

CASE REPORT

On Fitness to Plead: When the Accused is Speech-less

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Abstract

Forensic psychiatric evaluation of a suspected mentally disordered offender includes diagnosis, treatment whenever applicable, criminal responsibility and most importantly, the determination of the fitness to plead. The evaluation would be more challenging in a person with aphasia. Herein, we present a case of transcortical mixed aphasia (TMA) that was sent by court for forensic psychiatric evaluation. We describe the process of helping the suspect to stand trial with the guidance from the speech language therapist (SLT) through alternative communication methods (ACM). The presence of aphasia remains a challenge to the assessment and its validity of fitness to plead for the accused. Hence a multidisciplinary approach is essential to assess and subsequently assist the accused in his fitness to plead.

Keywords: Traumatic Brain Injury, Fitness To Plead, Aphasia, Alternative Communication Method

Introduction

Every forensic psychiatric evaluation of a suspected mentally disordered offender involves three assessment domains comprising the mental disorder diagnosis, criminal responsibilities, and fitness to plead in the court. The fitness to plead of a mentally-disordered offender is based on the Pritchard criteria which has been adopted by the Malaysian Criminal Justice system [1]. The offender is considered fit to plead when he or she has sufficient intellect: (i) to understand the nature of the charge and the possible consequences of a finding of guilt; (ii) to instruct his legal counsel; (iii) to

understand the evidence against him; and (iv) to understand the course of the proceedings at the trial so as to make a proper defence. A fifth factor of having sufficient intellect to challenge jurors is no longer relevant in Malaysia as trials by jury are no longer in practice in Malaysia. There has always been a question mark over the query if those who suffer from mental illness have the capability to plead or not.

Here, we present a case that focuses primarily on the topic of fitness to plead in a forensic psychiatry setting where the offender is presented with a doubt of fitness to plead to stand for a court trial.

Case description

This is a 31-year-old male with an underlying history of traumatic brain injury as a result of a motor vehicle accident 5 years prior to his index offence. He had undergone left decompressive craniectomy and evacuation of subdural haemorrhage over the left frontoparietal region. The head injury was complicated with post traumatic seizure. He was charged for drug offences and was subsequently ordered to an approved psychiatric hospital for assessment. During initial assessment, deep concave indentation over the left side of his skull with his childlike cheerful demeanour were the most prominent features that stand out. His speech was limited to answering only “I don’t know” to most questions, which left the assessors wondering about his ability to comprehend, and subsequently express his thoughts. Collateral histories gathered from close relatives strengthened the patient’s history of impaired speech since the brain injury.

Throughout the ward admission, he demonstrated a consistent interaction with the staff and other patients in the ward with his limited range of speech which leaned towards the direction of acquired speech disorder. Clinical Psychology reported that the neuropsychological assessments may suggest a possible overall cognitive impairment in relation to his condition. Hence, a referral to internal medicine was done. During the medical assessment, the patient was able to identify himself and only follow simple one-step instructions such as lifting his left arm and closing his eyes. Central nervous system and relevant physical examinations were unremarkable. Routine laboratory investigations including full blood picture, renal and liver profiles were normal. Contrast Enhanced Computerized Tomography (CECT) scan of

the brain showed left fronto-temporal-parietal craniectomy and marked reduced volume of the left fronto-temporal-parietal lobe (Figure 1). As assessing patient understanding and communication remained a challenge, a referral to a speech language therapist (SLT) aiming to establish and facilitate comprehension of information and expression of the patient’s thoughts was made. Detailed assessments which were done through a series of linguistic tests, showed that the patient had developed moderate cognitive impairment, severe auditory comprehension deficits, and severe word finding difficulty. The provisional diagnosis given was transcortical mixed aphasia (TMA). Hence, SLT suggested implementing alternative communication methods (ACM), which in his case, alternative communication picture (ACP) is used (Figure 2) to aid with the court hearing. With serial assessments and appropriate training, the patient was finally able to communicate via ACP, and to stand trial without being deprived of having his say.

Discussion

Aphasia is a communication disorder consisting of a combination of speech and language disorders as a result of brain pathology particularly at the perisylvian region of the left cerebral hemisphere that is responsible for symbolic communication. [2]. Transcortical aphasia (TA) is less common as compared to Broca’s or Wernicke’s aphasia. TA is a type of aphasia with the relative preservation of repetitive speech. TA can be further classified into transcortical motor aphasia, transcortical sensory aphasia and transcortical mixed aphasia (TMA) depending on the site of damage [2]. As in this case, the patient was only capable of repeating “I don’t know” in response to all sorts of questions directed to him after sustaining the brain injury.

The impairment in language comprehension and expression in a person with aphasia has a direct effect on the determination of decision-making capacity [3]. It is a tricky situation in the legal perspective and for the forensic psychiatrist when faced with a patient with difficulties in communicating, particularly in aphasia. This type of offenders might not be able to instruct and/or communicate effectively with their counsel and might be unable to understand the nature of the proceedings. As referring to this particular case, the patient had limited capability to communicate which posed a threat to his fitness to plead. While retaining a healthy degree of clinical suspicion for possibility of malingering in the forensic population when primary gain of diminished criminal responsibility or acquittal is at stake, to ensure justice to the accused, comprehensive investigations to ruled out possible organic causes are necessary. It is important to emphasize that if an accused is unfit to plead, it does not necessarily mean that he/she is innocent or otherwise. There is also a possibility of further detention under s.344 of the Criminal Procedure Code [4].

When encountering such cases as illustrated above, one of our main roles is to bridge the gap between the disability and the potential capability of the accused to stand for court trial, by means of providing relevant assistance such as integrating ACM. This is with the knowledge that people with aphasia of acquired disorders relatively recently have the potential to improve with the relevant assistance and therapy [5]. In this case, SLT plays the role as assessor and therapist who provide assistance and rehabilitation to transcribe incomprehensible thoughts to comprehensible thoughts for the court to understand, hence assisting the court trial. Development of ACP is on case by case basis depending on serial assessments. Pertaining to this case, SLT

found that this patient responded more than 80% accuracy when the maximum of three pictures with 7cmx7cm shown on the same paper (Figure 2). Moreover, the picture utilized should be real life photos instead of symbol illustrations. Besides, patient also able to respond correctly on true and false question by pointing finger to the picture of 'tick' or 'cross'. To the authors' best knowledge, there were no previous empirical research or case reports that investigates issues directly related to fitness to plead and aphasia particularly in a forensic psychiatric setting.

Conclusion

In summary, the presence of aphasia remains a challenge to the assessment and its validity of fitness for the accused to plead. We do not want to overstate and assume the patient's understanding or opinion in decision-making pertaining to the charges. It is pertinent for forensic psychiatrists to involve relevant multidisciplinary teams to assess the accused capacity to plead and consider how the capacity can be improved. Everyone has the right to plead despite of his or her disabilities.

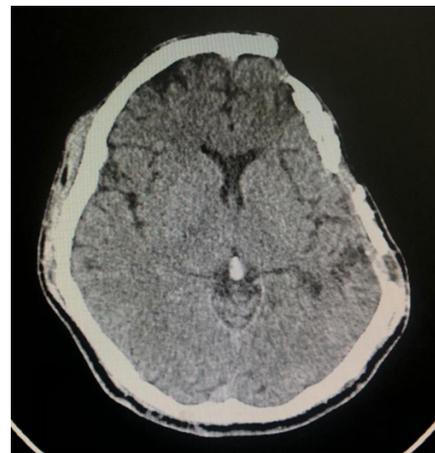


Figure 1. CECT Brain showed left fronto-temporal-parietal craniectomy and marked reduced volume of the left fronto-temporal-parietal lobe.

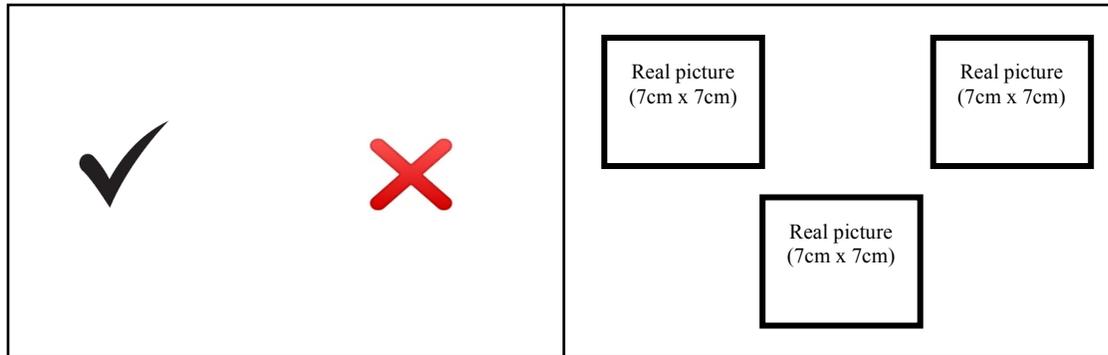


Figure 2a. Arrangement of Alternative Communication Pictures (ACP) that specially designed to suit this patient for true false questions

Figure 2b. Arrangement of Alternative Communication Pictures (ACP) that specially designed to suit this patient for multiple choice

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Declaration

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