The Determination of Criminal Insanity in Western Nigeria

Author(s): Leigh Bienen

Source: *The Journal of Modern African Studies*, Jun., 1976, Vol. 14, No. 2 (Jun., 1976), pp. 219-245

Published by: Cambridge University Press

Stable URL: https://www.jstor.org/stable/160058

The Journal of Modern African Studies, 14, 2 (1976), pp. 219–245

The Determination of Criminal Insanity in Western Nigeria

by LEIGH BIENEN*

THIS article grew out of a more detailed study of all tried cases of homicide in Western Nigeria from 1966 to 1972.[1] While reading more than 100 court transcripts and trial opinions, I was struck by what seemed an inordinately large number of accused with symptoms which westerners associate with mental or emotional illness. I was also conscious of judges being forced to apply an awkward, and at best difficult, standard for the determination of criminal insanity with sparse direct evidence and, in many cases, without the help of expert testimony. The statutory standard is a variant of the so-called 'M'Naghten rule' of British jurisprudence which is operative in most of the United States. The procedures surrounding the presentation of the defence of insanity, the calling for an examination by a psychiatrist, the submission of expert testimony, are also the same in Western Nigeria as in most American jurisdictions, although there are significant differences in the manner in which the law and rules of procedure are applied, the use and exclusion of evidence, and particularly the treatment of expert psychiatric evidence.

The results were often clearly not the same as they would have been in similar conditions in the United States. Was this primarily the result of temporary, circumstantial differences? For example, in Western Nigeria, only one psychiatrist was available to present expert testimony in all criminal cases. Or, were the differences due to the fact that the received British law had been adapted, modified, or even ignored in the determination of criminal insanity? Perhaps the British definition of madness or social deviance was too culturally determined to be acceptable to the judges in Western Nigeria?

While the application of the M'Naghten standard rarely produced

* An attorney currently doing research on sex offenders and their victims at the Center for Rape Concern, Philadelphia General Hospital, Pennsylvania. The author wishes to thank the staff of the Rockefeller Foundation Office in Ibadan and the University of Ibadan Computing Centre for their help in Western Nigeria.

[1] For results regarding all 114 cases and 205 accused, see Leigh Bienen, 'Criminal Homicide in Western Nigeria, 1966–1972', in *Journal of African Law* (London), XVIII, 1, Spring 1974, pp. 57–78.

outrageous results, there were enough visible differences to raise these questions. And while the court records were sometimes sparse, details are presented here about the application of the defence in specific cases and the court procedures involved. While it is clear that other judgements would have been given under a jurisdiction governed by the U.S. Durham rules, or by the insanity standard of the American Law Institute's model penal code, I would argue that procedural differences, particularly the difficulty of preserving and presenting evidence in a society where record-keeping is not a matter of course, are more important than any differences in the statement of the law.

Given that the rules are completely foreign, in an area of law where cultural differences are extremely important, they function far better than might be expected. The 'right/wrong' test is indefinite enough, apparently, to encompass any sort of social awareness, whether it be of traditional taboos, the written law, or some more general notion of acceptability. While the adoption of the M'Naghten standard may have been unwitting – this was written into the West Nigerian Criminal Code in 1916 simply because it prevailed in Britain at the time – perhaps its great virtue is that it is amorphous enough to accommodate widely divergent circumstances.

How else can we account for the fact that the same standard seems to be equally effective when applied to a Yoruba whose notions of madness depend in part upon a religious cosmology, to a non-Yoruba Nigerian with a conflicting set of traditional beliefs, to a nineteenth-century British shopkeeper, and to contemporary mass murderers in the U.S. Is it simply that the M'Naghten rule does not have some of the glaring faults of its more precise alternatives? Or, is it that jurisdictions such as Western Nigeria stick with M'Naghten simply because it is too much trouble to change, and that the formulation of the standard is by-and-large irrelevant? Or, is it that the problem is particularly intractable, even without the complications of cultural conflict and administrative difficulties? Even those jurisdictions with seemingly endless resources of expertise, judicial talent, funds, and goodwill, such as the Washington D.C. Federal District Court, seem unable to come up with a completely satisfactory way to determine criminal insanity.

BACKGROUND

The Western State of Nigeria is large and densely-populated, with about 11 million people (the number in Texas or Illinois) in an area of 29,100 sq. miles (close in size to Maine or South Carolina).[1] The inhabitants are over 90 per cent Yoruba who share a common language and tradition, although there are distinct cultural sub-groups. The average annual income *per capita* is about $225, and illiteracy is estimated at around 80 per cent. The population is officially classified as 49 per cent Christian, 43 per cent Muslim, and 8 per cent 'other'. However, many would also participate in traditional religions, a variety of which flourish in the State, and dissident sects co-exist and combine with orthodox Muslim and Christian practices.

Cocoa is the principal crop, and over 75 per cent of the population lives in the farm sector. There is also a long tradition of Yoruba city settlement. In addition to Ibadan, with about 2 million, there are 13 other cities in Western Nigeria with over 100,000 people.[2] This high level of urbanisation, uncommon in tropical Africa, is not, however, associated predominantly with white-collar salaried employment, with apartment living, or with the presence of an industrial working class. Migration patterns show a substantial movement from the rural areas by young, able-bodied men, who then sustain long periods of unemployment in the city.

In Abeokuta there is the western-oriented Aro Hospital for Nervous Diseases, with sole jurisdiction over the criminal insane. A large, unknown number of traditional healers and herbalists also care for people who have symptoms that in Europe would be considered indicative of mental illness. In 1972 there were eight psychiatrists in the State, and three of them handled all court referrals. Psychiatrists teaching in the universities at the time of this study played no rôle in the criminal justice process. Expert opinion was solicited only from the professional staff of Aro Hospital, and no supplementary or rebuttal psychiatric evidence was offered on the issue of insanity. In Western Nigeria the question is: Does the accused get *any* psychiatric examination? Varieties of opinion are not raised or disputed. Professional psychiatrists cannot promptly examine all the accused for whom such an examination might be relevant, and knowing the delays involved the court will often not call for expert testimony.

[1] Unless otherwise indicated, the statistical and demographic information in this section is from the Ministry of Planning and Reconstruction, *Western State of Nigeria Statistical Abstract* (Ibadan), 1970–71, based upon the 1963 census.

[2] Cf. Akim L. Mabogunje, *Urbanization in Nigeria* (London, 1968).

Nevertheless, an accused in Western Nigeria probably has better access to examination and treatment than in any other part of tropical Africa.[1] Facilities for the mentally ill must be understood in terms of health care generally available. In 1969 the State officially listed 151 doctors (about 1 for 73,000 people), 48 hospitals, 3,500 hospital beds, and 1,853 'mental patients'. Of the latter, 74 were identified as 'criminal lunatics'; in 1967, by comparison, the number was 124, and in 1960 it was 53.[2] It is generally conceded that a sizeable portion of the criminally insane remain in the prisons.

The great majority of 'mental patients' in the State are treated, with unknown and probably highly-varying degrees of success, by traditional healers and herbalists;[3] others are cared for by their families, or wander unsupervised in the cities and countryside. Often only after years of such experience will a patient seek help from Aro Hospital, and upon discharge may again return to the traditional healers. They employ suggestion, coercion, drugs, incantation, force, prayer, prophesy, and confinement: methods which have several analogues in western psychiatric care. And as with any healing art, some practitioners have a wide following, some are considered mediocre, and some are thought

[1] See Alan Milner and Tolani Asuni, 'Psychiatry and the Criminal Offender in Africa', in Milner (ed.), *African Penal Systems* (New York, 1969), pp. 319 ff.

[2] See 'Number of In-Patients Treated in Western State Mental Hospitals by Type of Lunatic, 1960–1969', in *Western State of Nigeria Statistical Abstract*, table 92, p. 105. The addition of one new professional staff member could affect the figures by somewhere near 30 per cent. The number of patients treated is limited by the available staff and beds.

[3] This information is from interviews and from several earlier studies. Homicide in Nigeria was studied by Paul Bohannan, *African Homicide and Suicide* (Princeton, 1960); Tolani Asuni, 'Homicide in Western Nigeria', in *British Journal of Psychiatry* (London), 115, 1969, pp. 1105–13; and A. Emovon and T. A. Lambo, 'A Survey of Criminal Homicide in Nigeria', undated mimeograph, Behavioural Science Research Institute, University of Ibadan.

Also relevant is work done outside the field of law. Several studies have dealt with witches and other traditional ways of treating mental illness. The Yoruba have attracted attention from ethnographers, and those interested in medical research, because of their elaborate and long tradition of treating the mentally ill. See e.g. Raymond Prince, 'Indigenous Yoruba Psychiatry', in Ari Kiev (ed.), *Magic Faith and Healing* (New York, 1964), pp. 84–120. The most systematic study was conducted by a joint team from Cornell University and Aro Hospital: T. Leighton, T. A. Lambo et al. *Psychiatric Disorder Among the Yoruba* (Ithaca, 1963). See also T. A. Lambo, 'Malignant Anxiety, A Syndrome Associated with Criminal Conduct in Africans', in *Journal of Mental Science* (London), May 1962, pp. 256–64; T. A. Lambo, 'Patterns of Psychiatric Care in Developing African Countries', in Kiev (ed.), op. cit.; Tolani Asuni, 'Suicide in Western Nigeria', in *British Medical Journal* (London), II, October 1962, pp. 1091–7; and Raymond Prince, 'The Yoruba Image of the Witch', in *Journal of Mental Science*, July 1961, pp. 795–805. Prince also helped to make a colour film of traditional methods of healing, called *Were Ni* (Mad Man), available through the Institute of African Studies, University of Ibadan.

Of particular interest to lawyers: R. B. Seidman, 'Witch Murder and *Mens Rea*: a problem of society under radical social change', in *Modern Law Review* (London), 28, 1965, pp. 47–61; and Milner and Asuni, loc. cit.

of as thieves. Nor are the charges insubstantial: a healer may ask a subsistence farmer for as much as $300 to treat a relatively minor ailment, and may insist upon cash in advance.

Madness from the traditional Yoruba point of view is not caused by disease, defects, or behavioural influences, but is at least partially the product of supernatural and spiritual forces. The traditional treatment of mental illness involves not simply a response to physical symptoms, but also magical rituals to reverse the preternatural element, and sacrifices to placate the supernatural causes of the complaint. Thus, a healer in Western Nigeria who was treating a patient for symptoms which might in the West be attributed to childhood trauma, would use herbal drugs, dietary therapy, physical restraint, and perhaps surgery. Whether or not any or all of these methods were used, there would also be incantations and prayers, possibly a sacrifice, and diviners might well be consulted as to the causes of the complaint.

More patients are treated by traditional healers than are, or could conceivably be, handled by the one psychiatric hospital in the State – and this hospital went, at least at one time, further towards accommodating its procedures to the local setting than the court institutions have been willing to do.[1] The incidence of mental illness in Western Nigeria is completely unknown, although the small amount of work done suggests that the pattern and incidence of psychiatric disorders are closely akin to those in the U.S. and Europe. Particularly, the

[1] See Lambo, 'Patterns of Psychiatric Care in Developing African Countries', loc. cit. pp. 449–50: 'One of the most unusual features of our pattern of care for the mentally ill in Nigeria is our unorthodox collaboration with the traditional healers . . . For a number of years [we have] made use of the services of African "witch doctors" . . . a procedure that is indefensible by Western standards. Through their participation we have enriched our scientific knowledge of the psychopathology and psychodynamics of the major psychiatric disorders occurring in these exotic societies. We have also been able to accumulate a mass of data on the natural history and prevalence of many psychiatric disorders, in terms of cultural and social variables (variables that are ill defined and remain resistent to Western forms of categorization). Without the help of the "witch doctors" we would not have known how and where to look and what obstacles to skirt in searching for simple disorders like obsessional neurosis in the indigenous population of Africa.'

While Aro Hospital has not maintained traditional healers on its staff, the entire philosophy behind the Aro village scheme combines traditional habits with some modern direction in order to maximise the effectiveness of care, given extreme shortages of supplies and trained personnel. The western-trained staff, headed by Dr. T. Asuni, remain especially sensitive to ways in which traditional notions can aid in cure and treatment.

Lambo also argues that even highly educated Nigerians, presumably including judges, retain many traditional beliefs: 'In a study of a group of Nigerian students who broke down during their courses of university study in Great Britain in 1957, it was found that the symptoms in more than 90% of the patients offered clear-cut evidence of African traditional beliefs in bewitchment and machinations of the enemy.' Ibid. p. 445, See also Lambo, 'Characteristic Features of the Psychology of the Nigerian', in *West African Medical Journal* (Ibadan), IX, 3, 1960, pp. 95–104.

frequency of depressive forms of mental illness has been severely underestimated in the past. Schizophrenia is commonly reported as the most prevalent psychosis.

The legal implications of this are as follows: although the incidence and forms of mental illness may be similar to that in the West, the articulation of expert testimony and the legal definition of insanity in western terms are at considerable variance with the expression of the symptoms, and with widespread traditional beliefs in the origin of insanity. Scientific opinion in the U.K. and Nigeria may agree that an accused who claims his mother is a witch, and is poisoning his food, suffers from a specific, identifiable form of paranoia. However, for the judge, the layman, the defence attorney, and the accused himself, the very form of the expression of this delusion may preclude a finding of criminal insanity.

An additional difficulty is that certain highly relevant evidence, such as the testimony of traditional healers, is excluded when there is nothing in the form of a recorded medical history of the accused to replace such evidence. It may be argued that sophisticated developments in Freudian theory are equally beyond the grasp, for example, of the ordinary citizen in the U.S.; however, basic assumptions about the nature and treatment of madness would be shared by members of the public, by most accused, and by the administrators of justice. No such common assumptions about madness, whether perpetrated by television, comic books, or the school system, are shared by Nigerian villagers and those who are given the task of administering the criminal standards for insanity.

HOMICIDE LAW AND PROCEDURE IN WESTERN NIGERIA

The law of homicide is completely statutory, with trial jurisdiction resting with the High Court.[1] An accused will be arrested, detained, and brought within a stated period to a magistrate's court, where a police officer, not a lawyer, will present the State's *prima facie* case.[2] The accused will not be represented by counsel at this preliminary hearing,

[1] The law of homicide is contained in the Nigerian Criminal Code, ch. 27, sections 306–29, and is word for word identical with the Criminal Code in the Western State. The Northern States are governed under a different system of substantive and procedural law: the Nigerian Penal Code of the North and the Northern Nigerian Criminal Procedure Code. There are no degrees of murder: capital punishment is mandatory upon conviction. Manslaughter is the residual category for all homicides which are not murder.

An annotation of cases is included in Lionel Brett and Ian McClean, *The Criminal Law and Procedure of Lagos, Eastern Nigeria, and Western Nigeria* (London, 1963); the discussion of homicide is on pp. 676 ff.

[2] However, magistrates do not have trial jurisdiction over homicide; these cases go to them only for preliminary hearing, and are then referred to the High Court for trial. Appeal from conviction is first to the Western State Court of Appeal, established in 1967, and finally to the

unless he has engaged a private attorney. In homicide cases the accused will usually not be released on bail prior to the trial, which will be before the High Court at the quarterly assizes. Upon conviction of murder a sentence of death is mandatory. There is no equivalent to the Public Defender's office, nor is there any means-test before a court-appointed counsel is assigned to the accused who has not engaged private counsel at the opening of the trial, which is almost always the case. The indigent accused will have no legal advice either during pre-trial detention or during the magistrate's hearing.

The judiciary has been completely Nigerian since shortly after independence in 1960. The universities have been producing lawyers since the mid-1960s, but most judges and many older members of the bar have been trained at the Inns of Court in London. The current system of magistrate's courts and high courts was established in 1933 and reorganized in 1955. Major amendments and changes in the statutory criminal law have been rare, and there have been none to either the law of homicide or the standard for criminal insanity. Changes in criminal law are now promulgated by the military, as exemplified by the Robbery and Firearms Decree of 1970, which mandated public execution and summary trial of those accused of armed robbery.[1]

Most accused in homicide cases come from the lowest strata of society. Two years will probably elapse between the crime and the trial judgement. The language of the courts, of the statutes, and of the police records is English. Most accused require an interpreter to understand what is being said at their trial. Although it is obviously desirable that any confession be in the first language of the accused, the Nigerian rule is that it does not have to be so written.[2] The issue of the admissability of the confession may be raised, however, at any stage. In some cases, two interpreters are required: first to translate from English to Yoruba,

Federal Supreme Court. Requests for clemency then rest with the Western State Committee for the Prerogative of Mercy. Clemency can also be granted by the Governor of the State, and by the President of the Federation.

[1] The Armed Robbery Tribunal consists of one high court judge, one military officer, and one police officer, and is outside the court structure; there are no appeals from its decision. As of December 1972, 18 accused had been so sentenced and publicly executed in Western Nigeria.

By way of contrast, judicially-ordered death sentences are not publically recorded, and are not reported to any but the immediate family of the accused. The trend, however, has been towards a decrease. Although 66 in 114 cases, involving 205 accused, had the death penalty upheld through all stages of appeal, only 35 were executed during the period 1966–72, and they included some sentenced previously. In recent years, particularly, the number of judicially-ordered executions has declined markedly, although the reasons are not clear. In 1970 and 1972, only one such execution was carried out; in 1971, there were four.

[2] The common procedure is for a police officer to take the confession in the language of the accused, who will sign the English-translated and transcribed version after it has been read aloud to him and retranslated. Since counsel for the defence first consults the accused many

and then to a second traditional language, such as Hausa or Ibo. The translation process, coupled with the fact that the trial judge writes out the record by hand, makes the proceedings slow.

An accused in a capital case is not allowed to plead guilty, although his confession may be admitted against him. There is nothing equivalent to the U.S. practice of plea bargaining in the Western Nigerian system. If an accused is convicted, he will be represented by a different attorney for the Western State Court of Appeal, and yet a third will be assigned for the final appeal to the Federal Supreme Court. Usually a single well-known attorney will handle all appeals of capital cases before a single court for a year.

The Criminal Code includes references to juries – but there are none in Western Nigeria. A few have in the past been convened in Lagos, although the practice has been extremely rare and is not likely to be continued. None the less, the elaborate formulation of certain rules and procedures, designed for jury instruction, remains incorporated in the Code. Debates in the U.K. or U.S. over what is a 'disease of the mind', or 'natural mental infirmity', or an 'irresistible impulse', have been primarily concerned with how a jury would understand such language. Here, it is a judge of the Nigerian High Court who applies this set-piece language to determine the fact of insanity. In cases which came to trial elsewhere this might be determined by a jury.

Problems of cultural interpretation are further compounded by the fact that adjustments and developments in British case-law regarding insanity are no longer the common law of Nigeria. Since independence the judges seem to be trying to rely only on Nigerian cases, and primarily upon decisions of the Federal Supreme Court. There is little Nigerian common law on insanity. The judge will usually simply state that the rule is the M'Naghten standard (not a strictly accurate statement), and proceed to stress the literal, statutory language.

PROCEDURES GOVERNING THE DETERMINATION OF CRIMINAL INSANITY

The question of insanity or competence to stand trial may be raised at any stage, but most commonly is first raised at the trial,[1] when the

months afterwards, it is not uncommon for the confession and/or the translation to be objected to at the trial. Few such objections are sustained, however. See the Evidence Act, pt. 2, sections 27–32. The relevant Nigerian case law is: *R. v. Omokaro*, 7 W.A.C.A. 146; *R. v. Prater* (1960), 1 A.E.L.R. 298 (need for corroboration); and also *R. v. Kanu* (1952), 14 W.A.C.A. 30.

[1] The form of judgement for an insanity acquittal is: Not Guilty by Reason of Insanity. See *R. v. Yayiya of Kadi Kadi* (1957), N.R.N.L.R. 207. The common law on insanity is: *R. v.*

accused has the advantage of counsel. Previously a magistrate may make a finding of competency to stand trial, but only on the basis of medical opinion.[1] No such reliance upon professional opinion is required for finding insanity. This distinction may be partly explained by jurisdiction. Perhaps the safeguard of medical testimony was thought to be required at the magistrate level, while a high court judge could be granted the discretion.

The standard used at trial is a variant of the M'Naghten rule, which was enacted by statute into the Western Nigerian Criminal Code in 1916, and has not been revised or modified since:

A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is in such a state of mental disease or natural mental infirmity as to deprive him of capacity to understand what he is doing, or of capacity to control his actions, or of capacity to know that he ought not to do the act or make the omission.

A person whose mind, at the time of his doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the real state of things had been such as he was induced by the delusions to believe to exist.[2]

Evidence rules have been introduced which relate to the particular

Mungu, 14 W.A.C.A. 379; *R. v. Amponsah*, 4 W.A.C.A. 120; *R. v. Dim*, 14 W.A.C.A. 154; *R. v. Adi*, 15 W.A.C.A. 6; *R. v. Aliechem* (1956), 1 F.S.C. 64. The case-law on insanity in Nigeria is summarised in *R. v. Yayiya of Kadi Kadi*, supra. Some few older cases will use the English special verdict: Guilty but Insane.

[1] The law regarding unsoundness of mind, such as to render an accused unfit to stand trial, is set out in the Criminal Procedure Act, pt. 25, sections 222–35. In all the cases of homicide which were reported and tried during the period 1966–72, only one accused person was found unfit to stand trial: *State v. Sunday Lawayi*, Ibadan, 10c/1966. The common procedure is to remand an accused who shows symptoms of mental illness to Aro Hospital. The statutory limit upon such a detention is one month, followed by two months; however, a further extension is a formality. Medical testimony, but not necessarily that of a psychiatrist, *is required* before a finding of unfitness to stand trial. Also, if the accused is found fit to stand trial, that proceeding is a part of the trial. Cf. the rule in U.S. federal law, where findings and evidence at the hearings on fitness to stand trial, and on the issue of insanity, are kept strictly separate, e.g. *Greenwood v. United States*, 350 U.S. 366 (1956). Medical testimony *is not required* for a finding of insanity leading to acquittal.

[2] Criminal Code Law, ch. 5, section 28. The practical application of the second paragraph is very limited. This refers to the treatment of an accused suffering from delusions. A 'mistake of fact' defence is substituted in those cases, i.e. if the mistake, had it been true, would have been exculpating, then the delusion will exculpate.

See the discussion and annotation in Brett and McClean, op. cit. pp. 477 ff. The standards in other African jurisdictions are discussed by Milner and Asuni, loc. cit., and Aguda, ch. 12, 'Mental Abnormality', in *Principles of Criminal Liability in Nigerian Law* (Ibadan, 1965). See also A. Aguda, *Select Law Lectures and Papers* (Ibadan, 1971), pp. 50 ff. (history of the criminal code), and pp. 149–50 (treatment of insanity under customary law).

circumstances in Nigeria. For example, evidence of the madness or insanity of ancestors or blood relations is admissible without medical corroboration. In practice, however, such testimony is rarely offered, because of the social stigma attached to hereditary madness. Diagnostic evidence may not be presented by traditional healers or herbalists, but the fact that they were at some time consulted by the accused is admissible. Often the healer or herbalist will have long since moved and cannot be found, and a third party will be allowed to testify that the accused consulted a traditional healer in the past. The fact that an accused was formerly a patient at Aro Hospital is also admissable, and in some cases seemed to be a highly persuasive piece of evidence in the determination of insanity.

The onus is on the accused to prove insanity. There is a presumption of sanity, but the burden is not the criminal standard (beyond a reasonable doubt), but the civil standard (on the balance of the probabilities). Nigerian law does not recognize the defence of 'diminished responsibility' introduced into British law in 1957, although the 'irresistible impulse' defence, which has been rejected in Britain, is available. Under customary law at least some forms of insanity would have been a defence to murder, but such insanity must be obvious to everyone. The classical Muslim jurists recognised insanity as partial exemption from criminal responsibility; under their jurisprudence (currently an influence only in Northern Nigeria) a killing by an insane person was not excused, but was in the same category as accidental homicide, for which compensation was due.[1]

Delays in the medical examination of the accused are commonplace, and it may be this prospect that discourages some judges from calling for expert witnesses. The findings here suggest that the failure to call for such testimony may itself be highly influential upon the judicial outcome. Police and prison officials are mandated to look for and report indications of mental instability among detainees and prisoners. However, most reports suggest that a sizeable portion of the prison population is mentally disturbed. A pre-trial detainee is unlikely to be sent to Aro Hospital unless he exhibits extreme symptoms, and similarly anything less than very abnormal behaviour by an accused prior to trial is unlikely to be noticed or recorded.

An additional problem in the determination of insanity arises from the delay before expert opinion is granted. Since a considerable lapse, probably about a year, will occur between the crime and the psychiatric examination, the testimony will diagnose the mental state of the accused

[1] Aguda, ibid. p. 149.

at the time he was seen by the specialist. And while he may state that the accused could not have developed his present disturbance solely within the intervening period, the Western Nigerian judges have often been unwilling to accept this expert opinion. The statutory language ('if at the time of doing the act . . . he is in such a state of mental disease') has been very narrowly construed, the way it would not be in most U.S. jurisdictions.[1]

An American court would not have difficulty accepting the proposition that an accused who is judged psychotic in May was equally psychotic the previous August. However, in the cases studied here, the Nigerian judges asked witnesses if the accused appeared and acted normally around the period of the crime. Specific evidences of abnormality were several times ruled irrelevant to the issue of insanity, unless strictly contemporaneous to the crime. This particular result would be avoided, in the majority of U.S. jurisdictions, by expert opinion stating that certain forms of mental illness may be episodic, or not necessarily manifest in overt symptoms at all times. In most U.S. courts the notion would be acceptable that a person may be mad while not overtly appearing mad to all with whom he has come in contact. The irony is that the defence of insanity is now rarely raised in the U.S. because capital punishment is at least temporarily suspended. Most accused prefer the prospect of a definite penal sentence, with clear prospects for appeal and release, to the indefinite, perhaps lifelong, commitment to a mental institution.[2]

In Western Nigeria, where there is only one mental institution, and that so overcrowded it is unlikely to keep patients longer than absolutely necessary, the burden of proving insanity and the corresponding recommendation of commitment is considerably more difficult than it would be in the U.S., where such facilities are numerous, where there is available a variety of expert testimony, and where the procedures governing the finding of insanity are elaborately developed. The greater familiarity of U.S. judges with psychiatric concepts may account for more widespread judicial acceptance of the fact that a condition justifying the designation 'mental disease' could be present with no overt sign. The circumstances of several of the homicides reported here would present to a westerner classic symptoms of specific psychoses.

[1] Particularly, the refusal to relate back psychiatric evidence to behaviour at the time of the time of the crime, as in Case 6, p. 244 below, would be an unlikely result in the U.S. Also, in Freudian-conscious America the very stereotyped killings of parents would be likely to be found the actions of an insane person. In the U.S. the fact of a detailed confession would not be cited as evidence that the cognitive requirement of the M'Naghten test was fulfilled.

[2] Recent developments in the 'right to treatment' cases may reverse this trend in the U.S.

The question of what should be the legal standard for insanity becomes very acute in a society where the commonly-held notions of madness are at such variance with the institutionalised western norm, and where the legal standard became fixed when notions of mental disease were just developing in Europe. An additional complication is the fact that a belief in witches may be associated with psychiatric impairment. The Aro–Cornell finding is not that it is evidence of mental disturbance to believe in witches, but rather that those villagers who showed signs of mental disturbance were more likely to believe in witches.[1]

Particular convictions are expecially associated with mental disturbance: for example, belief in witches and *juju* is strongly associated with indicators of psychiatric impairment, unlike belief in other supernatural figures, such as *elegbe*, the little people seen only by children, and *abiku*, the child who is born over and over, and is said to be 'born to die'. If these findings are further substantiated, perhaps accounts of fantasies involving witches will be relevant and admissible evidence in the future. Or, to put it another way, perhaps the expression of insanity in terms defined by Yoruba culture will not preclude the application of the western standard to find insanity.[2]

THE RÔLE OF EXPERT PSYCHIATRIC TESTIMONY

What has been the rôle of expert evidence in a country where psychiatrists and all doctors are extremely scarce, and where the beliefs of the general population are counter to the general tenets of western psychiatry? First, the opinions of the European-trained psychiatrists are not always accepted by Western Nigerian judges. The fiction has

[1] Leighton, Lambo, et al. op cit. pp. 146–7. Specifically, table VII-8: 'Certain Cultural Items by Psychiatric Rating of Respondents in the Yoruba Villages'.

Without going into the way in which psychiatric impairment was measured, nor to dismiss serious criticism of the study which has been made, it is worth reporting the following: 5 per cent of those rated 'well' believed in witches, and 55 per cent of those with 'severe' psychiatric disorder believed in witches.

The difficulties of distinguishing between an 'irrational' belief in the supernatural and a legitimate, traditional belief, in the supernatural is discussed in Lambo, 'The Role of Cultural Factors in Paranoid Psychosis among the Yoruba Tribe', in *Journal of Mental Science*, 101, 1955, pp. 239–66. The message seems to be: Even a western-trained Yoruba psychiatrist cannot tell for sure.

[2] There is *dicta* to the effect that self-defence might be a possible defence to witchcraft-associated homicide: 'In murder cases a defence founded on witchcraft has always been rejected except in cases when the accused himself has been put in such fear of immediate danger to his own life that the defence of grave provocation has been proved.' *Konkomba v. The Queen* (1952), 14 W.A.C.A. 236. However, until 1968 there had been no case in Nigeria which had upheld the defence. In 1974 the Western State Court of Appeal again considered and rejected the defence of self-defence in connection with an attack upon a supposed witch.

been maintained that insanity is a matter of fact for a jury to decide, not a question to be determined by expert opinion.[1] But given that there are no juries, does the rule that the court need not be bound by such expert testimony make sense? Should there not be a presumption that psychiatric opinion is reliable? While a U.S. court would not feel bound to find insanity simply because a psychiatrist said the accused was psychotic or schzoid, the court would have to go to considerable lengths to justify not finding criminal insanity in the face of such an opinion. True, the burden of proof is on the accused. But can an accused be said to have a fair chance of proving insanity if the trial judge can simply disregard a psychiatrist's opinion that he suffers from emotional impairment? What could be better proof of insanity?

In fact, most Western Nigerian judges do not disregard such evidence, once they have taken the trouble to call for expert testimony. Or, perhaps it is that those judges who are more sympathetic to psychiatric norms are more likely to call for expert examination. For whatever the reason, the critical juncture seems to be the decision to call for expert testimony. Clearly, whether because of administrative congestion and delays, or for reasons of persuasion and preference, expert psychiatric testimony was not asked for in all cases where it might at least have been relevant. Hopefully, the situation has improved since the days shortly after independence, when the forensic psychiatrist at Aro requested and was refused the opportunity to examine all indicted murderers in the State.[2]

The fact that the death sentence is mandatory upon conviction of murder might suggest that the accused would be likely to offer the insanity defence on slim or non-existent grounds. On the contrary, in the cases examined here there seemed to be no instance of a totally unsubstantiated use of that defence. The trial judge can in his discretion deny the defending attorney's request for expert testimony, and this request will not be granted unless there are some grounds for raising insanity as an issue. In the cases considered here, one of the more surprising facts is that insanity was raised as a legal issue, with or without expert testimony, in relatively few cases; 44 of all the accused showed signs of mental disability, and less than half had expert testimony formally presented at their trials. Insanity was an issue at trial for only 19 per cent of all the accused. This compares with an estimated 30–50 per

[1] Aguda, 'Mental Abnormality', p. 265, citing British cases and the West African Court of Appeal case, *R. v. Edem Udo Inyang* (1946), 12 W.A.C.A. 5. Surely the time has come to abandon the fiction that juries have been, or will ever be, determining insanity in Western Nigerian trial courts. Holding up the norm of a non-existent Nigerian jury only adds irrelevance.

[2] Milner and Asuni, loc. cit. p. 355, fn. 36.

cent of all murderers who were acquitted as insane in the U.K. prior to the abolition of capital punishment.[1]

Let us now consider these results in detail. Only 20 of the 44 accused who showed signs of mental abnormality were examined by a psychiatrist at some stage of the proceedings. The tabulation with judgement is as follows: 17 of the 20 who were found guilty of murder and sentenced to death were never seen by a psychiatrist at all, and had no expert testimony presented on their behalf: 19 were not examined, and no information was available on the question of expert examination for the remaining 5. On the other hand, 13 of the 16 acquitted for insanity were seen by a psychiatrist who gave evidence at their trials. Of the 19 for whom no expert testimony was presented, 17 were found guilty of murder and sentenced to death, and only one was acquitted as insane.

The calling for expert testimony did seem to be determinative. Only one accused who did not have a psychiatric examination was acquitted, and only three who did were judged to have the requisite criminal *mens rea* for a finding of guilty of murder.

The judgement of guilty of murder was affirmed by the Court of Appeal in 10 cases, in 8 of which the accused was never seen by a psychiatrist. The conviction was overturned and an acquittal for insanity was entered in one case in which expert testimony had been presented and ignored. In two additional cases the conviction was overturned when no expert testimony had been presented at trial. The records for the Federal Supreme Court indicated that in two cases studied here the conviction was affirmed in the absence of expert testimony. The appellate courts do not seem to be acting as an important corrective force.[2]

The call for expert testimony did seem to add considerably to the

[1] Marvin Wolfgang in his study of homicide in Philadelphia found only 17 insanity acquittals for 621 offenders, although an additional 3 who committed suicide in custody were later classified insane. At every stage of the criminal justice system the proportion of those found insane increases, and Wolfgang's offenders were 'those listed in police files as responsible for criminal homicide', which means that this data came from the earliest stage of the formal process. See *Patterns in Criminal Homicide* (Philadelphia, 1958), p. 26, fn. 1. The rate of 2·7 per cent acquitted for insanity still seems exceptionally small in comparison to reports from Britain indicating that about 33 per cent of all homicide offenders are declared insane at some stage of the process. The proportion of accused found insane in Western Nigeria was 8 per cent of all those who came to trial. The comparisons of studies using vastly different methods is at best an estimation, however.

The bias in favour of women in granting the insanity acquittal may simply be a reflection of the apparently almost universal unwillingness to give the death sentence to women. See H. Bedau, 'Death Sentences in New Jersey, 1907–1960', in *Rutgers Law Review* (New Brunswick), 19, 1964, pp. 1–64, and other works on the death penalty by the same author.

[2] These figures describe cases which were heard on appeal and had been filed as of 1 January 1973. The Western State Court of Appeal was founded in 1967. Some of the cases in this study would not yet have been heard on appeal or reported, and some earlier cases would

length of time to trial judgement. In the 20 cases where the accused was seen by a psychiatrist, 3 took 18–24 months to complete trial, 7 took 2–4 years, and 3 took even longer. For the 19 accused who were not seen by a psychiatrist, 2 took 18–24 months to complete trial, 5 took 2–4 years, and none took longer. Neither the location of the crime nor the residence of the accused seemed to be significant as regards the request for expert testimony; 75 per cent of those accused who were seen by a psychiatrist were from the rural areas.

In general, the cases which involved the mentally ill took considerably longer between the crime and the high court judgement than those which did not. Of the 44 accused who were mentally ill, 13 took 2–4 years to complete proceedings, compared to 10 of the 161 in the category of 'all other accused'. In fact, only 36 per cent (16) of the mentally ill completed trial within 2 years, compared to 82 per cent (132) of the other group.

There was, however, a striking relationship between the incidence of acquittals for insanity and the judicial Division. The Abeokuta High Court handed down a disproportionately large number of acquittals for insanity, a result which can be directly attributed to the presence of Aro Hospital. Expert testimony was easily available, and perhaps the trial judge here was also more sensitive to the presence of insanity as an issue, given Abeokuta's history as a centre for traditional healing. Although only 10 per cent of all the accused came to trial before the Abeokuta High Court, 31 per cent of all the insanity acquittals were handed down there. If access to expert advice is an important factor in the decision to call for psychiatric opinion, perhaps more accused in other Districts will be acquitted and judged insane in the future.

SUMMARY AND SUGGESTIONS

For those who showed signs of mental disturbance, the presence of expert testimony at their trial seemed to be strongly related to the judicial outcome. There is no reliable information in this study as to why expert testimony was not requested in particular cases: for example, the predisposition of the judge, the competence of defence counsel, the distance from Abeokuta, the season of the year, or the unavailability of a professional psychiatrist. However, the decision not to call for a court

have gone directly to the Federal Supreme Court on appeal. There has been a backlog in the reporting of these cases, and the appeal figures are incomplete for both courts. For example, although no official records could be found to confirm this, at least two convictions for murder had recently been overturned by the Federal Supreme Court.

examination seemed to be highly prejudicial to the accused: there was almost no chance of being acquitted as insane without the help of expert testimony.

Nigerian judges, like their American counterparts, may reject a psychiatric finding; but in Western Nigeria there were no conflicts or even gradations of expert testimony. Psychiatric opinion was always submitted by the staff of the only mental hospital, and there were no doctrinal differences from one case to the next. The call for expert testimony did significantly delay a trial.

If the outcome of the trial is related to the presentation of expert opinion, then this testimony should be available to all accused in capital cases as a matter of right. Given the small number of homicide cases which actually come to trial, this should not be an excessive burden on the professional staff of Aro Hospital. The Criminal Procedure Code could be easily amended to make the calling for some sort of mental examination mandatory.

Those homicides in which there was an element of witchcraft were likely to result in conviction, although the Western Nigerian trial judges were not unwilling in some such cases to acquit for insanity. This result seems to modify the response of colonial courts to such cases.[1] The present generation of judges have been unsympathetic to various forms of the witchcraft defence, and have perhaps been less willing to give credence to such 'traditional' beliefs than were their colonial predecessors. Nigerian judges in *dicta* seem to be impatient with stories about bewitchment. The colonial courts strained to find a solution for the peculiar jurisprudential dilemma presented, and for

[1] Seidman, loc. cit. uses several cases of 'witch-murder' – or homicide in which the accused offered in his defence the sincere belief that he was killing a witch – to argue that the law in this area is unadaptive to the needs of modernisation. Do the present Nigerian courts dodge this issue, as Seidman argues was the practice of the latter-day colonial courts, by sentencing the accused to death and recommending executive clemency? The answer is that they do not – and it could even be argued, I think, that in only those few cases which got to the highest courts of appeal was that ever the rule in pre-independent Nigeria. My guess would be that at the level of the district officer, a finding of insanity did at least occasionally occur, as did a reduction to manslaughter.

Seidman's argument that 'witch-murderers' have never been acquitted under the insanity or any other defence is weakened by his principal reliance upon cases from the 1940s and 1950s which were handed down by British judges (who looked to the Colonial Office for support) in the East African and West African Courts of Appeal, both no longer in existence. While these cases are still technically precedent in Nigeria, no one would today suggest, as Seidman implies they might, that the norm of reasonableness to be applied to Nigerian villagers is the same as the standard for an 'ordinary Englishman'. Indeed, in the provocation cases this is specifically contradicted: the norm of reasonableness is that of a man in the same standing of life and 'degree of civilisation' as the accused. Cf. *R. v. Okoro* (1942), 16 N.L.R. 63; accord, *R. v. Adekanmi* (1944), 17 N.L.R. 99; and *R. v. Afonja* (1955), 15 W.A.C.A. 25.

reasons of philosophical consistency were left with a discordant result. Nigerian judges do not seem to consider that the problem is worth serious thought.

This somewhat artificial puzzle of jurisprudence may well disappear, without ever having been solved, given recent evidence that most accused in cases involving allegations of witchcraft show additional, independent signs of mental abnormality. In future they may simply raise the insanity defence, and the courts will avoid the strained results of the colonial cases. Indeed, the judges in Western Nigeria seem to be moving in the direction of declaring these accused insane, while the colonial courts were unable to do so.

There were no really distinctive patterns of homicide among accused identified as mentally ill. However, they were more likely to kill members of their immediate family; to kill for no motive; to kill singly; to kill women and children; to kill with readily available matchets; to kill in the villages and rural areas; to kill with excessive violence; to kill their victims in their homes; and to kill members of their own ethnic group. The accused who were in the group of mentally ill were also processed through the courts more slowly, and were more likely to be found guilty by the trial judge.

Recommendations for change would be primarily in the area of procedure. It would be desirable to preserve evidence as regards the issue of insanity. Given that in the absence of a public defender system an accused is unlikely to see an attorney prior to trial, at least the psychiatric or medical examination could be requested at the preliminary hearing. Then, when the defence attorney appears a year and a half later, evidence would be there for the presentation of the insanity defence, if mandated. The magistrate could order the examination at the preliminary hearing stage, which occurs immediately after detention. This would perhaps correct the manifestly unjust result in those cases where an insanity defence was summarily rejected because there was no evidence as to the state of mind of the accused at a time near to the crime.

In addition, more detailed reports of the behaviour and appearance of the accused in custody, as well as the institution of a background investigation immediately after the crime, might preserve useful facts for the defence. The current emphasis upon the confession, and the interviews of prosecution witnesses, should at least be balanced by the preservation of evidence which might help the defence; for example, from members of the family or witnesses who observed the accused in custody. I would argue that the 'voluntary' standard has been in

practice stretched to the point where it goes against the common law principle of the right against self-incrimination. Perhaps this right, if the Nigerians wish to preserve it, could be better guaranteed by the institution of procedural rules surrounding the taking of a confession. Or perhaps the Nigerian courts do not wish to continue to recognise this principle.

It is difficult to see how the revision of the statutory standard for insanity would be more than window-dressing. What is currently in force is actually closer to the substantial capacity test of the American Law Institute than to the classic statement of the M'Naghten rule. The second part of the present formula might well be eliminated; it takes care of few cases not covered in the first section. What is needed for clarification is a substantial body of case-law from the Western State Court of Appeal and the Federal Supreme Court. There seems to be no indication that the law is going to be developed by decree or statutory amendment. Such fine points as the formulation of standards for irresistible impulse, diminished responsibility, and subnormality must be set out in the opinions of these courts. As that case-law develops, references will become increasingly infrequent to British cases, to British standards and rules, and to the older appellate cases of the West African Court of Appeal.

With regard to evidence, the rule forbidding traditional healers from testifying as to acts or behaviour of patients in their custody should be reconsidered, since this might be highly relevant to the issue of insanity. While the judiciary has been understandably suspicious of such testimony, there is no reason why the rules of relevancy and impeachment could not limit these witnesses. Once the fact of the absence of juries is admitted, the question of the admission of evidence from a traditional healer is easier to handle. While the argument may be made that a jury of villagers could not distinguish fact from opinion or belief in such testimony, a judge could certainly make that distinction. The credibility problem would be no different than for any other witness. Why not assume that the judge is competent to weigh the value of such testimony? – especially since he is allowed to participate in the questioning of witnesses. As long as traditional healers treat more psychiatrically disturbed patients than will ever see the inside of a mental hospital, then the exclusion of such testimony, where there is nothing to replace it, seems unnecessarily prejudicial to the accused.

Finally, all references to juries should be removed from the Criminal Code Act, the Criminal Procedure Code, and the Evidence Act. Since it is highly unlikely that juries will be established in the future – they

have never served in the past in the Western State – why not have the written law accurately reflect this fact? At present, the entirely mythical distinctions based upon a jury system which are enshrined in the codes are irrelevant, and they also introduce several serious distortions. The stated reason why a judge need not accept psychiatric opinion or call for expert testimony is that insanity is a matter of fact to be decided by the jury. However, in current practice the rule simply allows the judge to disregard such evidence, or refuse to call for expert testimony, without any justification. While ultimately the acceptance of such expert opinion may legitimately rest with the judge in his rôle as the trier of fact, why should not he be required to outline the basis for his decision? The enactment of a statutory presumption in favour of accepting the finding of the psychiatric opinion would at least require the judge to explain how he weighed the expert opinion against other evidence in a particular case.

Many other evidence rules, painstakingly developed with the idea in mind of a British jury of more than a century ago, are also inappropriate to a Nigerian judge operating in the 1970s. Once the procedural rules clearly state that trial is without juries, then the 'due process' will become less complicated regarding the admissability of confessions, the relevance of the testimony of traditional healers, and other such matters. The system is needlessly encumbered by rules designed for an imagined jury of Nigerian villagers – resembling the '12 good men and true' of nineteenth-century Britain – which has never come into being, and is unlikely to exist in the future.

APPENDIX A: RESEARCH METHOD AND STATISTICS

Cases were from all parts of the Western State, and opinions were handed down by judges in eight Districts. Formal reports were first established in 1966, and cases decided after 31 December 1972 were excluded. While filing and reporting were not always reliable, the 205 accused (in 114 cases) represent something close to all those charged with homicide who came to trial in this period. All convicted offenders in capital cases are entitled to an automatic appeal, and so a record would be likely to exist for all homicide trials. Fitness to stand trial is an aspect of trial, and the findings are reported as part of the trial record. The files showed only one case of an accused found unfit to stand trial.

The mentally ill were identified on the basis of three questions: 28 showed up on the first, an additional 10 on the second, and a further 6 on the third, to total 44, or 22 per cent of the total 205. The 161 not

included in this group were those in the last/null category in all three questions.

Question 1. Evidence of mental illness from manner or method of crime:

1. Accused under the delusion he is not killing a specific person or a human being.
2. Accused kills and wounds indiscriminately.
3. Mutilation or dismemberment of victim.
4. Accused claims killing is done under divine instruction.
5. Any other aberrant behaviour at the scene of the homicide.
6. None of the above, no answer, not applicable.

Frequency: 28/44. 50 per cent were found guilty of murder, and 46 per cent were acquitted as insane.

Question 2. Mental history of accused prior to crime:

1. Recent consultation with traditional healer.
2. Had been a patient at Aro or other mental Hospital.
3. Had symptoms or complaints associated with mental illness (e.g. headaches, blackouts, seizures, fits, amnesia, violent episodes), but never consulted healer or doctor.
4. Had exhibited violent, bizarre, or aberrant behaviour, but never consulted healer or doctor.
5. Recent affiliation with syncretic or apostolic church.
6. No previous medical record, symptoms or behaviour, no answer.

Frequency: 30/44. 53 per cent were found guilty of murder, and 36 per cent were acquitted as insane.

Question 3. Symptoms of mental illness after crime or while in custody:

1. Attempts suicide.
2. Claims amnesia, or no knowledge of crime, despite evidence linking him to crime or eye-witness reports (this category is not an alibi or general denial of guilt).
3. Falls asleep after crime, indicating epilepsy.
4. Refuses to eat, drink, speak, or move in custody.
5. Observable aberrant or bizarre behaviour (e.g. eats excrement, urinates on food).
6. Disturbed speech, other indications of incoherence.
7. None of the above, not applicable, no answer.

Frequency: 23/44. 48 per cent were found guilty of murder, and 35 per cent were acquitted as insane.

Errors are likely to lie in the direction of an under-reporting of the accused who were mentally ill. Trial records often indicated nothing about the behaviour of an accused in custody or prior to the crime. In other cases there would be neither a description of the crime, nor the manner of identification of the accused. In one case the name of the accused appeared nowhere in the record. Table 1 shows how the

TABLE 1

	Mentally ill accused N=44	All other accused N=161
Sex of accused		
Men	86	96
Women	14	4
	100%	100%
Relationship of accused and victim		
Marital and kinship	59	9
Lovers, former lovers	5	1
Business and economic relationships	9	10
Acquaintances	9	48
No prior relationship	16	31
No answer	2	1
	100%	100%
Alleged motive		
Quarrel over personal relationships	30	8
Allegation of witchcraft	22	1
Associated with other crimes (robbery, rape, abortion)	2	9
Quarrel over property	5	22
Political and civil motives	5	41
Other motives, including accident	6	18
No motive	30	1
	100%	100%
High Court verdict		
Guilty of murder	46	29
Guilty of manslaughter	2	11
Insanity acquittal	36	0
Acquitted and discharged	16	60
	100%	100%

44 identified as mentally ill compared with the other 161 accused of homicide.

Only one-third of those identified here as mentally ill were acquitted for insanity. The number of guilty judgements for those so identified is also significantly higher than the number of guilty judgements for all other accused. This result may reflect the fact that the circumstances surrounding these homicides made guilt easier to prove. Also, the high proportion of convictions for those identified as mentally ill may merely reflect the fact that they were more likely to be detained at the scene of the homicide and more likely to confess.

In the matter of confessions, significant differences can be seen between the Western Nigerian jurisprudence and the current law in the United States or Britain. While the legal standard would be similar in all jurisdictions – namely, only 'voluntary' confessions would be considered admissable – it is clear that whether under a Miranda theory or

under a theory of self-incrimination, almost all of the confessions admitted here against the accused who showed signs of mental incompetence would be excluded in the U.S. or Britain.

Among those who were acquitted as insane, the largest single category was the accused who killed and wounded indiscriminately. Of those who were acquitted as insane on the basis of behaviour or symptoms prior to the homicide, the largest number of acquittals were for those who had recently consulted a traditional healer. Perhaps this particular indicator of mental illness was one to which judges in Western Nigeria were likely to give weight, despite the evidentiary rule not allowing the admissability of such testimony. Those most likely to be found guilty of murder despite evidence of mental instability were those who claimed to have suffered from symptoms such as blackouts, seizures, fits, but had never consulted a traditional healer or doctor. In general, those who demonstrated incapacity or illness during the commission of the crime itself were most likely to be acquitted as insane, and those who first showed signs of mental impairment in custody were the least likely to be so acquitted.

An apparent bias shows up when judgement is cross-tabulated with sex of accused. Women received 21 per cent of all acquittals for insanity, a far larger proportion that their representation among the accused who were identified as mentally ill (14 per cent) or 'all other accused' (4 per cent). This bias is apparently reflected universally in the application of the death penalty to women.

On appeal, 23 per cent of those convicted in the mentally-ill group had the verdict upheld by the intermediate appellate court, as opposed to 9 per cent in the group of 'all other accused'; 7 per cent of the mentally ill had their convictions overturned by the intermediate appellate court, as opposed to 9 per cent in the other group. On appeal to the Federal Supreme Court, convictions were upheld for 5 per cent of the mentally ill, and 8 per cent for the other group. Not all cases would have finished the entire appellate process, however, and at the time of this research there was a considerable backlog in the reporting of Federal Supreme Court cases.

A relatively small number of strangers were killed by accused who showed signs of mental disturbance. There were no significant differences between the two groups of accused with regard to choice of weapon. The absence of poison is noteworthy, particularly given that fear of being poisoned is a common paranoid delusion among Yoruba. Suicide by poison is not infrequent, particularly the drinking of insecticide. Here there were no poisonings by accused who were identified as mentally

ill, and only five by 'all other accused'; of these, four were in connection with abortionfacents, European medicine obtained from a chemist.

Accused who were identified as mentally ill were more likely to come from rural areas, which may simply indicate the greater burdens upon police in the cities. A violence measure was cross-tabulated with other variables. For accused who were mentally ill, the homicides involving witchcraft and immediate relatives were more likely than not to be committed with excessive violence. The mentally disturbed were somewhat older than the other accused, and their victims tended to be older, although they also killed many more children. Of the 44 killed by the mentally ill, 23 were male and 21 were female; but the victims in all other cases were overwhelmingly male (86 per cent). Data compiled on circumstances of arrest showed that 23 per cent of the group identified as mentally ill either turned themselves over to police or traditional leaders, or made no attempt to resist arrest; the comparative figure for 'all other accused' is 10 per cent. The mentally ill killed as often during the day as during the night, whereas the others were twice as likely to kill at night. Ethnicity of victim and accused show no significant differences between the mentally ill and other accused. The largest number of accused and victims in both groups were Ọyọ Yoruba.

APPENDIX B: SELECTED CASES

The following excerpts from court opinions illustrate the way in which legal issues relating to the determination of criminal insanity are presented at trial. Cases were chosen as relatively detailed examples of recurrent difficulties. Most accused were illiterate villagers who either turned themselves over to the police, sometimes after walking several miles to the nearest station, or were brought in by local people immediately after the homicide. Commonly, two years goes by between crime and trial, and events which were initially confused may never be clarified. If insanity is an issue, the delay is often longer than two years. In the meantime, witnesses have died or disappeared, and those available to give evidence so long after the event may have 'structured' their testimony. The customary hazards of a delayed trial are compounded by the fact that witnesses will be illiterate, unfamiliar with the police and court procedures, and their testimony will probably be recorded in a foreign language.

Sometimes crucial facts are not available from the record; for example, the date of the psychiatric examination, details of the crime, the relation of witnesses to events, the biographical background of the accused, or details of the accused's behaviour while in custody. The

judge edits the testimony as he makes the record. His summary is usually the only official record, although this is sometimes supplemented with information from the files of the appellate defence attorney. Citations are to official, unpublished reports held in the Ibadan High Court library. The association between homicide and allegations of witchcraft is not uncommon, as the perpetrator kills a supposed witch either in self-defence or while under the influence of imagined spells. The accusation that a witch causes ill-health, barrenness, impotence, or madness is frequent.

1. *Arasiyu Aransi v. The State* (Abeokuta, 2c/71)

The accused claimed in court that he was under the delusion he was slaughtering a ram when he killed his wife. He also testified that he had a previous history of such delusions. Some time earlier he had beaten one of his sons almost to the point of death under the delusion that he was a goat. At another time the accused claimed to have unwittingly stabbed himself in the stomach. On the occasion of the homicide for which he was on trial, he testified that an elderly man came and ordered him to slaughter the ram, when in fact he killed his wife. A herbalist who once treated the accused for symptoms of mental illness had died, and was unable to verify that he had been consulted. No member of the family of the accused testified as to his state of mind at the time of the crime or previous symptoms. The record states that if the accused had indeed suffered from delusions someone would have known about it. There was no cross examination of the accused as to his delusions. There was testimony that the victim had stated that she was afraid of her husband after the attack on her son, and that she had planned to seek a divorce.

The court found that the threat to seek divorce was sufficient motive for the homicide. The insanity defence failed. Guilty of Murder. Appeal failed at the Court of Appeal.

2. *Omojemite Jesse v. The State* (Ondo, 10c/70)

The accused, an Urhobo, claimed that ever since a native doctor had been treating his mother-in-law he had been unable to have sexual relations with his wife, the victim. The son testified as a prosecution eye-witness. The victim died of multiple cuts inflicted by a matchet, and was also mutilated. The doctor was also attacked by the accused. The accused's junior wife in the polygamous family had previously left him. The victim had also threatened to leave him. The accused alleged that his wife and the native doctor had committed adultery together. 'She said I had forgotten my lost life, that I was neither a woman nor a man. I really lost my life.' The accused went to the nearest police station and gave himself up. The confession was taken in Urhobo and translated into English. During the trial the accused objected to the translation, and also partially repudiated the confession.

The defence of provocation failed. The issue of insanity was not raised by the defence. Guilty of Murder. Appeal dismissed by the Court of Appeal, C.A.W. 6/71.

3. *Johnson Ajayi v. The State* (Ondo, 6c/71)

The accused killed his mother with a matchet. He was unmarried and lived with the deceased, whom he claimed was responsible for his present ill-health through witchcraft. The accused had been a patient at Aro Hospital for three years where his mother had helped care for him. A nephew testified that although the accused had suffered from mental illness, he was cured at the time of the crime. A prosecution witness testified that he observed the accused in his cell six days after the killing, and there was no external sign of abnormal behaviour at that time. The accused testified that upon discharge from Aro Hospital he was told a blood condition caused his mental condition, and he was advised not to drink or smoke.

The court commented that although there was evidence of mental illness, the accused 'knew what he was doing'. The confession was 'a clear and coherent account of the killing of the deceased by the accused'. Consequently, the requirement of sanity was satisfied. Guilty of Murder. Appeal dismissed at the Court of Appeal, C.A.W./1/72.

4. *Inuwa Momoh Katsina I v. The State* (Abeokuta, 22c/70)

The accused was a Hausa farm labourer, the victim Yoruba. The proceedings in court were reported to the accused through two interpreters. The accused had killed his landlady's son-in-law, whom he had known nine years, and had wounded four others while resisting capture. The accused lived alone, and was reported to have frequently complained that no one from his town lived in the village. He insisted that he was guilty, but a plea of not guilty was entered over his protests. The accused claimed the deceased wanted to kill him and inherit a plot of land he had been occupying. As his defence the accused claimed that a mob from the village was coming to attack him. The defence did not raise the issue of insanity, but the trial judge took it upon himself to consider the question, which was framed in the following terms: 'whether the accused was suffering from morbid delusions at the time of the incident'? The accused testified that he saw a crowd of villagers who had come to attack him; but he also admitted it was dark, and that he could not see anything.

The court found as a fact that there was no morbid or insane delusion: 'I do not believe there was any such mob . . . I do not also believe that the deceased carried a rope with which he threatened to hang accused . . . neither do I believe that the villagers shunned him when he returned from the farm.' The judge admitted, however, that some sort of delusion existed: 'That delusion does not exculpate the accused, in that the evidence shows clearly that at the time of the incident he knew what he was doing.' The delusion was judged to be only 'partial', and the accused was criminally responsible to the extent as if the state of things had been as he suspected. Guilty of Murder. Appeal failed at the Court of Appeal.

5. *Ayokano Agbomedarho v. The State* (Ilesha, 12c/71)

The accused, an Urhobo, killed two children of his aunt with whom he had been living for three months. The victims were a boy aged six, who was almost decapitated, and a boy aged eight. The accused then ran away into

the bush and attempted suicide. Subsequent to his arrest he claimed amnesia regarding all events surrounding the murders, with the exception of the fact that he remembered he had not taken the cutlass, the murder weapon, into the bush with him afterwards. The accused claimed there was no quarrel between himself and the mother of the deceased children, nor with the children themselves. The accused's uncle was also a member of the household.

The judge commented: '[the] pattern of woundings and killings in this case might suggest the handiwork of one not in full possession of one's facilities. But this in itself will not be sufficient to establish a plea of insanity under our laws.' Guilty of Murder. Conviction affirmed by the Court of Appeal, C.A.W. 10/72.

6. *Augustine Chukwu v. The State* (Ondo, 8c/70)

The accused, an Igbo, killed and raped the 12-year old daughter of his former employer with considerable brutality. The weapon was a matchet, and the accused was incoherent at the time of the trial. The accused had once been employed by the victim's father. There was evidence suggesting paranoid, or perhaps justified, fears on the basis of tribal identification. At one time the accused had been a patient at Aro Hospital. His behaviour in prison had been highly abnormal. His sole defence was insanity. He confessed, then retracted the confession at his trial, and stated that he did not know why he was in court. The homicide was committed on 23 January 1968, and the accused was arrested nine days later. On 8 February the accused was in custody, and the police reported that he behaved normally while accompanied to search for the murder weapon. Although the record did not include the exact date of the expert testimony, the court concluded that the accused must have been examined as to his state of mind on 19 March 1968. On that day he appeared abnormal, unkempt, and deranged. The psychiatric report stated that the accused could not possibly have understood the nature of his acts.

The trial judge concluded that the accused's state of mind at the time of the killing must be presumed to have been normal, since nothing was known to the contrary. The court relied upon the fact that the witnesses who saw the accused on the 1st and 8th of February noticed nothing abnormal. Guilty of Murder. Judgement overturned by the Court of Appeal, and a judgement of Not Guilty by Reason of Insanity entered, C.A.W. 2/71.

7. *Ajayi Anikara v. The State* (Akure, 36c/66)

The accused was the barren wife of the deceased. She claimed her husband had wanted to use her [body parts] for ritual sacrifice to obtain wealth. The accused behaved abnormally during the trial, and she had been treated for symptoms of mental illness by a native doctor, whom, she claimed, had raped and imprisoned her. The court said there was some evidence that the accused was insane before the commission of the crime. The couple had gone to the place where the murder took place in order to have the accused treated by a traditional healer. The court also saw the refusal of the wife to take food to her husband as a sign of mental illness.

The accused was found to have committed the homicide, but she was

acquitted on grounds of insanity. The accused was remanded to Aro and remained there for eight months.

8. *Raimi Ishola Amodu v. The State* (Abeokuta, 323c/69)

The accused killed his mother, confessed, and turned himself over to the police. He claimed that his mother killed his wife with witchcraft.

The court commented: 'the accused announced the killing of his mother the way a person would announce the birth of a child'. The accused and deceased had been living together previous to the crime, and the accused's wife had been dead for six years. There was psychiatric testimony that the accused suffered from schizophrenia, and had received shock treatment. The date of the crime was 7 June 1969; the psychiatric examination took place on 16 December 1969.

The court concluded that too long a time had elapsed between the psychiatric testimony and the crime. Guilty of Murder. Appeal dismissed at the Court of Appeal.

9. *Clement Omoniyi v. The State* (Ondo, 3c/70)

The accused killed his mother by decapitation. He was found covered with blood and led the police to the victim. The accused suffered from the delusion that this was not his mother, although the victim (aged 60) lived with him, fed him, provided him with medicine, and presented herself as his mother. Evidence was given that the accused was mentally ill three months previous to the crime, and that villagers tied him to a tree for a time saying that he was mad.

In making its decision the court relied upon *Rex v. Sunday Omoni* (1949), 12 W.A.C.A. 511, in which the standard of insanity was whether the accused knew what he was doing and that he ought not to do it. Because he confessed in detail, the court said that the accused knew what he was doing at the time of the crime and that he ought not to do it. Guilty of Murder. Appeal dismissed by the Court of Appeal.