake. I also asked him in the context of her actions that day and after her visits to Pick n Pay and Dischem when she would have thought for the first time that she wanted to shoot her children? His reply was the following: “I think at probably in my view, her first thoughts, or when she stopped the car she decided, probably an overwhelming feeling when she is driving the car I am going to kill myself although this is, I know now, is covered by, you know, by amnesia, you know, but probably this arose as the fact, I am shooting myself now but my poor children, you know, that is going to stay alive and they will be suffering, as I have discussed it before, with a so-called altruistic of … altruistic type of suicide. So I think that at that stage, she decided that it is to kill herself, but she must, it will be very selfish to leave her children to suffer, and that is the, you know that, through her mind you know that at that stage is like with a … I would say that, if there is no like, sane automatism, she might not have done this you know, if the medication did not, the concentration and the inference you know that …”. It was then pressed upon him to state when did she decide to kill

herself and the children and his opinion was that this would have occurred at the scene of the shooting. He stated that in his opinion she wanted to kill herself, but then in the last moment she decided she must kill her children. That was the most likely scenario. She first wanted to kill herself and then changed her mind. In his view, the depression and despair and the overwhelming feeling of loneliness would have started on the third day after taking medication. He was also referred to his comment in his report that deals with the hallmark of severe depression and that extended suicide “is a hallmark of severe depression, when mothers want to kill themselves, but do not want to leave the children suffering without their protection and therefore take their lives”. He was asked whether she had thought that at the time and whether that had been her reasoning. He replied that that was the delusional way of reasoning to protect the children by killing them.

In that context her Counsel, by way of further re-examination asked whether that thinking process was rational? In his view it was a severe symptom of psychotic depression.

88.

Dr G. J. Muller:

Dr Muller was called by the State in reply to the expert evidence led on behalf of the accused, as had been arranged when the proceedings commenced. He handed in a "clinical pharmacological/toxicology report". Amongst others, he holds a Ph.D. degree in medical sciences, pharmacology and toxicology from the University of Stellenbosch. He was first registered as a medical practitioner in 1968. He was provided with all the relevant reports and record of evidence led, and that formed the basis of his own written report.

His shortened curriculum vitae reads as follows: "Dr Muller has 50 plus years' experience as a general practitioner, specialist anaesthetist, clinical pharmacologist and toxicologist. He attended and presented scientific papers at 76 national and 36 international congresses and is the author/ co-author of 54 publications and contributed to 20 book publications. Dr Muller is the founder of the formal Tygerberg Pharmacology and Toxicology Consultation Centre in 1983. He has been directly and indirectly responsible for the management of approximately 150 000 patients

with regard to drug therapy and acute poisonings since 1977. He also acted as a consultant/expert witnesses in approximately 140 medico-legal/forensic clinical pharmacology and toxicology cases".

89.

Dr Muller also attended Court from 31 July 2017. He confirmed that his report was correct. His report contains a discussion of the medicines and substances involved in this trial and he also referred to the various package inserts relating to each particular medicine which is a document approved by the Medicines Control Council. He gave his evidence with reference to his report and gave his comments on the various medicines or substances that were mentioned by the accused and other expert witnesses. I will deal with this by way of a summary.

- Symbicort Turbuhaler 160mçg inhaler:

  This is a Schedule 4 medicine indicated for the treatment of asthma. It contains 160mçg of budesonide per inhalation ("puff") and 4.5mçg of formoterol per inhalation.

Budesonide is a corticosteroid with a local anti-inflammatory effect in the airways.

Formoterol has a direct broncho-dilatory effect on the bronchial smooth muscle of the lung. The package insert mentions certain adverse side-effects. This turbuhaler had been prescribed for the accused's youngest child aged two years. He referred to the accused's evidence that she used it on several occasions in the two days before, and on the day of the incident.

Budesonide addresses the inflammatory part of asthma. He said that the mechanism of action of corticosteroids is complicated and it takes time for the effects to kick in. As a consequence most of the effects of oral (in contra-distinction to the use of a tablet) corticosteroid medications are not immediate, but only become apparent after several hours (four to eight hours). He gave evidence as to the side-effects which would follow from continued administration of high doses over long periods. In such a case, it would take at least two weeks or more of high doses for certain serious adverse effects to develop. For example, the ingestion of an acute massive

overdose is tolerated well. Toxicity is therefore only induced by long term, relatively high therapeutic doses. It must be remembered that this was said in the context of corticosteroids been given orally or in injectable form. A major advance in asthma therapy was therefore the development of gluco-corticoids (e.g. budesonide) that could be delivered to the lungs via inhalation. This allowed for the targeting of the drug directly to the site of inflammation allowing drastic cuts in dosage with a major reduction in the number and degree of side-effects. Although inhalational corticosteroids are not without systemic side-effects (small amounts are absorbed in the gastro-intestinal system), it usually takes weeks to months to develop.

A dose of less than 800mçg budesonide a day is known not to cause any significant systemic adverse effects if taken over a period of less than six months. The Symbicord turbuhaler 160 contains 160mçg budesonide per puff. This is one twentieth of a 3mg budesonide oral dose. The doses of inhalational budesonide are now in the micrograms dose range. It is clear from the low dose and the short period of use in the accused (two – three

days) that the possibility of developing adverse effects is virtually non-existent. It is therefore highly unlikely that the budesonide played any role in the events leading up to the incident – on its own or in combination with other drugs. He added in evidence that prednisone had a different molecular structure from budesonide and that it did not really play a role here. It was inconceivable that the low dose of budesonide would within a period of two to three days have relevant side-effects. The chances of the relative normal dose of budesonide "causing suicide or induction of side-effects like suicide" were for him impossible, and he was even surprized that it came up as a possibility.

- Formoterol:

If one has an acute asthma attack it would take three to four hours for budesonide to work as an anti-inflammatory drug. When formoterol is added it causes bronchodilation within minutes. By administering formoterol by inhalation the dose is very low and therefore the incident of side-effect is minimal. With a low dose and occasional use of the aerosol, the potential to

have caused serious central nervous system side-effects in the case of accused was negligible – either on its own or in combination with other pharmacological agents such as budesonide.

- Migril tablets:

Migril is a Schedule 2 medicine indicated for the relief of acute migraine attacks. The main ingredient is ergotamine. This medicine can be bought over the counter and it is an everyday drug used for asthma, pain and inflammation. Cyclizine is added in the preparation for its anti-metic and sedative effects. A common side-effect of Migril tablets is nausea and vomiting. No more than four tablets should be given in any one attack of migraine. A Migril tablet contains 2mg of ergotamine per tablet. A dose of more than 15mg per 24 hours or more than 40mg over a few days would be likely to cause toxicity. Adverse effects are nausea and vomiting and occur in approximately 10% of patients on therapeutic doses. The side-effect is however problematic in that nausea and sometimes vomiting are part of the symptomatology of a migraine attack in any event.

He was of the view that the induction of an isolated psychotic incident (homicidal) without any of the other toxic effects is highly unlikely even in the presence of other drugs. It was also highly unlikely that budesonide had any effect on the side-effect profile of ergotamine.

Cyclizine is an antihistamine with prominent sedative effects and is most often used to treat nausea and vomiting. It is generally regarded as a safe drug. It was highly unlikely that the cyclizine contributed to the development of a so-called syndrome of sane automatism on its own or in combination with other drugs. As far as caffeine was concerned there was more of it in one cup of coffee than in one Migril tablet. It is contained in a soft drink such as Red Bull i.e. 80mg in 250ml. An average cup of brewed coffee contains about 100mg of caffeine, instant coffee 75mg and a cup of tea 50mg.

He noted that the accused could have ingested a total of 280mg on the day of the incident (Red Bull 80mg and Migril two tablets). The chances that caffeine contributed to the accused's actions was considered highly unlikely even in association with other medicines involved.

- K-Fenak tablets:

  K-Fenak is a Schedule 2 medicine used for the “emergency treatment of acute gout attacks and the treatment of post traumatic conditions”, according to the package insert. Each tablet contains 50mg of diclofenac potassium. The package insert describes diclofenac as a non-steroidal anti-inflammatory drug with analgesic and anti-inflammatory activities. Its recommended dose is two to three tablets in divided doses. The package insert also lists certain central nervous system side-effects, but specific “psychotic reactions” are not specified in the package insert. Diclofenac is one of many so-called non-steroidal anti-inflammatory drugs, others including aspirin and ibuprofen (Mypaid Forte). Psychiatric side-effects with the use of diclofenac were not reported. It was unlikely that this non-psychotic/non-psychotropic drug played any role in the conduct or behaviour of the accused on the day of the incident. Negative drug interaction effects are also not expected to be relevant.

- Mypaid Forte tablets:

This is a Schedule 3 medicine and a prescription is required. It is indicated for the relief of mild to moderate pain of anti-inflammatory origin. Each tablet contains ibuprofen 400mg and paracetamol 325mg. No psychotic or psychiatric side-effects are mentioned in the package insert. Ibuprofen can have effects on the central nervous system in elderly patients and depression has been reported in a small percentage of patients. In was in his opinion highly unlikely that ibuprofen played a role in the behaviour of the accused on the day of the incident – either on its own or in combination with other drugs.

- Paracetamol:

Paracetamol is an effective alternative to aspirin as an analgesic. Its anti-inflammatory action is weak. It lacks many of the side-effects of aspirin, such as gastrointestinal intolerances and is well tolerated in therapeutic doses. Adverse effects are few and it is not an agent that one would expect to cause any significant central nervous system side-effects. Mypaid Forte, compared to Panado tablets also contains a relatively low dose of

paracetamol. One would not expect this agent to have had any effect on the actions of the accused on the day of the incident – either on its own or in combination with other drugs.

- Empacod tablets:

  Empacod is a Schedule 2 medicine and is indicated for the symptomatic relief of mild to moderate pain and fever. It also contains paracetamol in the same quantity as in one Panado tablet. It also contains 20mg of codeine which is together with paracetamol an analgesic. The recommended dose for adults is one tablet four times daily. Codeine has a central nervous system depressor effect, but suicidal and homicidal behaviour are not expected to develop with the use of codeine and has not been described, even in combination with other non-psychotic drugs.

- Ethanol (one glass of wine):

  Dr Muller, with reference to the evidence that had been provided to him calculated that the incident occurred two to three hours after the consumption of the glass of wine. Side-effects would be minimal and he added that the

caffeine in the Red Bull could have neutralized most of the effects of the small amount of ethanol consumed. He admitted in cross-examination that this comment was made tongue-in-cheek, but nevertheless added that coffee was often a customary after-dinner drink.

90.

General comments:

Dr Muller said that any drug, no matter how trivial its therapeutic drug actions, has the potential to cause unwanted side-effects. A toxic dose is usually a dose that is four to five times the therapeutic dose, and the term “toxic effects” is usually reserved for overdose events.

91.

Idiosyncratic reactions:

An idiosyncratic reaction is an unexpected adverse drug reaction event that is not foreseen from a knowledge of the basic pharmacology of a drug. The mechanisms are often poorly understood and are often genetically determined.

92.

Drug interactions:

The use of several drugs simultaneously is often essential to obtain the desired therapeutic objective or to treat co-existing diseases. A potential drug interaction refers to the possibility that one drug may alter the intensity of the pharmacological effects of another drug given concurrently. The nett result may be enhanced or diminished effects of one or both of the drugs. The most important and/or relevant adverse drug interactions occur with drugs that have potentially serious adverse effects where the dose which can cause the desirable effects is close to the dose that may have serious side-effects. None of the drugs/medicines/substances that the accused took or was prescribed for her belong to those with the narrow therapeutic index.

93.

Homicide:

Dr Muller testified that there was a lot of mention of suicide in these proceedings, but that "nobody mentions homicide for some or other unknown reason". He could not find any association between the drugs, and the medicines used by the accused and the induction of homicide. In the last 40 years working in the Tygerberg Pharmacology and Toxicology Consultation Centre, he had not come across a case where the consumption of the mentioned drugs that the accused consumed led to the induction of homicide.

94.

Automatism:

Dr Muller testified that automatism is where automatic behaviour is generated without conscious control or will: lack of capacity to contain one's will.

95.

Conclusion:

Referring to the evidence of the accused relating to the quantity or doses of the medicines used, Dr Muller was of the view that this was either not known or unclear and that he would assume that the medicines were taken in therapeutic doses and intervals. The budesonide, caffeine and ethanol doses were too low to have a noticeable systemic adverse effect on the accused. Paracetamol, codeine, cyclizine and formoterol are relatively safe drugs in therapeutic doses. Their potential to cause adverse drug interactions with other drugs used, is also negligible in the apparent doses involved. Ergotamine in Migril is known to cause serious side-effects when given over long periods in relatively high doses. However, psychiatric side-effects have only been described in overdose leading to acute poisoning. His view based on the available facts of the plea of "sane automatism, due to a short-lasting psychotic depressive episode with prominent suicidal tendencies (leading to homicide) as a result of a combination of side-effects of medication and substances intake", was pharmacologically and clinically highly improbable.

His report is dated 18 August 2017.

He was referred to the evidence of Mrs Van Rooyen where she said that she saw something around the mouth of the accused which was either spittle or foam. His view was that this was over-emphasized and did not indicate anything specific. I referred him to the evidence of Dr Savov who alleged that the so-called foam around the accused's mouth was a sign of toxicity. Dr Muller was of the view that he would not include that as an acute toxicology feature. I will deal with that aspect again when I refer to the evidence of Dr Pooe, and what the accused told her.

96.

Cross-examination of Dr Muller:

The question of the significance of foam on the accused's mouth at the scene with Mrs Van Rooyen was discussed with him and the evidence of Dr Savov, who had deemed this to be particularly significant. He did not agree with that view. Dr Muller's view in fact, after some debate with Counsel about whether or not spittle had appeared on the accused's mouth or whether it had been foam, said that "if you

now see a patient with a little bit of foam around the mouth out of the blue, to think about acute poisoning is probably a little bit ridiculous".

In the context of the significance of scheduling of medicine, Mr Pistorius on behalf of the accused put to Dr Muller that it was not the accused's case that she had overdosed on any medication. It was also not her case that any particular medication caused the relevant side-effects, but that it was a combination of the medicine which then resulted in a short lasting psychotic depressive episode. She did not rely on the fact that for instance Symbicort was an overdose and hence a very adverse reaction. He agreed that side-effects could present themselves even in therapeutic doses. He also agreed that not all people would experience the same side-effects from the same medicine, and that the same person could experience different side-effects from one day to another.

It was also put to him that there were a large number of uncertainties with regard to the number or quantity of medication taken by the accused, and Dr Muller agreed. It was put to him that Prof Brink had said that there was a possibility that there had been adverse reactions in the sense of her short-lasting psychotic episode. Dr

Muller was of the view that this was a mere theory. It would not make any sense to say that there had been a drug interaction if the difference in effect had just been 1%. Prof Brink's comment about the interaction of drugs and calculations of dosage needed for toxic effects was put to him for comment, and his view was that the whole paragraph was very theoretical and did not lead to any conclusions. Dr Muller gave the example of the possibility that a meteorite could fall on the Court building. On that type of argument, that event could also not be excluded. I put to him that what he meant was the possibility was so remote that one would not take it into account, and he agreed that that was what he had meant. Dr Muller also conceded that one could not exclude the side-effect in the form of depression. He also added that one could not exclude the possibility that there could have been depression. This was however highly unlikely. He agreed that the possibility of a specific side-effect could not be excluded on the facts of this case.

97.

The work of Dr Leischmann, ***Organic Psychiatry 4th Edition***, was put to him and in particular, the topic of side-effects of steroid therapy, which included severe depression and psychosis. It was put to him that the particular negative or adverse side-effects could start within five days. Dr Muller was of the view that this textbook had to be seen in the proper context. It is a psychiatric textbook, and not a pharmacology textbook. The particular page referred to corticosteroids in general and budesonide. The authors had referred to ordinary oral corticosteroids and not at budesonide dosages which were completely different. He was asked whether he excluded memory impairment as a side-effect of budesonide and replied that he did not exclude it, but that it would take weeks to months to develop.

The Symbicort leaflet was put to him and he was referred to the heading: "Psychiatric Disorders". The reference to depression and behavioural disturbances was also put to him and he had no problem with that, but added that the pamphlet did not mention how long after the start of the treatment these disturbances would or may present themselves. He was of the view that any evidence that said that the

particular side-effects could develop within five days was wrong and ill-informed. It was then put to him that it could not be excluded that the Symbicort could have contributed and could have caused the particular side-effects on the date and the preceding dates in question. Dr Muller did not agree with that and was of the view that it was completely misinformed. He had specifically concentrated on that issue and had looked at the literature very widely and had reviewed scientific papers. He could not find any reference to that in the literature that this was possible. The textbook that had been shown to him did not specify budesonide and only referred in general to corticosteroids. The accused's Counsel then put to him that his instructions were that, irrespective of the dosage or the period or interval, the possibility of developing an adverse effect could not be excluded. The witness did not agree. He said that in all the literature he could find no mention of such. With reference to Prof Brink's report where he dealt with budesonide, it was put to him that in sufficient doses one may see maximal acute side-effects within about half an hour and lasting a few hours. Dr Muller was of the view that this was a misinterpretation. The acute effects referred to in that report were pharmacological

effects, and not side-effects for instance. It referred in fact to the anti-inflammatory effect. He looked at the relevant literature and had studied it thoroughly. It was stated that if one uses the budesonide it could have an anti-inflammatory effect within hours on the cell of the lung. The fact that Prof Brink said that this would also refer to psychotropic effects was completely wrong. No literature would or did confirm that. With reference to Prof Brink's report it generally said that it had not been his function to criticize his report, but that if he marked everything that he disagreed with, it would have been like a Ph.D. study. He was asked why his evidence in that context had not been put to Prof Brink, and replied that he did not look at it that critically at that stage, but it became clear to him that many of the statements and references were quite wrong. Dr Muller also had a problem with Prof Brink's reference to "psychotropic effect". This could mean the whole discipline of psychiatry, which was not his field of expertise in any event, and was not even defined.

He confirmed that in literature he had not come across any comparable case where the results were as relied upon by the accused. Mr Pistorius then put his position as

follows: “The accused through her experts investigated, because we also do not know, what caused her to do this terrible thing. And I put it to you, not improbably, a very real possibility exist that this is indeed particularly what happened in this case”. Dr Muller’s comment was “highly unlikely”. It was then put to him that the phenomenon that the accused’s defence dealt with was “maternal filicide based on very particular psychogenic and pharmacological explanations”.

98.

In re-examination, Dr Muller again emphasized that the articles that had been handed in as exhibits that dealt with steroids, did not refer to budesonide, and had nothing to do with that compound. The references used in that context were therefore inappropriate. It was his view in the light of all the facts, his experience, and his research that the accused’s particular defence was highly improbable.

I put to him the difference between “possible” from a scientific point of view and the improbability of unlikelihood thereof. I put to him that in a criminal trial, the question was whether the accused’s version could be reasonably possibly true. His view was

that he would use the words “highly unlikely”, “improbable”. One could not exclude a possibility, but it was highly unlikely that the medication was the cause of the incidents. He also explained that when it was said that a drug would have certain effects within five days, it was meant that it would be so from five days onwards. As far as Dr Savov’s comment was concerned, the particular Friday was the third day of the use of medication. Dr Muller stated that he had done research on the particular effects of budesonide, and it was nowhere mentioned in the relevant literature that budesonide could have those particular side-effects within a day or two or three. Most references would say that a condition could develop within three to six months. Some references mentioned a possibility of two weeks.

I deemed it appropriate to ask Dr Muller what was meant by depression in the present context. Dr Muller was of the view that one would not speak of depression if that condition had been present for one day, but that he had a longer term in mind. This would then be pathological depression. Irrespective of the fact that he was not an expert on that particular topic, he said he would exclude depression that would develop “if your dog died”. He was of the view that if one looked at the

pharmacological side-effects of the drug which referred to depression, it would usually mean a pathological depression. The particular inserts, when referring to depression, never specified what was meant by that. It was then put to him that it was the accused's version that the possibility of "a short-lasting psychotic episode of depression" could not be excluded. Dr Muller was of the view that before he could exclude it, the way it was put to him, it was difficult to exclude because it did not make any sense. Adv Pistorius then elected not to canvas this topic any further with the witness, because he was not an expert.

It was then also put to Dr Muller that the glass of wine consumed by the accused could have enhanced the metabolism rate of the intake of medication. Dr Muller's reply was bluntly "nonsense". Dr Muller was in any event of the view that whilst ethanol was a depressant, caffeine was a stimulant and there was therefore a counter action. Dr Muller again emphasized that the accused's defence of "short-lasting psychotic episode due to the combination of the particular medications", was last on the list of possibilities.

99.

Dr J. M. Pooe:

Dr Pooe is a senior specialist psychiatrist at the Adult Mental Health Services in Weskoppies Hospital, including forensic work. She holds the position as specialist psychiatrist in the Department of Psychiatry, University of Pretoria. She qualified as a doctor in 2000 and as a psychiatrist in 2009. She did about 60 panel observations in terms of the relevant provisions of s. 77 and 78 of the ***Criminal Procedure Act***. In the present instance, she observed the accused in terms of a Court order by the Pretoria Magistrates Court together with Dr Du Plessis and Prof Pretorius. Both of them were on a panel of medical specialists who provide services to the Department of Justice when requested to do so. Dr Du Plessis had been appointed by the Court and Prof Pretorius for the defence.

100.

The accused was admitted to an open ward for patients that were actually not psychotic. Those patients suffer mostly from depression, but they are also high

functioning and could take care of themselves. They do not need a lot of supervision. Normally, the person to be observed would be in a more secure ward, but the accused here was given an exception and placed in the open ward. Observation takes place over a prolonged period of time and a number of interviews with the particular persons would need to be held. There is also a nursing team who looks after the daily requirements of the particular persons.

101.

She interviewed the accused a number of times and also took notes.

102.

In the context of that topic, Ms Leonard on behalf of the State mentioned that she had discussed with Mr Pistorius for the defence the requirements of s. 79 (7) of the ***Criminal Procedure Act***, which reads as follows: “A statement made by an accused at the relevant enquiry shall not be admissible in evidence against the accused in criminal proceedings, except to the extent to which it may be relevant to the

determination of the mental condition of the accused in which event such statement shall be admissible notwithstanding that it may otherwise be inadmissible". On that basis Ms Leonard sought to introduce evidence regarding the conversations and the information supplied. In that context, I was referred to ***S v Kok 1998 (1) SACR 532***, which also dealt with a defence of "sane automatism". Combrink J held that this defence fell within the ambit of the term "mental condition", so that evidence of statements made by the accused during the enquiry would be admissible. Prior to that, it was held in ***S v Dobson 1993 (2) SA 86 € at 89***, that during such observation process the psychiatrists do not try to determine whether the information they have received is correct or not, but to determine the accused's mental state, and in particular to see whether he can understand and appreciate the concept of wrongfulness. This dictum was approved by Theron JA in ***S v Chauke 2016 (1) SACR 408 at 415, par. [16]***.

Ms Leonard wanted to introduce the evidence not to prove the truth of the statements made by the accused, but to show what the mental condition of the

accused was at the time of the commission of the offence in the light of the fact that Dr Savov, called by the accused, had given evidence on that particular topic.

On that basis, I allowed the evidence, despite the objections of Mr Pistorius. He also objected on the basis that s. 35 (1) (c) of the ***Constitution of South Africa*** was applicable and that no one was or could be compelled to make any confession or admission that could be used against him in evidence. He contended that the referral for observation was done on a compulsory basis in terms of the ***Criminal Procedure Act***, and that the rights of the accused been infringed upon, because she had not been afforded the right to have legal representation. He submitted that once an accused is referred for mental observation, he or she should have been advised that she would be questioned at length and that the answers would be written down. He also objected on the basis that one would not know whether the accused's answers to questions had been given voluntarily or not.

103.

Ms Leonard submitted that Dr Savov had given evidence on behalf of the accused in the context of her mental state at the time of the commission of the offences. He also put on record what had been discussed between him and his client. The State was therefore entitled to lead evidence in rebuttal as it were in the context of trying to determine the mental condition of the accused at the time of the crime. The evidence of Dr Pooe and her notes were for that purpose, and not for the purpose of proving guilt.

104.

It must be remembered that when the accused appeared before the Magistrates Court, she was legally represented. Prior to that, she had been examined by Dr Kariuki who had also drawn a report. During the bail application, she had also referred to certain medication and the report of Dr Kariuki was handed in at the Lower Court. Dr Savov had made a specific finding according to terms of the provisions of s. 78 of the ***Criminal Procedure Act*** and had found that due to a

"mental illness" the accused had not been able to appreciate the wrongfulness of her actions and act accordingly. Ms Leonard emphasized that she was not trying to prove any confession, but was only dealing with the concept of criminal responsibility. I may add to that, that it appears from the record of the evidence that the open ward for the accused had been "arranged". It must be remembered that her husband is a psychiatrist and that he knew Dr Savov. She was also represented at the hearings and proceedings in the Magistrates Court and the process that was to follow thereafter would not have been a surprise to her. Importantly also, the accused also at no stage during her evidence complained about the process during the relevant observation by the psychiatrists, or that any of her rights had been infringed. Her own evidence therefore did not lay the basis for the finding, or even suggestion that any of her constitutional rights had been infringed during the process of observation. I also invited Mr Pistorius to re-call the accused to give evidence should she dispute any of the assertions made by Dr Pooe. This invitation was not acted upon. There was obviously also no challenge to the constitutionality, or otherwise, of the provisions s. 77 to 79 of the ***Criminal Procedure Act***.

105.

During Dr Pooe's evidence, Mr Pistorius then also deemed it fit to ask for the file of the hospital which was not in Dr Pooe's possession, as well as the notes made by the other two psychiatrists, if there were such. Those notes also were not available to Dr Pooe, and it was also clear that any such note, without the evidence of the particular author thereof, would have had no evidential value merely by the presentation thereof. Mr Pistorius was then given an opportunity to look at Dr Pooe's notes, after which the request to order the production of the hospital file and the notes of other psychiatrists who was not proceeded with. The defence had been in possession of the report of the three psychiatrists for a considerable period of time and no prior application for any production of possibly relevant documents had been made.

106.

Dr Pooe also added that their notes were such that they could only be interpreted by their author or by another psychiatrist. The accused was also not forced to

participate in any interaction against her will. The process and duties were explained to her, the reason why she was sent for observation and the fact that the psychiatrists had a duty towards the Court to compile a report. The accused throughout was pleasantly co-operative.

107.

From the observations made by the psychiatrists and their interactions with the accused they came to the conclusion that there was no indication that the accused had any mental disorder or psychotic process on the day of the crime. The crux of her evidence in this particular context is the following:

1. The accused acted rationally on that Friday from the time she woke up throughout the day “until a few minutes when she actually said she cannot remember what had happened”;
2. She last had a memory of strapping her children into the car and driving;
3. When she came to, she found that her children were both dead;

4. Prior to that there was no indication or there was no reason for her to suspect that she was acting in a manner out of proportion;

5. Her actions on that day were precise, they were purposeful and she was able to drive her vehicle;

6. The accused did not mention anything that could have contributed to someone who was mentally disturbed at that time;

7. During that day, she had felt extremely suicidal and down and she felt she wanted to end her life;

8. She took her husband's gun from their bedroom and thought of killing herself, but then abandoned the thought and put the gun in the boot of the car;

9. She could not explain to Dr Pooe why she had not taken it back to the safe;

10. The accused explained that she had been feeling down from Wednesday and had been experiencing some fatigue and tightness in her chest;

11. On Thursday she started feeling very depressed and had suicidal thoughts. At that time she was also menstruating;

12. On Thursday she had difficulty in sleeping, but did not tell her husband about her feelings;

13. On Friday she took her children to school as usual and upon return found her husband not at home which upset her;

14. She called him and he explained that he had been to a warehouse for supplies to the house that they were in the process of building;

15. They had a disagreement about a particular bathroom and she misinterpreted when he said to her "I will build you this house and leave you with the children". She did not ask him what he meant by that, but told Dr Pooe that she had misinterpreted the comment that he would leave;

16. In the context of what Mrs Van Rooyen and Captain Mokgapa had testified, the accused told her that at that particular plot she was not actually looking for help, but looking for help to kill herself and could not understand what had actually happened. Dr Pooe's opinion was, and that of the other psychiatrists having regard to their conclusion in their written report, that the accused was rational at that time. From the relevant statements, there was

no indication to say that she had been psychotic or was “talking nonsense or being disorientated”. She actually gave the names and telephone numbers of the persons that she wanted to call, namely her mother and husband.

108.

The conclusion of Dr Savov was put to her and she said that after an episode of sane automatism, the perpetrator would have acted with bewilderment. They would want to help the victims, because they would be unable to understand what they had done. They would also be able to remember what had triggered that automatism. Even if such a person could not recall the actual shooting, they would remember just before what prompted them, or what had triggered them to commit the alleged crime. In her discussions with the accused, no such trigger or cause was identified. She was familiar with the work of Prof Kaliski, Psycho-Legal Assessment, and the fact that he was of the view if there was any question of premeditation, sane automatism would not be relevant. Furthermore, in the context of what the accused had told the other psychiatrists, there were inconsistencies in her version. She

regarded that fact as very important and was of the view that the accused might not have been very truthful.

109.

Dr Savov's view that the accused had been suffering from dissociative amnesia was put to her and Dr Pooe was of the view that having regard to the diagnostic criteria that were used by psychiatrists, before dissociative amnesia could be diagnosed, there ought not to have been any substances, alcohol, drugs or medication that that person had taken or consumed. This appears clearly from DSM V (Diagnostic and Statistical Manual of Mental Disorders) under the heading "DISSOCIATIVE AMNESIA". The same comment is made in DSM IV. She had been told that the accused had taken medicine on that particular day, and in particular, Migril and K-Fenak which she had taken at lunch. In the morning she had used Symbicort and Mypaid Forte. Those were all the references relating to medication provided to her. After she realized that the children were dead, she took all the medication that she had bought that day and consumed it.

110.

During the observation the Weskoppies Unit would also ask for a psycho-social report relating to background information such as the persons, relatives, and the workplace. They would also obtain support from a psychologist and this was done in the present instance. This report found nothing abnormal and she said: “There were no depressive symptoms, no psychotic symptoms. She was found to be intelligent and her memory was intact except for the incident”. She was also found not to be feigning. The accused was obviously consulted a few months after the incident occurred and during her stay in hospital she was emotional and she was sad when relating the incident about her children. There were no signs to suggest that she was suffering from depression at the time of admission into the hospital. When Dr Pooe used the word “depression” she said that she used it in the context of it being a psychiatric disorder, or a major depressive disorder. Her view was that during, and prior to the commission of the crime, she only had a “low depressed mood. But she did not meet the criteria to call it a disorder”.

111.

Cross-examination of Dr Pooe:

She confirmed that none of the 60 panel observations she had partaken in had pertained to amnesia specifically. There was one case that related to automatism. This was a rare condition and was not often seen. The clinical manager at the hospital had decided to place the accused in a low risk ward. The reason given was that the accused was the wife of a colleague and they were not going to subject her to a closed ward. A special request had been made and it was indicated that the panel had to consist of three specialists.

112.

She was satisfied that there was no malingering by the accused as far as amnesia was concerned. There was also no history of mental illness, no history of substance abuse, no history of any anti-social conduct and the profile was that of a person happily married. She also had sincere bereavement after the incident. She added that she accepted that the accused acted totally out of character on that day. She

agreed that the purpose of Dr Kariuki's report was to assess whether or not the accused was likely to commit suicide. She accepted that the accused had taken medication as had also been stated by Dr Kariuki. In the proceedings in the Magistrates Court that fact had also been mentioned. She took note of the fact that the accused had used Symbicort on Wednesday, Thursday and Friday, that she took Mypaid Forte on Friday morning and that at around 14h00 she had taken Diclofenac and Migril. She agreed that she was dependant on the accuracy of the information given by a patient and also agreed that the patient could forget at times.

She was aware of the fact that Symbicort could present a reaction such as depression. She was asked whether she had thoroughly examined the possibility of adverse side-effects of medication used. Her opinion was that the accused had been in a depressed mood which she had attributed to her monthly period. She also had migraine. The only medication that was new to her had been the Symbicort inhaler which was not even an adult dose. She agreed that it could happen that despite long use of a medicine, adverse side-effects could suddenly occur. That also applied to Symbicort. Even in a therapeutic dosage adverse side-effects could

present themselves. She agreed that there was a difference between a depressive disorder and depression induced by medication. The accused had not been suffering from a major depressive disorder. Her opinion was, she had a depressed mood caused by medication and by her monthly period. She had also undergone stress, and therefore they could not suddenly blame the medication for her “low mood”. She agreed that the accused had a feeling of self-depreciation and unworthiness on Friday. Having regard to the criteria used to analyse depression, she stated that the symptoms would have had to last for two weeks or longer and had to be observed by others. In her case the relevant symptoms started three days before the incident. She did not agree that a depression for two days could be called “an episode”. If it was substance adduced, it would last for the period of the substance, as she put it, and this could be for a short period.

113.

She agreed with the reference book “Psycho-Legal Assessment in South Africa”, which also referred to the Fenwick criteria. A person feeling depressed could still

drive a motor vehicle purposely. She agreed that the state of automatism could be between two and three minutes. It was put to her that the accused's defence was that "she was medication induced, depressed, and she developed a short-lasting psychotic depressive episode, induced by adverse effects of medication". Dr Pooe had a problem with the proposal and did not understand what it meant.

114.

She was again referred to the DSM IV diagnostic criteria for mood disorder, and said that the accused started feeling depressed, according to the history given to them or, feeling down, on Wednesday. That did not stop her from doing her usual activities. The same applied to Thursday and Friday. The criteria were that the particular depressed mood must be prominent and persistent. In this case it was not. The criteria also were that this particular mood had to persist for a period lasting at least for two weeks and had to be, or would be observed by others.

Her feelings of wishing to commit suicide were then put to the witness for comment and her view was that when one assesses this one would have to consider a

number of factors. The thought of suicide would be one, then there would also be an intention and a plan. On Thursday she may have had the thoughts, but no plan. On Friday, during the day she had a plan, but did obviously not go ahead with it. Many people think of suicide she said, and in some instances the thoughts evolve into an actual plan. That is what occurred on Friday when she had the intention and obtained the gun.

The concept of “parental filicide” was put to her, and she was aware of it. She was asked whether she had considered the possibility or the existence of parental filicide or so-called extended suicide. Dr Pooe confirmed that she had discussed that with the accused, and at no stage during her suicidal thoughts did she include her children into her plans. She never at any moment eluded or thought that she could actually kill her children. She also mentioned that the accused had wanted to kill herself at noon, but thereafter did not have the suicidal intent any further. She was asked whether one could exclude the possibility that she had a sort of last minute decision to do that? Dr Pooe could not answer that inasmuch as she had not asked the accused that question. Mr Pistorius then replied “well that is the crux of our case

as well. If one do not consider that, (sic) certainly one cannot exclude that". It was then put again by Mr Pistorius that "one cannot exclude the possibility in our last, that she at the last moment, decided to before killing herself kill the children and then herself". Dr Pooe said that she had asked the accused whether she had intended to kill the children and was answered in the negative. Mr Pistorius' retort was then the following: "But certainly she wants to kill herself and the children is with her, (sic) one cannot retrospectively exclude the possibility that she also at the spur of the moment decided to kill the children, in a process of maternal suicide or extended suicide".

115.

The medication then taken by the accused was debated and Dr Pooe was of the view that at about 14h00 she had taken two K-Fenak and two Migril. She would have taken it as prescribed. In the morning she had taken Mypaid Forte as the accused had told her. The accused had not told her about her interaction with the pharmacist on Friday afternoon.

116.

Dr Pooe again emphasized that it was her opinion that it was not only because of the medication that she experienced all the alleged symptoms. Added to that would have been her menstrual period and the stresses that she was going through at the time. The medication did not necessarily make the actual depression worse, according to her.

117.

Dr Pooe admitted that she had no reason to believe that the accused had amnesia about the event. She did however not agree that it could be termed “dissociative amnesia”, because the use of medication, as already said, excluded that diagnosis. The relevant diagnostic test was used by psychiatrists worldwide and Dr Savov’s opinion in this context was incorrect. In her view, sane automatism also entailed that the particular person would have a recollection of what had happened until the moment of the automatism commenced. The state of sane automatism would change after the persons had realized what they had done. That could be a very

short-lasting period. Dr Pooe was of the view that the accused had remembered what had happened after the incident, for instance by referring to the fact that she tried to kill herself with a bottle after attempting to shoot herself with the gun. She then went to the vehicle, drank all the medication that she had bought and started running. Those were the facts given by the accused to Dr Pooe, which in her view were relevant to her mental state. In her opinion one could not use the word “medicine” and “automatism” in the same sentence.

118.

With reference again to the DSM criteria, it was again put to Dr Pooe that the defence was not claiming that the accused suffered from a depressive mood disorder, but that she suffered “due to her general depressive mood disorder short-lasting”. This would fit perfectly to the general criteria be they in DSM IV or DSM V. Dr Pooe in this context referred to criteria c) which stated: “The depressive symptoms preceded the onset of the substance or medication used”. It also goes to say that the symptoms persist for a substantial period of time, e.g. about a month

after the person had stopped using the medication. Dr Pooe pointed out in this context that the accused's symptoms disappeared within a few days after admission. Again, in the context of the opposing views of Dr Savov and Dr Pooe relating to the proper and correct use of the criteria referred to in DSM IV or V, Mr Pistorius put to her that it could not be ruled out that the accused had acted in a state of sane automatism, involuntary intoxication. She had accordingly acted in a short-lasting depressive psychotic episode of depression and that she did not act voluntarily. Dr Pooe disagreed and was of the opinion that nothing supported that view. Dr Pooe agreed that according to the Fenwick criteria, her actions were completely out of character, but that she differed with the view put to her that there was no evidence of premeditation. She said that the accused had the opportunity to put the gun back on the day when she no longer felt the need to do it, yet she did not do so. She did however not know what she intended doing with the gun later.

119.

Dr Pooe was also of the view, in the context of sane automatism criteria that it was not common for a person to forget up to the time of the crime. A person would forget the crime itself, but would be able to give a clear account up to the time when the crime was committed. And that person would also be able to give a clear history after the particular incident. She also disagreed that there was any evidence of delusional thinking. After her interviews with the accused, there were no signs or evidence of any psychotic symptoms.

120.

After re-examination I put certain questions to Dr Pooe relating to the warnings contained in the pamphlet pertaining to the use of Symbicort. It referred to “side-effects special precautions” and the fact that these would occur in less than 0.01%. In the context of the reference to “depression” she said that the accused had been depressed even before she took her medication as a result of her menstrual period at the time and the other stresses involving the building of the new house. The

percentage of 0.01% was insignificant. Depression was more in the context of being sad and not in the context of a disorder.

The accused's actions before the incident were again put to Dr Pooe by myself namely her visits to Pick n Pay and Dischem, her driving some 20km to Wallmansthal and her comment was asked. Dr Pooe was of the view that her actions at the time were accurate and precise. She was rational at the time. She added that the fact that she does not remember what happened still remained a mystery to all of them, because she had snapshots of what happened after that.

121.

Murder and automatism:

1.

Murder:

Murder is the unlawful and intentional causing of the death of another human being.

See: ***Criminal Law, C. R. Snyman 5TH Edition, Lexis Nexis 2008***.

Causing the death means that there must be a voluntary act (in the present context). The act is voluntary if the accused is capable of subjecting his bodily movements to his will or intellect.

The form of culpability required is intention. The test in respect of intention is subjective. This subjective mental state may however be inferred from the objective facts proved by the State. Awareness of unlawfulness is an integral part of this intention.

2.

Automatism:

The question in this context is whether the accused acted voluntarily at the critical moment.

See: ***Criminal Law, Snyman*** *supra* at 55.

The author states that the question is simply whether the act was voluntary, in other words, whether the person concerned was capable of subjecting his/her bodily movements or his/her behaviour to the control of his/her will.

It must also be considered that mere amnesia after the act, that is, inability to remember what happened at the critical moment, is not to be equated with automatism, because the question is not what an accused can remember of the events, but whether she acted voluntarily at the critical moment.

According to the opinion of three psychiatrists referred to in the medical report of Weskoppies Hospital, and the evidence of Dr Pooe, there is no question of mental illness being involved at the critical moment.

122.

In cases of automatism due to involuntary conduct, the onus is on the State to prove that the act was voluntary, although the State is assisted by the natural inference that, in the absence of exceptional circumstances, sane persons who engage in conduct which would ordinarily give rise to criminal liability do so consciously and voluntarily.

In general, the attitude of the Court towards a defence of automatism is usually one of great circumspection. Even where “sane automatism” is pleaded and the onus is

on the State, the accused must base her defence on medical or other expert evidence which is sufficient to create a doubt as to whether the action was voluntary.

Snyman *supra* at 57 says the following in this context: "The mere subconscious repression of an unacceptable memory (sometimes described as "psychogenic amnesia") does not mean that X in fact acted involuntarily. It is well-known in psychology that if a person experiences a very traumatic event, recalling the event in the mind may be so unpleasant that the person's subconscious "blocks", as it were, subsequent recollection of the event. This then results in such person being subsequently unable to recollect what happened. This inability to remember is not the same as the inability to subject a person's bodily movements to her will or intellect. It is the latter inability which is the crux of the test to determine whether the defence of automatism not attributable to mental illness should succeed or not. What a Court must determine when X relies on the defence of such automatism is therefore not X's ability to remember what happened when the alleged crime was committed, but whether at a crucial moment she had the ability to subject her bodily

movements to her will or intellect". In ***S v Eadie 2002 (3) SA 719***, the Supreme Court of Appeal examined this particular defence in great detail. It referred to previously decided cases and also referred to the view of Dr S. Kaliski, a psychiatrist who described the characteristics of sane automatism. A person who acts in a state of sane automatism would typically have been subjected to a great deal of stress producing a state of internal tension building to a climax which in most cases is reached after the person concerned has endured ongoing humiliation and abuse. The climax is triggered by an event unusual in its intensity and unpredictable in its occurrence. When one acts in this state one's cognitive functions are absent. This means that actions are unplanned and one is unable to appreciate surrounding events. Acts perpetuated in this state may appear to be purposeful, but should typically be out of character. When the period of automatism has passed, the person concerned comes to his senses, is bewildered and horrified by the results of such actions and lends assistance to the victim. There would be no concerted effort to escape from the scene. Persons acting in this manner usually claim amnesia. (See page 727 to 728).

123.

The Supreme Court Of Appeal referred amongst others to ***S v Henry 1999 (1) SACR 13 SCA***, where Scott AJA said the following at 20 (c) to (e): “For the very nature of things the only person who can give direct evidence as to the level of consciousness of an accused person at the time of the commission of the alleged criminal act is the accused himself. His *ipse dixit* to the effect that this act was involuntarily and unconsciously committed must therefore be weighed up and considered in the light of all the circumstances and particularly against the alleged criminal conduct viewed objectively”.

In ***S v Cunningham 1996 (1) SACR 631 (A)*** it was said in the context of the natural inference that assists the State, as I have mentioned, the following (at 635 J to 636 B): “In discharging the onus upon it the State, however, is assisted by the natural inference that in the absence of exceptional circumstances a sane person who engages in conduct which would ordinarily give rise to criminal liability does so consciously and voluntarily. Common sense dictates that before this inference will be disturbed a proper basis must be laid which is sufficiently cogent and compelling to

raise a reasonable doubt as to the voluntary nature of the alleged *actus reus* and, if involuntary, that this was attributable to some cause other than mental pathology".

124.

Having discussed numerous cases relating to sane automatism, the Supreme Court of Appeal made it clear that one has to carefully consider the accused's actions before, during and after the event. Account must be taken of whether there was planned, goal-directed and focused behaviour. Also, a detailed recollection of events militates against a claim of loss of control over one's actions.

125.

Having discussed various cases and textbooks on this particular topic, Navsa JA said the following in ***S v Eadie*** *supra* (at par. 64): "I agree that the greater part of the problem lies in the misapplication of the test. Part of the problem appears to me to be a too-ready acceptance of the accused's *ipse dixit* concerning his state of mind. It appears to me to be justified to test the accused's evidence about his state

of mind, not only against his prior and subsequent conduct but also against the Court's experience of human behaviour and social interaction. Critics may describe this as policy yielding to principle. In my view it is an acceptable method for testing the veracity of an accused's evidence about his state of mind and as a necessary break to prevent unwarranted extensions of the defence. The Kensley and Henry cases adopted this approach.

65. To maintain the confidence of the community in our system of justice the approach of this Court, established over almost two decades and described earlier in this judgment, should be applied, consistently. Courts should bear in mind that the phenomenon of sane people temporarily losing cognitive control, due to a combination of emotional stress provocation, resulting in automatic behaviour, is rare. It is predicable that accused persons will in numbers continue to persist that their cases meet the test for non-pathological criminal capacity. The law, if properly and consistently applied, will determine whether that claim is justified".

126.

Tests for evaluating the evidence:

When I evaluate the evidence, I will keep the following considerations in mind and will apply them:

1. The onus of proof to show that the accused had the criminal capacity at the relevant time, is on the State. I have referred to what was stated in ***S v Eadie*** *supra* in this context;

2. When evaluating or assessing the evidence, it is imperative to evaluate all of such evidence.

   See: ***S v Chabalala 2003 (1) SACR 134 (SCA)***;

3. All the evidence must be considered holistically and a Court should not be selective in determining what evidence to consider.

   See: ***S v Van der Meyden 1999 (1) SACR 447 (W) at 450***;

4. The question for determination is whether, in the light of all the evidence, the guilt of the accused is established beyond reasonable doubt. The breaking down of a body of evidence into its component parts is a useful aid for a

proper understanding and evaluation. A Court however must guard against a tendency to focus too intently upon separate and individual parts of the evidence. A detailed and critical examination of each and every component in the body of evidence is required, and once it has been done, it is necessary to step back and consider the mosaic as a whole.

See: ***S v Hadebe and Others 1998 (1) SACR 422 (SCA) at 426 H***;

5. As far as the defence of the accused is concerned, it must be asked whether it is reasonably possibly true in the light of all the evidence, including also the intrinsic probabilities. In order to convict, there must be no reasonable doubt that the evidence implicating the accused is true, which can only be so if there is at the same time no reasonable possibility that the evidence exculpating her is not true. The two conclusions go hand-in-hand. Thus, in order for there to be a reasonable possibility that an innocent explanation which has been proffered by the accused might be true, there must at the same time be a reasonable possibility that the evidence which implicates her might be false or mistaken.

See: ***S v Sithole and Others 1999 (1) SACR 585 (W) at 590*** and ***S v Liebenberg 2005 (2) SACR 355 (SCA) at 358***;

6. The question that must be asked, having considered all the evidence, is whether the accused acted whilst being criminally responsible, i.e. having the required criminal capacity to act, in other words, did she have the required intention whilst appreciating the wrongfulness thereof?

7. Where the role of experts is concerned, such evidence cannot displace the decision of a Court. The true nature of the alleged criminal conduct must be considered, not only on the basis of any relevant expert evidence, but in the light of all the facts in circumstances of the particular case. The Court must then also decide whether it can safely accept an expert opinion and a Court is also entitled to ask whether such expert evidence was given independently and objectively. In the ultimate analysis, the crucial issue of an accused's criminal responsibility for his/her actions at the relevant time, is a matter to be determined, not by experts or psychiatrists, but by the Court itself. The Court must thus of necessity have regard not only to expert evidence, but

also to all the other facts of the case, as I have said, including the reliability of the accused as a witness and the nature of his/her proved actions throughout relevant periods.

See: ***S v Harris 1965 (2) SA 340 (A) at 365 B to - and S v September 1996 (1) SACR 325 (A) at 328***.

127.

I have been supplied with detailed Heads of Argument by both Counsel for the State and the defence and I am grateful for their efforts. I will utilize those and arguments emanating therefrom when referring to the evidence presented.

128.

Certain facts were admitted in terms of the provisions of s. 220 of the ***Criminal Procedure Act***. Apart from those, the following facts are not in issue:

1. The accused is a young lady aged 34, and led an active professional and private life. She married her husband, a practicing psychiatrist in Pretoria, in

2011. They had a relationship whilst he was still married and in total had known each other intimately for some 12 years at the time the commission of the offences. There was no history of any substance abuse, nor of any violent behaviour. She had been suffering from migraine attacks since her early childhood and had been prescribed medication for that condition. Apart from that, she was physically fit and had utilized the services of a personal trainer on a regular basis. She was also actively involved in the practice administration of her husband. Her husband also had two children from a previous marriage who also resided with them at the time of the particular incident;

2. Her husband was the licensed owner of the .38 revolver and the ammunition that the accused obtained from a locked safe on Friday 17 April 2015;

3. The accused shot and killed her two children with this revolver which held five bullets;

4. Access to this safe could only be gained by the use of an electronic code;

5. The revolver was removed from the safe prior to the accused fetching her youngest child on that Friday from his crèche;

6. It was taken to the car and eventually placed in its boot;

7. The youngest child died of a gunshot wound to the head;

8. The eldest child was shot twice – in the arm, and the head;

9. The shot to the head was fired from close range;

10. On Friday 17 April, after having taken the revolver she drove to Pick n Pay (Silver Water) where she bought diapers for the youngest child, amongst others. From there she drove to Dischem, Glenfair where she bought various items including medication for herself;

11. The till slip at Pick n Pay reflected the time of 12h50. The till slip counter at Dischem reflected the time at 13h31. She then picked up her eldest son from school (Loreto) and then drove about 24km on the national highway to the north (direction Bela-Bela), took an off-ramp, drove through a tollgate, arrived at a T-junction, turned right and continued until this became a gravel

road and then chose to drive between a number of options of minor roads to turn left;

12. Several of these minor roads were negotiated which then led to a secluded and deserted area in a field forming part of the old Wallmansthal Defence Force Base;

13. There she shot her two children;

14. She then proceeded from the vehicle across a field to the home of Mrs Van Rooyen;

15. She spoke to Mrs Van Rooyen, Mr Dorfling and Captain Mokgapa;

16. The BMW car was found in the field approximately 4km from the house of Mrs Van Rooyen;

17. A revolver with five spent bullets in the cylinder was found on the front seat of the vehicle.

129.

Evidence analysis:

As has become apparent, I deemed it necessary to refer to the evidence as a whole in some detail. When analysing all of the evidence, both for the State and the accused, I will refer to the contentions made by Counsel for the State and the accused and will state my views and conclusions.

All of the evidence must be seen against the background of the written Plea Explanation tendered by the accused in terms of the provisions of s. 115 (2) of the ***Criminal Procedure Act***. I have quoted this in full. The crux of her defence against which all the evidence must be considered and analysed is that per par. 5.2: "My defence to the charges is one of sane automatism due to a short-lasting psychotic depressive episode with prominent suicidal trends, as a result of a combination of side-effects of medication and substance intake". In par. 5.4, it was added that the combination of side-effects to the medication "caused a short-lasting, but severe substance induced psychotic depressive episode with prominent destructive and suicidal trends". It will be noticed that the reference to "destructive" trend was added in par. 5.4 and does not appear in 5.5 which deals with the side-effects of the medication used. I will obviously return to the evidence of Dr Savov, but at present it

is convenient to mention that he was of the view that the accused's actions could be accommodated into so-called "extended suicide" (also known as "mercy-killing", "altruistic suicide" or filicide). This was a hallmark of severe depression when mothers wanted to kill themselves, but did not want to leave their children suffering without their protection, and therefore decide to take their lives "to spare them from suffering". During cross-examination of Dr Muller, it was put to him that it was the accused's case that a combination of the medicine used resulted in a short-lasting psychotic depressive episode. During the cross-examination of Dr Pooe, it was put to her that the accused's defence was that "she was medication induced, depressed, and she developed a short-lasting psychotic depressive episode induced by adverse effects of medication". At a later stage, it was put to her that she had taken a last-minute decision to kill her children and that that was the crux of the defence. Adv Pistorius also then put "one cannot exclude the possibility in our last, that she at the last moment, decided to before killing herself kill the children and then herself". The following further proposition was then put to Dr Pooe: "But certainly she wants to kill herself and the children is with her, one cannot

retrospectively exclude the possibility that she also at the spur of the moment decided to kill her children, in a process of maternal suicide or extended suicide". It is difficult to reconcile that version with the one relating to "sane automatism" during which short period the accused could not have formed the intention to kill whilst appreciating the wrongfulness thereof.

130.

Most of the evidence tendered by the State relating to the accused's conduct after the shooting, is not in contention and was not disputed. The accused herself said so, because in most instances she could not remember the relevant events.

In my view there is no reason to doubt the veracity of the evidence of Mrs Van Rooyen, Captain Mokgapa and Mr Dorfling. They were frank and candid and I have no hesitation in accepting their evidence.

131.

Mrs Van Rooyen testified in some detail about the accused's actions that afternoon and the conversation that was held with her. There was some debate as to whether there was spittle in the mouth of the accused or whether this was foam, and what the significance thereof was. Dr Savov was of the view that the "foam" was a sign of the toxic effect of medicine. The accused herself did not mention that after the shooting she had taken all the medicine that was in her car that she had previously bought at Dischem. This only emerged from the evidence of Dr Pooe, who said that the accused had given her that information. This was not disputed. On the probabilities therefore, there is in my view no factual basis for the opinion of Dr Savov that this "foam" was a sign of the toxicity of the medication taken by the accused. Even if this was foam however, this does not mean there was a causal effect between the toxicity of the medicine taken by the accused and the shooting of her children. The accused did not contest the evidence of Mrs Van Rooyen. It was however put to her that the last recollection that the accused had of the children, was at the Loreto School, of which she had a snapshot image of them sitting in the

vehicle. The accused remembered speaking to Mrs Van Rooyen, but could not remember all the specifics, but only that she did want to commit suicide then.

132.

When Captain Mokgapa gave evidence, it was put to her that she had a snapshot image of her eldest son on the field of the school and strapping the children in the car. It was also put that she remembered waking up whilst lying on the ground in the field with her son K. lying on the gravel surrounded by blood. She also remembered looking for her son A. and ran screaming his name to the front seat where she saw him slumped over. She also had a snapshot memory of putting the gun against her head, but that the gun would not fire. She did however hear clicking sounds. She could also recall finding a beer bottle in the field which she wanted to break so that she could stab herself, but this bottle shattered into small pieces. She also remembered asking Mrs Van Rooyen for a knife, or a gun, or bullets to kill herself with. She also had a snapshot image of a female person pulling her over the side of the wall and telling her to sit down. It was not put to Captain Mokgapa that the

accused remembered phoning her mother from Mrs Van Rooyen's phone. It was also not put that she remembered sitting behind the steering wheel of a car whilst driving to an unknown destination. This was stated by Dr Savov in his report. It was also not put that she remembered finding the gun on the ground next to her when she woke up in the field after the shooting.

According to Mrs Van Rooyen, the accused appeared rational, although highly excited.

133.

I took into account the two statements that Mrs Van Rooyen made to the police. She testified that she spoke in Afrikaans and that her statements were written in English and thus presumably translated by the relevant police officer. She also testified that she did not read through the statements as she had accepted that the police officer would write what she had told him. In my view there is no material difference between her evidence in Court and that contained in the statements, even assuming that a proper basis had been laid for that type of cross-examination. The accused

confirmed that she had met her and had told her that she did want to commit suicide, but apart from that said that she could not recall the conversation.

134.

Mr Dorfling:

Mr Dorfling's evidence was straight forward. He arrived at the scene after having been phoned by Mrs Van Rooyen. The accused told him that she had shot her two boys and she was concerned that her husband would kill her. She pointed in the direction where the car was to be found and mentioned that it was a blue BMW. He did not notice any foam or spittle on her face. She looked upset. It was also submitted that he was a credible witness and I agree. He did not mention in his witness statement what the accused told her. His reason was that in his opinion the person taking the statement from him was trained to do so, and should have guided him in what to say. It was put to him that the accused could not remember talking to him.

I agree that I can accept his evidence as being truthful.

135.

Captain I. Mokgapa:

I have dealt with her evidence in some detail. Of particular importance, is the accused's statement when asked why she had killed her children: the reply was that she struggled for 12 years in her marriage, which is according to the accused's own evidence the time that she had known her husband. The accused was crying on the scene, but could tell her what had happened. A number of significant points were put to her by the accused's Counsel as to what she had remembered. I have referred to those. The Captain did not notice any smell coming from the accused in the police vehicle, nor was she told that the accused wanted to relieve herself.

There is no reason to doubt the voracity of this witness. It was, amongst others, put to her that the accused could not admit or dispute her evidence as she could not remember.

136.

Pathologists:

Dr Kgoete testified that the younger child was shot through the left upper eyelid. It was a distant wound without any gunpowder residue.

This is not in issue.

Dr D. du Plessis testified that K. was killed by a gunshot wound through the head, but that he also had a gunshot wound on the back of the right forearm with fractures of the radius and ulna. There was evidence of a close range wound.

This evidence is also not in issue.

137.

Captain Solomon Modisane (the ballistic expert):

This officer did a crime scene reconstruction and prepared a report which I have referred to. His view was that the youngest child was shot when the accused was positioned outside the vehicle on the left hand side. K. was shot at close range, not more than a metre from the head. He concluded that the first shot hit this child whilst most probably had his right forearm in a defensive position. The bullet went through the arm and hit the left front passenger seat on the side. There was a hole

in the seat visible which was surrounded by a small bloodstain pattern or body fats. His view was that this child was shot in his arm inside the vehicle. He was then also shot outside the vehicle, because there was accumulation of blood outside.

The particular firearm involved was a revolver with a revolving cylinder. It took five bullets. For every shot fired, the trigger would have to be pulled.

He reconstructed the scene from proper photographs taken of the crime scene and post mortem reports.

He testified that he had dealt with over 3000 cases since 2008. It was submitted that he was a credible witness who ensured that he had the best evidence available to enlarge and improve the quality of the photographs. He had also inspected the vehicle which had been repaired and made a reconstruction.

It was submitted that his evidence corresponded with objective facts and that it should be accepted.

I agree.

138.

Dr Muller:

I have dealt with his evidence and his report in detail. His view was that the doses of Symbicort that the accused used were too low due to the inhalation factor, and that the period over which she allegedly used it was in any event too short for her to have experienced any material side-effects. He was also of the view that the particulars provided by the accused regarding the doses and intervals was also particularly vague. He noted that the accused had claimed that she experienced suicidal feelings already on Thursday, and that by Friday therefore, it would have been one and a half days after the usage of Symbicort. He could not find any reference that Symbicort was known to cause homicide or suicide. No mention was made of this in the package insert.

In his opinion, adverse side-effects would probably only occur after usage of two weeks in high doses.

A claim by Dr Savov that prednisone was known to cause severe psychosis, was simply wrong. The extract from the literature that he produced referred to oral drugs

which also had a different chemical composition, and it was in any event stated that this had to be used for fourteen days or longer before such severe side-effects could emanate.

The other dugs allegedly used such as paracetamol, codeine, cyclizine and formoterol, were relatively safe drugs in therapeutic doses. Their potential to cause adverse drug interactions with other drugs was also negligible.

He also stated that the foam around the mouth of the accused that was allegedly there (or spittle), meant nothing, and in his opinion it was “ridiculous” to say that the accused had been suffering from acute poisoning. It must be remembered in this context that Dr Muller was not aware of the fact that the accused had told Dr Pooe that she had taken all the medication that was in the car after having shot the children. Dr Savov also did not deal with this topic. The accused herself did not say that she took any particular medicine in over-dose prior to the incident.

His view was that the evidence of Dr Brink was very theoretical, more in line with an academic argument, and that his conclusion was not a real possibility. The reference to the book of Dr Leischmann was also of no value in that it did not refer to

budesonide. It referred to oral corticosteroids which were of a different composition. The side-effects of budesonide did include depression and memory impairment, but this would only occur after a substantial period of time. He did not agree that the side-effects could occur within five days. It is correct that this was not put to Dr Brink, but Dr Muller said that as a lay person he did not appreciate that this had to be done.

He was adamant that in the light of the facts of the matter, his own research, and experience of medication and substances used by the accused did not have the claimed side-effects, and did not have any bearing on the murders.

139.

It was contended by the State that his evidence should be accepted and that his view that the amount of budesonide inhaled by the accused was very small, was never disputed. The accused's evidence in this context was in any event so vague and so contradictory with statements to various witnesses, that it could in any event

not be determined with accuracy how much she had inhaled. On her own version that is indeed so.

There is in my opinion a particularly significant comment made by Dr Muller during his evidence: he said a lot of time had been spent discussing the side-effects of each particular substance, either by itself or in combination with others, and that this was done particularly to show that the accused had been suffering from depression to some degree already from the Thursday, but particularly on Friday. He expressed some amazement about these lengthy debates, and stated that it was wrong to concentrate on that topic and the mentioning thereof in various inserts or pamphlets, whilst he could find no reference anywhere to the probability or likelihood that any of the medicines either by themselves, or in combination, could lead to homicide. In my opinion this was a sound and justifiable comment, having regard to the totality of the evidence presented in the context whether or not a combination of medicines allegedly used by the accused would lead to depression, when it would do so and the extent of such depression. Against that background, the evidence of the accused's husband, Dr M., is of course also of importance who, as an experienced

psychiatrist, stated that in his opinion his wife did not show any signs of a clinical depression. She was simply "down" on Thursday. That was also the accused's own evidence, who coupled this feeling to her menstrual cycle. This also applied to her depressed and/or sad feeling on Friday. On her own evidence also, she acted wholly rationally and purposefully throughout Wednesday to Friday afternoon.

140.

Dr Pooe:

I have also dealt with her evidence in detail. The crux of her opinion was that the accused suffered from no mental illness and was criminally responsible at the time of the crime. It was submitted that she had motivated her opinions well and was able to provide a proper basis therefor. Her evidence can be reconciled with the objective evidence and the facts referred to by Mrs Van Rooyen and Captain Mokgapa, who explained the accused's conduct, and her own admission that she had shot and killed her children, why she did it and how she did it. Dr Pooe admitted that the accused was possibly suffering from amnesia relating to her actions on that Friday

afternoon and that she was not faking such. She was however of the opinion that there was no indication that the accused had suffered from any psychotic process on the day of the shooting. She acted wholly rationally on that Friday throughout the day "until a few minutes when she actually said she cannot remember what had happened". All of her actions on that day were precise and purposeful. She also referred to the fact that the accused had mentioned to her that she had misinterpreted her husband's statement that "I will build you this house and leave you with the children". As I have said, the accused did not mention this in her evidence, and this can be sensibly related to what the accused had said to Mrs Van Rooyen when stating why she had shot the children. She did not agree that there was any question of automatism, especially because a person would remember what had prompted them or had triggered them to commit a particular crime. In her discussions with the accused no such trigger or cause was identified. There were also inconsistencies in the version of the accused. As far as the reference to "depression" was concerned, it was her view that during, and before the shooting, she only had a "low depressed mood. This did not meet the criteria to call it a

disorder". As I have said, this was also the view of the accused's husband, Dr M.. I have already mentioned that it was put by the accused's Counsel that her defence was that "she was medication induced, depressed, and she developed a short-lasting psychotic depressive episode, induced by adverse effects of medication". Dr Pooe's view was that she had a problem with this proposal and did not even understand what that meant. The accused's mood on Thursday and Friday was not prominent or even persistent and observed by others. It is significant that the accused's Counsel put to her, that one could not exclude the possibility that the accused made a last minute decision to kill her children. Dr Pooe could not answer that, as she had not asked the accused that question. The accused's Counsel then said: "Well that is the crux of our case as well. If one do not consider that, (sic) certainly one cannot exclude that". He also put, as I have said, that one cannot exclude the possibility that "she at the last moment, decided to before killing herself kill the children and herself". If that was then the accused's case, which is not her case as explained in the Plea Explanation, then on the accused's own evidence she had the necessary *mens rea* or intention to kill. Mr Pistorius' further proposition to Dr

Pooe was then: “But certainly she wants to kill herself and the children is with her, (sic) one cannot retrospectively exclude the possibility that she also at the spur of the moment decided to kill the children, in a process of maternal suicide or extended suicide”. As I have said, if that was then the accused’s version as put to Dr Pooe on three separate occasions, then the defence of sane automatism cannot co-exist therewith. The topic of “extended suicide” was one that was particularly close to the heart of Dr Savov as will be apparent from the evidence that I dealt with in great detail.

The description of medicine taken by the accused was also not consistent with her version given to others. Dr Pooe was also particularly insistent that one could not use the word “medicine” and “automatism” in the same sentence. Dr Pooe was of the view that there was no evidence that the accused had acted in a “short-lasting depressive psychotic episode of depression and that she did not act voluntarily”. Although she agreed that according to the mentioned Fenwick criteria, her actions were completely out of character, she did not agree that there was no evidence of premeditation.

In the context of sane automatism, and the criteria used to describe such, it was not common for a person to forget up to the time of the crime. A person would forget the crime itself, but would be able to give a clear account up to the time when the crime was committed and would also be able to give a clear history after the particular incident. According to the accused she had no memory of what occurred after strapping the children into their seats at the Loreto School at about 15h00 on Friday afternoon, until she "woke-up" at the scene of the shooting.

141.

Dr Pooe also mentioned that the accused had been "depressed" even before she took medication as a result of her menstrual period at the time and the other stresses involving the building of the new house. The alleged "side-effects" pertaining to the use of Symbicort would occur in less than 0.01% of cases and this was insignificant. In the present context, the "depression" was more akin to "being sad" and should not be seen in the context of a disorder.

142.

I agree with Ms Leonard's argument that the evidence of Dr Pooe, an experienced psychiatrist, having regard to all relevant information made available to her, including the interviews with the accused, did not support the accused's defence of "sane automatism", or even clinical depression as a result of the combination of medicine taken.

I agree that from a proper analysis of Dr Pooe's evidence in the light of all the other relevant facts put before me, and the State's evidence as a whole, that the facts are not supportive of the accused's defence of sane automatism and in fact point to the opposite, i.e. premeditated behaviour.

143.

The evidence for the accused:

Before dealing with the evidence by the accused, and the evidence of Dr Savov and Prof Brink, I need to note that by dealing with the evidence in separate chapters, I certainly do not intend to judge such in isolation. It is in my view more convenient to

do so, but at all stages I do keep in mind that all of the evidence must be critically examined in its totality so as to complete the mosaic that I have referred to in par. 126 above.

144.

I have dealt with the evidence of the accused in detail, and in particular, her actions on Wednesday, Thursday and Friday. On her own evidence there is nothing to support any version that she was clinically depressed, that she acted out of character and that she over-dosed on medicine. In fact, all of her actions until at least 15h00 on Friday were purposeful and rational.

145.

I have also referred to the bail proceedings for which the accused had filed an affidavit and had submitted a report by Dr Kariuki, a psychiatrist. He had examined

the accused on 28 April 2015. It was argued by Ms Leonard that it was clear from the bail proceedings' record that the accused agreed with the report of Dr Kariuki, which was an important aspect relating to the consistency of her versions. It is of course apparent that her version before Court differed in a number of important aspects with regard to what medication she used, and also details of the alleged state of amnesia. Dr Kariuki's report does not mention any of the alleged snapshot memories. There was no mention to Dr Kariuki of migraine, menstrual pains or headache on the Wednesday. She did however testify that she explained all her pains to Dr Kariuki. She also only mentioned to him that she took Symbicort and Mypaid Forte up to the time that she went to Dischem. No explanation for this omission was tendered. She also did not disclose to Dr Kariuki her evidence about seeing the children on the scene of the shooting, calling their names and running around the car looking for the youngest one. She also did not mention wanting to stab herself with a bottle, or phoning her mother, or asking Mrs Van Rooyen to assist her in killing herself. I will accept however that the accused did suffer from menstrual pains and an associated feeling of slight depression during that period.

Her husband was of similar view, and, because thoughts of suicide were not mentioned to him, he was not even unduly perturbed by her behaviour or condition.

146.

It was also submitted that she either could not, or did not want to commit herself at all about the number of times she took medication, when she did so, or in which dose. She also could not remember the number of puffs of Symbicort she took on any particular day, but nothing indicates any over-dose. Regarding the use of Mypaid Forte, she also did not want to commit herself at all. She could not give details of the dose prescribed by the doctor or how many tablets she took. She also could not remember how many pills she took on the Friday. She could also not say whether she took the Migril tablets according to the prescription on the Wednesday or Thursday. On the Friday she took either two or three tablets after being at Dischem. That was in conflict with her evidence-in-chief, where she stated expressly that she did not remember exactly how many tablets she took. The same vagueness or uncertainty involves the intake of K-Fenak and Empacod. She could not give

details of the intervals at which medication was taken. Neither Dr Savov's, nor Prof Brink's evidence and report, can be reconciled with this version. In fact, Dr Savov regarded the over-use of Symbicort as being the "leading cause" of the incidents whilst the accused's evidence and descriptions of her actions between Wednesday and Friday do not support this opinion at all.

147.

She also mentioned during cross-examination that she had sought a protection order against her husband before they were even married out of anger and fear, but not because of a history of abuse. This had not been disclosed to anyone before.

148.

I have dealt with all the particular details of her actions prior to the shooting, and at the scene of the shooting afterwards. In the light of all of her evidence, Ms Leonard made the following material submissions:

1. The accused was neither a truthful, nor a reliable witness and she did not hesitate to lie when it suited her;

2. A perusal of all of the evidence showed that her defence was “developed” after she had seen Dr Kariuki. Her Counsel had mentioned that a private investigator had sourced the receipts from Dischem pursuant to the incident. It was accordingly submitted that this is why she now claimed, different from her initial explanation to Dr Kariuki of having only taken Symbicort and Mypaid Forte for the relevant three days, that she also took the medication mentioned on the receipts. That was then the reason why there were so many contradictions relating to if she took certain medicine, when she took it, at which intervals and in which doses;

3. On the day of the incident, when she spoke to the State witnesses, she was fully able to relate what had happened and why. Her “defence” of the

medication and substances being the cause of the shooting grew as time passed. Initially she maintained to Dr Kariuki, Dr M. and Prof Brink that she could not remember what had happened (én bloc amnesia). Later on she averred to Dr Savov, Dr Pooe and to the Court that she had snapshot memories of certain incidents. This was also put to Captain Mokgapa. Prof Brink also said that she had recollections prior to – and after the incident. To the State witnesses she was able to relate that she shot the children, the smaller one once, and the elder one twice, and that she made certain that they were dead. This indicated that she knew that she had shot them and did not fit in with her evidence of having only select snapshot images not covering the actual shooting of the children;

4. Her evidence on several aspects was not consistent and it was contradictory, and she adapted and changed the details of her defence to suit her case as time went by. This could not merely be attributed to normal failure of the human memory or forgetfulness. Her version as given to various persons, namely Dr Kariuki, Prof Brink, Dr Savov and even her husband confirms this,

i.e. the differences in the various versions regarding the details of amnesia, the details of the medication she used, the moments when she first experienced suicidal feelings or thoughts, and the specific aches and pains giving rise to the medication used on specific days were not consistent, and consequently conflicted with the evidence in Court, and with that what had been said by other persons. This was indicative of the fact that she was not truthful. Had she been honest, these versions would have stayed consistently the same in material respects;

5. Her version about what happened on the day of the incident, is also not in keeping with the probabilities, and not reasonably possibly true in light of all the prevailing circumstances. It was highly improbable that she would act as she did whilst being in a psychotic state only for a few moments of the shooting, and then remember some of the details of the shootings, for instance that she shot the eldest child twice. In that context, the evidence of Dr Pooe was particularly important, namely that she knew what had happened and that intention was indicated;

6. The basis for the expert opinion of Prof Brink that she committed the crimes while being psychotic due to toxicity caused by the intake of five medications and substances was negated by her vague and contradictory evidence about the medicine intake, if one refers to the evidence of Dr Savov and the report of Dr Kariuki, and the claim that she could not remember when she took medication, how much she took and at what intervals. This has serious consequences for the view expressed by him. The information that Prof Brink used for his research and conclusion, differs vastly from her final testimony;

7. It ought to be seriously considered that the accused only indicated to Dr Kariuki that she used Symbicort and Mypaid Forte. If she did use the medication referred to in the Plea Explanation, and in Court, she would have mentioned it to him. It must be remembered that at a later stage she gave specific details to Prof Brink, Dr Savov and Dr Pooe;

8. It was accordingly a case of her having developed the “medication theory” as time passed, in an attempt to escape her actions, still her conscience and prevent a reply to any uncomfortable question as to the reason why she

killed her children. It is now a matter of herself becoming a victim, and this is indicative of the fact that she was not truthful about what had happened;

9. The Court was therefore left with no acceptable evidence about what medication she used, when she used it, the dosages and the intervals. Dr Muller in this regard also testified, as I have said, that the medication or substances described, could in his view not cause the side-effects claimed within such a short period, and did not give rise to the actions of the accused as claimed by her, and her witnesses. Dr Pooe was of the same view, and it was submitted that this evidence was acceptable, scientifically sound, well-based, and consistent with probabilities and objective facts.

149.

The accused's evidence regarding as to what medicine she took is without any doubt ambivalent, vague and contradictory. I will take Symbicort as an example,

although the same vagueness applies to the use of Mypaid Forte, Migril, Empacod and K-Fenak. As far as the use of Symbicort was concerned, the following appeared:

1. On Wednesday: A few puffs, could be three or four of Symbicort;
2. Under cross-examination: Cannot say how many puffs;
3. Thursday: Symbicort in the morning and in the evening a few puffs on and off;
4. Under cross-examination: Not known how many puffs;
5. Friday: A few puffs of Symbicort when back from school;
6. Under cross-examination: Not known how many puffs of Symbicort.

The accused admitted that she was guessing how many Symbicort puffs she took from Wednesday to Friday.

Dr Kariuki was told that Symbicort and Mypaid Forte only was taken between Wednesday and Friday.

Dr Pooe was told that Symbicort and Mypaid Forte were taken on Friday before 7h00 and K-Fenak and Migril at 14h00.

Dr Brink was only told that five puffs of Symbicort were taken on Friday.

Dr Savov was told that on Wednesday several pumps of Symbicort were taken, the same on Thursday and on Friday an unknown number of pumps. As I have said, when the same analysis is done relating to the other medication allegedly consumed, the same vagueness and inconsistency, and in fact contradictions appear from the record of the evidence. I will give another example: Dr Brink was told that on Friday the accused took at least five puffs of Symbicort, two Mypaid Fortes, two Empacods and two K-Fenaks. Dr Savov was told that on Friday she took an unknown number of Symbicort puffs, Migril and Mypaid Forte, K-Fenak before lunch and after the visit to Dischem additional K-Fenak, Migril and Empacod. Dr Pooe was told that on Friday she took Symbicort puffs and Mypaid Forte before 07h00, and K-Fenak and Migril at 14h00. Dr Kariuki was told that between Wednesday and Friday she only took Symbicort and Mypaid Forte. No-one, except Dr Pooe was told that she had taken all of the medicine that she had bought at Dischem that had remained, after the shooting of the children. Despite that, she was able to make all the observations and have all the conversations, at the plot of Mrs Van Rooyen.

150.

An analysis of the version relating to amnesia shows the following:

1. The accused testified that she had snapshot images from the moment that she strapped the children in the car at Loreto School and getting into the car. Details however developed as the case progressed and that detail appears from the evidence of Captain Mokapane. Dr Kariuki was told that there was én bloc amnesia. From picking up the eldest son at the school, the accused does not remember anything till after the incident. She did remember trying to shoot herself, but did not remember taking and firing the revolver. Prof Brink was told that there was én bloc amnesia and that the accused does not know anything about the shooting. Dr Savov was told that there were snapshot images starting after school, the memory of sitting behind the steering wheel of a car, driving with two children strapped in. Dr M. was told that there was én bloc amnesia and that the accused could not remember anything at all.

151.

Argument on behalf of accused:

In the context of the medicine taken, and her feelings on Thursday and Friday, the following was submitted in the written Heads of Argument, and repeated during argument in Court:

1. "The accused on 16 April 2015, upon waking up, experienced tightness of chest and was having menstrual pains, severe body pains and a headache.
2. For these pains she used Mypaid Forte medication and Migril tablets as she is a long standing sufferer of migraine headaches since grade 8;
3. The accused experienced an uncomfortableness with tight chest and difficulty in breathing which she then alleviated by taking some puffs of an asthma inhaler (Symbicort) that was prescribed by her husband, Dr M. to her youngest son A..
4. During the day she took additional Mypaid Forte tablets for the menstrual pains as well as Migril tablets without relief of her symptoms;

5. The accused confirmed that she got sporadic relief for the tightness of her chest and would use the asthma inhaler from time to time during the day as it had proven to give her some relief earlier in the day;

6. She confirmed that she was still experiencing headache and menstrual pains and took further Mypaid Forte tablets and in general felt miserable.

7. The accused testified with regard to the normal routine of the day but that she however could not do her physical exercise as usual, as she felt too tired and had no energy;

8. The accused confirmed that already on the Thursday (16 April 2015) during the day she felt particularly sad and lonely after dropping off the deceased (A.) and could not explain where these feelings were coming from. The accused confirmed that she thought of suicide and cried and could not understand these feelings and attributed that possibly to her menstrual cycle;

9. She however progressively felt worse and thoughts of suicide would come and go during the day.

10. She would also feel down and would take the Symbicort asthma inhaler puffs throughout the day to relieve the feelings of tightness of her chest.

11. The accused testified that on the Thursday afternoon she took the children to their swimming lessons but felt exhausted and down and did not take her own swimming lessons. She confirmed that she felt sad and was not her usual self;

12. The accused confirmed that on Thursday night she had a very restless night and woke up during the night having suicidal thoughts. She confirmed that she sat in the bathroom and cried, and did not understand what was happening. She did not mention her feeling of suicidality to her husband;

13. On Friday 17 April 2015 she woke up with extreme body pains and headache and felt miserable. She still had body aches and headaches and took some medication. She did not take any breakfast and did not see her husband as he had already left for the building site and work;

14. The accused confirmed that during the day she felt extremely lonely and experienced yet again thoughts of suicidality. She confirmed that her physical

symptoms were a severe headache and an onset of a migraineous attack. She confirmed that she could not do any exercise, had no appetite but tried to do a little bit of work after dropping off the children;

15. Of paramount importance is that suicidal thoughts would come and go during the day. She had a terrible headache and felt a lot of stress and tension. She described that she tried to keep herself busy but that she took the last Mypaid Forte's in the house and also took some Symbicort inhaler;

16. The accused confirmed that she made herself a sandwich but did not eat the whole sandwich and had a glass of red wine.

17. The accused testified that she experienced a feeling of suicidality and went to her bedroom and took her husband's gun from the safe. Upon taking the gun she went and sat in the car, contemplating shooting herself but did not do so and cannot explain why she did not commit suicide.

18. She confirmed in order to try and distract herself she put on the volume of the radio very high and drove out of the yard. She went to the Silver Water

Pick n Pay to buy some items. She *inter alia* bought some nappies for the youngest of the two (2) deceased as well as other items.

19. The accused thereafter went to Dischem in Glen Fair and explained to the pharmacologist on duty that she experienced severe headaches and pains and that the medication that she is using is not helping.

20. Upon advice of the pharmacist on duty further medication was bought inter alia Migril, K-Fenak and Empacod tablets. Of significance is also the other medication that she bought for the youngest deceased who was coming down with the flu;

21. She confirmed that she consumed these medications in combination, intermittently and/or individually as she cannot recall exactly with the Red Bull energy drink which she also had bought at Dischem;

22. The accused's evidence which was further unchallenged was that she then drove to the youngest of the two (2) deceased's crèche and recalls lying next to him for a few seconds. Thereafter she and the youngest deceased went to the Loreto School to fetch the eldest of the two (2) deceased;

23. She states that she only has snapshot images of strapping in the children in the car and getting herself into the car. She cannot recall from thereon how she ended up at the place where the actual shooting incident occurred;

24. She states that she can only recall waking up lying on the ground and that she had images of putting the gun against her head and pulling the trigger of the firearm but that it would not go off;

25. She confirmed that she did not know where she was. She confirmed that she ran trying to find ways to kill herself and ended up at the yard of Mrs Van Rooyen asking for assistance. She can recall that she requested her to help to kill herself but does not have an independent recollection of the interaction between herself and Mrs Van Rooyen, Mr Dorfling and Captain Mokgapa. She also requested Captain Mokgapa to help her kill herself;

26. She however confirms that she was later placed in a police van, vomited, relieved herself and was in a state of confusion and felt cold. She cannot recall what happened during the shooting incident itself. She however recalls that in the police van she had to relieve herself and also vomited;

27. The accused confirms that she recalls being taken to a police station but only has real significant recollection the following day. She did not know what happened and could not explain how she killed her children;

28. The accused states that upon waking up in the police cells on Saturday 18 April 2015, that she asked her husband where her children were as she did not know.

152.

It is therefore plainly clear from the evidence of the accused, and her statements to the various persons that I have referred to, that one cannot say what medication she took, when she took such, what doses were taken at what intervals and even on which days. In the light of those facts, the evidence of Prof Brink needs to be considered (again, I must repeat that I do not do so in isolation).

I have dealt with his evidence and his report in detail. It is important to note that he conceded that his report was prepared in reliance on the information provided to him. If the information was incorrect, his finding would be influenced. He did not

discuss the shooting incident with the accused, but only the medications used. He also had no information relating to the evidence presented in Court. He was told that she had no recollection of the shooting incident itself. He admitted that had he known that the accused had told Mrs Van Rooyen that she shot the one child once, and the other one twice, it would have made a difference in terms of exactly what side-effects she was experiencing. As far as memory loss was concerned, he conceded that if certain side-effects of medication presented themselves, they would remain there for a period of time until the substance of the drug or medicine was out of the system. One would then have memory loss for the whole period. Dr Pooe was of the same view, I may add at this stage, but Dr Savov, not. He was also not aware of any snapshot images that the accused had referred to, and would have expected that after the medicine was taken (if there was memory loss in fact), that there would be no recollection of what happened. He also conceded that he did not have the exact dosages taken or the intervals at which they were taken, he could make any definite conclusion to say what side-effects the accused would have experienced. He also conceded that his discussion of budesonide and its impact

was based on it taken in tablet form, and not as an inhalant as in case of the Symbicort Turbuhaler the accused used. In the latter case, the impact was less. He also conceded that the side-effects of budesonide would only kick in after a use of five days or longer. On its own, it would not have caused the particular side-effects, contrary to the view of Dr Savov. In inhalant form, the dosage was too low to cause the side-effects on its own. The formoterol dose was also too low in inhaled form and would not cause central nervous system reactions. He also conceded that if the specific dose of Migril taken and the intervals at which such were taken, was not correct, his findings would definitely be impacted upon. He also conceded that the side-effects of ergotamine that he described in his report were associated with large doses exceeding normal therapeutic doses. He conceded therefore that in order to say that it was reasonably possible that the combination of the drugs could have caused the actions of the accused, he would need the exact doses and the intervals at which the drugs were taken. He also conceded that he could not find any references indicating that the medications taken by the accused would cause suicidal thoughts.

153.

It was submitted by Ms Leonard that Prof Brink's evidence is speculative, improbable and in any event, not based on the evidence before Court in its totality. It certainly does not tie up with the evidence of Mrs Van Rooyen and Captain Mokgapa. At best his evidence was guess work and he made serious concessions which were fatal to the defence of the accused. In addition, parts of his evidence directly contradict those of Dr Savov. It was clear that the accused did not convey all the information to him, especially not that she did have certain snapshot memories. If the effects of the medication had in fact kicked in as described by the accused, or on her behalf, he would have expected an én bloc loss of memory for the whole period, and would not have expected the behaviour of the accused as testified by the State witnesses, nor would he have expected her reasoning at the home of Mrs Van Rooyen. It is further important to note that his whole discussion about elements of Symbicort related to its use in pill form and not in inhaled form.

Dr Muller disputed Dr Brink's evidence relating to the cause of side-effects, and of course also which substances were actually used and to which extent.

154.

Ms Leonard therefore submitted that Prof Brink's evidence does not show a reasonable possibility that the accused killed her children whilst being in a psychotic state after having used the combination of five medications and substances. It was also highly improbable that the accused would only suffer from this so-called psychotic state for the short period that she shot her children. This would stretch credulity.

155.

Simply from the point of view of studying the evidence of the accused relating to the medication used, when, which doses and at which intervals, and taking into account the information related to Prof Brink, I am of the view that the criticism of his

evidence is well-founded on the facts and as a result of a process of logical and clear reasoning. His evidence certainly does not support the accused's defence, and in fact to a material extent, even contradicts it. He did not have all the facts at his disposal. His analysis of the ingredients of – and possible side-effects of Symbicort were based on its use in pill form, and not as an inhalant even prescribed for a two year old child. He ought to have known that there was no evidence of over-dosing. I accept that his evidence was given bona fide, but it was not based on facts and therefore not reliable.

156.

Dr M. M.:

He did not regard his wife, the accused, as having been clinically depressed during that week. In fact, she just felt "down" as the result of her menstrual cycle. Of importance is that she told him that she could not remember anything of the shooting. That is what Dr Kariuki and Prof Brink was told as well.

During the bail proceedings, he testified that he did not know that his wife had used Symbicort. In his evidence in this Court, he said that she had told him about that on Thursday evening. He was not aware that she had shortness of breath problems – was his evidence at the bail hearing. He also testified at the bail hearing that when he saw the accused at the scene of the incident, she was devastated, but three or four days later, had completely recovered. Something had therefore caused "this disturbance".

According to Dr Savov, they did consult, though Dr M. said they did not. There are these inconsistencies, but the crux of his evidence in this Court is that the accused was not clinically depressed, nor did anything appear to him to be out of the ordinary during Wednesday to Friday afternoon.

157.

Discussion of Dr Savov's evidence:

I have referred to his evidence in detail. Before he consulted with the accused on 30 September 2015, he had already received collateral information in the form of Dr

Kariuki's report, supplied apparently as being the defence of the accused, and had already consulted with her husband. He then agreed to "take on the case" and admitted her to hospital apparently to treat her for depression.

He was of the view that the accused had amnesia/loss of memory of the events surrounding the incident, which commenced from the time she collected her eldest son, until the moment she woke up and realized that she had shot the children. In his opinion this memory loss is consistent with the features of dissociative amnesia which was triggered off by extreme shock and facilitated by side-effects of medication. He said that this was a well-known diagnostic category in the international psychiatric classification system DSM IV. In his report under the heading "Discussion" he set out in detail her activities on Friday 17 April 2015, as well as details of all the medication that she had taken. His opinion was that she had developed "a short-lasting severe medication-induced psychotic depressive episode characterized by escalating feelings of sadness, despair, loneliness, failure and overwhelming self-destructive trends". He added that this episode could be directly related to the combination of side-effects of medications: "Which are well-

known for their ability to provoke suicidal ideation". He considered Symbicort and Migril as the most important in this regard. He referred in his report to the "FDA Safety Update" which he sought to introduce as an exhibit, which I held to be inadmissible, because of its irrelevance and hear-say nature. His opinion then was that her actions could be accommodated into the so-called "extended suicide" (also known as "mercy-killing", "altruistic suicide" or filicide). This was a hallmark of severe depression where mothers wanted to kill themselves, but did not want to leave the children suffering without their protection, and therefore take their lives to spare them from suffering. He was of the view that this category was well-known in clinical and forensic psychiatry. He added that in medico-legal terms her behaviour covers the criteria of "sane automatism" caused by involuntary intoxication.

158.

It was submitted by State Counsel that his evidence should not be accepted for the following reasons:

1. He is a psychiatrist and has no formal training as a pharmacologist, yet he ventures into this field with disastrous results. His claim that Symbicort causes suicide as proven by textbooks and FDA reports is wrong, and is also refuted by Prof Brink and Dr Muller;

2. His claim that prednisone being a steroid illustrates that Symbicort was also a steroid, and therefore known to cause psychosis and severe depression was also not correct. Prednisone was a different type of steroid with a different molecular structure and the discussion in the textbook which allegedly supported his contention dealt with the tablet form of prednisone, which was in a much higher dosage than the inhaler which was even used by the two year old. In any event, the particular textbook stated that this adverse effect starts within 15 to 30 days;

3. The textbook that he relied upon also did not say that these adverse effects can start within three days;

4. The accused herself did not state that she had taken an overdose of any particular medicine or Symbicort, either individually or in combination, and his

whole opinion about pharmacological topics was suspect, and not supported by the literature or by factual evidence;

5. He also tried to sit on two chairs at once: on the one hand he tries to explain the memory loss and snapshot images by reference to dissociative amnesia, and on the other hand he tries to explain the actual shooting by relying on sane automatism. It was submitted that these two, on the facts of the case, could not co-exist. If it was true that sane automatism caused by medication or substances triggered the event, there would not have been snapshot images according to the evidence of Dr Pooe. If it was dissociative amnesia caused by the shock of the incident then there was no defence to the charge of murder;

6. His evidence about snapshot images fitting into the picture is in direct contrast to that of Prof Brink, who was of the view that there would have been an én bloc amnesia for the period of toxicity with snapshot memories not to be expected;

7. The allegation of snapshot images is also not in keeping with the evidence of the State witnesses, especially Mrs Van Rooyen, to whom the accused reported that she had shot her children, why and how;

8. He overlooked important criteria and warnings in the DSM IV and V, that had to be observed before a diagnosis of dissociative amnesia can be made, as pointed out by Dr Pooe;

9. His evidence regarding the severe depression of the accused was in direct conflict with that of the accused herself, and with that of Dr M., a trained psychiatrist. His claim that a severe depression can start two and a half days after the intake of medication is highly improbable and farfetched for that reason;

10. Dr Savov claims that there was automatism, but acknowledged that there cannot be automatism if there was premeditation. His view that on the facts of the case that there was no premeditation was blatantly wrong. The actions of the accused to obtain the gun, keep it in the car when she transported her

children, and then drive the car via a long route to a secluded place before shooting them, shows clear planning;

11. His evidence was also contradicted by that of Prof Brink and Dr Muller regarding the state of toxicity that he relied on. This opinion was not even supported by the evidence of the accused herself, nor that of her husband.

159.

It is clear that amongst others I must determine to what extent the opinions advanced by experts was founded on logical reasoning, and how the competing sets of evidence, if there be such, stood in relation to one another, viewed in the light of the probabilities.

See: ***Louwrens v Oldwage 2006 (2) SA 161 SCA at 175 H***.

The cogency of the underlying reasoning of each expert must be examined and it is logic, that if the premise is false, the results will be false.

160.

I need to deal briefly with the role of an expert in this context. Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form and contend by the exigencies of litigation. An expert should provide independent assistance to the Court by way of objective, unbiased opinion in relation to matters within his expertise. He should never assume the role of Advocate. He should make it clear when a particular question or issue falls outside his expertise. An expert is not a hired gun who dispenses his/her expertise for the purposes of a particular case. He does not assume the role of an Advocate, nor gives evidence which goes beyond the logic which is dictated by the scientific knowledge which that expert claims to possess.

See: ***Schneider v AA and Another 2010 (5) SA 203 WC at 211 to 212***.

An expert should not perform his mandate in a restricted manner. He should not present a case influenced as to form or content by the exigencies of litigation.

See: ***Widdrington (Estate of I. C. Wightman, 2011 QCCS 1788 (Can L II)*** referred to the ***Price Waterhouse*** decision *infra* at par. 161.

161.

In my opinion, Dr Savov's evidence falls far short of this standard, and I say that for the following reason:

1. He was satisfied that the accused's "defence" was a good one before "taking on" the case;
2. He knew the accused's husband as a colleague;
3. He personally made investigations and enquiries about the state of their marriage and gave hear-say evidence in that regard;
4. He insisted on relying on "exhibits" which by any method of interpretation had nothing to do with the facts of the present matter, were irrelevant and of a hear-say nature, and even then professed to deal with suicidal tendencies resulting from Symbicort in a minute number of cases and not with homicide;
5. He was particularly voluble and argumentative and repeatedly inclined to lose sight of the real nature of the defence of the accused in the light of the Plea Explanation;

6. He had no – or insufficient facts relating to the intake of medicine by the accused to have arrived at the dogmatic conclusion that he did, which is not even mentioned in the Plea Explanation;

7. The factual evidence at the scene, and the evidence of the accused pertaining to her actions on Wednesday, Thursday and Friday, read together with the evidence of her husband did not support the wide-ranging opinions of Dr Savov;

8. In Court he actively associated himself with the defence, and especially when Dr Pooe was cross-examined prompted the accused's Counsel which questions should be asked. I referred to those statements when I dealt with the evidence of Dr Pooe. On her own evidence, the accused did not suffer from any clinical depression, either on Wednesday, Thursday or Friday. There was on the accused's version, and that of her husband, no signs of toxicity or overdosing, at least until 15h00 on Friday, at which time the accused said that she could not remember what occurred thereafter. It must be remembered that Dr Pooe said that she was informed by the accused

(and this was never denied) that after the shooting she had taken all the medication that was still in the car. That in my view is most probably also the reason why there appeared to be "foam" in the mouth of the accused at the scene with Mrs Van Rooyen (if it was such). Even then, the accused was able to convey what had happened, although she was in a state of excitement.

An expert must be made to understand that he is there to assist the Court. If he is to be helpful, he must be neutral. The evidence of a witness is of little value where he, or she, is partisan and consistently assists the cause of the party who calls him.

See ***Price Waterhouse Coopers Inc. v National Potato Co-Cooperative Ltd [2015] 2 ALL SA 403 at par. 98 and 99***

162.

When did the automatism start and end:

Dr Savov was of the view that automatism was only over a very short period and would have lasted in fact for only a few minutes. It would have started just prior to the shooting, and after she had shot the first child, she would be "coming out of it".

If that is so one must ask: why did she then shoot the second child twice? During argument and in the accused's Counsel's written Heads of Argument it was said that: "When the evidence is considered Dr Savov explains that the accused's conduct by driving a motor vehicle, taking an off-ramp and going through a tollgate can be explained from a psychogenic perspective and is this conduct not to be misunderstood as a state of automatism. The Court is reminded that depression is not a coordinative condition. The accused was also not yet in a state of automatism when she drove her car". When that proposition was put to me during argument, I asked Mr Pistorius the obvious question: if that is so and a state of automatism does not yet exist, why would the accused then drive to Wallmansthal? Mr Pistorius' reply was that he did not know, but suggested that at that stage she was in a state of severe depression and still intended to kill herself. Therefore, on the version of Dr Savov, the state of automatism arose just prior to the shooting and, on his evidence an "extended suicide" was about to occur, in which case the accused intended to kill her children first, and herself thereafter, to save them from the misery if they were to be left behind. If that is to be accepted then of course the accused would have had

the intention to kill the children, fully aware of what she was doing and why. She could never have thought and did not think at the time that this was not wrongful.

163.

I fully agree with the comment made by Dr Muller, in a rather exasperated manner, that he could not understand why the evidence on behalf of the accused concentrated on severe depression as a result of medication, when the accused herself did not testify to that, nor was it confirmed by her husband and most importantly where there was no indication whatsoever that any of the medication taken, either by itself or in combination, would most probably lead to homicidal tendencies. I have dealt with the evidence of Prof Brink whose report is simply not based on the facts of the matter. The concessions that he made were in any event fully destructive of the accused's defence. Dr Savov was not an independent expert witness in my opinion and his views were also not based on the facts of the matter, nor were they supported by accepted literature.

164.

The accused explained what she had done to the witnesses at the Mrs Van Rooyen's residence, and mentioned a number of material facts in that regard. She also explained why she had done it, and the question is whether it is a coincidence that the 12 year period that she mentioned on the scene is, in fact the period that she had known her husband. Is it a further coincidence that she had been told over the telephone by her husband on Friday morning that he would build the house for her and leave her with the children? Dr Pooe gave this evidence and it was never disputed. On the probabilities, that seems to be the reason why she drove to Wallmansthal, namely to kill the children first and then herself. On the medical evidence as a whole, there is no evidence that she was in a state of automatism from 15h00 to the actual time of the shooting, in fact that is not even her case as expounded by Dr Savov and argued in Court. Her own evidence is that she had amnesia from the time she left the Loreto School with her children at about 15h00. Dr Pooe explained that she did indeed have snapshot memories and that she could remember driving the car that afternoon. According to the evidence of Dr Pooe,

which was not disputed, automatism implies that there had to be a trigger. In this case, there was none if automatism only arose at Wallmansthal. It also implied that there would be a recollection of what had happened until the moment of automatism occurred. The state of sane automatism would also change after the person had realized what they had done. Dr Pooe was also of the view that the accused had not been “psychotic”. If sane automatism was present, the person would forget the crime itself, but would be able to give a clear account up to the time when the crime was committed. A clear history would also be given after the particular incident. It was her view that there had been no evidence of any delusional thinking, and after her interviews with the accused, there were no signs or evidence of any psychotic symptoms. The facts of this case support the expert views of Dr Pooe, especially if read together with the evidence of Dr Muller in the context of effects of the medication that was discussed in this case.

165.

The accepted literature on the topic of automatism by Prof Kaliski and Fenwick indicate that there should be a clear cause for the automatism. In this case, there was none. There is also no evidence on which it could be sensibly argued that Symbicort and Migril, as Dr Savov would have it, or in fact all the other medication taken together, would have caused the irresistible urge to kill the children and herself. In fact, most of the emphasis during the trial was on severe depression. It is also clear from the medical evidence that the shooting itself was goal directed and not previously rehearsed. The accused testified that she had suicidal thoughts already on the Thursday, and if this is so, on anyone's evidence, it is improbable that those thoughts had been caused by any non-therapeutic dose of medication. It must be remembered that neither she – nor her husband – testified that she was in a state of severe depression on Thursday night when she complained about her feelings and pain, related to her menstrual cycle and migraine.

166.

Taken into account the Kaliski and Fenwick criteria, one of the hallmarks of a definition of automatism is that there should be no evidence of premeditation. In this case, premeditation can safely be inferred from the fact that the accused removed the gun from the safe, obviously did not shoot herself, did not return the gun to the safe, but placed it in the boot of the car. She thereafter drove to a secluded area completely unknown to her, via a route which required a decision-making process where she shot first the young child, and then the second child twice. Dr Pooe was of the view that premeditation could be inferred from these facts. After the event, the accused explained what had happened, what she had done and even why. She explained where the vehicle could be found, how she had tried to kill herself, and was then mainly concerned with the fact that her husband would kill her. Dr Pooe was also of the view that this conduct was not in keeping with the criteria for sane automatism. The accused also did not seek help for the children as one would have expected and obviously this was so, because she knew that she had killed them. On her evidence, there is no explanation why she shot the eldest son twice if she was in a state of sane automatism. If there was automatism at the time of the shooting,

the accused would not have known the details of her incident, nor would she have known that there were not enough bullets to shoot herself. Prof Kaliski, in his work that was referred to, also stated that during a state of automatism an accused would not be able to find a pistol. Nor would this person be able to shoot accurately. In this case the accused must have taken the revolver from the boot, closed the boot and shot the children with a direct aim from a fairly close position. By shooting the eldest son twice, she obviously intended to ensure his death. She fired the shots after opening the doors of the car, and no shots were fired without a direct aim.

I agree with Ms Leonard's contention that all of these mentioned actions are indicative of a voluntary goal directed behaviour and not automatic behaviour at all.

167.

As has been pointed out, amnesia is not an excuse, and does not mean that an accused is not criminally responsible at the time of the commission of an offence or did not act voluntarily. It was put to Captain Mokgapa that the accused had snapshot

memories prior to – during, and after the incident. Prof Brink said in his report that she had a memory to a certain extent, prior to – and after the shooting. Dr Savov said she had a vague recollection of driving to an unknown destination and snapshot memories of trying to shoot herself.

168.

I agree with Ms Leonard that there is no reasonable possibility that the innocent explanation given by the accused might be true in light of all the evidence, intrinsic probabilities, and common human experience. There are no exceptional circumstances herein, as discussed in ***State v Eadie*** *supra*, upsetting the natural inference that a sane person who engages in conduct which would ordinarily give rise to criminal liability does so consciously and voluntarily. There is no reasonable doubt created with regard to the voluntariness of her actions and the criminal responsibility of the accused. It is clear even on the evidence of Dr Savov that she decided to shoot the children when she stopped the car at Wallmansthal. This was also put to Dr Pooe by the accused's Counsel and it was said that this "last minute

decision" was actually the crux of the case. Logically, this would exclude a finding that she acted in a state of sane automatism only whilst shooting the children. If a reason is to be sought for the killings, it is to be found on the probabilities, in the accused's own version given to Mrs Van Rooyen.

169.

No submissions were made on behalf of the accused relating to the fire-arm charges. The reference to the calibre of the bullets was amended during the trial to refer to .38 rounds in Charge 4.

170.

In the light of all of the above, the accused is found guilty as charged.

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JUDGE H.J FABRICIUS

JUDGE OF THE GAUTENG HIGH COURT, PRETORIA

Case number: CC122/2016

Counsel for the State: Adv E. Leonard SC

Adv Moake

Counsel for the accused: Adv P. Pistorius

Instructed by: Johan van Zyl Attorneys

Dates of Hearing: 6 February 2017
7 February 2017
31 July 2017
1 August 2017
2 August 2017
4 August 2017
4 September 2017
5 September 2017
6 September 2017

Date of Judgment: 5 December 2017 at 09:00