IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

CRI-2016-004-001619
[2016] NZHC 2443

THE QUEEN

v

EVELYN KATHLEEN SEN

Hearing:	13 October 2016
Counsel:	B D Tantrum and N J Small for Crown S J Bonnar QC for Defendant
Judgment:	13 October 2016

ORAL JUDGMENT OF DOWNS J

Solicitors:
Meredith Connell, Auckland.
S J Bonnar QC, Auckland.

The case

[1] This is a sad case. The defendant killed her four-year-old daughter—but was insane when she did so. This judgment contains my reasons for that conclusion and the allied conclusion the defendant should be indefinitely detained as a special patient.

The background

[2] The defendant called 111 at 4.04 am on 7 August 2015. She was distressed. The defendant told the telephonist her daughter had passed away. The authorities attended. They found the body of Maggie Watson, the defendant's daughter, lying on a bed in the lounge. It was obvious Maggie had not *just* died. Her body was cold and there was evidence of rigor mortis. Later analysis of Maggie's blood revealed the presence of an extremely high level of Mirtazapine. Mirtazapine is an antidepressant medication. But it is not suitable for children or young people. And Maggie's body contained 134 times an adult's dosage.

[3] The defendant had also consumed Mirtazapine, but obviously not enough to cause her any substantial harm. And, the defendant inflicted shallow cuts to her own wrists.

[4] The defendant was admitted to an acute mental health unit on 7 August 2015 and transferred to the Mason Clinic the next day.

[5] She exercised her right to silence through counsel when the Police sought to speak to her approximately six months later.

[6] It is helpful at this juncture to go back in time. Since 3 December 2012, the defendant had sought help from her general practitioner in relation to her mental health. Between then and August 2015, the defendant had told her doctor:

(a) She was troubled by a belief Police were following her and tracking her whenever she left her home. The defendant also complained of an apparently related belief her home was under some form of

surveillance, either through a satellite dish or some form of what she described as 3D technology.

(b) That someone was coming into her house when she was not home, and that the intruder would leave a strong but unfamiliar "male odour".

(c) There was an evil presence in her house, possibly a demon. Her daughter had seen a "black snake" inside the home. The defendant said she had not seen anything but rather felt the presence of something unwelcome.

(d) That her neighbours were involved in a conspiracy against her, perhaps also the Police. She said that one neighbour had told her that Maggie would begin to engage in self-harm, and another neighbor had allegedly said to her, her daughter would be suffocated to death.

(e) She spoke of rituals performed by her church group that left lasting sensations, such as a cross burning into her forehead, despite the absence of any observable injury.

(f) Of the strange sensation of an unknown source placing weight upon her shoulders and then leaving her body through her mouth.

(g) And, about the use of needles to transmit "a surge of negative emotions" (including anxiety and fear), albeit these had been alleviated by a healer she had consulted while in Malaysia approximately two months prior to August 2015.

[7] The doctor's notes record apparently fluctuating psychotic symptoms on the part of the defendant, and evidence of possible paranoia and depression. That was the experience of other lay witnesses too. For example, when the defendant returned to Malaysia with Maggie between 19 March and 14 June 2015, her family thought

she was "not living in this world … her mind goes to a different arena". I pause at this juncture to acknowledge the presence of the defendant's parents.

[8] The defendant accused her father of sending her to New Zealand to be sacrificed, apparently because she was possessed with unclean spirits. She said Maggie was similarly afflicted. The defendant's parents took the defendant to a traditional healer to exorcise the defendant; see [6](g) above. That person thought the defendant was deeply troubled. However, no one seems to have thought Maggie was in danger.

[9] I return to her death. The prosecution alleges, or alleged, the defendant murdered Maggie by giving her Mirtazapine in some way. I have already mentioned the 111 call. In addition to telling the telephonist her daughter was dead, the defendant said "Oh my God, I'm stupid. Oh my God, I cannot live without her". To attending ambulance officers the defendant said there were demons in her house and she, the defendant, was possessed by them. The defendant also said she had suffered a black-out or black-outs and had no recollection of material events; an account repeated to at least one medical practitioner when the defendant went that morning to Auckland Hospital.

[10] The defendant engaged Dr Duff, a consultant psychiatrist, on 29 February 2016. Dr Duff has prepared two reports in which she expresses the opinion the defendant was insane when she killed her daughter. The Crown has engaged Professor Mellsop, a professor of psychiatry. He too is of the opinion the defendant was insane. The Crown accepts the only reasonable verdict is not guilty by reason of insanity.

The defendant

[11] The defendant is 44-years-old. She has lived in New Zealand for the past eight years. The defendant has no family here; they remain in Malaysia. The defendant was unemployed at the time of the offending and on a benefit. As observed, she sought help from her doctor in relation to her mental health from 3 December 2012, and her doctor prescribed her Mirtazapine.

[12] The defendant appears to have suffered a sense of isolation. Whether that was in consequence of her ill mental health, a feature of it, or an amalgam of both, is unclear. But whatever the position, the defendant was unknown to mental health professionals until she was admitted for treatment in the immediate aftermath of Maggie's death.

[13] Beyond events of 6–7 August, there is no evidence the defendant was anything other than a good mother.

The procedure

[14] Section 20 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 creates a mechanism by which a Judge may find a defendant not guilty on account of insanity when the defendant relies on that defence; the prosecution agrees the only reasonable verdict is not guilty on account of insanity; and the Judge is satisfied on the basis of expert evidence the defendant was insane.

Analysis

[15] The first legal requirement is one in relation to which the Act is curiously silent;[1] satisfaction the defendant committed the charge save for the defence of insanity.

[16] I am satisfied but for that defence, the defendant murdered her daughter. The defendant and Maggie were alone at the time. The defendant was the only person who could have administered Mirtazapine. And as I have observed, the dosage was fatally large. It is inconceivable Maggie ingested such a large amount of the drug by accident. And in fairness to the defendant, she has never suggested as much. Moreover, the defendant now acknowledges killing her daughter.

[17] The next legal requirements are:

(a) The defendant's advancement of insanity as a defence; and

---

1 *R v SM* [2014] NZHC 605.

(b) Prosecutorial agreement the only reasonable verdict is not guilty on account of that defence.

These conditions are satisfied as confirmed at the hearing this morning.

[18] The final requirement is judicial satisfaction the defendant was insane on the basis of expert evidence. As observed, the experts are of the view the defendant was insane. However, under the Act, their view is not determinative. As Lang J has observed in this area:[2]

> It is important that the Court not be seen to be a mere rubberstamp for the views expressed by the professionals, or indeed, by the Crown and defence … because our criminal justice system generally requires crimes such as this to be determined by a jury and not by a Judge sitting alone.

[19] I respectfully agree. However, it is not easy to envisage the circumstances in which a Judge would reach a different view from that shared by the defendant, prosecution and all relevant experts. But the section is clear. It is the Judge who must be satisfied of insanity.

[20] The law presupposes a person is sane. However, insanity is established when the defendant proves he or she was suffering a disease of the mind at the time of the offence to such an extent the defendant could not understand either:

(a) The nature and quality of their actions in committing the offence; or

(b) Their actions (in committing the offence) were morally wrong having regard to common standards of morality.

[21] Proximate insanity is relevant but not decisive.

A disease of the mind?

[22] The experts agree the defendant was suffering a disease of the mind at the time she killed Maggie. The initial diagnosis was schizophreniform disorder, which is similar to schizophrenia. The difference between the two conditions lies only in

---

2 *R v Brown-Howarth* HC Whangarei CRI-2006-088-2445, 10 December 2007 at [19].

diagnosis: a diagnosis of schizophrenia requires symptoms to have been present for a period of at least six months, whereas a diagnosis of schizophreniform disorder requires the presence of symptoms for only one month (or a significant portion of a month). The consensus now is that the defendant suffers schizophrenia. That is the view of both Dr Duff and Professor Mellsop.

[23] Dr Skipworth, a third expert, examined the defendant for the purpose of assessing her trial fitness. He says there is clear evidence "Ms Sen was suffering from a major mental illness with onset several months prior to the alleged offending".

[24] The evidence of various lay witnesses supports this conclusion: they describe the defendant as acting as if she were mentally unwell. And while defendants sometimes pretend to be hearing voices or possessed by demons in order to escape punishment, no one has suggested that of this defendant. Clearly, she *was* mentally unwell.

[25] I am satisfied the defendant suffered a disease of the mind at the time she killed Maggie.

Did the defendant understand her actions were morally wrong?

[26] The defendant places no reliance on the alternative criterion she did not understand the nature or quality of her actions, and for good reason—both experts are of the view the defendant understood she was administering a fatal dose of Mirtazapine. So, this leaves for resolution whether the defendant knew her actions were morally wrong having regard to commonly accepted standards of morality.

[27] The experts agree on this issue in the defendant's favour, but it has troubled me. The defendant "emphatically denied" killing her daughter to Dr Skipworth. Indeed, she gave an alternative account of what happened, and one he considered "clear and well articulated". For this reason, Dr Skipworth initially considered insanity was not an available defence because, as he put it: "Ms Sen is not suggesting as a result of her psychosis she killed Maggie. Rather, she is stating she did not kill Maggie."

[28] Dr Skipworth has since provided a brief supplementary report in which he records his understanding the defendant now accepts responsibility for what occurred, and that if the defendant had done so to him, he would not have advanced the view the alleged offending was incompatible with insanity. That deals with one of my concerns. But there is another which arises because of what the defendant said shortly after the killing:

(a) The defendant told the ambulance officers she was hearing voices, and that she had suffered a black-out or black-outs, and had no recollection of the events.

(b) The defendant gave an emergency doctor the same account.

[29] These statements could be seen as a proximate acknowledgement by the defendant she knew she had done wrong.

[30] The defendant has explained this apparent dissonance to Dr Duff on the basis "a different me" killed Maggie, and she wants to "shut out the details of the acts" to enable her to continue to deny them at some level. Dr Duff concludes the defendant believed she was acting morally by killing Maggie on the basis she believed she and her daughter were possessed by a demon.

[31] Professor Mellsop was alive to this issue. He noted:

> The defendant's claims of black-outs and lack of memory could be hypothesised as reflecting a wish to avoid legal implications, moral responsibility or because any of her own responsibility would be inconsistent with her deep religious beliefs. However, the evidence that she was suffering from a relatively severe form of schizophrenia over the two years prior to 8 August 2015 is widespread and consistent. The accounts of several witnesses and the degree of her impaired thinking, which matches her own description of confused thinking, and inability to make decisions, suggests that schizophrenic thought process disorder was prominent.

[32] The Professor continued:

> Despite her apparent attempts to deny her actions, her seemingly untruthful claims of impaired memory and black-out, it is my opinion and on the balance of probabilities the degree of her thought disorder and the penetration of her delusional beliefs were of such intensity that they rendered

> her incapable of knowing the moral rightfulness or wrongfulness of her actions at the time.

[33] Both experts addressed this issue in evidence today. Dr Duff said there was nothing necessarily sinister in the defendant's inconsistent remarks given her disordered thought processes, the nature of the incident, and the possible effect of Mirtazapine. It will be recalled the defendant consumed some of that drug as well.

[34] Professor Mellsop did not disagree with Dr Duff's evidence, although he considered it unlikely Mirtazapine played a role in the way Dr Duff described. This is because the defendant was on other occasions inconsistent when Mirtazapine had no involvement. But both experts remain of the view the defendant was not aware she had done wrong.

[35] I accept their evidence for the reasons they gave.

Disposition

[36] As to what happens now, the options are limited. Pursuant to ss 24 and 25 of the Criminal Procedure (Mentally Impaired Persons) Act, I must make one of three orders. First, order the defendant be detained as a special patient in a hospital under the Mental Health Compulsory Assessment and Treatment Act 1992. Second, order the defendant be treated as a patient under the same Act. Or third, order the defendant's immediate release. Unsurprisingly, no one has invited me to do that.

[37] The choice is therefore between a special patient order or patient order under the Mental Health Compulsory Assessment and Treatment Act. To speak of a choice in this context is not entirely accurate. A special patient order must be necessary in the interests of the public or any person or class of person who may be affected by my decision. This is because special patients are indefinitely detained in a secure mental health facility until the Minister of Health, acting after advice from medical professionals, is satisfied continued detention is no longer necessary to ensure public safety. Consequently, a special patient order is not lightly made; while the order

need not be essential, it must be more than expedient or desirable.[3] A patient order is much less restrictive.

[38] I have no doubt a special patient order is necessary in the interests of the public; a class of potentially affected persons; or both:

(a) The offending involved a killing which would amount to murder but for the defence of insanity. And, the victim was a young child—the defendant's daughter. The seriousness of these circumstances requires no elaboration. Public safety must be the pre-eminent consideration when a defendant takes another's life while insane.

(b) The experts agree a special patient order is necessary. Dr Duff notes while the defendant is at low risk of future offending having regard to statistical tools, this is offset by various factors including the defendant's poor insight in relation to her condition, ongoing symptoms of mental illness and non-compliance with treatment. Professor Mellsop shares this concern.

(c) More particularly, both he and Dr Duff consider the defendant presents an unacceptable risk of harm to anyone vulnerable coming within her care.

(d) In this case the defendant's interests and those of the community largely elide: the defendant needs treatment. Successful treatment will require time and resources in the context of a highly structured environment; features only a special patient order can provide.

(e) The defendant's volatility reinforces this view. Dr Duff is troubled a patient order could result in the defendant's premature discharge, because of the absence of safeguards in such an order. And as she observes, not only are the risks to others "complex", the defendant is also at risk of self-harm, even suicide.

---

3 *M v R* [2012] NZCA 142, (2012) 28 FRNZ 774 at [17].

[39] For completeness, I note neither party wished to offer a view other than the defendant should be dealt with as a special patient.

[40] So, I conclude the defendant was insane when she killed her daughter, and that the only appropriate outcome is to detain her indefinitely as a special patient for the reasons I have given.

……..

Downs J