**REPUBLIC OF SOUTH AFRICA**

**IN THE HIGH COURT OF SOUTH AFRICA**
**GAUTENG DIVISION, PRETORIA**

**CASE NO: I001/21**

(1) REPORTABLE: YES / NO
(2) OF INTEREST TO OTHER JUDGES: YES/NO
(3) REVISED.

10 JULY 2024
DATE SIGNATURE

In the matter between:

**THE LIFE ESIDIMENI INQUEST**

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**J U D G M E N T**

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**TEFFO, J :**

INTRODUCTION

[1] Following the termination of the Service Level Agreement ("*SLA*") between the Gauteng Department of Health ("*GDOH*") and Life Esidimeni Care Centre ("*LE*"), the mental health care users ("*MHCUs*") were moved out of LE, where they stayed for many years, to various non-governmental organisations ("*NGOs*"), homes and hospitals. Shortly thereafter they started to die.

[2] Professor Makgoba ("*the Health Ombud*") was requested to investigate the circumstances that led to the deaths of the MHCUs. His report paved the way for the referral of the dispute between the families of the deceased MHCUs, the survivors and those who were affected, and the GDOH to arbitration before the former Deputy Chief Justice ("*DCJ*"), Dikgang Moseneke. In the arbitration the State conceded liability and the arbitrator had to determine the issue of quantum to compensate the claimants for the damages suffered.

[3] Subsequently the dockets of 141 deceased MHCUs were sent to the National Director of Public Prosecutions ("*NDPP*") in Pretoria for a decision. After investigation, the NDPP declined to prosecute. A recommendation was made to the Minister of Justice and Correctional Services for the holding of a formal inquest into the deaths of the MHCUs of LE. The Minister in turn requested the Judge President of this Division to designate a judge to preside over the joint inquest.

BACKGROUND

[4] LE had a contract with the GDOH to provide care facilities for the care, treatment and rehabilitation of the MHCUs. The contract started as far back as 1970. LE made available 2 260 beds for chronic MHCUs at its five facilities (Witpoort, Randfontein, Rand West, Waverley and Baneng) across Gauteng where it provided step down facilities for adult and juvenile MHCUs.

[5] In 2014 subsequent to the announcement by the former Minister of Health, Dr Aaron Motsoaledi, of the National Mental Health Policy Framework and Strategic Plan ("*NMHPF*") 2013-2020, the GDOH took a decision to reduce the number of beds in the five facilities of LE.

[6] The initial plan ("*the Gauteng Mental Health Strategy 2020*") proposed was intended to reduce the number of beds by 200 per year, to which LE agreed, as well as to complete the project by 2020 at which point LE would have discharged 1 400 MHCUs. Efforts to reach the proposed target were made. After several meetings between the GDOH and LE, as well as an investigation into LE's compliance with the SLA and the cost implications by the Health Advance Institute ("*HAI*"), in February 2015 Ms Mahlangu, the former Member of the Executive Council for Health ("*MEC*"), informed LE that she had decided to terminate the SLA between the GDOH and LE at the end of March 2016 due to the GDOH's budgetary constraints.

[7] The notice of termination of the contract dated 29 September 2015 and signed by Dr Selebano reached LE on 5 October 2015. The reasons advanced for the termination of the contract were that the GDOH had wanted to comply and align the mental health care with the World Health Organisation ("*WHO*") recommendations of integrating every MHCU into the community, the desire to move the patients closer to their communities, and to save costs as the GDOH could not afford to pay for the services rendered by LE.

[8] During the period, April 2015 to January 2017, Ms Qedani Mahlangu was the MEC for Health in Gauteng Provincial Government. Dr Barney Selebano was Head of Department while Dr Makgabo Manamela was Director of Mental Health Services.

[9] Subsequent to the termination of the LE contract, Dr Selebano and thereafter Dr Manamela started arranging meetings with various LE facilities to discuss the movement of MHCUs out of LE. Existing NGOs (those who already

had SLAs with the GDOH), and the prospective ones, were approached and requested to expand their service offering and increase their capacities in order to receive MHCUs from LE.

[10] Prospective NGOs were encouraged to consider opening new facilities. At the time of the meetings, some of these NGOs did not have any infrastructure to perform the care of the MHCUs. Promises were made to those who did not have any facilities to use state-owned facilities. Plans to renovate abandoned nurses' homes at Kalafong hospital could not proceed as the premises were regarded as not fit for human occupation. Eventually, Precious Angels owned by Ms Ethel Ncube obtained two houses, one in Atteridgeville and the other one in Danville, Pretoria West, to accommodate the MHCUs. Anchor house owned by Ms Dorothy Franks occupied certain wards at the Cullinan Care and Rehabilitation Centre ("*CCRC*"). Another NGO, called Love Disciples International ("*LDI*") which was supposed to also operate from certain wards at CCRC, withdrew from the project. This NGO was replaced by Siyabadinga and it operated from the wards at CCRC premises.

[11] There was no proper assessment of the NGOs to determine their readiness to receive the MHCUs. New NGOs were not trained to care for the MHCUs. No proper audits were done before the MHCUs were placed at NGOs. No authorised processes were followed in the appointment of NGOs they were struggling financially. They ran out of funds as they were only paid three to four months after receiving the MHCUs. As a result of the delay in paying the NGOs, their staff members resigned. Therefore, there was not enough staff members at some NGOs to care for the MHCUs. At the start of the project, there were

certain NGOs which were not yet in existence. NGOs to which MHCUs were transferred did not have SLAs at the time of placement. Licences for NGOs were issued without audits and inspections. Previous Angels, Anchor and Tshepong availed themselves to take in children and not adult MHCUs. However, they received adult MHCUs. The project hastened subsequently and nicknamed the "*Marathon Project*". At Anchor male and female MHCUs were mixed in one ward. Most of the MHCUs were not correctly placed with the different NGOs. They had to be sent to hospitals for a few days for proper assessments.

[12] Some of the NGOs earmarked to receive the MHCUs from LE were able to properly care for them while others had little or no experience, and were virtually ill-equipped to care for them. In addition to the NGOs, the GDOH officials contemplated utilising existing acute mental health care institutions, viz, Weskoppies and Sterkfontein hospitals to receive MHCUs discharged from LE facilities.

[13] The officials of the GDOH went ahead with the plans to terminate the LE contract and discharged or transferred the MHCUs to other facilities against the warnings and advice by noteworthy, knowledgeable and experienced role players in the field of mental health. Discussions between the South African Depression and Anxiety Group ("SADAG") and the officials of the GDOH did not yield any results. SADAG then brought an application to have a curator appointed for the MHCUs. The GDOH opposed the application. However, the matter was settled before it went to trial on the basis that SADAG would be consulted before further discharges from LE took place. Despite the settlement

agreement, the GDOH officials proceeded with the transfers of the MHCUs from LE without consultations with SADAG.

[14] The period for the termination of the LE contract was extended to 30 June 2016. The GDOH placed their officials at the various facilities of LE to assist with the selection of the MHCUs and placing them at the identified hospitals and the NGOs. Dr Sophie Lenkwane and Ms Nonceba Sennelo were placed at Waverley Care Centre and Ms Salome Mashile and Ms Frieda Sennelo at the West Rand Complex. Some MHCUs who were at CCRC for years were moved to the various NGOs in order to make way for MHCUs from LE. Some MHCUs who left LE on the understanding that they were going to CCRC ended up with NGOs. A lot of MHCUs were placed in NGOs that did not have the capacity to accommodate them.

[15] Other MHCUs were discharged and went home to be cared for by their families despite their objections that they would not able to care for them. In the end 141 MHCUs died between the end of April 2016 and January 2017. Many MHCUs died in the care of new NGOs within Tshwane District. 7 MHCUs died after having been transferred to Anchor; 18 to Precious Angels; 15 to Tshepong; 6 to Siyabadinga; 3 to Bophelong Suurman; 3 to Shammah; 2 to Rebafenyi and 2 to Ubuhle Be Nkosi. Furthermore, 21 MHCUs died after their transfer to CCRC, 27 to Mosego home; 15 to Takalani; 1 to Bophelong Mamelodi; 2 to Baneng Care Centre; 1 to Randfontein LE; 1 to Waverley LE; 1 to an unknown facility and 1 was sent home.

[16] Most of the deceased were buried or their bodies were disposed without any further investigation as their causes of death were endorsed on the death

certificates as natural causes. Even in most instances where post- mortem examinations were conducted, the causes of death were endorsed as natural causes because the circumstances of the "*Marathon Project*" were not known to the pathologists. Potential medical evidence could therefore not be obtained. However, medical opinions on the strength of the available medical reports had been obtained where possible.

ADMISSIBILITY OF THE ARBITRATION RECORD

[17] The inquest began on 19 July 2021. Most of the witnesses who among them some persons of interest in the inquest, had still not yet obtained legal representation despite being requested to do so in the notice for the commencement of the hearing and several meetings held prior to the hearing.

[18] At the commencement of the inquest, the evidence leaders presented a copy of the record of the arbitration proceedings in terms of section 235(1) of the Criminal Procedure Act[1] ("*the CPA*") as *prima facie* evidence to prove that any matter purporting to be recorded thereon was correctly recorded. This piece of evidence was formally admitted and became part of the evidence as there was no objection to its admissibility at the time.

[19] On 16 February 2022, long after he had joined the proceedings, Mr Pienaar SC, acting on behalf of Ms Hanna Jacobus raised an objection to the admissibility of the record of the arbitration proceedings as evidence in the inquest. The basis for the objection was that the admission of the evidence in the inquest proceedings in terms of section 235(1) of the CPA was improper in

[1] Act 51 of 1977

that inquest proceedings are not criminal proceedings. The requirements for the admission of evidence in terms of section 235(1) of the CPA were not met, and therefore such evidence is inadmissible. Reliance in this regard was placed on the decision in *Wessels and Others v Additional Magistrate, Johannesburg and Others*[2].

[20] Mr Phihlela acting on behalf of several NGOs on instructions from Legal Aid South Africa, also objected to the admission of the arbitration record as evidence in this inquest. He argued that it was not clear whether the witnesses who gave evidence in the arbitration were warned of their right to remain silent and advised that the evidence they gave, maybe used against them in subsequent proceedings. He claimed that the admission thereof would be unfair to the witnesses as it might potentially amount to an ambush. Furthermore, he submitted that it added no discernible value to the inquest proceedings and had the potential to taint the inquest proceedings.

[21] In response to the above submissions, the evidence leaders argued that sections 8 and 13 of the Inquests Act[3] remained dispositive. They submitted that in respect of the admissibility or production of a document, section 8 of the Inquests Act provides that the laws governing criminal trials shall *mutatis mutandis* apply in an inquest. This therefore makes section 235 of the CPA applicable pertaining to the presentation of evidence. Section 235 of the CPA does not make the inquest proceedings criminal proceedings. The arbitration record constitutes judicial proceedings in that it is an official document.

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[2] 1983 (1) SA 530 (T)
[3] Act 58 of 1959

[22] They further argued that section 13 of the Inquests Act grants the judicial officer holding the inquest a discretion to allow any documents into evidence and urged the court to consider the interests of justice when exercising its discretion to admit the arbitration record as it provides an important picture of what happened during the period when the MHCUs were moved out of LE facilities to the respective NGOs and/or their homes and/or hospitals.

[23] The evidence leaders further submitted that the *Wessels* judgment[4] was not applicable in the matter *in casu*.

[24] Submissions were also made on behalf of section 27. These submissions are largely in agreement with the submissions made by the evidence leaders. Counsel for section 27 further asserted that the Inquests Act requires the court, in the interests of justice, to exercise its discretion in relation to the admissibility of the declarations and interrogatories – which form the basis of the arbitration record. It was contended that the presiding officer is given a wide ambit in relation to the procedure to be followed, as well as the production of documents.

[25] Section 235 of the CPA provides:

> "***Proof of judicial proceedings**. – (1) It shall, at criminal proceedings, be sufficient to prove the original record of judicial proceedings if a copy of such a record, certified or purporting to be certified by the registrar or clerk of the court or other officer having the custody of the record of such judicial proceedings or by the deputy of such registrar, clerk or the other officer or in case where judicial proceedings are taken down in shorthand*

[4] *supra*

*or by mechanical means, by the person who transcribed such proceedings, as a true copy of such record, is produced in evidence at such criminal proceedings, and such copy shall be prima facie proof that any matter purporting to be recorded thereon was correctly recorded.*"

[26] Section 8 of the Inquests Act reads as follows:

"***Witnesses and evidence at inquests**. –*

*(1) The judicial officer who is to hold or holds an inquest may, on his own accord or at the request of any person who has a substantial and peculiar interest in the issue of an inquest, cause to be subpoenaed any person to give evidence or to produce any document or thing at the inquest: Provided that the said judicial officer shall, if so requested by the attorney-general within whose area of jurisdiction the inquest is to be held or is being held, cause persons or any particular person to be subpoenaed to give oral evidence in general or in respect of any particular matter at the inquest.*

*(2) The laws governing criminal trials shall mutatis mutandis apply to securing the attendance of witnesses at an inquest, their examination, the recording of evidence given by them, the payment of allowance to them <u>and the production of documents and things</u>.*"

[27] Section 13 of the Inquests Act provides:

"*13.* ***Admissibility of declarations and interrogatories*** *– (1) Upon production by any person, any document purporting to be a statement under oath or affirmation by any person in connection with any death or*

*alleged death in respect of which an inquest is held, or any certified copy thereof, shall at the discretion of the judicial officer holding the inquest be admissible proof of the facts stated therein: Provided that the said judicial officer may admit any statement which is not so admissible, or certified copy thereof, if that judicial officer, having regard to –*

*(a) the form and contents of the document in which any such statement is contained;*

*(b) the availability of the person who made any such statement;*

*(c) the probative value of any such statement;*

*(d) any prejudice to any person which the admission of any such statement might entail; and*

*(e) any other circumstance which should in the opinion of that judicial officer be taken into account;*

*is of the opinion that any such statement, or any certified copy thereof, should be admitted in the interests of justice.*

*(2) The judicial officer may in his discretion cause the person who made such statement to be subpoenaed to give oral evidence at the inquest or may cause written interrogatories to be submitted to him for reply, and such interrogatories and any reply thereto purporting to be a reply from such person shall likewise be admissible in evidence at the inquest …*"

[28] Mr Pienaar SC asserts that because inquest proceedings are not criminal proceedings and do not qualify as such[5], the admission of the arbitration record as evidence in the inquest proceedings in terms of section 235(1) of the CPA was improper. At the same time, he raises a procedural irregularity that failure to have the arbitration record certified in terms of section 235(1) of the CPA has resulted in the arbitration proceedings being tainted and can therefore, not be received and admitted as evidence in this inquest. Mr Pienaar SC relies primarily on the non-compliance with the procedure outlined in section 235(1) of the CPA for the admission of evidence as well as the *ratio* in Wessels.[6]

[29] The *ratio* in the Wessels judgment included the court's finding that an important distinction existed between an inquest and a criminal trial. The court further found that in terms of the Inquests Act, the laws governing criminal trials were imported into inquest proceedings for certain stated purposes which included the examination of witnesses. Mr Pienaar SC argues that when having regard to the *ratio* in Wessels the procedural laws governing criminal trials are imported to inquest proceedings for certain purposes only, and therefore that section 8(2) of the Inquests Act cannot be regarded as a blanket authorization to provide for all situations that may arise, (least of all when the peremptory provisions of section 235(1) of the CPA have not been complied with), the arbitration record must be rendered inadmissible because inquest proceedings

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[5] *Wessels and Others v Additional Magistrate, Johannesburg and Others supra*
[6] *Wessels and others v Additional Magistrate, Johannesburg and others supra.*

are not criminal proceedings[7]. I agree that from the language of section 235(1) of the CPA, the section is couched in peremptory terms.

[30] Section 27 and the evidence leaders however contend that arrangements can be made for the certificate of the officer having custody of the record to be handed in after the fact in compliance with section 235 (1). I could, however not find any case law that supports this submission and provides for retrospective certification. However, be that as it may, I am not convinced that the section completely bars retrospective certification of a record once it has been submitted into evidence. Further that a failure to certify the record is completely fatal, and that cannot be remedied after the fact.

[31] It is important to note that there is no express provision either in terms of section 235 or the judgment in *Wessels* that states that the stated purpose for which the laws governing criminal trials can be imported into inquest proceedings is limited to the examination of witnesses. Although the proceedings need to be criminal in order for section 235 to apply as submitted by Mr Pienaar SC, as was held in *Wessels*, certain criminal trial procedures can be imported to inquest proceedings for stated purposes. In *Timol v Magistrate, Johannesburg*[8] one of the stated purposes for importing laws governing criminal trials into inquest proceedings was to secure the recording of evidence given by the witnesses in terms of section 8(2) of the Inquests Act. It stands to reason that the list of 'stated purposes' is not exhaustive and there currently

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[7] Pienaar SC's submission in the reply that the SCA in *S v Thomas and Another* 1978(1) SA 329 (A) and *S v Swanepool* 1979(1) SA 478 (A) approved of the ratio in *Wessels* seem to be incorrect given that the judgment in *Wessels* was handed down after the judgments in both *Thomas* and *Swanepoel.*

[8] 1972 2 All SA 274 (T)

exists no recent case law limiting the list. Therefore, a consideration of each matter on a case by case basis would be necessary when determining whether a criminal trial process can be imported to an inquest.

[32] In addition, according to *Hiemstra's Criminal Procedure*, a record does not prove that the accused actually committed the act. It only proves the fact of the conviction and that the witnesses said what the record portrays. Whether the court made the correct finding will have to be decided afresh. This rationale can be applied to the inquest proceedings. Admission of the arbitration record will not be for the purpose of proving guilt and the determination of the finding of the arbitration will have no bearing in the inquest proceedings given that both processes are separate and distinct.

[33] The court in *S v Nomzaza and Another*[9] held that section 235 of the CPA only provides how the record of judicial proceedings can be proved, not what evidence is admissible. An understanding of the above judgment would be that section 235 of the CPA cannot therefore be relied upon to determine the admissibility of evidence. This would therefore mean that the objection to evidence on the grounds that it is inadmissibly admitted in terms of section 235 would be improper when regard is had to the *Nomzaza* judgment.

[34] Mr Pienaar SC also makes reference to section 13 of the Inquests Act in reply. However, a reading of this section still holds that the admission of evidence remains the discretion of the judicial officer holding the inquest when having regard to the probative value of the evidence as well as any potential prejudice. A certified copy is not the only means through which the evidence

[9] 1996 (2) SACR 14 (A) at 16f-g

may be rendered admissible. As such, Mr Pienaar's argument with regard to section 13 is illogical because the arbitration record meets the requirements for admission – at the discretion of the judicial officer holding the inquest –as set out in section 13. Even if the arbitration record, which consists of a number of witness statements, is deemed inadmissible, the admissibility thereof can be still be saved when regard is had to section 13 and the discretionary nature to admit such evidence in the interest of justice.

[35] In the end procedural law must be applied in a manner that serves the interests of justice[10]. This is much made clear by section 173 of the Constitution which gives the courts 'the inherent power to protect and regulate their own process, and develop the common law taking into account the interests of justice.' This would therefore mean that when considering procedural law and errors pertaining to procedural law, the interests of justice remain paramount and a court will for example have the inherent power and discretion to determine whether rigid compliance to procedure justifies rendering the arbitration record inadmissible and whether this approach would be in the interests of justice.

[36] I am in full agreement with the evidence leaders that applying section 235 of the CPA in this inquest will not make these proceedings criminal proceedings. Inquest proceedings are not criminal proceedings and were never intended to be. There can be no doubt that the arbitration record constitutes judicial proceedings given that it is an official document. The evidence leaders'

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[10] See *Chief Lesapo v North West Agricultural Bank and Another* 2000 (1) SA 409 (CC) where the Court emphasized justice's role as the compass guiding procedural law's application. See also *South African Broadcasting Corporation Ltd v National Director of Public Prosecutions and Others* 2007 (1) SA 523 (CC) at para 38-40

submission that section 235 of the CPA assists with the proof of the authenticity of the arbitration proceedings and that when the record was presented as evidence no objections were raised as to its authenticity and/or admissibility and/or the handing in thereof, thus making it properly handed in and placed before this Court, has merit.

[37] In relation to section 13 of the Inquest Act, the evidence leaders submitted correctly that the evidence that is contained in the arbitration record is evidence under oath which was tested under cross-examination. Most of the witnesses who testified in the arbitration have testified in the inquest. There can be no procedural prejudice as the witnesses who testified in the inquest were and could be cross-examined on the evidence presented at the arbitration.

[38] Relying on the decision in *Botha v Minister of Justice and Constitutional Development and Others*[11], Counsel for section 27 contended for the need to interpret the Inquests Act purposively and argued that a rigid interpretation of the Act would be at odds with the general purpose of the Inquests Act which is seeing that justice is ultimately done where death is caused by means other than natural causes[12].

[39] It was further submitted that failure to admit the arbitration record into evidence would mean that the parties would have to call witnesses to prove each one of the documents contained therein – resulting in a long and protracted process which will in turn create a huge cost to the State and the

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[11] *Botha v Minister of Justice and Constitutional Development and Others* 2014 (1) SACR 479 (NCK) para 26
[12] *Botha v Minister of Justice and Constitutional Development and Others* 2014 (1) SACR 479 (NCK) para 25

parties in the inquest which would not be in the interests of justice. They maintain that public interest and the interest of justice require that the evidence that was presented at the arbitration be admitted in the inquest.

[40] When conducting an inquest, every single piece of information and evidence is vital as each piece of information and evidence plays an important role in conducting a thorough investigation and uncovering the truth and circumstances surrounding unsolved death not due to natural causes. Allowing the arbitration record into evidence is consistent with the purpose and mandate of an inquest and plays an important role in furthering the objective of conducting an inquest.

[41] It would in turn be in the interest of justice and in line with the need for transparency, openness and the promotion of public confidence in the process for a holistic and comprehensive view of the matter to be presented to the court and one way of doing this would be through a consideration of the arbitration record. The underlying purpose of an inquest is to promote public confidence and satisfaction and to reassure the public that all deaths from unnatural causes will receive proper attention and investigation so that, where necessary, appropriate measures can be taken to prevent similar occurrences. As such attempting to derail any process that would help fulfil the mandate of an inquest is not only grossly irregular, it is at odds with the interest of justice.

[42] Another issue that was raised concerns the applicability of the *Wessels* decision[13] to the matter *in casu*. The main point of contention in this matter was whether the applicants, against whom allegations were made that they caused

[13] *Wessels and Others v Additional Magistrate Johannesburg and Others, supra*

the death of the suspect while he was in custody, could refuse to testify at an inquest held to investigate and determine the circumstances under which the suspect died in police custody. The applicants, who were members of the South African Police Force, argued that inquest proceedings were analogous to criminal trials, and as such they were entitled to all the privileges enjoyed by accused persons at such trials. It is clear that this matter does not provide any clarity whether evidence heard in arbitration proceedings is admissible in an inquest. It therefore finds no application in the present matter.

[43] I have also considered the submissions made by Mr Phihlela which I find to be tenuous. It is important to take into consideration that the evidence led in the arbitration, should it be admitted, does not bind the inquest court. There is therefore, no reason why it would be prejudicial to the witnesses and/or taint the court's mind. Moreover, a consideration of the arbitration record is for the sole purpose of furthering the objective of the inquest proceedings and not so much to ambush the witnesses and use the testimony they gave in the arbitration proceedings against them in the inquest.

[44] Mr Phihlela's submissions seem to infer that the inquest will be treated like a criminal trial which, as already discussed, is not correct. In an inquest there is no accused person. There is therefore no likelihood of an ambush to a witness. Even if there is a suspected person, she/he may be absent and not be represented, and such a person will not be prejudiced, as the case may be in a criminal trial, by his silence[14]. What these submissions seem to skirt over

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[14] *Timol and Another v Magistrate Johannesburg and Another* 1972 (2) SA 281 (T) at 291H-292B

is that the ultimate purpose of an inquest is not to ambush, prosecute and convict but to investigate and uncover the truth and as such, every single document, statement and witness is therefore necessary to achieve this objective.

[45] Having regard to the submissions made and upon consideration of the provisions of section 13 of the Inquests Act, I am in full agreement with the evidence leaders and counsel for section 27 that the arbitration record is admissible as evidence in the inquest even without the application of section 235 of the CPA. The evidence that is contained in the arbitration record is evidence under oath which was tested under cross examination. Most of the witnesses who testified in the arbitration have testified in the inquest and were cross-examined on that evidence. There was therefore, no procedural prejudice in that regard. Having said that, and considering the fact that it is the evidence that was presented at the arbitration that paved the way for the holding of this inquest, that evidence will assist this inquest court with important information and an overview of the matter. I am therefore persuaded under the circumstances that the arbitration record is properly before court and forms part of these proceedings.

SUMMARY OF EVIDENCE

Cassandra Chambers

[46] She is the operations manager of SADAG, an organisation that provides counselling and care for people who are depressed, suicidal, anxious, have panic attacks and have been through trauma. It also offers telephonic

counselling to people with mental issues and refers them to clinics, hospitals and psychiatrists.

[47] After the GDOH had made a public announcement on 10 October 2015 about the termination of the SLA with LE, SADAG received various calls and emails from concerned family members of the MHCUs regarding what would happen to their loved ones at the different LE facilities as they could not take care of them. She unsuccessfully tried to obtain information from Dr Manamela. Following a Radio 702 interview with Ms Qedani Mahlangu, Dr Manamela met with officials of SADAG and family members. They raised concerns regarding the transfer of MHCUs from LE facilities. Dr Manamela assured them that MHCUs would receive good care at the NGOs. There was no clear plan or project time-line as to when the MHCUs would be moved. NGOs were not identified and licensed. There were no figures of the total number of MHCUs that were to be moved. Most of the registered NGOs in Gauteng were full to capacity.

[48] NGOs provided stepdown facilities. They could not provide care to many MHCUs who needed specialised care and lifelong chronic treatment.

[49] No proper assessment and identification of the MHCUs and NGOs were done by the GDOH. This, together with the overhastiness of the project resulted in SADAG, section 27 and SASOP (the South African Society of Psychiatrists) writing a letter to the GDOH which was discussed at a subsequent meeting between the parties. Eventually, the parties came to an agreement that the GDOH would not place the MHCUs in NGOs without a

proper plan in place and SADAG agreed to work in consultation with the GDOH on the project plan.

[50] After the transfer of 55 MHCUs to Takalani, SADAG launched an application to obtain curatorship for the MHCUs. The application was not successful. Thereafter, SADAG did not have further communication with the GDOH as their relationship had broken down irretrievably. Subsequently, news broke out that patients were being moved to NGOs around Gauteng. Family members had not been notified of when and where the patients were being moved to.

[51] SADAG endeavoured to assist the families to locate their loved ones and facilitate meetings with NGOs. They could not as they were prohibited to visit NGOs and the NGOs were not permitted to speak to them. Although the GDOH was warned that their actions might have serious health consequences for the MHCUs, SADAG did not foresee the eventual result.

[52] SADAG received reports from family members about the conditions at the NGOs but Ms Chambers could not assist the court with specific cases which form the subject matter of the inquest. SADAG also received reports about shortages of food and clothes at the NGOs and assisted them by donating food, clothes and blankets.

Dr Basuku Morgan Mkhatshwa

[53] He was the Managing Director of LE at the time the GDOH took a decision to terminate the SLA with LE. Most of his evidence has been covered in the background. It would not be ideal to repeat it. After Ms Qedani Mahlangu had

informed LE at a meeting in February 2015 that she had decided to terminate the SLA with LE by the end of March 2016, she refused to enter into any further discussions. She referred to the manner in which Brazilians dealt with the MHCUs and the fact that her family cared for a mentally-ill patient all by itself.

[54] LE voiced their concerns regarding the ability of NGOs to clinically assess the MHCUs, to provide medical and psychiatric care, be cared for by specialised nursing and rehabilitation personnel and receive other professional support.

[55] The time-frame proposed by the GDOH to transfer the MHCUs was not sufficient. The patients were placed in the custody and under the care of LE following assessment and referral by a team which included psychiatrists. They were assessed as in need of institutionalisation. The patients were referred to LE via institutions such as Sterkfontein and Weskoppies. The program at LE was to treat, care for and rehabilitate the MHCUs so that they could be discharged and placed into the care of their families, communities or NGOs. In order to ensure a safe discharge, LE had a programme to grant the MHCUs short leave of absence (LOA) during weekends to assess whether they could cope and adjust to living with their families. Once they were satisfied that the patients were accepted into their communities and were well-adjusted, they would discharge them.

[56] Their experience was that some patients did not have the necessary support system resulting in patients defaulting on the treatment. They would then relapse and be admitted to the state hospitals for diagnosis, admission

and referred to institutions such as Weskoppies and Sterkfontein. They would again be referred to LE.

[57] Some patients were not capable of discharge back to their communities. Various factors played a role which included the nature of the circumstances where they came from or specific events that led to their admission. Their families felt that they would rather have them institutionalised as opposed to them suffering the same hardships that led to their institutionalisation.

[58] LE was concerned about the conditions at the NGOs and whether the facilities and the staff were adequate. It offered to assist by assessing and vetting the NGOs. However, the offer was turned down.

[59] Several meetings were held between LE and the GDOH officials which included the one held on 26 April 2016 where amongst the issues discussed were the termination of the LE SLA and the MHCUs' decanting plan. A day thereafter the witness received a transfer and decanting plan in terms of which all MHCUs would have been transferred within a period of 7 (seven) weeks and that by 17 June 2016, the project would have been completed. This time-frame was set after the period of termination of the contract with LE was extended to 30 June 2016. The proposed project plan was contrary to the Mental Health Care Act[15] as well as the SLA which stipulated the manner in which the MHCUs were to be discharged.

[60] On 30 June 2016, 133 MHCUs who were mostly nursed at sick bays and completely dependent on activities for daily living, and who needed

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[15] Mental Health Care Act 17 of 2002

placement in hospitals, required transfer. LE was informed that the MHCUs were destined for CCRC. There were no beds at CCRC and the MHCUs were eventually transferred to Precious Angels.

[61] The challenges they faced during the transfer process were that some MHCUs would be selected for transfer to a specific NGO. On the day of transfer or a day preceding the transfer, the NGO where the MHCUs were supposed to be transferred to, would inform them that they could not accommodate those MHCUs selected and required other MHCUs. This resulted in the urgent need to prepare the other MHCUs and also prepare their documentation, and file their prescriptions. Some NGOs would make arrangements to collect the MHCUs on a specific date but fail to turn up. Some NGOs would arrive in transportation that were not suitable for MHCUs.

[62] LE ensured that MHCUs were transferred with a photograph identifying them, a record of their mental and health condition, medication for the treatment of their mental and physical health conditions. Where a MHCU was to be placed in a state hospital, 7 days' supply of medication was provided and where the MHCU was to go to an NGO he/she was provided with 28 days' supply of medication. The MHCUs were also provided with a prescription permitting them to obtain a supply of medication for the next 28 days and their personal effects and clothing.

[63] The GDOH agreed that the MHCUs could be transferred with discharge summaries. LE was not involved in the assessment of the NGOs. When it requested the list of prospective NGOs, the GDOH refused to provide it. LE

was not informed in advance where the MHCUs would be transferred. The transfers to NGOs were not carefully planned.

[64] He warned the GDOH of the potential calamity that the process of moving MHCUs out LE would result in.

[65] He denied that LE withheld medical records of MHCUs because it was not paid by the GDOH. He testified that because of the time-frames that had been given to LE to make full records of the MHCUs to be transferred available, it was not impossible. However, the MHCUs left with discharge summaries which summarised their status and condition at the time. The GDOH was informed that if they wanted copies of the full medical records, they could come to LE facilities and make them.

<u>Zanele Buthelezi</u>

[66] She was the Nursing Manager at LE Waverley during the Marathon Project. She first learned of the termination of the LE SLA during the strategic planning sessions with the GDOH and that the termination would take place in phases, effecting a reduction in beds by 20% per annum.

[67] She later heard through LE Head Office of the immediate termination of the SLA. LE Waverley informed the family members about the situation during the first week of December 2015. Some of them visited the NGOs and were not in favour of the move to transfer their loved ones to the NGOs. The witness confirmed Ms Mahlangu’s visit to LE Waverley in January 2016.

[68] LE requested a list of NGOs earmarked to receive the MHCUs and their admission criterion but that was never provided with same. The normal

procedure for transferring the MHCUs that included a proper assessment by the Multi-Disciplinary Team ("*MDT*") was initially followed, but as the pace of the discharges increased, it was abandoned and the criteria used by Dr Lenkwane and Ms Sennelo to identify the MHCUs for specific facilities was random. The number of planned transfers also changed as NGOs arrived to fetch MHCUs.

[69] Dr Lenkwane and Ms Sennelo complained that the process was hurriedly arranged and some NGOs were not ready to receive MHCUs. Furthermore, they were working under the instruction of Dr Manamela and everyone was afraid of the former MEC, Ms Mahlangu.

[70] There was no space for the last 38 MHCUs to leave LE Waverley in any of the NGOs. They could also not be placed in the designated hospitals. They had to be transported to LE Randfontein. All the MHCUs were well-kempt before their transfer.

[71] Before the Marathon Project the MHCUs would be assessed by the MDT who would satisfy themselves that the MHCUs were suitable for discharge and transfer. They would visit the family and/or NGO earmarked to receive the MHCU and communicate with them, thus preparing the MHCU for transfer. The MHCU would then be sent on LOA, initially for seven days, then fourteen days and thereafter a month. Once it was established that the MHCU was adjusting to the new environment without relapsing, the MHCU would be discharged and be transferred. The Marathon Project deviated from the transfer process they have been following for many years. It did not follow the process set out in the SLA.

Lebethe Reuben Richard Lebethe

[72] He is a medical doctor and during the termination project he was the Acting DDG: Clinical Services, and was responsible for forensic pathology services (FPS). He was part of the meeting where the project team for the termination of the LE SLA was formed with Mr Mosenogi as the project leader. He was part of the team on *ad hoc* basis. Due to his other responsibilities in the department, he could only perform any duties on a part-time basis. He was therefore unable to keep up to date with the project.

[73] He attended two meetings, one at LE Randfontein with Mr Mosenogi and Dr Selebano and the other one at LE Waverley in Germiston chaired by Ms Mahlangu. In both meetings the family members of the MHCUs were informed of the termination of the LE SLA and they were not happy. He also, without going into detail, referred to report back meetings, meetings with psychiatrists where their general attitude was that the discharge of the MHCUs should be done systematically.

[74] MHCUs were moved from LE to Takalani after an agreement with SADAG that such a movement would only take place with a proper plan acceded to by SADAG. SADAG and other groups brought a court application to stop the move. Dr Selebano was not available to make the opposing affidavit. The opposing affidavit was prepared in his name although the information contained in it was supplied by Dr Manamela. He was requested to sign the affidavit as he was the acting HOD at the time in the absence of Dr Selebano.

[75] He was not involved in the movement of the MHCUs. He only became involved when the MHCUs started to dye. He visited Previous Angels after the

deaths and found all the facilities there not suitable to house the MHCUs. The MHCUs at Previous Angels were eventually moved to Kalafong hospital and Sterkfontein. He also visited Takalani prior to the placement of the MHCUs and found the NGO suitable to house them.

[76] He also visited Rebafenyi in December 2016 after receiving messages that the NGO was planning to close down around 23 and 24 December. Tiitsetso Malebye, the Manager, indicated that the reason for the plan to close the NGO was the difficulties in receiving payment from the GDOH. Rebafenyi houses 1 and 2 did not have sufficient food and soap for the MHCUs. The care workers were also insufficient. Rebafenyi 3 was, however, well run although the 3 facilities operated under one licence. It was later decided to move the MHCUs to other facilities.

[77] He was also involved in convincing the families of the deceased MHCUs to assent to autopsies. Sizwe Hlatshwayo was a resident of Anchor House (Anchor) when he died. Dr Lebethe explained the importance of an autopsy to Sizwe's family and made the necessary arrangements to have it done.

Levy Molefi Mosenogi

[78] He was employed by the GDOH as the Chief Director for Policy, Planning and Research as well as for Monitoring and Planning. Around November 2015 during a meeting where the former MEC was reviewing the Quarterly Performance of the GDOH, he was requested to become the Project Leader of the team which consisted of, amongst others, Dr Manamela with the mandate to ensure the termination of the LE contract and the movement of MHCUs by 31 March 2016. When the project team was implementing the project plan,

they encountered challenges with the smooth transition of the MHCUs. This impacted the projected implementation period. He alerted Ms Mahlangu of the challenges.

[79] There was a shortage of beds at various NGOs or they could not obtain enough beds within the projected period and this affected the readiness of the NGOs to accommodate the MHCUs and the time to train them on handling and taking care of the MHCUs.

[80] He requested an extension of the contract for a further period of 6 to 12 months. He also requested or proposed to the department to procure two other LE facilities as an alternative to the termination project in case the NGOs were unable to care for the MHCUs. Eventually the project timelines were extended by a period of 3 months to 30 June 2016.

[81] He also testified about his visits to the different LE facilities prior to assuming his duties as a Project Leader and thereafter with the former MEC, the former HOD, some senior managers and some members of the project team, and the role he played in encouraging the family members of the deceased MHCUs to form a family committee to enable them to have regular interaction with the GDOH through the project team. He further described the legal battles between the GDOH, SADAG and others details which were not relevant to the issues before court save to indicate the dissatisfaction of SADAG, the families and others about the persistence by the GDOH to forge ahead with the Marathon Project.

[82] At the completion of the project, before he could compile a report to be presented, to amongst others, the former MEC, deaths occurred and Dr

Manamela prepared a summary report which was provided to the Health Ombud.

[83] He also referred to meetings he attended with the project team, the former MEC and Dr Selebano at the different LE facilities, Waverley on 29 January 2016 where the family members were notified about the termination of the LE contract, their unhappiness about the decision and the concerns raised which related to the challenges they would face if they were to receive the MHCUs at their homes. After his visit to Baneng, it was decided to exclude Baneng from the termination project for a period of one year.

Nonceba Cynthia Sennelo

[84] She is a psychiatric nurse and was employed by the GDOH in the Mental Health Directorate (MHD) as a Deputy Director. After the termination of the LE SLA several teams were established to assess the MHCUs at the various LE facilities as the departmental clinicians refused to do the assessments. Dr Manamela tasked her to go to LE Waverley and establish the number of MHCUs in their care.

[85] After reporting back to Dr Manamela, she together with Dr Lenkwane were tasked to fast track the discharge of MHCUs from LE Waverley. Dr Gail Ure of LE Waverley provided them with a list indicating the number of MHCUs, their medication, profiles and levels of functionality. The list was to be used as a guideline to indicate whether the MHCUs could be transferred to NGOs, hospitals or discharged into the care of their families.

[86] They also did their own assessments guided by the staff of LE. According to Dr Manamela's plan, MHCUs at LE Waverley had to be discharged by 31 May 2016 and LE Randfontein and Rand West by 30 June 2016. On 31 May 2016 the remaining 55 MHCUs at LE Waverley, were sent to Baneng and Randfontein.

[87] Dr Manamela provided them with a list of NGOs and hospitals which indicated the number of available beds for the placement of MHCUs. As this was mainly NGOs in the Tshwane District, she was concerned that the local clinics would not be able to absorb the strain of the NGOs. She voiced her concerns on several occasions. NGOs were supposed to be linked to local clinics to provide for the medical needs of the MHCUs.

[88] After the placements, she and Dr Lenkwane were tasked to go and do inspections at Precious Angels. They found the facility in Mosalo Street in Atteridgeville not suitable. 18 MHCUs were housed in a four roomed house with stairs. There was a shortage of food. Adult MHCUs used cot beds and there were no recreational facilities. She recommended the closure of the facility. However, instead of following her recommendation, Dr Manamela sent other officials to verify her findings.

[89] She also visited Rebafenyi which she felt should not have received the MHCUs.

[90] On 16 September 2016 after deaths were reported, Dr Manamela requested her, Ms Jacobs and Ms Rochelle Gordon to go and inspect the place at Tygervalley in Lynnwood, Pretoria, with the intention of relocating the MHCUs from Precious Angels facilities where most deaths occurred.

[91] She further explained that the project was frustrating as her concerns and opinions were ignored. The project was rushed and she described the conditions under which they worked for the duration of the project as stressful, tiring, and having an overwhelming sense of fear.

[92] She was deployed to LE Waverley from 11 to 31 May 2016. The time was not sufficient and the community was not prepared. The strategic plan provides that if you de-institutionalise, you will have to upscale the community service to ensure that the MHCUs go nearer to their homes and the clinics are ready to accommodate them and provide them with proper treatment.

Hanna Hendrika Jacobus

[93] She is a psychiatric nurse and was employed by the GDOH as a Deputy Director in the MHD. During 2013 she received a National Strategic Plan 2013-2020 and was tasked to compile a Gauteng Strategic Plan for the improvement of mental health care as well as de-institutionalisation of the MHCUs. The strategic plan was drafted and handed over to Dr Manamela. The plan was looking at downscaling the patients at LE by 200 beds and spaces per year.

[94] Around July-August 2013 Dr Manamela informed them that LE would probably be closing down. They asked her how that was possible because they did not have step-down facilities. At that time there was still a lot of work to be done. New NGOs were not to be opened for the following 3 years as they had to first upscale the existing ones. In another meeting Dr Manamela informed them that LE was definitely going to be closed. They indicated to her that the closure of LE was not part of the strategic plan.

[95] She explained the procedure for the formation and/or expansion of an NGO. A registered nurse must be employed when an NGO is registered and ready to receive patients. An NGO is issued a licence after signing a SLA with the department. She drew up licences on a computer, would meet with the district office personnel who would review the NGO file to ensure that everything was complete and correct. Once all the NGO information was verified with the district office, she would issue the licence to a specific NGO and it would then be handed over to the Director of Mental Health for review and sign off the licence. This procedure was not followed during the Marathon Project.

[96] She noticed that a lot of information that appeared on the licences was not the same as the information she and Mr Thobane provided to Dr Manamela. For example, the bed capacity on the licences issued to the NGOs would in some cases be different from the information provided to Dr Manamela. Dr Manamela called her on several occasions to adjust the licence capacity of the NGOs without following proper procedures.

[97] She confirmed that training was not provided to the new NGOs. She and Mr Thobane were tasked with visiting all the new NGOs and existing ones that wanted to expand.

[98] In December 2015 she was still trying to evaluate and identify hospital buildings and wards to accommodate the NGOs. She only visited NGOs in January 2016. At some stage she and Mr Thobane went to inspect Precious Angels premises again after it was reported that their bed capacity was different

from their initial review. They confirmed that Precious Angels moved facilities and the houses where it operated were not approved by the GDOH.

[99] Anchor house was allocated a ward at CCRC. On 23 June 2016 prior to the placement of patients, she had to go to CCRC after Ms Dorothy Franks complained to her telephonically that she did not have the capacity to care for the patients she had received from CCRC. They were received without any files and administrative documentation. When she questioned Ms Nyatlo, the CEO of CCRC about why she discharged the patients to Anchor, she said it was an instruction from Dr Manamela as they had to create space for LE patients. She could not provide patients' documents because that was hospital property. Ms Franks was supposed to receive children and not adult patients. At that time patients were moving around on wheelchairs and others were roaming. She asked Dr Manamela as to what was going on. Dr Manamela indicated that the placement was temporary and that the patients would later be relocated to suitable NGOs.

[100] On 29 June 2016, it was after 18:00 when she witnessed the arrival of a bus full of patients at Anchor house. She approached the bus driver after she could not get hold of the placing team, and informed him that those patients were not supposed to come to Anchor. The bus driver indicated that he brought the patients to Anchor on the instructions from Dr Manamela. When she spoke to Dr Manamela, she ordered her not to send the patients away. The patients were not taken out of the bus until Dr Manamela arrived. Upon her arrival in the company of Mr Thobane and Ms Ethel Ncube of Precious Angels, Dr

Manamela sent her to Pretoria West and Tshwane District hospitals to fetch linen.

[101] When she returned to CCRC she learned from Ms Franks of Anchor house that Dr Manamela and Ms Ncube took some patients from Anchor wards and the patients who were in the bus were placed at Anchor. The patients that were removed from Anchor to Precious Angels were sick and some of them were psychiatric cases. Anchor was best placed and capacitated in terms of professional staff sent by Ms More to support CCRC, Anchor and Siyabadinga to care for those patients. This led to the mixture of male and female patients at Anchor house.

[102] She also mentioned an incident where Dr Manamela moved patients from a ward belonging to Siyabadinga at CCRC without considering different opinions to making space available for Anchor to accommodate LE patients.

[103] She and Mr Thobane visited Rebafenyi House No 3 which they found unsuitable to house the MHCUs.

[104] Early 2016, as Deputy Directors in the MHD had a meeting with Dr Mazamisa who was the Chief Director of Hospital Services and Supervisor of Dr Manamela. They felt that the plan to meet the deadline was not feasible. There was no proper assessment of the NGOs for them to be ready to receive the patients. They raised concerns in the meeting relating to the short time frames and the way the project was hurriedly conceived. Dr Mazamisa requested Dr Manamela to escalate their concerns to senior management. They did not reive feedback and Dr Mazamisa later resigned from the department.

[105] Her evidence also covered the role she played after the placements where she was involved in the inter-transfer of patients from one NGO to another as she could determine that they were not correctly placed. This included her intervention to resolve the situation where some NGOs ran short of medication. She did not know about the existence of Siyabadinga until after the deaths of the MHCUs. She was also tasked to look after the patients that were moved to Weskoppies and Tshwane District hospitals after the closure of Precious Angels.

[106] Proper procedures were not followed prior to the placement of MHCUs at the NGOs. They could not audit the NGOs as Dr Manamela had indicated that there would be no time to do that. Dr Manamela did not want the district office to get involved although the auditing of NGOs was a district office function. She had to involve the district office as the coordinators were familiar with the NGOs in their areas. NGOs that availed themselves to care for children MHCUs were given adult MHCUs and when they enquired why that was done, Dr Manamela said the placement was temporary. It was clear that the intention was to get all LE facilities empty and deal with the problems later. After the placements she received numerous complaints from NGOs which included amongst others, the fact that they were allocated more patients than what was indicated to Dr Manamela by her and Mr Thobane. When she asked Dr Manamela about it, she said the placement process was almost done that would be sorted out later.

[107] Many of the critically ill patients ended up with NGOs. When she queried the relocation teams as to why these patients were not sent to hospitals, they

indicated that they engaged with several CEOs at the different hospitals who intimated to them that they did not have space to accommodate LE patients. She also had to fech patients from some NGOs and take them to hospital for medical attention. She fought with hospital CEOs and doctors for flooding them with ill MHCUs.

[108] NGO managers informed her that MHCUs were discharged with only a supply of 7 days' medication and due to the chaos and the extreme pace of the project, some of the NGO managers did not keep track of the medicine supply. They ran into medication problems. She and Ms Rochel Gordon had to hijack hospital pharmacies at night to assist with medication. They received assistance from Kalafong hospital during the day and mostly Weskoppies at night. The regional pharmacy could not supply the district as usual as it had to supply the NGOs with the required medication.

[109] When a MHCU is discharged from one facility to another, he/she had to be evaluated by a doctor to confirm the findings of a referral. Because of the time constraints that could not be met, the witness had to go to Kalafong hospital for assistance. The Chief Operating Officer at Kalafong hospital allocated one doctor and a district doctor to assist her. These doctors travelled to various NGOs to assess the LE MHCUs.

Dr Sophie Thelma Lenkwane

[110] She is a qualified psychiatric nurse specialist with a PhD in psychiatric nursing. She was previously employed as a Deputy Director MHD in the GDOH. She corroborated the evidence of Ms Nonceba Sennelo regarding the role she played during the Marathon Project which included amongst others,

her deployment to LE Waverley and the visit to Precious Angels after the placements. She confirmed the state in which they found the facility in Mosalo Street, Atteridgeville, the concerns they raised with Dr Manamela and her responses. In addition to that, she indicated that she assisted Ms Ethel Ncube to locate the family of Christopher Makhoba and assist with arrangements for his funeral.

Rochelle Catherine Gordon

[111] She is a professional nurse employed as a Mental Health Co-ordinator in Tshwane District. She was in control of all the NGOs that provide mental health services in Tshwane District. A complete list of her duties appear in her statement.

[112] She explained the procedure regarding the procurement process in respect of NGOs in Gauteng. Before the NGO could provide service to the GDOH, the GDOH places an advertisement in a newspaper and the NGO can submit an application to provide a service. The GDOH, upon receiving an application, will give the district office a mandate to visit the interested NGOs. The Provincial Office submits the application form to the District Office. The district officials will conduct a pre-audit and give guidelines to the NGOs. When the NGO is ready they will inform the District Office who will go to the NGO again to conduct an audit with the multi-disciplinary task team and the provincial stakeholder. The multi-disciplinary team (MDT) comprises the occupational therapist, environmental health officer, dietician, social worker, infection control officer, and a psychiatric nurse.

[113] The district makes a recommendation to the province. The final audit and adjudication is done with the legal team, the provincial team and the MDT. When the team is satisfied that the NGO meets all the requirements, it will submit a report to the Mental Health Directorate (MHD). Ms Hanna Jacobus will then issue a licence which is signed by the HOD, Dr Selebano. The licence is then sent to the district which issues it to the NGO.

[114] This procedure was not followed in respect of the new NGOs that received MHCUs from LE during the Marathon Project. Dr Manamela assured them that the mistakes would be rectified at a later stage and that she was pressured by Ms Mahlangu to finalise the project. None of the new NGOs she visited in the company of Ms Hanna Jacobus and Mr Frans Thobane were ready to receive the MHCUs. Most of the NGOs were new and did not have the experience of taking care of the MHCUs. These NGOs were not trained.

[115] The witness was at LE Waverley on 12 May 2016 when LE Waverley started discharging the MHCUs to different NGOs. Tshepong in Atteridgeville received 152 patients from LE Waverley on that day. On 28 May 2016 it received 33 more patients from LE Rand West. 35 patients were discharged from LE Waverley to Odirile in Hammanskraal on 19 May 2016. On 25 May 2016 it received 6 more patients. Two more patients were discharged from LE Waverley to Odirile. On 25 May 2016 El Shaddai in Centurion, received 8 patients from LE Waverley and 3 more from LE Waverley. On 27 May 2016 El Shaddai Care Centre received 8 more patients from Tshephong. The centre received highly functional patients.

[116] On 9 May 2016, 9 patients from LE Waverley were discharged to Bophelong Care Centre in Mamelodi. On 19 May 2016 the Centre received additional 5 patients from LE Waverley. All the 14 patients were female. On 26 May 2016, 58 patients from LE Waverley were transferred to Rebafenyi House 1 and another 55 went to Rebafenyi House 2 from Rand West. On 7 July 2016, 21 patients were discharged for placement at Rebafenyi House No.3 from Odirile and Ubuhle Be Nkosi Care Centres. Shammah House in Cullinan received 50 patients from LE Waverley on 24 May 2016.

[117] On 24 June 2016, 30 MHCUS from LE Rand West were discharged to Ubuhle Be Nkosi, and on the same day it received additional 10 MHCUs from Baneng Care Centre. On 30 June 2016 40 MHCUs were discharged from LE Rand West to be placed at Bophelong Care Centre in Hammanskraal. Sebo sa rona Care Centre in Soshanguve received 32 MHCUs from LE Rand West on 16 May 2016. On 23 May 2016, 30 patients from CCRC were transferred to Anchor House. Anchor received 40 more patients from LE Waverley on 29 June 2016.

[118] She and Mr Mohale had to assist Tshepong over weekends during the months of June, July and August 2016 when the NGO did not have money to pay its staff members who as a result did not report for duty.

[119] When the MHCUs were in the NGOs, clinics in the district struggled to cope with handling the influx of patients who were not budgeted for. The NGOs were told to go to the nearest clinics or hospitals for medical treatment. However, there was no budget for medication as no funds were allocated for that purpose. The project was poorly planned. Things were rushed and the

GDOH was not considerate towards the MHCUs. There was no formal communication with the hospital managers about the arrangement to accommodate the MHCUs from the NGOs. MHCUs had to wait for a long time before they received medical treatment.

[120] The audits at the different NGOs were conducted after the NGOs had received the patients.

Bertha Micky Molefe

[121] She is the mother of Sophia Molefe (one of the deceased MHCUs). Following the closure of LE Randfontein, the deceased was sent home even though she informed the personnel of LE that she was not able to care for her. She was given two weeks' medication and told to visit the nearest local clinic when the medication for her daughter was finished. They did not give her the script. She eventually obtained the script at LE and managed to get the medication. The deceased was aggressive and uncontrollable at home. She also refused to take her medication.

[122] The witness appeared on a television program called Checkpoint where she discussed her daughter's plight. Thereafter she was visited by the GDOH employees who promised to attend to her problem with caring for her daughter. The day thereafter, Dr Selebano visited her at her workplace and promised a suitable facility would be found for her daughter. Dr Manamela also visited her. She did not hear from them prior to the demise of her daughter.

[123] On 26 August 2016, she went shopping. She then received a call from her other daughter informing her that the deceased was drunk in the street. She

immediately went home where she treated her with an asthma inhaler and, when she went to the laundry basket where she kept the deceased's medication to fetch another inhaler, she realised that the deceased had consumed all her medication at once. She did not have a safer place where she could keep the medicine. The deceased was taken to Leratong hospital where she later died.

Dr Eric Dorina Onoya

[124] He is a medical doctor in private practice and was formerly employed by the Garankuwa Forensic Pathology Services at Sefako Makgatho hospital. On 31 August 2016, he performed an autopsy on the body of Virginia Macaphela and recorded his findings in the post-mortem report handed in as Exhibit L1. A histological examination was also performed and the findings were recorded in a report handed in as Exhibit L2. His opinion has been recorded in a document handed in as Exhibit L3. The witness's evidence in respect of Ms Virginia Macaphela will be discussed in the judgment.

Dr Shirley Stuart

[125] Her qualifications were placed on record. She is a forensic pathologist in the service of the GDOH. She was involved in the four autopsies of the deceased who form part of the inquest, namely, Phoebe Soudum, Sam Sam, Unknown adult male, and Aaron Ngqondwana.

[126] In respect of Phoebe Soudum, she was consulted as a senior with regard to the reporting of this autopsy done by Dr Shongwe. Dr Stuart compiled the histological report and confirmed the contents of the post-mortem report compiled by Dr Shongwe. The cause of death is indicated on the post-mortem

report as "*probable pulmonary causes including asthma with chronic bronchitis, correlation with medical history and any other contributory evidence is essential. Toxicology report is pending.*" The post-mortem report was handed in as Exhibit M1. The histology report was handed in as Exhibit M2 and the toxicology report was handed in as Exhibit M3.

[127] The chemicals that were found in the blood of the deceased are salicylic acid of a concentration of 10,1 microgram per millilitre, Fluconazole in a concentration of 1 milligram per millilitre and Valproic acid.

[128] Although Fluconazole was also detected at autopsy, on the autopsy findings that were made available to her, there was no clear indication of a fungal infection. She was unable to see a clear connection between these drugs and the cause of death. The histology findings are in keeping with the possibility of asthma and none of these drugs were used specifically for the treatment of asthma. There were also findings of defused alveoli: damage in the lungs, which are due to a number of causes, which have not been made clear on whether negligence or foul play caused the death of the deceased.

[129] With regard to Sam Sam, she compiled the post-mortem report after conducting a post-mortem examination on the deceased. The post-mortem report was handed in as Exhibit M4. She also prepared a histology report and an additional opinion which were handed in as exhibits M5 and M6 respectively.

[130] The cause of death of the deceased, Sam Sam was determined to be "*aspiration pneumonia against a background of blunt force head injury*". She opined that the blunt force head injury was not very recent. She was unable to

indicate how old the injury was. She explained that she received a history of a fall which is consistent with the injury as well as the cause of death.

[131] Her further evidence was that the finding of aspiration pneumonia against the background of a blunt force head injury means that the aspiration relates to a foreign material which could have been gastric content or any other foreign material in the lower airways which then causes inflammatory reaction to the lungs. The matter found was microscopically found to be a vegetable matter within the lung tissue. This can be explained when someone vomits and inhales the vomit. Blunt force head trauma raises the possibility of decreased consciousness, and possibly a decreased cough reflex. It raises the possibility of nausea and therefore a contributory factor to the death of the deceased. She concluded that regardless of the duration of the time between the injury and the death, she cannot rule out the contribution of the injury to the sequence of the events that led to death.

[132] Dr Stuart also performed a post-mortem examination on the body of an unknown male person and compiled a post-mortem report which was handed in as Exhibit M7. She also drafted an opinion in respect of this deceased which was handed in as Exhibit M8. The cause of death was determined as probable pneumonia against the background of emphysema. She explained that one of the most common causes of emphysema is chronic smoking. This, she described as a decreased elasticity of the alveolar sacks or the airbags. The elasticity of the lung is compromised, and the patient experiences difficulty in breathing as a result. She opined that the pathological findings point towards natural causes. She did not receive any medical records

from either LE and/or the NGO. The standard of care of the patient was not clear to her and she could not provide an opinion whether there was a possibility of malpractice or negligence.

[133] When asked whether she found any current bedsores and/or infection during the autopsy, she testified that there were signs of chronic illness and debilitation which she described in the post-mortem as follows:

> "*An 80x95 mm dimension pressure sore involving the superolateral region of the right buttock, with complete loss of skin in the centre of this region.*
>
> - *A 40x28 mm dimension pressure sore involving the lateral malleolus of the right ankle.*"

[134] In her opinion the first sore was a large wound which had the risk of infection and both sores were contributory factors. She conceded that no mention was made on the post-mortem report that there was systematic infection on the pressure sores that contributed to the death. However, she was adamant that pneumonia itself was a high risk and a consequence of systematic infection.

[135] Dr Stuart conducted a post-mortem examination on the body of Aaron Ngqondwana and compiled a post-mortem report which was handed in as Exhibit M9. The histology report in respect of the deceased was handed in as Exhibit M10. The doctor wrote an opinion which was handed in as Exhibit M11 nine months after her initial post-mortem report. That was after she was requested to comment on whether there could have been malpractice or

negligence that led to the death of the deceased. She was provided with a docket which contained large volumes of the nurses' notes. His evidence in relation to Mr Ngqondwana will be discussed later in the judgment.

Dr Musa Aubrey Makhoba

[136] He is a medical doctor specialising in forensic pathology. He was employed at the Forensic Pathology Services in Pretoria as a forensic pathologist. He conducted a post-mortem examination on the body of the deceased, Kenneth Sithole, referred to in some documents as Kenneth Soka, and recorded his findings in the post-mortem report handed in as Exhibit N1 where he concluded that the cause of death of the deceased was "*aspiration pneumonia and acute on chronic pyelonephritis (infection of the urinary track) complicated by sepsis*". The infection involved more than one system. It was found in the kidneys and lungs. His external examination indicated that the deceased may have been chronically ill before his demise.

[137] Dr Makhoba also provided an opinion on the cause of death of Kenneth Sithole and his opinion was handed in as Exhibit N2. In his opinion the doctor indicates the possibility of lack of care of the deceased at Anchor. Unfortunately, due to lack of relevant documentation, he could not give a definitive answer.

[138] He also conducted a post-mortem examination on the body of the deceased, Frans Dekker and noted his findings in the post-mortem report which was handed in as Exhibit N3. The doctor also provided an opinion on the cause of death of Mr Dekker which was handed in as Exhibit N4. The witness's evidence about Mr Dekker will be discussed later in the judgment.

[139] Dr Makhoba performed an autopsy on Daniel Charles Josiah and noted his findings in the post-mortem report handed in as Exhibit N5. I will discuss his evidence later in the judgement.

[140] He also performed an autopsy on Charity Ratsotso and noted his findings in the post-mortem report handed in as Exhibit N6. The cause of death of the deceased was recorded as having been in keeping with food aspiration complicated by necrotising pneumonia. The deceased had a seizure that pre-disposed him to food aspiration.

[141] Dr Makhoba supplemented the findings in the post-mortem report with three opinions which were handed in as Exhibits N7, N8 and N9 respectively. In a nutshell Exhibits N8 and N9 basically state that due to lack of information, he is not able to properly give an opinion on the case and the chronology of the events that led to the seizure and the resulting death.

[142] Dr Makhoba further conducted a post-mortem examination on the body of Timothy Nxumalo and noted his findings in the post-mortem report handed in as Exhibit N10. The cause of death of the deceased was noted to be burns complicated by cellulitis and acute bronchopneumonia. The doctor described the wounds he found on the body of the deceased which included burn wounds. These wounds showed features of a healing burn wound that was treated with a wound dressing and a covering crepe bandage.

[143] The witness also performed an autopsy on the body of Joseph Gumede. He noted his findings in a post-mortem report handed in as Exhibit N11. According to this report the deceased died of severe coronary artery disease complicated by myocardinal infarction. In his chief post-mortem findings, he

described the deceased as a diabetic case with extensive organ changes as a result of diabetes. Changes to the kidney can be ascribed to uncontrolled diabetes over a long period of time.

[144] The post-mortem report was supplemented by two opinions which were handed in as Exhibits N12 and N13. In the doctor's opinion clinical care of the deceased at Anchor had not been optimal and the facility lacked the necessary equipment to deal with the deceased's illness[16].

[145] Another post-mortem examination was done on the body of Lucky Maseko and the findings of Dr Makhoba were noted in the post-mortem report handed in as Exhibit N14.

[146] Dr Makhoba also provided an opinion which was handed in as Exhibit N15. When he drafted his opinion he made use of the hospital records where the deceased died.

Sandra Johanna Susanna de Villiers

[147] She is the sister to the deceased, Jaco Stoltz. Jaco was treated at CCRC for 18 years before he was moved to Siyabadinga to provide space for the MHCUs who were transferred from LE to CCRC. When Siyabadinga was closed down, he was moved back to CCRC on 19 July 2016.

[148] Prior to his transfer to an NGO, Jaco was in good health although he needed assistance in dressing himself and taking care of his bodily functions like bathing. He was mentally and intellectually disabled and had no underlying

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[16] Paragraphs 9 and 10 on page 3882 case lines

illnesses. He intellectually functioned at the level of a 9 years' old child. He did not like change. When he moved to unfamiliar surroundings, he became ill.

[149] On 4 June 2016 there was a donation drive at Siyabadinga organised by Helpende Hand and the families of the MHCUs. Hanna Jacobus came to Siyabadinga and ordered everyone who was there to vacate the premises. She visited Jaco on 19 June 2016 and observed that he was coughing and the air-conditioner in his room was set on a high temperature. He was hungry and thirsty.

[150] She visited Jaco on 26 July 2016 at CCRC just after he was moved back from Siyabadinga. He was dirty, smelled of urine, had a sore on his arm and a mark on his back. Photographs of Jaco were taken on that day.

[151] When she visited Jaco again on 28 August 2016, she noticed that he had a blue eye, probably a traumatic contusion. He was again hungry and thirsty.

[152] She visited Jaco again on 19 September 2016. He did not look good and was very unhappy. She took him to Dr Lombard who examined him and found him to be dehydrated with a high blood sugar level. Jaco had lost a lost of weight. Photographs of his condition were taken again on that day. After consultation she took Jaco back to CCRC.

[153] When she visited Jaco again on 24 September 2015, he was in a wheelchair and looked very ill. She asked the nurses at CCRC whether they had given Jaco medication prescribed by Dr Lombard. They informed her that

they were only allowed to give him medicines prescribed by the doctor at CCRC.

[154] On 26 September 2016 Jaco was taken to Mamelodi hospital where a drip was administered on him and he was sent back to CCRC. On 3 October 2016 the witness phoned CCRC to enquire about Jaco's health. At first they could not find him. She was thereafter informed that he was no longer on wheelchair and doing well. Later in the day she received a phone call from CCRC, she was informed that he was very sick and they were taking him to hospital. It was indicated to her that Jaco was vomiting although he was on medication.

[155] The personnel at CCRC could not find Jaco's file. They were on their way to take him back to CCRC when she intervened and Jaco was then admitted at Mamelodi hospital. He was kept in the surgical ward until he died on 14 October 2016.

[156] The witness's evidence at the arbitration is also on record. She also testified that Jaco was happy and healthy when he was at Siyabadinga.

<u>Dr Anton Deon Lombard</u>

[157] He is a medical practitioner with his practice in Rayton, Cullinan. He was previously a District Surgeon and he did some consultations at CCRC. Afterwards he was appointed as the CEO and became involved with the MHCUs who resided at CCRC on a daily basis. He got to know Jaco during his tenure at CCRC.

[158] He corroborated the evidence of Suzanna de Villiers that she took Jaco to him for consultation on 19 September 2016. He was shocked to see Jaco in the condition he was. Jaco had severe vomiting and dehydration. He also mentioned the marks on Jaco's body previously testified about. The overall condition indicated severe negligence in the care of Jaco. Most of the clinical indicators were normal except for an elevated blood glucose level and dehydration. The clinical notes for his consultation were handed in as Exhibit O3 and photographs taken during Jaco's consultation as Exhibit O2.

[159] He also corroborates the evidence of Ms De Villiers regarding the prescription he gave Jaco and the note he wrote addressed to the nursing manager of CCRC which was handed in as Exhibit O4.

[160] Dr Mabotja performed a post-mortem on the deceased's body and recorded his findings in a post-mortem report handed in as Exhibit O5. He also gave an opinion which was admitted into evidence as Exhibit O6.

[161] Dr Lombard's evidence regarding Dr Mabotja's findings in his post-mortem report and his opinion was that the findings indicated that the deceased was chronically ill and this weakened his immune system which contributed to pneumonia. As a result of insufficient nutrition, he was emaciated. He also had bedsores which resulted from poor care.

[162] Although the deceased was admitted at CCRC, Siyabadinga and Mamelodi hospital, the neglect happened at CCRC. He never had any conversation with the personnel at CCRC and had not received any feedback from them regarding the letter he had sent with Ms De Villiers. After consulting

with the deceased on 19 September 2016, he never heard from Ms De Villiers until after the death of Jaco.

[163] Dr Lombard further testified that vomiting is a symptom of peptic ulcer and that the dehydration could have resulted from continuous vomiting.

Dr Mosou Paul Morule

[164] He is a medical doctor with, *inter alia*, a diploma in forensic pathology. When he performed the autopsy on the body of Deborah Phetla, he was employed as a Forensic Medical Specialist at the Forensic Pathology Services in Diepsloot. He noted his findings in the post-mortem report handed in as Exhibit P1 and later provided an opinion which was also handed in as Exhibit P2.

[165] The cause of death was determined to be asphyxia due to aspiration of blood. This was due to an injury of the larynx. The larynx of the deceased was found to be perforated and contused. Both her lungs showed blood in the airways. They were oedematous, with leopard skin appearance. Foreign bodies which included pieces of plastics and brown paper were found in the stomach content. According to the witness, the aspirated blood would most probably have come from the traumatised larynx, which most probably was caused by swallowing of an object that was hard and sharp enough to cause perforation and which was not seen during autopsy examination.

[166] He did not find any evidence of blood in the stomach. There was no correlation between the foreign bodies he found in the stomach of the deceased and the injury in her larynx. Something else that was not found in the stomach

contents, could have caused the injury. The abnormalities noted in the kidneys can be explained as traumatic injury to the kidneys or post-mortem changes if the period between death and the autopsy is considered.

[167] It appears from the information on the periodical report of the deceased, Exhibit P3 that the deceased was prone to eating rubbish. In his opinion (Exhibit P2) on whether the findings in the post-mortem report can point to anybody responsible for the deceased's death, Dr Morule concluded that the care of the deceased where he was admitted and resident was not adequate, appropriate and professional.

Stella Thembisile Mofokeng

[168] She is the sister to the deceased, Sibusiso Mthombeni who was diagnosed with Schizophrenia and dipolar disorder and ended up in the care of LE Randfontein.

[169] After the closure of LE, with some difficulties, she established that the deceased was transferred to Bophelong Suurman in Hammanskraal. The first time she visited him there, he seemed fine but was hungry. During her second visit, she realised the deceased had lost weight. When she visited him the third time, her brother could not walk by himself. He was supported by two care workers. He was later taken to Jubilee hospital where she was informed that he had developed TB and diabetes. He was admitted. Afterwards his condition improved. He was discharged and then admitted again.

[170] In October 2016, she heard that the MHCUs had been removed from the NGOs and taken to Weskoppies. The deceased was, at that time, admitted

to Kalafong hospital. His condition improved and he was discharged to Weskoppies. At some stage his condition deteriorated and he was again admitted to Kalafong hospital where he later died (on 5 April 2017).

Mahlatse Theophilus Nofile

[171] He was a general worker at Precious Angels at the facility in Danville where he worked for four to five months. He left his job because he was not remunerated and he worked long shifts. He made two statements handed in as Exhibits R1 and R2 where he describes the circumstances at the NGO. His duties were to bath, cook, feed and change nappies of the MHCUs. Two nurses who worked separate shifts administered medication to the MHCUs. There was a shortage of food at the NGO and all the MHCUs were fed the same food. No provision was made for specific diets. MHCUs only received one meal per day.

[172] Christopher Makhoba was one of the MHCUs who was cared for at Precious Angels in Danville where he worked. The witness's further evidence regarding this patient will be discussed later in the judgment.

[173] He could not provide information relating to the death of Terrence Chaba. In his evidence he mentioned the names of other MHCUs who died after he had left the NGOs. They were: Siphiwe Makunga who was sick and wheelchair-bound when he arrived at the NGO. His condition worsened during his stay at the NGO. Siphiwe Thabethe who they assisted to walk. Solly Mashego who they found dead one morning when they reported for duty. He was epileptic and suffered from a stroke.

Professor Gregory Ronald Tintinger

[174] The witness is a specialist in internal medicine, sub-specialising in pulmonology. He drafted three opinions regarding possible causes of deaths in respect of Terrence Chaba, Lucky Maseko and William Mvulane. He used the deceased's LE records and their post-mortem reports to formulate his opinion. The opinion relating to Terrence Chaba was handed in as Exhibit S1. The opinion about Lucky Maseko was handed in as Exhibit S2 and the one concerning William Mvulane as Exhibit S3.

[175] Prof Tintinger's evidence about Terrence Chaba will be dealt with later in the judgement.

[176] Similarly, he was concerned about the care and nutrition Lucky Maseko received at Precious Angels which resulted in his serious loss of weight and being chronically ill. He opined that a person should not lose more than 5% of his weight over a period of 3 months. Lucky Maseko lost approximately 43% of his weight from the time he left LE until the day of autopsy when his weight was recorded by the forensic pathologist. The autopsy did not find any underlying conditions that could count for such severe loss of weight. Pneumonia is often the common final pathway for severe debilitating conditions such as starvation. Epilepsy and aspiration can also predispose a person to pneumonia. Tests done on a CSF sample of the MHCU during his admission at the hospital revealed no underlying cerebral infection of meningitis.

[177] When he compiled his report in respect of William Mvulane, Prof Tintinger also looked at Kalafong hospital records where the MHCU was admitted prior to his death. He notes in his report that at Kalafong hospital William Mvulane was found to be chronically ill with evidence of a previous

cerebrovascular accident or stroke. There was also evidence of a decubitus ulcer or pressure sore, and his blood glucose was found to be low. Hypertension with cardiac dysfunction together with epilepsy and multi-infarct dementia was also diagnosed. He concluded that the reasons for the clinical deterioration of the MHCU's condition are probably multi-factorial and include neurological disorders such as epilepsy, multi-infarct dementia and a previous stroke. All these medical conditions are risk factors for the development of pneumonia.

[178] The above conditions may have contributed to the decline in the MHCU's condition and subsequent death in hospital. He could not, therefore, determine whether or not the circumstances at the NGO where the MHCU resided prior to his admission at the hospital played any role in his health decline. In his view, the MHCU's underlying neurological problems could have predisposed him to the pneumonia that caused his death.

Professor Abel Pienaar

[179] The Curriculum Vitae of Professor Pienaar stating his qualifications and experience was confirmed and handed in as Exhibit T1. Professor Pienaar provided opinions relating to the deaths of six MHCUs who were moved from LE to the different NGOs. When compiling his reports, he perused the records of the MHCUs, the DSMV Manual of mental disorders to do psychiatric comparisons, snapshots from the Fairview and Gunzben scales of assessment

for intellectual disability, the Mental Healthcare Act[17], National Health Act[18], The Nursing Act[19] and the Intellectual Disability Act[20].

[180] The report pertaining to Aaron Ngqondwana was handed in as Exhibit T2 and that of Frans Dekker as T3. The reports of Samson Nhlapo, Charity Ratsotso, Tiaan Crause and Joseph Gumede were handed in as Exhibits T4, T5, T6 and T7, respectively.

[181] Aaron was diagnosed with Intellectual Disability which included both intellectual and adaptive functioning deficits in conceptual, social and practical domains. He was further diagnosed with epilepsy.

[182] The information Professor Pienaar had about the MHCU was a brief transfer entry from LE which reported his physical assessment and the fact that he needed total patient care, the statement of Dorothy Franks which mentions that the MHCU's condition on arrival at the NGO was not satisfactory in terms of personal hygiene and there were no observable injuries.

[183] Professor Pienaar also mentioned the report of Miss Martha Monyatsoa who states that Aaron was subsequently confined to a wheelchair. In his opinion this physical incapacitation along with Aaron's mental developmental status, indicate that he totally needed immediate supervision at all times and he depended on the nursing staff to achieve the activities of daily living. This was lacking and Aaron was able to consume a large plastic which was detected at

[17] Mental Health Care Act, 17 of 2002
[18] National Health Act, 61 of 2003
[19] Nursing Act, 33 of 2005
[20] Intellectual Disability Act, 2003

autopsy. He concluded that all nursing categories should be investigated by the South African Nursing Council for alleged misconduct.

[184] Professor Pienaar further testified that patients with severe and/or profound Intellectual Disabilities need close monitoring which means direct monitoring of the patient is important and monitoring of care as well as monitoring the condition of the patient. Should any condition of the patient deteriorate, whoever is in direct or indirect contact with the patient should become aware of the condition with immediate effect.

[185] Samson Nhlapo was diagnosed with Intellectual Disability which is a disorder with the onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. His ability to achieve activities of daily living primarily depends on the level of developmental disability which was not specified. He also had diabetes mellitus.

[186] Professor Pienaar concluded that due to the limitations noted in the admission report, the transfer, medical prescriptions and clinical records, there was a total healthcare negligence.

[187] He testified that when a severe and intellectual patient is transferred to another facility, there should be a complete transfer report. This entails a total physical examination of the patient wherein the health challenges of the patient would be highlighted, and the mental health status assessment wherein the current level of the patient's intellectual disability would be indicated. The stepdown facility (NGO) where the patient is transferred must also keep its record at all times.

[188] Around 2002 already, Charity Ratsotso was diagnosed with profound mental retardation. Professor Pienaar describes the MHCU's level of incapacity as the most severe form of childhood development mental disorders. According to him the MHCU needed total direct care 24 hours a day, 7 days a week (24/7), and could under no circumstances cope with indirect care, although such care is not practically available in public facilities.

[189] Due to the deceased's mental health disorder and the prescribed medication, he was dependant on comprehensive, total healthcare. He was completely dependent on healthcare providers at all times. The findings in the post-mortem report supports lack of care. Due to the deceased's mental disorder as well as the heavy psychotropic medication, muscle tone relaxed, and this made it difficult for him to swallow. He could not swallow food particles and this was not noticed by the caregivers. Professor Pienaar regards this conduct gross negligence in healthcare, especially basic care (feeding and drinking). He found that at Anchor there was no responsible healthcare giver. There was healthcare negligence at CCRC, Anchor and Mamelodi hospital, specifically with regards to basic healthcare (general health observation and interventions), with regard to feeding considering the mental status, recorded health care and post-mortem findings.

[190] Tiaan Crause was diagnosed with intellectual disability, a disorder with onset during the developmental period which includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. His level of developmental disability was stated to be severe. He was also diagnosed with epilepsy which is a chronic disorder characterised by a

spontaneous tendency for recurrence of unprovoked seizure. Such patient should consistently adhere and comply with the prescribed treatment. There should have been close monitoring of the deceased at all times as well as increased level of assistance in order for the deceased to achieve activities of daily living.

[191] Professor Pienaar notes in his report that one cannot distinguish between the care, treatment and rehabilitation of LE and CCRC. LE clinical reports have not been provided but from CCRC to Siyabadinga it appears as if the provision of patient care drastically deteriorated. There has been lack of nursing professionals empowered and equipped with the necessary knowledge on how to care, treat and rehabilitate the mentally ill patients at Siyabadinga. It became clear during cross-examination that the deceased had never been a patient at LE. He was a patient at CCRC.

[192] Joseph Gumede was diagnosed with Schizophrenia. He also suffered from diabetes mellitus. He was transferred from LE to Anchor for continuity of care, treatment and rehabilitation. The manager at Anchor indicated that the NGO never had a glucose testing machine even though they had diabetic patients under their care. According to Professor Pienaar, the deceased's diabetes was at a complicated state. He had a bilateral knee amputation which implies that management and monitoring of his blood glucose, blood pressure and other vital signs required close monitoring. The results of the post-mortem indicate the cause of death of the deceased to be due to severe coronary artery disease probably complicated by myocardial infarction and that ischemic heart disease most probably was due to poorly managed diabetes mellitus. Holistic

patient care, treatment and rehabilitation was inadequately provided to the deceased.

Dr Myuviso Talatala

[193] He is a specialist psychiatrist in private practice at Dr S K Matseke hospital. His qualifications and experience have been placed on record. He is a member of several psychiatrist societies and the previous President of SASOP (from 2014 to 2016). In that capacity he provided an affidavit in the litigation regarding the transfer of MHCUS from LE in 2015. This litigation was brought against the GDOH because SASOP heard rumours of the GDOH's intention to terminate its contract with LE. They tried to engage with the GDOH regarding its intention by writing several letters and also requested meetings to discuss and negotiate the process of discharging the MHCUs. They did not receive any cooperation. The GDOH eventually announced that it was terminating its contract with LE. SASOP had no option but approached the courts together with SADAG.

[194] Around 2012/2013 the GDOH organised meetings where they introduced the NMHPF and it was agreed that they had rapidly deinstitutionalised from 1994 to the time of the policy. They already encountered problems with what they had done. Patients ended up in jail and streets because they were prematurely sent to communities that were not ready to receive them. In the new policy it was emphasised that they should develop community beds with the healthcare services so that any further deinstitutionalisation would be that those patients when they leave the

institutions, they will be well-received by the community psychiatrist services ready to receive them to avoid patients ending up in the streets and/or jail.

[195] After reviewing the dockets of 10 deceased MHCUs, consisting of LE documents, prescriptions and notes, NGOs, clinical and hospital notes, post-mortem reports and police documents, he provided expert opinion on the circumstances that could have contributed to their deaths. The evidence relating to Virginia Macaphela will be discussed later in the judgment.

[196] The same will apply to the Doctor's evidence about Terrence Chaba.

[197] Dr Talatala also discusses condition of Aaron Ngqondwana (Aaron) who was transferred from LE to Anchor on 29 June 2016 and died on 7 February 2016. Aaron was a 31 year' old MHCU with severe/profound intellectual disability with associated cerebral palsy. He also suffered from epilepsy. He had been institutionalised from age of six until his death. He was admitted at LE Randfontein at the age of 24 years. After his transfer to Anchor, he went on leave of absence (LOA) from 31 December 2016 to 15 January 2017. He returned to Anchor and died on 7, February 2017. He was taking sodium valproate and lamotrigine which are anticonvulsant used to treat epilepsy. The medication may also be used to control abnormal behaviour in people with intellectual disability. The use of the two anticonvulsants in one patient as in Aaron's case is an indication that it was difficult to control his epilepsy or abnormal behaviour or both.

[198] The diagnosis of intellectual disability, the combination of these anticonvulsants and the chronic institutionalisation of Aaron indicates the severity of the impairment that he had and the difficulty one would have to

discharge him into the care of his family. Even transferring him out of LE Randfontein to another institution of equal competence would be risky and would need to be done with extreme caution.

[199] The post-mortem revealed a large piece of plastic sheet in his stomach and his cause of death was aspiration pneumonia. Dr Talatala opined that this is an indication that Aaron swallowed plastic and it irritated his stomach; this led to vomiting and aspirating on his vomitus. Alternatively, Aaron would have swallowed the plastic and had a seizure as he is a known epileptic. With the seizure he lost consciousness and aspirated on his stomach contents. Both these scenarios or even their combination show that Aaron was unable to look after himself. He needed supervision to prevent from swallowing the plastic which he could swallow if not supervised. He could have swallowed the plastic if he was starving.

[200] In addition to the above anticonvulsants, clozapine was also found in Aaron's blood and in his stomach contents on toxicology. Dr Talatala said he could not find any record of Aaron being on clozapine. A prescription of clozapine should have been used with caution in patients with epilepsy as clozapine lowers seizures threshold. The record shows that clozapine was not prescribed for Aaron. He could therefore have swallowed an unprescribed medication. According to the doctor, Aaron's psychosocial disabilities made him unsuitable for placement in an NGO. The placement put him at risk of inadequate care which resulted in him swallowing a plastic sheet that resulted in aspiration pneumonia and ultimately death.

[201] Aaron was not at Anchor when he died. He was already transferred back to CCRC. When confronted with this fact during cross-examination, Dr Talatala opined that CCRC was not a suitable place for MHCUS like Aaron given the severity of his sickness. CCRC did not have the experience of looking after patients like Aaron. He confirmed that because Aaron was on LOA days prior to his passing and then returned to CCRC, it is not known where he swallowed the plastic.

[202] Charity Ratsotso was transferred from LE to CCRC on 12 May 2016 and from CCRC to Anchor on 23 June 2016. He was 49 years old and diagnosed with profound intellectual disability/severe mental retardation and epilepsy. He was admitted to Mamelodi hospital Emergency Department as an unknown male patient on 29 June 2016 and he passed away on 11 July 2016. He had been institutionalised since childhood. He has been at LE for 13 years.

[203] There was a prescription of medication for Charity dated 18 May 2016 which he had to repeat for 6 months. When he was moved from CCRC to Anchor he became an unknown patient and his lost identity continued to Mamelodi hospital. He was therefore at the risk of stopping his medication abruptly as doctors at the receiving institution would not have known which medication to give him. Although Charity was said to be suffering from epilepsy, the doctor could not find any record of anticonvulsants medication.

[204] The periodical reports recorded that Charity needed supervision. It was not appropriate to move him to a less specialised facility. Charity died of aspiration pneumonia. It is likely that he had a seizure and aspirated. The information about his epilepsy and the need for treatment was lost between

institutions. His transfer from LE put him at the risk of this consequence. The risk was even higher in a patient known to be in need of supervised care. The transfer from LE and the inadequate care at the various facilities where he was transferred, put him at the risk of possible seizures and the consequent aspiration, pneumonia and death.

[205] The evidence of Dr Talatala relating to Christopher Makhoba will be discussed later in the judgment.

[206] The same applies with the doctor's evidence of Frans Dekker.

[207] Koketso Mogwerane was transferred from LE to Rebafenyi on 27 May 2016 and died on 15 June 2016. He suffered from Schizophrenia. He was found dead after having fallen over night. There was no care at night and no post-mortem was done. The NGO where he was transferred prior to his death should have monitored him as LE did, and slowly reduce this monitoring to allow him to adjust to the new environment.

[208] Deborah Phetla was transferred from LE to Takalani home on 23 March 2016. She was born with intellectual disability, profound mental retardation and epilepsy and she died on 26 March 2016. She was prone to swallowing inedible things. She was not suitable for the NGO. She need to be monitored.

[209] His evidence concerning Matlakala Motsoahae will be discussed later in the judgment. The same applies to the evidence of Daniel Charles Josiah.

[210] During cross-examination he was asked to comment about the condition of Ryan Willem prior to his death and how he died of dehydration while in

hospital. Ryan was at Ubuhle Be Nkosi for a short time and taken to Tshwane hospital from 1 June to 7 June 2016. After his discharge he was readmitted on 10 June and died 19 July 2016. He was diagnosed with dehydration. Dr Talatala could not comment as there was no information to explain what happened. The diagnosis was not clear. The dehydration was only mentioned after death and not on his first day of admission at the hospital. It also appeared that he had pneumonia while the hospital thought he had TB.

[211] Dr Talatala could not comment on the condition of Timothy Nxumalo due to lack of documentation.

Mahlodi Daphney Ndlovu

[212] She was a social worker employed by the GDOH and stationed at CCRC during the years 2015/2016 when the MHCUs were moved from LE to several NGOs and hospitals. She made several statements to the police regarding her knowledge of the process and the patients who died at CCRC and other NGOs. The first three statements that she made were admitted into evidence as Exhibits V1, V2 and V3 respectively. The other statements which related to some of the deceased, namely, William Fakude, Mojalefa Sangweni, Thabo Monyane, Jabulani Mhlongo, Francois Badenhorst, Benedict Lakwa, Busisiwe Tshabalala, Howard Louw, Matofela Leroabe, Refilwe Seshoka, Leonard Breedt, Sizwe Hlatshwayo, Tiaan Crouse and Emily Mthembu, were also admitted into evidence as Exhibits V4 to V18 (with Exhibits V15 and V16 relating to Sizwe Hlatshwayo).

[213] The contents of Exhibits V3 to V18 are not relevant to the issues before this inquest. The witness also made corrections to her statement, Exhibit V1

which were handed in in a statement marked Exhibit V19. These corrections in Exhibit V19 do not alter the relevant information contained in Exhibit V1.

[214] In Exhibit V1 Daphney described her duties at CCRC at the time, which were: to facilitate the process of admission of the MHCUs, conduct home visits to the families of MHCUs and give counselling before and after the admissions, and facilitate the process of the discharge of the MHCUs from CCRC. She also collected information who were transferred to CCRC or left CCRF which included the ID's of the MHCUs, contact details of their families and their addresses. She was part of the multi-disciplinary team (MDT) who assessed patients at LE facilities to be transferred to CCRC. She did not have any decision-making powers as part of the MDT regarding the placing of the MHCUs at the different facilities. MHCUs were moved from CCRC to NGOs which were housed in the premises of CCRC, Siyabadinga. She knew nothing about Anchor.

[215] She confirmed that Charity Ratsotso was among the MHCUs who were transferred from LE to CCRC on 12 May 2016 and later from CCRC to Anchor. After the closure of the NGOs, Anchor and Siyabadinga, all the MHCUS who were placed at the two NGOs were returned to CCRC and resulted in the over-crowding of CCRC. CCRC had a bed capacity of 150 but after the closure of two NGOs, and the absorption of all their MHCUs, its bed capacity increased to 267 MHCUs.

[216] The family of Charity Ratsotso was notified about his transfer to CCRC and Anchor. Sometime in December 2016, long after Charity was discharged to Anchor, she received a call from a certain Mr Phasha who alerted her that

Charity's family was looking for him. She went to Anchor with proof of Charity's discharge to Anchor which she showed Ms Franks after she had denied that Charity was under their care. Immediately thereafter an employee at Anchor, one Mr Tshepiso Mola informed her that they had taken an unknown patient in Mamelodi hospital. In Exhibit V2 she stated that she handed the documents she had which related to the MHCUs who were transferred to Siyabadinga, to be received by Ms Dianne Noyile. Exhibit V3 relates to a list she prepared of all the MHCUs over the age of 21 years who had been in CCRC for a period longer than 3 years who were eventually transferred to Siyabadinga.

<u>The NGOs</u>

<u>Tiisetso Malebye</u>

[217] He was the Manager of Rebafenyi. After he showed interest in operating an NGO, Rochelle Gordon contacted him late in 2015 and invited him to a meeting. He later met with Hanna Jacobus who explained to him that the NGO will receive MHCUs who are high functioning and only need home-based care who will then be re-integrated into the community. She further informed him that the department would provide nurses to care for the MHCUs. He was then invited to attend a meeting in Johannesburg with his mother who had questions about the project. The meeting was held in November 2015 and he attended with his mother. The issue of decanting LE was discussed and the NGOs who were existing at the time showed their dissatisfaction with the rates the department was willing to pay per patient.

[218] Subsequently, inspections were conducted at the two houses where they intended to operate the NGO. He was requested to complete the forms

for the license application. During February 2016, Hanna Jacobus called him and told him that the license was approved. The Schurweberg property was licensed to accomodate 55 patients and 57 were for the Hennops property. He then received the licenses and he was informed to fix the bathrooms of the Hennops property. Both properties were certified ready to receive patients by the department of health. He was further told to appoint a professional nurse in each facility together with a certain number of care workers. He was unable to secure the appointment of professional nurses.

[219] On 26 May 2016 he was called to come fetch the patients at LE Waverley. He met Ms Nonceka Sennelo and collected 55 patients who were transported to the Hennopsriver facility. Not all the patients were in possession of their files and some were not issued with medication. The patients were not assessed on arrival at the facility. Subsequent to receiving them, the facility had a challenge with medication and the staff patient ratio. Some patients relapsed and the team from Tshwane district intervened to assess the patients. Dr Mataboge assessed the patients and wrote out new prescriptions for them. Some of the MHCUs who were not properly placed, were transferred to other facilities that included Weskoppies. The patients were received in bad conditions on both dates. They were filthy and had one pair of clothing.

[220] He attended on NGO meeting at Weskoppies a month after receipt of the MHCUS which meeting was convened by Dr Manamela. At the meeting the NGO representatives who were present complained about the financial difficulties they were experiencing and lack or delay of medication for patients.

[221] On 17 July 2016 Rebafenyi received 51 patients from LE Randfontein who were placed at the facility in Schurweberg. After the patients had settled in, he informed Ms Fridah Ndlovu about the NGO. Fridah had a house in Amandasig which she wanted to convert into an NGO. Ms Hanna Jacobus informed the witness that it was not necessary for Fridah to apply for a license as both of them would use the same license. Fridah eventually received patients from CCRC. The arrangement was that the witness would transfer the money into Fridah's bank account after the GDOH had made the payments.

[222] As time went by, they realised that the NGO needed a lot more than they had initially envisaged in terms of the creation of facilities for the MHCUs and the staff for patient relationship that was needed to run the two houses. They felt they were understaffed and could not afford to pay for the additional staff that was needed. The grants they received from the GDOH could not meet the threshold of the patients they had. Towards the end of December 2016, he engaged with the Rebafenyi Victim Empowerment Board (the "*Board*") and a letter was sent out to the GDOH notifying them of his intention to terminate the contract by 31 December 2016. He also contacted Dr Manamela and informed her that she had put the lives of the patients in danger. The contract was eventually terminated and the staff of Rebafenyi remained until the MHCUS were relocated by GDOH on 31 January 2017.

[223] He was not involved in the day to day running of the two houses and did not have information about the events that led to the death of the MHCUs who died in the care of the NGO. Koketso Christopher Mogoerane and Sampson Nhlapo were admitted to Rebafenyi on different dates. The staff at

Rebafenyi did not have experience to care for the MHCUs. They put their lives in danger. The staff component at Rebafenyi consisted of one retired registered nurse who was only appointed three months after receipt of the MHCUs, one auxiliary nurse, one enrolled nurse, nine caregivers and four cookers. They did not have any dietician, occupational therapists, and social workers on site. They relied on the GDOH to provide that service. The menu at the facilities was introduced by Ms Salome Mashile from the MHD and Weskoppies sent a dietician to assist.

[224] Sampson Nhlapo was placed at the facility in Schurweberg. He had a stroke and was taken to Kalafong hospital where they stayed the whole night with him in the casualty section. He was ultimately admitted in the morning and then died. When he was received at Rebafenyi, he was in good condition. The patients received at Rebafenyi were high functioning.

[225] Koketso Christopher Mogoerane was at the Hennopsriver facility. He died a week or two after arriving at the facility. He does not know the circumstances that led to his death.

[226] Under cross-examination it was put to him that there was evidence that when the MHCUs were transferred from LE to the NGOs, Ms Buthelezi and two officials of the GDOH who were at LE Waverley ensured that all the necessary documentation and records required for the transfer of MHCUs were provided. He explained that the problem was with the contents of the patients' files. Not all the medical prescriptions were in the files. He could not say whether the medical records of Sampson Nhlapo and Koketso Christopher Mogoerane were sufficient or not. He further testified that when they received MHCUs they did

not have nurses. They thereafter received nurses from the GDOH and structures were put into place which required them to have nurses.

Neil Wesselo

[227] The witness made several statements which were handed in as Exhibits Y1, Y2, Y3a and Y3b (which relate to the deceased, Isaac Tloloane), Y3a, Y4b and Y4c (which relate to the deceased, Happy Makhubela) and Y5 which relates to the deceased Michael Thlolwe.

[228] The witness's evidence pertains to Shammah house. Shammah house operated as a Non-Profit Organisation (NPO) and was issued with an NPO Certificate on 17 May 2010 by the Department of Social Development. The house accommodated the homeless people and psychiatric patients discharged from Weskoppies hospital. Shammah house did not have a license in terms of the Mental Health Act provisions to accommodate MHCUS because the centre did not receive any subsidy from the GDOH.

[229] In December 2015 Ms Hanna Jacobus visited the centre and informed them about the notice by the GDOH to terminate the LE contract. The GDOH was intending to transfer the MHCUs from LE facilities in the care of the NGOs. She requested the management of Shammah to assist in accommodating the MHCUs from LE. They initially indicated their unwillingness to receive the patients as the centre was not equipped. Ms Jacobus threatened to cancel their certificate. They eventually agreed to assist. The witness did not attend the meeting with the GDOH regarding the LE project. The management of Shammah house never applied to accommodate the MHCUs and neither did they make any presentation in that regard.

[230] During February 2016 the representatives of the GDOH visited the centre to inspect the building. The inspection team recommended that some extensive alterations be made to the building. The centre did not have enough funds to settle costs for the alterations and the owner used his own money to make the alterations. It also did not have enough beds. They bought additional beds at Selby hospital. Although the GDOH promised to give the centre some beds, they didn't. All the alterations were made and the centre was ready to receive the MHCUs.

[231] The centre collected 50 MHCUs at LE, Waverley in May 2016. Some patients had medical files, however 13 patients did not have identity documents. On the same day the manager of Refilwe Clinic was contacted and arrangements were made for the patients to be seen by the medical team from the clinic. The condition of the patients was not good. They were under-nourished. Some of them only had t-shirts without shoes and no luggage.

[232] Upon arrival at Shammah house the patients were placed accordingly. They were given warm clothes, bedding and received food. The following day the medical staff from Refilwe Clinic came to the centre and the patients were tested for TB, diabetes and blood pressure. The patients were also injected for flu. The patients who did not have files were seen by a psychiatrist who eventually gave them prescriptions. The patients were issued with medication.

[233] The following patients were admitted at Shammah house and later died: Happy Makhubela who was from LE, Waverley. The nurse noticed that his eyes were yellow. He was then taken to Mamelodi hospital where he was admitted for medication and treatment. He later died in hospital. Patrick

Michael Thierry who was healthy and in good condition, got injured when he was pushed against the wall by one of the patients and broke his collar bone. He was taken to the clinic for medical treatment. He was recovering very well and sadly died in his sleep due to natural causes. Rudolph Botha was out with his brother who came to visit him on a Sunday. The next day when the nurse checked his blood pressure, it was very high. There was no improvement a day thereafter and he was taken to the clinic where nothing was diagnosed. On Wednesday his condition became worse and he was taken to Mamelodi hospital where he later died.

[234] Shammah house did not have a license in terms of the Mental Health Care Act. It operated with a NPO certificate. On 21 May 2016 officials from the GDOH who included Rochelle Gordon, Frans Mohale and infrastructure officers visited the centre to conduct an audit and inspection. Eventually Shammah house received a license to accommodate 110 MHCUs and the SLA. On 21 July 2016 the multi-disciplinary task team from GDOH visited Shammah house for inspection.

[235] The MHCUs received a balanced diet although they did not have a dietician. They had a first-aid kit. The centre received guidelines, protocols and procedures in dealing with aggressive MHCUs from the GDOH. The MHCUs progress reports and medical conditions were recorded in the medical files. The Centre had a full component of staff. A professional nurse gave the healthcare workers in-service training to be able to handle aggressive MHCUs and the patients who needed physiotherapy were referred to Refilwe Clinic.

[236] In March 2017 a team from the GDOH came to Shammah house and all the MHCUs were examined by the doctors and psychiatrists. Three days later all the MHCUs were removed from the Centre by the GDOH and transferred to different hospitals. During cross-examination Mr Wesselo stated that the audit that was conducted on 21 July 2016 as indicated on case lines did not occur. Shammah house had a full component of staff from the end of May 2016 and this was before they received MHCUs from LE. He could not recall whether the deceased Michael Thlolwe was suffering from diabetes and hypertension.

Dr Ramadimetja Emily Kekana

[237] She is a registered nurse and her qualifications, which range from a Diploma in General Nurse to a Doctorate in Public Management, have been placed on record. She is employed by the GDOH as an Assistant Director Nursing and stationed at Mamelodi hospital. She made several statements which were handed in as Exhibits Z1, Z2 (relates to the deceased Sibusiso Mthombeni), Z3 (relates to the deceased Hendrik Maboe) and Z4 is a statement of Ms Stella Mofokeng which also relates to the deceased, Sibusiso Mthombeni.

[238] Bophelong was registered in Tshepiso's name and was run by experienced qualified registered nurses, together with care workers who were orientated about how to operate the centre. The witness trained Bophelong staff members in preparation for receipt of patients from LE on disaster management, how to take vital signs, note medical records, exercise patients and feeding them.

[239] During February 2016 the GDOH invited all NGOs to a meeting. Tshepiso attended the meeting where they were informed that the department required more NGOs to accommodate patients from LE. The NGOs who were interested were requested to leave their contact details. Arrangements were made for a house situated at Stand 708 Suurman in Hammanskraal to be converted into an NGO and a license of the NGO was applied. The NGO was subsequently registered in Tshepiso's name and a license was obtained for the house. The officials of the GDOH visited the centre and inspected the facility. They indicated that the facility could receive 40 patients. The facility was required to have a cupboard for medication, first-aid kits, bed and linen. Arrangements were made to get the facility patient ready.

[240] On 30 June 2016 Bophelong received 40 male patients from LE. The patients who were accompanied by Mr Mogale and two care workers, had a summary of their medical records and 28 days' supply of medication. They were stable although malnourished and wearing stained pyjamas. They were taken to Suurman Clinic and Jubilee hospital for assessment.

[241] Two patients died at Jubilee hospital whilst under the care of Bophelong. They had underlying conditions and their deaths were unpreventable. Hendrick Maboe who was epileptic, had psychosis and HIV, was on ARV's, went to the clinic three times and was later referred to the hospital. The hospital was unable to get hold of his family members to consent to treatment. His BP was very low. A nurse from Bophelong ultimately gave consent for the treatment and Hendrick died after two weeks in hospital. Siyabulela Msimango arrived at the

centre late afternoon from CCRC accompanied by Mr Mogale. He looked sick and was sent to the clinic which referred him to the hospital where he later died.

[242] 36 patients were removed from Bophelong on 28 September 2016 by officials from Tshwane District with their files to Weskoppies hospital due to the infrastructure renovations and for their safety. Bophelong was informed that the patients would return after the construction was completed. The witness denied that any of the MHCUs were hungry. She maintained that there was food available at the NGO which was well balanced and the food was seen by the GDOH officials when they did their unannounced visits. The place was suitable to house the MHCUs. The house had four toilets ablution system fully in place. The basins they had were used for emergency purposes, in particular, when the municipality cut their water supply. They would draw the water and fill up the basins people to wash themselves.

[243] Siyabolela Msimanga was medically examined at Jubilee hospital and on 8 September 2016 an assessment was made of severe sepsis, DIC with petechial, pancytopenia, dehydration, hypernatremia and possible disseminated tuberculosis.

[244] The witness was not aware that Sibusiso Mthombeni suffered from tuberculosis. They also realised after he started to lose weight and took him to the clinic for an examination. He was taken to the clinic in July and thereafter to the hospital where he was treated for TB and diarrhea. He was discharged and later readmitted as he refused to eat due to lack of appetite and diarrhea. He was discharged again from the hospital and returned to Bophelong. Again, he was readmitted to Jubilee hospital where he later died.

[245] During cross-examination the witness stated that she was serving at Bophelong as an advisor and project manager and was a member of the executive of Bophelong Suurman.

Mmaletsatsi Elizabeth Mokgojoa

[246] She was the director of Mosego home where she was responsible for operations which included finances and logistics. She had no direct relations with the MHCUs. Mosego home was founded in 2008 and is situated in Krugersdorp in Mogale City. Dr Sekhukhune was working at Lifecare which later became known as LE. The witness is trained to care for MHCUs as a psychiatric registered nurse. She has a diploma in nursing, post-basic course like community psychiatry and midwifery and a BCur Degree with UNISA.

[247] All MHCUs who were discharged by doctors at LE were admitted to Mosego home. Before the Marathon Project Mosego home had 6 houses and was licensed to accommodate 141 MHCUs. They expanded and managed to acquire two additional houses and were eventually licensed to accommodate 200 MHCUs. During the Marathon Project they received the last 29 of the 74 MHCUs from LE and accommodated them in house No. 117. Before they could receive the MHCUs, they had an audit by the officials from the department. They put beds in their house according to the audit recommendations to avoid overcrowding. The rooms were big and could accommodate four beds per room.

[248] The MHCUs from LE did not come with their comprehensive medical records. They only came with the discharge form/MHCA Form 3 and the periodical form/MHCA Form 13. On the discharge form the doctor who

discharged the patient wrote a brief history of where the patient was came from since he/she became mentally ill, if he/she had any other condition, all the diagnosis and the treatment that the MHCU was taking, but not a record of how the condition was managed. The periodical form was completed by the hospital and related to the mental and physical condition of the patient, functioning and family contacts. If they had received comprehensive medical records, they would have rejected some of the MHCUs that were transferred to their facility. The MHCUs were transferred to the facility with underlying illnesses, and they were not aware of the illnesses.

[249] During the Marathon Project Mosego Home received the following MHCUs: Johannes Dlongwane who died at Mosego, Hartman Matthys who died at Helen Joseph, Ishmael Mvundla who died at Mosego, Rebecca Hlabathi who died at Mosego the same day after her discharge by Leratong hospital, Yamnik Anthony Nicholas who died at Mosego, Hermanus Bronkhorst who died at Mosego, Michael Mokgethi who died at Leratong hospital and Jonathan Mothapo who died at Yusuf Dadoo hospital.

<u>Dr Dorothy Sekhukhune</u>

[250] She registered Mosego home which was involved in the caring of the MHCUs. From time to time Mosego would receive MHCUs from LE as a form of deinstitutionalisation. Patients were received in small numbers and would be monitored by a psychiatrist until they were discharged into Mosego home. In 2012 she got involved in Takalani home situated in Diepkloof, Ramolongoane Street. She was approached by the GDOH to become the interim administrator

of the facility after it was placed under administration. She went to the facility to restore it.

[251] Takalani started to receive patients from LE in 2016. It submitted documents of its intention to expand as it had a ward that was empty. The process of admitting patients unfolded and Takalani would send a social worker, registered nurse and a clinical manager to go to LE Randfontein where they would assess the patients on arrival and would take them with them if they found them suitable. They received the last periodical report, medication prescription and the transfer form 11. Takalani had its own staff members and never received by staff from LE. Their staff component consisted of registered nurses with experience in psychiatry. They had also enrolled nurses and care workers. She did not know the MHCUs personally as she was not involved with the day to day running of clinical services.

[252] Before patients could arrive from LE, section 27 had a court case against the department of health alleging that Takalani was not qualified to render services. However, afterwards section 27 also assessed the facility. They were satisfied with what they found at Takalani. The GDOH made unannounced and announced visits at the facility to make sure that it was ready to accept MHCUs. The facility was always in possession of a license and the license was renewed annually based on the audits conducted.

[253] Takalani received the first MHCUs on 23 March 2016. Deborah Phetla came to Takalani on 23 March 2016 in the afternoon with a group of 6 female patients from LOA. Upon their arrival, the witness put in the CCTV camera around the facility, inside and out, for proper monitoring and security of the

MHCUs. They were aware that Deborah Phetla was prone to eating foreign objects and made sure that she was placed right in front of a care worker so that she could monitor her closely. Deborah Phetla was the first MHCU to die at Takalani and the family collected the body. She only stayed at the facility for two days or two nights and then died. It was reported that she vomited after dinner and the staff cleaned the vomit. She went to sleep but did not wake up the next morning. After the Health Ombuds' report all MHCUs were removed from Takalani and transferred to Selby hospital and LE Baneng.

Mavis Mokgosinyana

[254] She is a qualified registered nurse, a midwife and the clinic manager of Mosego home. Her evidence covers various deceased MHCUs and she made several statements pertaining to them. Her statements marked Exhibits W1A, W1B and W1C were admitted into evidence and relate to Christiaan Hartman Matthys. Hartman was moved from LE Randfontein on 6 May 2016 to Mosego home where the witness assessed him. During his stay at the NGO, the MHCUs was referred to the local clinic for several problems. On 7 August 2016, the witness observed a septic wound on the deceased's buttocks which started as an abscess. She took him to the local clinic where he was referred to Yusuf Dadoo hospital where he received treatment and encouraged to stay in bed. However, he kept on sneaking out to smoke. On 28 August 2016 Hartman presented with difficulty in breathing and refused to be touched by a nurse who wanted to take his vitals. He was taken to Helen Joseph hospital where he died on 29 August 2016.

[255] The statement of the witness regarding the deceased Joseph Mabena was handed in as Exhibit W2. She mentions in the statement that she fetched the deceased from LE Randfontein after he was assessed there and she also assessed him at Mosego home. Nothing is mentioned about the circumstances that led to his death.

[256] A further statement marked Exhibit W3 was admitted into evidence and it pertained to Daniel Malan. The deceased was received from LE Randfontein. On 7 June 2016 there was a fight between Daniel and a fellow MHCU who hit Daniel with a chair. Daniel was the aggressor. He was later admitted to Leratong hospital where he died on 20 June 2016 as a result of the assault.

[257] The witness statement handed in as Exhibit W4A related to the deceased, Sam Sam contains no information that is of assistance to court and the statement marked Exhibit W4B concerning the deceased Sam Sam states that he arrived at Mosego home on 6 May 2016 and the witness assessed him. When he left LE he had chronic medication with him prescribed for a month. He later died at Leratong hospital. No further information was provided.

[258] The witness statement regarding Michael Mokgethi was handed in as Exhibit W5. It only confirms his arrival at Mosego on 6 May 2016 and that he died at Leratong hospital. The following statements handed in as Exhibits W6, W7 and W8 in respect of Dawid Senekal, Jonathan Mothapo and Johannes Sidney Mothapo were similarly structured. The statement relating to Gerhardus Meyer handed in as W9 explains that the deceased fell as he was leaving the house to go to the toilet and sustained a head injury. He died before the ambulance arrived. Further statements handed in as Exhibits W10 related to

Solomon Moatshe, W11 Paul Khubeka, W12 David Mabati, W13 Hermanus Bronkorst, W14 John Mahloko, W15 Peter Mvundla, W16 Sipho Moutloutse, W17 Rebecca Hlabathi, W18 Nicholas Anthony Jannik, W19 Howard Ndlovu, W20 Ishmael Makwe, W21 Lucas Motshweneng, and W22 Fanasi Mthalani.

[259] The witness' supplementary affidavit marked Exhibit W23 was also admitted into evidence. The statement contained a list of the deceased which according to her were part of the Marathon Project and those who were not.

[260] She testified that when the MHCUs arrived at Mosego home, she did proper medical observations of them, which included eyesight, gait, obvious injuries, marks and hearing. Peter Mvundla died in his sleep. Paul Khubeka was epileptic. However, she could not remember the circumstances of his death. Tshepiso Muntlashe had been referred to Dr Yusuf Dadoo hospital where he died. He was epileptic. Solomon Moatshe became ill. He was taken to Dr Yusuf Dadoo hospital where he died. Johannes Senekal was on leave of absence (LOA) to his mother and died during that visit. Nicholas Jannik was a smoker who did not adhere to the rules. He died in his sleep. Hermanus Bronkhorst had flu and was taken to the clinic for treatment. He did not eat well and his condition deteriorated. An ambulance was called in the morning. However, he died. Rebecca Hlabathi was admitted to Leratong hospital. She appeared weak when she returned to Mosego and had difficulty with breathing. She was put on a ventilator. However, she passed away.

[261] Johannes Dlongwane was weak when he woke up in the morning. His vitals were taken. Unfortunately, he died before the ambulance arrived. John Mahloko was at Dr Yusuf Dadoo hospital for a month before he was

discharged back to Mosego. He was weak and his teeth grinded. They fed him with a syringe and then took him back to Dr Yusuf Dadoo where he was booked to be taken to Leratong hospital. Unfortunately, he died at Mosego before he could go to Leratong hospital. Sam Sam had difficulty swallowing. He was taken to Leratong hospital where he died. Michael Mokgethi was weak. He was also taken to Leratong hospital where he died. Ishmael Makwe had a condition that caused his feet to swell. He was referred to Dr Yusuf Dadoo hospital where he was further referred to Leratong hospital and later died.

[262] On 20 February 2017 Fanasi Nthalani went for a bi-annual check. The doctor realised that he had difficulty breathing. Treatment was prescribed. However, by 15:00 his condition had worsened. He was admitted to Dr Yusuf Dadoo hospital and subsequently died on 28 February 2017. David Mabati was the MHCU who hit Daniel Malan with a chair. He had sores in his mouth and started losing weight. At the clinic a sputum specimen was obtained and tuberculosis was diagnosed. He was taken to Dr Yusuf Dadoo hospital where he was admitted and later died. Jonathan Mothapo suffered from a heart condition and became weak. He was taken to Dr Yusuf Dadoo hospital where he later died. Moses Mabena was transferred to Selby hospital on 4 April 2017 from Mosego where he later died. The following MHCUS were not admitted to Mosego: Cindy van Rooyen and David Letoaba.

[263] Mosego home received MHCUS who were frail but looked healthy and it had sufficient means to care for the MHCUs. Before the Marathon Project Mosego refused to admit frail MHCUs. According to the witness Johannes Dlongwane and Rebecca Hlabathi were frail.

Patricia Mbatsha

[264] She is a registered nurse with a diploma in midwifery, psychiatry and community health nursing. Her other qualifications which included a certificate in dispensing medication, and the management of HIV and AIDS, were placed on record. Her evidence relates to the NGO called Ubuhle Be Nkosi. She made various statements which were admitted into evidence. These are Exhibits CC1, CC2 and CC3 (relate to the deceased Timothy Nxumalo), CC4 and CC5 (relate to deceased William Mvulane) and CC6 (the witness's amendments to her statements).

[265] She was invited to attend a meeting at Weskoppies hospital where the issue of NGOs was discussed. She told Mr Thobane that she intended utilising a house at Orchards to operate an NGO. In March 2016 Hanna Jacobus, Rochelle Gordon and Julian Lehau came to inspect the house. They informed her that the place was not suitable and requested her to make some improvements on the property for it to be compliant. She told them that she would like to care for only female patients irrespective of their age. There was no discussion about the mental capacity of the patients she would receive as well as their underlying illnesses. The team informed her that the facility can take 20 patients. She was only informed in June that female psychiatric patients were not available and that she could only male patients. She could no longer use the house in Orchards because her neighbours felt comfortable with female patients. She had to look for another place and she eventually found a double story house in Marabastad with a laundry and a kitchen. The building was an

old prison. Hanna Jacobus and Frans Thobane came to inspect the building and qualified it as compliant.

[266] She then bought beds and linen for the facility. She was not certain whether she received her license before or after she had received the patients. The license was issued for the Orchards Home. She received 40 male patients from LE Waverley and West Rand facilities. The staff component at Uble Be Nkosi consisted of care workers, admin officers and the witness as a qualified nurse. Almost all the patients had diarrhea upon arrival at the NGO. They came with a pair of clothing which they were wearing, two weeks of medication marked and placed in ice-cream containers. Their files were not comprehensive and contained discharge information. Most patients looked very ill and their condition was more physical than psychotic. She was told that she would be able to handle the patients as he was qualified. She screened the patients upon arrival and none of them was dehydrated. She informed Folang clinic about the patients, but she was not linked to any pharmacy.

[267] One patient whose condition was deteriorating, was referred to Steve Biko hospital where he was diagnosed with TB. The patients stayed at Marabastad for a month. After a month the team from the GDOH came to the facility and recommended that she move the patients as the place was not compliant. She moved the patients to a place in Lanseria which Mr Thobane inspected. He liaised with the West Rand District to provide support. The place was not easily accessible and she informed the GDOH of her intention to move. The patients were then moved to a plot in Centurion. They remained there until they were relocated.

[268] Two patients die in her care. The third patient, William Mvulane was no longer in her care when he died. One of the two patients, Willem Ryan was ill when he arrived at the NGO. He refused to eat. He was admitted to Tshwane District hospital where he was diagnosed with TB. The hospital discharged him after two weeks. He came back to the NGO and then admitted to hospital again. Timothy Nxumalo could not walk and he looked elderly. He communicated little. The witness was unable to put him in an old age home because of his mental condition. William Mvulane was very weak. He suffered from hypertension. From time to time he was taken to hospital when he died.

[269] The witness was in constant communication with Rochelle Gordon and Julian Lehau where he informed them that the NGO was not coping because most of the patients were ill and she had to use medication and glucose strips from her own private clinic. In a meeting that she attended she requested them to take the patients back and they indicated that they were unable to do so. They suggested to reduce the request in writing and also give a notice in that regard. She also told Dr Manamela her problems and complained that the department was not supporting them. Dr Manamela advised her to take out a loan. She did not receive the grant as per the SLA with the GDOH. She used money from her private clinic to subsidise the NGO.

[270] During cross-examination she explained that she complained because many patients that she received at the NGO had comorbidities and the patients were above the age of 60 while her license did not permit the NGO to care for people who were frail and had comorbidities. The MHCUS that she received did not comply with the license requirements that was issued for the NGO.

Dianne Noyile

[271] The witness made several statements which were handed in as Exhibits DD1, DD2, DD3, DD4, DD5, DD6, DD7, DD8 (relates to the deceased Karam Seele), DD9 (pertains to the deceased Jabulani Mhlongo). She was appointed as the CEO of Siyakadinga on 1 May 2016. There was nothing in place to run the NGO. Hanna Jacobus was phoned and she advised the witness to fetch beds and any other items needed from Steve Biko hospital. Hanna Jacobus was aware that Love Disciples International (LDI) no longer existed and that Siyabadinga would operate from CCRC. Siyabadinga was registered as an NPO but did not receive a license. They operated without a license because they were waiting for it. The license was issued to LDI and when she enquired from Hanna Jacobus about it, she indicated that the license of LDI was already printed and would be rectified after everything had settled down. The application was submitted. Dr Manamela inspected the premises and the witness did not receive any complaint.

[272] Siyabadinga which was housed in CCRC premises started to receive patients from CCRC from 5 May 2016. Up and until 26 June 2016 it received a total of 72 patients. Not all the patients had discharge forms. The patients were not assessed. They were received in a general health condition save for Tiaan Crouse who was shaking all the time and was not eating. They were not aware of the dietary requirements of the patients except that some were taking normal food whilst others were on a soft diet.

[273] On 16 June 2016 the 4 wards of Siyabadinga were reduced to 2 wards. The other 2 wards were allocated to Anchor house by Dr Manamela. On 20

June 2016 the witness was requested to attend a meeting at the GDOH where she was introduced to Dorothy Franks, the owner of Anchor house. Dr Manamela, Dr Selebano, Hanna Jacobus, Rochelle Gordon and Mrs Nyatlo also attended the meeting. The witness was informed that her NGO and Anchor house should share the property and that Anchor would use a mobile kitchen.

[274] The staff component of Siyabadinga consisted of three pre-nurses, two Auxiliary nurses and 43 healthcare workers. They experienced problems with medication and it took approximately 2 weeks to resolve the problem. They eventually received proper medication from Tshwane Regional Pharmacy. On 1 July 2016 Dr Manamela, Hanna Jacobus and Matilda Malaza brought 3 patients from LE. These patients did not have proper identification and/or medication, transfer files or prescriptions.

[275] On 8 July 2016 Siyabadinga received a letter from the GDOH stating that the NGO was operating illegally and they were instructed them to vacate the premises. They vacated the premises on 9 July 2016. The following patients died under the case of Siyabadinga: Jabulani Mhlongo, Ilse Fredericks, Tiaan Crouse, Francois Badenhorst, Jaco Stoltz, Refiloe Sefoka, Thabo Monyane and David Mpofu. Jabulani Mhlongo had an uncontrolled epilepsy. He was taken to Mamelodi hospital. He did not receive immediate help until the witness called Dr Manamela and informed her what was happening. The patient was eventually admitted after more than 5 hours. He subsequently died at the hospital. Ilse Fredericks died in her sleep at the time when CCRC hospital had sent them nursing sisters to work with them.

[276] When Tiaan Crause arrived at Siyabadinga he was shaking and his condition worsened as days went by. He was taken to Refilwe clinic where he died in the consultation room. Francois Badenhorst and Jaco Stoltz were fine and alive when they were instructed to vacate the premises. Refiloe Sefoka became disorientated the day Dr Manamela and Hanna Jacobus packed the patients in the two wards. She was taken to Mamelodi hospital the following day. She relapsed in two days and was admitted to hospital for a week and later died. Thabo Monyane and David Mpofu demised after they were ordered to vacate the premises.

[277] The witness was not formally trained to take care of persons who are mentally-ill. She was informed that Siyabadinga would receive patients who are stable from CCRC. She could not appoint a professional nurse due to financial constraints and whenever problems were raised with Dr Manamela she would indicate that it would be attended to as soon as the transfer process was completed. She was not directly responsible and/or involved in the day to day care of the MHCUs. Her responsibilities were amongst others, the day to day running of the centre, getting reports from the community workers working in the wards and making sure that there was food at the centre.

[278] She received 46 patients on 18 June 2016 and by the end of 20 June 2016 she had received 74 patients. Siyabadinga started receiving patients from CCRC on 9 May 2016. The NGO was governed by a board of directors. She was at the centre to see the day-to-day running of the centre. There were community healthcare workers who were working in the wards taking care of

the patients. They provided a daily report about the feeding and medication given to the patients. All this information was reported to the board of directors.

[279] The information contained in her statement about Francois Badenhorst was obtained from the Auxiliary nurse who was looking after him. No problems were reported. She was no longer at Siyabadinga when Jaco Stoltz died. The information contained in her statement about him was obtained from his sister, Sandra. The information about Refiloe Sefoka came from staff members. When Refiloe Sefoka was taken to hospital by ambulance, she was on a weekend off. She therefore did not report for duty.

[280] The family of Thabo Monyane used to visit him at the centre. The family contacted the witness on Women's day notifying her that they would be taking him to hospital as he was not doing well. Later on they informed her about his passing. David Mpofu was also visited by his grandmother. The families of Jaco Stoltz, Thabo Monyane and David Mpofu assisted with donations of food and clothes.

[281] She left Siyabadinga on 8 July 2016 and people left the facility on 12 July 2016.

<u>Dorothy Franks</u>

[282] She also made several statements which were handed in as Exhibits EE1 to EE5. She was the owner of Anchor house between 2013 and 2016. She received an email from Hanna Jacobus in November 2015 inviting her to attend a meeting at Sterkfontein hospital on 13 November 2015. The attendees were requested to assist with accommodating MHCUs from LE. She then

started to look for a place to accommodate the MHCUs. She also applied for a license for the NGO. During April 2016 she received information about accommodation that was available at Kalafong hospital. The place required renovations. Engineers from the GDOH went to inspect the place and found it not to be suitable for habitation. During June 2016 she was referred to a place in the premises of CCRC (unused wards) where she started to prepare to operate her NGO. On 23 June 2016 she received 30 patients who were male and female although the place could only accommodate 25 patients as the other ward was utilised by Siyabadinga. She did not receive files or proper identification of the patients and Hanna Jacobus took the matter up with the CEO of CCRC. The patients also did not come with medication. On 24 June 2016 Rochelle Gordon came to the premises and intervened.

[283] The staff of Anchor consisted of several care-workers, one registered nurse and a psychiatrist. They did not have a dietician. On 29 June 2016 she received an additional 40 patients who came directly from LE.

[284] The patients who died under her care were: Robert Sithole, Kenneth Soka, Joseph Gumede, Charity Ratsotso, and Howard Louw. Robert Sithole's condition at the NGO deteriorated. He was taken to the hospital and later died. Kenneth Soka was taken to Mamelodi hospital where he died. Joseph Gumede was taken to CCRC clinic for treatment and died. Charity Ratsotso had epileptic fits. He was taken to Mamelodi hospital where he died. Howard Louw was transferred to Anchor. He was transferred back to CCRC. He died when Anchor was no longer in her care.

[285] She left Anchor on 13 October 2016 and the management of the NGO was taken by the GDOH on 1 November 2016 and her duties were terminated.

[286] On 29 June 2016 she received a total of 70 patients. She told Dr Manamela in the presence of Hanna Jacobus, Frans Thobane and Rochelle Gordon that they would not be able to accommodate the extra 40 patients that came to the centre. Arrangements were made with Ethel Ncube to fetch some patients. Anchor remained with 61 patients after 6 patients were sent to Precious Angels (Ethel Ncube) and 3 to Siyabadinga (Dianne Noyile). She did not receive any funding from the GDOH and had to pay expenses from her pocket until September.

Ethel Ncube

[287] She was the director of Precious Angels during the Marathon Project. She made several statements regarding the circumstances that led to the death of the MHCUs who were at Precious Angels and under her care. The statements have been admitted into evidence and range from Exhibit GG1 to Exhibit GG25.

[288] On 9 November 2015 she received an email from Hanna Jacobus in which she was invited to a meeting which related to the termination of the LE contract. She did not attend the meeting. During February 2016 she was invited to a second meeting which was held in Johannesburg. At the meeting Dr Manamela explained the requirements for the NGOs; it was a requirement to have a facility, a number of caregivers and professional nurses to receive the MHCUs.

[289] She was supposed to have utilised a place at Kalafong hospital. However, after the place was inspected, it was found not to be suitable for habitation. She went to look for another place. She requested her uncle's assistance in making his house available to accommodate the MHCUs. She acquired cot beds for the children and received a license for 150 patients for the Kalafong hospital facility. She did not receive children at the NGO. She was requested to take adult MHCUs and she agreed.

[290] On 23 June 2016 she fetched 22 MHCUs from LE Randfontein who came with one set of clothing, a summary of their files and a container with a toothbrush and washing rags. The patients were also provided with medication for 28 days. She did not receive complete medical reports for the patients.

[291] The NGO did not have a professional nurse, dietician and occupational therapist. The patients were only assessed after two weeks of transfer at the NGO by the officials of the GDOH. On 28 June 2016 the NGO received 11 male patients and 3 more patients who were destined for Rebafenyi. Most of the patients the NGO received were psychiatric cases who did not meet the criteria of patients she had applied for and was qualified to take. She complained to Dr Lenkwane and she advised her to take the patients as the department would come and assist her when the time comes to swap adults with children. On 17 and 19 July 2016 she requested sister Rebecca from Bophelong to assist with the assessment of the patients and take their vital signs.

[292] She made a second house available to accommodate the MHCUs after she was requested to assist. An audit was conducted at the property and

it was certified to be compliant to accommodate 20 patients. Shortly thereafter she received 9 female patients from CCRC, who included Virginia Machapelah. The patients were taken to the house in Mosalo Street, Atteridgeville. She also received 11 more female patients from Anchor which were sent to Mosalo.

[293] The following patients died in her care and the information was received from the caregivers: Julia Kedibone Tshawe died on 12 July 2016 at Kalafong hospital. She was a severe intellectually disabled patient who came from Anchor house. She was admitted to the hospital with complications. Christopher Makhoba died on 3 July 2016 at the Precious Angels facility in Mosalo Street, Atteridgeville. He was an epileptic patient and wheelchair-bound. He was not able to eat and drink. He was fed through a syringe. He was found dead in the morning without complaints. In the facility there was one caregiver who had knowledge to treat or handle epileptic patients. Joseph Mohomusi died at the Precious Angels facility at Danville on 1 August 2016. He had a history of diabetes which they were not aware of. She had no knowledge of the problems of giving him medication nor was any report made about him refusing to take medication. The facility did not have the contact details of his next of kin. Virginia Machapelah died on 15 August 2016 at the Precious Angels facility at Mosalo Street in Atteridgeville. She could not provide any further information about her death as she did not receive any reports concerning her.

[294] Daniel Charles died on 8 August 2016 at Pretoria West hospital. She received a call that he was sick and she called an ambulance. The ambulance was delayed and she took him to the hospital with her own transport. The

patient was declared dead on arrival at the hospital. Christina Herbst died at Mosalo Street where she was reported sick and her feet were swollen. Solly Mashego died on 6 August 2016 at the facility in Danville. A night before his death he fell sick. An ambulance was called and he was declared dead.

[295] On 18 July 2016 and at the facility in Mosalo Street, Sarafina Ngcobo woke up and had breakfast. She then went to bed and died in her sleep. Terrence Chaba, who was at the Danville facility, became ill. He was taken to Pretoria West hospital where he was admitted and died on 17 August 2016. When Simphiwe Makhunga arrived at the Danville facility, he was bedridden. He showed progress and started to crawl. He was taking food and medication very well. He suddenly became ill and was taken to Kalafong hospital where he later died on 12 August 2016. When Eric Mashiloane arrived at the Danville facility, he was not healthy but naughty. His health deteriorated. He was taken to Pretoria West hospital where he died on 2 August 2016.

[296] Koko Nene was bedridden when she arrived at the facility on 29 June 2016. She was fed with a syringe. She fell sick on 5 July 2016 and was admitted to Kalafong hospital where she died on 12 July 2016. Jeremiah Modise arrived at the facility on 23 June 2016. He could not put his legs straight. He fell sick and died on 24 July 2016 at the centre. Matlakala Elizabeth Motsoahae arrived at the centre on 29 June 2016 from Anchor. She was eating well but had bedsores. She was moved to the facility in Mosalo. She started vomiting through the nose and was taken to Kalafong hospital on 10 August 2016 where she died on 26 August 2016. Seipati Pilane was bedridden when she arrived at the facility in Mosalo on 6 July 2016. She ate very well and drank a lot of

water. She fell sick and was taken to Kalafong hospital. She was not admitted. She died on 19 July 2016 at the centre.

[297] Magdeline Viljoen looked well upon her arrival at Mosalo on 6 July 2016. Her health condition deteriorated and she was taken to Kalafong hospital where she demised on 3 September 2016. Lucky Maseko was bedridden and weak when he arrived at the Danville facility on 23 June 2016. He was spitting the medication which had to be crushed in order to be administered. He got better but later his health deteriorated. He was referred to Pretoria West hospital where he was admitted and died on 4 September 2016. Simphiwe Thabethe was one of the patients who was taken by the GDOH after they were relocated from the facility. The witness received information that he died at Tshwane hospital. Julian Peterson was also among the patients who were relocated by the GDOH from the facility and she died at Steve Biko Hospital.

[298] The NGO did not receive any funding from the GDOH for a period of three months. They sometimes ran out of medication and received assistance from the Atteridgeville Clinic and a private clinic owned by Patricia Mbatsha. Mr Mohale assisted with the prescriptions of the patients. It took a long time to receive the required medication for the patients.

Carinna Butsi Morale

[299] The witness also made several statements, some of which relate to the deceased MHCUs who were at Tshepong Health Care Centre prior to their deaths. The statements were handed in as Exhibits FF1 to FF7. She was the director of Tshepong. She is a qualified community healthcare worker and previously worked at the South African National Tuberculosis Association

(SANTA) as a full-time caregiver. Her duties included amongst others, visiting tuberculosis patients discharged from the centre back to the community to provide them with counselling and ensuring that they were taking their medication regularly as prescribed.

[300] During 2010 the GDOH terminated Tshepong license and the centre started doing outreach programmes for TB patients from 2010 to 2016. Sometime in 2011 the witness applied for a license to care for MHCUs. In December 2015 Frans Thobane visited the witness at Tshepong and enquired whether they were still interested in taking care of the MHCUs. Mr Thobane further told her that she could receive patients from LE and that a team from the GDOH would be visiting the centre for inspection. On 9 December 2015 Rochelle Gordon from Tshwane District Office visited the centre and provided her with the guidelines.

[301] On 22 January 2016 a team from the GDOH and Tshwane District Health Services which included Hanna Jacobus and Rochelle Gordon visited the centre for inspection. Subsequent thereto a meeting was held and she was informed of the expectations, how to rehabilitate the MHCUS back into the community. She was promised a starter kit to supplement the centre with items which they were short of, but they did not receive any. She was further informed that her building was suitable to receive patients. She recruited 66 care workers, 25 healthcare workers, 5 enrolled nurses, 4 registered nurses. The dietician of Weskoppies was used to assist with hospital food preparation and additional beds were received. They also received assistance with medication from Tshwane Health Service Pharmacy.

[302] She received the license on 22 March 2016 to accommodate 186 patients. The NGO received a total of 185 MHCUs on 12 and 28 May 2016, respectively from LE Waverley and Rand West Care Centres. The MHCUs had in their possession referral letters, medication for 21 days which had expired and incomplete medical records. They did not have their identification books. The MHCUs were clinically not well and they were assessed by medical doctors. They were dirty with no clothing and shoes. She tried to refuse to take the MHCUs as she believed they had to be admitted to hospital.

[303] She contacted Dr Manamela and notified her about the expired medication and it was replaced. The MHCUs received on 12 May 2016 from LE Waverley only had seven days' medication. The issue was resolved after 5 days. The MHCUs were eventually identified by their badges and stickers which contained their names and photos.

[304] The MHCUs were checked for high blood pressure and blood glucose levels by the medical staff upon their arrival at the centre. Most of the MHCUs suffered from Schizophrenia or were hyperactive and the others were admitted for drug-related illnesses. The centre did not have the capacity or equipment to cater for the physical or wheelchair bound and bedridden patients. It was only after she had voiced her concerns about the challenges the NGO faced regarding medication and prescriptions that the former MEC, Ms Mahlangu and the GDOH sent doctors to check the MHCUs and provided new scripts to enable them to collect the medication at the Tshwane District Health Service.

[305] The MHCUs did not have any medical history. It took two to three days to diagnose them and for the centre to receive the diagnosis to be able to know how to treat them.

[306] On 1 September 2016 the whole staff did not report for duty because they did not receive their salaries. She contacted Hanna Jacobus and Dr Manamela. The medical staff from Weskoppies was sent to assist in taking care of the MHCUs. After lunch Solomon Khanyile and Jabu Nengelele escaped or disappeared. It is not known how they escaped.

[307] MHCUs who died at Tshepong centre were Sinah Mosalo, Abel Nkgwe, Paulus Makgane, Frans Dekker, Jan Snyders, Meshack Mejwale, Johannes Botha, Frederick Nelson, Jabulani Mnisi, Patricia Ngobela, Johan Ungerer, Willliam Golden and Elton Gouws. Sinah Mosalo was not well when she arrived at Tshepong. She was wheelchair-bound and bedridden with serious bedsores. She was taken to Kalafong hospital where she was admitted and later transferred to Leratong hospital. She died at Leratong hospital. Abel Nkgwe was very weak when he arrived at Tshepong. He was bedridden and could not feed himself. He needed assistance for his mobility. He was in and out of hospital. He died at Kalafong hospital. Paulus Makgane was healthy and strong when he arrived at Tshepong. He was taking medication regularly. He did not show any sign of chronic illness until on 5 November 2016 in the morning when he started experiencing breathing problems. He was immediately taken to Kalafong hospital for medical treatment. When the medical staff at the hospital was attending to him, his condition became worse and he then died.

[308] When Frans Dekker arrived at Tshepong, he was very sick. He was bedridden and could not walk. He had very deep bedsores. He was also in and out of hospital. He could not speak. He had open sores on his buttocks which were oozing pus. He was admitted to Kalafong hospital on 18 October 2016 where he later died on 7 November 2016. Jan Snyders was also not well when he arrived at Tshepong. He had a sizeable abscess on the head which he kept on scratching. He was also regularly in and out of hospital. During cross-examination it became evident that Jan Snyders received treatment at the Department of Dermatology in Helen Joseph hospital for eczema. Meshack Mejwale looked healthy when he arrived at the facility. He had lunch and went to bed to rest. He was later found dead. Johannes Botha was suffering from cancer. He was ill and taken to Kalafong hospital for medical treatment. He was then referred to Steve Biko hospital for further treatment. The family was informed about his admission and his brother refused to give consent for the patient to be operated.

[309] When Frederick Nelson arrived at Tshepong he was very strong and did not look ill. He went to bed after supper without any signs of illness. At approximately 00:00 he wanted to bath. When the care worker went to check on him at 03:00, he found him dead. The witness did not give information regarding the following deceased MHCUs as she did not have any personal knowledge of them: Jabulani Mnisi, Patricia Ngobela, Johan Ungerer, William Golden and Elton Gouws. Although she gave information about Paulus Makgane, Meshack Mejwale, Johannes Botha and Frederick Nelson, she also did not know them personally.

[310] In one of her statements marked Exhibit FF6, the witness also refers to Aaron Mkhwanazi who came to Tshepong on 12 May 2016 from LE Waverley. He was weak with a swollen leg but was able to walk without help or support. He used to go to Kalafong hospital for medical checkup and was eventually admitted on 28 February 2017 for medical treatment. The witness only heard about his passing when the Investigating Officer called her to enquire about his next of kin. The staff at Kalafong hospital did not inform her about his death.

Priscilla Olga Nyatlo

[311] She was employed by the GDOH as the CEO of CCRC from November 2010 until 4 July 2016. She was responsible for the general management of the facility that included patient care, human resources, physical as well as the financial resources of the facility. The criteria for MHCUS to be cared for at CCRC was for those who suffered from severe and profound intellectual disability. The hospital admitted patients of between 3 and 21 years and the patients could only stay at the facility for a period not exceeding 3 years.

[312] During December 2014 she attended a meeting chaired by Dr Selebano where the finances of the GDOH was discussed. Dr Selebano and the CFO at the time, Mr Mahlangu proposed that a team should be assembled to identify projects that would save money. The first initiative was to close down facilities like Selby hospital that was used as a step down facility for Chris Hani Baragwanath hospital and the termination of the LE contract. The patients of LE would be discharged in phases.

[313] CCRC received 20 patients from LE in 2015 in accordance with the scale down plan. During 2015 in a meeting chaired by Ms Qedani Mahlangu the attendees were informed that a decision was taken to terminate the contract with LE and all the patients would be discharged to all psychiatrist hospital including CCRC as well as the NGOs in Gauteng. Siyabadinga started to operate as an NGO on the premises of CCRC. CCRC began to discharge patients to Siyabadinga as it was then receiving patients from LE.

[314] On 20 June 2016 a meeting was held at the offices of the GDOH which she attended with Mr Mosenogi, Dr Manamela, Hanna Jacobus, Rochelle Gordon and Dorothy Franks. Dianne Noyile also joined them and Mr Mosenogi told her that Dorothy Franks was the owner of the new NGO called Anchor which would also occupy the wards at CCRC. She was instructed to assist the NGOs in the premises of CCRC with the resources.

[315] CCRC received a total of 101 patients from LE even though some of them did not meet the admission criteria for CCRC. Some patients received from LE to CCRC were further discharged to Anchor as directed by Dr Manamela. The patients were identified by Sister Manaka and no criteria was used to discharge them. The witness did not have any personal knowledge of the patients that were received and/or transferred which included Jaco Stoltz and Jan Deneicker.

[316] She only became aware that patients were discharged from CCRC to Anchor on the instruction from Dr Manamela when she received the information from Sister Manaka who was acting as a Matron at CCRC at the time. She did not enquire how many patients were transferred. She did not have any medical

background and relied on the recommendations of the MDT to indicate which patients could be discharged.

Dr Makgabo Johanna Manamela

[317] Her qualifications and experience were placed on record. Her highest degree is a Doctorate in Psychiatry from the University of Johannesburg. She moved within the ranks of different positions in the department until she was appointed as the Director of Mental Health Services in 2010/2011. She was in charge of the Mental Health Services in Gauteng. Gauteng Province has five districts, namely, Tshwane, Ekurhuleni, Johannesburg (COJ), Sedibeng and West Rand. The five Deputy Directors and one Assistant Director (AD) reported directly to her in the province. These Deputy Directors were Mr Frans Thobane who was in charge of LE, Ms Hanna Jacobus who was overseeing Mental Health NGOs, Dr Lenkwane who was overseeing hospitals, psychiatry hospitals and the hospital wings that provided mental health services, and the private mental health hospital partly in the province.

[318] Ms Mashile was overseeing substance abuse services in their province as well as the City of Johannesburg Community Mental Health Services. Ms Frieda Sennelo, a social worker, worked with Ms Mashile. Ms Nonceba Sennelo was overseeing all the community Mental Health Services.

[319] The GDOH developed a vision 2014/2020 plan under her leadership. During the first year they had expected to accomplish the vision of reducing 200 beds per year for five years. LE had challenges. Towards the end of July or August, LE managed to reduce the 200 beds.

[320] She became aware of the termination of the LE contract over the radio. She did not receive any formal communication until she received a letter indicating the termination of the contract. The reasons provided for the termination of the LE contract were that the department had financial challenges and from the plan they had, they were expected to up-scale community mental health services and to have an opportunity to up-scale the mental health services in the community. They continued to carry on with plan and the MEC and the HOD appointed project leaders and the project teams which included her as the Project Deputy. It is not necessary for the purpose of this inquest to mention all the other members of the project team.

[321] The first date to implement the termination project was 31 March 2016. Due to difficulties in meeting the proposed target, an extension of 3 months was received. A meeting was held at LE Waverley which was chaired by the former MEC where the reasons for the termination of the LE contract was explained to the families of the deceased MHCUs. They were told that the GDOH did not have enough funds to continue with LE. The families were not happy about the news of termination of LE contract.

[322] Her role during the termination project was to support the project, convene meetings, and report on the developments made. She had to profile the type of patients at LE and establish how many patients were eligible to go home and the NGOs. Where the families were unable to take care for the patients or support them, what were the reasons and how many still needed to be hospitalised or be admitted to a psychiatrist hospital.

[323] At the time of the termination of the LE contract, the GDOH did not have enough capacity to absorb all the patients at the other facilities. As a result, they invited the old and new NGOs as well as other stakeholders, SADAG and SASOP to a meeting at the beginning of November 2015. New NGOs were identified in a particular district. Whoever was responsible for the district would go and visit the NGO and inform them of the beds they were interested in, and the team would take the NGOs through the process that should be followed until a license was issued. The license was submitted by the district that knew how many patients to place in an NGO as well as the type of patients that would be placed in that NGO. An indication would be given whether it was an adult or child patient. A SLA would have been concluded between the NGO and the GDOH. When all had been done, the license was submitted to the witness's office for her to sign it as director and it was taken back to the district for the district to issue it to the NGO.

[324] She explained that the licenses that she had signed for the old and the new NGOs were eventually issued. However, during the process she was informed that she was not supposed to have signed them. The HOD was the one who was supposed to sign them.

[325] Dr Lenkwane and Ms Nonceba Sennelo were placed in LE Waverley where they started with the placements during May 2016. They assisted in assessing and ensuring that every patient was assessed by doctors before they were allocated to the NGOs or hospital. They also assisted the MDT of LE and they managed the process when the patients were moving from the ward to the NGOs or to the hospital. They ensured that the patients were moved

appropriately with what was expected and to the relevant places. They were facilitating and coordinating the placement of the MHCUs from LE Waverley to the NGOs and/or other facilities.

[326] She did not play any active role but when they had challenges, she would be called for assistance. Meetings were held every Monday where reports would be given in order to support one another. She was not aware of the mode of transport that was used to transport the MHCUs who were moved from LE to other facilities. She only became aware of transport issues when she was contacted with regard to problems. She did not play any role in determining how many patients would be placed at a specific facility. Regarding that, the NGO first liaised with the identification team which in turn liaised with the placement team. The placement team provided information regarding the number of beds at the specific NGOs and when the patient would be fetched or in the case where the patients were brought to the facility; when they would be transported or delivered. Two doctors were deployed to LE to assess the patients guided by the MDT and then determine their criteria and who would be transferred to the hospitals and/or the NGOs.

[327] Anani was a new NGO that received a total of 25 patients. None of the patients who were at Anani died. Anchor had a total of 49 patients and there were three deaths. At Areyeng in the COJ, no death occurred. Areyeng received only three patients from LE. Bokang received 23 patients and none of them died. Bophelong in Mamelodi was an old NGO which received six patients and there was one death. 40 patients were transferred to Bophelong in Mashemong, Hammanskraal, and they only had one death. At Dolphin Acre

they received three patients and none of them died. Only one patient was transferred to Hephzibah from LE and there were no deaths reported. Ghanana which was also an old NGO in the West Rand received 10 patients from LE and nine of them died.

[328] At Lapeng there were 30 patients and none of them demised. Mosego home received 76 patients and only 5 of them died. Odirile which was also an old NGO, received 42 patients and no deaths were reported. Precious Angels had 42 patients and there were 17 deaths. A new NGO called Rebafenyi received 81 patients and only two deaths were reported. Saint Mitchell which was also an old NGO in Ekurhuleni received 12 patients and no deaths were reported. 34 patients were transferred to Sibosarona and only one death was reported. Shamma house received 50 MHCUs and there was only one death.

[329] 96 patients from the two LE facilities were transferred to Takalani which was an existing NGO and 12 deaths were reported. One patient was transferred to Tekalang and there was no death reported. An old NGO called Thuli's home received 28 patients from LE Randfontein and none of the patients demised. Tshepong was a new NGO and it received a total of 186 patients. Only four patients died at Tshepong. Tumelo had 28 patients and only one of them died. Ubuhle Benkosi had a total of 40 patients and only one death was reported.

[330] There were approximately 1442 patients at the LE facilities as from 1 June 2015. They did not have enough NGOs. Subsequent to the issuing of the termination letter, they had to call meetings and begin working on establishing new NGOs and to request the existing NGOs to expand. At that time there were only 116 beds available. During the bi-weekly meeting with the MEC and/or the

infrastructure DDG, they would report about their problems, the number of beds and how many NGOs were ready, how many beds they were getting from the old NGOs, how many they could get from the new NGOs and the departmental hospitals (Cullinan, Sterkfontein or Weskoppies).

[331] She did not have the powers to stop the termination of the LE contract. The decision to terminate the contract was taken by the Executive. She had to carry out the department's legal instructions of terminating the contract. They had challenges. They had to ensure that there was infrastructure because when the termination letter went out, they were busy with the 200 beds. They did not have enough beds at the time. They had to work hard to ensure that they had beds where the patients would be placed. They had to ask the district to submit the list of new and old NGOs and those NGOs that wanted to expand. Some of the old NGOs did not have the funds to expand. They only had 6 months to obtain sufficient beds for the MHCUs. These challenges were brought to the attention of the former MEC, Ms Qedani Mahlangu. She only responded by saying they needed to ensure that the termination process proceeded. The witness roped in the engineers from the infrastructure unit to assist with the infrastructure challenges and the finance section to become involved in resolving the financial challenges.

[332] Hanna Jacobus, the NGO Manager from the MHD would identify the NGOs and then liaise with the district to identify the new NGOs or the old NGOs that wanted to expand or those that had the resources to open a new wing. Ms Jacobs worked with Mr Frans Thobane and the other Deputy Directors (DDs) and supported the district. There were District Coordinators for West Rand,

Ekurhuleni, Sedibeng, and Johannesburg. These District Coordinators had to make sure that the NGOs were audited and in compliance to receive the MHCUs. The purpose of the audit was to ensure that the NGOs that would be licensed had been assessed and evaluated, and met the minimum requirements to manage the MHCUs.

[333] During the placement of the MHCUs they experienced problems in that the MHCUs were placed at facilities that were not allocated to them. This was rectified by placing those MHCUs in other more suitable facilities. Patients that were discharged into the care of their homes and/or NGOs left LE with medication for 28 days. Arrangements were made by establishing a link between the NGO and the hospital or clinic nearby for MHCUs who needed their services regarding medication or medical care to access such services.

[334] When she visited Tshepong, this NGO already had financial problems. There were complaints that the NGO received medication for 7 days. She requested Weskoppies to assist the NGO with medication. The NGO did not have enough food for the MHCUs and the witness intervened by referring the NGO to local stores for more food. She further requested a company that supplied bedding and clothing to assist the NGO.

[335] She also visited Precious Angels together with Dr Lebethe and the former MEC. They found that the NGO had two professional nurses, and the patients were accommodated in a house that was a bit small. There was a delay in paying the NGO and it began to have a food shortage. They found adult male patients in cot beds. The witness also visited Takalani where she

did not observe too many problems. All the NGOs only had one common problem of not being paid on time.

[336] She then introduced a strategy called "*adopt the NGO*". She requested the team from the MHD to own an NGO by assisting it in respect of all aspects and challenges. When the witness began to hear the reports of the deaths, the department could only support the NGO and endeavour to prevent more deaths. In respect of food, the department arranged a meeting with the NGOs where a dietician from Masala would provide food to the NGO that needed food and the account would be settled after the department had paid the NGO.

[337] In preparation for the transfer of the MHCUs from LE to the different NGOs, the district coordinators provided them with a list which indicated that in the specific district there were certain NGOs which were newly established and the amounts of beds they had. The old NGOs also indicated the number of beds they had available. This information was verified after their meeting with the district coordinators. The NGO managers provided information regarding the number of staff members they had and the places where they could place the MHCUs as well as what they would need to look after them. They also had to look at aspects that did not fall under the MHD which include amongst others, the issue of having sufficient funds to look after the patients.

[338] The department tried to ascertain from the NGOs whether they would be able to maintain or assist their patients for a month or two while they were still preparing their paperwork for refunds and payment from the department. There were arrangements made for the NGOs that struggled financially to

receive advance payments. For that period there were arrangements for the hospitals to assist with furniture.

[339] During the transfer process, she was not directly working with the patients. She was receiving reports. The status of the NGO was reported to her through the audit process. When she visited the NGOs, the purpose was not to check whether the NGO was in compliance with the audit report. She was more interested in the quality of care that the MHCUs received at the NGOs and how they were treated. She also looked at the infrastructure regarding the type and number of the patients received. She did not check the records of how the audits were done, how many patients the NGO received from LE and the number of treatments.

[340] Discharges were determined in accordance with the condition and the level of function of the MHCUs at the time they were assessed and ready for discharge, and the type of the hospitals and NGOs and the service they provided for patients or planned to offer. They also decided that CCRC would receive patients that were mentally disabled and with physical disablements. Moreover, MHCUs who were going to Weskoppies and Sterkfontein would be those patients that had chronic mental illness, for e.g., schizophrenia or uncorrected depression or anxiety.

[341] The selection of the NGOs for placement of the MHCUs was determined according to the type of the patients the NGO was interested in taking care of. Under normal circumstances patients would be scrutinised in a critical manner to determine whether they could be sent to an NGO first or hospital. The doctors and nurses at LE together with the GDOH teams at the two LE facilities would

look at the level of functioning and advise each other which patient to transfer to the facility.

Dr Tiego Ephraim Selebano

[342] The witness is a medical doctor. His qualifications and experience were placed on record. He was in private practice from 1998. He worked at different places before he joined the GDOH. From 2010 he was employed by the GDOH as the CEO of Charlotte Maxeke Academic hospital and moved within different ranks in the department until he was appointed as HOD in the GDOH.

[343] As HOD he reported to the MEC. He was effectively the administrative leader of the health department. As head of administration, he ensured that all other programs, including health policies were implemented. These policies were set at National level. All the MECs in the country met at MINMEC also known as the National Health Council (NHC) together with their HODs as well as the Minister of Health and the Deputy Minister of Health. MINMEC or NHC was chaired by the Minister. All the HODs of all the provinces in the country sat in the technical committee for the NHC chaired by the DG for Health. Before anything could go to the MEC, it would be processed by NHCTECH, policy issues, trends, anything that was of concern in the country, would be processed in that committee and the DG would make a presentation for discussion at the MINMEC between the MEC's and the Minister.

[344] MINMEC meetings were held quarterly. The planning department was responsible for the annual performance of the department. The HOD was responsible for delivering the plan and had to ensure that everybody was up to speed and doing their work. The Premier had what was called the Premier's

Budget Council, the PBC. They prepared the budget and presentations would be made by the MEC to the Premier's Budget Council.

[345] During 2014 the GDOH was in a bad financial space. The department inherited the accruals. Every year their expenditure increased whilst they did not have the capacity to pay their debts. They had bad audit outcomes. They decided to deal with their budgetary constraints and endeavoured to find defects in the system, fix them and effect outstanding payments and make reallocations. The discussions to terminate the LE contract commenced at the Gauteng Cabinet (where HOD's in Gauteng with their individual MEC sat) and then taken to the PBC. As Head of Administration, when the decision was made regarding LE, they sat as managers, MEC and all of them, budget and finance staff, had a discussion after which a decision was taken to terminate the contract.

[346] The project of terminating the contract relationship between the GDOH and LE and upscaling was the responsibility of the MHD. However, the presentation was done by Dr Manamela at the senior manager's meeting. The plan was approved at a senior management meeting and he signed it off. The senior management consisted of the MEC, the witness, the DDGs and Chief Directors.

[347] Weekly meetings chaired by the former MEC were held to assess the progress of the implementation of the project and whenever the former MEC was not available, the witness would chair the meetings. These meetings were attended by the DDGs, Chief Directors, Directors, finance, everybody, people from DID, Public Works, the HOD once attended as well as the HOD from Social

Development and the team. The feedback relating to the progress in the project was twofold, the pre-movement of patients where they would get reports from Social development that some patients did not have identity documents, some did not have SASSA cards. Post-movement they were informed about the placement progress according to plan.

[348] He became aware of the deaths of the MHCUs towards the end of August 2016 when the news was in the papers and the political parties were raising the matter in the legislature. By the time they were informed about the situation, all the MHCUs were transferred from LE. The witness, the managers and the MEC then decided to close some of the NGOs towards the end of September. The patients who were at the NGOs which were closed were moved to the psychiatrist hospitals, Sterkfontein and Weskoppies.

[349] During cross-examination he testified that the GDOH terminated its contract with LE because they could not pay them for their services. The decision was taken by the Premier's Budget Council or the Cabinet. He did not sit in the discussions when such decisions were taken. The HODs did not attend further meetings. The MEC provided a feedback on what the PBC and the Cabinet had decided. DDGs worked with strategic issues not granular issues which include medication, SLAs, licenses etc. The issue of licenses was raised around September, long after the patients had been transferred, and no meeting was held in relation thereto. He further testified that the NGOs had licenses and the licenses that he signed, was only as co-signature. He explained that the Ombudsman said the licenses were unlawful because Dr Manamela and her unit signed the licenses and he was supposed to sign them.

He co-signed the licenses and requested that they be attached to the original licenses issued together with his memorandum.

[350] He did not speak to any team member who created the implementation plan and did not even know who these people were. Dr Manamela presented the plan to the executive team. He did not visit Takalani. He was confident that it was a place that would provide access to quality mental healthcare to all users in their care. He relied on his colleagues as they are the ones who dealt with NGOs, went to the premises and found it to be a suitable facility.

Ms Qedani Dorothy Mahlangu

[351] She began her evidence by placing her roles and responsibilities as an ANC leader within the Provincial Executive Committee (the "*PEC*") and the Provincial Working Committee (the "*PWC*") on record. Further responsibilities and roles were the service she provided in different sub-committees as a member as well as the type of meetings she attended in her respective roles and when she attended them. From 2004 to 2009 she was the MEC for local government. From 2009 to 2010 she was the MEC for Health and Social Development. From November 2010 to July 2012 she was the MEC for Economic Development and from 2012 to 2014 she was the MEC for Infrastructure (Public Works). In 2014 she was redeployed as the MEC for Health until 2017 when she resigned on 1 February 2017.

[352] According to the annual report, she had about 62 726 employees in the department of health. The employees were highly skilled, from level 1 to level 2. They were largely medically trained professionals from the nurses to all

categories, which include doctors, professors and some who were linked to universities.

[353] The state of the finances of the GDOH did not improve much since she left in 2010. In the 2012/2013 financial year, the provincial government took a decision to put the GDOH under the support and assistance of Treasury in terms of section 18(2)(g) of the Public Finance Management Act because their finances were not in good standing.

[354] During the arbitration proceedings she testified that the reason for the termination project was to enable the MHCUs to be integrated into the communities instead of keeping them permanently institutionalised in the hospitals in line with the Mental Health Care Act. For far too long the MHCUs have been treated as social outcasts. This was to ensure that the MHCUs lived amongst the members of society instead of being locked up in the mental institutions. She also indicated that the project was responding to the negative findings by the office of the auditor-general on the LE SLA.

[355] The LE contract which can be traced back as far as 1 August 1979, had continuously created an audit query due to its perpetual nature. The department had also been unable to maintain the costs of LE for some time. She was advised by Dr Selebano which advice she accepted and relied upon before the termination of the LE contract. Dr Selebano obtained a legal opinion from which he advised the department to terminate the LE SLA.

[356] In line with PFMA and other legislation, she provided guidance when she was required to do so. She held informal meetings with the officials in line with the roles of the executive authority when necessary to ensure the

implementation of the project. The project committee was required to meet on a weekly basis. She attended several meetings whenever she was available. During the initial phase of the project, she was given the assurance by the project committee through the HOD that the implementation of the project was on track despite a few teething problems. Issues of concern such as shortage of food and blankets were not presented in formal meetings except for the supply of medication which was referred to in a couple of meetings. She had no reason to suspect that the project was at risk level, or the lives of the MHCUs would be jeopardised when all operational plans were presented to her which included the briefing by the HOD on the legal opinion. She received positive reports on a continuous basis regarding the implementation of the project.

[357] Section 27 took the GDOH to court challenging the implementation of the termination of the LE contract. She only became aware of the matter after it was finalised in court. In January 2016 she met with the families of the patients that would be affected by their move from LE and they were afforded an opportunity to ask questions to clarify the uncertainty. She did not receive any report save for those that related to patients that arrived at Weskoppies and Sterkfontein hospitals with only one pair of clothing items and the patients who were weak and malnourished. These patients were immediately taken to Kalafong hospital.

[358] The first key challenge that was brought to her attention was the shortage of food at an NGO in Cullinan. She visited the facility to see if the department could resolve the problem. She was not aware of the deaths of the MHCUs at the NGO facilities. During September 2016 she received a question

through the legislature on the LE project. She became aware of the deaths of the 36 MHCUs at the various NGOs on the evening of 12 September 2016. She received the information from the office of the HOD. She then requested the Health Ombudsman to conduct an investigation into the cause of the 36 deaths.

[359] When she visited Precious Angels during September 2016, the owner informed her that the NGO never received any payment from the GDOH. She found out that the NGO was not registered with the Provincial Treasury. She then requested the HOD and the CFO to assist the NGO with the necessary registration and documentation to enable payment. She found out through the media that 68 patients died. Subsequently, she requested Dr Lebethe to facilitate the performance of the autopsies of the deceased patients and to register the cases with the police and obtain a case number. She together with the HOD divided themselves into the different teams and they were joined by the ministerial team. They visited the various NGOs to inspect the infrastructure and to ascertain whether there were adequate sleeping arrangements as well as the availability of their medication, food and first-aid kits. She also visited Bophelong Suurman in Hammanskraal accompanied by Professor Freedman from the National Department of Health and Jeanette Hunter, and the Mental Health Review Board Representative.

[360] She relied on the expertise of the people below her regarding the MHCUs, specifically at the time after the PBC had pronounced that they needed to do cost-containment at LE, Selby and other institutions. These were projects relating to patient care. Dr Manamela has a PhD in Psychiatry. If she advised

that she agreed with a program, the witness had no reason to disagree, because Dr Manamela was an authority in the topic. If the HOD said he was her eyes and ears, when there was something the witness did not understand, she would enquire from him what the solution or answer was. If he said to her MEC this was the route to go, she would then support the decision that was taken. She did not have any reason to doubt them.

[361] Towards the end of February 2016 she had a meeting with the officials of the GDOH led by Dr Selebano as well as senior managers forming part of the district, five chief directors and the project team where the project manager, Mr Mosenogi and Dr Manamela were present. One of them made a presentation requesting the extension of the LE contract. They eventually agreed that the contract must be extended until the end of June. It was reported that the period would provide sufficient time to complete the work that was still ahead. After the extension in February which was for a period of three months, no further request was made for another extension.

[362] She assumed that the licenses that were issued were legal. She did not play any role in the issuing or approval of licenses for any of the NGOs. She was adamant that the decision to terminate the LE contract was taken by the provincial government led by Premier Makhura. She was part of the team when the decision was made. The implementation process was the responsibility of the GDOH. She did not have the authority to take such a decision on her own.

Barbara Creecy and David Makhura

[363] Ms Creecy was the MEC for finance and Mr Makhura was the premier of Gauteng Provincial Government during LE calamity. The two witnesses were

not part of the process following the termination of the SLA with LE. They only testified on a limited issue as to who took the decision to terminate the LE contract. The court requested them to testify after hearing the evidence of Ms Q Mahlangu. Both witnesses together with Ms Q Mahlangu formed part of the PBC. Ms Creecy and Mr Makhura denied that the decision to terminate the LE SLA was taken at the PBC on 26 November 2014. Their evidence was to the effect that the PBC did not have the authority to take such a decision. Only the HOD of the GDOH, Dr Selebano had that authority.

[364] Ms Creecy further testified that no budgetary constraints existed for the GDOH to terminate the SLA with LE.

<u>Professor Leslie Ann Robertson</u>

[365] Her qualifications and experience were placed on record. She is a psychiatrist and has worked in Sedibeng District as a community psychiatrist. She explained community based mental health services as a counteraction to the old style with sort of colonial era institutionalised services which were in standalone hospitals. From the 19th and/or early 20th century, everyone with a severe mental illness would be locked away because of not having the right medicines to treat them. As medicines were developed and with a better understanding of what mental illness it is, the right of these patients to live in their communities became stronger and more well observed. However, in order to live in their community, they have to be able to access care closer to their homes.

[366] Community mental health services are essentially the equivalent level of care closer to a person’s home that one would have in a standalone

institution. It enables a person to live in their families or in their communities given that they have an illness. In the years she spent in Sedibeng district as a consultant, she worked with NGOs who provided residential and daycare centres. Deinstitutionalisation essentially means closing institutions and transferring the place of care from the institution to the community. This entails three aspects to the process. One was the closure of long stay institutions and move the patients from the institution to the community. There was also upgrading, upscaling services in the community with psychiatrists, psychologists, social workers and occupational therapists and others like admin clerks, they modelling for everything, and increasing the beds in the general hospitals.

[367] They started the process bit by bit before 1994 by developing wards at Chris Hani Baragwanath hospital in order to increase the number of beds. Developing community mental health services means developing the service, not moving the patient. Accepting that being a patient is about providing the infrastructure, staffing and personnel for that patient.

[368] The reason for the National Mental Health Policy Framework was that community mental health service had not been developed, but people had been rapidly deinstitutionalised. The policy specifically included a strongly worded cautionary statement to stop deinstitutionalisation until community mental health services had been developed. In the Gauteng in 1994 they had 70 beds in long stay hospitals per 100 000 in a population. By 2004 they had reduced that number by half to 35. By 2008 they had reduced it again (not sure of the ratio), they had reduced it by 2000 and something. From 2008 onwards they

were not able to continue reducing those beds as there were no services to keep people stable in the community.

[369] In June 2015 after hearing from Dr Manamela at one of the MHD meetings that the former MEC for health, Ms Mahlangu was planning to reduce the number of beds and also about restrictions on admissions at LE, as SASOP they wrote to the MEC to caution against that decision. At that time, they were aware of a long-term plan of ending the contract, but there was no termination date yet. They were concerned about the reduction of beds because they were not coping with the demand on care with the revolving door patients. They were concerned that there was an under-estimation of the severity of the illness. They had not fully estimated the severity, themselves. The illness was more severe than they had thought. They were concerned that the community-based residential facilities (the NGOs) would not offer an equivalent service to what was offered in a standalone hospital.

[370] They were concerned that they did not have enough beds at NGOs and the NGOs did not have the expertise or the equipment to care for the people who were to be deinstitutionalised. Their real concern was that the services they had in the province, were being dismantled at that time.

[371] They did not get a response to the letter from the MEC and everybody else. The termination of the LE contract eventually happened in September 2015. The witness wrote to the MEC and the officials in the GDOH on 30 October 2015 after the MEC had announced in public the decision to terminate LE contract. They wanted to have a meeting with the MEC and discuss the matter. They wanted to raise their concerns in a coherent manner. Nobody

responded to the letter. She was not directly involved in the litigation that happened in December 2015. The aim of the litigation was to stop the discharge process or the deinstitutionalisation process until a mutual plan had been agreed to by all the parties and was given January 2016 as a deadline. No agreement was reached by the end of January 2016. In March 2016 the GDOH was already discharging and deinstitutionalising patients. There were labour issues at Takalani and the litigation was to hold the discharge of patients to Takalani. The litigation failed to stop the process and the patients were placed at Takalani and other NGOs.

[372] In a subsequent correspondence addressed to Dr Manamela and cc'd to Dr Selebano, Mr Mosenogi and others, she was very worried and noted her concerns that they were not sufficiently equipped to receive a large number of seriously ill MHCUs and she went back to the meeting of 22 April 2016 where she had said when she saw the preparation being put into the hospitals and the caution with which the MHCUs were being transferred to the hospital unit, she became acutely aware of how unprepared they were in the community. She also realised how ill-equipped she was to evaluate the NGOs for reception of the MHCUs. This was after she had visited and agreed to the readiness of three NGOs.

[373] Normally NGOs receive one user at a time after being discharged when deemed well enough to live in the community. So in the normal process of discharge somebody has assessed the MHCU in full capacity. She did not know whether or not the NGOs would cope with receiving groups of ten or more people. She just evaluated them in terms of a best case rather than a worse

case, scenario regarding the MHCUs they received. She was also worried about the number of MHCUs being placed in each home and the caregiver to MHCU ratio. She had agreed that the NGOs were ready based on the MHCU load of established NGOs, that they were within the official standards set out by the directorate and that none of the NGOs would financially survive if they would reduce the number of users.

[374] The NGOs were overcrowded and there were insufficient caregivers per user. The caregivers were not trained in mental care. Most of them had experience in home-based care for HIV Aids and some of them had experience in care for the elderly and intellectually disabled. This is not the same as caring for somebody with a severe psychiatric disorder. She was also concerned that the NGOs were not adequately equipped for the severity of the illness of the MHCUs. She did not get any response to the correspondence and understood at that point that she would not be part of the project team and that there was no more communication.

[375] They did not accept 80 MHCUs in Sedibeng districts. They stopped at 63 and decided not to take more MHCUs as they realised they were not going to manage them. There was nothing more until she heard on the news that 36 people died. They had been warned about the staff they saw and worked with. Their focus, their most difficult issue was actually young men with disruptive and aggressive behaviour. They did not anticipate death. In their letters and warnings, they really concentrated on severe mental illness, the psychosis, chronic psychotic disorders, severe bipolar disorder and less on the conditions of the people (the physical health conditions) of patients with severe intellectual

disability with cerebral palsy, epilepsy as well as severe dementia. They did not realise that people with these severe disabilities were being cared for at LE as well. They only saw those revolving door patients who were in and out. They MHCUs were severely frail and much more fragile.

[376] She was a member of the expert panel which was established when the Health Ombud was appointed to investigate the deaths. The expert panel report was attached to her affidavit. Following the revelation of the deaths in the parliamentary legislature, the Ombud was requested to investigate the circumstances surrounding the deaths of the MHCUs who were moved out of LE to the NGOs. Dr Talatala called her to ask if she would be willing to be enlisted on the panel and she agreed. She was then called to a meeting at the office of the Health Ombud to meet the other panel members. In the course of the investigation they visited the NGOs to gain an understanding of the circumstances. Their work was limited to the clinical records of the 38 MHCUs who had died from LE; the different NGOs and in some cases, from some of the hospitals. They wanted to get a better understanding of what happened at the NGOs. She visited many NGOs and amongst them were Bophelong Suurman in Hammanskraal, Tshepong and Lapeng.

[377] When they visited Bophelong Suurman in Hammanskraal, 33 MHCUs had already been removed and placed in Sterkfontein and Weskoppies hospital as a rescue effort to prevent further deaths. The NGO had received 40 young male patients with mental illness. They lost two MHCUs. The house was crowded and she felt that the manager did not understand what psychosis is or how to manage somebody with psychotic illness and used substances.

Furthermore, the facility was not suitable to care for the patients who were taken there who were suffering from psychotic illness. The beds were spread through the house, out in the garage and outbuildings. They were just everywhere.

[378] She conceded that psychosis epilepsy and HIV are complex conditions. She testified that they were incredibly difficult to manage. Reference was made to the deceased, Hendrick Billy Maboe who was at Bophelong Suurman, Hammanskraal, had psychosis epilepsy and HIV, and died within a month after being placed at the NGO. When asked what kind of care the patient with such comorbidities would require, she explained that epilepsy would have to be controlled with anti-epileptic medication. However, the impact of severe stress on the epilepsy is not known. We know there is an interaction between severe stress and more difficult control of epilepsy, sometimes. The severity of the HIV is also not known but it also needs to be managed with the antiretrovirals together with any HIV related illness that could need management.

[379] People with mental illness who have HIV are more likely not to adhere to antiretroviral medication. They have a higher mortality rate of HIV and HIV related illness even when in care. Psychosis is extremely difficult. It is the most severe illness. It should be called like a brain failure syndrome.

[380] Tshepong was an old TB hospital. It was more remote. The NGO received 87 patients in one day. They had 14 nurses and the NGO had received over 80 MHCUs with a complete mixed bag of illnesses and disabilities. As she was taking rounds, in one of the wards she saw patients who she felt were hospital patients who needed hospital care. The manager told her about the challenges the NGO had which included, amongst others,

difficulties in accessing the clinic, physical health and mental health treatment from the clinic. They also did not have adequate transport themselves and appropriate transport to take people with severe physical disabilities to the clinics. They used an old car.

[381] She also testified that 45 patients had been transferred from one NGO to another. From what they had seen, it was clear that there was no preparation when the MHCUs were moved. It was chaotic. She confirmed that Virginia Macaphelah was one of the MHCUs who was moved from one facility to another. However, she could not give details regarding her circumstances as she indicated that when they were conducting investigations they concentrated on the group and not the individual MHCUs.

[382] Sometimes they had patients at the NGOs who had no discharge summaries. They did not get any of the mental health forms. Doctors would then take histories from the patients as to their illness, their comorbidities, their medicines and to work with the carers in the NGO as to how to make a plan for them. Their nursing staff as well as their mental health manager had to run around the NGOs and made sure that they deliver a service for various primary care clinics. The family physicians came in and the medical officers went to the NGOs to examine the MHCUs.

[383] She explained sepsis as a general term that relates to any kind of infection. A natural cause of death is a death which is as a result of an illness as opposed to a result of trauma or violence or injury or violence. An unnatural cause of death is when it is inflicted from an outside source. A natural cause of death is a physiological process coming from the body's mechanisms.

[384] A person with severe intellectual disability is vulnerable to dying from another cause, pneumonia, TB, dehydration, etc. depending on the circumstances under which they live. A person with severe mental illness is also more vulnerable to dying from related causes.

[385] She further explained how she got to the article with the title "*mortality analysis of people with severe mental illness transferred from long stay hospital to alternative care in the Life Esidimeni tragedy*" attached to her affidavit. When they conducted their investigation, they found that the investigation was limited by the lack of data. The data was inconsistent throughout. It was very hard to know what happened because of poor documentation. The Ombudsman requested the GDOH to collect the data accurately. There was a data verification team set up within the GDOH. This happened after the release of the Ombud report and during the LE arbitration hearings. The verification team was getting data and trying to work out exactly who went where and what happened throughout.

[386] They received data of patients who were transferred between October 2015 and June 2016. 1 442 patients were transferred from LE to NGOs, CCRC, Sterkfontein or Weskoppies during that period. They were looking to transfer to alternative care facilities. That did not include the people transferred to their homes and people who were transferred from one place to another in order to make space. They did not include patients who were transferred from CCRC to Anchor to make space for patients from LE. They only included those patients who were transferred after the announcement of the termination date in October 2015. When they conducted the investigation they realised that

nobody knew how many patients were at LE at the time because in September 2015 they had already closed Witpoort.

[387] They could determine from data the kind of numbers transferred each month according to the data verification team. From October there were 10 patients going to CCRC or an NGO and went to a psychiatric hospital, in May and June huge numbers were transferred as the project had to end. They followed all these transfers until the end of August 2017. The first death was in January 2016 and the figure went up in July and August 2016 and then it went down. They related the deaths to the date of transfer after October 2015 and found that 70 percent of the deaths occurred in the first six months of the users being transferred and the first two months of transfer was the period of the highest risk. In the period of time they had for the study, they documented 131 deaths. At the time the media was indicating 144 deaths from LE because they were including 13 deaths which happened from internal movement between NGOs, these were not people from LE. They were people who were already at CCRC or at an NGO who were moved and died, their deaths were precipitated by that move. They did not include the 13 deaths because those deaths were not from the cohort of people who were moved from LE to either CCRC, an NGO or an academic hospital.

[388] 42 patients were transferred from LE in April, 831 in May and 418 in June and the deaths happened in the first couple of months after transfer. Their explanation was that that was a reflection of the spike in numbers shifted out of LE in haste, rapidly moved into NGOs which were not well prepared. From that number of 1 442, 211 patients were transferred to academic hospitals and

1 231 to CCRC or NGOs. By 400 days there were 4 deaths out of the 211 transferred to Weskoppies or Sterkfontein. 98 percent of that group of 211, had survived the transfer. On the other hand, at 400 days, they found 123 people had died and 90 percent of that group that went to CCRC or NGOs, had survived the transfer at 400 days.

[389] In a standardised mortality ratio, they compared all of the deaths in those groups that occurred in 2016 to the deaths that occurred in the general population for 2016 in each age group. They broke it down by age groups to see if there was a difference. They only included deaths that occurred between January and December 2016 which gave them only 103 deaths. They dealt with a total of 1 442 deaths. They found that overall the mortality ratio of the entire group was 4,9 which is 5 times higher than the general population with the mortality ratio of just under four, 3.9 for men and 6.3 for women. So, the women were 6 times more likely to die. People with severe mental illness have a higher mortality rate than the general population, but they expected that mortality rate to be double, two times higher, not five times higher or six times higher than the general population. This means that the mortality rate of this cohort, excluding people who died internally, excluding people who could not be located, was much higher than what one would expect from that age group or for people with mental illness. When the MHCUs were discharged, it reflected their difficulty in accessing care, mental healthcare after discharge.

[390] During cross-examination she testified that after not receiving any response from the MEC's office where she had sent the emails dated 23 June 2015 and October 2015, she did not make any follow-up. With regard to the

statistics of the mortality rate of the MHCUs that she testified about she stated that they did not analyse the death rates of the MHCUs at LE and compare it to that after discharge. In the investigation they got data from LE and they attempted an analysis as part of the circumstances around the death. The reason for not doing it was because the Ombud was not tasked to investigate the death rates at LE. It was never raised as a problem by government, the GDOH conducted regular audits, the HAI also conducted an analysis of LE. Furthermore, the GDOH audited LE every year, they never found an extraordinary high death rate.

[391] She was adamant that amongst the concerns she raised in the two letters addressed to the MEC were that the GDOH was told that the NGOs were not equipped and adequately resourced to care for people from LE. Regarding the statistics that she testified about, she conceded that the compilation thereof, the decision on what statistical test to use for the analysis fell outside her expertise. Interpreting the meaning from a clinic perspective and the meaning of the result from a clinical perspective fall within her expertise. She conceded that mortality data in the general population rises everywhere in winter. Winter is a factor especially among frail people. The response to this is to increase the care and the intensity of care for frail people.

[392] The post-mortem dockets on the deceased MHCUs were never presented to her.

<u>Applicable legal principles</u>

[393] In terms of section 16 of the Act[21] the judicial officer holding an inquest is required to make the following findings at the conclusion of the inquest:

> "*(2) (a) as to the identity of the deceased person;*
>
> *(b) as to the cause or likely cause of death;*
>
> *(c) as to the date of death;*
>
> *(d) as to whether the death was brought about by any act or omission involving or amounting to an offence on the part of any person.*
>
> *(3) If the judicial officer is unable to record any such finding, he shall record that fact.*"

[394] The Court in *Freedom under the Law v NDPP*[22] had this to say about an inquest:

> "*[72] An inquest is an investigatory process held in terms of the Inquests Act which is directed primarily at establishing a cause of death where a person is suspected to have died of other than natural causes. Section 16(2) of the Inquests Act requires a magistrate conducting an inquest to investigate and record his findings as to the identity of the deceased person, the date and cause (or likely cause) of his death and whether the death was brought about by any act or omission that prima facie amounts to an offence on the part of any person. The presiding*

[21] The Inquests Act, No. 58 of 1959, as amended

[22] *Freedom under the Law v NDPP and others* 2014 (1) SA 254 (GNP)

*officer is not called on to make any determinative finding as to culpability.*"

[395] The Act does not require proof beyond a reasonable doubt for such a finding to be made:

"*The officer presiding at an inquest does not always have all the available evidence at his disposal. He submits his report to the Attorney-General who then has to decide whether or not a prosecution should follow. If a prosecution does follow it will be for the trial court to decide whether the case against the accused has been proved beyond a reasonable doubt. The presiding officer at the inquest need to go no further than to ask himself whether a prima facie case has been established against any particular person.*

*In deciding whether a prima facie case has been established, some regard must, in my opinion, be had to the reliability and credibility of witnesses if they have given evidence at the inquest. The fact that evidence has been produced which, if accepted, would prove that some person has committed an offence which brought about the deceased's death will, in my opinion, not be sufficient to justify a positive finding if it is obvious to the officer presiding at the inquest that there is no prospect of such evidence being believed at a subsequent criminal trial.*

*Bearing in mind the object of an inquest, it is my opinion that the test to be applied is not the 'beyond reasonable doubt' test but something less stringent. In my opinion, the test envisaged by the Inquests Act is whether the judicial officer holding the inquest is of the opinion that there*

*is evidence which may at a subsequent criminal trial be held to be credible and acceptable and which, if accepted could prove that the death of the deceased was brought about by any act or omission which involves or amounts to the commission of a criminal offence on the part of some person or persons.*"[23]

[396] In *Hirt & Carter (Pty) Ltd v IT Arntsen NO and others*[24] the SCA also had this to say:

"*Having regard to the provisions of the Act and the nature of an inquest, the findings are never finally determinative. There are processes that follow in relation to which there will be further interrogation. In terms of s 17 of the Act the record of the proceedings is forwarded by the judicial officer to the Prosecuting Authority. Decisions are made thereafter and a prosecution might follow or not. If a criminal trial ensues a different evidentiary burden rests on the State. Further evidence will be produced and evaluated.*"

[397] The inquest judicial officer must make a finding not only on whether a criminal act or omission, caused the death but also on the identity of the actual offender.[25]

[398] It is trite that in our law the only two offences with the causing of death as an element are murder and culpable homicide. The evidence in the inquest must relate to all the elements of the offence. One of the most important

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[23] *In re Goniwe & Others (Inquest)*, 1994 (3) SA 877 SE at 879H-880C
[24] (277/2020) [2021] ZASCA 85 (18 June 2021)
[25] *De'Ath (Substituted by Tiley) v Additional Magistrate, Cape Town*, 1988 4 SA 769 (C) 775F-G

element to consider in offences of this nature is to determine whether there is a causal link between the act or omission and the death.

Causation and reasonable foreseeability

[399] A distinction must be made between factual and legal causation.

Factual causation

[400] In *International Shipping Co (Pty) Ltd v Bentley*[26], the court observed that:

> "*As has previously been pointed out by this Court, in the law of delict causation involves two distinct enquiries. The first one is a factual one and relates to the question as to whether the defendant's wrongful act was a cause of the plaintiff's loss. This has been referred to as 'factual causation'. The enquiry as to factual causation is generally conducted by applying the so called 'but-for' test, which is designed to determine whether a postulated cause can be identified as a cause sine qua non of the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such a hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; aliter, if it would not so have ensued. If*

[26] 1990 (1) SA 680 (A) page 700E-702D

*the wrongful act is shown in this way not to be a cause sine qua non of the loss suffered, then no legal liability can arise. On the other hand, demonstration that the wrongful act was a causa sine qua non of the loss does not necessarily result in legal liability. The second enquiry then arises, vis whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes called 'legal causation'. … Fleming The Law of Torts 7th ed at 173 sums up this second enquiry as follows:*

> *'The second problem involves the question whether, or to what extent, the defendant should have to answer for the consequences which his conduct has actually helped to produce. As a matter of practical politics, some limitation must be placed upon legal responsibility, because the consequences of an act theoretically stretch into infinity. There must be a reasonable connection between the harm threatened and the harm done. This inquiry, unlike the first, presents a much larger area of choice in which legal policy and accepted value judgments must be the final abiter of what balance to strike between the claim to full reparation for the loss suffered by an innocent victim of another's culpable conduct and the excessive burden that would be imposed on human activity if a wrongdoer were held to answer for all the consequences of his default.'"*

[401] In *Lee*[27] the court observes that:

> "*In the case of 'positive' conduct or commission on the part of the defendant, the conduct is mentally removed to determine whether the relevant consequence would still have resulted. However, in the case of an omission the but-for test requires that a hypothetical positive act be inserted in the particular set of facts, the so-called mental removal of the defendant's omission. This means that reasonable conduct of the defendant would be inserted into the set of facts. However, as will be shown in detail later, the rule regarding the application of the test in positive acts and omission cases is not inflexible. There are cases in which the strict application of the rule would result in an injustice, hence a requirement for flexibility. The other reason is because it is not always easy to draw the line between a positive act and omission…*"

Legal causation

[402] Our courts have, however, accepted that both the requirements of factual and legal causation have to be satisfied before criminal liability for a '*consequence crime*' can arise.[28] The court in *Sampson v Legal Aid South Africa*[29] epitomises the enquiry required for legal causation as the following:

> "*… When one determines whether legal causation exists or not considerations of policy come into play. There must be a reasonable*

[27] Lee v Minister of Correctional Services 2013 (2) SA 144 (CC) para 38
[28] *S v Mazibuko* 1988 (3) SA 190 (A) at 201
[29] [2022] ZANCHC 49; (2023) 44 ILJ 422 (NCK) at para 29

> *connection between the harm threatened and the harm done. In International Shipping the court held that the test in our law for determining remoteness is a flexible one.*" [footnotes omitted]

[403] Therefore, the enquiry set for legal causation is whether the defendant's conduct is sufficiently closely linked to, or the proximate cause of the harm suffered for legal liability to ensue, or whether the harm is too remote. This inquiry is flexible (no single test can apply) and assessed in the light of what legal policy, reasonability, fairness and justice require. The test for legal causation is a flexible one in which factors such as reasonable foreseeability, directness, the absence or presence of a novus actus interveniens, '*proximate cause/direct consequences'*, '*fault and adequate cause*', '*inherent risk'* and '*only*' cause all play their part[30].

The novus actus (or nova causa) interveniens test

[404] An act or event is likely to be regarded as a *novus actus* (or *nova causa*), if, in the light of human experience, it is abnormal or unlikely that it will follow the accused's act. The accused need not be the sole cause of the consequence. Two persons, acting independently, may inflict successive wounds on a victim who dies from their combined effect. If the first wounds combined physiologically with the subsequent wounds to cause death, the law will be less likely to regard the subsequent wounds as constituting a *nova causa*.

[30] *S v Mokgethi* 1990 (1) SA 32 A

[405] The court in Grootjohn[31] held that a later intervening act/event is deemed to break a chain of causation only if it is a completely independent act, having nothing to do with, and bearing no relationship with X's conduct.

[406] In Skosana,[32] Viljoen AJA noted that there may be a set of circumstances where it is difficult to determine whether an act or omission caused a result either solely, contributorily, or cumulatively with others, but that these difficulties relate to proof[33]. The court had this to say:

*"In applying [the but for test] to a case where successive acts or omissions have preceded a given result determine which of those acts or omissions constituted a cause, singly, cumulatively or contributorily, of the result one has, of course, logically to bear in mind that a reconstruction of events for purposes of testing the causal effect of a particular person's default by eliminating from the series of events that default, only affects the causation relating to that particular person's negligent act or omission and not that of any other person who may be involved in the series."*[34]

[407] The victim's pre-existing physical susceptibilities never rank as a *nova causa interveniens*. The pre-existing nature of these susceptibilities precludes them from being considered as *intervening* between the accused's conduct and the unlawful consequence. The accused takes a victim as he finds him or her with all pre-existing physical susceptibilities, such as a weak heart or thin skull. This is the so-called '*thin-skull rule*'[35]. The accused cannot use the victim's

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[31] 1970 (2) SA 355 (A) 364A
[32] *Minister of Police v Skosana* 1977(1) SA 31 (A)
[33] *Skosana* 34
[34] *Ibid*
[35] *Du Plessis* 1960 (2) SA 642 T; *Ntuli* 1962 (4) SA 238 (W)

particular physiological condition as a defence. The criterion is knowledge of an ordinary sensible person who, in addition, has extra knowledge which X may have[36]. Further, it is not necessary for X to have foreseen the precise way the deaths would happen, it is sufficient that she would have foreseen the possibility of death in general[37]. This type of foreseeability should not be confused with foreseeability under the fault requirement.

Medical intervention

[408] In *S v Tembani*[38] the court clarified the South African approach to the causal potency of intervening medical treatment in the following terms:

"*The deliberate infliction of an intrinsically dangerous wound, from which the victim is likely to die without medical intervention, must in my view generally lead to liability for an ensuing death, whether or not the wound is readily treatable, and even if the medical treatment later given is substandard or negligent, unless the victim so recovers that at the time of the negligent treatment the original injury no longer poses a danger to life ….*"

[409] The SCA in *Fourway Haulage SA (Pty) Ltd v SA National Roads Agency Ltd,*[39] has cautioned that the courts should, in applying these tests, not use them dogmatically or exclusively, but rather with some measure of flexibility to avoid an unfair or unjust result.

Negligence

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[36] Ibid
[37] *Bernardus* 1965 (3) SA 287 (A) 296, 298; *Van As* 1976 (2) SA 921(A) 928
[38] 2007 (1) SACR 355 (SCA) at para 25
[39] [2008] ZASCA 134; 2009 (2) SA 150 (SCA) at para 34

[410] The test for negligence is straightforward and summarised in the frequently cited judgment of *Kruger v Coetzee* 1966 2 SA 428 A at 430E-H. "*If a reasonable person would have foreseen the reasonable possibility of harm and would have taken reasonable steps to prevent it happening, and the person in question did not do so, negligence is established*". It is the facts of each case which may complicate the application of the principle. The judgment of *Tilana Alida Louw v Dr Stephan Grobler and Netcare Universitas Hospital* [2021] ZAFSHC 223 is a reminder that the approach in any case is no more than a specific application of the generally expressed test for negligence.

[411] In the case of a medical malpractice claim, a medical practitioner diagnosing and treating a patient is expected to exercise the level of skill, care and diligence exercised at the time by members of the profession to which he/she belongs. A deviation from that standard, which causes harm, results in culpability. The same principles apply where the claim is for negligence against any expert in their field. The level of skill, care and diligence which may be expected in the particular context is often the subject of extensive and much debated expert evidence and legal argument.

[412] The first limb of the traditional test is: Would a reasonable man, in the same circumstances as the accused, have foreseen the reasonable possibility of the occurrence of the consequence or the existence of the circumstance in question, including its unlawfulness?

[413] The accused's negligence must relate to the consequences or the circumstances in issue. This relationship between negligence and the consequences or circumstances in issue is expressed in terms of reasonable

foreseeability: Would a reasonable person in the position of the accused have foreseen the possibility of the occurrence of that consequence or the existence of that circumstance?

[414] On a charge of culpable homicide, the prosecution must prove beyond reasonable doubt that a reasonable person in the position of the accused would have foreseen the possibility of death[40].

Discussion

[415] Prior to the holding of this inquest, the former Deputy Chief Justice heard the evidence in an arbitration and made his findings. As indicated earlier in the judgment it is worth noting that the two processes are separate and distinct from each other. In an arbitration, the former DCJ had to determine quantum in order to compensate the families of the deceased MHCUs and those who survived the Marathon project after the State had conceded liability. In terms of section 16(2) of the Act, the Inquest Court is enjoined to investigate and record the findings as to the identity of the deceased person, the date and cause (or likely case) of his death and whether the death was brought about by any act or omission that *prima facie* amounts to an offence on the part of any person.

The elements of the offences

[416] There can be no doubt that the only relevant offences in the matter *in casu* are murder and culpable homicide. The concepts "*an act and a*

[40] See *S v Van der Mescht* 1962 (1) SA 521 (A), *S v Bernardus* 1965 (3) SA 287 (A) and *S v Van As* 1976 (2) SA 921 (A)

*consequence resulting from it*' are often used in defining these offences. The common law definitions of these offences simply require the killing of another. Where the act is left undefined, any act resulting in the death of a human being will suffice. In the event of the presence of a legal duty to act, an omission to act in a specific manner will suffice. Where a person stands in a protective relationship to another such as a parent or guardian, omitting to care for the person can result in a conviction. Such a protective relationship existed between the GDOH and the NGOs and the MHCUs.

[417] In order to answer the question posed in section 16(2)(d), the consequence of death must have resulted from the act or omission. In this inquest the result to be established is unnatural death. In the absence of surrounding circumstances where the only inference that can be drawn is that a deceased had died an unnatural death, medical evidence is a *sine qua non*.

<u>The deaths</u>

[418] The dockets of the deaths in this inquest can be divided into two categories, namely, those wherein the autopsies were not conducted and those wherein the autopsies were conducted.

<u>No autopsies</u>

[419] This Court had to investigate the dockets of 141 deceased persons. In about 105 of these dockets, no post-mortem examinations had been conducted. The medical cause of death of each deceased is therefore unknown. The available *viva voce* and other available evidence do not provide sufficient proof that those deceased's deaths were unnatural save for the

deaths of Christopher Makhoba, Matlakala Motsoahae and Koketso Christopher Mogoerane whose circumstances will be discussed later in the judgment. The information that is available in respect of the rest of the deceased falling under this category is not of much assistance in determining the factual causes of death of the deceased. It is therefore not possible to ascertain whether the requisite result for the offences of murder and culpable homicide, to wit, unnatural death, can be proven.

Christopher Makhoba

[420] He was born on 6 September 1970 and died on 3 July 2016 at the age of 45. He was epileptic, intellectually disabled and wheelchair-bound. Mr Makhoba stayed in LE Waverley for seven years before he was transferred to the Randwest facility on 31 May 2016 and again to Precious Angels on 23 June 2016. He was assessed by Dr Wadvalla on the day of his transfer and the doctor recommended that he should not be discharged to an NGO because he was frail, disabled and vulnerable, and he needed 24 hours' care.

[421] Mr Nofile who worked at the Danville facility of Precious Angels where Mr Makhoba was resident prior to his death testified that he was fed mashed food which he rejected. They had to force him to eat and have his medication which he sometimes refused. He lost weight and became aggressive when he did not get his medication. Mr Makhoba's condition was reported to Ms Ncube but she did not give it attention. On the day of his death he was found lying unresponsive on the floor. Emergency personnel were called in. They later arrived and declared him dead.

[422] Mr Makhoba's prescription from LE dated 13 June 2016 records that he was on haloperidol, Clonazepam, Epilim and Carbamazepine. Dr Talatala presented evidence that a combination of these medication indicates that Mr Makhoba required complex care. Sister Julia Mamatshele, a care worker at PA, stated in her statement that there was not enough food at the facility and the type of food available did not follow a specific diet. There was no medical equipment like blood pressure machines, wheelchairs and thermometers. Nontlantla Eunice Ndlovu, another worker at the facility confirmed the conditions at the NGO at the time, Mr Makhoba's weight loss and furthermore, that Mr Makhoba's wheelchair was taken away from the NGO on the day he arrived. She further stated that she made several calls to Ms Ncube expressing her concern that Mr Makhoba needed medical attention and should be taken to a medical facility. Ms Ncube's response was that they were all adults and should figure out a plan. Ms Ncube called a private doctor but Mr Makhoba was not taken to hospital.

[423] On the evening of 2 July 2016, Nontlantla Ndlovu found Mr Makhoba lying on the ground and took him back to bed. Around 02:00 the following morning, she found him on the ground again, gasping for air and placed him on a sponge mattress. He was cold and not responding in the early hours of 3 July 2016.

[424] Ms Ncube denied that she was ever notified about Mr Makhoba needing urgent medication and stated that when she was notified about someone's ill health, she would call an ambulance.

[425] Dr Talatala testified that Mr Makhoba needed specialised care, supervised feeding and without supervised feeding, he might not eat and would die of hunger. An institution that admits a patient like Mr Makhoba, must monitor his sugar blood levels as he could not tell if he was hungry or not. It was unlikely that he could communicate that he had not eaten enough. Ms Ncube admitted that the NGO did not have a blood sugar monitor. Although there was no post-mortem, the pathologist, Dr Rossouw deduced that the likely cause of death was linked to Mr Makhoba's mental condition and questioned whether his feeding was adequate since it was managed with a syringe. Dr Talatala opined that the care at the NGO was of below expected standard or that the NGO did not have the care that Mr Makhoba needed.

[426] Mr Makhoba stayed at LE for 7 years without any problems. He could hardly spend three months at Precious Angels. The evidence shows that there was lack of proper care and medical training at the facility. Although there is no medical evidence to explain the cause of his death, it appears that the staff at the facility could not take care of a MHCU in the condition of Mr Makhoba. I cannot find any evidence that shows that the cause of death was unnatural.

<u>Matlakala Motsoahae</u>

[427] Ms Motsoahae was born on 12 September 1944 and died on 26 August 2016 at Kalafong hospital at the age of 72. The docket does not contain LE records. Kalafong hospital clinical records indicate that she was diagnosed with Alzheimer Dementia three years prior to her death and was bedridden. She was on Ridaq. Ms Ncube denied that Ms Motsoahae was on treatment.

[428] She was a resident of LE Randfontein for two years before she was moved to Anchor home and then to Precious Angels. She was admitted to Kalafong hospital on 10 August 2016 and a healthcare worker informed the nurses at the hospital that Ms Motsoahae had a history of vomiting. She was admitted with deep bedsores on the hip, presented with decreased level of consciousness, she had lower respiratory tract infection, a septic hand, renal impairment and hypernatremia. She died two weeks after her admission to hospital on 26 August 2016.

[429] Dr Talatala testified that it was unlikely that Ms Motsoahae would have developed bedsores if she was up and about. It gives the impression that the NGO did not cope with her care needs. Ms Motsoahae would need direct care and to have been turned every two hours. Dr Talatala concluded that she should not have been placed at the NGO in the condition she was unless people wanted to hasten his death. According to the doctor Ms Motsoahae was inappropriately placed at Precious Angels resulting in her not receiving adequate monitoring – leading to a development of bedsores and other complications which led to her death. The staff at the NGO did not notice that she was physically ill. They just could not take care of her. Dr Talatala opined that Ms Motsoahae's condition seemed to have deteriorated rapidly from the time of her transfer from LE to the time of her death. It is clear from this evidence that Ms Motsoahae's death cannot be regarded as natural.

Koketso Christopher Mogoerane

[430] He was born on 21 December 1960 and died on 15 June 2016 at Rebafenyi at the age of 55. He suffered from schizophrenia. He had been

institutionalised since the age of 26 and had been at LE for many years before he was moved to Rebafenyi on 26 May 2016.

[431] According to the evidence of the brother of the deceased, when he went to visit him at Rebafenyi he found that he had lost weight, was distressed and was very hungry. Dr Talatala testified that the medication used to treat schizophrenia increases appetite and if the NGO was not able to provide food, this would cause hunger and distress. It appears that there was a shortage of staff at Rebafenyi and there were no professional nurses at the time the deceased was there. Ms Nonceba who confirmed the inadequacy of staff at Rebafenyi at the time, testified that the fact that Mr Mogoerane fell at night without no-one noticing until in the morning, demonstrated lack of sufficient staff and should not have happened. Dr Talatala opined that the NGO should have continued to monitor the deceased as LE did and slowly reduce this monitoring to allow him to adjust to the new environment. Something like this would not have happened at LE.

[432] Tiisetso Malebye testified that the staff at Rebafenyi did not have the experience to care for the MHCUs. They put their lives in danger. A registerd nurse was only appointed three months after receipt of the MHCUs. There was no dietician, occupational therapist and social workers. This indicates that the NGO could not care for patients like Mr Mogoerane.

Deaths with autopsies

Magdelina Viljoen

[433] Ms Viljoen with ID No 550629 0016 08 9 died on 1 September 2016 at the age of 59. According to the statement by her brother, Mr Martinus Petrus Herbst, Ms Viljoen was previously involved in an accident. She was admitted to Johannesburg hospital where she stayed for a long time. After her discharge she was not right. She was taken to LE Witpoort and later to LE Randfontein. She was not well and he did not suspect any foul play. The statement does not give details as to when the deceased began institutionalisation at LE. From other available information it appears the deceased ended up at Precious Angels where she was admitted from 6 July 2016 after her transfer from Anchor house. She became ill and was taken to Kalafong hospital where she met her death on 1 September 2016. A post-mortem examination was conducted on her body by Dr Rossouw. The cause of her death was recorded as consistent with lobar pneumonia.

[434] In his supplementary opinion Dr Rossouw states that it is not uncommon for chronic psychiatric patients to develop complications which may include physical and/or infective diseases. He further states that the medication probably did not contribute to the cause of death. He concluded that there were no reasons to suspect any negligence on behalf of medical and/or hospital staff.

[435] I cannot therefore find any evidence that indicates that the deceased's death was not natural.

Siphiwe Makhunga

[436] He had been a resident of Precious Angels from 23 June 2016. He became ill and was transported to Kalafong hospital on 11 July 2016 where he died on 12 July 2016. A post-mortem was conducted on his body by Dr

Blumenthal and he recorded the deceased's cause of death as being "*natural causes should be considered - Bronchopneumonia*". His supplementary opinion does not take the matter any further to indicate an unnatural death. Dr Blumenthal's findings are corroborated by an expert summary of the treatment the deceased received at Kalafong hospital by Dr Laundin. In the absence of any other contrary evidence, I am persuaded that this death was natural.

<u>Nene (was only identified by this name</u>)

[437] She was a resident at Precious Angels from 23 June 2016 until she was admitted to Kalafong hospital on 5 July 2016 and she died on 6 July 2016. The post-mortem report records her cause of death as "*malnutrition complicated by bronchopneumonia may be considered*". She was at Precious Angels only for twelve days.

[438] In his opinion dated 1 June 2017 Dr Rossouw states that the deceased was a known psychiatric patient who was known to be suffering from epilepsy. He further states that degrees of malnutrition as well as complicating physical diseases are not uncommon in chronic psychiatric patients. From the Kalafong hospital record, it is noted that the deceased was only identified as an unknown female who was brought to the hospital by the nursing staff at the facility. She was moved from Randfontein care facility to Anchor. The history that was given was that she had been convulsing continuously for ± 13 hours before being brought to Kalafong hospital. No other history was given. The clinical records of Kalafong hospital on 5 July 2016 indicates her GCS as 8/15. She was convulsing, was cachexic/wasted and looked chronically ill. She was presented in status epilepticus complicated by aspiration pneumonia.

[439] Dr Rossouw also opined that malnutrition is a common occurrence with chronic patients. I accept that the evidence indicates a natural death.

Virginia Machapela

[440] She was a resident of Precious Angels since 29 June 2016 until she passed away on 15 August 2016. Dr Onoya noted in his chief post-mortem that the body of Virginia Macaphela was emaciated and dehydrated; there was gangrene on both her feet; her lungs were pale and the liver was congested. Histology investigation showed insignificant changes.Toxicology screening showed no abnormality.

[441] Dr Onoya concluded that the cause of death was unascertained on autopsy. Evidence of a widespread infective process could not be established. Evidence of dehydration on internal autopsy could not be established. During cross-examination by Mr Luyt, Dr Onoya testified that he could not find that emaciation and dehydration caused the death of the deceased. However, that could not be excluded. He did not have enough information to conclude that the deceased died mainly of dehydration. His internal findings of dehydration were not enough to conclude that it caused the deceased's death. He explained that while people with diabetes often get gangrene, he did not have information on whether the deceased was diabetic or not. If she was diabetic, that would explain the gangrene to her feet but not the dehydration. He opined that the dehydration caused the gangrene. This was as a result of a chronic process that happened over time. Long term dehydration could also cause necrosis.

[442] Dr Talatala corroborated this evidence and further opined that such findings were indicative of poor care. It is not known why this specific deceased was malnutritional and dehydrated and the cause of the gangrene could not be explained. There is corroborating evidence from the care workers of Precious Angels to the effect that there were food shortages at the facility and the type of food which was available at the time did not follow a specific diet.

[443] Dr Talatala found that Virginia Macaphela was not suitable for placement at an NGO as this was evident from the periodical report signed at LE on 5 March 2015. Virginia was diagnosed with dementia and admitted at LE on 14 May 2014. She stayed at LE for 2 years before she was moved. She was transferred to Anchor and then to Precious Angels. She was emaciated and grossly underweight at the time of her death.

[444] The post-mortem tells of someone who was very sick at the time of her death and suggests that the care she received at the time was poor. It was reckless to discharge her into the care of an NGO against the recommendation in the periodical report. There was neglect in the manner in which Virginia was cared for at the NGO. Alternatively, those who cared for her in the NGO did not have the competence to look after a patient with dementia. She required assistance with activities of daily living. She needed supervision with her meals and fluid intake. She needed assistance with taking action when a gangrene developed. She had many deficiencies. She had memory deficiencies. She had an executive function deficit. She did not have the ability to plan and organise her life and day. Virginia was not on medication and her medical report was

incomplete. It was reckless to have a patient die in the psychiatric ward from gangrene without an opinion of a surgeon.

[445] It appears that the care of the deceased at the NGO was poor. This is indicative of a death that was unnatural. The NGO had a duty of care towards the deceased and it failed her. This conduct hastened her death.

Terrence Chaba

[446] Terrence Chaba was transferred to Precious Angels on 23 June 2016 and he died on 15 August 2016 at Pretoria West hospital. After conducting an autopsy, Dr Blumenthal recorded his findings in a post-mortem report. The cause of death was recorded as "*natural causes should be considered: Bronchopneumonia*". In his second opinion Dr Blumenthal explains how complicated the interaction between the different medical conditions is. He then deferred to Prof Tintinger who opined that the deceased's poor nutritional state as a result of poor care at the NGO increased his susceptibility to bronchial pneumonia and ultimately his death. Further that the deceased should not have been placed at an NGO facility.

[447] Prof Titinger concluded that Terrence Chaba's health had deteriorated significantly since his transfer from LE to his death. He became concerned about the care Terrence Chaba received at Precious Angels and recommended that an investigation be conducted to evaluate the care that the MHCU received at the NGO after his transfer from LE.

[448] Dr Talatala's report also mentions Terrence Chaba. According to the periodical report dated 18 November 2015, Terrence had a behavioural

disorder, secondary to general medication condition which is epilepsy. He also had a moderate cognitive disability/intellectual disability. He was on the following medication: clozapine, clonazepam, Epilim and Biperiden.

[449] Terrence had been at LE for 2 years and was always wheelchair-bound although LE says he would throw himself out of the chair. Self-care and feeding were under strict supervision. He was in Precious Angels for under two months before he was transferred to Pretoria West Hospital where he was admitted as an unknown patient who was chronically ill and unkempt with dirty clothes. It was also noted that he had threatening bedsores. His condition deteriorated significantly from LE to his death. The post-mortem also found cachexia with poor nutrition.

[450] The report further stated that Terrence was a complicated patient who needed specialised psychiatric care. By so saying the doctor explained that he was not implying that it was impossible to discharge Terrence to a suitable place in the community. All he meant was that the place where he was to be discharged would have to be equipped for the complications he had with a team that was prepared to assist him. He seems not to have been appropriately placed in an NGO as he needed strict supervision with self-care and feeding. Without such supervision he could die from malnutrition and neglect.

[451] Terrence lost a significant amount of weight in the three months up to his death. The doctor found that the inappropriate discharge of Terrence at LE against the recommendation in the periodical report, and the inadequate care at the NGO, contributed to his poor nutritional status he suffered at the NGO, his susceptibility to bronchopneumonia and ultimately his death.

[452] This evidence proves that there were unnatural factors such as poor care and neglect which caused the deceased's death. The NGO had a duty to care for the deceased and it has failed to do so.

Eric Mashiloane

[453] He was also a resident of Precious Angels since 23 June 2016 until he died on 18 July 2016 in Pretoria West hospital. Dr Blumenthal performed an autopsy on the deceased and concluded that natural causes should be considered. I could not find any circumstantial evidence or expert opinion that indicates that possible unnatural factors could have precipitated the natural causes.

Lucky Maseko

[454] He was also a resident of Precious Angels since 23 June 2016 and he died on 3 September 2016 on his way to Pretoria West hospital. According to Dr Makhoba the deceased died of asphyxia due to food aspiration. Large chunks of food blocked the airway resulting in the air not being able to reach the lungs. The deceased was severely underweight due to not consuming enough calories which condition could cause fatique and result in the person choking.

[455] Dr Makhoba further testified that during autopsy he did not find any evidence of the sepsis referred to in the hospital records as the probable cause of death. He was unable to provide an opinion on the standard of care the deceased received at the NGO. He did not any find evidence to criticise the care of the deceased at the hospital.

[456] Prof Tintinger was concerned about the care and nutrition the deceased received at Precious Angels which resulted in his serious loss of weight and being chronically ill. The deceased lost approximately 43% of his weight from the time he left LE until the day of autopsy. He opined that the autopsy did not find any underlying conditions that could count for the severe loss of weight. Furthermore, pneumonia is often the common final pathway for severe debilitating conditions such as starvation.

[457] The evidence leaders submitted that it was not clear from Prof Tintinger's evidence that the weight loss beyond reasonable doubt had precipitated the choking referred to by Dr Makhoba as aspiration. The choking has not been clearly linked to the starvation. That significant amount of weight loss however still points towards gross neglect. Prof Tintinger testified that the autopsy did not find any underlying conditions that could count for the significant weight loss. I find that there are unnatural factors that contributed to the death of the deceased.

Josiah Daniels

[458] He was born on 8 January 1974 and died on 8 August 2016 at the age of 42. He was epileptic and suffered from cerebral palsy. He was on Epilim and Carbamazepine with a history of an old clavicle fracture. He was a resident at LE for 17 years before he was moved to Precious Angels on 23 June 2016. He died less than two months after being moved. He was dead on arrival at the hospital. The cause of death was described as necrotizing pneumonia. According to the pathologists Mr Josiah was severely underweight.

[459] Dr Makhoba concluded that the cause of death was in keeping with natural causes: necrotising pneumonia. This is a serious kind of pneumonia resulting from cells dying, causing other cells to die with a necrosis effect. Signs of this illness can only appear on radiological examination of the person's chest but just looking at the person one cannot see them. Specialised diagnostic apparatus is required to diagnose this illness. The Body Mass Index (BMI) of the deceased was 15 kg/m² and this shows that he was severely underweight. Several enlarged lymph nodes in the thoracic cage were also indicative of chronic illness.

[460] Dr Talatala testified that for Mr Josiah to have died of pneumonia before he was presented for appropriate medical care is an indication that there was probably a delay from the staff at Precious Angels in noticing that he was suffering from a respiratory disease. He attributed this to either negligence or inexperience by the staff in picking up signs of illness in a person with cerebral palsy and the intellectual disability. Dr Talalata opined that the fact that Mr Josiah had cerebral palsy meant that he would not have articulated his symptoms in the usual way. There could have been unusual symptoms such as refusing to eat or being withdrawn. The nursing care at Precious Angels was compromised by the fact that a professional nurse would come and assist twice or three times a month. The NGO had cleaners who became care workers, untrained in medical care but providing care to MHCUs. According to Talatala Ms Josiah was inappropriately placed at Precious Angels.

[461] There is evidence that unnatural factors played a role in the cause of this death.

Sibusiso Mthombeni

[462] He was a resident at Bophelong Suurman since 30 June 2016 until he died on 5 April 2017 at Jubilee hospital. According to the post-mortem report compiled by Dr Blumenthal the cause of his death is described as bilateral pneumonia: history of an insulin overdose. The insulin overdose referred to in Dr Blumenthal's two opinions appears to be based on hearsay evidence with no admissible first-hand information available.

[463] There is no surrounding and expert evidence that points towards unnatural death.

Paulos Makgane

[464] From 12 May 2016 Mr Makgane became a resident of Tshepong. He was doing well until he started experiencing troubles with breathing on 5 November 2016. He was taken to Kalafong hospital where he died in Emergency Ward. The cause of his death was described as natural causes-Bilateral bronchopneumonia (Background of metastatic adenocarcinoma). He reiterated in his two opinions that the deceased's death was clearly natural. In the absence of any other evidence to counter this evidence, I accept that the deceased's death was in keeping with natural causes.

Harold Nkosi

[465] On 23 June 2016 the deceased was transferred to CCRC from LE Randfontein. He died on 4 October 2016 at Mamelodi hospital. The post-mortem report compiled by Dr Rossouw noted Mr Nkosi's death to be

tuberculosis pneumonia. No further evidence is available to counter a finding of natural death.

Jan Denicker

[466] Mr Denicker was a resident of Siyabadinga after he was moved from CCRC in order to make space for LE patients who were discharged to CCRC. His health fluctuated and he met his death on 16 June 2016. Dr Lombard conducted a post-mortem and noted the cause of his death as "*aspiration of stomach contents cannot be excluded*". There is no other evidence to suggest death other than by natural causes.

Joseph Gumede

[467] He was diagnosed with Schizophrenia. He also suffered from diabetes mellitus. He was transferred from LE to Anchor. The manager at Anchor indicated that the NGO did not have a glucose testing machine. Professor Pienaar opined that the deceased's diabetes was at a complicated state. He had a bilateral knee amputation which implies that the management and monitoring of his blood glucose, blood pressure and other vital signs required close monitoring. The results of the post-mortem indicate that the cause of death of the deceased was due to severe coronary artery disease probably complicated by myocardial infarction and that the ischemic heart disease most probably was due to poorly managed diabetes mellitus. Holistic patient care, treatment and rehabilitation was inadequately provided to the deceased.

[468] He was admitted to Anchor Care Centre on 29 June 2016 and died on 24 July 2016 at the Cullinan Clinic.

[469] The deceased was already severely ill when he was admitted to Anchor. He died a month after his admission. The evidence does not prove that he died an unnatural death.

Jaco Stols

[470] He was one of the MHCUs who were transferred from CCRC to Siyabadinga to prepare room for patients from LE. The statement of his sister Ms De Villiers who also gave *viva voce* evidence indicates that she was happy with the deceased's treatment at Siyabadinga. After the closure of Siyabadinga he was moved back to CCRC. Dr Mabotja performed an autopsy on the deceased's body and recorded her findings. He noted the cause of the deceased's death on the post-mortem report and a supplementary opinion. The post-mortem *inter alia*, indicated a gastric ulcer which Dr Lombard testified could explain the continuous vomiting that eventually led to the deceased being dehydrated. No bedsores were noted on the post-mortem report and on Dr Lombard's clinical notes.

[471] CCRC clinical files of the deceased indicates a diligent observation of the deceased and medical intervention when necessary. This is contrary to the evidence of Ms De Villiers and Dr Lombard who despite their concern about the deceased's treatment at CCRC, allowed him to go back to these conditions which according to them led to his death. This evidence points towards a natural death.

Kenneth Soka (Sithole)

[472] He was transferred to Anchor house from CCRC on 29 June 2016 and he died at Mamelodi hospital on 16 August 2016.

[473] Dr Makhoba's comments about the treatment the deceased received at Anchor was not conclusive due to lack of relevant documentation. There is no other information to justify a finding of an unnatural death.

Timothy Nxumalo

[474] He was a resident at Ubuhle Be Nkosi since 24 June 2016. He died at Kalafong hospital on 5 December 2016. Dr Makhoba testified and also confirmed that the deceased died of "*Burns complicated by cellulitis and acute bronchopneumonia*". It is not known how the burns occurred. The medical records of both Ubuhle Be Nkosi and Kalafong hospital indicate proper care of the deceased by both institutions. The *viva voce* evidence of Ms Patricia Mbatsha was to the effect that the deceased was elderly and could not walk. He communicated little. Ms Mbatsha was unable to put him in an old age home because of his mental condition.

[475] In his evidence Dr Makhoba described the cause of the deceased's death as natural. In the absence of any other evidence to the contrary, I accept the evidence that the death of Mr Nxumalo was natural.

William Mvulane

[476] He was also a resident at Ubuhle Be Nkosi from 24 June 2016. He was elderly, diabetic and incapacitated. He was admitted to hospital on several occasions. In the end he was admitted to Kalafong hospital where he died on

11 March 2017. Dr Blumenthal performed an autopsy on his body and noted the cause of his death in the post-mortem report as “*natural causes: left lung lower lobe bronchopneumonia*”. Professor Tintinger confirmed that the death of Mr Mvulane was natural.

<u>Frans Dekker</u>

[477] He was born on 10 September 1968 and died on 7 November 2016 at Kalafong hospital. He had dementia and was wheelchair-bound due to an earlier motor vehicle accident. He was a resident at LE since 2003 before he was moved to Tshepong on 12 May 2016 and was only taken to Kalafong hospital in October 2016 for the treatment of bedsores. The cause of his death was described as “*septic decubitus ulcers complicated by sepsis*”. The bedsores were very serious. They had spread over several parts of the body and have been surgically debrided *antemortem*.

[478] Dr Makhoba opined that Tshepong was not equipped to handle someone who had bedsores to that degree. Bedsores of this nature needed continuous management which included surgical, medical, ICU management and possible high care management.

[479] He was on Epilim, Carbamazepine, Clopixol Depot and Orphenadrine at LE. On 9 May 2016 he was examined by a doctor and there was no reference made to bedsores at the time. He was taken to Kalafong hospital on 19 June 2016 with a swollen eye from falling. The hospital records also did not mention the bedsores.

[480] Professor Pienaar noted the medication the deceased took, and opined that his physical incapacitation together with the mental status of dementia, as well as the heavy psychotropic medical prescription, increased the risks of bedsores because of his diminished movement.

[481] The registered nurse at Tshepong, Dipuo Mothiba stated that on 17 October 2016 (5 months after admission) she noticed that the deceased was sick and weak, and had bedsores. Following, the report she got from Patrick Khumalo, and her report of the deceased's condition to the CEO of Tshepong, Carina Morale, the deceased was taken to Kalafong hospital where he was admitted on 19 October 2016. Shortly thereafter, he was found to be significantly ill and required surgical intervention. He underwent debridement surgery on 22 October 2016 for the diagnosis of multiple septic bedsores. The deceased did not recover. He subsequently died on 7 November 2016.

[482] Professor Pienaar opined that with the deceased subsequently confined to a wheelchair, this physical incapacitation indicates that he was partially, if not fully, dependant on the nursing staff to achieve activities of daily living. With the mental status of dementia, the incapacity was enhanced because of the cognitive diminished functioning of the deceased. In addition, the heavy psychotropic medication prescript also decreases the voluntary movement.

[483] He found that there was gross negligence in basic health care, psychosocial health care, and general health observation and recording from the NGO. Regarding Frans Dekker, Dr Talatala's view was that he was not a suitable patient to be transferred to an NGO. He had cognitive impairment and behavioural issues and needed care in a structural environment.

This evidence is sufficient to prove that the death of Mr Dekker was not natural.

Siswe Hlatshwayo

[484] He was one of the MHCUs who were moved between facilities after he was moved out of LE. From LE he was transferred to CCRC on 23 May 2016 and further discharged to Anchor on 23 June 2016. On 6 September 2016 he was treated at Mamelodi hospital, given medication and sent back to Anchor. His condition deteriorated on 10 September 2016 and an ambulance was summoned but he died before arrival at the hospital. After conducting a post-mortem on the body of the deceased, Dr Mabotja noted the cause of his death as pneumonia.

[485] There is no evidence of any unnatural factors that could have contributed to his death.

Tiaan Crause

[486] He was a resident at Siyabadinga from 19 May 2016 after he was discharged from CCRC to make space for LE patients. He was epileptic. On 1 June 2016 he fell ill and was noticed shivering. He was hastened to Refilwe Clinic where he was certified dead on arrival. Dr Paul Lombard performed an autopsy on the deceased's body and noted the cause of his death to be "*aspiration of stomach contents cannot be excluded*". He opined in a supplementary opinion that there is a relationship between malnutrition and epileptic seizures if one looks at the deceased's very low body mass. The reason for the very low body mass is unknown. The deceased had spent 12 days at Siyabadinga prior to his death. His weight intake is unknown. Professor

Pienaar conceded that the complications during an epileptic seizure is not uncommon. The evidence shows that Mr Crause died a natural death.

Samson Nhlapo

[487] Before he was admitted to Kalafong hospital on 24 June 2016, he was a resident at Rebafenyi. He was diagnosed with a middle cerebral artery infarction and died the following day. Dr Blumenthal performed an autopsy and noted the cause of his death in a post-mortem report as "*natural causes should be considered (right middle cerebral haemorrhagic infarction)*".

[488] Dr Blumenthal in his supplementary opinion does not include the stated cause of death as one of the effects of wasting. Prof Pienaar's opinion does not take the matter any further. I cannot find any evidence that indicates an unnatural death.

Vuyo Ngqondwane

[489] The cause of death was determined to be aspiration pneumonia. The deceased ate a piece of plastic. His gastric content at autopsy included a large foreign object, an orange plastic sheet which Dr Stuart indicated was estimated through the use of photographs to be approximately 50 to 60 cm by 20 cm. The symptoms that would present in such a case would include nausea and vomiting, stomach ache as well as aspiration pneumonia.

[490] She further testified during cross-examination that the deceased inhaled a foreign material into the airways. Foreign material was found in the lungs of the deceased at autopsy. The deceased was severely underweight with a height of 1,64 m and a weight of 36 kg. This was a sign of malnutrition. On the

neck structures, she found a bloodless field dissection which revealed haemorrhage into and around the sternal head of the left sternocleidomastoid muscle. This, according to Dr Stuart, signifies a trauma in that area. There were no injuries in the area. In the normal cause there would be no bleeding in those muscles.

[491] In her view consuming that size of plastic would not have gone unnoticed by people in the vicinity of the deceased as it could have caused pain and vomiting. It would not have been easy to swallow that kind of a plastic. That could have been a long drawn out process.

[492] In an opinion she provided later she noted that the deceased had features of chronic disability in keeping with the history of cerebral palsy. When she analysed the nurses' notes, she noted some irregularities. Two entries were made in the clinical records from CCRC on 9 July 2016 which stated that at 08:00 medication was given to the deceased and he was very rude and aggressive all day beating them. The other entry made at the same time on the same day stated that the deceased was well all day long.

[493] The nursing notes of 8 October 2016 recorded that the deceased had diarrhea. According to Dr Stuart, the episodes of vomiting and running stomach are in keeping with the large object he consumed.

[494] There were also nursing notes of 10 November and 6 December 2016 where blood pressures of 83/56 and 96/52 had been recorded respectively which she regarded as having been abnormally low. The patient was not well at all and required medical attention. She in fact expected that a doctor should have been called but that did not happen.

[495] The notes made on 4 January 2017 did not make sense at all. The first one made at 08:00 indicated that the deceased had breakfast and a later one recorded at 12:30 stated that the deceased was still on leave of absence on that day. The record was clear that the deceased was on leave of absence (LOA) from 31 December 2016 to 15 January 2017.

[496] Her further evidence was that there were no notes made between 12 to 18 July 2016 and 17 August to 3 September 2016. The last notes were made on 15 January 2017. There were no records for three weeks and immediately prior to the death of the deceased which date has been recorded as 7 February 2017.

[497] She was unable to tell when the foreign object was ingested. It did not make sense to her that the deceased's blood pressure was very low on 6 December 2016 according to the clinical notes of CCRC and suddenly on 15 January 2017 when he returned from LOA, the blood pressure was normal. She was insistent that the ingestion of the foreign object was significant to the demise of the deceased. In her view there is a possibility that the deceased could have ingested the foreign object a few weeks prior to her death and this could have been during the periods she could not find any notes. She therefore concluded that in view of the irregularities described above, the possibility of an act of commission or omission which may be criminal in nature having contributed to the death, (and thus deeming it unnatural), or, the possibility of malpractice or negligence, is probable.

[498] There is no evidence to indicate where and when Mr Ngqondwana ingested the plastic. He was on LOA from 31 December 2016 to 15 January

2017. This was a few weeks before he died. Dr Stuart was not able to find all the nursing notes of CCRC for the weeks prior to the death of the deceased. Although there could have been some foul play in handling the deceased at CCRC, without the evidence as to where and when the foreign object was ingested, it would be difficult to conclude that this death was unnatural.

<u>Charity Ratsotso</u>

[499] Ms Ratsotso spent 14 years at LE before she was moved to CCRC on 12 May 2016. She was further moved to Anchor on 23 June 2016 in order to make space for LE patients. On 30 June 2016 Mr Ratsotso was taken to Mamelodi hospital as an unknown MHCU and was diagnosed as having continued seizures. He remained at Mamelodi hospital until his death in the early hours of 11 July 2016. His identity was only established on 8 July 2016, three days before his death, through a call between the social worker at CCRC and Tshepiso Mmola of Anchor. However, Ms Franks maintained that Mr Ratsotso remained unknown long past his death, until he was identified by Ms Daphney Ndlovu on 17 January 2017.

[500] Mr Ratsotso's identity was lost and Anchor home did not know who he was or what care of medication he required. He should have been on a series of medication which should not have been stopped abruptly at the risk of causing seizures.

[501] Mr Ratsotso was admitted to hospital because he was having continuous seizures and died of aspiration pneumonia, likely when he inhaled food during a seizure. He was underweight when he died at 42 kg.

[502] The loss of his identity at Anchor Home and at Mamelodi hospital which put him at the risk of stopping his medication abruptly proves that unnatural factors contributed to his death. The death of Mr Ratsotso can therefore not be regarded as a natural death.

<u>Matthys Christiaan Hartman</u>

[503] Mr Hartman resided in Mosego home from 6 May 2016 until he died on 29 August 2016 at Helen Joseph Hospital. Dr Hollard conducted a post-mortem and recorded his findings in a post-mortem report where he noted the cause of death as "*bronchopneumonia complicated by acute respiratory distress syndrome*". The doctor further noted that the features of chronic neglect must be investigated.

[504] In her supplementary opinion the doctor stated that the deceased was emaciated and had a bedsore upon his admission to Helen Joseph hospital. The deceased weighed 49,7 kg when he was discharged from LE and at autopsy he weighed 47 kg. It cannot therefore be correct to say that he became emaciated during his stay at Mosego.

[505] Regarding the reference to the bedsore, Helen Joseph clinical records refer to the sore as a bedsore. However, Ms Mokgosinyane who is also a registered nurse, described the sore as an abscess which description corresponds with the one on the post-mortem report. I find it strange that the deceased could have suffered from bedsores if he was mobile. From all the expert evidence heard, bedsores develop when a person is immobile and pressure is inflicted on the same area of the skin for a long time. I accept the

evidence that the deceased had an abscess and not a bedsore. There is, therefore, no evidence to indicate that the death of the deceased was unnatural.

Josephine Masuku

[506] Ms Masuku resided at Takalani from 1 April 2016 until she died on 18 July 2016. Dr Klepp performed an autopsy on her body and recorded her findings in the post-mortem report where the cause of death had been noted as "*coronary artery insufficiency – Natural*". The doctor also provided an opinion which does not take the matter any further. I cannot find any evidence that proves that the deceased did not die of natural causes.

Deborah Phetla

[507] The evidence shows that the conditions at Takalani and lack of sufficient supervision caused Ms Phetla's death. She had access to and was able to swallow (or to swallow and cough up) something hard enough to damage her larynx to the extent that it bled and she aspirated blood. Takalani received a periodical report that stated that Ms Phetla was prone to eating rubbish. Despite this she was insufficiently supervised. She survived for 38 years in mental institutions but died within a few days of being moved to Takalani. This evidence is sufficient in my view to conclude that the cause of death of Ms Phetla was unnatural.

Manyane Sophia Molefe

[508] She was discharged home after the closure of LE Randfontein. She gained access to her medication held at home and died after being treated at Leratong hospital. After performing an autopsy on the deceased's body, Dr

Lowe noted the cause of death in a post-mortem report as pneumonia following a history of tablet overdose.

[509] It appears from the report of Dr Wojtowicz that the pneumonia was ventilator associated. The deceased extubated herself from the ventilator while in the ward and the ward doctors whose identification is not known ignored the consultant's recommendation to return the deceased to ICU.

[510] While the deceased's mother testified that the deceased was discharged home under her care despite the fact that she informed the staff at LE that she was not in a position to care for her, LE records show that the deceased's family had requested on repeated occasions that she be discharged in their care. A progress note which appears on CL 6668 records that the deceased's mother visited her on 27 April 2016 and that the relationship between them was good. Furthermore, the patient's mother requested her discharge on that day. A note dated 29 April 2016 also records the family had requested that the deceased be discharged to be under their care. A similar note was made on 2 May 2016. At CL 6662 there is another note by a psychiatrist at LE which records that on 29 April 2016 the deceased's family had requested her discharge.

[511] It also appears that while the deceased was at Leratong hospital after she took an overdose, she was transferred from ICU into a ward during September and it was later discovered that she had an infection. The report at the hospital states the following:

> "*Patient was discussed with ENT doctor who suggested to continue nebulisation and Solucortef and to only intubate if really necessary as it*

*would traumatise the throat more, suggested ICU. Consultant reviewed patient 11/09/2016 9h21 found silent chest with stridor, suggested ICU.*"

[512] Dr Khumalo also recorded the following:

"*Consultant assessed patient as ICU candidate, this was not followed up by ward doctors – to call ICU to assess patient.*"

"*Patient was reviewed 11/09/2016 14h30, stridor was noted, but no stats were recorded in bed letter. Consultant note on some page above was not considered, no further assistance to assess patient was done with senior doctor.*"

and

"*specific doctors who looked after the patient specifically addressed, and warned.*"

[513] The deceased was noted to be calm and cooperative with normal speech and stable mood. The evidence proves that doctors at Leratong hospital significantly contributed to the deceased's death in that they failed to take proper steps in consequence of her infection.

[514] I find that the deceased's death although it appears unnatural, it was not causally connected to the decision to terminate the LE contract and even if it was, there was a *novus interveniens*.

<u>Phoebe Soudum</u>

[516] She was a resident of LE Baneng when she met her death. She was not one of the MHCUs who were moved out of LE facilities. She appears on the list of the deaths of LE patients because her death falls within the targeted period. I cannot find any evidence to indicate that her death was not natural.

Piet Sekgaolela

[517] He was also resident at LE Baneng when he met his death on 15 April 2017. His death occurred within the targeted period. He was never moved out of the LE facility. Dr Kgoele who performed an autopsy on the body was unable to ascertain any anatomical cause of death. The significance of her finding are explained in her supplementary opinion and do not support a finding of unnatural death. I therefore cannot find any other evidence to indicate that the cause of death was not natural.

Moses Mabena

[518] He was a resident of Mosego home since 5 May 2016 until he fell ill on 4 April 2017. He had been admitted to Solomon Stix Morewa hospital when he died on 15 April 2017. In the post-mortem report compiled by Dr Ngude, the cause of death was described as in keeping with natural causes. There is no further evidence in the report to counter the fact that the deceased died a natural death.

Unknown adult male

[519] There is limited information in the docket of the deceased person. He was admitted to Leratong hospital on 28 June 2016 and he died on 25 August 2016. A person named Lerato Korki brought the deceased to the hospital

indicating that he was from LE Randfontein. This information was not confirmed. LE Randfontein referred the investigation to Naledi Old Age home which never existed or ceased to exist.

[520] There is nothing from the post-mortem report completed by Dr Stuart after performing an autopsy on the deceased's body and his supplementary opinion to suggest that the deceased's death was unnatural. Under the circumstances I find that the deceased died a natural death.

Daniel Benjamin Malan

[521] He was a resident of Mosego home. He died on 20 June 2016 and an autopsy was performed on his body by Dr Lunga Shongwe. The doctor completed a post-mortem report wherein he recorded his findings and noted the cause of the deceased's death as "*multiple blunt force injuries*". David Mabati, who was also MHCU, who had caused the injuries had also died. No-one can be held responsible for the deceased's death.

Sam Sam

[522] He was a resident at Mosego home since 5 May 2016. He had difficulty in swallowing and was referred to Leratong hospital on 21 February 2017 for gastroscopy. The gastroscopy was not performed and the deceased died on 5 March 2017 at Leratong hospital. He died of aspiration pneumonia against a background of a blunt force, head injury. I could not find evidence of any unnatural factors that could have contributed to his death.

Karrin Lackman

[523] She was admitted to LE Waverley from an old age home, Lapeng on 27 April 2017. He died on 8 June 2017. An autopsy was performed by Dr Medar who recorded his findings in a post-mortem report where he noted the cause of death of the deceased as "*consistent with natural causes – upper and lower respiratory infection*". There is no other evidence in the docket to counter the findings of Dr Medar. I am satisfied from this evidence that the deceased died a natural death.

Reynock Mncube

[524] Bekizwe Mncubethe states in her statement filed in the docket that the deceased was her uncle. He was formerly a resident at LE Randfontein Care facility. He was discharged and left for home in the care of his family during September or October 2015. The exact date could not be established. On 28 April 2016 she gave him his medication and when she returned home after work, the deceased was not at home. She searched for him and later found his body at the mortuary. It appears from the evidence that the deceased was found lying next to the road breathing very slightly. He was declared dead upon arrival of the ambulance.

[525] Dr Hansmeyer performed an autopsy on the body of the deceased and recorded her findings in a post-mortem report where the deceased's cause of death was noted to be "*myocardial infarction due to underlying coronary artery disease*". There is no other evidence to indicate that the deceased did not die a natural death.

[526] This docket was investigated with all others as the death of the deceased occurred within the targeted time frame. There is no evidence to

indicate whether the deceased was discharged from LE after the termination of the LE contract.

Unnatural deaths

[527] The court has ruled that the deaths of Virginia Macaphela, Terrence Chaba, Lucky Maseko, Josiah Daniels, Frans Dekker, Charity Ratsotso, Matlakala Motsoahae and Deborah Phetla appear to be unnatural.

[528] Virginia Machaphela died emaciated, with severe malnutrition, dehydration and gangrene on both legs. The pathologist, Dr Onoya found that the prominent cause of death can only be linked to these findings.

[529] Terrence Chaba was found by Dr Blumenthal to be thin/cachexia and had received poor nutrition. Prof Tintinger confirmed that the weight loss that Mr Chaba experienced would probably have rendered him weak. His health had deteriorated significantly since his transfer from LE to his death. Dr Talatala opined that the inappropriate discharge of Terrence at LE against the recommendation in the periodical report and the inadequate care at the NGO contributed to his poor nutritional status he suffered at the NGO, his susceptibility to bronchopneumonia and ultimately his death.

[530] Lucky Maseko died of asphyxia due to food aspiration. Large chunks of food blocked the airway resulting in the air not being able to reach the lungs. He was severely underweight due to not consuming enough calories which condition can cause fatigue and result in the person concerned choking easily.

[531] Josiah Daniels was severely underweight with a body mass index of 15 $kg/m^2$. He died of pneumonia before he was presented for medical treatment.

According to Dr Talatala there was a delay in picking up his condition at the NGO.

[532] Frans Dekker died of septic decubitus ulcers complicated by sepsis.

[533] Charity Ratsotso's death was in keeping with food aspiration complicated by necrotising pneumonia. He had a seizure that pre-disposed him to food aspiration. Charity had a prescription of medication dated 18 May 2016 which he had to repeat for 6 months. During movement from CCRC to Anchor and from Anchor to Mamelodi hospital, his identity was lost. According to Dr Talatala, Charity was at the risk of stopping his medication abruptly as the doctors at the receiving institution would not have known which medication to give him. Charity was epileptic but there was no record of his anti-convulsant medication in his life.

[534] Deborah Phetla died of asphyxia due to aspiration of blood. According to Dr Morale the aspirated blood would most probably have come from the traumatised larynx which most probably was caused by swallowing an object that was hard and sharp enough to cause perforation and which was not seen during autopsy examination.

[535] Matlakala Motsoahae was admitted to Kalafong hospital with deep bed sores on the hip, presented with decreased level of consciousness. She had lower respiratory tract infection, a septic hand, renal impairment, and hypernatremia. She died two weeks after her admission. She was bedridden and suffered from Alzheimer dementia.

[536] Koketso Mogoerane died after falling at night unattended at Rebafenyi. There was no care in the upper level at Rebafenyi at night. His body was only found in the morning. This death was not investigated and a post mortem was not done.

Criminal responsibilities

Qedani Dorothy Mahlangu

Factual causation

Would the harm still have occurred if the court is to substitute the reasonable conduct for the conduct of Ms Mahlangu?

[537] For liability for an omission to result, there must first be a legal duty to act. The GDOH had a legal duty towards the MHCUs.

[538] Ms Mahlangu took the decision to terminate the LE contract. The evidence shows that the reasons for termination of the LE contract, were not valid and justified.

[539] At the time of the termination of the LE contract the NMHPF was in place. This policy specifically included a strongly worded cautionary statement to stop deinstitutionalisation until community mental health services had been developed. Ms Mahlangu knew of the plan in Gauteng to decrease the beds by 200 a year in order to ensure that the MHCUs' needs were catered for during any deinstitutionalisation process. Prior to taking the decision to terminate the LE contract, she was warned about the risks of rapid deinstitutionalisation.

[540] LE received the notice of termination of the LE contract end of September 2016 which meant a notice of only 6 months ending on 31 March 2016. The project was hurried and could not be implemented within that short time period.

[541] Before, during and after the decision to terminate the LE, Ms Mahlangu was warned against the risks of the project by various stakeholders among them SASOP, SADAG, SAMF, LE and the families who were not happy with the move.

[542] Dr Mkhatswa, the former Manager of LE testified that LE voiced their concerns regarding the ability of the NGOs to clinically assess the MHCUs, provide medical and psychiatric care, be cared for by specialised nursing and rehabilitation personnel and receive other professional support. LE was concerned about the conditions at the NGOs and whether the facilities and staff were adequate. It offered to assist by assessing and vetting the NGOs but the offer was turned down.

[543] The project was implemented in haste and had many challenges. Dr Mkhatshwa further testified that at a meeting where Ms Mahlangu informed LE about the decision to terminate the contract, she refused to enter into further discussions. Ms Mahlangu should have heeded the warnings of all the groups mentioned and not terminate the LE contract before ensuring that there were systems in place to cater for the movement of MHCUs. Alternatively, she should have given the project more time to avoid moving the MHCUs hurriedly in large numbers to ill-equipped NGOs who were not ready to receive them.

[544] If the court is to substitute the reasonable conduct of Ms Mahlangu described above in line with the test for factual causation, the deaths would not have occurred. Factual causation has therefore been established.

Legal causation

[545] The question to ask in relation to legal causation is whether Ms Mahlangu's conduct is sufficiently closely linked to, or the proximate cause of the deaths. This inquiry is flexible (no single test can apply) and assessed in the light of what legal policy, reasonability, fairness and justice require. There must be a reasonable connection between the harm threatened and the harm done. The evidence is clear that all the stakeholders, the families, psychiatrists and LE were concerned about the conditions at the NGOs and the care that the MHCUs would receive at the NGOs. About 60% of the MCHUs were not dischargeable out of LE because of their serious health conditions and fragility. The GDOH did not want to disclose to names of the NGOs where it had intended to transfer the MHCUs to LE. The GDOH turned down the offer of LE to assist with the assessments and vetting the NGOs. In my view the harm that was threatening at the time of the termination of the LE contract which all the groups mentioned wanted the GDOH to guard against, eventually happened. Experts who knew the MHCUs and their ailments both physically and mentally warned Ms Mahlangu before she took the decision to terminate the contract with LE as that would lead to disastrous consequences.

[546] Ms Mahlangu knew that the MHCUs were vulnerable, however, she took the decision to terminate the LE contract which resulted in the movement of the

vulnerable MHCUs to NGOs which were not ready to care for them; it would make their suffering and deaths probable.

[547] The evidence leaders argue that the results that followed the decision are not naturally or normally expected from the act. They submitted that in respect of the deaths of Virginia Macaphela, Terrence Chaba and Mannyane Sophie Molefe the novus actus interveniens were present. Although they conceded that the decision to terminate the LE contract and the implementation of the decision were taken in the face of the warnings that dire consequences may ensue, they asserted that the possibility of starvation never came into the loop.

[548] I do not agree that the deaths that followed were not naturally or normally expected from the act. Relying on the decision in Grootjohn[41] I am not persuaded that there were novus actus interveniens that broke the chain of causation. When I consider all the facts in this matter, it is my view that there was no later intervening event/act that broke the chain of causation. Everything that happened after the termination of the LE contract until the deaths, was a continuous process. Ms Mahlangu was warned against the decision to terminate the LE contract. She did not heed the warnings and the GDOH proceeded to implement the decision which resulted in the transfer of the MHCUs to the NGOs who were not ready and could not care for them. The evidence is clear that most of the MHCUs who died, if not all of them, died of poor care. There is overwhelming evidence that at Precious Angels, where most MHCUs died, there was no medically trained personnel to care for the

[41] Ibid

MHCUs. Care workers who were not trained to care for the MHCUs bathed them and also cared for them. These are the people who were initially hired as cleaners. They could not pick up certain symptoms of sicknesses which the medically trained personnel would have picked up and ensured that they get proper medical attention. Some patients died before they could get treatment.

[549] The issue of the care and the conditions at the NGOs is what LE and others were concerned about when they warned of the dire consequences that would result.

[550] In S v Van As[42] the court explained the difference of foreseeability when dealing with negligence and when dealing with legal causation. The accused in that case smacked a very overweight person on the cheek. The victim fell backwards, hit his head on the floor and died. The court held that the death was not reasonably foreseeable. The accused was not found guilty of negligence in relation to the death of the deceased. That did not mean that the accused's conduct was not the cause of death. Under legal causation for the foreseeability theory, an act is a legal cause of a situation if the situation is reasonably foreseeable for a person with normal intelligence.[43] It is not necessary for the foresight to correlate with how the person eventually died, it is enough that death was foreseen for liability to arise under causation.[44] The argument by the evidence leaders can therefore not succeed in this regard.

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[42] S v Van As 1976 (2) SA 921 (A)
[43] Stavast 1964 3 SA 617 (T) 621; John 1969 2 SA 560 (RA) 565-571.
[44] Burchell, South African Criminal law and Procedure: General Principles of Criminal law,4 ed. p375

[551] Ms Mahlangu confirmed in her evidence that the MHCUs were vulnerable, experts in the field of Psychiatry warned her of the dire consequences that could result, she cannot now distance herself from the entire process that she was not involved in the implementation. There is overwhelming evidence that she chaired regular meetings where reports about the implementation were made to her. She was well-informed of what was happening on the ground. As a result, it is sufficient that she would have foreseen the possibility of death in general. Her conduct is, in my view, sufficiently closely linked to, or the proximate cause of the harm suffered.

[552] Applying the legal principles referred to and the test for legal causation, I am satisfied that the conduct of Ms Mahlangu also meets the test for legal causation.

[553] A strict application of this test as the evidence leaders have done, would yield unjust results in that while the court has established that there is factual causation between the deaths in this inquest, no person could be responsible for these deaths.

<u>Dr Makgabo Manamela</u>

[554] She was the Deputy Project Leader but she ran the project all by herself. She was the director of the MHD and has a PhD in Psychiatry. Mr Mosenogi did not have the same qualifications relevant to Mental Health. The GDOH officials who were at LE Waverley, to speed up the transfer process, testified that she interfered with their processes. She took the work that was done by the District. She would call and tell them what to do, for an example when Ms Morale came to fetch the patients and demanded more of them, Dr Manamela

would call to inform them to increase the numbers and prepare more patients for Ms Morale. Dr Manamela was aware of the NMPHF and that it was strongly opposed to deinstitutionalisation without first developing community service centres but continued to implement the decision to move MHCUs out of LE to the NGOs who she knew were not of the same standard of care as offered by LE. She is a psychiatrist nurse. She should have known better. She was actively involved. She visited the NGOs. She always received challenges and the complaints from the group. Her evidence was that she had to implement the decision to terminate the LE and support. She had a choice to refuse to implement the decision like the GDOH clinicians who boldy refused to get involved in the process.

[555] She knew that there were no sufficient beds available for over 1 400 MHCUs to be moved out of LE at the time of the termination of the LE contract but proceeded with the implementation.

[556] Some NGOs were not ready to receive the MHCUs when the MHCUs were placed at their facilities. She was also actively involved in some placements. There is evidence on record that Dr Manamela moved patients from Anchor house to Precious Angels. These were sickly and frail patients who were well-placed at Anchor with the staff of the GDOH to assist them. She moved the MHCUs from Anchor where male and female MHCUs were mixed, to Precious Angels which NGO she knew was not equipped and did not have professionals to care for the MHCUs.

[557] All the proper processes to prepare the NGOs to care for the MHCUs were not followed. Assessments for patients were not done on their arrival at

the NGOs. NGOs were not trained. They were provided with licenses when their facilities were not inspected and audits were not done. When Ms Sennelo told her that Precious Angels was not suitable to care for the MHCUs before their death, she left the NGO to continue operating until MHCUs started dying.

[558] She frequented the NGOs and saw what was happening. The way things unfolded, the GDOH just wanted to move all the MHCUs out of LE facilities and dump them with the inexperienced NGOs who knew nothing about mental health care. Her conduct ultimately resulted in the deaths of the MHCUs. If Dr Manamela did not sign the licenses or vetted the NGOs before the MHCUs were placed in NGOs, the MHCUs would have not been placed at some of the NGOs as most of them would not have qualified to care for them. They would have been taken to places where they would have received proper care. They would not have died of bedsores, emaciation, starvation, etc.

Would the harm still have occurred if the court is to substitute the reasonable conduct for the conduct of Dr Manamela?

[559] The harm would have not occurred without the conduct of Dr Manamela. Therefore, factual causation has been established.

[560] Legal causation is also established when one considers the test for legal causation. There was a sufficiently close link between Dr Manamela and the deaths.

Dr Tiego Ephraim Selebano

[561] The evidence did not show that he took the decision to terminate the LE contract. He was instructed to write the letter of termination and sent it to

LE. No evidence was presented to show that he was actively involved in the implementation of termination project. Factual causation can therefore not be established.

Ethel Ncube

[562] Submissions have been made that the conduct of Ms Ncube also contributed to the deaths of the MHCUs. It has to be noted that even though Ms Ncube has been referred to by the evidence leaders and others as the owner of Precious Angels, there is no evidence to support that fact. In all her statements before court and when she testified she referred herself as the director of Precious Angels.

[563] Precious Angels applied for a license to operate and care for MHCUs like other NGOs. The license was granted to Precious Angels. It was the duty of the GDOH to see to it that inspections and audits were done at the NGOs before the licenses were isued. No fault can be attributed to Precious Angels for the conduct of the officials of the GDOH.

Negligence

Would a reasonable person in the position of Ms Mahlangu have foreseen the reasonable possibility of harm and have taken reasonable steps to prevent it from happening, and she did not do so?

[564] As discussed earlier, Ms Mahlangu received numerous warnings before, during and after the termination of the LE contract. It cannot therefore be said that she did not foresee the possibility of deaths.

[565] Ms Mahlangu was able to take the decision to terminate the contract and could also extend the period for the implementation. As the MEC for Health at the time, she could have stopped the process and or extended the period of implementation of the termination project. Alternatively, she could have closed the NGOs which could not care for the MHCUs, like Precious Angels and move the MHCUs to other NGOs or hospitals which could give the MHCUs better care or care equivalent to the care they received from LE.

[566] Her evidence was that she was not involved in the implementation. She relied on people like Dr Manamela who were qualified and had the expertise to implement the decision. As indicated the evidence shows that she chaired meetings where reports were made to her regarding what was happening. She further testified that she never received complaints that there were challenges. Dr Manamela testified that Ms Mahlangu did not want them as MHD to bring problems to her; she wanted the project to succeed. A reasonable person in her position would have foreseen the reasonable possibility of the deaths and have taken steps to prevent them but she failed to do so. The LE contract was terminated despite numerous warnings.

[567] In my view there is prima facie evidence of negligence on her part.

Would a reasonable psychiatrist nurse in the position of Dr Manamela have foreseen the reasonable possibility of the harm and have taken reasonable steps to prevent it happening, and she did not do so?

[568] Dr Manamela is a psychiatrist nurse with a PhD in Psychiatry. She has experience and should know the type of patients the MHCUs are. She knew that at the time the decision to terminate the contract was made, there were no

beds to accommodate all the MHCUs who were at LE facilities. Some NGOs who were received the MHCUs to care for them, were not in existence. She did not follow proper procedures when she licensed the NGOs. She allowed the MHCUs to be moved out of LE to NGOs in large numbers despite their conditions at the time. A reasonable psychiatrist in her position would have foreseen the possibility of death and would have taken reasonable steps to prevent it from happening. She failed to do so. I find that there is prima facie evidence of negligence on her part.

[569] Public servants should at all times endeavour to resist any interference by politicians in the execution of their professional duties. They should be guided by the provisions of Chapter 10 Section 195 of the Constitution that speaks to basic values and principles governing public administration. Similarly, politicians must also refrain from applying undue pressure on public servants.

<u>Conclusion</u>

[570] Having heard all the evidence in this inquest, I have come to the conclusion that the deaths of the following deceased namely:

1. Matlakala Motsoahae;
2. Virginia Macaphela;
3. Terrence Chaba;
4. Lucky Maseko;
5. Josiah Daniels;

6. Frans Dekker;

7. Charity Ratsotso;

8. Deborah Phetla; and

9. Koketso Mogoerane

were negligently caused by the conduct of Ms Dorothy Qedani Mahlangu and Dr Makgabo Manamela.

[571] Ms Dorothy Qedani Mahlangu proceeded to terminate the contract between LE Care Centre and the GDOH despite numerous expert advice and warnings from the professionals in Mental Health and stakeholders. The deceased were further moved out of LE facilities to NGOs which were ill-equipped and inexperienced to provide proper and adequate mental health care. Ms Mahlangu's conduct led to regrettable and unfortunate deaths, some of which could have been avoided.

[572] Dr Makgabo Manamela proceeded to hastily fascilitate the implementation of the plan against expert advice from professionals and stake-holders. She could have saved many lives. She visited the NGOs and could see that they were not adequately equipped and some of the personnel were not adequately qualified to care for the MHCUs. Some of the NGOs were licensed without following the prescribed protocols.

[573] Effectively, Ms Qedani Dorothy Mahlangu and Dr Manamela created circumstances in which the deaths of the deceased were inevitable.

[574] Consequently, the court makes following findings:

1. In respect of the deaths where no autopsies were performed, save for the death of Matlakala Motsoahae and Koketso Mogoerane, the court is unable to make a finding regarding the question in section 16(2)(d).

2. In respect of the deaths where there were autopsies performed, save for Virginia Machapelah, Terrence Chaba, Lucky Maseko, Josiah Daniels, Frans Dekker, Charity Ratsotso and Deborah Phetla, the court is unable to make a finding regarding the question in section 16(2)(d).

3. Section 16(2):

   (a) The deceased Gwendoline Virginia Machphela ID NO. 660108 071 2085 A 50 years' old female.

   (b) Date of death 15 August 2016.

   (c) Cause of death unascertained, severe malnutrition, dehydration and gangrene were major contributions.

   (d) Yes, Ms Qedani Mahlangu and Dr Makgobo Manamela.

4. Section 16(2):

   (a) The deceased is Terence Maphea Chaba 880203 569 08 4. 28 years' old male.

   (b) Date of death 15 August 2016.

(c) Cause or likely cause of death Natural causes should be considered. Bronchopneumonia, semi-starvation may have predisposed deceased to the development of Bronchopneumonia.

(d) Yes. Ms Qedani Mahlangu and Dr Makgabo Manamela.

5. Section 16(2):

(a) The deceased is Lucky Maseko. Date of Birth 1 January 1980 36 years' old Male.

(b) Date of death 3 September 2016.

(c) Cause or likely cause of death in keeping with asphyxia death due to food aspiration.

(d) Yes, Ms Qedani Dorothy Mahlangu and Dr Makgabo Johanna Manamela.

6. Section 16(2):

(a) The deceased is Josiah Daniels. Id. No. 7401086163089 Male.

(b) Date of Death 8 September 2016

(c) Cause or likely cause of death in keeping with natural causes: necrotising pneumonia. Court find that he was severely underweight and there was a delay in picking up his condition at the NGO. He died before he could receive treatment.

(d) Yes, Ms Qedani Mahlangu and Dr Makgabo Johanna Manamela

7. Section 16(2):

(a) The deceased is Charity Ratsotso Date of birth 26 September 1968 48 years Male

(b) Date of death 11 July 2016

(c) Cause or likely cause of death in keeping with food aspiration complicated by necrotising pneumonia.

(d) Yes, Ms Qedani Dorothy Mahlangu and Dr Makgabo Johanna Manamela.

8. Section 16(2):

(a)The deceased is Deborah Phetla Id No. 7505251335081 Female

(b) Date of death 26 March 2016

(c) Cause or likely cause of death consistent with asphyxia due to the aspiration of blood.

(d) Yes, Ms Qedani Dorothy Mahlangu and Dr Makgabo Johanna Manamela

9. Section 16(2):

(a) The deceased is Frans Dekker Id No. 6809105026080 Male

(b) Date of death 7 November 2016

(c) Cause or likely cause of death septic decubitis ulcers complicated by sepsis.

(d)Yes, Ms Qedani Dorothy Mahlangu and Dr Makgabo Manamela.

10. Section 16(2):

(a) The deceased is Matlakala Motsoahae Date of birth 12 September 1944 Female

(b) Date of death 26 August 2016

(c) Cause or likely cause of death Unknown No post mortem Presented at hospital with deep bedsores on the hip, decreased level of consciousness, lower respiratory tract infection, a septic hand, renal impairment, and hypernatremia.

d) Yes, Ms Qedani Dorothy Mahlangu and Dr Makgabo Manamela

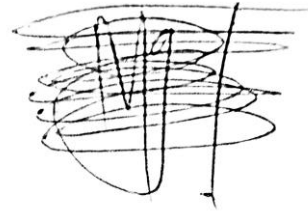
11. Section 16(2):

(a) The deceased is Koketso Christopher Mogoerane Id No. 6012215715086 Male

(b) Date of death 25 June 2016

(c) Cause of death or likely cause of death unknown no post mortem. He died after falling at night unattended.

(d) Yes, Ms Qedani Dorothy Mahlangu and Dr Makgabo Johanna Manamela.



**M J TEFFO**
**JUDGE OF THE HIGH COURT**
**GAUTENG DIVISION, PRETORIA**

Appearances

| | | |
|---|---|---|
| Families of 44 deceased & SADC | Adv Adila Hassim SC<br>Adv Rajab-Budlender SC<br>Adv Thabang Pooe | Section 27 |
| Families of 4 deceased | Adv Phylis Verster and<br>Adv Matthew Klein | Hurter Spies |
| Gauteng Govt<br>(Office of Premier and GDoH) | Adv W R Mokhare SC<br>Adv V Rikhotso<br>Adv Tebogo Hutamo<br>Ms Thandiwe Matshebela | Werksmans |
| Qedani Mahlangu | Adv Lawrence Hodes SC<br>And Adv Teneille Govender | SA and RHK Attorneys |
| Dr Manamela | Adv Russel Sibara and<br>Adv Makhani | State Attorney |
| Dr Selebano | Adv Craig Watt-Pringle SC and Adv Henry Martin | Ramsay Webber |
| Hannah Jacobus | Adv W F Pienaar SC | State Attorney |
| Daphney Ndlovu | Adv Rendani Munzhelele | State Attorney |

| | | |
|---|---|---|
| Nonceba Sennelo | Adv Lisle Mboweni | State Attorney |
| Dr Lebethe | Adv Tiny Seboko | State Attorney |
| Rochelle Gordon | Adv Amanda Gxogxa | State Attorney |
| Levy Mosenogi | Adv Kgaogelo Ramaimela & Adv B Mathlape | State Attorney |
| Sophie Lenkwane | Adv Maite | State Attorney |
| Life Esidimeni (Sanele Buthelezi and Dr Mkhatshwa) | Adv Harry van Bergen SC | Ric Martin |
| Carina Morale – Tshepong | Tlou Phihlela | Legal Aid |
| Patricia Mbatsha - Ubuhle Benkhosi | Adv E Prophy | Keheditse Masege Attorneys Inc |
| Dorothy Sekhukune (Takalani), Maletsatsi Mgotsoa (Mosego) | Adv Prophy | Keheditse Masege Attorneys Inc |
| Dorothy Franks (Anchor) | Tlou Phihlela | Legal Aid |
| Beauty Kekana (Bophelong Suurman) | In person | In person |
| Ethel Ncube (Precious Angels) | Tlou Phihlela | Legal Aid |
| Dianne Noyile (Siyabadinga) | Tlou Phihlela | Legal Aid |
| Titsetso Malebe (Rebafenyi) | Manamela Attorneys | Mr Kwena Manamela |
| Bophelong – Mamelodi | No representation | |
| Neil Wesselo (Shamma) | In person | In person |
| Ms Priscilla Nyatlo | Adv Geoffrey Shabangu | State Attorney |

Date heard 19 July 2021 to 2 November 2023
Date of Judgment 10 July 2024