GOVERNMENT OF SOUTH AFRICA

V

SHRIEN DEWANI

EXPERTS' JOINT STATEMENT

Following directions given by the Senior District Judge Mr Riddle on 29th June 2011 that there should be communications between the doctors to agree on what they can and to outline areas of agreement and disagreement in writing by 14th July 2011 at 5.00pm, we have been asked to address a number of questions. In order to do so we have had telephone conversations on 14.7.2011. Beforehand, NE had a discussion by telephone with Dr Cantrell, the treating consultant, in order to know the main relevant points that will be made in his own report, given that this was not yet available. These points were conveyed to MK in advance of our discussion.

In order to keep this statement as brief as possible, we have adopted the approach of referring to paragraphs of our recent reports relevant to each question, or each element of a given question.

1. *The diagnosis and the severity of the disorders*

   We are agreed that there are two diagnoses, depressive illness and post traumatic stress disorder (PTSD), and that each disorder is severe in degree. [NE para 3 page 19; MK opinion paras 1 and 3]

2. *The current risk of self harm or suicide whilst in the UK*

   We agree that the current risk of self harm or suicide is real and significant, in that Mr Dewani currently describes clinically convincing thoughts of suicide and has in the past taken a serious overdose, but that the risk is not immediate [NE paras 2 and 3 page 21; MK para 7 page 7 and opinion para 1]. NE believes that the long term risk of suicide is high, even in the absence of extradition, in the event that legal proceedings relevant to extradition, or thereafter, continue for many months [NE para 2 and 3 page 21]

3. *Fitness to plead, including ability to follow and understand Court proceedings and meaningfully participate in a trial*

   We believe that Mr Dewani is currently unfit to plead [NE para 4 page 21, paras 1,2,3 page 22; MK opinion para 7]

4. *Recommendations for psychiatric and pharmacological treatment requirements, together with an evaluation of any associated risks*

   We believe that this should ultimately be a matter for determination by the treating consultant, Dr Cantrell. However, we each have made some comments upon treatment (NE para 7 page 20; MK opinion paras 9,10,11]

5. *Prognosis including (a) expected timescales for recovery; (b) suitability of his ongoing placement at Fromeside or appropriate alternatives; (c) impact of requirement for continuing bail conditions*

(a) NE estimates the prognosis as at least 'poor to bad', and believes that it is not possible to give a robust view of any timescale for recovery, so long as the 'maintaining factor' of the current legal proceedings operates. Hee would only hope for some real possibility of improvement in the two conditions in the event that it proved possible, at some stage, to reintroduce anti-depressant medication. [NE para 3 page 19, paras 6 7 page 20, para 1 page 21**).** MK believes the prognosis is very hard to predict but, whilst acknowledging the importance of the maintaining factors, is more optimistic about significant gains being made once antidepressant treatment had been re-instigated and psychological treatment thereby facilitated. In MK's view every effort should be made to get the CK level down (MK Opinion paras 10 and 13).

(b) We agree that, even if the allegations against Mr Dewani in South Africa were to be true, he does not pose any real risk of harm to others, and certainly not sufficient for treatment in a medium secure unit such as Fromeside Clinic. There would be some clinical advantages to a move to a less secure environment. However, it is not likely that any other type of unit would accept him. Also, there is specific medico-legal expertise within a medium secure unit relevant to his legal situation, which would not be available in a non-forensic facility.
(c) We agree with Dr Cantrell that this is likely to facilitate the treatment of Mr Dewani's depression and PTSD if his bail conditions were altered so as to allow him daily (not overnight) home leave [MK opinion para 12], thereby ameliorating some of the deleterious effects which go with treatment in Fromeside.

6. *The risk of psychosis recurring and, if so, fitness to travel to South Africa*

We believe that there is a significant risk of a further relapse into psychosis (as occurred in the Priory Hospital) , even in the current treatment setting, if the severity of either/both of his disorders as they currently are expressed were to increase.

We believe that Mr Dewani, in his current state, and <u>without</u> further relapse into psychosis, is unfit to travel to South Africa. Of course, his unfitness to do so would be even greater were he to relapse into psychosis.

7. *Likely impact of order for extradition on mental health and risk of self harm or suicide*

We believe that his mental disorders would be highly likely to worsen further, and his risk of suicide to become even higher, probably 'very high', in the event of an order being made for extradition. [NE para 3 page 21, para 4 page 22; MK opinion para 6]

8. *The likely impact of imprisonment and any perception of the risks of imprisonment in South Africa on mental health including (a) Mr Dewani's long term ability to demand access to protection and care; (b) his fitness to plead and (c) his level of suicide risk. Insofar as this assessment depends on an assumed level of availability of the psychiatric and therapeutic services in the South African prisons system this should be identified and the level stated.*

(a) We presume that 'care' refers to 'receipt of mental health care'. If so, then, given that once extradited his mental disorders would be very likely to worsen further in their severity, his 'ability' to seek treatment would worsen. This is because he is likely to worsen in his level of therapeutic 'drive', his cognitive abilities and his level of insight into his condition. As regards his ability to seek protection, either from self harm or from harm arising from others, would similarly diminish.
(b) We believe that, because his disorders would likely worsen, his fitness to plead would be further reduced, albeit he is already unfit to plead in his current UK context.
(c) We believe that, again because his mental disorders would be likely further to worsen if he was extradited, it would follow that his suicide risk would further increase. We believe that, in that context, his risk of suicide would then be 'high'. [NE paras 5, 6 page 22, para 2 page 23; MK opinion para 6]

The latter conclusion in (c) would be valid even in the context of continuation of hospital (not prison) psychiatric care in South Africa equivalent to that which he is currently receiving. In the event that he were to be in prison, and receive the treatment available there, as it can best be gleaned available from the documents we have seen, which are extremely limited, then the risk would increase even further, and also the ability to manage that high risk of suicide would in prison be much inferior to the management that could be achieved within a hospital setting equivalent to that in which he is currently treated. [NE para 5 page 22, para 2 page 23]. However, we appreciate that the arrangements for psychiatric care in South Africa are matters that will be explored more fully in Court next week.

In preparing this joint statement we are mindful that our duty is to the court and not to either legal side that instructs us. We also confirm that we have prepared this statement solely between ourselves and without reference to those who instruct us legally.

Professor Nigel Eastman **Professor Michael Kopelman**