

## Epileptic Homicide : A Case Report

By JOHN GUNN

**SUMMARY** This case report augments a paper published in 1971 (Gunn and Fenton) in which it was indicated that automatic behaviour is a rare explanation for the crimes of epileptic patients. It was claimed that although two possible 'automatic' crimes were committed by two epileptic patients among the 46 male epileptics at Broadmoor there were no such crimes committed by any of the 158 male epileptic prisoners who came into a national sample. Since then it has become clear that one man serving life imprisonment, excluded from the epileptic prisoner sample in 1967 because of a doubt about his diagnosis, is definitely epileptic and probably killed his wife during an epileptic attack or its immediate sequela.

### Case History

Mr A was charged with murder in 1963, when he was 48. By that time he had a long history of recidivism and had been sentenced to a total of 27½ years imprisonment and borstal. However, there was no previous record of violence or threats of violence, his crimes being petty thefts, especially bicycle stealing. His medical history included a statement from his mother that he had had a difficult birth and had had a seizure which lasted one hour when he was 2 days old. The next possible epileptic event occurred when he was 13 and serving a sentence in an industrial school; he says he was admitted to hospital unconscious or semi-conscious. The notes of this event have been destroyed and he says he was given no explanation for the episode. He remembers that at 17 years his head used to shake and jerk uncontrollably. In later years, according to him, he suffered from partial blackouts when 'everything has gone dim, semi-darkness, and a giddiness in myself seemed to make me unsteady in my balance'. None of these events was witnessed, and a careful scrutiny of his prison records revealed no recorded incidents during his many years inside gaol.

During 1962, whilst on probation, Mr A was befriended by a voluntary social worker.

Their friendship blossomed, and they were married in March 1963. His recall is that the marriage was happy in every respect and they had no sexual or financial problems. One Monday in June 1963 Mrs A visited her doctor, and afterwards she told a neighbour that she had either hay fever or a cold and must stay in bed for two or three days. That evening Mr A telephoned his mother-in-law to let her know that her daughter would not be visiting her on the Tuesday, as was her usual practice. On the Tuesday a friend visited and stayed until 8.30 p.m. Early the following morning Mr A told a neighbour that his wife had gone to see his mother-in-law. Soon afterwards he was seen at the bus stop wearing his best clothes and carrying a suitcase. At 10.30 a.m. he telephoned his mother-in-law to say that her daughter was much better. Two days later he gave himself up to the police, saying he had murdered his wife.

Mrs A's body was found in bed under the eiderdown; the hands had been crossed on the chest after death. There were severe injuries to the face and head, and defensive injuries to the right arm and hand. Post-mortem examination showed that at least seven blows had been delivered with a claw hammer. Mr A's official statement was that on the Tuesday evening he had taken a hammer up to the bedroom to nail

a clothes rack to the wall and he had left the hammer in the bedroom. 'I woke up about 5 a.m. on Wednesday. My wife woke up about the same time. We joked about a bit, so there was nothing wrong. I got out of bed about 6 a.m. I got partly dressed, when my eyes saw the hammer. All I remember now is picking it up. I hit my wife. I murdered my wife. I don't know how many times I hit her. I went downstairs. I lit the fire. I made a cup of tea, I took a cup of tea upstairs for my wife. I saw she was dead. I covered her over with the bedclothes.'

At his trial the prison doctor commented that the logical sequence of his actions and the absence of any sign of confusion indicated that he was not suffering from any epileptic condition. An EEG examination was carried out for the defence by Professor Hill and Dr Fenton. They reported 'severe generalized abnormality of background activity, especially the right hemisphere. Arising from this are atypical spike and wave discharges of subcortical origin. These findings suggest early diffuse brain damage'. Professor Hill also reported that the various EEG records available 'provide unequivocal evidence from the EEG point of view of epileptic activity, and in a man of his age (48), given these records, it would be highly probable that at some time in his life he would have suffered cerebral damage to the right hemisphere . . . It is not, of course, possible to say how these findings may relate to the crime with which he is charged'. The defence psychiatrists noted that the accused gave a vague history of giddy turns, but like the prison doctors, they were not convinced that these were epileptic fits. However, at the trial Mr A's defence of diminished responsibility by reason of diffuse brain damage was accepted by the jury. He was found guilty of manslaughter and sentenced to life imprisonment.

For the first four years of his subsequent imprisonment Mr A had no epileptic fits but he did suffer from recurrent headaches accompanied by loss of temper and slight feelings of familiarity.

In 1967 his solicitor wrote to the Prison Department suggesting that his client should be considered for cerebral surgery. In the medical

review which followed this intervention Mr A admitted to his prison doctor that he had been evasive and untruthful to his medical examiners before his trial. He said that on the fateful morning he got up, went downstairs to make the tea, and then went unconscious. The next thing he remembered was the dog licking him. The kettle had boiled dry and he was stained with blood.

A course of anticonvulsants was started. Three months later a medical report indicated that his headaches had disappeared, he had had no outbursts of temper, his demeanour had improved, and he looked better.

Three months after that report he was referred to a neuropsychiatric centre for an opinion about surgical treatment. By arrangement his anticonvulsant drugs were stopped, and four days later he went into *status epilepticus*. His EEG was grossly abnormal with a distinctive slow wave discharge confined to the right fronto-temporal region. At one point during his stay in hospital his speech became slurred, he had only patchy recall from the previous week and he confabulated, though he remained conscious all the time. The neuropsychiatrist reported that the abnormal mental state he witnessed was an unusually severe and prolonged post-ictal effect; yet it might have passed notice without careful questioning. 'This, with the finding of a temporal lobe lesion capable of provoking a psychomotor seizure, makes it possible that he might carry out some act during or soon after a fit, and afterwards have no memory or only fragmentary memory of the act.' He also added 'it is entirely possible that he obscured the typical features of a psychomotor seizure and/or post-ictal confusion, by telling the most convincing and self-protective story he could make up'. Surgery was not recommended.

Since 1967 Mr A has suffered from epileptic seizures with increasing frequency. They begin with a clouding of consciousness, followed by a clonic contraction of the supra-orbital muscles on the left side. These initial phenomena may last up to three or four hours and are then followed by a typical *grand mal* attack which lasts three or four minutes. He has remained unconscious for periods of up to three days, but

the attack can usually be aborted with intravenous diazepam. Often the fit is followed by up to 48 hours of disorientation in time and place, during which he is bedridden and helpless. At these times he is also frequently restless, expressing disconnected paranoid ideas which can go to overt verbal hostility, however, no physical aggression has been witnessed either in prison or since his release. This confusional state can also be aborted by intravenous diazepam. With the help of a complex anti-convulsant regime his fit frequency has been reduced to three or four a year.

A prisoner with such a history was of course extremely difficult to resettle and he remained in gaol for 13 years, until 1976, when he was discharged to a hostel for epileptic offenders. Since the hostel has no residential staff Mr A has to be admitted to hospital each time he has a seizure, but with diazepam treatment he is usually discharged again within 48 to 72 hours.

### Discussion

Much of the medical interest in this case lies in the difficulty of making the epileptic diagnosis at the time of the trial. At that stage the following features pointed towards epilepsy: infantile convulsions, a previous episode of unconsciousness, a vague history of blackouts, a motiveless out-of-character murder, the odd account of the murder as given by the prisoner, and a very abnormal EEG. However there were some powerful reasons to doubt the diagnosis: there was no clear history of clinical epilepsy, he reported that he could remember the incident, but was not disturbed in his consciousness at the time, the murder and its aftermath were part of an intelligible sequence of events, infantile convulsions are common and usually benign, the history of the lapse of consciousness was vague and unconfirmed.

With hindsight it is clear that the objections to the epilepsy diagnosis were exaggerated. For example, Professor Fenton remembers the case well and points out in correspondence that Mr A's 'infantile convulsions occurred two days after birth and lasted one hour, quite unlike the timing and duration of febrile seizures'. Equally, the logical sequence of events is not incompatible with epileptic automatism,

for whilst it is true that it is unusual to find a high degree of integrated behaviour associated with automatism, behaviour which is apparently purposeful, such as searching, drinking, smoking, undressing, are all described (Fenton, 1972). Furthermore, the possibility of a panicky confabulation, as suggested by the neuropsychiatrist, does not seem to have been raised.

Nevertheless due allowance must be made for the fact that all these remarks are easy with hindsight and that at the time the question of whether this was another case where a prisoner was trying to get off the hook on spurious medical grounds must have loomed large. The epileptic survey of which this case is a part (Gunn, 1977) indicates the rarity of aggressive automatisms. Even so, the jury must have had some doubts as they brought in a compromise verdict of diminished responsibility. A compromise because if (and we must still say if) Mr A killed during an epileptic automatism he should have been acquitted; on the other hand if Mr A did not have epilepsy at the time of the attack then he should have been found guilty of murder. Diminished responsibility would have been an appropriate verdict if the defence had raised the general question of psychological disorder contributing to the crime, or the specific issue of a paranoid state at the time. An acquittal on the grounds of non-insane automatism would have produced an interesting situation for Mr A would have walked from the court a free man even though the fact that he killed his wife was not in dispute. The diminished responsibility verdict gave the judge the opportunity of sending Mr A either to prison or to hospital. He chose life imprisonment. It is difficult to know why: perhaps he wasn't convinced by the medical evidence, perhaps he didn't understand the advantages of hospital in a case like this, perhaps no hospital placement was offered to the court.

Using hindsight again, it is clear that a hospital placement would have been more appropriate, for then more intensive investigation would have been immediately available. Most importantly the rehabilitation process could have been started much sooner, for there is surely no doubt that 13 years in prison was far too long for this patient; the prolongation

of imprisonment was brought about by the extreme difficulty the Home Office found in getting suitable accommodation, with medical surveillance.

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