JUDICIARY OF
ENGLAND AND WALES

Judge Howard Riddle, Senior District Judge (Chief Magistrate)

In the Westminster Magistrates' Court

The Government of South Africa
v
Shrien Dewani

Findings of fact and reasons

The Government of South Africa is represented by Mr Hugo Keith QC and Mr Ben Watson. The defendant, Mr Shrien Dewani, is represented by Miss Clare Montgomery QC and Mr Julian Knowles QC.

The history of this case is documented in my judgment dated 10th August 2011 and in the judgment of the Divisional Court [2012] EWHC 842 (Admin). I sent the case to the Secretary of State who, on 28th September 2011, ordered extradition. This decision was successfully appealed, as I should have adjourned the original hearing under s91 (3) (b). The case was remitted to me to decide, after a suitable adjournment, whether the condition in s91(2) of the Extradition Act remains satisfied, and to decide again whether extradition would be compatible with articles 2 and 3 of the defendant's Convention rights on account of his mental health.

Preliminary matters

Before the hearing I considered an application to excuse the attendance of Mr Dewani. The application was supported by the clinicians treating the defendant, who is detained under the Mental Health Act. I accepted an assurance from his lawyers that his absence

would not be a factor in the litigation. I am satisfied that he is present during the proceedings through lawyers (s11 MCA) and that his absence is voluntary.

There was an agreed application by the parties that the evidence in these proceedings be recorded and transcribed. In accordance with the Consolidated Criminal Practice Direction I granted the application provided it is used as an agreed note for the parties and is not to be used as an official transcript.

A preliminary matter raised, though argued in the course of the proceedings, was whether the Court is required to discharge Shrien Dewani by virtue of s104(6) of the EA 2003. It is submitted by Miss Montgomery that the court is required to discharge Shrien Dewani by virtue of s104(6) because it has answered one of the questions remitted to it by the High Court differently to how it was answered in its judgment of 10th August 2011.

Section 104(1), 106(6) and 104(7) of the EA 2003 provides:

> (1) On appeal under section 103 the High Court may:-
>
> (a). allow the appeal.
>
> (b). direct the judge to decide again a question (or questions) which he decided at the extradition hearing.
>
> (c). dismiss the appeal.
>
> (6) If the judge comes to a different decision on any question that is the subject of a direction under subsection (1) (b) he must order the person's discharge.
>
> (7) If the judge comes to the same decision as he did at the extradition hearing on the question that is (or all the questions that are) the subject of a direction under subsection (1)(b) the appeal must be taken to have been dismissed by a decision of the High Court.

One of the questions remitted for consideration by the High Court was whether the condition in s91 (2) of the EA 2003 remains satisfied in respect of Shrien Dewani. The

defence say that question has been positively answered by the court because the case has been expressly adjourned under s91 (3) (b) on several occasions since 31st July 2012 and the power to adjourn under that section only arises if the s91 (2) condition is made out. Hence it follows that the question in relation to s91 (2) has been answered differently to the way it was answered on 10th August 2011 (when I declined to adjourn the case but instead sent it to the Secretary of State). It follows, says Miss Montgomery, that the court is required to discharge Shrien Dewani under s104 (6) of the EA 2003.

Miss Montgomery points to official court records that show that the various adjournments have been expressed to be under section 91(2). Given the way the question was framed by the Divisional Court, it seems to me unsurprising that the adjournments have been expressed to be for this purpose. The higher court had determined that the section 91(2) condition had been made out. That would remain the position unless and until this court decides the question again. There is no question but that the hearings since July 2012 were case management hearings and not decision-making hearings. Nobody would have understood that the case management hearings would or could have led to a decision based on any contested evidence. It is right that the parties needed to persuade me that a lengthy adjournment was appropriate. There was always the possibility that the medical evidence would show that Mr Dewani had made a sufficient recovery to make the question unarguable. However the question did remain arguable, and needed four days of court time to hear the evidence and submissions. In short no decision has so far been made by this court on the question referred back by the Divisional Court.

The other issues

In the light of assurances given by the South African authorities, Miss Montgomery is not pursuing the articles 2 and 3 arguments. The only remaining question for me arises under s91 EA 2003.

Section 91 Physical or mental condition

> S 91(1) This section applies if at any time in the extradition hearing it appears to the judge that the condition in subsection (2) is satisfied.
>
> (2) The condition is that the physical or mental condition of the person is such that it would be unjust or oppressive to extradite him.

(3) The judge must

(a) order the person's discharge, or

(b) adjourn the extradition hearing until it appears to him that the condition in subsection (2) is no longer satisfied.

The test was considered by the Divisional Court in this case.

"[73] In our view, the words in s91 and s25 set out the relevant test and little help is gained by reference to the facts of other cases. We would add it is not likely to be helpful to refer a court to observations that the threshold is high or that the graver the charge the higher the bar, as this inevitably risks taking the eye of the parties and the court off the statutory test by drawing the court into the consideration of the facts of the other cases. The term "unjust or oppressive" requires regard to be had to all the relevant circumstances, including the fact that extradition is ordinarily likely to cause stress and hardship; neither of those is sufficient. It is not necessary to enumerate these circumstances, as they will inevitably vary from case to case as the decisions listed at para 72 demonstrate. We would observe that the citation of decisions which do no more than restate the test under s91 or apply the test to facts is strongly to be discouraged. There is a real danger that the courts are falling into a similar error as courts fell into in relation to s23 of the Criminal Appeal Act 1968 and as described by the Lord Chief Justice in *R v Erskine* [2009] EWCA Crim 1425, [2009] 2 Cr App Rep 29, [2009] 2 Cr App Rep 29, [2010] Crim LR 48.

[74] The only issue that could arise is whether the words "unjust or oppressive" are to be read in the sense used in cases such as *Kakis* or to be read in the context of art 23.4. We agree with the observations of Maurice Kay LJ in *Prancs* at para 10 that the words are plainly derived from *Kakis*. The Parliamentary history of the Extradition Bill suggests that the provision was introduced into what is Pt II for the reasons we have given at para 67 and then the Bill was amended to add the provision to Pt I. Although that may not assist in determining whether s25 (and hence s91) is to be read as reflective of art 23.4, the use of the term "unjust or oppressive" plainly indicates that Parliament intended its own test.

[75] In the light of the psychiatric evidence before the Senior District Judge this was not a case where there was unlikely to be a recovery within a reasonable time; indeed the evidence pointed to a recovery within a reasonable time. The Senior District Judge was therefore correct to conclude that the Appellant's discharge under s91 (3) (a) should not have been ordered. This was a case where the issue arose under s91(3)(b), that it is to say whether the hearing should be adjourned until it appeared that the Appellant's mental condition was such that it would no longer be unjust or oppressive to extradite him.

[76] In such a case what is unjust or oppressive is fact sensitive. Take the case of a person who is recovering from an acute injury or physical illness where the prognosis for recovery is certain. In such circumstances, making an immediate order would be unjust or oppressive if there was a real risk to life and a short delay would obviate the risk. There is virtually nothing by way of detriment to the interests of justice in such a delay.

[77] The test is more difficult to apply where the quantification of the degree of risk to life is less certain and the prognosis is also less certain. In such a case, the interests of justice in seeing that persons accused of crimes are brought to trial have to be brought into account."

Whether or not it is unjust or oppressive to extradite a defendant is a matter for the court to determine on the facts of a particular case. Generally it is unhelpful to consider the facts of other cases in reaching that determination. The court must apply a sense of justice to all the facts and reach a decision in accordance with conscience. In this case I must consider all the relevant facts, based on the evidence put before me, and in the light of the guidance of the higher court. There is no need to amplify on that guidance, save on two specific points raised by Miss Montgomery. I agree that the UK test, the section 91 test, the *Kakis* test, does not detract from the Framework decision test. I do not agree with her that, in conducting the balancing exercise, the importance of honouring our international obligations is not a factor to be weighed in this case.

The Conclusion of the Divisional Court on Oppression

"[78] In the present case, given the findings which we have upheld that extraditing him to South Africa would not violate arts 2 and 3 of the Convention on the basis of the prison conditions in South Africa, his mental illness apart, it is plainly in the interests of justice that the Appellant be tried in South Africa as soon as he is fit to be tried.

[79] The strength of the psychiatric evidence was a striking feature of this case. Not only were the principal witnesses called by the Appellant and the Government of South Africa psychiatrists of great eminence and distinction, but their evidence before the Senior District Judge was essentially agreed, as we have set out. The opinion of the consultant treating him was to the same general effect.

[80] In our view, the medical evidence as to the unusual combination of PTSD and depression to such a severe degree and the Appellant's other conditions was clear that extradition would present a real and significant risk to the life of the Appellant. We attach considerable significance to the evidence of Professor Kopelman on 19th July 2011 that extradition would worsen his condition and make it more difficult to get him into a position where he was fit to plead. It must be an exceptional case where the expert called on behalf of the requesting Government is of the view that extradition at the present time would jeopardise the present treatment and the prospects of recovery increasing the prospects and speed of recovery are in the interests of justice, as they will increase the prospects of a trial being held sooner rather than later.

[81] It is likely that, if returned, he would be sent to Valkenberg pending his recovery or a decision on his fitness for trial. There was, however, no undertaking that he would be held there. It was not clear whether this was because once surrendered it would be for the court in South Africa to determine whether it should order he should be referred to a secure hospital or, if the decision was that of the Government of South Africa, it was not prepared to give such an undertaking. There was some evidence that the facilities at Valkenberg were satisfactory, though not as good as those the Appellant currently enjoys. Nonetheless questions remained as to whether he would be held in an individual room and, if not, whether the protection afforded to him would be adequate. There was also uncertainty as to the availability of the necessary amount of psychiatric care or access to private psychiatric care.

[82] It was unfortunate, given the way in which the hearing developed before the Senior District Judge that Professor Kaliski did not give evidence at that hearing by video link upon which he could be cross-examined. The experts based in London did not have first hand knowledge of what was available in Valkenberg and there was powerful evidence from Dr Larissa Panieri-Peter which raised issues that required answers that were fuller than those set out in Professor Kaliski's letter which was before the Senior District Judge. We were provided by the Government of South Africa after the conclusion of the hearing with a letter from Professor Kaliski dated 15th December 2011; this dealt with the provision of care on the basis the Appellant was not charged on return or was charged and remanded to the secure ward at Valkenberg. Objection was taken to its admissibility. It did provide some further details, but it would not be just to take the further letter into account without affording the Appellant the opportunity to challenge the evidence. That evidence should have been adduced and that opportunity should have been afforded at the hearing before the Senior District Judge.

[83] Thus balancing his unfitness to plead, the risk of a deterioration in the Appellant's condition, the increased prospects of a speedier recovery if he remains here and, to a much lesser degree, the risk of suicide and the lack of clear certainty as to what would happen to the Appellant if returned in his present condition, we consider that on the evidence before the Senior District Judge it would be unjust and oppressive to order his extradition. Despite the highest respect in which we hold decisions of the Senior District Judge, we consider that he erred and should have exercised his powers under s 91(3)(b) and ordered that the extradition hearing be adjourned.

[84] Although we have reached that decision on the basis of the evidence before the Senior District Judge, we also have had the benefit of the further medical evidence and the opinion of Dr Cantrell from which it is apparent that the Appellant is making a slow recovery under his current treatment regime. That confirms the view we had reached on the evidence before the Senior District Judge that the Senior District Judge should have adjourned the extradition hearing.

[85] We do not consider that we should determine, as the position currently stands and in the light of our decision in relation to s91, what conclusion on the issue of fitness for trial might be open to the court in South Africa at an appropriate time, given the limited

nature of the respects in which the Appellant is unfit to stand trial and the prospects of the Appellant's recovery: (cf *Re Davies* (transcript, 30th July 1997), *R(Warren) v Secretary of State for the Home Department* [2003] EWHC 1177 (Admin) at paras 26 - 28, *United States of America v Tollman* [2008] 3 All ER 150 at paras 162 - 172 and *Lynch v The High Court in Dublin* [2010] EWHC 109 (Admin)). It may be necessary for this to be done at a later stage of these proceedings, if there is disagreement as to the extent of the Appellant's recovery. If that question arises, then it may also be necessary to determine the merit of the argument advanced on behalf of the Appellant that fitness to plead proceedings in South Africa (where the law is the same as in *R v H* [2003] 2 Cr App Rep 2) are not criminal proceedings and will not result in a conviction. It is said by Miss Montgomery QC to follow that he is therefore not "accused" within the meaning of s70(4) nor accused of conduct punishable with more than 12 months imprisonment and so not accused of an extradition offence under s78.

[86] We do not consider it right in the circumstances of uncertainty relating to the Appellant's mental condition to set out our conclusions on the facilities at Valkenberg. That might be necessary in the future, but as conditions at Valkenberg may also change, it would not be appropriate to do so now. Nor have we considered other aspects of the adequacy of the care that could be provided to provide sufficiently for the risk of the Appellant's suicide. What is required must depend on the Appellant's mental condition at that time. Although it is our provisional view, in the light of the authorities and the six factors enumerated by Dyson LJ in *J v Secretary of State* [2005] EWCA Civ 629, that there are significant difficulties in the Appellant's case under arts 2 and 3 in relation to suicide, it would not be appropriate to express any concluded view in contradistinction to the concluded view we have expressed at para 35 on the risks from HIV/AIDS and assault.

CONCLUSION

[87] We will consider submissions from counsel as to the order we should make given the terms of 2003 Act and what directions, if any, we should make as to keeping the progress of the Appellant under review or as to the timing of the further hearing in the Magistrates' Court. At such a hearing or any further hearings, the position may be that there is a dispute as to whether the Appellant has made a sufficient recovery that the condition in s91 (2) is no longer satisfied. Subject to any submissions counsel may wish to make to us, it is our present view that in such circumstances it will be open to the Appellant not only to rely on s91, but also to rely on arts 2 and 3 in so far as any violation would be attributable to the lack of facilities in relation to the then state of his mental illnesses."

A summary of relevant facts in 2011

In my findings of fact dated August 2011 I recorded that there was no doubt that Shrien Dewani was suffering from two severe and incapacitating mental illnesses. He was not faking them. There was then a real and significant risk of suicide. That suicide risk would increase if he were extradited to South Africa.

I understand that the higher court carefully reviewed for itself the evidence that had been put before me. I of course adopt their findings on the evidence.

The Divisional Court put it in this way: "the medical evidence as to the unusual combination of PTSD and depression to such a severe degree and the Appellant's other conditions was clear that extradition would present a real and significant risk to the life of the Appellant. We attach considerable significance to the evidence of Professor Kopelman on 19TH July 2011 that extradition would worsen his condition and make it more difficult to get him into a position where he was fit to plead."

At the time of the hearing before me it was likely that, if returned, Mr Dewani would be sent to Valkenberg Hospital pending his recovery or a decision on his fitness for trial. There was, however, no undertaking that he would be held there. It was not clear whether this was because once surrendered it would be for the court in South Africa to determine whether it should order he should be referred to a secure hospital or, if the decision was that of the Government of South Africa, it was not prepared to give such an undertaking. There was some evidence that the facilities at Valkenberg were satisfactory, though not as good as those Mr Dewani had here. Nonetheless questions remained as to whether he would be held in an individual room and, if not, whether the protection afforded to him would be adequate. There was also uncertainty as to the availability of the necessary amount of psychiatric care or access to private psychiatric care.

At the last hearing before me, the parties agreed that it was not my function to determine whether this defendant was unfit to plead and stand trial. There was no dispute between the doctors on this. They were unanimous that the defendant was unfit to plead. I concluded that it was unlikely that any court would disagree with the combined weight of opinion that was put before me. My conclusion was that on the evidence I heard, a court is likely to conclude that Mr Dewani is unfit to plead. However I added that this is not inevitable, either today or in the future.

On the facts I was wrong to conclude that extradition was not oppressive and did not breach s91 EA 2003.

The current position

The undertakings

Undertakings have been given by the South African authorities. They are attached to this judgment, and were clarified during the course of these proceedings. They mean that, if extradited, Mr Dewani will not be detained in a prison while there is reason to believe that he needs psychiatric care. He will either be bailed, or be detained in the general psychiatric ward at Valkenberg Hospital. I have no hesitation in accepting that undertaking.

Valkenberg Hospital

At the hearing in 2011 there was little first-hand evidence about conditions at Valkenberg Hospital. The Divisional Court said it would have been preferable had such evidence been available. Dr Cumming travelled to South Africa at the end of March 2013 and has provided a detailed report on the facilities at Valkenberg, concentrating in particular on the acute or general services as opposed to the forensic services.

The report speaks for itself, but concludes that Dr Cumming "had no qualms about the quality of care within the acute services at Valkenberg Hospital." Elsewhere he says that there is "absolutely no evidence that attitudes around care were any different to those in the UK." "Senior clinical staff were well trained and clinically skilled; I had every confidence that they would be able to deliver appropriate and good quality care to Mr Dewani and more so now that the recent report of Dr Cantrell indicates some improvement. Though there are issues in terms of finding the best fit (in terms of the clinical package within Valkenberg Hospital) they have a wide range of facilities and considerable expertise to rise to any clinical challenge." [In oral evidence he confirmed that while Ward 1 was the best fit for this patient, the ward is closed at weekends so other arrangements would need to be made. He had confidence that appropriate arrangements would be made.] He gave evidence about staff ratios, which compared favourably with the position here.

The defence commissioned its own report from Dr Janet Parrott. However this report was not put before the court. Professor Eastman also made his own enquiries, in particular by discussing the position with Dr Jedaar, a consultant psychiatrist who was previously, for a decade, head of the forensic service at Valkenberg Hospital. Professor Eastman writes "I am not in position directly to comment on the services from my own assessment, and so must accept Dr Cumming's view; although I am concerned that Dr Jedaar, who practises in South Africa and knows the service well, does not hold a similar view, and Professor Kaliski has written in terms that his advice is that Mr Dewani should go to the private hospital."

The evidential position is that Dr Cumming's report is not challenged by any significant evidence, and I accept it as providing an accurate picture of the facilities that would be available to Mr Dewani if extradited. Professor Eastman's reservations about the quality of care at Valkenberg Hospital clearly remain, but he gave evidence that his conclusions discount those reservations.

The hearing 1st July – 4th July 2013

The hearing on 1st July proceeded by Mr Keith taking me through his skeleton argument, and referring me to some of the papers in the bundle. On 2nd and 3rd July I heard evidence from Dr Cumming and from Professor Eastman. On 4th July I heard submissions from the parties and adjourned until today for judgment. An agreed note was made of the evidence. While that note is not the official transcript, nevertheless it gives a clear picture of the evidence provided to me, and I need not therefore set out that evidence in full.

Background and updating material

At the time of the last hearing in front of me (July 2011) Mr Dewani had moved from the Priory Hospital, Bristol to the Fromeside Clinic, Bristol.

On 14th December 2011, that is after the last hearing before me, but before the Divisional Court hearing, Dr Cantrell, the consultant forensic psychiatrist who had been treating Shrien Dewani, wrote a report referring to him making slow but positive progress. In a

letter dated 28th June 2012 Dr Cantrell refers to an improvement as a result of the prescription of the antidepressant drug agomelatine. Both the depressive disorder and the PTSD had probably moved into the very lower ranges of moderate severity. The risk of completed suicide had very slightly, but discernibly, decreased. The extradition proceedings themselves act as maintainers. The doctor then anticipated a reasonable recovery within a period of 6 to 12 months time. However if extradition proceedings were not stopped, but merely adjourned, it would take longer - at least one year. A further letter from Dr Cantrell, this time dated 17th September 2012, says that antidepressant medication has materially improved SD's depression. It was in the severe range, but he now suffers with depression of moderate degree. He now suffers with very few, if any, thoughts of active suicide. With the small improvement in mood the damage and distress caused by his PTSD has become clear. This condition is in the severe range. He remains extremely hypersensitive. In particular he has highly characteristic symptoms of hyperacusis (hypersensitivity to extraneous sounds). This provides a profound disability. However, "Mr Dewani will certainly recover from his difficulties at some stage".

Further letters follow from Dr Cantrell and, as a result of representations made on the defendant's behalf, bail conditions were varied in early January 2013 to allow him to move from Fromeside Clinic and be treated in Blaise View. Dr Cantrell ceased to be Mr Dewani's treating psychiatrist but undertook to remain the principal communicant with the court. On the 10TH April 2013 Dr Cantrell wrote to Mr Dewani's solicitor expressing the joint views of himself and the new treating psychiatrist, Dr Harland.

> "In essence he is improved.
>
> In terms of mood he remains moderately depressed. He is amotivated, anergic and pathologically apathetic. These disabilities are more of a moderate degree however.
>
> He is clear with me and with his treating team that, whatever the difficulties he faces, he has neither plan nor thoughts to kill himself. Situations such as self harm or of an impulsive type of course must always remain an intrinsic risk.
>
> His cognition, that is his ability coherently to pick up, follow and consider a train of thought, is now much improved.

In terms of his PTSD, this also is now only ranged in the moderate degree."

On 20TH June Drs Amos and Harland (but not Dr Cantrell) wrote that Mr Dewani has been relatively settled over the last few months. His mental state has been helped by the medication he has been taking as well as the move to a rehabilitation unit. He was probably at his best about two months ago [so late April] when he was taking pregabalin as well as agomelatine. However it was decided to stop his pregabalin on 23RD April, following abnormal blood results. There has since been some deterioration in his mental state. This was not related to his depressive symptoms but to his post-traumatic stress disorder. In particular he is suffering with increased sensitivity to sound and his sleep has been disturbed. After obtaining expert opinion it was decided to start Shrien Dewani on gabapentin rather than pregabalin, as a precaution. The new medication was started shortly before the hearing and is hoped to have a similar beneficial effect on the symptoms of the PTSD to pregabalin.

Dr Cumming was able to conclude from all the information available to him that there seems to be a general consensus from both staff and Mr Dewani himself that he had improved. The move to a quieter environment was a factor, as were suggestions from the Maudsley in terms of management of PTSD, notably the use of specific medication to help address his symptoms. The easier opportunity to go home also seems to have been beneficial. Even though the pregabalin had been stopped, and this was a setback, nevertheless his condition has improved overall.

The experts' evidence

Professor Nigel Eastman (instructed by the defence lawyers) and Dr Ian Cumming (instructed by the Republic of South Africa) both prepared detailed reports for this hearing. They also met on 1ST July 2013 and prepared a joint statement. That statement speaks for itself. Briefly, there is agreement that Shrien Dewani has Post Traumatic Stress Disorder. IC says "moderate/severe". NE says "severe". It is agreed that SD also has a moderate to severe depressive illness. The current risk of self harm and suicide while in the UK is real but not immediate. It is agreed that SD is currently unfit to plead under English law. If SD is extradited now, it is highly likely that there would be a requirement for a fitness to plead process in South Africa.

The movement from Fromeside Clinic to Blaise View earlier this year had some impact on SD's mental state. He has also shown some beneficial response to a particular type of medication. These factors illustrated the likelihood that placement and treatment will have some influence upon prognosis. Neither expert expects a full recovery from either of SD's disorders, (Professor Eastman in the foreseeable future, Dr Cumming in the immediate future) whether treated in the UK or in South Africa. Any improvement is likely to be extremely slow, and the end point is uncertain. There is a somewhat better prognosis concerning the depressive illness. There is likely to be a worsening of SD's symptoms consequent upon extradition but the experts believe this worsening could be managed by the general psychiatric services in South Africa. Travel to South Africa would be extremely problematic and thus result in deterioration in his mental state for a period around the time of transfer. There should be appropriate clinical care before, during and after the journey in order to manage the risks that it will represent. Extradition will increase the risk of self harm and/or suicide.

The disputed evidence

The main disagreement between the experts is referred to in the joint report, and clarified by the live evidence.

Professor Eastman believes that the improvement in SD's mental conditions will be maximized, and the speed of recovery maximized, by continuation of treatment in the UK for up to 6 months prior to transfer to South Africa. There is "a reasonable prospect of lesser worsening after further treatment for a period of six months in the UK." He refers to the possibility that continuing current treatment in Blaise View and using the newly prescribed medication, may open the door to recovery. That opportunity would be lost if the defendant is extradited prematurely. If there is no such improvement within six months then NE believes that there would then be no advantage in further delay.

Both experts believe that SD's symptoms are likely to worsen following extradition, although Dr Cumming said there may be no difference to the distress whether he is moved now or later. IC believes that the worsening will be temporary and the lost ground will be recovered. He considers that the extradition process is a factor helping to maintain SD's illness. There is an advantage in moving on, but it is not certain. He also

suggests that the regime in Valkenberg may be more prepared to challenge the patient than has been the case hitherto, and that such a challenge would be helpful. He can see the sense in Professor Eastman's approach, but has a different view. In short he suggests that delaying extradition may not help, and the clinical toll could be made worse by delay. There is no reason why the rate of recovery should be different in Valkenberg to Blaise View, although it could be slower or quicker.

The written evidence from the experts on the disputed points

Both Professor Eastman and Dr Cumming prepared updated reports for the court in early June 2013. Each of these reports needs to be read with care. However here I will produce only the final opinion of Dr Cumming (paragraphs 84-92) and a summary of key points from Professor Eastman.

(1) Dr Cumming

"Since my last report, Mr Dewani has remained in hospital though in January 2013 he moved to an open unit to help address his hypersensitivity to a busy and noisy unit. He was also assessed by the Trauma service from The Maudsley which confirmed the diagnosis of PTSD and made some helpful suggestions in terms of management. Part of this included the use of pregabalin as a medication to help address his symptoms. The latter is a drug primarily used for epilepsy and neuropathic pain which has a function in the management of anxiety. The latter was withdrawn in late April due to a raised CK level.

From my review of his notes and discussion with the clinical team, his CK level remains elevated. My current understanding is that there may be no link between the raised CK level and the prescription of pregabalin; I am aware that he remains to have a cardiac CT and MRI scan which if clear will likely lead to the pregabalin being started again. It is worth noting that though the CK level is raised it has not been anywhere [near] the markedly high levels which have been seen earlier. The admission to hospital when he presented with chest pain seems to have been a viral infection. At the time of writing his physical health seems largely settled.

In terms of progress, there seems to be a general consensus from both staff and Mr Dewani himself that he had improved and that this was linked to the use of pregabalin. The effect is mainly upon his symptoms of PTSD which have helped reduce his general arousal levels and hypersensitivity to noise and light. The improvement has been documented by Dr Cantrell and though there is also supported within the RIO notes, the improvement is present but not obviously evident. I noted that setting aside the input of pregabalin, being placed in Blaise View and the easier opportunity to go home also seems to have been beneficial. Dr Harland confirmed that despite the recent setback there had been an improvement (considering her review of him on 3.6.2013) and that he was better than when he first arrived at Blaise View. Thus though the pregabalin has been stopped for the time being he was still improved. Overall his PTSD remains in the moderate/severe range since the setback with pregabalin.

Mr Dewani seems to have engaged with the team and for instance has attended various 1:1's, individual psychology sessions and various other reviews and assessments; though as characterised his time on Fromeside he has tended to be either off the ward for most of the day or in his room.

Due to the dominating nature of the PTSD symptoms, the underlying depressive symptoms are often obscured; overall I felt that there was an improvement in his mood and thus he is less tearful, not as sad, his movements are less retarded and his mood seems less depressed. Suicide remains an unclear issue and in addition to comments in my earlier report, there has been no expression of intent or any actions which are compatible with such thoughts.

His current management plan would seem to be one of re-starting pregabalin or gabapentin to see if this can capture back the improvement in his PTSD symptoms. Mr Dewani will continue with psychology and other individual work and benefit from the quieter atmosphere of Blaise View.

In my view there may be some advantage in pressing on with a move to South Africa and also getting closer to his court case. The clinical team recognise that the court case and extradition is a maintaining factor for his symptoms. I question how likely it is that Mr Dewani will thus fully recover whiles he remains in the UK. Mr Dewani has been clear

that he is motivated towards a trial in South Africa and is not trying to evade his responsibilities therein. I would expect that his removal to South Africa could see an initial decline in his mental state but that with care and input from psychiatric services in South Africa there is no reason why this should not be followed by improvement and back to the level of function that he has shown before.

In terms of his fitness to plead, Mr Dewani is clearly aware of the charge and what the terms guilty and not guilty mean; in my view the main issue which will impact upon his ability to function within the trial at this point will be the hyperacusis he experiences and his problems in concentration. Considering how he has presented at interview this will have an impact upon his ability to follow proceedings and instruct counsel. However this should be balanced with times when he has demonstrated an ability to concentrate and also an ability to recall, understand and convey his needs and wishes in an assertive and logical manner. This view seems to be shared with his consultant in my discussion with her on 4.6.2013. On balance the recent deterioration would seem to make him unfit to plead but I feel that the issue is more marginal than before and should take into account a global perspective on his functioning.

Considering my earlier review of Valkenberg, I remain of the belief that this clinical condition is within the capability of services at that hospital to monitor and manage. It will of course be for the clinical team to consider which of the units he can be placed in and this might require some adaptation in service design."

(2) Professor Eastman

"I do agree with the clinical team in both regards. Further, on the evidence of my own clinical assessment of Mr Dewani on 10.5.2013, in my opinion, he still suffers from severe PTSD, and moderate to severe depressive illness. Indeed, as regards his PTSD symptoms, these were as severe as they were when I saw him in 2011.

As regards specifically his risk of suicide, in my opinion he is not at immediate and real risk. However, any further deterioration in his state would likely increase the risk, with the likelihood of 'completed suicide' being dependent also upon his clinical management in the context of any such inherent risk…

Specifically in terms of the Pritchard Criteria in relation to 'fitness to plead', in my opinion, he could certainly understand the charge he faces and could certainly decide whether to plead guilty or not. Further, he could exercise his right to challenge Jurors. However, in my opinion he could not effectively instruct solicitors or counsel, neither could he follow the course of proceedings in any adequate fashion, nor could he give evidence on his own behalf and in his own defence. Even more fundamentally, I do not believe that, in the state I observed him to be, he would be capable of interacting with his lawyers in advance of a hearing so as to prepare adequately for that hearing…

A further major problem is that, as he was when I saw him, his intrusive symptoms of PTSD, as well as his hyperarousal, was such that attempts to deal with matters with his own lawyers leading up to a trial would be essentially 'intolerable' to him in terms of the highly likely effect of this in enhancing further his PTSD symptoms, in particular his 're-experiencing' symptoms. Even my attempt to take him through his previous account to me of what happened in South Africa, from a clinical prospective, and with a gentle approach as a doctor might use, he was immediately obviously 'unable' to continue, due to the fear of what the impact would be upon his mental symptoms. I was entirely convinced that this reaction was genuine, based both upon how he presented at the time, as well as more generally upon records concerning him in relation to the likely validity of his symptoms per se and also the fact that his 'avoidance' of recalling events related to the traumatizing events is entirely to be 'predicted' in someone with the condition. A similar mechanism would also make him unable to give evidence…

Essentially, in my opinion, there is a 'Catch 22' problem in regard to the inter-relation between the nature and severity of Mr Dewani's particular symptoms, worsened as they are by an objective recollection, or requirement of recollection, of events relating to circumstances surrounding his wife's killing and the necessity of legal process to address those circumstances. Hence, albeit I think it is likely that Mr Dewani does in fact want to 'undergo a trial and clear his name' (in his terms), the process that would be required in order to approach and achieve this would highly likely so enhance his symptoms that it would make him unable to proceed to trial…

Ultimately, the only real prospect of escape from the 'Catch 22' situation I have described must lie in improvement in Mr Dewani's mental symptoms, almost certainly arising from re-instatement of medication similar to that which caused improvement recently but which had to be stopped, sufficient then to allow specific psychological treatment explicitly directed at addressing the traumatic events that have laid the foundation of his condition…

Specifically as regards those latter recommendations, as I have already noted, I pay heed to Dr Gene-Cross's opinion that, at the time she interviewed the defendant towards the end of last year, when he was at Fromeside Clinic it was not possible to apply direct treatment of his PTSD symptoms; rather, all that could be applied were more general management techniques, plus particular medication, as a 'precursor' to treatment directed specifically at reversing the PTSD symptoms by psychological therapy…

However, as I have ready indicated, in my opinion it is highly likely to be the latter that is required in order for Mr Dewani to achieve any reasonable level of mental health. It is also highly likely, as I have indicated, that such a level of mental health, consequent on direct and specific psychological treatment of his PTSD symptoms, would be necessary in order for him to be 'fit to plead', and for there to be confidence that he would remain fit to plead under the stressors of being in South Africa per se, in what context he was contained, and of going to trial…

The foregoing said, as I have already indicated, it was the introduction of particular medication that also significantly improved Mr Dewani beyond the necessary change of environment and, in my opinion, unless he can restart on medication likely to have the same beneficial effect upon his PTSD symptoms as did the pregabalin, he is unlikely to improve sufficiently to approach the prospect of an improved clinical state capable of allowing direct psychological treatment of his PTSD symptoms, so as to open a real prospect of trial."

The live evidence

As mentioned above, there is an agreed note of the evidence. I will summarize it, albeit at some length, here.

1. On the 2nd July **Dr Ian Cumming** gave evidence for most of the day, and for some of the following morning. He adopted his reports which give details of his expertise. He is one of the national leads in prison psychiatry in England and Wales. He has experience of "thousands of cases". There is no doubt as to his very considerable experience and expertise.

He was asked about his 4 hour interview with Mr Dewani in August 2012. Mr Dewani was obviously distracted, particularly by noise, which meant he was unable to concentrate for long. However you could bring him back when he was distracted. He gave detailed answers and a good account. He spent about 45 minutes (with a break) talking about the index offence. It was difficult but he was not incapacitated from answering questions. His underlining conditions made it difficult but not insurmountably difficult to get adequate information from him for clinical purposes.

Mr Dewani is seen by a consultant maybe once a week and there are also ward rounds. People work in a team at the hospital. Notes are taken and there are thousands of entries over a period of time about Mr Dewani. Generally there were no concerns about his behaviour and no evidence of distressing thoughts.

He has been taught "grounding" which consists of a number of simple techniques which are to do with anxiety. Nevertheless there appears to be a general and unhelpful resistance by the patient to treatment. There is a sense that he is not taking responsibility yet not being challenged. Sometimes to get a patient better you have to push. There may be a large number of reasons why he has not been challenged. He is not malingering. A pervasive theme is his preference to be in his room or at his family home rather than engaging in treatment.

As for suicide, there was only one potential incident and this was 2½ years ago. There has been plenty of opportunity to take his life, particularly when he is at home although he is accompanied to and from his home.

There were good and bad days and there was some improvement before he started to take agomelatine and further improvement after taking the medication. His hypersensitivity to noise is particularly striking.

The doctor was asked about court proceedings being a maintaining factor. As his health improves so the problem of going to another country and facing trial gets closer, and is very unpleasant.

He confirmed his report on Valkenberg Hospital. He was clear that Mr Dewani would be placed on the general side as opposed to the forensic side of the hospital. Of the wards of Valkenberg, Ward 1 is closer to Blaise View but with a higher expectation for patients to join in a programme. The hospital can tailor a care plan to provide a range of treatment for an individual patient.

Dr Milligan is the head of the acute unit who would oversee Mr Dewani. The hospital is aware of the type of drugs he is on at the moment. They know about the drugs and are familiar with them. They have access to these drugs. There is nothing in terms of clinical need that cannot be dealt with at Valkenberg. They have considerable expertise with PTSD. There are advance plans to rebuild parts of the hospital starting in 2014.

In cross-examination he was taken to the experts' agreed note. His position is that extradition could be immediate. Professor Eastman's view is that there would be less damage if there is a delay of six months. He wasn't "entirely sure" that it follows that it is sensible and obvious to wait for improvement before extradition takes place. He accepted that now Mr Dewani is back on medication he could be better quickly, but nevertheless believes that the longer extradition is delayed the harder the process might be. There will be deterioration on arrival in South Africa, but the exact impact cannot be known and he is confident the South African services can deal with any regression.

He denied putting too much weight on the clinical notes and said he had spoken to the clinicians, nursing staff and in particular Drs Cantrell and Harland. He was cross-examined about passages read to him in chief that suggested Mr Dewani was inadequate in his compliance with clinical process. He agreed that irritability is a classic symptom of PTSD and that avoidance is also a symptom of his condition. However the staff at Blaise

View would like him to be more engaged and to use the techniques they are suggesting. It is reasonable to ask patients to go to meetings. Dr Cumming rejected the suggestion that it was reasonable not to mix with patients who are schizophrenic or psychotic. However, he was avoiding hypersensitivity to noise rather than the patients. His sensitivity is a marked disability. He winces about the noise.

The witness said he had been very careful in his report and tried to have balance. Nevertheless the sense is that Shrien Dewani is not really engaging with the process, in a way that is different to other patients. There is a real sense of retreat. Staff need to be robust to challenge this and indeed they were asking him to become more engaged. A firm approach is sometimes necessary for the patient's benefit. This patient was desperate to get back on pregabalin, despite the risk to his physical health. This medication provides a "quick fix". Nevertheless there is a therapeutic effect of mixing with other people. Everyone wants him to be better and mixing would help that process.

As far as underlying capacity is concerned, the defendant remains a highly intelligent and articulate man but is unfit and will remain unfit for some time at the least. If he is returned to South Africa quickly it is highly likely that there will be a fitness process, although Dr Cumming is not prepared to prejudge the outcome of that process.

As for the risk of suicide, Mr Dewani is not aggressively saying that he will commit suicide and has never said that. While under the care of Blaise View Mr Dewani may well have had opportunities, when alone in his room, to harm himself, but has not done so. It is difficult to gauge the increase in risk if he is sent to South Africa.

He was asked about the best chance of ensuring that the defendant became fit for trial. He agreed that environment is very important, and the patient needs quiet; low key; the benefits of going home; care; the skill of the people working with him, and many other things. His family is very supportive. The facilities at Valkenberg are not Blaise View. He will not have his close family there. The challenge will be to put together a package of care as to how the clinicians there will meet Mr Dewani's needs. They have the components and the expertise. The best ward for the process is Ward 1, although this does not operate at weekends. Nevertheless they should be capable of making appropriate arrangements. There are options. We cannot say what sort of unit that they,

the South Africans, should have. They will look at his needs when he arrives. Adaptation is common and there is no reason to believe they cannot do this at a Valkenberg. Dr Cumming agreed that the high care unit is not appropriate, and unit (Ward) 4 is not ideal. He was asked about the level of violence in Valkenberg, and was unable to answer. He had been concerned to ensure there was a proper process for dealing with complaints of violence.

Cross-examination resumed on Wednesday 3rd July after further undertakings had been given about where Mr Dewani would be detained if extradited.

Dr Cumming accepted that the decision not to provide his lawyers with detailed instructions about events in South Africa was not made by Mr Dewani but by his lawyers in consultation with the clinicians. Mr Dewani had been perfectly willing to give his account to the doctor. There is now a difficulty in disentangling what he actively remembers from other information that has been provided to him. The passage of time makes this process more difficult for any defendant.

There is highly likely to be a fitness to plead process in South Africa. The doctor's recollection was that current medication will continue and that the South African medical team will make its own assessment in time. There is no doubt that there will be liaison between Valkenberg and Dr Harland from Blaise View. This means that there will be no dislocation and the patient will receive the same medication at first. Dr Cumming does not know if fitness to plead would be assessed quickly. Whatever the usual position in South Africa it is clear that a very exceptional approach to his management would be taken.

Dr Cumming was asked about the procedure for state patients and did not accept that they were necessarily detained for life. Release can be a drawn-out process but people do leave after proper assessment at Valkenberg. Mr Dewani would be assessed and the clinicians would make their own decisions and planning. The new facilities amount to more than just buildings and the hospital process is geared to getting people out into the community. When the expert visited Valkenberg the hospital was releasing people during the day, for example to work.

On the subject of maintaining features it is difficult to proportion the biological and the maintenance factors. They are both relevant. Sleep patterns and appetite are more obvious. It is important to understand that the symptoms of PTSD and depression overlap. You can be led into error by trying to tease out which symptoms are caused by which conditions. It is the overall condition that is producing these symptoms. It could be that both the events in South Africa and the extradition process are maintaining factors. Extradition is a factor but not the full picture. Sometimes leaving things for too long can also have a subversive effect on health.

Dr Cumming was then taken to the expert's joint statement prepared on the 14th July 2011 and behind tab 7 volume 1. The position with point 1 (the severity of the disorder) is now moderate to severe. The position in point 2 (risk of suicide) remains real and significant. The position with point 3, fitness to plead, remains that he is currently unfit to plead. In point 5 (prognosis) progress is slow and uncertain. Neither expert expects a full recovery in the immediate future. In point 6 the doubt over psychosis has been resolved – it was not psychosis but serotonin syndrome. As for travel to South Africa (also point 6) the defendant could be put on a plane but this would need full consideration, a care plan, and preparation. Sedative drugs are not ideal. If there is focus on the mechanics then with good care this could be done. On point 7 (likely impact of extradition) it is agreed that the defendant will deteriorate. It is difficult to know how his medical state (and therefore fitness to plead) would deteriorate but logical to think that it would. The suicide risk will further increase.

He was then asked about his views for the next 6 months. It is highly likely that if gabapentin is restored then Mr Dewani will get back to where he was before the drug was stopped, which is better than today. He was better able to concentrate and his mood was better. SD wants to get back on the drug. We don't know whether there is an additive effect of waiting for improvement from the gabapentin. There is an advantage in moving on. You cannot be certain. He is cautious in how he puts it. Some times the longer you leave it the harder it is. There is an advantage in pressing on, but he has not said there is a need to move now. It was put to Dr Cumming that there are advantages in Professor Eastman's suggestion – that is, waiting for another 6 months during which time there is a near certainty of progress, but if there is no progress then there is a strong case for going back to South Africa. Dr Cumming could see the sense in that approach but has a different view. It is equally possible that with the support and input of the

services in South Africa, that they can manage that change just as well. There are aspects of that process which cannot be predicted.

As for the process of transfer, this would involve some negotiations between the teams. It would be reasonable for him to feel the benefit of gabapentin before he undertakes any travel. The general view is that the medication should start to have effect within 2-3 weeks from the hearing [so by mid to late July 2013]. There is no formula as to when the optimum effect might be reached. People vary considerably and there is the placebo effect.

In re-examination Dr Cumming said that there may be no difference in the distress caused to Mr Dewani whether he is removed now or later. Even in 6 months time he will not have fully recovered. He will regress when extradited but there is no reason why he should not recover after that regression. The total clinical toll could be made worse by leaving it longer and longer. There would be no interruption in the use of gabapentin during the extradition process. There will be a handover and the receiving hospital will prepare very well. The expected deterioration will be a spike but Mr Dewani should find that Valkenberg is ok and will pick up. They may take a more robust approach to treatment than Blaise View and that may well be to the patient's advantage. A best guess is that deterioration would reverse. The reverse earlier this year was not massive. There is no reason why the rate of recovery should be different in Blaise View to Valkenberg, although it could be slower or even quicker in Valkenberg as the more robust approach may help.

Counsel returned to the risk of suicide. News that he is going to be extradited is one effect. Removal was another effect. So you can expect one spike and then another spike. It cannot be quantified but Dr Cumming does not question the ability of Blaise View and of Valkenberg to manage the risk. When extradition was ordered by the Secretary of State on 26th September 2011 this was managed by cancelling Mr Dewani's home leave. The news seemed to have little effect but the defendant was noticeably quiet over the next day or so. Dr Cantrell says that the risk of suicide is downwards. It is not inevitable that there will be a determination that Mr Dewani is unfit to plead in South Africa. That is a determination for them to make.

2. <u>Professor Eastman</u> has a long and distinguished career in forensic psychiatry. I summarized his qualifications in 2011. There is no doubt that he is a leading expert in his field. He gave evidence on the afternoon of 3rd July.

His view in 2011 was, and remains, that Shrien Dewani suffers from severe PTSD, and now a moderate to severe depressive illness. In his recent interview he found SD to be no better as regards PTSD, but his depressive illness is somewhat better. He remains of the view that the defendant is not fit to plead, and nothing he heard from the material put the previous day to Dr Cumming undermines that conclusion. The longer PTSD continues, the worse the prognosis. A particular difficulty for this defendant is that the event at the root of his trauma is repeated daily because of the extradition and prospective criminal proceedings. This is a re-traumatizing experience. Unless treatment, including specific psychological treatments (which have not yet been capable of being tried) can achieve improvement there will not be fitness to plead.

The professor's point, which he says is an obvious common sense point, is that those treating SD should have the opportunity to get him into the best possible state before subjecting him to the trauma of extradition. His deterioration at the time of extradition would be from a better state than he is now. There is also a reasonable chance that if he goes in a better state, then his dip itself may be less. This all depends on whether there is improvement during the six month period suggested. If any improvement had not taken place within six months [that is by the end of 2013] then "I don't believe at that point I would be able to say that there is a reason for further delay".

The prospects for achieving fitness to plead are very poor if he is extradited now, but there are grounds for some hope if treated here, because he improved significantly on pregabalin. If you can open a door through one means of treatment, then that allows you to go on to another means of treatment. So if his symptoms of arousal are significantly diminished by gabapentin, then that is likely to open the door to engaging him in a more assertive way in specific psychological treatments. It has been shown that door could be opened with medication. If you are trying to get the best possible advantage from opening the door, then why would you add in an unnecessary stressor? Clinically it makes no sense.

The professor spent some time considering the role of the services at Valkenberg. Although he accepts he has no documentary basis on which to disagree with Dr Cumming's report, nevertheless he clearly has significant misgivings about the appropriateness of the setting at Valkenberg. Although he respects Dr Cumming, he believes the doctor is wrong because he is applying a generic principle to the wrong patient.

In cross-examination the professor agreed that the drug agomelatine was the primary driver for the improvement in SD's depressive disorder, and that this is still being prescribed and taken. None of the reporting clinicians have noted since April that the depressive symptoms have worsened and indeed those symptoms are not as severe as when he first saw SD. There has, he agreed, been a significant and sustained improvement on account of the anti-depressant intervention alone. The hyperacusis and other significant symptoms of PTSD were significantly aided by pregabalin. He agreed that although there has been a regression with the PTSD symptoms, Mr Dewani was still better than when he had arrived at Blaise View in January. One of the beneficial effects was on SD's ability to concentrate. He also has some basic grounding techniques. Both the drug and the grounding techniques were causes of the improvement seen, but when the medication was removed he was unable to use the grounding techniques as easily. These techniques are well known and there is no reason why they cannot be continued. However the professor was concerned about the context of treatment and expressed doubts about the quality of the environment in Ward 4 as opposed to Ward 1 in Valkenberg. Although he does not doubt the skills of the individuals, he appeared to doubt the ability of clinicians at Valkenberg to provide an appropriate integrated approach with pharmacological intervention and psychological intervention. He appeared to have a doubt as to whether Ward 1, the best ward from the point of view of the environment, would have the necessary experience of the conditions suffered by this defendant. However he accepted that at Blaise View they also did not normally deal with patients such as Mr Dewani.

As far as fitness to plead it is concerned, the professor thinks the defendant is "a long way from the line, and Dr Cumming thinks he is closer to it." He does agree with Dr Cumming that part of treating somebody with this condition is to be gently assertive with them. He thinks, although he was properly cautious about this as he is not the clinician in

this case, that if he were the treating physician then he might be somewhat more assertive with SD, but in a very gentle way.

Although there would be a likely worsening of symptoms consequent upon extradition, that could nevertheless be managed by the general psychiatric services in South Africa. However, that does not mean that the risk of completed suicide isn't greater in South Africa. It simply means that in Valkenberg they are in a position to respond to that risk.

He was asked about the sense behind his suggestion of a six-month delay when he believes that any improvement will be extremely slow. He accepted that this is a good point, but even though the prognosis is poor it makes no sense clinically to add the stressor of moving him now. He accepts that whether there is an early or late move to South Africa the problems caused by the move and by the change of environment will need to take place. His point is that it is a lesser hostage to fortune to send him after having tried further treatment in a place that has seemed to be beneficial. There are unknowns in the move to South Africa, and why take the chance?

As for the journey, he and Dr Cumming agreed that it is possible to manage the transfer of even a very disturbed patient. There can be appropriate clinical care to manage the risk.

He was asked about the number of references in his report to the risk of transfer to the forensic service in Valkenberg. He was asked whether, given that it is no longer a live issue that SD would be held in the forensic service unit, he would change his view. He said he would not because he had formed his opinion from a number of perspectives, and has answered all questions now in terms of the general services.
In re-examination he gave four reasons why he expects more rapid and greater improvement in Blaise View than in the general psychiatric unit in South Africa. It is a very peaceful environment; a known environment; the family is close at hand (although he is cautious about this as he would try to have him spend less time with his family); and he is very well known to the staff at Blaise View.

Summary of current position

The parties have prepared a file of medical reports/transcripts of the medical evidence for this hearing. This file contains 18 documents with opinions from seven different medical experts, several of whom have reported on more than one occasion during the past two and a half years. It is inevitable that those reports and transcripts show differences of opinion or differences of emphasis, both as to the current position and to the likely future position. Nevertheless, overall a reasonably clear picture emerges.

Mr Dewani's wife Anni was murdered on their honeymoon in South Africa in November 2010. Very shortly afterwards he began to show symptoms of PTSD and then he became obviously unwell. In March 2011 Professor Eastman concluded that SD was suffering from two disorders; first, PTSD and second, depressive illness. He records that the symptoms of PTSD began shortly after the murder and before the extradition proceedings began.

Shrien Dewani has been treated for these conditions ever since. He has been in hospital and detained under section 3 Mental Health Act. At the time of the first extradition hearing in July/August 2011 it was clear that extradition would present a real and significant risk to the life of Mr Dewani.

Since the first extradition hearing he has improved.

He has been treated throughout the period with agomelatine. There has been a slow but steady improvement. Nevertheless he remains moderately depressed (according to his treating doctors in April 2013) or with a moderate to severe depressive illness (according to Professor Eastman).

He has also been treated for PTSD. The move from Fromeside to Blaise View, which is quieter, proved helpful, as did learning diversion techniques. Medication, specifically pregabalin, also helped. This was withdrawn on 23RD April 2013 because of a rise in his CK levels. In April his PTSD was ranged in the moderate degree by his doctors. Thereafter his mental state dipped (it is now assessed as moderate/severe or severe), although he is still better than when he arrived at Blaise View. New medication was

prescribed a few days before this hearing began. There is optimism that this medication will restore the improvements noted in April.

The risk of suicide is real but not immediate. He has been clear with his treating team that he has no thoughts of killing himself. There have been no attempts at self-harm since the last hearing. His general mental state has improved. Perhaps most importantly, we now have clear evidence of the quality of care available at Valkenberg. Real concerns remain. I was told last time that as he improves, so the risk of suicide increases. Extradition would be another risk factor, at least for a time. Nevertheless the real and significant risk to his life, which was a central factor in 2011, has diminished.

The experts agree that SD is not fit to plead under English law. If extradited in the near future there is likely to be a fitness to plead process. [I do not know how soon such a process would take place. I assume there would be a period of further treatment and assessment first.] Dr Cumming does not think an unfitness finding is inevitable, even after a comparatively early hearing, as he considers the question more marginal than before. Professor Eastman thinks there is a long way to go. Even if he is found unfit, and becomes a state patient, I accept Dr Cumming's evidence that Mr Dewani's case will be kept under appropriate review, because of his special circumstances and because the ethos of the hospital is to rehabilitate people for release into the community. I do not doubt the fairness of the South African legal process.

[The defence has argued that it is not lawful to extradite Shrien Dewani for the purposes of fitness to plead proceedings in South Africa. I hesitate to answer that question, because it is not the question asked by the Divisional Court. However, it may be appropriate to confirm that on the facts as they are now, my answer is the same as it was in 2011.]

If extradited to South Africa, Mr Dewani will not go to prison, at least while there remain concerns about his mental health. He will appear in court shortly after his arrival and will either be granted bail or will be remanded to Valkenberg Hospital. There he would be treated in the general, acute, services as opposed to the forensic services. The evidence is

that he will have good quality of care there. The evidence about the quality of care was not available at the previous proceedings.

The journey to South Africa will be difficult but can be managed. Extradition will cause a dip in the defendant's health, but there are reasonable grounds to believe that improvement will follow. There will be a smooth clinical handover and it is probable that current treatment will be maintained while the clinicians at Valkenberg (if he is remanded there) make their own assessment. Valkenberg is alive to the risk of suicide and there is no reason to doubt that Mr Dewani will be cared for well by the staff and have his needs met.

Opinions vary as to the likelihood and timescale of any improvement. The experts in this case do not expect a full recovery from either of SD's disorders (Professor Eastman in the foreseeable future, Dr Cumming in the immediate future). Any improvement is likely to be extremely slow, and the end point is uncertain. Dr Cantrell stated in September 2012 that Mr Dewani will certainly recover from his difficulties at some stage, although he was much more cautious about the PTSD. More recent reports refer to improvements.

Professor Eastman and Dr Cumming differ in their opinion as to the effect of treatment on this defendant. They both expect a deterioration in his mental state for a period around the time of transfer. Dr Cumming believes that is likely to be a temporary setback. Professor Eastman's primary position, if I can put it this way, is that he does not expect a full recovery in the foreseeable future, whether treated in the UK or in South Africa. However there may be an improvement here in the next six months. A door may open during that time, but is far less likely to open if extradition takes place now.

I have had the advantage of reading and hearing evidence from two undoubted experts in the field. They give opinions as to what might happen, not predictions. They clearly disagree on at least one question, while respecting each other's opinion. Insofar as their opinions differ, I cannot conclude which of them is right. The arguments seem to me to be finely balanced. So the evidential position is that extradition now may mean that an opportunity for recovery is missed. It may mean that recovery is simply set back

temporarily. It may mean that there are advantages in pressing on with extradition now, rather than delaying further.

Decision

The question I am asked is whether the condition in s91(2) of the Extradition Act remains satisfied, and to decide again whether extradition would be compatible with articles 2 and 3 of the defendant's Convention rights on account of his mental health. The articles 2 and 3 points are abandoned.

It is not in question that Shrien Dewani will be returned to South Africa. The Divisional Court decided that this court was correct to conclude in 2011 that Mr Dewani's discharge under s91 (3) (a) should not have been ordered. The treating clinicians continue to state that Mr Dewani will recover.

There has been recovery, but it has been slow. It may be a long time before Mr Dewani is fit to plead, but he may be closer to that point. It is not impossible that if returned now, then after a reasonable period of further treatment and assessment he will be found fit to plead, and a trial can take place.

The evidence is that Mr Dewani will receive the care he needs in South Africa. Perhaps as a result the risk to life was no longer at the forefront of the argument. There remains a real risk of suicide, but also confidence that in South Africa, as here, there are systems in place to try to minimize that risk. Shrien Dewani remains seriously ill, but the prognosis is uncertain. Although the evidence is that Mr Dewani is unfit to plead now, he may or may not become fit to plead in the foreseeable future. It is far from certain that he will recover more quickly if he remains here, and there is respectable evidence that delaying extradition may make the clinical toll worse, so that there are advantages in moving on. In such a case, as the Divisional Court said [para 77] the interests of justice in seeing that persons accused of crimes are brought to trial have to be brought into account.

Balancing the evidence that has been put before me, I find that the condition in s91 (2) of the Extradition Act no longer remains satisfied.

In those circumstances s104(7) applies. That is, the appeal must be taken to have been dismissed by a decision of the High Court.

Howard Riddle
Senior District Judge (Chief Magistrate)

24th July 2013