

LEGAL ASPECTS OF PSYCHIATRY

- Dr. DS Nambi

Introduction

Legislation forms an important component in the implementation of mental healthcare. Legislation is an expression of society with regard to the way it views and cares for mentally ill individuals. It has long been known that there is a dynamic relationship between the concept of mental illness, the treatment of the mentally ill and the Law.

Forensic psychiatry is the branch of medicine that deals with disorders of the mind and their relation to legal principles. Forensic psychiatry continues to be concerned primarily with mentally disordered offenders but now encompasses a wide range of offences and gives much more prominence to diagnosis, management and treatment, in prison, hospital or the community, using the skills of various mental health professionals.

The development of this speciality has resulted in growing links with colleagues in other disciplines, the Law, criminology, psychology, sociology and many others. There is an increasing awareness regarding mental health in our population. Along with this comes an increasing involvement of psychiatry with the Law. Patients who require expert psychiatric opinion in the judiciary are:

1. Those who may do harm to themselves or to society.
2. Those who may not look after themselves, the welfare of their family or property.
3. Those who may turn out to be dangerous if they act upon their abnormal thinking.
4. Spouses of mentally ill patients may require psychiatrists' evidence in the court of law in the matter of divorce.

There is now increasing awareness of rights in our democratic set up which results in an increase in litigation. Civil rights movements and consumer protection councils are gaining more and more importance in our day-to-day life.

Hence mental health professionals should have a better understanding to the medico-legal aspects of mental health. The mental health professional should know the following basic forensic psychiatry

1. Crime and psychiatric disorders.
2. Criminal responsibility.
3. Civil responsibility.
4. Laws relating to psychiatric disorders.
5. Admission procedures of patients in a psychiatric hospital.
6. Civil rights of the patient.
7. Psychiatrists and the Court.

Crime and psychiatric disorders

Traditionally criminality has been associated with mental illness, though there is no definite evidence. The studies of the relationship between dangerous behavior and mental disorders reveal that "there did seem to be a greater than chance association between mental, disorder and crime"

The frequency of the association between crime and mental illness depends on the sample being studied, which could be mental illness among criminal offenders, the history of criminal offences in psychiatric patients and correlation in community samples.

While some studies suggest a weak association, if any, between crime and mental illness (Rappoport et al. 1965, Hafner and Boker, 1982) assessment of frequency of a history of crime among psychiatrically ill has shown a consistent association at least in several of the offences. (Cohen, 1980, Sosowsky, 1980).

An analysis done by Walker and McCabe, (1973) of hospital order cases, showed that 41% of the count could be diagnosed as having schizophrenia, 35% mentally subnormality, 12% psychopathic disorder and 8% affective disorder (Gunn, 1977). It is to be understood that crime may not always be directly related to current psychopathology, other factors such as the personality structure and the social setting may be equally important.

Schizophrenia

In India some studies of mentally ill criminals show schizophrenia to be the commonest diagnosis (Somasundaram, 1960, Varma and Jha, 1966, Nambi, 1992). Schizophrenia was the commonest (74%) diagnosis among 58 Broadmoor patients who killed their relatives. Taylor, (1982) reviewing schizophrenia and violence came to the following conclusions:

1. That schizophrenia disposes the patients to violence though the overall numbers are small.
2. That paranoid and catatonic excitement are the subgroups most likely to be associated with violence.
3. That the violence is more common as a late accompaniment of the illness.
4. That the violence is more common in those patients who have recurrent exacerbations, rather than those who are continuously ill.
5. That at the time of the offence the offender is generally psychotic and without insight.

Vivkkunen, (1974) found that only one-third offended directly as a result of their delusions and hallucinations. The remaining two-thirds offended because of problems arising from stress produced within the family.

In paranoid disorders criminal acts may follow from delusional belief. Paranoids are more hostile than normal or other subgroups of schizophrenia. A well recognised association is that of homicide associated with delusional jealousy.

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Affective disorders

Affective disorders appear less frequently than expected among violent offenders as a whole. In some cases homicide will precede suicide or attempted suicide. Mothers who kill their children often suffer from depression (Somasundaram,1973). According to West,(1968) the incidence of murder in association with depression is considerably high. About one out of every three English murderers killed themselves immediately after the crimes. In the United States by contrast, the relative frequency of depressive murder is much less. The affective disorder accounted for 15% of the insane murders in Europe; 0% in Moscow, and 4% in New York.

Epilepsy

The association of offending and epilepsy is summarised by Gunn,(1969)

1. The offence may occur in a disturbed state induced directly by a fit. This appears to be rare.
2. The offence and the fit may be coincidental.
3. The brain damage which caused the epilepsy may have led to personality problems resulting in antisocial behaviour.
4. The subject may have developed strong antisocial attitudes as a result of the difficulties he has experienced in life as a consequence of his illness.
5. An early deprived childhood environment may have both, engendered antisocial attitudes and exposed the subject to epileptogenic features.
6. Antisocial subjects may expose themselves to dangerous situations and sustain more head injuries than normal, which may cause epilepsy.

Epileptic crimes are of historical importance from the forensic psychiatric point of view for it was in a case of an epileptic murder in Scotland that the plea of diminished responsibility was accepted by the Law there.(Whitlock,1963). In a Chennai study of crimes committed by persons with epilepsy, out of 115 criminals mentally ill, 15 were found to be suffering from epilepsy i.e. 13% (Somasundaram, 1972).

The various abnormal mental states associated with epilepsy, like confusion, stupor, depression or excitement could be raised in the Court of law, but automatism is a comparatively simple defence raised in many cases.

Epilepsy poses a problem to the psychiatrist especially in relation to crime, but in many cases, this could be untangled by careful history taking, observation and EEG findings.

Neuroses and crime

The incidence is unknown. In a study of shoplifters, 10% were found to be neurotic but there was no control study. Gunn,(1978) gave a primary diagnosis of neurosis to 9% of a prison population; but it is difficult to know how this would compare with the general population. There is one particular syndrome, the Ganser syndrome, which has been described as a reaction to imprisonment. Ganser was certain that the condition was not malingering but a genuine illness which he believed was hysterical in nature.

Personality disorder

There are close associations between crime and personality disorder, particularly antisocial personality disorder. Gunn,(1977) diagnosed abnormal personality in 20% of prisoners in prisons in South East England. Bluglass found psychopathic personality disorder in 40% of newly convicted prisoners in a Scottish prison; and Guze,(1976) described 70% of prisoners discharged from American prisons as 'sociopathic'; Gueze,(1976) recommended that psychiatrists should use the word 'psychopathic disorder' in current legal proceedings. It is widely held that the legal concept of

psychopath is unsatisfactory. The legal definition is difficult to apply in practice.

Mental retardation

Contrary to earlier beliefs, there is no evidence that most criminals are of marked low intelligence. Recent surveys have shown that most delinquent youths are within the lower part of the normal range of intelligence and only about 3% are mentally retarded.

Mentally retarded people may commit offence because:

1. They do not understand the implication of their behaviour, or
2. Because they are susceptible to exploitation by other people.

The commonest offences by mentally retarded people are:

1. Sexual offenses
2. Arson
3. Drug peddling

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Alcohol and drug dependence

After a long controversy about the relationship between crime and addiction, recent research has unequivocally demonstrated that criminality is an integral part of established addiction. In the USA, it is estimated that narcotic addicts commit over 50 million crimes per year. Much of the crime relates to the need to purchase drugs. There is strong evidence suggesting a high incidence of criminal record in established drug users. In an American study of 354 narcotic addicts (Shoffer et al,1984) delinquency was committed by every addict in the sample. Offences committed by the addicts are of two types

1. Drug related, and
2. Non-drug related with the implication that drug related offense (Possession, supply and larceny) are an inevitable aspect of the life style of the street addict. An FBI analysis in 1966 indicated that 26% of heroin addicts had a conviction for violence and 74% were for larceny. In a study of 243 Baltimore narcotic addicts (Ball et al,1983)the main offense behaviour emerged as theft (38%), followed by drug dealing (27%),pimping and gambling (26%),confidence games and forgery (8%) and violence (2%).

The link between cannabis used and offending are complex. Abuse itself may give rise to offences, apart from crimes related to illegal trafficking. It is widely believed that cannabis takers are much less delinquent than other drug abusers, such as users of heroin, cocaine and morphine.

The link between alcohol and crime has been recognized for many years. Lanke,(1975,1976) showed that during the period 1960-73 , a high statistical correlation existed between violent crime rates and alcohol consumption. A whole variety of different types of crimes have been indicated. These include homicide, sexual crimes, marital assaults, sexual crimes against children, crimes against property and crimes of violence. Gilles,(1976) in a study of homicide in Scotland on 400 individuals found that 58% of males has been intoxicated at the time of crimes as were 30% of females. Alcohol-related driving offences were noted to be at their peak at night and week ends, the periods when drinking is at its heaviest. Apart from above mentioned crimes related to alcohol, offences like illicit arrack sale and distillation are prevalent in some parts of our country. There is an alarming increase in criminal activity associated with drug addiction in South India, especially Tamil Nadu, during the past 13 years after the ethnic conflict in neighboring Sri Lanka. The youth infiltrated in South India indulged in large-scale drug trafficking especially of brown sugar (heroin). Around 70% of brown sugar (herion) addicts of Chennai are involved in criminal activities like stealing, assault etc. In another study at the Institute of Mental Health,Chennai on the prevalence of alcohol and drug abuse among mentally ill prisoners (Criminal lunctims) out of 30 patients, 15 of them have abused alcohol and 5 abused cannabis prior to their commission of crime.

Female offenders

Female criminality is infrequent compared with that of males. This may be due to the lower identification and reporting of female crime.

The commonest offence by women is stealing, shop-lifting which account for half of women offences. Violence and sexual offence are uncommon in women (O'Connor,1987). A substantial proportion of crime by women is associated with psychiatric problems are premenstrual syndrome, drug dependence and antisocial personality.

In a study of mentally ill female prisoners (female criminal lunatics) at Chennai, it was found that out of 537 mentally ill prisoners admitted during a 20-year period, only 26 were female, which forms around 4.84% of the total criminal lunatics (Nambi et al,1992). The commonest crime is murder and the common diagnosis are schizophrenia and depression (Nambi et al.1992).

Criminal responsibility

Though mentally abnormal offenders are only a small minority of all offenders the psychiatrist can play an important role by helping to identify, assess and manage them. The psychiatrist may be asked to give advice in relation to the following issues:

1. Fitness to plead (Fitness to stand trial)
2. Mental state at the time of offence, before and during trial and during imprisonment.
3. Diminished criminal responsibility.
4. The psychiatric management of offenders.

Fitness to stand trial

If the accused in a crime be of probable mental illness and not fit to stand trial, the court can order a psychiatrist to observe, treat and give an opinion regarding his fitness to stand trial. The dependent must be in a fit condition to defend himself. The issue may be raised by the defence, the prosecution or the judge. If the accused is found unfit to plead, an order is made for admission to a mental hospital where he will be detained and discharged later for trial after he is found fit for trial.

In ascertaining fitness to plead; it is necessary to determine whether the person:

1. Is oriented to place, person and time.
2. Understands the questions asked.
3. Understands the nature of the charge.
4. Understands the difference between guilty and not guilty.
5. Is able to instruct his advocate.
6. Is able to follow the evidence presented in the court, and
7. Is able to challenge the selection of jurors

A person may be suffering from severe mental disorder but still be fit to stand trial.

Criminal responsibility

Mentally ill offenders usually stand trial in the same way as their offender, but when sentence is passed consideration is given to their mental state and to the possibility of psychiatric treatment. In determining whether or not a person is guilty it is necessary to consider his mental state at the time of the act.

Before anyone can be convicted of a crime, the prosecution must prove.

1. That he carried out an unlawful act (Actus reus) (Intent).
2. That he had a certain guilty state of mind at the time, namely mens rea (Guilty mind).

When a person is charged with an offence, defence can be made that he is not capable because he did not have a sufficient degree of mens rea. This defence can be raised in several ways.

1. Not guilty by reason of insanity (under the Mc Naughton rules).
2. Diminished responsibility (not guilty of murder; but guilty of manslaughter, which requires a lesser degree of criminal intent).
3. Incapacity to form an intent because of an automation.
Eg: If mother kills her child in the first year of its life, she is not usually held legally responsible for murder but only for the less serious crime of infanticide.

According to Section 84 of the Indian Penal Code of 1860 "Nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law".

This is based on one of the famous McNaughton rules: The Phase of Insanity is generally brought forward during the trial state. The accused is found not guilty, if insanity is established. The concept of diminished responsibility, automatism and the irresistible impulse test-have not gained any momentum in the Indian legal scenario.

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Legal insanity vs medical insanity

The word insanity has no technical meaning in law or in medicine. Insanity comprises a degree of mental disturbance, so menacing and so disabling, that the person may be considered to be legally immune from certain responsibilities. Insanity is a defence because, not knowing what he is doing, or not knowing the moral nature of his act, the insane person is incapable of forming the intentions that are required for unlawful killing. He has not the 'mens rea'(guilty mind)for any offence. An insane person is an innocent person, who has nothing to answer for.

Medical insanity would cover abnormality of mind, delusion and cases of irresistibility, all of which warrant diminished responsibility. Legal insanity as such, envisages that the unsoundness of mind of the subject must be such as to make the offender incapable of knowing the nature of the act, or not knowing that what he is doing is wrong or contrary to the law.

The McNaughton Rules

Daniel McNaughton was a 29 year old, son of a Glasgow wood-turner, a man of 'gloomy and reserved social habits' which included membership of religious groups and the Tory party. He decided to murder Sir Robert Peel, the Prime Minister. He made elaborate plans and travelled to London, but in fact mistakenly shot and killed Edward Drummond, Peel's private secretary, in daylight in front of numerous witnesses on 20th January, 1843. During the trial, McNaughton himself admitted that "they have accused me of crimes of which I am not guilty, they do everything to harass and prosecute me, in fact they wish to murder me. I was driven to desperation by persecution". McNaughton knew what he was doing and was aware that he was committing a criminal act but felt compelled to do so, an act he performed with cool deliberation.

Psychiatrists were called and it was accepted:

- a) That his delusions were real.
- b) That the act was committed under a delusion.

McNaughton was found "not guilty on the grounds of insanity".

McNaughton himself was sent to Bethlehem and later Broadmoor asylum where he died in 1865.

In McNaughton's case the Lord Chancellor put to a panel of His Majesty's Judges five questions designed to clarify the legal position. Their replies given on 19th June 1843, constitute the so-called 'McNaughton rules'.

The following contain the main points of the McNaughton's rules:

1. Every man is to be presumed to be sane, until the contrary be proved.
2. An insane person is punishable, if he knew at the time of committing such a crime that he was acting contrary to law.
3. To establish a defence on the ground of insanity, it must be clearly proved that at the time of the committing of the act, the accused was suffering under such defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong".
4. Finally it is the jury's role to decide whether the defendant was insane.

The 'rules' stressed the importance of the

1. The defendant's notion of understandability of right and wrong.

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Durham Rule (1954)

"An accused person is not criminally responsible, if his unlawful act is the product of mental disease or mental defect". In this, the causal connection between the mental abnormality and the alleged crime should be established. This rule is also known as "Product Rule".

American Law Institute (ALI) Test

'A person is not responsible for criminal conduct if at the time of such conduct, as a result of mental disease or defect he lacks adequate capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the Law'.

The ALI Test is similar to the combination of the McNaughton rule and the Irresistible Impulse Test. This rule excludes psychopaths. This popular test is now used by all courts in the USA.

CIVIL RESPONSIBILITY

Before a court of Law, all persons are considered to be same, otherwise it is to be proved. A person has no responsibility in the following conditions, if he is proved to be a lunatic.

Testamentary capacity (Testament=Will)

As per Section 59 of the Indian Succession Act,1925, "Every person of sound mind, not being a minor, may dispose of his property by will".

A will can be declared invalid if it is proved that at the time of making the will, the testator:

1. Was of unsound mind.
2. Did not have the mental capacity to understand the consequences of the act.

Marriage

Under the Hindu Marriage Act,1995, a marriage with a person who was an idiot or a lunatic at the time of marriage, can be declared as null and void on application.

Judicial separation

If lunacy starts after marriage and continues for two years, even with treatment, the other party can apply for legal separation.

Divorce

Divorce can be decreed if the other party has been incurably of unsound mind for a continuous period of at least three years. But the other party has to pay for the maintenance of the lunatic.

Witness

Under the Indian Evidence Act,1872 (Section 118), a lunatic is incompetent to give evidence in a court of law if he is unable to understand the questions asked or to give rational answers to them by virtue of lunacy.

Contract

Under the Indian Contract Act, 1872 (Section 11) every person to be competent to contract, must be a major and of sound mind, i.e. he is capable of understanding the contract and of forming a rational judgment as to its effect upon his interests.

Transfer of property

Under the Transfer of property Act, 1882 (Section 7) only persons competent to contract, are authorized to transfer property.

The right to vote and the right to stand for election

No person of unsound mind can contest an election or exercise the franchise of voting.

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Laws relating to psychiatric disorder

Mental Health Act, 1987

The enactment of the Mental Health Act, 1987 is a landmark in the mental healthcare delivery in India. It is not simply a cosmetic improvement over the outdated Indian Lunacy Act, 1912, but represents the conclusion of lengthy presentation by the Indian Psychiatric Society to the Government of India. This Act came into force in April 1987, as per the government of India order, even though it is still in hibernation in some States.

The Mental Health Act is " an act to consolidate and amend the law relating to the treatment and care of the mentally ill persons, to make better provisions with respect to their property and for matters connected with or incidental thereto."

The Mental Health Act has the following objectives:

1. To regulate admission to psychiatric hospitals or psychiatric nursing homes, of mentally ill persons who do not have sufficient understanding to seek treatment on a voluntary basis, and to protect the rights of such persons while being detained.
2. To protect society from the presence of mentally ill persons who have become a danger or nuisance to others.
3. To protect citizens from being detained in psychiatric hospitals or psychiatric nursing home without sufficient cause.
4. To regulate responsibility for maintenance charges of mentally ill persons who are admitted to psychiatric hospitals or psychiatric nursing homes.
5. To provide facilities for establishing guardianship or custody of mentally ill persons who are incapable of managing their own affairs.
6. To provide for the establishment of Central Authority and State Authorities for mental health services
7. To regulate the powers of the Government for establishing, licensing and controlling psychiatric hospitals and psychiatric nursing homes for mentally ill persons.
8. To provide for legal aid to mentally ill persons at state expense in certain cases. the Government of India has constituted Central Mental Health Authority. Before implementing the Mental Health Act in the States, the states have to take action regarding the following:
 - i. To establish a State Mental Health Authority.
 - ii. To spell out guidelines for establishment of private psychiatric hospitals and nursing homes.
 - iii. Formation of a Board of Visitors.

In the Mental Health Act, 1987, a modest attempt has also been made to bring mental illnesses on par with physical illness, thus reducing the stigma attached to mental illnesses. The Mental Health Act has modified certain terms and definitions. The Act uses the term mentally ill person instead of lunatic, mentally ill prisoner, instead of criminal lunatic. Other new terms are psychiatric hospital instead of lunatic asylum, psychiatric nursing home and psychiatrist. New terminology and definitions are given in **Chapter 1**. The Mental Health Act has 10 chapters in total, consisting of 100 sections.

Chapter 2 deals with establishment of mental health authorities at the Center and at State levels. These authorities will regulate and coordinate mental health services under Central and State Governments, respectively. **Chapter 3** lays down the guidelines for establishment and maintenance of psychiatric hospitals and nursing homes. Also, there is a provision for a licensing authority who will process applications for licenses. No private psychiatric hospital or nursing homes will be allowed to function without a valid license, which has to be renewed every five years.

There is also a provision for an inspecting officer who will inspect the psychiatric hospitals and nursing homes to prevent any irregularities.

Chapter 4 deals with the procedures of admission and detention in psychiatric hospitals or nursing homes. In addition to the five methods allowed by the Indian Lunacy Act of 1912, one more method have been incorporated.

Chapter 5 deals with the inspection, discharge, leave of absence and removal of mentally ill persons.

Chapter 6 deals with the judicial inquisition regarding alleged mentally ill persons possessing property, custody of their person and management of their property.

If the court feels that the alleged mentally ill person is incapable of looking after both himself and his property, an order can be issued for the appointment of a guardian, If however, it is felt that the person is only incapable of looking after his property but can look after himself a manager can be appointed.

Chapter 7 deals with the liability to meet the cost of maintenance of mentally ill persons detained in psychiatric hospitals or nursing homes.

Chapter 8 is aimed at the protection of human rights of mentally ill persons. It provides that:

1. No mentally ill person shall be subjected, during treatment, to any indignity (whether physical or mental) or cruelty.
2. No mentally ill person, under treatment, shall be used for the purpose of research unless:
 - i. Such research is of direct benefit to him.
 - ii. A consent has been obtained in writing from the person (if a voluntary patient) or from the guardian/ relative (if admitted involuntarily).
 - iii. No letters or communications sent by or to a mentally ill person shall be intercepted, detained or destroyed.

2. Admission under special circumstances It is an involuntary hospitalization when the mentally ill person does not or cannot express his willingness for admission. Admission is made, if a relative or a friend of the mentally ill person applies in writing for admission and the medical officer in-charge of the hospital is satisfied that the admission will be the interest of the mentally ill person. The duration of admission cannot exceed 90 days.
3. Admission through reception orders.

a) Reception order on application

An application for a reception order may be made by the medical officer in-charge of a psychiatric hospital or nursing home or by the husband, wife or any other relative of the mentally ill person. This application for admission should accompany the medical certificates from two medical practitioners of whom one should be a Government doctor. On receipt of this application the magistrate may issue a reception order for admission after he is satisfied that the alleged person is suffering from mental illness.

b) Reception orders on production of a mentally ill person before a magistrate

(Admission of a dangerous wandering mentally ill person). The police officer in-charge of a police station may take into protection any person found wandering at large whom he has reason to believe to be mentally ill. He should produce him before the nearest magistrate within 24 hours. The magistrate shall examine the person and assess his capacity to understand and if he is satisfied that the said person is a mentally ill person, the magistrate may pass a reception order, authorizing the detention of the said person as an inpatient in a psychiatric hospital, and later should the medical officer certify that such a person is a mentally ill person, he should be given care and treatment in a psychiatric hospital.

Every officer in charge of a police station, who has reason to believe that any mentally ill person is cruelly treated or is not under proper care and control by relatives or other persons, shall report this to a magistrate. This complaint to the magistrate can also be submitted by any individual. The magistrate may summon such relatives along with the patient and order the relative or other person to take care of the mentally ill person. If this relative willfully neglects to comply with this order he shall be punishable with a fine up to Rs 2,000. If there is no person legally bound to maintain this mentally ill person he can issue a reception order for admission to a psychiatric hospital.

c) Admission as an in-patient for inquisition

A district court holding an inquisition regarding any person who is found to be mentally ill, may direct such a person for admission in a psychiatric hospital.

Inquisition is examination or investigation whether the person who is alleged to be mentally ill is of unsound mind and incapable of managing his affairs.

Application can be made by

1. Any relative.
2. Advocate General.
3. Public Prosecutor, or
4. District Collector.

The magistrate will give notification and the order for an enquiry.

3. Expert witness.

The expert witness has special knowledge and experience within a defined field and his opinion is requested rather than his description or recollection of facts which form part of the case itself.

Do's and Don'ts as expert evidence

Do's :

- The psychiatrist must be punctual.
- He must dress appropriately.
- Appear confident (but not arrogant).
- Speak clearly and audibly.
- Keep to the point.
- Evidence should be comprehensible and simple language.
- Keeps sentences short.

Don'ts :

- Do not use jargon.
- Do not use technical expressions not generally understandable by a lay person.
- Do not use words of foreign origin (Eg: cyclothymia instead of 'mood swings').
- Do not use polysyllabic or uncommon words.
- Do not lose your temper even if provoked by the council.

Replies to questions, although put by the advocate, will be addressed to the judge and head of jury. The conventional appellation to the judge is "your Honour" in the lower courts and "your Lordship" in High Courts. Most often the counsel and judges are courteous and considerate towards the expert witness, but their questions will be probing in nature.

In all cases it is advisable to go over the case-files and documents briefly beforehand to refresh the memory. In criminal cases, it may be helpful to see the accused again before the proceedings start. This is particularly important where the issue is fitness to plead.

The performance in the witness box and the impression that the witness makes on the court are obviously, important in contributing successfully to the proceedings and their outcome.

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