IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NO: I001/2021

IN THE LIFE ESIDIMENI INQUEST BEFORE MADAM JUSTICE TEFFO

WRITTEN SUBMISSIONS ON BEHALF OF 44 FAMILIES AND THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP (REPRESENTED BY SECTION27)

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A. INTRODUCTION AND EXECUTIVE SUMMARY

1 These submissions are prepared on behalf of the families of 44 mental health care users ("MHCUs")[1] who died under the most inhuman, cruel and degrading circumstances while under the care of the State. Most of the MHCUs who died suffered starvation, dehydration, neglect, torture, and severe violations of their human rights.[2]

2 These proceedings take place in terms of the Inquests Act 58 of 1959 ("the Inquests Act") and this Court is tasked specifically with determining whether these deaths were "*brought about by any act or omission prima facie involving or amounting to an offence on the part of any person.*"[3] In other words, it is for this Court to decide whether the conduct or omission of any person *prima facie* involved or amounted to an offence. Notably, this Court is only required to make a *prima facie* finding. Once this Court does so, it is then for another court to decide whether the individuals concerned are ultimately held criminally liable. This Court's role is, therefore, not the same as in a criminal trial.

3 The MHCUs who died did so while under the care of organisations tasked by the State – in particular Ms Mahlangu and Dr Manamela - to take care of them. This case is unique and unprecedented in South Africa and is a chapter of our history

[1] SECTION27 list of clients, Vol 0, page 4.

[2] Arbitration award, Vol 400, page 22271.

[3] S16(2) of the Inquests Act.

which we collectively hope will never be repeated. The primary way to do that is to hold responsible:

3.1 those who had the power and knowledge to stop the transfer of MHCUs to places where they would suffer and likely die; and

3.2 those who were tasked to take care of them and instead allowed them to die.

4 Each of the deceased MHCUs died in conditions of neglect and the circumstance of each death is relevant to each other death. This is because the evidence has shown that all of the deaths occurred in a context created by the conduct of Ms Qedani Mahlangu and Dr Makgabo Manamela and, in some cases, Ms Ethel Ncube.

5 The similarities between the 10 deaths on which we focus (listed in paragraph 6 below) are notable:

5.1 Five of the 10 MHCUs were moved to ill-prepared NGOs despite periodical reports that specifically recommended against their being discharged to any NGO. The other five MHCUs do not have periodicals in evidence but they were each complicated cases and would have been difficult to manage in NGOs.

5.2 Nine of the 10 MHCUs were moved in large groups – up to 85 on a single day to a single NGO. This is contrary to good practice and the health and lives of MHCUs.

5.3 Three of the 10 MHCUs were moved from one NGO to another following their move out of Life Esidimeni, exacerbating the difficulty in adapting to a new place.

5.4 Seven of the 10 MHCUs died emaciated or having lost a significant amount of weight. This alone indicates the problems in care and access to food in the NGOs.

5.5 Four of the 10 MHCUs died with bedsores or gangrene, indicating the poor nursing care.

6 Due to the availability of more extensive information in respect of some of the deaths, and our limited capacity to undertake a full analysis in respect of each death, in these submissions, we limit our argument to the deaths of 10 MHCUs. We do not, however, suggest that these are the only deaths that can be attributed to the conduct of the above three actors. We submit that one or more of the above three actors are *prima facie* responsible for the deaths of the 10 MHCUs below:

6.1 Virginia Machpelah;

6.2 Deborah Phehla;

6.3 Frans Dekker;

6.4 Charity Ratsotso;

6.5 Koketso Mogoerane;

6.6 Vuyo Aaron Ngqondwane;

6.7 Christopher Makhoba;

6.8 Terrence Chaba;

6.9 Daniel Josiah; and

6.10 Matlakala Motsoahae.

7 We submit that based on the evidence before this Court a *prima facie* case of culpable homicide has been made against the former MEC, Ms Mahlangu; the Director of the Mental Health Directorate, Dr Manamela and Ms Ethel Ncube, the owner of the Precious Angels NGO.

7.1 As the MEC, Ms Mahlangu made the decision to implement and to continue to implement the rapid and widescale transfer of MCHU's despite ominous warnings and pleas for more time from her own officials and experts. Her actions in insisting that the transfer go ahead and in refusing to provide the full extension of time requested by her officials, as well as her failure to stop the process when warned, *prima facie* caused the deaths of each of the 10 MHCUs whose names are listed above.

7.2 As the Director of Mental Health, Dr Manamela was at the coal face and was aware of the concerns of her own team about the undue speed with which MHCUs were being transferred and the dire implications for them. Notwithstanding this, she supervised the transfer of hundreds of MHCUs including to unlicenced NGOs with a lack of resources, skill and trained staff. The process of transfer was so chaotic that even

expert medical practitioners warned the Department that this was a dangerous process which should be stopped. As the Director of the Mental Health Directorate, Dr Manamela ought to have refused to continue the transfer of MHCUs to NGOs she knew to be unlicenced and unable to care properly for such patients. She did not. Instead, she signed off on unlawful licences and instructed her subordinates to continue the transfer undeterred. Had she refused to sign the licences many lives would have been saved. Dr Manamela's actions and her failure to stop the transfer when warned, *prima facie* caused the deaths of each of the 10 MHCUs whose names are listed above.

7.3 As owner of the NGO Precious Angels, Ms Ncube housed MHCU's in the most deplorable conditions, she knowingly operated an unlicenced NGO, continued to accept MHCUs even after it was clear that she had neither the staff, the resources, nor the facilities to care for them and that taking additional people would compromise. She employed unskilled workers to take care of MHCUs who required specialised care and allowed MHCU's to be housed in conditions that were squalid and inhumane. Ms Ncube's actions and failure to take action *prima facie* caused the deaths of Virginia Machpelah, Deborah Phehla, Frans Dekker, Charity Ratsotso, and Koketso Mogoerane.

8 We therefore submit that all three of these individuals are *prima facie* responsible for the deaths of some or all of the 10 MHCUs identified above and that this Court ought to find as such.

9 In these submissions we first consider the legal history of this matter and then look to the legal framework including what the Inquest judge is empowered to find and the approach that this court must take to causation. We then look to the conduct of each of the three people whose conduct attracts criminal liability, describing that conduct and linking it to the deaths. Finally, we lay out the evidence as it relates to the 10 deceased and demonstrate how these deaths came about as a result of the conduct of Ms Mahlangu, Dr Manamela, and, in the case of five of the deceased, Ms Ncube.

B. WHAT HAS GONE BEFORE: THE INQUEST, THE ARBITRATION AND THE OMBUD'S REPORT

10 In September 2019, the National Prosecuting Authority announced that there was insufficient evidence to bring charges in the 141 cases it investigated over the Life Esidimeni tragedy. The Acting Director of Public Prosecutions, Advocate George Baloyi, decided that a formal and joint inquest into all deaths related to the Esidimeni tragedy be held in the North Gauteng High Court, Pretoria before a judge.

11 The inquest proceedings started on 19 July 2021 and lasted 130 court days over a two-year period. The court heard from 40 witnesses including Department officials, NGO owners and staff members, forensic pathologists and experts in nursing and mental health care.

12 Prior to the inquest, the details of the Life Esidimeni disaster were dealt with in an investigation and report by the Health Ombud; and in an arbitration presided over by former Deputy Chief Justice Dikgang Moseneke.

13 The Health Ombud conducted a thorough investigation that relied on evidence provided by numerous stakeholders, which culminated in the publication in February 2017 of a comprehensive report entitled "The Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province".[4]

14 The arbitration began in October 2017 and it culminated in March 2018, when the arbitrator, Justice Dikgang Moseneke, delivered the arbitration award.[5] The full record of the evidence from the Arbitration was ruled to be part of the record that served before this court.[6]

15 In plain-speaking language Justice Moseneke's judgment begins with the following:

[1] This is a harrowing account of the death, torture and disappearance of utterly vulnerable mental health care users in the care of an admittedly delinquent provincial government.

16 There are several key findings by Justice Moseneke that are relevant to this inquest.

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[4] M. W. Makgoba, The report into the circumstances surrounding the deaths of mentally ill patients: Gauteng Province (Pretoria: Office of the Health Ombud, 2017). Vol 200, page 17933.

[5] Arbitration Award, Vol 400, page 22271.

[6] Court's ruling, Vol 413, page 45709. This is in line with section 14 of the Inquests Act which allows, at the discretion of the inquest judicial officer, for the reception in evidence of the inquiry records held in terms of other statutes.

17 First: The deaths that occurred were "not natural but caused unlawfully and negligently" by the employees of the Government. Importantly, the government conceded this in the Arbitration.[7]

"*All three of them [Mahlangu, Selebano and Manamela], in slightly varying formulations said "mental health care users die". That must be true. All human beings die at some stage. But here matters were plainly different. All evidence points to unnatural causes of death. That is the finding of the Ombud and one that the Government has conceded. Again, that concession is correctly made*."[8]

18 Second: Officials were warned of the inevitable outcome but they chose to continue. The responsible officials – including Ms Mahlangu, Dr Selebano and Dr Manamela, were warned of the consequences of the transfer of mental health care users but did not heed the many warnings.

> *The Department did not heed any of these pointed warnings of potential harm to mental health care users. Ms Mahlangu, Dr Selebano and the former head of the Mental Health Directorate (Directorate), Dr Makgabo Manamela (Dr Manamela) obstinately went ahead with mass removals, without involvement of and consultation with families and concerned health professionals. As a result, at least 144 people in their care died and barring the missing patients, just over 1400 patients survived the*

[7] Arbitration Award, Vol 400, page 22276.

[8] Arbitration Award, Vol 400, page 22310.

torturous conditions after their forced displacement from Life Esidimeni facilities.[9]

19 Third: Ms Mahlangu, Dr Selebano and Dr Manamela failed to act in the face of deaths occurring. Regarding the failure to act even when the deaths were of evident concern, Justice Moseneke says the following:

Asked the same question during the hearing,[regarding the question by the provincial legislature early on the process of moving patients] *Ms Mahlangu, Dr Selebano and Dr Manamela pleaded ignorance. They claimed that nobody told them of the deaths. So many patients under the care of their Department died and they say they never heard of the deaths. This answer is as improbable as it is untrue. All three key decision makers in the Marathon Project, in evidence, sought to escape the inevitable and foreseeable results of their reckless and unlawful plan to displace mental health care users from Life Esidimeni facilities.*[10]

20 Fourth: The NGOs were incapable of providing the necessary care for MHCUs and the three officials knew this. A number of the NGOs to which the MHCUs were sent were not properly vetted as suitable for their care.

"Many of the destinations of the mental health care users were treacherous. The evidence suggests that they may be properly dubbed death traps or sites of torture."[11]

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[9] Arbitration Award, Vol 400, page 22288.

[10] Arbitration Award, Vol 400, page 22309.

[11] Arbitration Award, Vol 400, page 22301.

21 Fifth: On whether the deaths were reasonably foreseeable, Justice Moseneke found as follows:

> *The high-water mark of the response of these three high ranking Government officials is that they had no reason to believe that the displaced mental health care users would die or suffer severe ill-treatment and torture. On the facts as a whole, this response is so improbable that it must be false.*[12]

22 Although this Court is not bound by the findings of Justice Moseneke, we will submit that there is no good reason to depart from those findings. Even though those findings were made in the context of the arbitration they are directly relevant to these proceedings. As this division has held in *Institute for Accountability in Southern Africa v Public Protector*:

> *Judges have a duty to form and express opinions concerning issues raised before them (including those that are relevant in the context of this matter), and they arrived at those opinions aided by procedures (including the law of evidence) which were designed to ensure that they base those opinions on the correct information.*[13]

23 In other words, they cannot be equated with the mere inadmissible opinion of ordinary individuals. In order to make contrary findings, we submit with respect, this Court would have to explain the basis for doing so.

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[12] Arbitration Award, Vol 400, page 22288.

[13] 2020 (5) SA 179 (GP) at para 31.

C. THE LEGAL FRAMEWORK

24 It is worth remembering that a basic principle of criminal law is to ensure that people take responsibility for their actions (and the outcome of their actions). This is the essence of treating persons as moral agents. Cameron and Ferreira explain:

> *The idea is that our sense of self depends in large part on being held responsible for the outcomes of our actions. If we were not held to be in some way identified by what we bring about in the world we would lose our distinctive identity. Perry says that "it is outcomes that make us what (and who) we are. It is the outcomes of actions that give us a history as persons, and our history as persons contributes in very large measure to our identity as individuals."*
>
> *Seeing others as appropriately responsible for the outcomes of their own behaviour is essential to recognising them for who they are. As Honoré argues:*
>
> *That we should think of ourselves as responsible agents, as taking on responsibility for other people and things, and as having it thrust on us, is what makes possible a shared sense of one's identity and character and that of others. It makes possible a life in common in which people relate to one another as individuals, each with distinctive traits, virtues and shortcomings, and with a history that is largely made up of what they have done, of their achievements and failures."*[14]

25 This Inquest is a step towards ensuring that the relevant people are held responsible for their actions and, contrary to what the evidence leaders and others have suggested, the law supports this step.

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[14] E Cameron and N Ferreira, Tony Honorés Contribution to Jurisprudence, Speech at Seminar in honour of Professor Tony Honoré, UCT, 14 March 2009.

The Inquests Act

26 This inquest arises from the deaths of MHCUs who were in the care of the state. They died following the decision and actions of Ms Mahlangu, the former MEC of Health in Gauteng, and/or Dr Manamela, the former head of the Mental Health Directorate to move them out of Life Esidimeni, the facility in which they had been receiving treatment and care, to a number of unlicensed NGOs scattered across the province.

27 Prior to dealing with the evidence before this Court, it is important to consider what this Court is called to do. The starting point is the Inquests Act.

28 In the preamble of the Act provision is made for the holding of an inquest in cases of death occurring from other than natural causes.[15] The principal aim of the Act according to section 2 read with sections 3 and 5(2) is to investigate the factual circumstances of deaths occurring from other than natural causes.

29 An inquest proceeding is seen as a medico-legal state investigation in the form of a public non-adversarial inquiry into the proximate causes of a person's unnatural death which has not been the subject of a criminal prosecution. The High Court in *The re-opened inquest into the death of Ahmed Essop Timol*[16] described an inquest as "an inquisitorial *cum* investigation process".

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[15] There are other acts that provide for inquests, including section 10 read with section 14 of the Civil Aviation Act 13 of 2009 ("Civil Aviation Act") which makes it possible to hold a joint inquiry and inquest where an aircraft accident has resulted in the loss of life. See also section 100 of the Defence Act 42 of 2002 ("Defence Act").

[16] (IQ01/2017) [2017] ZAGPPHC 652 (12 October 2017).

30 In *Timol v The Magistrate of Johannesburg*[17], the Court had this to say about inquests:

> *"Nevertheless, the inquest must be so thorough that the public and interested parties are satisfied that there has been a full and fair investigation into the circumstances of death."*

31 The principal procedural aim of an inquest is two-fold:

31.1 to determine the likely cause of death of a deceased person; and

31.2 to determine whether any individual person may be held criminally responsible for the death of the deceased.

32 Another important purpose of an inquest is to promote public confidence in the criminal justice system by reassuring the public that a death from any unnatural cause will receive proper attention and investigation and that appropriate measures will be taken to prevent similar occurrences in future.[18]

33 In *Marais NO,*[19] supra, this Court also emphasised the important underlying purpose of an inquest at 901F-G:

> *"The underlying purpose of an inquest is to promote public confidence and satisfaction; 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, and so that persons responsible for such deaths may, as far as possible, be brought to justice."*

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[17] 1972 (2) SA 28 (T).

[18] See also *Timol v Magistrate, Johannesburg* 1972 2 SA 281 (T) 287F-H; *Wessels v Additional Magistrate, Johannesburg* 1983 1 SA 530 (T) 532E-533A.

[19] *Marais NO v Tiley* (377/88) [1990] ZASCA 40; 1990 (2) SA 899 (AD); (30 March 1990) at 901E-F, 902A-B.

34 The SCA in *Van Heerden and Another v Joubert NO and Others*[20] added that:

> *"The State has an interest in the proper investigation of deaths due to other than natural causes. Even if nobody can be held responsible for a death in a particular case, it may still remain pertinent to determine the circumstances and cause of death in order that appropriate measures can be taken to prevent similar occurrences. There might therefore be reasons to proceed with an inquest in the present case."*

35 Recently, in *Freedom Under Law v NDPP*[21] the North Gauteng Division of the High Court also had this to say about the purpose of 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 the 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 officer is not called on to make any determinative finding as to culpability."*

<u>The inquest findings</u>

36 In terms of section 16(2) of the Act, an inquest judicial officer is required to record a finding at the conclusion of the inquest inquiry in respect of a number of distinct facts-in-issue. In words of the Inquests Act, the judicial officer shall record a finding:

(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;

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[20] (577/92) [1994] ZASCA 101; 1994 (4) SA 793 (AD); [1994] 2 All SA 468 (A) (19 August 1994) at p 4.

[21] *Freedom Under Law v National Director of Public Prosecutions and Others* 2014 (1) SA 254 (GNP).

(d) as to whether the death was brought about by any act or omission prima facie involving or amounting to an offence on the part of any person.

37 In terms of section 16(3) where the judicial officer is unable to reach a finding, he or she shall record that fact.

38 The words "*prima facie*" were inserted by section 7 of the Inquests Amendment Act 8 of 1991, one of the last amendments to the Act.[22] The amendment is a clear indication of the limited ask of the Inquest Court.

39 In *Freedom Under Law*[23] the Gauteng Division of the High Court held that the judicial officer "*is not called on to make any determinative finding as to culpability*."

40 When making a positive finding, a judicial officer is simply required to be of the opinion that there is "*evidence available which may at a subsequent criminal trial be held credible and acceptable and which, if accepted, could prove that the death of the deceased was brought about by an act or omission which involves or amounts to the commission of a criminal offence on the part of some person or persons" (thus, that a specific case has merit for prosecution)*.[24]

[22] The Act was most recently amended by the Inquest Amendment Act 145 of 1992 and the International Co-Operation in Criminal Matters Act 75 of 1996. It has been subjected to very limited scrutiny by the Superior Courts.

[23] *Freedom Under Law v National Director of Public Prosecutions and Others* 2014 (1) SA 254 (GNP) ("F*reedom Under Law*") para 72.

[24] *In Re Goniwe & Others (Inquest)* 1994 3 SA 877 (SE) 880B.

41 In *Re Goniwe and Others (Inquest),*[25] the test to be applied in arriving at a conclusion in terms of section 16(2)(*d*) is dealt with:

> *"The presiding officer at an inquest need go no further than to ask himself whether a prima facie case has been established. . . ."*

42 And at 880B-D:

> *"Bearing in mind the object of an inquest it is my opinion that the test to be applied is not the "beyond a reasonable doubt" test but something less stringent. In my opinion the test envisaged by the Inquest Act is whether the judicial officer holding the inquest is of the opinion that there is evidence available 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 an act or omission which involves or amounts to the commission of a criminal offence on the part of some person or persons."*

43 The SCA added in *Hirt & Carter (Pty) Ltd v IT Arntsen N O and Others*[26] that:

> *"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 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."*[27]

44 In *De'Ath (Substituted by Tiley) v Additional Magistrate, Cape Town ("De'Ath")*,[28] the court held that an 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

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[25] 1994 (3) SA 877 (SE) at 879I.

[26] (277/2020) [2021] ZASCA 85 (18 June 2021).

[27] Id at para 34.

[28] *De'Ath (Substituted by Tiley) v Additional Magistrate, Cape Town*, 1988 4 SA 769 (C) 775F-G.

the actual offender. According to the court while an inquest finding cannot attempt to convict anyone, it can certainly make a finding aimed at ensuring that where guilt exists it will not remain hidden.

45 In sum:

45.1 The Act provides for the holding of inquests in cases of deaths or alleged deaths apparently occurring from other than natural causes and for matters incidental thereto.

45.2 Inquests are not criminal trials. They are inquisitorial in nature and the main purpose of the proceedings is to determine the cause of death, or likely cause of death, of the deceased and if there is any person who caused or contributed to the death.

45.3 The Inquests Act does not impose the same onus that rests on the State in criminal trials. The Inquest Court is not required to make a finding of guilt. The standard of proof is less stringent than proof beyond a reasonable doubt.[29] The question for the court, in terms of section 16(2) of the Act is whether the deaths were brought about by conduct *prima facie* amounting to an offence on the part of any person or persons.[30]

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[29] *In Re Goniwe and Others (2)* 1994 (2) SACR 425 (SE); *Padi en 'n Ander v Botha No en Andere* 1995 (2) SACR 663 (W) at 665G.

[30] *Freedom Under Law v National Director of Public Prosecutions and Others* 2014 (1) SA 254 (GNP) at para 77.

The elements of the crime of culpable homicide

46 Culpable homicide is the unlawful negligent killing of a human being.[31]

47 We do not seek to prove each of the elements of the crime in respect of each of the deceased as the only element that is in real dispute is the element of causation.

48 On the evidence before the court, we note, however, that the deaths of the MHCUs were reasonably foreseeable and yet Ms Mahlangu, Dr Manamela and Ms Ncube's actions and failures to take action were at the very least negligent and were in fact reckless.

Causation

49 The evidence leader's opening statement and remarks of other legal representatives during the course of the Inquest made clear that causation is the only issue which the parties disagree about and which this Court is required to decide. We therefore lay out the applicable law and the approach that this court must adopt in relation to causation.

50 The evidence leaders contend that finding the existence of causation is the biggest challenge in the Life Esidimeni Inquest. This, we submit, is because the evidence leaders advocate for a very narrow understanding of causation and one which is inconsistent with our jurisprudence.

[31] *S v Burger* 1975 (4) SA 877 (A) at 878 H).

51 It is well-established in our law that to find causation, courts must adopt a two-phase enquiry: factual and legal causation.

52 Under the factual causation enquiry, *Skosana* is particularly instructive for our purposes. The 'but for' test caters for:

52.1 positive acts and omissions;

52.2 where there are multiple actors, whose conduct solely, cumulatively, or contributorily caused the result, and where each individual conduct can be tested on its own merit, without exculpating the others; and

52.3 where it is difficult to determine where an act/omission was the cause of the result - solely, cumulatively or contributorily – these are difficulties that relate to proof.

53 Under the legal causation enquiry, the question is whether the conduct or omission of the Department officials was too remote from the deaths for liability to follow.

Factual causation

54 According to *Skosana*, factual causation "*relates to the question as to whether the negligent act or omission in question caused or materially contributed to the harm"*.[32]

[32] Minister of Police v Skosana 1977(1) SA 31 (A) at 34

55 Corbett JA unpacks the meaning of "*to cause*" to be *"a necessary antecedent: in a very real and practical sense, the term embraces all things which have so far contributed to the result that without them would have not occurred. It covers not only positive acts and active physical forces, but also it covers the defendant's omissions as well as his acts*". [33]

56 The test for factual causation is the 'but for' test / *conditio sine qua non*. The inquiry simply is: "*Would the result have set in but for the negligent act or omission of the person concern*".[34] In *S v Van As*[35], confirmed in *Skosana*[36] where there is an act of omission, there is a need for a hypothetical addition. The courts are to determine what a reasonable person (based on what is required to satisfy their legal duty) would have done in the circumstances and whether they would have thereby prevented/reduced the harmful event.[37] The use of the 'but for' test was examined in *S v Daniels* and applied in a number of other criminal cases, including *S v Tembani.*[38]

57 *Skosana* further notes that there may be a set of circumstances where it is difficult to determine whether an act/omission caused a result either solely, contributorily, or cumulatively with another/others, but that these difficulties relate to proof.[39] Viljoen AJA posited:

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[33] Ibid 35.

[34] Ibid 44.

[35] 1967 (4) A 594 (A).

[36] *Skosana* 34

[37] *Lee v Minister of Correctional Services* 2013 2 SA 144 (CC) para 40;

[38] 2007 (1) SACR 355 (SCA) para 10.

[39] *Skosana* 44.

> *"in applying [the but for test] to a case which 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".*[40]

58 Viljoen AJA provides the following example:

> *"If it were alleged that a certain person was negligently responsible for a certain delay which has contributed to the result, a reconstruction of events by eliminating this delay would necessarily entail the advancement in time of subsequent acts or omissions. In my view such advancement would be irrelevant for purposes of testing the causation relating to any other person's acts or omissions".*[41]

59 *Skosana* thus confirms that each of their conduct/omission can be tested independently from the other to determine whether they were singly, cumulatively, or contributorily the cause of the relevant result.

Flexibility of the 'but for' test and the hunters analogy

60 *Lee* emphasised that the 'but for' test is not inflexible and had to make provision for *situations* where: "*the use of the substitution or notional, hypothetical lawful conduct for unlawful conduct in the application of the "but for test for factual causation may lead to an injustice*."[42] The Constitutional Court held that in some

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[40] Ibid.

[41] Ibid.

[42] *Lee* para 50.

circumstances factual causation would be established where the plaintiff has proved that, but for the negligent conduct, the risk of harm would have been reduced.[43]

61 There has been much confusion about the applicability of the but-for test since *Lee*. This Court need not detain itself on the question of factual causation for the reasons we set out below. The ultimate rational of *Lee* was to address the fact that in some cases, the application of the test yields unjust results. It has been accepted that there are cases in which the strict application of the rule would result in an injustice and therefore requires a flexible approach.[44]

62 This is commonly illustrated in the classic example of the two hunters. This is where two hunters (A and B) shoot at the same person at (roughly) the same time with identical guns. The victim could not show that his injury would have resulted 'but for' the conduct of A; nor could he in relation to B.

63 The unjust result is that neither is held liable for the harm.

64 On the approach taken by the evidence leaders, that would be exactly the result here. The Court would have to find that - although the deaths of the MHCUs were not natural, were preventable, and occurred in shocking circumstances – no one is responsible for causing their deaths.

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[43] Ibid para 60.

[44] HLA Hart and T Honoré, Causation in the Law, 2nd ed (Oxford University Press, Oxford, 2002) page 124; Chief Justice Beverly McLachlin, "Negligence Law – Proving the Connection" published in NJ Mullany and A Linden, Torts Tomorrow: A Tribute to John Fleming (LBC Information Services, Sydney, 1998) page 18; W van Gerven, J Lever, P Larouche, Tort Law (Hart Publishing, Oregon, 2000) page 441.

65 We note that the evidence leaders in their written submissions accept that factual causation has been established in this case. This is in our submission correct.

66 Ms Mahlangu 'pulled the trigger' by terminating the contract with Life Esidimeni on short notice, knowing the risks. She obstinately refused to reverse the decision, slow down the transfers of patients, or, indeed, even agree to the appointment of a curator ad litem to ensure that the best interests of vulnerable patients, who could not advocate for themselves, were protected. She remained involved throughout the project.

67 Dr Manamela, an expert psychiatric nurse, licensed NGOs that were clearly incapable of providing basic care, let alone care for MHCUs. She did so without following proper process, and instructed her staff to simply 'move people and we will sort it out later'.

68 Ms Ncube scrummaged around to get premises from her uncles to take patients. She knew she had no experience or resources to care for the MHCUs. She accommodated them anyway. As their health rapidly declined, she failed to ensure that the MHCUs received urgent medical attention.

69 In addition, we submit that legal causation has also been established.

Legal causation

70 It was established in *Mokgethi*[45] that there is no single test to determine legal causation, but that the broad test would ask the question: Was there a sufficiently

[45] 1990 (1) SA 32 (A).

close connection between the accused's conduct and the unlawful consequence?[46] The various tests of *novus actus interveniens*, the individualisation test, foreseeability test and the test for adequate causation are considered factors (not exclusive factors) to determining legal causation. Simply, the enquiry into legal causation is based on the legal convictions of the community and the policy considerations of reasonableness, fairness and justice as informed by various specific tests of legal causation. This approach is confirmed in *De Klerk v Minister of Police*.[47]

Adequate cause test

71 Applied in *R v Loubser*[48]*,* then later confirmed in *Grobler* and *Daniels*, "an act is a cause of a situation if, according to human experience, the situation will flow from the act".[49] The test always involves a consideration of the probable results of the act.

> *"In Loubser's case, X had inflicted a stick wound on Y's head. Y, living in apparently primitive conditions, did not heed his employer's advice to go to hospital, bound his wound with dirty rags and some days later contracted tetanus and died. Rumpff J considered that the crucial test in determining X's liability for Y's death was whether Y's conduct was abnormal or unusual in the light of human experience. It was held that it was not abnormal for a person living in a rural environment to do what Y had done and accordingly X had caused Y's death.[50]"*

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[46] *Mokgethi* 40.

[47] 2021 (4) SA 585 (CC) paras 29 -31.

[48] 1953 2 PH H190 (W.)

[49] *Grobler* at 560-561; *Daniels* at 332H.

[50] Burchell, South African Criminal Law and Procedure: General Principles of Criminal Law, 4 ed, p 98.

72 This test also recognises the 'thin skull' rule – where the accused takes the victim as found. The question is not whether a 'slight blow to another's head has the tendency to cause death', but rather 'does a slight blow to the head of someone who has a thin skull have the tendency to cause death?' In *Du Plessis*[51] and *Ntuli,*[52] it was confirmed that the accused cannot use the victim's particular physiological condition as a defence. The criterion is knowledge of an ordinary sensible person who, in addition, has the extra knowledge which X may have.[53] 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.[54] This type of foreseeability should not be confused with foreseeability under the fault requirement.

73 This aspect is particularly relevant in this case where the MHCUs were vulnerable. Prof Robertson testified to the fact that this was an extremely vulnerable population that is being put under "severe acute stress [which] is going to take its toll on the physiology of that person."[55]

Novus actus interveniens

74 From our case law,[56] the *novus actus* test is expressed in terms of an 'abnormal intervening act/event which serves to break the chain of causation. In

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[51] 1960 2 SA 642 (T).

[52] 1962 4 SA 238 (W).

[53] *Du Plessis* 1960 (2) S 642 (T); *Ntuli* 1962 (4) SA 238 (W).

[54] *Bernardus* 1965 (3) SA 287 (A) 296, 298; *Matau* 1986 (4) SA 670 (A) 677; *Van As* 1976 (2) SA 921 (A) 928.

[55] Inquest Transcript, 26 May 2023, Vol 424, page 54108.

[56] *Daniels* 1983 3 SA 275 (A); *Tembani* 1999 1 SACR 192 (W); *Counter* 2003 1 SACR 143 (SCA) 153

Grotjohn[57] the later events are deemed to break the causal link only if it is a completely independent act, having nothing to do with and bearing no relationship with X's act.

Medical intervention

75 In *Tembani*[58], the question was "*whether an assailant who inflicts a wound which without treatment would be fatal, but which is readily treatable, can escape liability for the victim's death because the medical treatment in fact received is sub-standard and negligent*." This was a question of law, which raised considerations of legal policy.[59] Cameron considered that improper medical treatment is regrettably all too common. Ultimately, he found that it did not break the causal chain and the person who inflicted the original wound could not be exculpated.[60] Importantly however is that "*at the time of the deficient treatment, the original wound was still an operating and substantial cause of death, and that it could not be said that it merely provided the 'setting' within which the negligent conduct of the hospital staff operated*."[61]

[57] 1970 2 SA 355 (A) 364A

[58] 2007 (1) SACR 355 (SCA)

[59] Para 10.

[60] Para 26.

[61] Para 25.

Fault v causation on foreseeability

76 The case of *S v Van As,*[62] illustrates the difference of foreseeability when dealing with negligence and when dealing with legal causation. In this case, the accused smacked a very overweight person on the cheek. The victim fell backwards, hit his head on the floor and died. The Appellate Division found that death was not reasonably foreseeable and therefore the accused was not guilty of *negligence* in relation to death of the deceased. However, that does not mean the accused's conduct was not the legal 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.[63] 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.[64]

77 In fact *S v Goosen*[65] illustrates the difference even further as described in Burchell as follows[66]

> *If X foresaw the (real) possibility of the death of the teller and nevertheless went ahead reckless as to the possibility (or accepting the risk of death into the bargain), he would be at fault (dolus or negligence). His conduct would be the factual and the legal cause of the Y's death (since the Y's pre-existing physical susceptibility to a heart attack will not rank as a novus actus interveniens breaking the causal link between the conduct of X and Y's death).*

[62] 1976 (2) SA 921 (A).

[63] *Stavast* 1964 3 SA 617 (T) 621; *John* 1969 2 SA 560 (RA) 565-571.

[64] Burchell, South African Criminal Law and Procedure: General Principles of Criminal Law, 4 ed, p 375.

[65] 1989 (4) SA 1013 (A).

[66] Discussed in Burchell 381.

78 In *R v De Bruyn*[67], the accused held a blasting certificate and was employed by a farmer to oversee blasting activities on a farm. Contrary to ordinary practice, however, he failed to plug some holes where charges had not fired, then allowed labourers to continue drilling without supervision and without warning them not to drill in the vicinity. A labourer drilled into a misfired hole and was killed in the explosion. The accused was charged with culpable homicide but contended that he was not liable, because the deceased caused his own death through negligence. The Court found that the deceased had not been negligent, merely ignorant. Furthermore, the accused had been under a legal duty to guard against the very thing the deceased had done. Consequently, the deceased's conduct was not a *novus actus interveniens* and the accused was convicted of culpable homicide.

79 This is particularly apposite to the present case in which Ms Mahlangu, Dr Manamela and Ms Ncube were under a legal duty to guard against placing MHCUs in a position where they might be neglected and might die as a consequence of the conditions of transfer, the conditions of the place they were transferred to, and the lack of appropriate care.

80 While not binding in our courts, we point out that in jurisdictions like the UK, neglect is regarded as a factual and legal cause of death in the context of an omission to provide medical care.[68]

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[67] 1953 (4) SA 206 (SWA)

[68] Summary taken from https://www.mills-reeve.com/getmedia/879553ba-fa93-4b48-874f-9abb2af81c1f/coroners-conclusions.pdf

81 On the question of what amounts to a death by “natural causes”, it was held by the Court of Appeal, in *R v Inner North London Coroner* [2001], that a death by “natural causes” should be considered an “unnatural death” where it was wholly unexpected and would not have occurred but for some culpable human failing, Lord Justice Brown stated that:

> *“It is the combination of their unexpectedness and the culpable human failing that allowed them to happen which to my mind makes such deaths unnatural. Deaths by natural causes though undoubtedly they are, they should plainly never have happened and in that sense are unnatural”.*

82 On Neglect:

> *“The leading authority on neglect remains R v HM Coroner of North Humberside and Scunthorpe Ex p Jamieson [1995]. For a conclusion to be returned which includes a rider of neglect the court must be satisfied that the deceased was in a dependent position and that as a matter of law there is evidence of:*
>
> *- A gross failure*
>
> *- Clear and direct causal connection between the gross failure and the death.*
>
> *The definition of the term “neglect” is set out in Jamieson in which it was held that:*
>
> *“Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position – because of youth, age, illness or incarceration – who cannot provide it for himself. Failure to provide medical attention for a dependent person whose physical condition is such as to show that he obviously needs it may amount to neglect. So it may be if it is the dependent person’s mental condition which obviously calls for medical attention (as it would, for*

example, if a mental nurse observed that a patient had a propensity to swallow razor blades and failed to report this propensity to a doctor, in a case where the patient had no intention to cause himself injury but did thereafter swallow razor blades with fatal results). In both the cases the crucial consideration will be what the dependent person's condition whether physical or mental appeared to be".

In the UK, for a finding in an inquest that neglect caused the death, one must show a failure to provide basic medical care - where the failure is gross and the need for basic medical care was obvious – i.e. what the condition of the patient *appeared* to be, not what it actually was. In addition, there must be a clear and direct causal connection between the conduct which is alleged to amount to neglect and the death. There must be a real opportunity of doing something effective in rendering care to the deceased which would have prevented death.

Approach that this court must adopt

83 In practical terms, we submit that the test for causation must be applied as follows:

83.1 First, the court must mentally eliminate as much of the conduct as (but no more of the conduct than) was negligent. In the case of a negligent omission, this involves eliminating the omission and substituting it with a hypothetical course of lawful conduct.

83.2 Second, the court must ask whether, if this much, but no more, of the conduct were eliminated (and the lawful conduct is substituted in), would the harm still have occurred?

83.2.1 If the answer is ‘yes, the harm probably would still have occurred’, then the negligent conduct probably was not a factual cause of the harm.

83.2.2 If the answer is ‘no, the harm probably would not have occurred’ then the negligent conduct probably was a factual and legal cause of the harm.

83.2.3 If the answer is that the use of the substitution of lawful conduct for unlawful conduct may lead to an injustice, but if it were not for the unlawful conduct the risk of harm would have been reduced, then the negligent conduct probably was a factual cause of the harm.

83.3 Third, the court must ask whether there is a sufficiently close connection between the conduct and the death. The conduct will be sufficiently close if the death was probable, there was nothing that broke the chain of causation, and public policy considerations of fairness, reasonableness, and justice determine it to be so.

84 We submit that a proper interpretation and application of the but-for test as well as the appropriate test for legal causation must result in a finding of causation between the acts and omissions of Ms Mahlangu, Dr Manamela, and (in respect of five of the 10 deaths) Ms Ncube.

85 We submit that on any of the tests set out above, legal causation has been established. We demonstrate this below.

D. THE PEOPLE WHOSE CONDUCT PRIMA FACIE AMOUNTED TO AN OFFENCE THAT CAUSED DEATHS

86 The conduct of Ms Mahlangu, Dr Manamela and Ms Ncube each caused the deaths of the MHCUs.

Qedani Mahlangu

87 Ms Mahlangu made a number of admissions that, even in the absence of other evidence, demonstrate her culpability:

87.1 Ms Mahlangu has admitted that she made the initial decision to terminate the Life Esidimeni contract.[69] While she disputes that she made the decision alone, the evidence shows that she was the ultimate decision maker whose decision led to the deaths.

87.2 There are three reasons on which Ms Mahlangu claims she based the decision to terminate the Life Esidimeni contract. None of these reasons stand up, as is shown below. One reason is that the Auditor General made negative audit findings about Life Esidimeni and that it was the legal obligation of the Department to address the overspending. There is no evidence of such findings, and Ms Mahlangu admitted that in the financial management reports of the Auditor General, a distinction is made between core and non-core services, and that the treatment and care of MHCUs constitutes a core

[69] Inquest Transcript, 5 May 2023, Vol 421, page 52886.

service provided by the Department and was therefore not liable to be a cost to be reduced.[70]

87.3 Ms Mahlangu admitted that she knew that MHCUs are some of the most vulnerable people in the community and that they are, in many instances, both physically and mentally frail.[71] She was informed of this in several meetings by Mr Mosenogi and Dr Manamela and knew that their transfer required circumspection and proper care. She knew, therefore, the risks that she was taking with MHCU's lives.

87.4 Ms Mahlangu admitted that she received several correspondences by experts and officials of the Department, family members and civil society, warning of the risks of termination and its implementation. However, Ms Mahlangu testified that she does not remember whether she responded to them and may have merely forwarded the correspondence to a government official. [72] She was, therefore, warned about the risks but chose not to take notice of the warnings.

87.5 At all times, Ms Mahlangu had the power to reverse the decision to terminate the contract or to reasonably extend the period of the implementation of the termination to enable some mitigation of the risks that she was warned about. Ms Mahlangu admitted that only she and Dr Selebano (reported to Ms Mahlangu) had the power to grant the

[70] Inquest Transcript, 5 May 2023, Vol 421, page 52895.

[71] Inquest Transcript, 4 May 2023, Vol 421, page 52845.

[72] Inquest Transcript, 4 May 2023, Vol 421, page 53038.

extension requested by the officials in February 2016.[73] She therefore had the power to stop the deaths but failed to do so.

Ms Mahlangu's duties as MEC of Health

88 Ms Mahlangu is the former MEC of the Gauteng Department of Health, a position she occupied for approximately four years.[74] She is qualified in economics and finance.[75] The MEC is the political head of health in the province and as a senior member of the ANC, Ms Mahlangu also served on several ANC structures.[76]

89 As the MEC for Health, Ms Mahlangu's duties are laid out in the Constitution and the National Health Act 61 of 2003. Together with the Premier, Ms Mahlangu's duty was to develop and implement policy.[77] In particular, Ms Mahlangu was responsible for ensuring implementation of national and provincial policy in terms of section 25(1) of the National Health Act. Ms Mahlangu was further responsible for the functions assigned to her by the Premier in terms of section 133(1) of the Constitution.

90 According to section 133(2) of the Constitution, Ms Mahlangu was accountable both *individually* and *collectively* with other MECs for the exercise of powers and performance of functions.

[73] Inquest Transcript, 5 May 2023, Vol 421, page 53096.

[74] Inquest Transcript, 2 May 2023, Vol 421, page 52503.

[75] Inquest Transcript, 4 May 2023, Vol 421, page 52801.

[76] Inquest Transcript, 5 May 2023, Vol 421, page 52494.

[77] Section 125(2)(d) of the Constitution of the Republic of South Africa, 1996.

Ms Mahlangu took the initial decision

91 Ms Mahlangu took the decision to terminate the contract with Life Esidimeni. Thereafter, she continued to make a series of reckless decisions in relation to the project for months. This included putting pressure on the Gauteng Department of Health officials to implement the termination project over an extremely short period of time. Ms Mahlangu made these decisions having been warned of the risks of termination, the impracticalities of continuing with the implementation of the project and the recklessness of insufficient measures in place to mitigate the risks and impracticalities.

The Premier's Budget Council did not take the decision

92 Despite evidence to the contrary, Ms Mahlangu claims that she did not make the decision to terminate the contract on her own, but that it was a collective decision. She argued that the Premier's Budget Council (PBC) took the decision to terminate the Life Esidimeni contract and that, as a member of the PBC, she was part of the decision[78] but was not the decision-maker herself.

93 The PBC is a sub-committee of the Provincial Executive Committee and includes the Premier and four members of the executive council representing clusters. The intention is to ensure alignment in the province and to include role-players in discussions around competing spending priorities.[79] It is the decision-making body on the macro level - deciding where to allocate funds over the medium

[78] Inquest Transcript, 5 May 2023, Vol 421, page 52969.

[79] National Treasury Instructions, Vol 005, page 2096.

term[80] - but does not make decisions on projects or the details of allocations within departments. An MEC is invited to present at the PBC and if the MEC presenting is one of the members of the PBC, they will be excused as members for the purposes of their presentation.[81] As acknowledged by Ms Mahlangu, the PBC discusses principles and not details.[82]

94 The evidence demonstrates that Ms Mahlangu presented at the PBC in the meeting of 11-13 November 2014 and then again at the meeting of 26 November 2016.

95 On 13 November 2014,[83] she made a detailed presentation with 140 slides,[84] which among others illustrated the Department's cost drivers and provided information on the Department's plan for cost containment. Life Esidimeni was not listed as a cost driver[85] and was not included as a cost containment opportunity.

96 Following the 13 November 2014 letter, MEC for Finance, Ms Barbara Creecy addressed Ms Mahlangu in a letter,[86] thanking her and the Department for the fruitful discussion in the PBC meeting of 11-13 November 2014 and requesting that she should come back to the PBC with the following feedback, "The

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[80] Inquest Transcript, 8 May 2023, Vol 421, page 53129.

[81] Inquest Transcript, 8 May 2023, Vol 421, page 53129.

[82] Inquest Transcript, 5 May 2023, Vol 421, page 52902.

[83] Inquest Transcript, 8 May 2023, Vol 421, page 53133

[84] PBC presentation for health, Vol 420, page 51995.

[85] Gauteng 2014/2015 budget, Vol 420, page 52077, confirmed by Ms Mahlangu, 8 May 2023, Vol 421, page 53138.

[86] Invitation to Premier's Budget Committee meeting, Vol 300, page 32310.

department should demonstrate the decision being taken on their budget and share the quantification of their cost containment." and "The department should demonstrate clearly areas where they would direct resources if there were additional resources."

97 Ms Mahlangu testified that this letter constituted an instruction to cut costs further.[87] The wording of the letter, and the evidence of Ms Creecy makes it clear that this is not the case. She testified that the reason for requesting Ms Mahlangu's return was that it was not clear from the 13 November 2014 meeting where the Department had decided to cut costs and where the Department would spend any additional allocation and there was a need for clarity. Ms Creecy was unequivocal that there was no instruction to cut further costs.[88]

98 Ms Mahlangu's own testimony is that she went to the meeting of 26 November 2014 to present the plan to decrease use of Life Esidimeni beds by 20% and thereby save R50.2 million. However, she did not attend the 26 November 2014 meeting to present on complete termination of the Life Esidimeni contract.

99 At the 26 November 2014 meeting, Ms Mahlangu made a presentation in which she presented a plan to give notice to Life Esidimeni to "begin the termination of the use of beds starting 2015". This action was anticipated to save "20% of the R251m pa currently paid to Life Esidimeni." The risk listed was that "departmental institutions may not have adequate capacity to absorb MHCUs from Life

[87] Inquest Transcript, 5 May 2023, Vol 421, page 53010.

[88] Inquest Transcript, 23 May 2023, Vol 424, page 53821.

Esidimeni facilities".[89] Ms Mahlangu confirmed that the presentation made to the PBC was in line with the policy to deinstitutionalise gradually, over five years.[90] The presentation also dealt with the intended non-renewal of the Selby Park Clinic and in that case (unlike in the case of Life Esidimeni) provided details about total cost saving and plans for budget shifts in the light of the non-renewal.[91]

100 Both Ms Creecy[92] and Mr Makhura[93] confirmed that the discussion in the PBC was in line with the presentation made by Ms Mahlangu and no requests or instructions were made to terminate the contract with Life Esidimeni in its entirety. The anticipated saving from the 20% reduction in beds was R50.2 million. The PBC was also not told that MHCUs would be taken to NGOs – their understanding in this regard was also in line with the presentation by Ms Mahlangu.

101 The resolutions from the 26 November 2014 meeting do not mention the Life Esidimeni contract by name, but notably state that "*The department should ensure that the reprioritization does not affect the quality of services*."[94] Ms Creecy testified that the discussion in the PBC related to whether the department would be able to provide the same quality of care in state institutions as was provided in Life Esidimeni.[95] Ms Mahlangu acknowledged that she told the

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[89] Gauteng Department of health Cost containment revenue enhancement measures, Vol 005, page 1697, confirmed by Ms Mahlangu on 8 May 2023, Vol 421, page 53158.

[90] Inquest Transcript, 8 May 2023, Vol 421, page 53153.

[91] Gauteng Department of health Cost containment revenue enhancement measures, Vol 005, page 1696.

[92] Inquest Transcript, 23 May 2023, Vol 424, page 53748.

[93] Inquest Transcript, 24 May 2023, Vol 424, page 53863.

[94] PBC meeting minutes, Vol 420, page 52394.

[95] LE arbitration 30 January 2018, Vol 005, page 1942.

families that the level of care would not deteriorate but didn't remember saying it to the PBC.[96] However, Ms Creecy's evidence is that the PBC had expressly addressed this issue.

102 While Ms Mahlangu says she left this meeting understanding that the Department could terminate the contract in its entirety,[97] the presentation, the testimony of Ms Creecy and Mr Makhura and the resolutions of the meeting show that there is no basis at all for this supposed understanding. In addition, Ms Creecy testified, and Ms Mahlangu agreed, that she would not need to return to the PBC if she could implement the plan to reduce beds by 20% and absorb MHCUs into government beds but would need to return if this was not possible.[98] This suggests that the plan was accepted as presented.

103 In line with section 140 of the Constitution, Mr Makhura also testified that:

> *"A written decision by the premier must be countersigned by another executed (sic) council member, if that decision concerns a function to that other member of council and let me explain who are there. So there are two members of the executive council who would have to countersign with me.*
>
> *One is the MEC responsible for that function, which is MEC Mahlangu and number two…because it is about finances MEC Creecy would have had to countersign… the only evidence you would be able to say there was such a decision is if it is communicated in writing … And that is why I said from the beginning there was no such decision made".* [99]

[96] Inquest Transcript, 5 May 2023, Vol 421, page 52991.

[97] Inquest Transcript, 8 May 2023, Vol 421, page 53426.

[98] Inquest Transcript, 8 May 2023, Vol 421, page 53166.

[99] Inquest Transcript, Vol 4242, page 54014-5.

104 It is clear that after the PBC meeting, Ms Mahlangu went on to take steps contrary to what she had presented in the PBC. The decision was neither made by the PBC, nor was it in line with what was presented to the PBC.

The decision to terminate the contract was not taken by Dr Selebano

105 The decision to terminate the contract was not taken by the Head of Department, Dr Selebano. Dr Selebano testified that the decision was taken at executive level (with discussions including those at the PBC).[100] In his appeal against the Ombud's report, Dr Selebano stated that the decision was taken by Ms Mahlangu.[101] His and the team's role was to implement.[102] He sat with the team from the Department and the MEC and they came to the conclusion that it was he who should sign the termination letter.[103] In his appeal against the Ombud's report he characterised this as an instruction from Ms Mahlangu.[104]

106 Of course, Dr Selebano was correctly identified as being the person to send a termination letter as he is, as the Head of Department, the accounting authority of the Department of Health.[105]

107 However, the formal termination of the contract reflects a policy decision that was made by the MEC – the decision to cease providing long term mental health care

[100] Inquest Transcript, Vol 413, page 49405.

[101] Tiego Selebano supporting affidavit, Vol 300, page 31277.

[102] Inquest Transcript, Vol 413, page 49327.

[103] Inquest Transcript, Vol 413, page 49328.

[104] Appeal by Dr Selebano against the Health Ombuds report, Vol 300, page 31278.

[105] Inquest Transcript, 23 May 2023, Vol 413, page 53749.

services in Gauteng through a single contract with a private service provider and instead to provide such services through hospitals and, it would emerge, NGOs.

108 Ms Mahlangu's decision was to "deinstitutionalise", in a manner contrary to national and provincial policy and thereby contrary to her obligations to ensure implementation of national and provincial policy in terms of section 25(1) of the National Health Act 61 of 2003. She admitted in the arbitration that the decision was taken without sufficient consultation,[106] it not having been raised in the Provincial Health Council,[107] the Min-MEC[108] or the National Consultative Health Forum.[109]

109 Ms Mahlangu was exercising executive authority in terms of section 133(1) of the Constitution and is accountable individually for the exercise of that authority under section 133(2) of the Constitution.

110 Ms Mahlangu remained involved in the project as MHCUs were moved. She says that the decision to move MHCUs to NGOs was presented to her in a meeting she was chairing, and she supported the decision.[110] Given the gravity of such a decision, it fundamentally changed the project and cannot be said to have been taken by officials. It was a policy decision taken by Ms Mahlangu as MEC. Ms Mahlangu admitted that she and Dr Selebano determined the timeframes of the

[106] Evidence of Mahlangu, 25 January 2018, Vol 300, page 29371.

[107] Evidence of Mahlangu, 25 January 2018, Vol 300, page 29311.

[108] Evidence of Mahlangu, 25 January 2018, Vol 300, page 29315.

[109] Evidence of Mahlangu, 25 January 2018, Vol 300, page 29319.

[110] Inquest Transcript, 9 May 2023, Vol 421, page 53195 and Evidence of Mahlangu, 24 January 2018, Vol 300, page 29103.

project.[111] Similarly, Ms Mahlangu was approached by the Project Leader, Mr Mosenogi, in February 2016 for an extension of the contract – a request that would not have been necessary unless Ms Mahlangu was the ultimate decision-maker.

111 But for her decision to terminate the contract, MHCU's would not have been transferred to places where they ultimately died.

No good reasons for termination of the contract

112 Ms Mahlangu provided three reasons for the termination. None of the reasons she gave has any merit. This was the finding by Justice Moseneke and remains unshaken.

113 The three reasons given for the termination were:

113.1 the policy requirement to deinstitutionalise MHCUs;

113.2 the Auditor-General's concern regarding the duration of the contract with Life Esidimeni; and

113.3 budgetary constraints.

114 We deal with each reason in turn.

[111] Evidence of Mahlangu, 24 January 2018, Vol 300, page 29186.

The first reason: Deinstitutionalisation

115 Deinstitutionalisation in South Africa has been implemented since 1994,[112] when there was a recognition that the mental health care system needed reform, informed by human rights-based legislation and policy. Long stay stand-alone hospitals had to be closed, as they removed MHCUs from society. Deinstitutionalisation allowed for MHCUs to be placed back into their communities, to receive less restrictive care, closer to home through upgraded and upscaled community-based services.[113]

116 Gauteng Province halved chronic psychiatric beds from 70 per 100 000 people in 1994 to 35 beds per 100 000 people in 2004.[114] While so doing, it developed some community-based services.[115] However, from 2008, when beds had to be reduced even more, there were no more services in the community to keep people stable. In fact, the issues faced in Gauteng – the need to develop community health services prior to further deinstitutionalisation – informed the firm warning encapsulated in the National Mental Health Policy Framework and Strategic Plan 2013 – 2020 (NMHPF).[116] The NMHPF states that recent situational analysis of South Africa's current mental health service provision found that:

> *"Deinstitutionalisation has progressed at a rapid rate in South Africa, without the necessary development of community–based services. This has led to a*

[112] Dr Mvuyiso Talatala opinion, Vol 412, page 37499.

[113] Inquest Transcript, 25 May 2023, Vol 424, page 54036.

[114] Dr Mvuyiso Talatala opinion, Vol 412, page 37499.

[115] Inquest Transcript, 25 May 2023, Vol 424, page 54035.

[116] Inquest Transcript, 25 May 2023, Vol 424, page 54038-9.

high number of homeless mentally ill, people living with mental illness in prisons and revolving door patterns of care".[117]

117 Perhaps for this reason, the NMHPF does not in fact mention further deinstitutionalisation, focusing instead on the development of community based facilities rather than the movement of people from institutions to those facilities.

118 Deinstitutionalisation requires that prior to any moves:

118.1 Community mental health services must be developed. Prof Robertson testified that the development of community services means upgrading and upscaling district services with "psychiatrists, psychologists, social workers and occupational therapists, and others like admin clerks".[118] In other words, the needs of the mental health care user do not change when they move from one place to another. Even with deinstitutionalisation, MHCUs must have access to infrastructure and multi-disciplinary health workers to cater for their health and well-being, both mental and physical needs. The reality is that community mental health services were at the time, and remain, weak.[119]

118.2 Acute psychiatric beds in general hospitals must be increased.[120] The importance of mental health tertiary care is that when MHCUs relapse

[117] National Mental Health Policy Framework and strategic plan 2013-2020, Vol 407, page 35114, para12.

[118] Inquest Transcript, 25 May 2023, Vol 424, page 54037.

[119] Inquest Transcript, 25 May 2023, Vol 424, page 54043.

[120] Inquest Transcript, 25 May 2023, Vol 424, page 54036- 54037.

or there is a need for immediate intervention, MHCUs ought to have access to tertiary care for acute care.[121]

118.3 MHCUs themselves must be suitable for discharge and must be prepared for the process, over a period of time.[122] Nursing expert Prof Pienaar gave an example of successful deinstitutionalisation at Witrand Hospital and Gelukspan in the North West Province. Prof Pienaar attributes the success of the process to the existence of a deinstitutionalisation plan with involvement of relevant stakeholders; a 2-3 year implementation period; the training of NGOs; an all of government approach; and protocols and procedures being in place for assessments of MHCUs, physically and mentally.[123]

119 Rather than complying with the NMHPF or following the experience of the North West, in the case of the "deinstitutionalisation" of the Life Esidimeni MHCUs:

119.1 The MHCUs at Life Esidimeni facilities, who were subjected to rapid discharge, were the "most severe MHCUs and the MHCUs we anticipated it would be the most difficult to discharge" according to Dr Talatala[124] As Dr Mkhatshwa and Ms Buthelezi[125] (whose evidence is not contested) testified, approximately 60% of the MHCUs at Life Esidimeni were non-dischargeable. This was because of the severity

[121] Inquest Transcript, 16 March 2022, Vol 413, page 44435.

[122] Evidence of Dr. Talatala, 14 November 2017, Vol 300, page 25414-25416.

[123] Inquest Transcript, 14 March 2022, Vol 413, page 44163-6.

[124] Dr Mvuyiso Talatala opinion, Vol 412, page 37499.

[125] Buthelezi Affidavit, Vol 005, page 1438, para 24.

of their conditions – in terms of both mental and physical health; their inability to take of themselves; being prone to relapse;[126] and therefore, in need of a structured environment.[127] This was a reality that Dr Manamela was aware of.[128]

119.2 There were systemic challenges and severe constraints facing community-based care and services[129] that Dr Manamela[130] and Ms Mahlangu[131] were aware of. Dr Manamela testified that the reason they renovated Weskoppies, Sterkfontein and CCRC was to accommodate the most vulnerable MHCUs. Of course, discharging MHCUs from a step-down facility, such as Life Esidimeni, to a very restricted environment, such as Sterkfontein and Weskoppies, cannot be considered deinstitutionalisation.

119.3 Prof Robertson testified that they were very concerned because people depended on Life Esidimeni. As clinicians they were aware that the level of care required by MHCUs given their illnesses, would not be available in the community.[132] These facilities did not have enough beds nor the expertise and equipment to care for people who were to be moved out of Life Esidimeni.[133]

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[126] Inquest Transcript, 3 September 2021, Vol 413, page 39059.

[127] Inquest Transcript, 7 Feb 2022, Vol 413, page 42561.

[128] Inquest Transcript, 26 November 2022, Vol 413, page 41041.

[129] Inquest Transcript, 25 May 2023, Vol 424, page 54043.

[130] SASOP minutes of meeting with Gauteng Director of mental health, 16 March 2015, Vol 200, page 18310.

[131] Letter from SASOP regarding the lack of beds, June 2015, Vol 200, page 18312.

[132] Inquest transcript, 25 May 2023, Vol 424, page 54041.

[133] Inquest transcript, 25 May 2023, Vol 424, page 54042.

119.4 As the evidence shows, most MHCUs were moved to NGOs far from their family homes, removing them from the communities into which they were supposed to be integrating. Some of the NGOs were in fact far from any community.[134] MHCUs were, therefore, isolated from other people and often from their families.[135] Many MHCUs were moved without their families even being notified.[136]

119.5 Neither the MHCUs nor the NGOs to which they were transferred were adequately prepared for the move. Instead, the move was rushed, with NGOs accepting MHCUs without having the resources or infrastructure to do so. MHCUs were not appropriately assessed and their placement into NGOs appeared to be random.

120 The policy of deinstitutionalisation does not, therefore, justify the termination of the contract and the rapid move of almost 2000 MHCUs.

The second reason: The Auditor-General instruction to review long-standing contracts

121 Whereas Ms Mahlangu cited in her Warning Statement "various negative audit findings by the Office of the Auditor General on the Life Esidimeni Service Level Agreement"[137] there is no evidence of any such findings being made. In fact, Ms Mahlangu acknowledged in her oral testimony that comments about the Auditor General did not say anything specifically about the Life Esidimeni contract.[138]

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[134] Evidence of Prof. Makgoba, 10 November 2017, Vol 300, page 25130, line 1 – 8.

[135] Evidence of Ms Grobler, 8 December 2017, Vol 300, page 28248, line 1 – 6.

[136] For example: evidence of Christine Nxumalo, 25 January 2018, Vol 009, page 2608-9.

[137] Dorothy Mahlangu Statement, Vol 420, page 52335.

[138] Inquest Transcript, 5 May 2023, Vol 421, page 52894.

122 Ms Creecy testified that she reviewed the management letters to the Provincial Department for the years 2013/14 to 2016/17 and was unable to find any reference to the Life Esidimeni contract. It is in the management letters that any instruction to review contracts would be found.[139]

123 The justification for termination based on the requirements of the Auditor General therefore falls away.

The third Reason: Cost saving

124 Cost saving was the third and final reason provided for termination of the contract.

125 Ms Mahlangu's decision to terminate the contract on the basis of cost containment ran contrary to a report commissioned by the Gauteng Department of Health from Health Advanced Institute ("HAI"), in which HAI found that the Life Esidimeni contract provided good value for money.[140]

126 Ms Creecy demonstrated clearly that not only was there no pressure on the Department to save money through moving MHCUs out of Life Esidimeni, but the instructions were clear that any cost containment efforts should relate only to non-core items. Both Ms Mahlangu[141] and Ms Creecy agreed that mental health care services are core services and Ms Creecy also noted that they are statutory services.[142] The intention of the province was to expand access to services not

[139] Inquest Transcript, 23 May 2023, Vol 424, page 53832.

[140] HAI presentation, Vol 200, page 19316. The HAI report, Vol 200, page 21744.

[141] Inquest Transcript, 5 May 2023, Vol 421, page 52895.

[142] Inquest transcript, 23 May 2023, Vol 424, 53809.

to decrease it, while containing costs.[143] The message about cutting non-core costs was clear in National Treasury Instruction 1 of 2014/15,[144] and in Ms Creecy's budget speeches of 2014[145] and 2015[146] which emphasised the need to ensure that quality services were maintained and that only non-core spending would be cut.

127 When Ms Mahlangu presented to the PBC on what the Department would do with the money in the event that further resources would be made available, none of the items listed was for paying Life Esidimeni.[147]

128 There was an increase in the Gauteng Department of Health budget in 2014/15[148] and the Department overspent in that year.[149] The following year, in 2015/16 following a further increase to the budget, there was also an underspend.[150] In 2016/17, the Department underspent on its budget. The mental health budget was also not decreased – in 2014/15 there had been an overspend and following an increase in 2015/16, there was an underspend.[151] There was thus no budgetary pressure to move all MHCUs out of Life Esidimeni.

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[143] Inquest Transcript, 23 May 2023, Vol 424, page 53811.

[144] National Treasury Instruction, Vol 005, page 2088.

[145] Speech by MEC for Finance 2014, Vol 005, page 2125.

[146] Speech by MEC for finance 2015, Vol 005, page 2143.

[147] Gauteng Health budget 2014/2015, Vol 300, page 32105.

[148] Inquest Transcript, 9 May 2023, Vol 421, page 53233.

[149] Gauteng health budget and expenditure, Vol 300, page 32193 and Inquest Transcript, 23 May 2023, Vol 424, page 53739.

[150] Inquest Transcript, 23 May 2023, Vol 424, page 53739.

[151] Mental health services budget and expenditure, Vol 300, page 32299 and Inquest Transcript, 23 May 2023, Vol 424, page 53739.

129 None of the reasons that Ms Mahlangu gave for the termination of the contract with Life Esidimeni therefore withstands scrutiny.

What Ms Mahlangu knew when she made the decision

"If I was a prophet Justice, I would have had foresight"[152]

130 The evidence demonstrates that Ms Mahlangu had been warned about the risks of rapid deinstitutionalisation before she took the decision to terminate the contract with Life Esidimeni.

131 Ms Mahlangu was aware of the National Mental Health Framework Strategy and Policy which makes clear the obligations on the Department in respect of MHCUs. She knew about the plan in Gauteng to decrease beds by 200 a year, in order to ensure that mental health care user needs are catered for during any deinstitutionalisation process.[153] While she is not medically qualified, Ms Mahlangu had an understanding of the vulnerability of MHCUs and the measures in the policy to cater to that vulnerability.

132 Ms Mahlangu also received a letter on 23 June 2015 from SASOP, which expressed serious concerns on the further 20% bed reduction and explicitly made the point that community-based services had yet to be adequately upscaled. In other words, even on the more gradual replacement of MHCUs, Ms Mahlangu knew that there were risks. The letter is attached to an email from Prof Robertson highlighting concern about possible unforeseen consequences."[154]

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[152] Evidence of Mahlangu, 25 January 2018, Vol 300, page 29369.

[153] Inquest Transcript, 5 May 2023, Vol 421, page 52881.

[154] Email from Lesley Robertson to Ms Mahlangu and others, 23 June 2015, Vol 207, page 35164.

133 While she remembered receiving the letter in the arbitration and calling and emailing Dr Selebano to deal with it,[155] Ms Mahlangu provided contradictory testimony in the inquest that she does not remember receiving the letter and it was likely handled through her office.[156] She does not remember if she followed up with officials.[157] SASOP received no response to their letter.

What Ms Mahlangu knew following her decision but before MHCUs started being moved

134 In the approximately six months between the contract termination and the large groups of MHCUs beginning to leave Life Esidimeni, Ms Mahlangu received swathes of information about the risks of the Department's approach. She failed to take action that was within her power to mitigate these risks. Instead, Ms Mahlangu led using fear and micromanaged the people within the project team.

135 On 30 October 2015, Prof Robertson sent a letter to Ms Mahlangu requesting a meeting and reiterating the concerns stated in the June letter, especially given the termination announcement. Prof Robertson received no response. Ms Mahlangu testified that she dealt with the letter by asking her Personal Assistant to forward it to Dr Selebano.[158] Ms Mahlangu explained that:

> "*I was the MEC for health responsible for the entire health system in Gauteng, and that point is very relevant, that at any given point in time my day will be packed with a lot of other things, and all of them were urgent at that point in*

[155] Evidence of Mahlangu, 24 January 2018, Vol 300, page 29115.

[156] Inquest transcript, 8 May 2023, Vol 421, page 53033.

[157] Inquest transcript, 8 May 2023, Vol 421, page 53038.

[158] Inquest transcript, 5 May 2023, Vol 421, page 52917.

time… I do not remember meeting with SASOP and prior, relating to these issues that they raised".[159]

136 Less than a month after the SASOP letter to Ms Mahlangu, on 26 November 2015, SADAG addressed a lengthy letter to Ms Mahlangu in which they raised their concerns regarding the termination of the contract, provided feedback from hospitals identified by Ms Mahlangu in her response to the Gauteng Legislature that showed those hospitals' inability to accommodate MHCUs. Furthermore, they questioned the process and suitability of NGOs and MHCUs for discharge.[160]

137 In response to this letter, rather than dealing with the concerns raised, which echoed those raised by the psychiatrists of SASOP and the risks listed in the policy, Ms Mahlangu sent an email to Dr Lebethe and Dr Selebano, among others, instructing them to "get our lawyers involved, these NGOs are dishonest!!!" Ms Mahlangu copied a private lawyer, John Ngcebetsha, on this email. It is clear that Ms Mahlangu was reading her emails at this stage. Ms Mahlangu said in evidence that her instruction was because she wanted the department to speak directly to families, rather than doing so through an NGO.[161]

138 In fact, when Ms Mahlangu spoke directly to families, she made clear that the decision was final. If families wanted MHCUs to stay at Life Esidimeni, they would

[159] Inquest transcript, 8 May 2023, Vol 421, page 53042-3.

[160] Letter from SADAG, 26 November 2015, Vol 200, page 18101.

[161] Inquest transcript, 8 May 2023, Vol 421 page 53046.

need to pay.[162] She also said that in Brazil, families took care of their MHCUs at their homes.[163]

139 The issue of quality of care given the termination of the Life Esidimeni contract was raised in the Gauteng Provincial Legislature on 30 November 2015 and Ms Mahlangu stated that the Department would be saving R300 million, and it could provide the same level of care outside of Life Esidimeni.[164] By this point, Ms Mahlangu had been warned by psychiatrists about the risk that the Department would not be able to provide the same level of care outside of Life Esidimeni. She said in evidence that she never queried the concerns raised because she relied on what experts inside the Department told her,[165] choosing to pay no heed to experts outside of the Department. In any event, Ms Mahlangu received several strongly worded warnings from experts within the Department.

140 Ms Mahlangu's refusal to act on the warnings led SADAG, SAFMH and families of MHCUs on 9 December 2015, to issue a letter of demand to Ms Mahlangu and officials in the Department. In the letter of demand, the stakeholders proposed the appointment of curators to protect the interests of MHCUs, given the concern that the Department was not protecting their interests.[166]

141 Having instructed officials to "get our lawyers involved", Ms Mahlangu testified that she does not remember whether she received the lawyers' letter from the

[162] Sophie Lenkwane Statement, V005, page 578.

[163] Inquest transcript, 18 November 2021, Vol 413 page 40358.

[164] Portfolio Committee oversight report, 30 November 2015, Vol 420, page 52413.

[165] Inquest transcript, 8 May 2023, Vol 421, page 53054.

[166] Letter from SECTION27 to Ms Mahlangu and others, Vol 200, page 18114.

stakeholders.[167] There was no response to the letter of demand and on 11 December 2015, SADAG sent a follow up email to Dr Manamela, copying Ms Mahlangu, requesting confirmation that discharges will be halted.[168]

142 On 16 December 2015, Ms Mahlangu was cited as first respondent in litigation for the appointment of curators to protect the interests of MHCUs following the termination of the Life Esidimeni contract. Dr Selebano testified in the arbitration hearings that Ms Mahlangu called him, chief directors and CEOs and a decision was made to defend the litigation. Ms Mahlangu said that she was not aware of the litigation at the time but was briefed by Dr Selebano about the litigation after it was concluded.[169] The litigation was settled by agreement on 21 December 2015.

143 On 29 January 2016, Ms Mahlangu attended a meeting with families at Life Esidimeni Waverley,[170] where they begged her not to terminate the contract.[171]

144 In February 2016, Ms Mahlangu received and ignored yet more clear concerns from at least three sources.

145 Dr Morgan Mkhatshwa deposed to two statements and testified in the inquest. He wrote and confirmed orally that Ms Mahlangu called a meeting with Life Esidimeni in February 2015 and informed Life Esidimeni that the Gauteng Department of Health had budgetary constraints and had decided to terminate

[167] Inquest transcript, 8 May 2023, Vol 421, page 53056.

[168] SADAG Letter, 11 December 2015, Vol 200, page 18119.

[169] Inquest transcript, 2 May 2023, Vol 421, page 52628.

[170] Affidavit of Buthelezi, V005, page 1436.

[171] Sophie Lenkwane Statement, V005, page 355.

the contract by the end of March 2017.[172] Life Esidimeni executive Kamy Chetty warned Ms Mahlangu that the MHCUs at Life Esidimeni are assessed by psychiatrists in government psychiatric hospitals and certified not fit to be discharged.[173] She further warned that whereas at Life Esidimeni, MHCUs are looked after by suitably qualified and experienced health care professionals, are clinically assessed daily and are seen by an in-house doctor or referred to hospital when needed, NGOs do not have adequate professional support to ensure that MHCUs are looked after or receive clinical care and some family homes are not suitable for MHCUs.[174] Dr Mkhatshwa testified that Ms Mahlangu did not want to entertain these concerns.[175]

146 The second warning to Ms Mahlangu came on 12 February 2016, in a letter from Mr Mosenogi.[176] He informed her that the time allowed for all MHCUs to be moved out of Life Esidimeni was too short, requesting an extension of one year or, at a minimum, six months, and proposed purchasing Life Esidimeni as a more viable alternative.[177] Ms Mahlangu claimed that she was ill so did not read the letter at the time although there was a meeting to discuss it.[178] At the meeting, Ms Mahlangu granted a three-month extension, half of the minimum that was initially asked for. She testified that this was based on the agreement of the people in the meeting but also admitted that the team could not have taken the

[172] Affidavit of Mkhatshwa, Vol 005, page 2291.

[173] Affidavit of Mkhatshwa, Vol 005, page 2292.

[174] Inquest Transcript, 30 August 2021, Vol 413, 48823.

[175] Inquest Transcript, 31 August 2021, Vol 413, 38565.

[176] Letter from Mosenogi to Ms Mahlangu, Vol 300, page 30205.

[177] Letter from Mosenogi to Ms Mahlangu, Vol 300, page 30207.

[178] Inquest Transcript, 8 May 2023, Vol 421, page 53080.

decision to extend without her and Dr Selebano's agreement.[179] She also testified when asked why a longer period was not granted, "*I did not, counsel because ... there was no further request for an additional extension after the first one*..."[180]

147 It is no surprise that there was no further request for extension. Officials of the Department testified that they were intimidated by Ms Mahlangu and that she was ultimately in control.

147.1 Ms Sophie Lenkwane described her as a "bully" and "pushy".[181] She said in evidence that she was afraid of Ms Mahlangu's threats and that they created a stressful environment where people worked in fear.[182]

147.2 Ms Buthelezi states that Ms Lenkwane and Nonceba Sennelo told her that everyone was afraid of Ms Mahlangu.[183]

147.3 Ms Mahlangu asked Mr Mosenogi if he "worked for Life Esidimeni" when he was raising the request for a tariff increase[184] and would repeatedly threaten people with dismissal. Mr Mosenogi identified this behaviour as coming from someone who "wants her own way" and would use words that are intimidating.[185]

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[179] Inquest Transcript, 8 May 2023, Vol 421, page 53096.

[180] Inquest Transcript, 5 May 2023, Vol 421, page 52885.

[181] Sophie Lenkwane Statement, Vol 005 page 357.

[182] Inquest transcript, 7 February 2022, Vol 421, page 42543.

[183] Affidavit of Buthelezi, Vol 005, page 1439.

[184] Inquest transcript, 5 May 2023, Vol 421, page 52889.

[185] Inquest transcript, 18 November 2021, Vol 413, page 40368.

148 The third ignored plea to Ms Mahlangu in February 2016 was a march held by families of MHCUs just four days after Mr Mosenogi's letter on 16 February 2016. Families marched to the office of the MEC and handed over a memorandum[186] which raised the concerns around the capacity of NGOs. Ms Mahlangu says that she was assured by Dr Selebano that he would deal with and respond to the concerns in the memo, but she does not remember if she followed up with Dr Selebano.[187] Dr Selebano responded to families on 7 March 2016.[188]

149 Ms Mahlangu heeded none of the warnings issued in February 2016 by Life Esidimeni, department officials and worried families.

150 On 12 March 2016 Ms Mahlangu, as MEC, was cited as a respondent in the urgent application brought by SADAG and SAFMH.[189] Ms Mahlangu claimed that she was unaware of the litigation.[190]

151 Three days later, on 15 March 2016, Ms Mahlangu answered questions about the project in the provincial legislature.[191]. Ms Mahlangu answered that MHCUs were being moved and celebrated the reduced costs to the Department. She said that 2000 beds had been "activated" and that NGOs had hired staff and been given licenses. She expressed confidence that "*the work that- with the NGOs and also with the provincial facilities, that work is going to help us to conclude*

[186] Memo from families against closure of Life Esidimeni, Vol 300, page 31173.

[187] Inquest Transcript, 8 May 2023, Vol 421, page 53077.

[188] Inquest Transcript, 2 May 2023, Vol 421, page 52629.

[189] Application brought by SADAG et al, 12 March 2016, Vol 200, page 18440.

[190] Inquest Transcript, 11 May 2023, Vol 421, page 52493.

[191] Inquest Transcript, 2 May 2023, Vol 421, page 52528.

this process even way before the end of June." The evidence shows that none of this was true.

152 Unusually for an MEC and contrary to Ms Mahlangu's repeated assertion that she was not involved in implementation, Ms Mahlangu chaired a number of meetings about the implementation of the project. There are minutes of or presentations from meetings held on 26 January 2016,[192] 17 February 2016,[193] 7 April 2016,[194] 22 April 2016,[195] and 13 May 2016[196] in the record. Nonceba Sennelo testified that Dr Manamela would directly report to Ms Mahlangu in these meetings, despite the ordinary departmental hierarchy suggesting otherwise.[197] In these meetings, Ms Mahlangu heard about various challenges that had been identified, the concerns of families, unreadiness of NGOs, the need for doctors to follow MHCUs to NGOs to assess suitability, and slow rate of progress relative to plans, among others. On 26 January 2016, the resolution was that all NGOs should be licensed by 5 February 2016 – just 10 days later.

153 Dr Thebe Madigoe, Clinical Head at Tara Psychiatric Hospital attended a meeting with Ms Mahlangu[198] in which he highlighted to Ms Mahlangu that:

153.1 doctors would need to ensure that MHCUs were fit for discharge before they can be moved from Life Esidimeni;

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[192] Mental Health project inception presentation, Vol 300, page 30885.

[193] Mental Health project progress report, Vol 300, page 30907.

[194] Mental Health Life Esidimeni termination project, 7 April 2016, Vol 300, page 30877.

[195] Mental Health Life Esidimeni termination project, 22 April 2016, Vol 300, page 30862.

[196] Mental Health Life Esidimeni termination project, 13 May 2016, Vol 300, page 30902.

[197] Inquest Transcript, 22 November 2021, Vol 413, page 40653.

[198] Inquest transcript, 5 May 2023, Vol 421, page 52934 – 52938.

153.2 moving long term MHCUs suddenly would result in the deterioration of their health due to various complications;

153.3 It would be necessary for stable MHCUs to be discharged initially for a few days and then for longer periods.

153.4 He also warned against the discharge of MHCUs in large numbers at once to an NGO – saying that only a few MHCUs should be discharged at a time into any identified suitable facility. This would ensure that the NGO had sufficient capacity to cope with the new MHCUs and MHCUs would have space to adjust to their new living conditions. He says that Ms Mahlangu acknowledged his concerns and advice.[199] Ms Mahlangu admitted in evidence that Dr Madigoe had explained these matters to her in the meeting.[200]

154 Ms Mahlangu said in the arbitration that she heard issues about undeveloped community care being raised in the meetings, but she thought they were being dealt with by district directors.[201] Ms Mahlangu testified that she did not query anything, just asked clarity questions because she's not operational and there are experts involved. She never asked officials about their ability to perform the tasks[202] and she did not ask officials about the concerns at NGOs because she had too much on her plate.[203]

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[199] Thebe Madigoe statement, Vol 005, page 1478.

[200] Inquest transcript, 5 May 2023, Vol 421, page 52934.

[201] Evidence of Mahlangu, 24 January 2018, V300, page 29114.

[202] Inquest transcript, 8 May 2023, Vol 421, page 53072.

[203] Inquest transcript, 8 May 2023, Vol 421, page 53072.

155 The evidence demonstrates that Ms Mahlangu knew about risks at NGOs and risks of transferring MHCUs there both before the termination and before the transfers started. She accepted the reports of officials that any risks would be mitigated[204] and ignored the repeated warnings from various corners. The extent of the action that she would take in response to concerns was to refer them to someone else and fail to follow up with them.

What Ms Mahlangu knew after transfers of MHCUs had occurred

156 Ms Mahlangu was involved in political campaigning during the most intense period of moves of MHCUs out of Life Esidimeni – in May, June and July 2016.[205]

157 On 5 August 2016, Ms Mahlangu received the final project report,[206] compiled by Dr Manamela. The report listed the "lowlights" of the project, which included some deaths;[207] users not being grouped according to needs; lack of assistive devices; lack of individual progress reports; expired food; lack of cleanliness; a shortage of medical equipment; insufficient staff due to non-payment; lack of clinical staff; insufficient blankets; lack of ARVs; overcrowded condition; unsuitable and unsafe infrastructure and security concerns, among others.[208] Ms Mahlangu acknowledged in her testimony that the concerns or "lowlights" in the report were serious.[209] She did not, however, report any challenges to the

[204] Inquest transcript, 8 May 2023, Vol 421, page 53032.

[205] Evidence of Mahlangu, 25 June 2021, Vol 300, page 29279 and Inquest transcript, 5 May 2023, Vol 421, page 52970.

[206] Gauteng Health termination of Life Esidimeni Brief, Vol 200, page 20809.

[207] Gauteng Health final report on termination, Vol 200, page 20856.

[208] Patient Progress report, Vol 011, page 2927.

[209] Inquest transcript, 8 May 2023, Vol 421, page 53099.

Gauteng legislature because she assumed that the issues were being dealt with.[210] While the report proposes actions and recommendations to resolve the issues, she is not sure if she followed up with the project team about whether they were resolved.[211]

158 Between 5 August 2016 and 1 September 2016, Ms Mahlangu took no action in relation to the shortcomings of the project.

159 On 1 September 2016, SECTION27 wrote to Ms Mahlangu informing her of seven deaths at Precious Angels.[212] Ms Mahlangu responded to the letter saying "*thank you Sasha will revert back to urgently*" [sic][213] but failed to revert. Ms Mahlangu's evidence on the letter changed. She first said that she raised the issue with Dr Selebano, and he said there was little that could be done about it[214] She then said she did not remember reading the letter or whether she responded to it.[215]

160 On 13 September 2016, Ms Mahlangu responded to questions in the legislature saying that there were "no complaints" about any of the NGOs other than Siyabadinga. Ms Mahlangu was specifically asked about the number of deaths and reported that 36 people had died following their moves out of Life Esidimeni.

[210] Inquest transcript, 8 May 2023, Vol 421, page 53100.

[211] Inquest transcript, 8 May 2023, Vol 421, page 53101.

[212] SECTION27 urgent letter, 1 September 2016, Vol 300, page 31641.

[213] Response from MEC Mahlangu, Vol 200, page 18963.

[214] Inquest transcript, 3 May 2023, Vol 421, page 52651.

[215] Inquest transcript, 8 May 2023, Vol 421, page 53104.

She said that most of the people who died did not have families. She said that "we have apologised".[216] None of this was true.

161 Despite the information that she had following the moves, Ms Mahlangu took no action. She could have prevented further suffering and death but failed to do so.

Ms Mahlangu knew the risks and what was going wrong, yet recklessly took the decisions that led to deaths

162 Ms Mahlangu took the decision to terminate the contract and pushed implementation of the termination project, in the face of warnings from within the Department, Life Esidimeni, families, experts, civil society and members of the provincial legislature. Ms Mahlangu had ample information before and after the termination to know disastrous the consequences of her decisions would be and then was.

163 Ms Mahlangu attempted to distance herself from both the decision to terminate the contract with Life Esidimeni and move all MHCUs out of the facility, and the implementation of that decision. The evidence demonstrates that she was in fact core to the decision and the implementation thereof. While as the political head of the department she did not sign the termination letter and should not have been involved in implementation, she overstepped the legal constraints of her role and began and enforced continuation of the project to move all MHCUs out of Life Esidimeni resulting in the deaths of MHCUs.

[216] Executive Q & A, 13 September 2016, Vol 420, page 52437.

164 Ms Mahlangu is criminally responsible for the death of MHCUs, because she took the decision to terminate the contract, insisted on its urgent implementation, and failed to stop implementation when she was warned on several occasions by her own officials and by specialists in the field. She had the power and the knowledge to prevent the deaths, but she did not do so.

Ms Mahlangu caused the deaths of at least 10 MHCUs

165 Without Ms Mahlangu's actions and omissions, the deaths would not have occurred. In particular:

165.1 As the MEC for Health, Ms Mahlangu took the decision to terminate the contract with Life Esidimeni.

165.2 Ms Mahlangu was actively involved in implementation through chairing of and playing a dominant role in project team meetings.

165.3 Ms Mahlangu did not abide criticism or contrary views. She intimidated her team into minimising problems but even where they did make the problems clear, she ignored their concerns or ordered that they be remedied without satisfying herself that this was possible or likely.

165.4 Ms Mahlangu was warned time and again from roleplayers outside of the Department and inside the Department about the risks and what was happening and she consistently failed to take appropriate action in response to these warnings to mitigate the risks.

165.5 Ms Mahlangu knew about the real problems and the deaths following the moves, at least in August 2016, but failed to take appropriate action

to save lives and prevent further harm, until the matter was taken out of her hands after she had to answer a question in the Provincial Legislature about the number of deaths.

165.6 Ms Mahlangu's refusal to listen to warnings and intimidation of those around her inevitably led to a bad project plan and implementation, resulting in poor NGO conditions with inadequate staffing, inadequate facilities, and insufficient food, blankets and medication.

165.7 The bad project plan and implementation and the NGO conditions led to the deaths of the 10 MHCUs.

166 If the Court is to substitute reasonable conduct for the conduct of Ms Mahlangu described above, in line with the test for factual causation laid out above, the deaths would not have occurred. The deaths could not have occurred without Ms Mahlangu's conduct and to hold otherwise on factual causation would be unjust.

167 In relation to legal causation, there was a sufficiently close connection between the conduct of Ms Mahlangu and the deaths. The MHCUs were (and Ms Mahlangu knew them to be) particularly vulnerable. Moving them at all, and then into ill-prepared NGOs, would make their suffering and deaths probable. The conduct meets the adequate cause test. The intervening conduct, in this case by Dr Manamela and Ms Ncube, was not independent but flowed naturally from Ms Mahlangu's conduct. The "original wound" of Ms Mahlangu's conduct was still operating. There was, therefore, no novus actus interveniens.

168 Finally, public policy and the legal convictions of the community require that conduct such as Ms Mahlangu's, that so directly precipitated deaths, be punished criminally.

169 Ms Mahlangu's conduct therefore meets the tests for factual and legal causation.

Dr Makgabo Manamela

170 Dr Manamela made a number of admissions that, even in the absence of other evidence, demonstrate her culpability:

170.1 It is common cause that the Life Esidimeni contract was terminated before NGOs had been identified, their bed capacity determined, and they had been audited for suitability for the over 1500 MHCUs to be discharged from the various Life Esidimeni facilities.[217] Dr Manamela admitted that at the time of termination there were only 116 NGO beds available, when she knew that over 1400 MHCUs had to be transferred from Life Esidimeni. [218]

170.2 Dr Manamela admitted that she and her team were responsible for ensuring that all the hospitals and NGOs where MHCUs would be transferred, met the minimum norms and standards of suitability and eligibility for service provision and quality of care.[219] However, as the evidence shows, Dr Manamela knew that NGOs such as Precious Angels were not adequately equipped to care for MHCUs, and yet a

[217] Inquest Transcript, 19 January 2022, Vol 413, page 41646 -7.

[218] Inquest Transcript, 28 November 2022, Vol 417, page 50996.

[219] Inquest Transcript, 28 November 2022, Vol 417, page 50941.

number of frail users were transferred – resulting in 20 hastened deaths, 5 of which Dr Manamela, together with Ms Mahlangu and Ms Ncube, is criminally responsible for.

170.3 With the responsibility to assess, evaluate and authenticate the suitability of facilities, Dr Manamela further admitted that it was her and the project team's responsibility to make recommendations for improvement of the facilities before transferring MHCUs. [220] As the evidence shows, NGOs such as Anchor House[221] and Precious Angels[222] were first audited from as late as July 2016, long after MHCUs had been transferred.

170.4 It is common cause that Dr Manamela signed all the licences for the NGOs, many dated 1 April 2016. Dr Manamela admitted that for her signature to appear on the licences it means she was satisfied that all the requirements had been met. Her verification process was merely to engage with the NGO managers, who she says "I have no reason to doubt the NGO manager. If I have any questions, I will post the questions and the NGO manager will give me an explanation". [223] Dr Manamela then confirmed with the Court that she signed licences without having sight of the relevant facilities.[224]

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[220] Inquest Transcript, 28 November 2022, Vol 417, page 50942-3.

[221] Audit Checklist, 19 September 2016, Vol 200, page 20558.

[222] Audit Checklist, 28 July 2016, Vol 200, page 20423.

[223] Inquest Transcript, 30 January 2023, Vol 419, page 51337.

[224] Inquest Transcript, 30 January 2023, Vol 419, page 51342.

170.5 Dr Manamela admitted that even though there was a plan for the termination of the Life Esidimeni contract, it was not adequately and properly planned.[225] The plan was also poorly executed, with Dr Manamela at helm of its implementation – resulting 144 deaths of MHCUs.

Dr Manamela's role as director of the Mental Health Directorate and de facto project lead

171 Dr Manamela is the former Director of Mental Health Services in the Gauteng Department of Health[226], employed from 2010 until she resigned in 2017. Dr Manamela is a qualified psychiatric nurse with a PhD in Psychiatric Nursing Science; a master's degree in advanced Psychiatric Nursing Science; a master's degree in public health; a B CUR, and an Honour's degree in Nursing Science.[227] Dr Manamela also practiced as a psychiatric nurse[228] and in testimony, Dr Manamela acknowledged that she was an expert in the nursing needs of MHCUs.[229]

172 Dr Manamela has a long career spanning 32 years in the health profession, where for over two decades she held managerial positions. In the Gauteng Department of Health, she was the CEO of two hospitals, and the Director of three, including of Mental Health Services.[230]

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[225] Inquest Transcript, 28 November 2022, Vol 417, page 50939-40.

[226]Makgabo Manamela statement, Vol 005, page 1648, para 1.

[227] Makgabo Manamela evidence notes, Vol 412, page 37672, para 2.

[228] Inquest Transcript, 28 November 2022, Vol 417, page 50986.

[229] Inquest Transcript, 28 November 2022, Vol 417, page 50987.

[230] Makgabo Manamela evidence notes, Vol 412, page 37673, para 3.

173 Dr Manamela was the most senior official responsible for mental health services in Gauteng for seven years, which includes the period before and during the termination of the Life Esidimeni contract.[231]

174 As the Director of Mental Health Services, Dr Manamela had the overall responsibility to manage, supervise, provide strategic leadership and implement policy for all mental health services and programmes in Gauteng – including at specialised hospitals, general hospitals that provide mental health services, and District Mental Health Services.[232] Dr Manamela oversaw five Districts, namely: Tshwane, Ekurhuleni, City of Johannesburg and Sedibeng.[233]

175 Dr Manamela led a team of five Deputy Directors in the Mental Health Directorate, and four CEOs of psychiatric hospitals in the province. She was also responsible for overseeing the work of the Mental Health Review Board and the coordinators of the five districts, even though both institutions directly reported to the MEC and the District Chief Directors respectively.[234]

176 However, the management of Life Esidimeni services fell squarely within the scope of work of Dr Manamela's directorate, which reported directly to her.[235] Despite Mr Levy Mosenogi's appointment on 10 November 2015, as the Project Leader of the Life Esidimeni Termination Project,[236] Dr Manamela was the *de facto* leader of the project.

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[231] Inquest Transcript, 28 November 2022, Vol 417, page 50988.

[232] Makgabo Manamela evidence notes, Vol 412, page 37673, para 4.

[233] Inquest Transcript, 17 October 2022, Vol 413, page 49883.

[234] Makgabo Manamela evidence notes, Vol 412, page 37673, para 5.

[235] Makgabo Manamela evidence notes, Vol 412, page 37674, para 5.

[236] Inquest Transcript, 15 November 2021, p.89, Vol 413, page 40078.

177 In a quarterly meeting held on 5 November 2015, Mr Mosenogi was instructed by Ms Mahlangu to take lead over the Life Esidimeni project, after she displayed dissatisfaction with the progress and performance of the Mental Health Directorate.[237] At this time, the project had already started, and was set to be completed by 31 March 2016.[238] After assessing the project plan prepared by Dr Manamela and found it wanting of an accountability system, Mr Mosenogi formally appointed officials and sub-team from other departments such as Infrastructure, Finance and Human Resources amongst others, to be part of the project team.[239] This included formally appointing Dr Manamela as the deputy project leader, because she possessed experience and expertise in mental health service that Mr Mosenogi did not.[240]

178 Even after Mr Mosenogi's appointment, it was Dr Manamela who chaired and met with the NGOs in an initial meeting in Sterkfontein on 13 November 2015,[241] where Frans Thobane presented on the Project Plan drafted by Dr Manamela.[242] According Hannah Jacobus, she had prepared a training document, but Dr Manamela interfered, and no training was provided to the NGOs.[243]

179 It was Dr Manamela who met with stakeholders on 30 November 2015,[244] where she gave details on operations, such as "caregivers need to be upskilled and

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[237] Affidavit of Mosenogi, Vol 407, page 36000, para 10.

[238] Inquest Transcript, 15 November 2021, Vol 413, page 40081.

[239] Levy Mosenogi statement, Vol 005, page 535, para 6.

[240] Inquest Transcript, 15 November 2021, Vol 413, page 40082-3

[241] Evidence of Manamela, 20 November 2017, Vol 200, page 26056.

[242] Life Esidimeni Progress report, 13 November 2015, Vol 005, page 370.

[243] Hanna Jacobus statement, Vol 005, page 1505, para 8.

[244] Minutes of meeting with SADAG and Department of Health, Vol 200, 18112.

NGO facilities need to be licensed before they can take on any user" and that "families don't have to run around looking for alternative places - that is the job of the Department."[245] The contents of the affidavit signed by Dr Lebethe (who was acting-HOD during the December 2015 litigation to appoint a *curator bonis*) was based on the information provided by Dr Manamela.[246]

180 In 2016, Dr Manamela continued to be the *de facto* project lead. On 9 February 2016,[247] Dr Manamela was part a stakeholder meeting, including SADAG and Life Esidimeni, where she made a presentation on the mental health care user profiles, which indicated the number of 'dependent' and 'independent' MHCUs.[248] Both the representatives of SADAG and Life Esidimeni disputed the numbers in presented by Dr Manamela as conflicting and outdated. For example, Dr Manamela's report stated that 90% of the MHCUs in Waverly were dependent and 10% were independent. Life Esidimeni corrected the data presented and informed Dr Manamela that "[i]n fact, much less than 10% of the MHCUs at Waverly were independent."[249]

181 On 22 February 2016, Dr Manamela chaired a meeting she arranged with NGOs who had shown interest in the project to assess their readiness in terms of staff, actual bed availability and space.[250] According to Frans Thobane's affidavit, it was in this meeting that Dr Manamela coined the term 'marathon' in relation to

[245] Minutes of meeting with SADAG and Department of Health, Vol 200,18113.

[246] Inquest Transcript, 6 September 2021, Vol 413, page 39605.

[247] Minutes of meeting with SADAG and Department of Health, 9 February 2016, Vol 200, page 18572.

[248] Minutes of meeting with SADAG and Department of Health, 9 February 2016, Vol 200, page 18573.

[249] Minutes of meeting with SADAG and Department of Health, 9 February 2016, Vol 200, page 18573.

[250] Lide Esidimeni Progress report, 3 November 2015, Vol 005, page 370.

the project. This is because the project had reached a point where the assessment of NGOs needed to be expedited, and Dr Manamela instructed that the Mental Health Directorate staff, District Office Staff and representatives from the Department of Infrastructure to improve NGO compliance.[251] At this stage, the project had been extended to the end of June, leaving only 4 months to ensure the readiness of NGOs, both old and new. Dr Manamela conceded that, when the placement process of MHCUs began in March 2016, there were not enough beds for the MHCUs to be discharged.[252]

182 In April 2016, Dr Manamela, accompanied by Hannah Jacobus, Ethel Ncube and Dorothy Franks, went to Kalafong Hospital together with the engineers from the Department, who then declared identified wards as unsuitable for human habitation.[253] According Hannah Jacobus,[254] Dr Manamela devised a plan to renovate wards in hospitals, including Kalafong Hospital. The plan was that these wards would be used by the new NGOs, which would have approximately 150 beds in the allocated wards. However, the wards were earmarked for demolition and therefore could not be renovated[255] - leaving new NGOs such as Precious Angels and Anchor Home without premises to house the MHCUs, who would be discharged to them in less than two months.[256]

[251] Affidavit of Thobane, Vol 407, page 36451.

[252] Evidence of Manamela, 25 June 2021, Vol 300, page 26502.

[253] Dorothy Franks statement, vol 005, page 359, para 4.

[254] Inquest Transcript, 18 January 2022, Vol 413, page 41631.

[255] Inquest Transcript, 18 January 2022, Vol 413, page 41631.

[256] Ethel Ncube statement, Vol 005, page 1466, para 6.

183 On 13 April 2016 a joint meeting between the Department and the Life Esidimeni management took place at Life Esidimeni Randfontein.[257] The purpose of the meeting was to plan for the process of discharging and placing of MHCUs. The meeting was required as the litigation between the Department and civil society organisations had concluded and thus the project could continue with two months remaining for the transfer and discharge to be completed. Dr Manamela outlined the plan, which would see the decanting of MHCUs in a period of 11 weeks, where the last two weeks were set for monitoring post placement.[258] Yet again concerns were raised, and according to Ms Mashile, there was no consensus reached at this meeting about the amount of medication to be given to MHCUs going to NGOs and those going to hospitals.[259]

184 For the rest of the project, the Mental Health Directorate continued to only report to Dr Manamela and received instructions from the Dr Manamela.[260]

185 The evidence shows that, at all material times, Dr Manamela had the requisite information to determine whether Life Esidimeni termination project would be a failure or a success, and whether not the health and lives of MHCUs were at risk. The evidence shows that Dr Manamela, the Director of Mental Health, the *de facto* project lead, a reasonable person and an expert in her field, knew the dangers and threats of the termination project and proceeded to implement her poor plans regardless.

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[257] Randfontein complex meeting, vol 412, page 37344.

[258] Randfontein complex meeting, vol 412, page 37345.

[259] Salome Motswagakgabo statement, Vol 005, page 1550, para 9.

[260] Affidavit of Hanna Jacobus, Vol 407, page 36643.

Dr Manamela licensed unsafe facilities and then failed to ensure they were paid

186 It was Dr Manamela who approved and signed the licences of the NGOs, all of which are dated 1 April 2016,[261] even though proper processes[262] had not been followed.

187 Ordinarily, Hanna Jacobus would compile the information and complete the licence. Her work was informed by the reports and visual inspections from the district officials.[263] She would then hand over the licences to Dr Manamela, with a file of supporting documents and a recommendation of whether the NGO is suitable. Often, Hanna Jacobus and Dr Manamela would sit together and discuss each case before the licences are signed by Dr Manamela and issued to the relevant NGOs.[264]

188 However, Hannah Jacobus has testified that what is usually a time-consuming process was not followed during the marathon project.[265] Instead, a different document was used.[266]

189 Unsurprisingly then, shortly after licensing, NGOs were found to be inappropriate for the care of MHCUs.[267]

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[261] Mental Health License San Michele Home, Vol 200, page 20299 – 20345.

[262] Inquest Transcript, 18 January 2022, Vol 413, page 41619.

[263] Inquest Transcript, 17 January 2022, Vol 413, page 41418.

[264] Inquest Transcript, 17 January 2022, Vol 413, page 41418.

[265] Inquest Transcript, 17 January 2022, Vol 413, page 41418.

[266] Evidence of Ms Jacobus, 18 January 2018, Vol 300, page 28386, line 16 to page 283888, line 9.

[267] Evidence of Dr Manamela, 20 November 2017, Vol 300, page 26089, line 6 – 20.

190 Apart from the questionable assessment before licensing and the apparent rapid deterioration of the NGOs following assessment and licensing, there were significant problems in the licenses themselves. The licenses reflected incorrect addresses,[268] incorrect mental health care user classifications,[269] and were all backdated to 1 April 2016 regardless of the date of signature.[270]

191 The NGOs were licensed for their planned number of beds and not for beds actually available.[271] Anchor House did not even have premises at the time that Dorothy Franks received her license from the Department for 150 beds. The license refers to Kalafong Hospital.[272] She testified that Dr Manamela and Hannah Jacobus arranged for her to occupy Cullinan[273] and that Dr Manamela and Frans Thobane promised to rectify the errors in the license.[274] At the time

[268] Precious Angels - Evidence of Dr Manamela, 20 November 2017, Vol 300, page 26078, line 20 – 21 and page 26079, line 1 – 5; Ms Jacobus testified that she compiled the license for Kalafong Heights and did not know who had prepared the license that permitted Precious Angels to operate in Lynwood Road – note Precious Angels operated in neither of these locations (Evidence of Ms Jacobus, 18 January 2018, Vol 300, page 28408, line 3, to page 28409, line 13). Ms Jacobus testified that when she raised concerns about NGOs occupying facilities that were different from those they were licensed for, Dr Manamela informed her that the corrections had been made afterwards (Evidence of Ms Jacobus, 18 January 2018, Vol 300, page 28414, line 13 -16.)

[269] Takalani Home was licensed as a residential facility even though it had previously been a child residential facility. Dr Manamela claimed that this was because adults with severe intellectual disabilities are viewed as children (Evidence of Dr Manamela, 23 November 2017, Vol 300, page 26494, line 5 – 9). Anchor Home was licensed to operate as a child residential facility but did not receive any children from Life Esidimeni (Evidence of Ms Franks, 30 October 2017, Vol 300, page 24542, line 10). Ms Jacobus denied that she had instructed Ms Franks to take in adults even though she was not qualified to care for adults with mental disabilities (Evidence of Ms Jacobus, 18 January 2018, Vol 300, page 28608, line 5 -11.)

[270] Evidence of Dr Manamela, 23 November 2017, Vol 300, page 26653, line 17 – 18.

[271] Evidence of Mr Mosenogi, 11 October 2017, Vol 300, page 22746, line 17 to page 124, line 6.

[272] Evidence of Ms Franks, 30 October 2017, Vol 300, page 24544, line 5.

[273] Evidence of Ms Franks, 30 October 2017, Vol 300, page 24550, line 5.

[274] Mrs Franks testified that the license she received had errors but Dr Manamela and Mr Thobane promised to rectify them (Evidence of Ms Franks, 30 October 2017, Vol 300, page 24622, line 5).

that the license for Precious Angels to operate out of Kalafong Heights was prepared, there were no beds available at the premises.[275]

192 Dr Manamela knew that the usual process was not followed, did not satisfy herself that NGOs complied with requirements, and the licenses that Dr Manamela signed were inaccurate in almost every respect: from the addresses, the date of signature, the number people who the NGO was supposed to care for, the mental illness or intellectual disability of the people the NGO was supposed to care for, and the age of such users. Dr Manamela signed licenses that enabled people to be sent to NGOs where they would inevitably suffer and some would die.

193 To add to Dr Manamela's negligence in this regard, there were significant delays between the arrival of the MHCUs in the incorrectly licensed and uncapacitated NGOs, and payment to those NGOs. This was predictable because Service Level Agreements were only signed after the MHCUs were moved and the Department would not have been able to pay in the absence of an SLA.[276] All of this was known to Dr Manamela and fell squarely within her responsibility.

194 No steps were taken by Dr Manamela to ensure payment until it was too late. It was only once problems arose that Dr Manamela liaised with the finance department.[277]

[275] Evidence of Ms Jacobus, 18 January 2018, Vol 300, page 28413, line 4 – 11.

[276] Evidence of Dr Manamela, 23 November 2017, Vol 300, page 26120, line 6 – 11.

[277] Evidence of Dr Manamela, 20 November 2017, Vol 300, page 26117, line 5 – 11.

195 In response to complaints by NGOs regarding non-payment the Mental Health Directorate referred the NGOs to companies that could help with dietician services, clothes,[278] and linen[279] on credit. The Directorate also provided a letter to help NGOs go to nearby shops to get food donated.[280]

The plan(s) and associated warnings

196 Dr Manamela was repeatedly warned about the inadequacy of her plans but failed to heed these warnings.

197 The National Mental Health Policy Framework specifically cautions against deinstitutionalisation before the upscaling and upgrading of community-based services,[281] and instead makes the development of community residential care facilities a key objective for deinstitutionalisation to occur, without unnecessary risk to health and life of MHCUs.[282] Similarly, the Gauteng Department of Health Mental Health Strategic Plan 2014 - 2020[283] lists, amongst others, as a key priority "[t]o facility and strengthen the establishment of community based mental health services to support deinstitutionalisation".[284] Not even the objective for reduction of 200 beds per annum forms part of the Department's Mental Health Strategic Plan.

[278] Evidence of Dr Manamela, 20 November 2017, Vol 300, page 26118, line 10 – 21.

[279] Evidence of Ms Jacobus, 18 January 2018, Vol 300, page 28470, line 7 -11.

[280] Evidence of Dr Manamela, 20 November 2017, Vol 300, page 26119, line 7 – 15.

[281] National Mental health policy framework and strategic plan, Vol 407 page 35114, para 12.

[282] National Mental health policy framework and strategic plan, Vol 407 page 35135.

[283] Gauteng Department of Health Mental Health Strategic Plan 2014 – 2020, Vol 200, page 18625.

[284] Gauteng Department of Health Mental Health Strategic Plan 2014 – 2020, Vol 200, page 18641.

198 Nevertheless, Dr Manamela spearheaded the implementation of the deinstitutionalisation of the MHCUs residing in the Life Esidimeni facilities. On 4 March 2015, Dr Manamela convened a meeting with senior psychiatrists, Life Esidimeni management and the Mental Health Directorate staff, and informed everyone that the contract with Life Esidimeni would be terminated by 31 March 2016.[285] Dr Yusuf Moosa,[286] the Head of the Clinical Unit within Johannesburg District, attended that meeting with other clinicians, who registered their disagreement with the plan to terminate the Life Esidimeni contract. Besides the short time frames, the process was not practical. The concerns raised were the adverse consequences on the mental health MHCUs from Life Esidimeni and on the limited mental health care services in the province; insufficient doctors in the district health system to care for the Life Esidimeni MHCUs that would be discharged to homes;[287] insufficient spaces available at NPO facilities for those requiring such care; and insufficient bed capacity at hospitals for those that required inpatient care. The clinicians refused to participate in the process, as it was proposed to them, as they stated it was morally and ethically incorrect.[288]

199 Dr Thebe Madigoe who worked at Tara Hospital, drafted a memorandum to Dr Manamela highlighting the serious concerns related to the reduction of beds at Life Esidimeni.[289] On 21 April 2015,[290] the email to Dr Manamela containing the

[285] Mahomed Moosa statement, Vol 005, page 1492, para 4.

[286] Mahomed Moosa statement, Vol 005, page 1492.

[287] This concern was also expressed by Prof Lesley Robertson – Inquest Transcript, 25 May 2023, Vol 424, page 54071.

[288] Mahomed Moosa statement, Vol 005, page 1492, para 4.

[289] Memo on the reduction of beds, Vol 407, page 37152.

[290] Email on the reduction of beds, Vol 407, page 37150.

memorandum was sent to Dr Pak and various other mental health care practitioners as well. Along with listing the concerns the memorandum further contained a request for an urgent meeting with Ms Mahlangu, to discuss these concerns. The memorandum served as a communication from all psychiatrists and psychiatric hospitals and psychiatric units of general hospitals in Gauteng, and as such, Dr Madigoe requested their inputs on the concerns that he highlighted. Despite raising their concerns, Dr Manamela continued to make plan, signalling that the department was to go ahead with its plan to terminate its contract with Life Esidimeni and transfer MHCUs out of the facility.

200 One of Dr Manamela's first plans can be found in the "Gauteng Department of Mental Health Services Project Report"[291] dated 15 July 2015. At this meeting attended by Ms Mahlangu, three options were presented as to how the placement of MHCUs from Life Esidimeni could be undertaken. Option one included the identification of beds from specialised psychiatric hospitals including Weskoppies, Sterkfontein and CCRC.[292] This option called for the renovations of these facilities. The total number of beds calculated post renovations to these facilities was 670.[293] The second option required the renovation of old hospitals such as old Germiston, Mamelodi and Tshwane Hospitals.[294] These hospitals would have been used for housing the NGOs and for taking care of chronic MHCUs. The third option was to purchase the Life Esidimeni facilities.[295]

[291] Life Esidimeni project report, 15 July 2015, Vol 200, page 20587.

[292] Life Esidimeni project report, 15 July 2015, Vol 200, page 20590.

[293] Life Esidimeni project report, 15 July 2015, Vol 200, page 20591.

[294] Life Esidimeni project report, 15 July 2015, Vol 200, page 20590.

[295] Life Esidimeni project report, 15 July 2015, Vol 200, page 20596.

201 On 21 September 2015, Dr Manamela held a meeting between the Mental Health Directorate, specialised hospitals and the Department of infrastructure and confirmed that the Life Esidimeni contract will be terminated and will be ending on 31 March 2016.[296] The minutes of the meeting, yet again, indicate the Department's own experts raising concern and alarm about NGOs not having the same level of experience and expertise as the staff from Life Esidimeni; 60% of the Life Esidimeni MHCUs not being dischargeable; and concern as to what will happen to the MHCUs should renovations not be completed.[297]

202 The day after the Life Esidimeni contract was terminated, on 30 September 2015, Dr Manamela signed the official project plan titled, "Project Plan: Termination of contract relationship between Gauteng Department of Health and Life Esidimeni and upscaling community based mental health services."[298] The project period was stated to be from 1 October 2015 to 31 March 2016.[299] The purpose of the plan was said to be the deinstitutionalisation of MHCUs from a restrictive environment, aimed at reducing departmental costs and addressing non-compliance with financial regulations and the Auditor General's report.[300] The project plan outlined five main objectives:[301]

202.1 Facilitating the assessment process for eligible users to be discharged to communities or homes.

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[296] Minutes of Mental Health Department, specialised hospitals and infrastructure, 21 September 2015, Vol 200, page 20647.

[297] Minutes of Mental Health Department, specialised hospitals and infrastructure, 21 September 2015, Vol 200, page 20648-9.

[298] Termination of contract between Life Esidimeni and Department of Health, Vol 300, page 31682.

[299] Termination of contract between Life Esidimeni and Department of Health, Vol 300, page 31683.

[300] Termination of contract between Life Esidimeni and Department of Health, Vol 300, page 31689.

[301] Termination of contract between Life Esidimeni and Department of Health, Vol 300, page 31690.

202.2 Facilitating and coordinating user placement at home or with non-profit organisations upon discharge.

202.3 Renovating specialised hospitals to accommodate users who may still require hospitalisation, as well as those already in hospitals needing long-term care under close supervision.

202.4 Renovating identified old hospitals to be used by NGOs.

202.5 Strengthening community mental health services in all primary health care and community health care centres.

203 A Plan B was included as a contingency in case there was not enough bed capacity for the MHCUs. In such a circumstance, MHCUs would be temporarily allocated to general hospitals.[302] As the evidence shows, Plan B was implemented, but instead of MHCUs being placed in hospitals, they were placed in NGOs. Quite notably, the project plan also includes the anticipated risks and challenges,[303] none of which include the systemic deficiencies of bed shortages, insufficient psychiatric staff at primary and community health facilities and an already overwhelmed health care system at a district level.

204 On 27 October 2015[304] the clinical experts of the Department raised concerns about the termination of the Life Esidimeni contract which they wanted to discuss with the HOD Dr Selebano. The practitioners addressed a memorandum to Dr Manamela in which they once again highlighted the concerns of all practitioners

[302] Life Esidimeni Project Plan B, Vol 300, page 31713.

[303] Life Esidimeni Project Plan B, Vol 300, page 31714.

[304] Memo to Director of Health, 27 October 2015, Vol 412, page 37670.

involved. One of the main concerns was the discharge of a colossal number of MHCUs in a short space of time. Further, it is not in dispute that the pace of the marathon project would have had a significant and adverse impact on the mental and physical health of MHCUs.

205 On 30 October 2015, SASOP sent an email to both Ms Mahlangu and Dr Manamela with an attached letter dated October 2015.[305] The letter once again alerted the department that SASOP was deeply concerned that community health services had not been sufficiently developed to accommodate the Life Esidimeni MHCUs.

206 On 26 November 2015, the SADAG addressed an extensive and detailed letter to Ms Mahlangu[306], Dr Manamela and Dr Mkhatshwa in which they raised their concerns around the termination of the Life Esidimeni contract. In the letter they also provided feedback from the hospitals identified by Ms Mahlangu in her response to the Gauteng Legislature regarding their inability to accommodate the MHCUs.

207 On 9 December 2015, SECTION27 sent a letter[307] to Ms Mahlangu, Dr Manamela, Mr Mosenogi and Dr Mkhatshwa on behalf of our clients SADAG, the South African Federation for Mental Health (SAFMH) and the association of families of some of the MHCUs at Life Esidimeni. The letter refers to the meeting that was had on 30 November 2015 between SADAG and the Department. It was

[305] Email to Ms Mahlangu, 30 October 2015, Vol 407, page 36765.

[306] SADAG Letter, 26 November 2015, Vol 200, page 18101.

[307] SECTION27 letter, 9 December 2015, Vol 200, page 18114.

at this meeting where the Department agreed not to discharge MHCUs from Life Esidimeni facilities until a plan was developed and implemented to ensure that at the very least the MHCUs would receive the same level of care as they did at Life Esidimeni. The letter made further reference to a meeting held on 2 December 2015. The letter referred to the project plan presented at this meeting which indicated that MHCUs were being discharged in direct conflict with the Department's promise to stop the process pending a consultation.

208 The letter further stipulated that SAFMH and SADAG wanted to work with and assist the Department but could not engage meaningfully with the plan as they were yet to receive it from the Department. Lastly, this letter refers to a document provided by Dr Manamela to SADAG and the SAFMH on 5 December titled, "LE Termination users, NPOs and staff." This document indicates that during the period of 17 August 2015 and 4 December 2015 a total of at least 353 MHCUs were being discharged from Life Esidimeni despite the Department's assurances that they were not aware of any discharges and would stop such a process.[308]

209 The third plan to note was in 2016, borne out of the frustration of the alleged sabotage by Life Esidimeni staff in delaying the placement process. Therefore, on 11 April 2016, Dr Manamela seconded her Deputy Directors Ms Nonceba Sennelo and Dr Sophie Lenkwane to Life Esidimeni Waverley, and Deputy Director Ms Salome Mashile and Social Worker Freda Sennelo to Life Esidimeni Randfontein.[309] According to Dr Lenkwane, Dr Manamela had instructed them to speed up the placement process of MHCUs to meet the termination date of 30

[308] SECTION27 letter, 9 December 2015, Vol 200, page 18116.

[309] Sophie Lenkwane statement, Vol 407 page 36344, para 9.

June 2016. Dr Gail Ure from Life Esidimeni provided the Mental Health Directorate with the number of MHCUs still at the Life Esidimeni facilities, the required medication, and the MHCUs profiles, which included the level of functionality.[310] This information was used to develop the placement and discharge plans dated 26 April 2016,[311] complied by Dr Manamela.[312]

210 The placement and discharge plan[313] indicates that as of 26 April 2016, 1442 MHCUs had to be placed in a seven week period. On average for the first five weeks, an expected 240 MCHUs had to be placed per week and an average of 119 MHCUs in the last two weeks. Witnesses to this marathon placement process have described the implementation of the plan as a "rush"[314] and "chaos".[315] Dr Rabia Wadvalla, who was based at Randfontein, provides the clearest illustration of the rushed and chaotic nature of the placements, states that:[316]

> *"1. A few days before 12 May 2016 we were informed that Tshepong was ready to receive 70 MHCUs and that they had to be male, intellectually disabled and ambulant MHCUs. Dr Khota saw the mental health care user's and he had discussion with me regarding the identity of the MHCUs from the different wards.*
>
> *2. On very short notice on 11 May 2016 at 16h00 the manageress from Tshepong called and advised that she could no longer have the intellectually disabled male MHCUs. The Life Esidimeni staff had to prepare female and male psychiatric MHCUs not older than a specified*

[310] Sophie Lenkwane statement, Vol 407 page 36344, para 9.

[311] Life Esidimeni placement and discharge times, Vol 300, page 30861.

[312] Inquest Transcript, 30 January 2023, Vol 419, page 51361.

[313] Life Esidimeni placement and discharge times, Vol 300, page 30861.

[314] Affidavit of Buthelezi, Vol 005, page 1438-9, para 25 and 26.

[315] Inquest Transcript, 7 February 2022, Vol 413, page 42626.

[316] Affidavit of Dr Wadvalla, Vol 005, page 1516, para 23 -7.

age. The morning of 12 May 2016 we had to select 70 MHCUs who fitted the profile and they needed physical examinations, records, medication and prescriptions. Dr Manamela was present on the 12th and she went into the wards during the selection process. Although the bus arrived early the morning it only departed late that afternoon.

3. *These types of changes caused significant upheaval, frustration and anguish for staff and MHCUs."*

211 Even though the placement of MHCUs had begun, Dr Manamela continued to receive warnings from psychiatric experts in the field. On 3 May 2016[317] Prof Robertson sent an email to Dr Manamela, where she repeated several concerns about the placement to the MHCUs of Life Esidimeni to NGOs with insufficient community mental health care services.

212 On 4 May 2016,[318] Prof Robertson wrote a second email to Dr Manamela regarding the placement of Life Esidimeni MHCUs in NGOs. She mentioned to Dr Manamela that the NGOs would not be able to manage a disruptive mental health care user and the risk of MHCUs absconding from NGOs would be quite high. She further stated that NGOs would not cope with receiving more than 10 MHCUs at a time. Lastly, she raised the concern that the district health system would not be able to adequately support NGOs and there was no system of community psychiatry in any of the provincial districts.

213 Despite, the concerns raised, Dr Manamela continued to implement the project plan. On 2 June 2016, SADAG sent a letter to Dr Selebano, Mr Mosenogi and Dr Manamela raising concerns about the move of users without the knowledge of

[317] Email from Lesley Robertson, 3 May 2016, Vol 407, page 36776.

[318] Email from Lesley Robertson, 3 May 2016, Vol 407, page 36779.

their families; NGOs that *"are little more than empty houses filled with beds without any professional care, without security or supervision, and some without sufficient beds for mental health users to sleep on"*; poor conditions at CCRC; adult users being moved en masse to Baneng; NGOs not being paid; users being sent to families who were unable to care for them; poor communication; and an *"extremely high rate of negative outcomes, including relapse and deaths, following the relocation of users".*[319]

214 Dr Selebano responded saying that "I am sure the colleagues who have been copied will engage with the contents of your email. Mr Mosenogi will provide me with a status report, and you may also talk to him directly. This is a painful chapter for all of us."[320] SADAG received no further response to this letter.

215 Families held a march and submitted a list of demands on 9 June 2016.[321] The demands raised issues around the shortages of medication, the lack of therapeutic activities at the NGOs, and not being aware of whether their family members have been placed, because it was not close to home as promised. On 15 June 2016, Dr Manamela responded[322] to the list of demands with false statements such as that "[a]ll the NGOs are assessed and accredited before they can place and receive any MHCUs. The NGOs that do not meet the requirement are disqualified. The NGOs that received MHCUs have met the specific requirements as on the audit form".[323]

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[319] Letter from SADAG, 2 June 2016, Vol 200, page 18953.

[320] Dr Selebano email, Vol 200, page 18955.

[321] Memo to Gauteng Department of Health from families, 9June 2016, Vol 300, page 31174.

[322] Memo to Gauteng Department of Health from families, 9June 2016, Vol 300, page 31182.

[323] Memo to Gauteng Department of Health from families, 9June 2016, Vol 300, page 31186.

216 The last plan of significance is Dr Manamela's "Adopt an NGO" strategy,[324] dated 20 August 2016,[325] after all the MHCUs had been discharged and placed. The purpose of the strategy was to ensure that the MHCUs from Life Esidimeni are receiving services as required and are settling well at the NGOs. All the NGOs would be allocated a Deputy Director from the Mental Health Directorate, whose specific responsibilities included conducting audits with the now available audit tool.

217 The "Adopt an NGO" strategy can only be explained as mechanism of damage control. Hannah Jacobus correctly captured that "the project consisted of constant crisis management",[326] and with structural deficiencies of bed shortages, an overwhelmed community-based services, the existence of a poor plan, the failure of the project was inevitable. Dr Manamela formally appointed her Deputy Directors on 26 September 2016, with a letter titled "Action plan regarding concerns at the NGOs, where MHCUs (mental health care user) from Life Esidimeni were placed".[327] By the time the 'Adopt an NGO' strategy had been formally initiated, 17 MHCUs had died at Precious Angels in a period of four months.[328] Overall, 47 MHCUs had died by this time.[329]

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[324] Termination of contract Strategy, Vol 005, page 637.

[325] Termination of contract Strategy, Vol 005, page 644.

[326] Affidavit of Hanna Jacobus, Vol 407, page 36641, para 20.

[327] Letter from Manamela to Lenkwane, 26 September 2016, Vol 005, page 590.

[328] List of deaths at Precious Angels, Vol 412, page 37552.

[329] Death Dates, Vol 16, page 50485.

Delegation to the Mental Health Directorate and Dr Manamela's interference

218 To implement the project plan and meet the June 2016 deadline, Dr Manamela divided the Mental Health Directorate into teams of three in April 2016.[330] Hannah Jacobus and Frans Thobane were responsible for identifying NGOs, and also finding bed capacity both at hospitals and NGOs.[331] As stated above, the other Deputy Directors and Social Worker were seconded to Life Esidimeni facilities to fast track the assessment, discharge and placement of MHCUs.[332]

219 According to Frans Thobane, he was asked by Dr Manamela to assess the bed capacity, staff capacity and health environment of the NGOs, however he was not given any specific assessment tool to determine NGO readiness, and he had neither the expertise nor the experience to do so.[333] Nonetheless, any problems encountered were reported to Dr Manamela.[334] In fact, Dr Manamela conceded that NGOs were licensed even though she had not received their financial statements, and merely accepted the say so of the NGOs that they had sufficient funds in their bank accounts to begin taking care of the MHCUs.[335]

220 Ms Meisie Lerutla, the Chief Director of District Health Services, confirms that there was a general outcry by the districts of Gauteng that there were insufficient

[330] Affidavit of Thobane, Vol 407, page 36451.

[331] Noncebo Sennelo statement, Vol 005, page 504, para 3.

[332] Affidavit of Lenkwabe, Vol 407, page 36344, para 9.

[333] Life Esidimeni Project progress report, Vol 005, page 376, para 7.

[334] Khalaeng Thobane statement, Vol 005, page 367, para 7.

[335] Evidence of Manamela, 24 November 2022, page 26664-5.

beds to cater for the MHCUs to be discharged from Life Esidimeni.[336] Instead of heeding the warning from the districts of limited capacity, Dr Manamela and the rest of the Mental Health Directorate took over the function of finding beds and auditing the NGOs.[337] Despite the district providing evidence of their limited bed capacity, Dr Manamela took over this function and indicated to the district where beds were available.

221 When the Mental Health Directorate indicated that they required more time, Dr Manamela stated that everything was on track and that they should continue. Dr Manamela's report back to the Mental Health Directorate indicated that senior management suggested that all was well, and that the placement process should proceed.[338]

222 Ms Ria van der Walt, Director: District Health Services,[339] stated that the districts only played a limited role after the placement of the MHCUs, where only then did they conduct audits and make recommendations on areas of improvement for NGOs.[340] Mr Mothomone Pitsi, former Chief Director: Tshwane District Health Office[341] states that when the districts were finally allowed to resume their functions, they found that there no Service Level Agreements were in place

[336] This was in line with Prof Robertson's earlier warning and her testimony at Inquest Transcript, Vol 424, page 54071.

[337] Affidavit of Lerutla, Vol 407, page 36292, para 10.

[338] Affidavit of Jacobus, Vol 407, page 36643, para 26.

[339] Affidavit of Van der Walt, Vol 407, page 36873.

[340] Affidavit of Van der Walt, Vol 407, page 36875, para 9.

[341] Mathomone Pitsi statement, Vol 005, page 556.

between the NGOs and Department. That means MHCUs were transferred to NGOs that were performing their duties without a contract.[342]

223 The Mental Health Directorate placement team was also delegated with responsibilities that were ordinarily the responsibility of Life Esidimeni staff and the qualified staff and clinicians of NGOs. According to Dr Lenkwane, Dr Manamela's constant interference during the placement of MHCUs caused a lot of confusion and stress. For example, the identification team would raise areas of concern that the NGOs had to address prior to receiving MHCUs and give them a specific amount of time to do so.[343] However, Dr Manamela would then call Life Esidimeni and tell Dr Lenkwane and Ms Sennelo to send a certain number of MHCUs to the NGOs which had not yet addressed their deficiencies and were not ready to accept MHCUs.[344]

224 On 29 June 2016, Dr Manamela was present at CCRC when one of the last groups of MHCUs left Life Esidimeni facilities. According to Ethel Ncube, Dr Manamela and Hannah Jacobus called her to come and fetch mental health care users from CCRC. Dr Manamela said this is because MEC and HOD were on their way. That they would lose their jobs because of the chaos of mixed MHCUs at Anchor.[345] On arrival, Dr Manamela, Hannah Jacobus, Frans Thobane and Rochel Gordon were there. Dorothy Franks showed her the MHCUs to be taken,

[342] Mathomone Pitsi statement, Vol 005, page 558, para 7.

[343] Affidavit of Lenkwane, Vol 407, page 36344, para 10.

[344] Affidavit of Lenkwane, Vol 407, page 36345, para 10.

[345] Ethel Ncube statement, Vol 042, page 7709.

including Virginia Machpelah.[346] Ethel Ncube received 20 mental health care user that day.

225 Hannah Jacobus' version of events of the 29 June 2016 are slightly different. She states that Dr Manamela and Frans Thobane arrived with Ethel Ncube. And then Dr Manamela sent her to go get linen.[347] Upon her return, Dorothy Franks informed her that Dr Manamela and Ethel Ncube had taken MHCUs, who Hannah Jacobus notes were psychiatric MHCUs and were better suited to be at Anchor, which had access to CCRC professional nurses.[348] In her SIU affidavit,[349] Hannah Jacobus states some of the MHCUs transferred to Precious Angels were sick and required hospital care with close observation. She said she shared her concerns with the CEO of CCRC, who addressed them with Dr Manamela. In response, Dr Manamela said, "Hannah just wants to rule everything. I will sort it out".[350]

226 Ultimately, Precious Angels had the highest number of deaths at an NGO with a total of 20.

Direct contact with Ms Mahlangu during implementation

227 During the implementation of the project, Dr Manamela had regular and direct contact with Ms Mahlangu.

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[346] Ethel Ncube statement, Vol 005, page 1468, para 13.

[347] Hanna Jacobus statement, Vol 005, page 1508, para 14.

[348] Hanna Jacobus statement, Vol 005, page 1508, para 14.

[349] Affidavit of Jacobus, Vol 407, page 36623.

[350] Affidavit of Jacobus, Vol 407, page 36636, para 8.6.

228 On 26 January 2016,[351] the Ms Mahlangu chaired a meeting between the senior managers and clinician. It was in this meeting that Ms Mahlangu made it clear that the termination was a done deal and that Dr Manamela must ensure that all new and old NGOs must be licenced by February 2016, and for the community services to the strengthened.[352] This was an impossible request to meet with the timeframe allocated.

229 On 17 February 2016,[353] Dr Manamela presented to Ms Mahlangu on the progress of the project. The presentation merely repeats the bed capacity presented in January, but also adds the concerns of the families, which are recorded extensively.[354] These include requests for the extension of time, concerns about the lack of suitability of NGOs and meaningful consultation. The way forward in the presentation failed to address these serious concerns and merely spoke to action points to further the project.[355]

230 On 7 April 2016,[356] Dr Manamela presented to the MEC and senior managers on progress of the project. A noted challenge was that hospitals continued to send MHCUs to Life Esidimeni despite the moratorium.[357] The officials met again on 8 April 2016, where the following resolutions were made:[358]

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[351] Minutes from Life Esidimeni termination meeting, Vol 200, page 20687.

[352] Minutes from Life Esidimeni termination meeting, Vol 200, page 20688.

[353] Mental health project progress report, 17 February 2016, Vol 300, page 30907.

[354] Mental health project progress report, 17 February 2016, Vol 300, page 30918.

[355] Mental health project progress report, 17 February 2016, Vol 300, page 30920.

[356] Life Esidimeni contract termination project, 7 April 2016, Vol 300, page 30877.

[357] Life Esidimeni contract termination project, 7 April 2016, Vol 300, page 30884.

[358] Resolution from contract termination meeting,8 April 2016, Vol 200, page 20698.

230.1 It was the responsibility of the Mental Health Directorate, under the leadership of Dr Manamela, to ensure that: the NGO marathon and verification of NGOs be finalized by the end of April 2016.

230.2 950 MHCUs must be moved by the end of April 2016 to identified NGO beds.

230.3 Medication should be supplied to users who would be sent to NGOs.

230.4 Emergency Medical Services (EMS) was to assist with the transport of MHCUs.

230.5 It was resolved that MHCUs from Life Esidimeni would be transferred to NGOs and that doctors would follow up with the users at the NPOs to assess if more suitable facilities were needed.

231 On 22 April 2016,[359] Dr Manamela made a presentation to Ms Mahlangu, where it was reported that more NGOs would be ready by May 2016 and that the meeting with Life Esidimeni held on the 13 April, resolved all the issues. This is not true, as there were still debates between the institutions about the amount of medication the MHCUs would be discharged and placed with.[360]

232 On 29 April 2016,[361] the progress report to Ms Mahlangu and senior management by Dr Manamela spoke to the fact that some family visits to NGOs occurred with clinicians. These NGOs included Tshepong, Takalani, Mosego and Rebafenyi.

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[359] Mental health contract termination project, 22 April 2016, Vol 300, page 30862.

[360] Facility inspection report, Vol 409, page 37313.

[361] Mental health contract termination project, 29 April 2016, Vol 300, page 20616.

233 The next interaction between Dr Manamela and Ms Mahlangu and senior managers would be on 13 May 2016.[362] Dr Manamela reported that the placements were under way and to be completed in 6 weeks, with two weeks of monitoring and evaluation after placement, and to be managed by teams of 3.

234 On 21 June 2016,[363] Dr Manamela presented a further progress report, which noted highlights and lowlights. As part of the highlights, it was reported that 1283 MHCUs had been discharged and placed, with only 253 remaining. As part of the lowlights, 22 MHCUs were reported to be too frail to be transferred to NGOs; family marches; medication support was needed in some districts; as well as deaths and abscondments. By this time in June, there had already been over 10 deaths of MCHUs and Dr Manamela had received SADAG's extremely serious letter dated 2 June 2016 warning of deaths.

235 Dr Manamela was central to creating the conditions that caused the deaths of 141 MHCUs. She knew how moves of MHCUs should work and led a process that followed none of this good practice. She knew about the conditions in NGOs and failed to take sufficient steps to improve them. She caused the deaths of MHCUs.

<u>Dr Manamela caused the deaths of at least 10 MHCUs</u>

236 Without Dr Manamela's actions and omissions, the deaths would not have occurred. In particular, the following conduct caused the deaths:

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[362] Mental health contract termination project, 13 May 2016, Vol 300, page 30902.

[363] Mental health contract termination project, 21 June 2016, Vol 300, page 20640.

236.1 Dr Manamela was a highly qualified and experienced psychiatric nurse and manager, the Director of Mental Health and the de facto project lead.[364] In this role she determined what would happen to implement the project to move all MHCUs out of Life Esidimeni and how it would happen. She took responsibility for the project and was well qualified to do so. She had the requisite information to determine whether the project would be a failure or a success and was in direct contact with Ms Mahlangu.

236.2 Dr Manamela knew and admitted that the project was not properly planned. She was repeatedly told about problems in planning and implementation but failed to take sufficient action to change approach.

236.3 Dr Manamela changed the way that the assessment and licensing of NGOs occurred, using provincial rather than district staff,[365] including people who were not experienced in the assessment of NGOs, and then signing licenses without evidence of compliance. This resulted in NGOs accepting MHCUs when they were not capacitated to do so.

236.4 Dr Manamela knew when she was signing licenses that the NGOs did not have the capacity to care for MHCUs.

236.5 Dr Manamela failed to ensure that the NGOs, whose licensing process she oversaw, had SLAs that would enable them to be paid.[366] This

[364] Makhoba Evidence notes, Vol 412, page 37672, para 2.

[365] Affidavit of Van der Walt, Vol 407, page 36875.

[366] Mothomane Pitsi statement, Vol 005, page 558.

resulted in subsidies not being paid and NGOs having serious financial problems.

236.6 Dr Manamela both planned a rushed process of moves and then intervened in the plans to make the process even more rushed and to ensure the movement of large groups of MHCUs at a time,[367] contrary to all good practice (of which she was aware).

236.7 Dr Manamela instructed the movement of MHCUs from CCRC to NGOs and between NGOs, resulting in the loss of MHCUs identities and significant disruption to their care.

236.8 Dr Manamela's failure to ensure that the NGOs to which she was moving MHCUs were capacitated to do so resulted in extremely poor conditions at many NGOs, including insufficient and untrained staff, insufficient food and blankets and shortages of medication.

236.9 Dr Manamela did too little too late after the movement of MHCUs had begun, using the Adopt an NGO programme but then failing to act on the findings, including failing to shut down Precious Angels as she said that there was nowhere else for MHCUs to go.[368] At the stage when her team who inspected Precious Angels advised that the NGO should be closed, 13 of the 20 eventual deaths had not yet occurred.

[367] Sophie Lenkwane statement, Vol 407, page 36344 – 36345.

[368] Sophie Lenkwane statement, Vol 005, page 356; Inquest transcript, 9 February 2022, Vol 413, page 42786.

237 If the Court is to substitute reasonable conduct for the conduct of Dr Manamela described above, in line with the test for factual causation laid out above, the deaths would not have occurred. The deaths could not have occurred without Dr Manamela's conduct and to hold otherwise would be unjust.

238 In relation to legal causation, there was a sufficiently close connection between the conduct of Dr Manamela and the deaths. The MHCUs were (and Dr Manamela knew them to be) particularly vulnerable. Moving them at all, and then into ill-prepared NGOs, would make their suffering and deaths probable. This conduct meets the adequate cause test. The intervening conduct, in this case by Ms Ncube, was not independent but flowed naturally from Dr Manamela's conduct. There was, therefore, no novus actus interveniens.

239 Finally, public policy and the legal convictions of the community require that conduct such as Dr Manamela's, that so directly precipitated deaths, be punished criminally.

240 Dr Manamela's conduct therefore meets the tests for factual and legal causation.

Ethel Ncube

241 Ms Ethel Ncube was the owner of Precious Angels, which saw the deaths of 20 MHCUs, the first of whom died less than two weeks after being moved into her care.[369] Ms Ncube's conduct caused the deaths of five of the 10 MHCUs whose deaths we focus on.

[369] List of deaths at Precious Angels, Vol 412, page 37552.

242 Ms Ncube admitted, in the course of the inquest, that neither she nor her staff had the relevant experience or training, that the facilities that she had secured were not appropriate, that she continued with the project despite promised assistance not materialising, and that she operated her NGO without a proper license.

243 Ms Ncube intended to care for children with intellectual disabilities in an extended day care centre. She changed her plan to accepting adult MHCUs when the needs of the Department changed. She had no trained or experienced staff. When she could not occupy government premises, she borrowed one house (in Danville) and then another (in Atteridgeville) from her uncles. She expected help from the Department but when it didn't come, she continued to accept more MHCUs anyway. She did not have enough food or blankets and she ran out of medication. MHCUs died of malnutrition, pneumonia, asphyxiation due to food aspiration, among other medical causes of death. Many of the MHCUs died emaciated.

<u>Ms Ncube knew that she lacked experience</u>

244 Prior to opening Precious Angels, Ms Ncube was the manager of Makabongwe Pathway Day Care Centre, an NGO that catered for children with profound intellectual disabilities.[370] In her position as manager of Makabongwe Pathway Day Care Centre, she developed a relationship with the Department, which was how she received an invitation to the Life Esidimeni termination meeting at

[370] Ms Ncube statement at SAPS, Vol 005, page 1645 para 2.

Weskoppies Hospital.[371] Her five-year plan was to expand Makabongwe Pathway Day Care Centre to include teenage, adult, and old age programs. At this stage, her interest was solely focused on establishing a daycare facility.[372] Ms Ncube confirms that Dr Manamela was also aware of her five-year plan, and the department invited her to attend this meeting based on their knowledge of her long-term plan.[373]

245 Ms Ncube in her statement admits to having no knowledge of the level of care that MHCUs in Life Esidimeni received, only had experience caring for children, and had no experience in operating a 24-hour care centre.[374] She stated "*I had no clue on running a 24 hour*."[375] She also testified that Dr Manamela was aware of her lack of relevant experience.[376]

246 She had no knowledge or experience of dealing with people with severe to profound intellectual disabilities or mental illnesses. Despite this, she accepted MHCUs with Alzheimer's, epilepsy, cerebral palsy and a variety of medical conditions.[377]

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[371] Inquest Transcript, 2 Feb 2022, Vol 413, page 45957.

[372] Manamela statement at SAPS, Vol 005, page 1645 para 3.

[373] Dr Manamela statement at SAPS, Vol 005, page 1645.

[374] Ethel Ncube written statement, Vol 005, page 1466.

[375] Inquest Transcript, 2 August 2022, Vol 413, page 48131 line 7.

[376] Inquest Transcript, 2 August 2022, Vol 413, page 48203.

[377] Inquest Transcript, 2 August 2022, Vol 413, page 48198.

Ms Ncube knew that her staff had no relevant knowledge or expertise

247 Ms Ncube had no professional staff and had hired cleaners who she then had working as careworkers.

248 Ms Ncube testified that the property in Atteridgeville only had two or three care workers for the day and night shift[378] and no security.[379]

249 The staff employed by Ms Ncube were not trained in first aid, they were not equipped to deal with issues without a professional and had no emergency equipment.[380] Ms Ncube in her testimony stated that they would use the children's first aid kit as that is all she had.[381]

250 Ms Ncube testified that the MHCUs were at Precious Angels for over two weeks before they were assessed by a professional nurse, Sister Rebecca, and a physiotherapist from Bophelong Clinic on 17 and 19 July 2016.[382] However, there is no evidence that the assessments in fact happened[383] and under cross examination, Ms Ncube changed her evidence to say that Sister Rebecca was not sent from Bophelong Clinic, but was a friend of hers.[384]

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[378] Evidence of Ncube, 17 October 2017, Vol 300, page 23319.

[379] Evidence of Ncube, 17 October 2017, Vol 300, page 23341.

[380] Audit checklist for Mental health facilities, Vol 200, page 20425 and 20426.

[381] Inquest Transcript, 3 August 2022, Vol 413, page 48668.

[382] Ethel Ncube statement, Vol 005, page 1468.

[383] Report on NGO support visits, Vol 005, page 588.

[384] Inquest Transcript, 3 August 2022, Vol 413, page 48670 as compared with Cross examination of Ethel Ncube, Vol 413, page 48373.

251 Ms Ncube testified that one of the promises from the Department of Health before she received the MHCUs was that they would provide the NGO with an assessment team, who would then explain the treatment and dietary needs of each user, especially in light of the fact that Ms Ncube had no clinical experience.[385] The assessment team, promised by Hannah Jacobus, never arrived while the MHCUs were at Precious Angels.[386] Ms Ncube kept accepting new MHCUs regardless.

252 Dr. Robertson, in her testimony, emphasises the importance of assessing patients upon their arrival at a facility. She stated that even if the patients were assessed at Life Esidimeni, it is necessary to reassess the patient again upon arrival to develop a care plan. This care plan would involve a doctor, medications, nursing care, and the involvement of allied healthcare professionals. The inability to conduct medical examinations after arrival at the NGO means that no proper, medically informed care plan could be developed for each patient.[387]

253 Mahlatsi Theophilus Nofile, a former employee of Precious Angels, initially employed as a cleaner at the Danville facility starting in June 2016, revealed that he and other staff members were tasked with caring for vulnerable MHCUs despite lacking any nursing knowledge or skills in bathing, cooking, and feeding. They endured extended shifts without any days off. Mr Nofile claims that Ms Ncube promised to enrol them in a home-based care course but failed to fulfil that promise. He describes the challenging working conditions of long hours, no

[385] Inquest Transcript, 2 Aug 2022, Vol 413, page 48136.

[386] Inquest Transcript, 2 Aug 2022, Vol 413, page 48157-8.

[387] Inquest transcript, 25 May 2023, Vol 424, page 54121.

days off, and no payment, which led to numerous staff members resigning from their positions.[388]

Ms Ncube accepted adults instead of children

254 Ms Ncube stated repeatedly that she planned and intended to care for children. But she knew when she was receiving MHCUs that none of them was a child and she took them in anyway.

255 Ms Ncube states that Dr Manamela announced during the February 2016 meeting that the Baneng facility had two wards, one for adults and another for children. She informed Ms Ncube that the Baneng facility would be closed due to the termination of the contract with Life Esidimeni. Additionally, Dr Manamela mentioned that the placement of children from Baneng would only commence in March 2017, but Ms Ncube should ensure her NGO's readiness in the meantime. She emphasized that NGOs dealing with children would exclusively receive children from Baneng Care Centre. Dr Manamela solicited Ms Ncube to consider expanding her NGO into a 24-hour care facility once she received the children from Baneng from March 2017.[389]

256 At some stage, Ms Ncube attended another meeting chaired by Dr Manamela, during which a change of plan was communicated regarding the discharge of the children from Baneng. The new plan was that the children from Baneng would only be discharged in 2017, as the contract between the department and Baneng had been extended. Since the children no longer needed immediate housing, Ms

[388] Mahlatsi Nofile statement, Vol 041, page 7698 para 4.

[389] Ethel Ncube statement, Vol 005, page 1466 para 4.

Ncube was asked to assist with the adults from Randfontein. Dr Manamela explained to Ms Ncube that with the termination date fast approaching, the Department lacked sufficient space to accommodate adult MHCUs.[390]

257 Ms Ncube visited Randfontein with Patricia Mbatsha to assess the MHCUs she would be receiving. On arrival at Life Esidimeni, Ms Ncube raised the fact that she only had experience in looking after children. Ms Ncube met with Dr Wadwalla, who took her on a tour of the wards and showed her the severe to profound intellectually disabled MHCUs. Ms Ncube enquired about the MHCUs' level of functioning, and Dr Wadvalla confirmed Dr Manamela's response that the MHCUs' level of functioning resembled that of children. Of course, though the MHCUs' level of functioning may be equated to that of a child, it is important to note that the MHCUs themselves were still adults.[391] Dr Talatala testified that the fact that a person has the mental age of a child does not mean that they can be cared for in a home for children because with adult bodies, they have different needs to those of children.[392]

<u>Ms Ncube knew that her facilities were not appropriate or prepared to accept MHCUs</u>

258 Ms Ncube was unprepared to receive the MHCUs when large numbers of people started being moved to her NGO. Her facilities were insufficient and she did not have the professional staff required. She ran out of medication and of food. MHCUs were found lying in bed without blankets. Seven of the deaths involved

[390] Affidavit of Hanna Jacobus, Vol 407, page 36640.

[391] Ethel Ncube statement, Vol 005, page 1467 para 8.

[392] Inquest transcript, 16 March 2022, Vol 413, page 44549.

pneumonia. Four of the deceased were significantly underweight or emaciated at the time of their deaths.

259 Precious Angels was established in two houses, following attempts to establish the NGO in an old nurses' home that turned out to be condemned. The houses were inappropriate for the care of MHCUs to start with and conditions worsened quickly.

260 On 22 February 2016, Ms Ncube attended her second meeting with the Department, co-chaired by Dr Manamela and Nonceba Sennelo, where the closure of the Life Esidimeni Baneng facility was discussed. During the meeting, Dr Manamela had a spreadsheet outlining the requirements for NGOs, specifying that each facility needed a specific number of caregivers and professional nurses. According to the spreadsheet, 150 beds were allocated to Ms Ncube's NGO, which was supposed to be situated in Kalafong. At this time, Ms Ncube had no actual beds nor staff.[393]

261 Ms Ncube was paired with Carina Morale from Tshepong. Dr Manamela instructed Ms Ncube and Ms Morale to visit Kalafong Hospital to enquire about acquiring beds. At this point, Ms Ncube had no knowledge of the level of care that MHCUs received at Life Esidimeni, nor did she have any understanding of how to establish or operate a 24-hour care centre.[394]

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[393] Ethel Ncube statement, Vol 005, page 1465-6 and NGO and Department meeting minutes, 22 February 2016, Vol 005, page 659.

[394] Ethel Ncube statement, Vol 005, page 1466 para 5.

262 Ms Ncube was allocated the old nurses' home at Kalafong Hospital from which to operate her NGO. After Kalafong was inspected and assessed by engineers, it was found to be unsuitable for human habitation. Ms Ncube was advised by Ms Jacobus at a meeting in Kalafong that she should seek alternate housing. Ms Ncube was aware that it would be difficult to establish housing for 150 MHCUs but states that she was informed by Ms Jacobus that she could get two different houses under one name. The urgency around procuring these facilities was conveyed to Ms Ncube as no other NGOs were willing to receive these MHCUs.[395]

263 Ms Ncube approached her uncle, Themba Mathebula, to use his Danville property to accommodate some of the MHCUs. Frans Thobane, Hannah Jacobus and Rochelle Gordon met with Mr Mathebula to assess the home, after which they indicated that it could accommodate 39 MHCUs. Furthermore, they suggested that if the garage is converted into a room, Ms Ncube would then be able to accommodate half of the MHCUs allocated to her, suggesting that 36 MHCUs would be accommodated in the converted garage of Mr Mathebula's Danville property.[396]

264 Ms Ncube said that she understood that the Danville property had been certified compliant as a result of the assessment conducted by the Department.[397] She acquired cot beds for the children she was expecting to receive.

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[395] Ethel Ncube statement, Vol 005, page 1466 para 6.

[396] Ethel Ncube statement, Vol 005, page 1467.

[397] Ethel Ncube statement, Vol 005, page 1467.

265 Ms Julia Mamatshele a care worker at Precious Angels from June 2016, was responsible for caring for MHCUs, cooking, feeding, bathing, changing clothes, diapers, and linen. She was also in charge of maintaining cleanliness in the premises and MHCUs' rooms. In her affidavit, she reveals that the food provided was often insufficient, and there were instances when the MHCUs had to share their lunch during supper. She states that all of the MHCUs were served regular food and none was on a special diet. Additionally, she confirms that Precious Angels lacked essential medical equipment such as wheelchairs, scales, blood pressure machines, surgical gloves, and thermometers.

266 On 20 July 2016, by which time seven MHCUs had died, Dr Manamela instructed Nonceba Sennelo and Sophie Lenkwane to visit Precious Angels, after Ms Ncube informed them about the death of Christopher Makhoba,[398] in a meeting held at Weskoppies.[399] A report was compiled,[400] which found significant deficiencies in the Atteridgeville property.[401] These included that there were 15 female MHCUs at the property with three in one room and 12 in another, in cot beds that were placed very close together. There was one toilet used by the staff as most of the MHCUs used nappies. Patient care was poor with three care workers who needed training on basic care and were just observing the MHCUs. There was no emergency equipment.

[398] Inquest Transcript, 7 February 2022, Vol 413, page 42308.

[399] Inquest Transcript, 22 November 2021, Vol 413, page 40475.

[400] Report on NGO support visits, Vol 005, page 582.

[401] Report on NGO support visits, Vol 005, page 586-8.

267 In her statement and again in testimony, Sophie Lenkwane confirmed that she found adults in cots beds and others on plastic mattresses without any blankets in the middle of winter. She testified that there was no food at the centre, except one or two cabbages.[402] Ms Ncube gave a menu of what users ate, based on the menu they were provided with by the Department,[403] but there was no evidence that the users in fact ate according to the menu.

268 Nonceba Sennelo immediately called Dr Manamela, "informed Dr Manamela about the challenges and recommended that the facility be closed as a matter of urgency"[404] and that the users could not be left in such a situation. Dr Manamela reportedly responded by saying that the MHCUs had nowhere to go if they closed Precious Angels.[405]

269 The report was submitted to Dr Manamela, who sent Hannah Jacobus and Frans Thobane for a second opinion following Nonceba Sennelo and Sophie Lenkwane's findings[406]

270 Between the initial visit by the Mental Health Directorate and the investigation by Hannah Jacobus and Frans Thobane, Seipati Pilane died on 22 July 2016.[407]

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[402] Sophie Lenkwane statement, Vol 005, page 356 and Inquest Transcript, 9 Feb 2022, Vol 413, page 40591.

[403] Inquest Transcript, 2 August 2022, Vol 413, page 48179.

[404] Inquest Transcript, 9 Feb 2022, Vol 413, page 40581.

[405] Sophie Lenkwane statement, Vol 005, page 356.

[406] Precious Angels visitation report, Vol 005, page 856.

[407] Death certificate of Seipati Pilane, Vol 042, page 7744.

271 On 28 July 2016, Hannah Jacobus and Frans Thobane conducted an audit and completed a checklist on both properties[408] It was found that users only had their beds for personal space. The professional nurse would come on certain days and for emergencies, if she is available.[409] Users are not grouped according to their individual needs, there are no individuals progress reports, users are kept indoors throughout the day and night, and staff is not trained in basic first aid techniques.[410] There is no emergency equipment.[411]

272 Frans Thobane also noted that there were cot beds (as did Ms Jacobus)[412] and there was not enough linen and blankets. Mr Lehau, who was present during the visit, provided blankets to the NGO. In oral testimony, Hannah Jacobus admitted that the visitation report of 20 July 2016 showed that the Atteridgeville property was wholly inadequate to care for MHCUs[413] and that the health and lives of MHCUs were at risk due to the conditions at Precious Angels.[414] It was agreed that users ought to be removed immediately.[415] However, it would be months before the NGO was shut down.

[408] Audit checklist, Vol 200, page 20423.

[409] Audit checklist, Vol 200, page 20424.

[410] Audit checklist, Vol 200, page 20425.

[411] Audit checklist, Vol 200, page 20426.

[412] Inquest Transcript, 19 January 2022, Vol 413, page 41677.

[413] Inquest Transcript, 19 Jan 2022, Vol 413, page 41468.

[414] Inquest Transcript, 19 Jan 2022, Vol 413, page 41693.

[415] Khalaeng Thobane statement, Vol 005, page 368.

Ms Ncube knew that she was operating without a license

273 Precious Angels was issued with two licences in the course of the project. Both licenses were for 150 people with severe to profound intellectual disability, each ostensibly dated 1 April 2016. One licence was signed by Dr Manamela for premises located at Lynwood Road, Tigervally, Pretoria.[416] The license was signed by Dr Manamela and granted to Ms Ncube for a Child Residential Facility before Ms Ncube could receive her NPO certificate.[417] The other licence is signed by Dr Selebano for operations located at Kalafong premises.[418] This is despite the hospital facility already having been declared unsuitable. Dr Selebano testified that he signed the license this after talking to the Ombud at the end of 2016.[419] Precious Angels never operated in either location. Ms Ncube admitted that she never received licences for the locations she operated from.[420]

Ms Ncube collected MHCUs multiple times, knowing that she could not care for them and the help from the Department was not coming

274 On 23 June 2016, Ms Ncube received a call from Salome Mashile from the Gauteng Department of Health to come and fetch the MHCUs from the facility.

275 Ms Ncube had no professional staff in her employ at the time and arrived at Life Esidimeni with a family friend. Ms Ncube met with Nonceba Sennelo, Sophie Lenkwane and Mr Mogale. The MHCUs were already seated in an EMS bus.

[416] Mental health license Precious Angels, Vol 200, page 20326.

[417] Ethel Ncube statement, Vol 005, page 1467 para 7.

[418] Mental Health License Precious Angels, Vol 300, page 30411.

[419] Inquest Transcript, 13 September 2022, Vol 413, page 49412.

[420] Inquest Transcript, 2 Aug 2022, Vol 413, page 48204.

There were 22 male MHCUs, each with a set of clothing, a summary of their files, and a container with a toothbrush and wash rag. The MHCUs were all given medication to last 28 days. Mr Nofile, an employee at Precious Angels, corroborated this by affirming that the MHCUs were transported under the supervision of Ms Ncube and, as far as he knew, had their medical files, prescriptions, medications, SASSA cards, and identification books with them.[421]

276 When MHCUs arrived at the Danville property, Ms Ncube was aware that she did not have access to a dietician, occupational therapist, or a professional nurse to adequately provide care to the MHCUs who had become her responsibility. No professional help was forthcoming from the Department. When Ms Ncube enquired from Ms Jacobus, she was told to continue admitting the MHCUs.[422]

277 The MHCUs stayed in Danville for two weeks without being assessed by anyone from the Department.

278 On 28 June 2016 Ms Ncube arrived at Randfontein to collect a second group of MHCUs. She was allocated 11 male MHCUs that were already seated in the EMS buses at the time of her arrival. There were also an additional three MHCUs from Rebafenyi who were sent to Precious Angels. Ms Sennelo explained to Ms Ncube that she should take these MHCUs and Rebafenyi will fetch them from her. The 11 MHCUs that Ms Ncube picked up from Randfontein were psychiatric MHCUs and did not meet the (amended) criteria she requested. Ms Ncube raised this concern with Mr Mohale who then referred her to Dr Lenkwane. Dr Lenkwane

[421] Mahlatsi Nofile statement, Vol 041, page 7698 para 3.

[422] Ethel Ncube statement, Vol 005, page 1468 para 9.

reassured her that if she takes the MHCUs the Department will assist her when the time comes for her to swap the adults with the children. Again, the Department did not send anyone to assess the MHCUs, hence Ms Ncube went to Bophelong to seek assistance with the assessment of MHCUs and to take their vital signs.[423]

279 By 28 June 2016, Ms Ncube had received 36 male MHCUs to reside in the Danville property.

280 Sometime after Ms Ncube received MHCUs from Randfontein, she was approached by Mr Frans Thobane, who requested her assistance in procuring a second house. This second house was intended to accommodate female MHCUs from Anchor House in Cullinan as Anchor House was accommodating males and females together in one room. Ms Ncube sought the involvement of Mr Thobane, Ms Jacobus, and Ms Gordan to speak with her uncle, Ernest Ncube, who owned a house at 19 Mosalo Street in Atteridgeville. The officials from the Department urged Mr Ncube to assist, stating that this arrangement would not be a permanent solution and that the MHCUs would eventually be relocated to a facility in Lynwood.

281 After obtaining consent from her uncle, made preparations for the new location using cot beds from Kalafong, as those were the only beds she had access to at the time. The cot beds, intended for children, were to be used to accommodate

[423] Ethel Ncube statement, Vol 005, page 1468 para 10.

adult MHCUs. Ms Ncube did not carry out any renovations, but she believed that this was not necessary because the MHCUs were bedridden.[424]

282 On 29 June 2016, Ms Ncube received a phone call from Ms Jacobus, instructing her to collect the MHCUs from Cullinan Care and Rehabilitation Centre. Shortly after Ms Jacobus' call, Dr Manamela also contacted Ms Ncube, emphasizing the urgency of retrieving the MHCUs before the arrival of Ms Mahlangu and Dr Selebano. Dr Manamela informed Ms Ncube that failure to collect the MHCUs promptly would result in job loss for all of them.[425]

283 Ms Ncube arrived at CCRC and was accompanied by Dorothy Franks, who guided her to the correct ward where the MHCUs were located. It was at this point that Ms Ncube witnessed a confrontation between Dr Manamela and Ms Jacobus regarding a particular mental health care user, later identified as Virginia Machpelah. Ms Jacobus reminded Dr Manamela that this mental health care user was related to a lady who had caused significant problems during meetings.[426]

<u>What makes Ms Ncube different to other NGO owners.</u>

284 Precious Angels saw the highest number of deaths of any of the NGOs. This very high death rate is linked to the particularly bad conditions at Precious Angels and the conduct of Ms Ncube in creating those conditions.

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[424] Ethel Ncube statement, Vol 005, page 1468 para 13.

[425] Expert Panel Report, Vol 412, page 37843.

[426] Ethel Ncube statement, Vol 005, page 1469 para 13.

285 The full document reflecting the dates and causes of deaths at Precious Angels is available in the record[427] but the key information is worth replicating here:

Docket	First name	Surname	Transfer date	Transferred from	Date of death	Cause of Death on post-mortem
4	Christopher	Makhoba	23-Jun-16	Randfontein	03-Jul-16	
3	unknown	female	23-Jun-16	Randfontein	06-Jul-16	Malnutrition complicated by bronchopneumonia
2	Siphiwe	Makhunga	23-Jun-16	Randfontein	12-Jul-16	Bronchopneumonia
8	Julia	Tshawe		Anchor	12-Jul-16	
10	Eric	Mashiloane	23-Jun-16	Randfontein	18-Jul-16	Natural causes
14	Saraphina	Ngcobo	06-Jul-16	Anchor	18-Jul-16	
75	Elizabeth	Botha	06-Jul-16		19-Jul-16	
5	Seipati	Pilane	29-Jun-16	Anchor	22-Jul-16	
17	Jeremiah	Modise	06-Jul-16	Randfontein	24-Jul-16	
13	Christina	Herbst	06-Jul-16	Anchor	4-Aug-16	
18	Solly	Mashego	23-Jun-16	Waverley	6-Aug-16	
12	Daniel	Josiah	23-Jun-16	Randfontein	8-Aug-16	Necrotising pneumonia
9	Terrence	Chaba	23-Jun-16	Randfontein	15-Aug-16	Bronchopneumonia
7	Virginia	Machpelah	29-Jun-16	Anchor	15-Aug-16	Unascertained
16	Matlakala	Motsoahae	29-Jun-16	Anchor	26-Aug-16	
1	Magdalena	Viljoen	06-Jul-16	Anchor	1-Sep-16	Consistent with lobar pneumonia
11	Lucky	Maseko	23-Jun-16	Randfontein	3-Sep-16	Asphyxial death due to food aspiration
6	Siphiwe	Thabethe			13-Nov-16	
15	Julian	Peterson			6-Dec-16	No PM but pneumonia on notice of death
43	Soma	Dlamini			30-Jan-17	No PM but multi lobar pneumonia on notice of death

286 Ms Ncube repeatedly collected MHCUs and took them into her care (22 on 23 June 2016; 11 plus an extra three on 28 June 2016; 20 on 29 June 2016) despite not having the facilities, staff or assistance that would be required to care for them. Almost half of the MHCUs who were moved to Precious Angels died.

[427] Date of deaths at Precious Angels, Vol 417, page 37552.

MHCUs died of pneumonia, asphyxiation and malnutrition. A number of them were emaciated when they died.

287 Ms Ncube entered into a Service Level Agreement[428] with the department, fully aware of the responsibilities it entailed. An "NB" was marked next to residential care on page 34 of the SLA.[429]

288 Despite knowing what her responsibilities were, she took on MHCUs who she was not qualified to care for, had insufficient staff to care for, into inadequate facilities, with insufficient food and medicine and blanket shortages, without a license that enabled her to operate. Ms Ncube's conduct exceeds that of the other NGO owners and she should be held liable for the deaths that occurred in her care.

<u>Ms Ncube caused the deaths of at least five MHCUs</u>

289 Without Ms Ncube's actions and omissions, the deaths of Virginia Machpelah, Christopher Makhoba, Terrence Chaba, Daniel Josiah and Matlakala Motsoahae would not have occurred. In particular:

289.1 Ms Ncube did not have, and knew that she did not have, the requisite expertise of experience, either herself or in her staff, to care for adult MHCUs, some of whom had mental illnesses, some of whom had intellectual disabilities, and some of whom had physical illnesses. Despite this, she accepted these MHCUs in three separate groups.

[428] Annexure of minimum services to be provided, Vol 200, page 20167-20168.

[429] Annexure of minimum services to be provided, Vol 200, page 20167.

289.2 Ms Ncube did not have a property at which to run her NGO and eventually managed to borrow two houses from her uncles, neither of which were suitable for accommodating MHCUs. The MHCUs were confined to their beds (for the women these were cot beds, intended for children. The beds were so close together that the door to the room and the cupboard doors could not move. There was no hot water.

289.3 Ms Ncube did not have enough food for the MHCUs, resulting in meals being reduced and the same food being fed to all, despite different dietary needs. Four of the 10 MHCUs we focus on died emaciated and one died with food that appeared to have been forced down her throat.

289.4 Three of the MHCUs died with gangrene or bedsores, clearly indicating inadequate care.

290 If the Court is to substitute reasonable conduct for the conduct of Ms Ncube described above, in line with the test for factual causation laid out above, the deaths would not have occurred. The deaths could not have occurred without Ms Ncube's conduct and to hold otherwise would be unjust.

291 In relation to legal causation, there was a sufficiently close connection between the conduct of Ms Ncube and the five deaths. The MHCUs particularly vulnerable and yet Ms Ncube housed them in conditions that made their suffering and deaths probable and failed to act quickly enough or at all when she could have saved their lives. The conduct meets the adequate cause test.

292 Finally, public policy and the legal convictions of the community require that conduct such as Ms Ncube's, that so directly precipitated deaths, be punished criminally.

293 Ms Ncube's conduct therefore meets the tests for factual and legal causation and she is prima facie responsible for the deaths of the five MHCUs listed above in these submissions who died under her care.

E. THE DEATHS ATTRACT CRIMINAL LIABILITY

294 Deaths were the inevitable result of the recklessness of Ms Mahlangu, Dr Manamela and Ms Ncube. The deaths that occurred were neither normal nor natural.

295 In this section we deal first with the argument that the deaths were to be expected in the population. We then consider the 10 MHCUs whose deaths can be attributed to the conduct of Ms Mahlangu, Dr Manamela or Ms Ncube.

The deaths were not normal

296 During the course of the Inquest, a number of implicated persons provided their opinion that mental health care user have generally high mortality rates and the deaths at the NGOs were not unusual. The cross examination of Dr Mkhatshwa by Advocates Phihlela and Prophy[430] resulted in the legal team representing Life Esidimeni uploading death statistics to show the deaths in context. That together

[430] Inquest Transcript, 7 June 2022, Vol 400, page 47927.

with the evidence of Prof Robertson which we set out below, refutes the suggestion that the deaths of 141 MHCUs was to be expected.

297 The evidence of Prof Robertson shows that the mortality rates in the NGOs were far from normal. Prof Robertson testified about the work of the Expert Panel whose investigation into the deaths was requested by the Health Ombud. The purpose of the Expert Panel investigation was to determine the truth, in as far as it could be ascertained, in relation to the facts, contributory factors and causes of death as well as the circumstances surrounding the deaths of 36 MHCUs who were identified.[431]

298 The Expert Panel deals generally with mortality rates in its report, explaining that mortality rates tend to be higher amongst people with mental illness than the general population.[432] The cause of death is usually comorbid chronic medical illness, including cardiovascular disease, respiratory, disease, diabetes mellitus, stroke and cancer. As smoking, sedentary lifestyles and poverty are more common amongst people with mental illness, increased mortality rates may also be attributed to these factors. Epilepsy and dementia are independently associated with an increased mortality risk, particularly in low-and middle-income countries and amongst the poor. The higher death rate is attributable to status epilepticus, drowning, burns secondary to seizures, and suicide.

299 In addition, the report explains that the risk of premature mortality is worsened by comorbid mental illness and/or cognitive impairment. Dementia is more

[431] Expert Panel Report for Health Ombudsperson on the investigation around the circumstances of deaths of patients at NGOs, Vol 412, page 37830.

[432] Expert Panel Report, Vol 412, page 37843.

commonly associated with death amongst the elderly. Common causes of death include pneumonia, urinary tract infections, bedsores, deep venous clots and chronic medical conditions.

300 However, the Expert Panel also highlighted that mortality can be excessive when there is poor help-seeking and poor clinical management. Lower rates of preventative and interventional medical procedures amongst the mentally ill contribute to the increase in mortality. Further that excess mortality amongst psychiatric MHCUs specifically after deinstitutionalisation or discharge from long term mental health care has been documented clearly in several countries. The vulnerability of these MHCUs means that extra care and attention should be paid to their physical as well as mental health, with accessible psychiatric and medical health care. Particularly close follow up is needed in the first 1 – 2 years after discharge from hospital.[433]

301 Using the information collected by the data verification team of the Department, Prof Robertson *et al* has been able to describe mortality among the MHCUs who were transferred out of Life Esidimeni between October 2015 and June 2016. Prof Robertson also collaborated with the Health Ombud in writing a published article based on the work of the Expert Panel and the Ombud's final report. The article asks and answers two questions, one of which related to the difference between the mortality rate of the Life Esidimeni cohort transferred and the general population in 2016:[434]

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[433] Life Esidimeni Clinical Record, Vol 009, page 2667.

[434] Mortality of people with severe mental illness transferred from long-stay hospital to alternative care in the Life Esidimeni tragedy, CJ Robertson and MW Makgoba, SAMJ 2018; 108(10): 813-817, Vol 412, page 37881.

301.1 The assessment of mortality used two measures: the age-adjusted death rate and the standard mortality ratio (SMR). The death rate reflects the number of deaths per 1000 population that would have occurred if people of the same age groups had died at the same rate as the study population over the same time period. The SMR is a ratio of the mortality in the study population (the observed deaths) to that in the general population (the expected deaths) over the same time period. The variables/ factors that were considered, using different models were:

301.1.1 Comparison of age at transfer between genders

301.1.2 Median survival rates between gender and transfer destination

301.1.3 Factors associated with mortality, which included age at transfer, gender and transfer destination.

301.2 The results are an age-adjusted death rate of 63/1000 among MHCUs transferred from Life Esidimeni to alternative facilities, which is almost 8 times the death rate of 8/1000 for the general population in 2016. The SMR was also significantly higher for all age groups, except people above 80, and was considerably higher for women than for men. The reason for the higher SMR among women is that they were older and

a significant number of them were not transferred to specialized hospitals – Weskoppies and Sterkfontein.[435]

302 An important factor in the survival rate in the Life Esidimeni cohort was where the users were transferred. Those transferred to specialised hospitals had a higher survival rate than those transferred to NGOs/CCRC, which "implies that inadequate care for the frailty of the MHCUs at CCRC and NGOs was the main cause of the high mortality in our cohort."[436]

303 In essence, the study found quantitative evidence of an excessively high mortality among MHCUs transferred from Life Esidimeni to CCRC and NGOs. Prof Robertson's evidence was not challenged by other expert evidence.

The death of Virginia Machpelah

304 Virginia Machpelah (docket 7) was born on 8 January 1966 and died 15 August 2016 at Precious Angels,[437] at the age of 50. She had dementia,[438] was wheelchair bound and could not communicate verbally.[439] Ms Machpelah was not on medication.[440] She just needed care.

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[435]Mortality of people with severe mental illness transferred from long-stay hospital to alternative care in the Life Esidimeni tragedy, CJ Robertson and MW Makgoba, SAMJ 2018; 108(10): 813-817, Vol 412, page 37883.

[436] Mortality of people with severe mental illness transferred from long-stay hospital to alternative care in the Life Esidimeni tragedy, CJ Robertson and MW Makgoba, SAMJ 2018; 108(10): 813-817, Vol 412, page 37884.

[437] Notice of death, Vol 009, page 2655.

[438] Patient notes, Vol 009, page 2685.

[439] Patient evaluation, Vol 009, page 2659.

[440] SECTION27 letter, 1 September 2016, Vol 200, page 18176.

305 Ms Machpelah's death can be attributed to the recklessness of Ms Mahlangu, Dr Manamela and Ms Ncube.

306 Ms Machpelah had been at Life Esidimeni Rand West[441] for two years[442] before she was moved in a bus to Anchor Centre and then transferred to Precious Angels. This is despite a periodical report of 5 March 2015[443] advising that Ms Machpelah should not be discharged to an NGO, because she was "severely, cognitively impaired".[444] The report further noted that Ms Machpelah would continue to need assistance with her daily living activities.[445]

Ms Machpelah's transfer

307 Ms Machpelah was transferred to Anchor Centre on 29 June 2016,[446] with over 14 other MHCUs, at around 6pm.[447] Hannah Jacobus was present that day expecting to assist Anchor Centre with the admission of 14 MHCUs. However, when she went onto the bus, Ms Jacobus noted that there were more users than expected. She called Dr Manamela who informed her to take the 14 users expected for Anchor and leave the rest on the bus and that she was on her way.[448]

[441] Patient information, Vol 009, page 2684.

[442] Periodical report on patient, Vol 009, page 2664.

[443] Periodical report on patient, Vol 009, page 2664.

[444] Periodical report on patient, Vol 009, page 2665.

[445] Periodical report on patient, Vol 009, page 2666.

[446] Dorothy Franks statement, Vol 009, page 2679.

[447] Mental health facilities List, Vol 407, page 36604.

[448] Inquest Transcript, 19 January 2022, Vol 413, page 41484.

308 Christine Nxumalo, the sister of the late Virginia Machpelah, received a text message from the Gauteng Department of Health on 30 June 2016 informing her that her sister would be relocated to Cullinan Care Centre.[449] However, Ms Nxumalo later discovered that her sister had not been moved to Cullinan but to Anchor Home and then to Precious Angels. Ms. Nxumalo was neither informed of her sister's relocation nor aware of the date when the move took place.

309 Ms Machpelah arrived at Precious Angels at the Atteridgeville property on the evening of 29 June 2016, with her medical history and no medication, as she was not on treatment. Ms Ncube describes Ms Machpelah as being in a wheelchair and not having the ability to talk and move on her own.[450] However, she testified that she was not aware that Ms Machpelah had Alzheimer's.[451]

310 The Department made site visits to Precious Angels, finding the facility wholly inadequate. The audit checklist dated 28 July 2016,[452] almost three weeks before Ms Machpelah's death, records that there were insufficient rooms to cater for the number of MHCUs and beds were very close together. MHCUs were confined to their beds. The staff members were used for all functions including care work, security, cooking and cleaning. Staff was not trained for either the mental or the physical care of adults, including care to prevent pressure sores or training in first aid. There were not enough tables and chairs for MHCUs to use at meal times or during leisure time. There was no hot water. There was no form of patient

[449] Christine Nxumalo statement, Vol 009, page 2598.

[450] Ethel Ncube statement, Vol 009, page 2602.

[451] Inquest Transcript, 3 August 2022, Vol 413, page 48722.

[452] Audit report, Vol 200, page 20423.

identification. Mental health users were not grouped according to need. There was no admissions register for MHCUs and no evidence of a daily roll call. MHCUs had not been receiving medication after it ran out. There was no equipment to monitor vital data or administer oxygen and no first aid box. The facility was dirty and smelly and the MHCUs were dressed in clothes that were not warm enough. There were not enough toothbrushes and facecloths for there to be one per person.

311 Despite the findings of the visitation report, audit checklist and inspection form, and calls for urgent intervention, Dr Manamela did not ensure that MHCUs were removed from Precious Angels.

Ms Machpelah's death

312 Ms Machpelah was at Precious Angels for just under two months before she died at Precious Angels on 15 August 2016.[453]

313 Ten days after her death, on August 25, her sister, Ms. Nxumalo, was informed by Ms. Ncube that Ms. Machpelah had died. Ms. Ncube mentioned that Precious Angels did not possess any contact information for Ms. Machpelah's family. Furthermore, Ms. Ncube stated that Ms. Machpelah's death was attributed to "stimulation treatment." Ms. Nxumalo managed to collect her sister's body on August 30, 2016, and transported it to Sefako Makgatho Health Sciences University for an autopsy.[454]

[453] Notice of death, Vol 009, page 2672.

[454] SECTION27 letter to Ms Mahlangu, 1 September 2016, Vol 200, page 19176.

314 While the immediate cause of death could not be ascertained at autopsy, the post-mortem findings revealed severe malnutrition, dehydration and gangrene on both legs.[455]

315 Dr Talatala confirms that Ms Machpelah was emaciated at a weight of 35kg and a height of 1,5m giving a BMI of 15,56.[456] Ms Ncube testified that she would not have been able to tell the difference of Ms Machpelah's weight loss from the day of arrival to date of death.[457]

316 Dr Onoya testified that Ms Machpelah's death ought to be considered in the context of neglect. This is because there was food present in her oesophagus, which appeared to have been pushed down her throat. In her state, Ms Machpelah would have been too weak to chew and would have required nasal feeding, a feeding mechanism that was not available at Precious Angels. Dr Onoya testified that while the immediate cause of death could not be determined, the prominent cause of death can only be linked to her dehydration and emaciation.[458] He elaborated, saying that gangrene, necrosis and dehydration contributed to the death.[459] Dr Onoya's description of sunken eyes being indicative of dehydration was supported by Dr Makhoba who said that sunken 'orbits' will tell you about the general hydration status of the deceased. Prof

[455] Post-mortem report, Vol 009, page 2616.

[456] Decision by review board, Vol 412, page 37369 –70.

[457] Inquest transcript, 3 August 2022, Vol 413, page 48724.

[458]Inquest Transcript, 8 August 2022, Vol 413, page 47397.

[459] Inquest Transcript, 22 February 2022, Vol 413, page 47419.

Tintinger in oral testimony has posited that the underlying cause of death is probably more important than the immediate cause of death.[460]

317 From the date of arrival to her date of death, Ms Machpelah was exposed to conditions of neglect. Dr Talatala's evidence confirms that Ms Machpelah's physiological condition was particularly vulnerable and her placement at Precious Angels was not suitable and was in fact a reckless act in light of the recommendation of the periodical report.[461] Her condition (dementia) would have meant that she needed to be reminded about meals and to stay hydrated.[462] Ms Machpelah's gangrene would have started with pain in her legs, and she would not have been able to express that she is feeling pain. She would require nursing care by a team who is familiar with her.[463] Dr Talatala also testified that if she had had gangrene at Life Esidimeni, this would have been recorded on the Life Esidimeni notes, suggesting that it began at Precious Angels. Dr Talatala concludes that the Life Esidimeni treating team who had advised against her discharge to an NGO, had anticipated the risks Ms Machpelah would have been exposed to if she were placed at an NGO.[464]

318 A total of six MHCUs died at Precious Angels before Ms Machpelah on 15 August 2016.[465] Ms Ncube signed the Service Level Agreement on 16 August 2016,[466] the day after Ms Machpelah's death. When asked under cross-examination

[460] Inquest Transcript, 25 March 2022, Vol 413, page 44678.

[461] Dr Talatala report, Vol 412, page 37501.

[462] Dr Talatala report, Vol 412, page 37501.

[463] Inquest Transcript, 16 March 2022, Vol 413, page 44240-1.

[464] Dr Talatala report, Vol 412, page 37501.

[465] Corrections to Mrs Ndlovu's statements, Vol 412, page 37521.

[466] Agreement between Precious Angels and Gauteng provincial Department, Vol 200, page 20035.

whether she had a responsibility to ensure that MHCUs under her care were properly taken of, not only in terms of food but also medically, Ms Ncube could only respond that she had asked for assistance from Bophelong Clinic and got her nurse friend to come do the vital signs for the MHCUs.[467]

319 The point, as clearly stated in Dr Talatala's evidence, was that if Ms Machpelah was properly cared for and if she was monitored properly, should have been taken to a hospital to check the gangrene so that a surgeon could amputate the leg, for example. The fact that she was not taken to hospital is indicative of negligent care.[468]

The legal cause of Ms Machpelah's death

320 Ms Machpelah's death was unnatural.

321 She was moved from Life Esidimeni despite her periodical report saying she should not be discharged to an NGO and needed assistance with her daily living activities. She was moved at night from one NGO to another in a big group without the knowledge of her family. She died weeks after two reports, which were communicated to Dr Manamela, found that the conditions at the NGO were terrible and not suitable for MHCUs.

322 She died emaciated, with severe malnutrition, dehydration and with gangrene on both legs. Dr Onoya found that the prominent cause of death can only be linked to these findings. She had not been taken to hospital, which would have saved

[467] Inquest Transcript, 3 August 2022, Vol 413, page 48728.

[468] Inquest Transcript, 3 August 2022, Vol 413, page 48729

her life. On autopsy, food was found in her oesophagus, which appeared to have been pushed down her throat.

323 She was the 14th person to die at Precious Angels.

324 Ms Mahlangu and Dr Manamela created the circumstances in which Ms Machpelah's death was inevitable. She should never have been taken to an NGO and yet she was and the conditions of the NGO were known but nothing was done to prevent deaths. Ms Ncube failed to act to prevent Ms Machpelah's death by taking her to hospital when needed, and ensuring that she was eating and drinking. They should each be held to have caused Ms Machpelah's death.

The death of Christopher Makhoba

325 Mr Makhoba (docket 4) was born on 6 September 1970 and died on 3 July 2016 at the age of 45.[469] He was epileptic and intellectually disabled.[470] He was also wheelchair bound.[471]

326 Mr Makhoba's death can be attributed to the recklessness of Ms Mahlangu, Dr Manamela and Ms Ncube.

327 According to his prescription from Life Esidimeni dated 13 June 2016, Mr Makhoba was on haloperidol, Clonazepam, Epilim and Carbamazepine.[472] Dr

[469] Makhoba death certificate, Vol 041, page 7597.

[470] Notice of death certificate, Vol 041, page 7617.

[471] Inquest Transcript, 3 March 2022, Vol 413, page 45860.

[472] Makhoba medication list, Vol 041, page 7628.

Talatala's evidence, described in more detail below, was that this combination of medication alone indicates that Mr Makhoba required complex medical care.

328 He had been at Life Esidimeni Waverly for seven years before being transferred the Randwest facility on 31 May 2016, and finally to Precious Angels on 23 June 2016.[473] This is despite Mr Makhoba having been assessed by Dr Wadvalla on the day of his transfer, who recommended that Mr Makhoba not be discharged to an NGO because he is "frail, disabled and vulnerable. He needs 24-hour care".[474]

Mr Makhoba's transfer

329 Mr Makhoba was transferred to the Danville property of Precious Angels on 23 June 2016,[475] with 21 other male MHCUs.[40] Ms Ncube went to collect them at Randfontein, and found the MHCUs already waiting beside the EMS bus.[476] She notes that every user had 28 days of medication, a change of clothes, toiletries, and a summary of their medical records. Ms Ncube admitted that she was not ready to receive the MHCUs, because she had not received support from the Department of Health. She took the users anyway. In fact, 5 days later, on 28 June 2016, she took a further 11 male MHCUs.[477]

[473] Makhoba patient information, Vol 041, page 7673.

[474] Makhoba transfer form, Vol 041, page 7632.

[475] Makhoba patient notes, Vol 041, page 7629.

[476] Inquest Transcript, 3 August 2022, Vol 413, page 48670.

[477] Inquest Transcript, 3 August 2022, Vol 413, page 48672.

330 While Mr Makhoba was assessed by Dr Wadvalla before he left Life Esidimeni,[478] he was not assessed when he arrived at Precious Angels. At the time, Ms Ncube had no professional nurse, dietician, or occupational therapist.[479] Despite promises from Hannah Jacobus that a medical team would assess the MHCUs upon arrival at the NGO, there was no such team present on the day. Ms Ncube stated (although Ms Jacobus denied)[480] that Hannah Jacobus informed Ms Ncube that the Department was busy and that she must admit the users in the meantime.[481]

Mr Makhoba's death

331 Mr Nofile testified that Mr Makhoba started to not eat well a few days after his arrival at Precious Angels. When he would refuse to eat, Sister Julia from Bophelong Clinic would feed him with a syringe, after making his food fine with her hands.[482] Mr Nofile explained that "he was refusing to open his mouth and we had to hold his hands and force his mouth open so that Sister Julia could feed him food with a syringe."[483]

332 Ms Makhoba began losing significant amounts of weight and exhibited aggressive behaviour when his medication supply was low.[484] Prof Robertson

[478] Makhoba patient notes, Vol 041, page 7629.

[479] Ethel Ncube statement, Vol 005, page 1468.

[480] Inquest Transcript, 2 February 2022, Vol 413, page 45956.

[481] Ethel Ncube statement, Vol 005, page 1468.

[482] Inquest Transcript, 2 February 2022, Vol 413, page 45961.

[483] Inquest Transcript, 2 February 2022, Vol 413, page 46019.

[484] Mahlatsi Nofile statement, Vol 041, page 7699 para 5.

stated “I do [not] think any of our NGOs can manage a disruptive user or any user who does not willingly take their treatment when it is given to them.”[485]

333 Mr Nofile asserts that Ms Ncube was informed about Mr Makhoba’s condition, but she failed to take him to the hospital for necessary treatment.[486]

334 According to care worker Julia Mamtshele, there was not enough food at the centre and the type of food available did not follow a special diet. Further, there was no medical equipment like blood pressure machines, wheelchairs and thermometers.[487] Another care worker, Nontlantla Eunice Ndlovu, corroborates the conditions at Precious Angels at the time, Mr Makhoba’s weight loss, and adds that Mr Makhoba’s wheelchair was taken away from the NGO on the day he arrived.[488] She states that she made multiple calls to Ms Ncube, expressing her concern that Mr Makhoba needed medical attention and should be taken to a medical facility. In response, Ms Ncube allegedly stated that they are all adults and should figure out a plan.[489]

335 When Mr Makhoba’s condition deteriorated a few days after his arrival at Precious Angels, Ms Ncube was informed several times that he needed medical attention.[490] Ms Ncube called a private doctor, but he was never taken to hospital.

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[485] Inquest Transcript, 25 May 2023, Vol 424, page 54079.

[486] Mahlatsi Nofile statement, Vol 041, page 7699 para 5.

[487] Mamatshele statement, Vol 041, page 7696.

[488] Mamatshele statement, Vol 041, page 7696.

[489] Nontlantla Ndlovu statement, Vol 041, page 7694.

[490] Eugenia Modipa statement, Vol 041, page 7667.

336 On the evening of 2 July 2016, Nontlantla Ndlovu found Mr Makhoba lying on ground and took him back to bed. Around 2am the following morning, she found him on the ground again, gasping for air and placed him on a sponge mattress.[491] He was found cold and unresponsive in the early morning hours of 3 July 2016.[492] Ms Julia Mamatshele checked Mr Makhoba's vital signs. After Mr Makhoba was pronounced dead, she proceeded to bathe his body and dress him.[493] The other careworkers on duty were Tshegofatso Tefo, Mathlatsi Nofile, Thabo and Zinhle.[494]

337 Mr Makhoba was the first mental health care user to die at Precious Angels,[495] two weeks after his transfer. Under cross-examination, Ms Ncube denied that she was ever notified about Mr Makhoba needing urgent medical attention,[496] and stated that when she was notified about someone's ill health, she would call an ambulance.[497] There were no medical assessments during Mr Makhoba's stay at Precious Angels.[498]

338 Dr Talatala testified that Mr Makhoba was a complicated mental health care user who needed specialised care. He was being treated for mental retardation with

[491] Nontlantla Ndlovu statement, Vol 041, page 7695.

[492] Inquest Transcript, 2 February 2022, Vol 413, page 45963-4.

[493] Julia Mamatshele statement, Vol 041, page 7696 para 3.

[494] Nontlantla Ndlovu statement, Vol 041, page 7695.

[495] Daphney Ndhlovu corrected statement, Vol 412, page 37521.

[496] Inquest Transcript, 2 August 2022, Vol 413, page 48705.

[497] Inquest Transcript, 3 August 2022, Vol 413, page 48714.

[498] Ethel Ncube statement, Vol 005, page 1468.

epilepsy, and from the combination of the medication he had been prescribed, it appears to have been difficult to treat the epilepsy.[499]

339 Dr. Talatala, in his expert report, notes that Epilim and Carbamazepine are anticonvulsants. The use of both these is complicated because they have drug-drug interactions with each other, resulting in their blood levels not corresponding to what one would expect if they were used individually. Therefore, their combination needs to be supervised by a doctor with experience in using these drugs. Mr. Makhoba was also taking clonazepam. A sudden withdrawal from any of these three medications would put Mr. Makhoba at risk of seizures. In addition to the above, Mr. Makhoba was prescribed Haloperidol, an antipsychotic used to treat psychosis and abnormal behaviour.

340 In Dr Talatala's affidavit, he highlights that Mr Makhoba's diagnosis of mental retardation, epilepsy, and the combination of medications he was on made him a complex patient requiring specialized psychiatric care.

341 Dr Talatala explained that the fact that Mr Makhoba needed feeding meant that he had to be under some sort of supervision. Without supervised feeding, Mr Makhoba may not eat and may die of hunger. Further if an institution accepts a mental health care user such as Mr Makhoba, his blood sugar levels must at least be monitored, because there is no other way to tell that he is hungry as it is unlikely that Mr Makhoba would communicate that he had not eaten enough. Basic medical equipment would be needed.[500] Ms Ncube admitted that Precious

[499] Inquest Transcript, 16 March 2022, Vol 413, page 44313.

[500] Inquest Transcript, 16 March 2022, Vol 413, page 44322.

Angels did not have a blood sugar monitor.[501] While a cause of death was not determined as there was no post-mortem, the pathologist (Dr Rossouw) deduced that the likely cause of death was linked Mr Makhoba's mental condition and questions whether his feeding was adequate since it was managed with a syringe.[502]

342 Dr Talatala concludes that the care at the NGO was of below expected standard or that the NGO did not have the care that Mr Makhoba needed.[503] Indeed, Mr Makhoba's periodical report indicated that he was not suitable for discharge to any NGO. Ms Ncube admitted that the MHCUs that were placed at Precious Angels should not have been placed there, and that specifically Dr Manamela and Hannah Jacobus were aware that the NGO was not capacitated to deal with psychiatric MHCUs.[504]

343 In his expert affidavit, Dr Talatala states that the type of care required for Mr Makhoba, in addition to specialized psychiatric care, is a team with experience in looking after individuals with intellectual disabilities, along with the patience and passion to do so. Dr Talatala emphasizes that any discharge to his family or to an NGO would have been risky and, if done, it would have to be executed with extreme caution.

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[501] Inquest Transcript, 3 August 2022, Vol 413, page 48719.

[502] Makhoba forensic report, Vol 041, page 7650.

[503] Inquest Transcript, 16 March 2022, Vol 413, page 44323.

[504] Inquest Transcript, 3 August 2022, Vol 413, page 48721.

344 Based on the evidence presented above, it is clear that Mr Makhoba required expert psychiatric care. A hospital with basic facilities would not have been able to accommodate his needs; therefore, an NGO would have been even more inadequate.

345 Ms Ncube conceded that Precious Angels could not offer Mr Makhoba the level of care he needed.[505]

The legal cause of Mr Makhoba's death

346 Mr Makhoba's death was unnatural.

347 He was moved from Life Esidimeni despite Dr Wadvalla's assessment on the day of his transfer recommending that he not be moved to an NGO. His complicated medication interactions alone would have made his care in an NGO impossible. Before Mr Makhoba's death, there had been no assessment of Precious Angels. He was in a big group of MHCUs moved to Precious Angels. Precious Angels did not have the facilities to properly feed Mr Makhoba and so he was force fed with a syringe. He lost a lot of weight but was not taken to hospital.

348 Mr Makhoba died unattended at night, despite having twice been found (in the twelve hours before his death) by the untrained staff at Precious Angels to be out of his bed and, in the second instance, gasping for breath.

349 Precious Angels was found, two weeks after Mr Makhoba's death, to be wholly inadequate for care of MHCUs.

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[505] Inquest Transcript, 3 August 2022, Vol 413, page 48718.

350 He was the first person to die at Precious Angels.

351 Ms Mahlangu and Dr Manamela created the circumstances in which Mr Makhoba's death was inevitable. He should never have been taken to an NGO and yet he was, and the conditions at the NGO were known but nothing was done to prevent deaths. Ms Ncube failed to act to prevent Mr Makhoba's death by taking him to hospital when needed, ensuring that his health was monitored, and ensuring that he had sufficient food. They should each be held to have caused Mr Makhoba's death.

The death of Terrence Chaba

352 Mr Chaba (docket 9) was born on 2 March 1988 and died on 15 August 2016 at Pretoria West Hospital,[506] at the age of 28. He was epileptic, had cerebral palsy, was intellectually disabled, and was confined to a wheelchair.[507]

353 Mr Chaba's death can be attributed to the recklessness of Ms Mahlangu, Dr Manamela and Ms Ncube.

354 According to his prescription from Life Esidimeni dated 21 June 2016, Mr Chaba was on Clozapine, Clonazepam, Epilim and Biperiden.[508] Dr Talatala's evidence, described in more detail below, was that this combination of medication alone indicates that Mr Chaba required complex medical care.

[506] Chaba declaration of death, Vol 010, page 2792.

[507] Chaba patient report, Vol 010, page 2807.

[508] Chaba medication list, Vol 010, page 2804.

355 Mr Chaba had been at Life Esidimeni Randwest for two years[509] before he was moved to Precious Angels. This is despite a periodical report of 18 November 2015[510] recommending that he should not be discharged as an assisted mental health care user,[511] and stating that, by necessity, self-care and feeding have been under strict supervision throughout his residence at Life Esidimeni.[512]

Mr Chaba's transfer

356 Mr Chaba was transferred to the Danville property of Precious Angels on 23 June 2016,[513] with 21 other male MHCUs.[514]

357 While Mr Chaba was assessed by Dr Wadvalla before he left Randfontein,[515] he was not assessed when he arrived at Precious Angels. At the time, she had no professional nurse, dietician, or occupational therapist.[516] Ms Ncube admitted MHCUs on the understanding that the Department would send staff to assess them and alleges that Hannah Jacobus informed Ms Ncube that the Department was busy and that she must admit the users in the meantime[517] (although Ms Jacobus denies talking to Ms Ncube during the transfers).[518]

[509] Chaba patient information, Vol 010, page 2878.

[510] Chaba patient report, Vol 010, page 2806.

[511] Chaba patient report, Vol 010, page 2808.

[512] Chaba patient report, Vol 010, page 2807.

[513] Ethel Ncube written statement, Vol 010, page 2768.

[514] Ethel Ncube statement, Vol 005, page 1467.

[515] Ethel Ncube written statement, Vol 010, page 2799.

[516] Ethel Ncube statement, Vol 005, page 1468.

[517] Ethel Ncube statement, Vol 005, page 1468.

[518] Inquest transcript, 1 March 2022, Vol 413, page 45956.

Mr Chaba's death

358 Mr Chaba was at Precious Angels for two months before he was admitted to Pretoria West Hospital on 8 August 2016.[519] He had been found by a care worker to need hospital care on 2 August (including experiencing decreased level of consciousness) but was only taken to hospital on 8 August 2016.[520] Ms Ncube took Mr Chaba to the hospital but failed to make his medical records available. Although Ms Ncube denied this,[521] the audit checklist revealed that while there was a storage facility in the NGO for files, most of the mental health care user files came from Ms Ncube's car.[522] In testimony, Ms Ncube said that a caregiver gave the doctors all of Mr Chaba's records.[523] Dr Talatala testified that the hospital was desperate for this information and without it would not have been able to adequately manage the mental health care user.[98]

359 Mr Chaba died a week later, on 15 August 2016, from bronchopneumonia.[524] Prof Tintinger, a specialist physician, testified that the findings of the autopsy reflected in the post-mortem merely provided the immediate cause death, but not the underlying cause of death "which is actually probably more important than the immediate cause of death".[525] He explained that the final cause of death was pneumonia, which is often the final common pathway for severe debilitating

[519] Ethel Ncube written statement, Vol 010, page 2768.

[520] Clinical records, Vol 010, page 2861.

[521] Inquest transcript, 4 August 2022, Vol 413, page 48228.

[522] Audit Checklist for Precious Angels, Vol 200, page 20425.

[523] Inquest Transcript, 4 August 2022, Vol 413, page 48240.

[524] Chaba Post-mortem report, Vol 010, page 2749.

[525] Inquest Transcript, 25 March 2022, Vol 413, page 44678.

conditions, which could include severe malnutrition or starvation.[526] This was confirmed by Dr Lombard who said that the condition of a mental health care user over a period of time (including malnourishment) can compromise their immune system and result in illness, of which pneumonia is the most common.[527]

360 The pathologist, Dr Blumenthal, found that the deceased was thin/cachexia and with poor nutrition.[528] Prof Tintinger, in oral testimony, explained that cachexia is "the end result of … a disease process and the patients lose a significant amount of weight and they usually are emaciated".[529] In testimony, Ms Ncube said she did not notice that Mr Chaba lost weight.[530] Prof Tintinger went on to elaborate that "the degree of weight loss that [Mr Terrence Chaba] experienced would probably have rendered him quite weak, he had difficult moving and walking, which would have predisposed to pressure sores. The bronchopneumonia may also be a consequence of the severe malnutrition emaciated state that this mental health care user was in."[531] Dr Talatala, a psychiatrist, further confirmed that because of the poor nutrition, Mr Chaba was predisposed to infections including bronchopneumonia.[532]

361 Prof Tintinger testified that he stood by his opinion that a detailed investigation be conducted to evaluate the care that Mr Chaba received at Precious Angels.[533]

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[526] Inquest Transcript, 25 March 2022, Vol 413, page 44679.

[527] Inquest Transcript, 1 March 2022, Vol 413, page 44002.

[528] Chaba forensic pathology report, Vol 010, page 2911. See photo album from Vol 010, page 2770.

[529] Inquest Transcript, 4 March 2022, Vol 413, page 44107.

[530] Inquest Transcript, 4 Aug 2022, Vol 413, page 48233.

[531] Inquest Transcript, 4 March 2022, Vol 413, page 43902.

[532] Inquest Transcript, 25 March 2022, Vol 413, page 44262.

[533] Inquest Transcript, 4 March 2022, Vol 413, page 43904.

From the Life Esidimeni latest records, Prof Tintinger noted that Mr Chaba was described as sufficiently nourished and with no recent injuries identified. Three months later, upon his admission to Pretoria West Hospital, Mr Chaba was described as unkempt, chronically ill, and with threatening bed sores on the right hip.[534] Mr Chaba lost significant amount of weight in a relatively short time – 17.1 kilograms between 18 May 2016 to the date of his death on 15 August 2016.[535] Mr Nofile testified that after the first month of the establishment being open, Precious Angels started to experience food shortages, where MHCUs would eat only one meal a day.[536]

362 Of further concern on the quality of care at Precious Angels is that the post-mortem noted pressure sores on Mr Chaba's buttocks.[537] Prof Tintinger confirmed that the nine by two centimetre in diameter pressure sore was quite large, and indicative of the fact that Mr Chaba was immobile for some time and therefore developed pressure sores.[538] To prevent pressure sores, the care needed includes regularly changing the position of the mental health care user, inspecting them and ensuring that their skin is intact.[539] As a wheelchair bound person, Mr Chaba needed this level of care, which he was receiving at Life Esidimeni as noted in the progress reports.[540]

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[534] Report on Chaba, Vol 010, page 2914.

[535] Life Esidimeni Clinical Records, Vol 010, page 2879 indicate that he weighed 63.1kg on 18 May 2016 while the Post mortem schedule of observation, Vol 010, page 2736 records that he weighed 46kg at death.

[536] Inquest Transcript, 3 March 2022, Vol 413, page 45859.

[537] Post-mortem exam report on Chaba, Vol 010, page 2749.

[538] Inquest Transcript, 4 March 2022, Vol 413, page 43905.

[539] Inquest Transcript, 4 March 2022, Vol 413, page 43899.

[540] Chaba patient report progress, Vol 010, page 2897.

363 Prof Tintinger explained that:

> *"Severe loss of weight and in a person who is emaciated and very weak, these MHCUs are not mobile, which can predispose to bronchopneumonia. They are also predisposed to aspiration and the reasons for that are that because they are weak their cough response is not normal, which predisposes to aspiration. They are also in this very weak state. They have difficulty swallowing especially solid food, and that may also predispose to aspiration, and aspiration is often the event that results in bronchopneumonia or pneumonia."*[541]

364 Dr Talatala testified that Mr Chaba had a complicated diagnosis and was on a complicated treatment regime.[542] He needed specialised care. The place he was discharged to needed to be equipped to deal with such complications. At the time, there was no such facility that could meet that challenge and "[t]hat is why then an option was made to keep him in Life Esidimeni"[543], as evidenced in his periodical report. Dr Talatala concluded that Mr Chaba was inappropriately discharged from Life Esidimeni, against the recommendation of the periodical report.[544] Life Esidimeni anticipated that Mr Chaba was not stable enough for an NGO and if he had remained there, he would not have declined as they would have picked up any spike in temperature and prevented progression of the bronchopneumonia.[545] Further, the inadequate care at the NGO contributed to his poor nutritional status, his susceptibility to bronchopneumonia and ultimately his death.[546]

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[541] Inquest Transcript, 4 March 2022, Vol 413, page 44116.

[542] Inquest Transcript, 16 March 2022, Vol 413, page 44258.

[543] Inquest Transcript, 16 March 2022, Vol 413 page 44260.

[544] Inquest Transcript, 16 March 2022, Vol 413, page 44261.

[545] Inquest Transcript, 16 March 2022, Vol 413, page 44262.

[546] Inquest Transcript,16 March 2022, Vol 413, page 44261.

The legal cause of Mr Chaba's death

365 Mr Chaba's death was unnatural.

366 He was moved from Life Esidimeni despite a periodical report recommending that he not be moved to an NGO and that he needed strict supervision for his self-care and feeding. His complicated medication interactions alone would have made his care in an NGO impossible. He was in a big group of MHCUs moved to Precious Angels.

367 Mr Chaba was taken to hospital some time into an illness. Ms Ncube did not produce his medical records and so the hospital was at a disadvantage in managing his care. Mr Chaba died after a week in hospital. He had bronchopneumonia, was thin/cachexia with poor nutrition (having lost 17.1kg in just three months) and had large bedsores.

368 Precious Angels was found, three weeks before Mr Chaba's death, to be wholly inadequate for care of MHCUs. The report was given to Dr Manamela but she failed to take action to remove MHCUs.

369 He was the 13th person to die at Precious Angels and one of seven to die with pneumonia.

370 Ms Mahlangu and Dr Manamela created the circumstances in which Mr Chaba's death was inevitable. He should never have been taken to an NGO and yet was taken to one where the conditions were known but nothing was done to prevent deaths. Ms Ncube failed to act to prevent Mr Chaba's death by taking him to

hospital when needed, ensuring that his health was monitored, and ensuring that he had sufficient food. They should each be held to have caused Mr Chaba's death.

The death of Daniel Josiah

371 Daniel Charles Josiah (docket 12) was born on 8 January 1974[547] and died on 8 August 2016[548], erroneously captured as 8 September 2016 on the post-mortem[549], at the age of 42. According to medical records dated 10 May 2016 produced to the Pretoria West Hospital by Ms Ncube, Daniel was epileptic and had cerebral palsy. He was on Epilim and Carbamazepine with history of old clavicle fracture.[550]

372 Mr Josiah's death can be attributed to the recklessness of Ms Mahlangu, Dr Manamela and Ms Ncube.

373 Mr Josiah had been at Life Esidimeni Randfontein for around 17 years[551] before he was moved to Precious Angels on 23 June 2016.[552] He died less than two months after being moved.

[547] Forensic report, V013, page 3313.

[548] Letter confirming death of Josiah, Vol 013, page 3295.

[549] Josiah post-mortem Vol 013, page 3317.

[550] Letter confirming death of Josiah, Vol 013, page 3295.

[551] Thobane written statement, Vol 013, page 3341.

[552] Ncube written statement, Vol 013, page 3289.

Mr Josiah's transfer

374 Mr Josiah was transferred to the Danville property of Precious Angels on 23 June 2016,[553] with 21 other male MHCUs.[554] Ms Ncube went to collect them at Randfontein.

375 He was not assessed when he arrived at Precious Angels. At the time, she had no professional nurse, dietician, and occupational therapist.[555]

Mr Josiah's death

376 Mr Josiah was at Precious Angels for 2 months before he died on 8 August 2016[556]. Mr Josiah was dead on arrival when Ms Ncube took him to Pretoria West Hospital.[557] Ms Ncube first confused him with another deceased but confirmed that he died in her car on the way to the hospital.[558] The post-mortem revealed the cause of death to be necrotizing pneumonia.[559] The pathologists schedule of observation noted that Mr Josiah was severely underweight.[560]

377 Dr Talatala testified that for Mr Josiah to have died of pneumonia before he was presented for appropriate medical care is indicative that there was probably a delay from the staff at Precious Angels in picking up that he had a respiratory

[553] Ncube written statement, Vol 013, page 3289.
[554] Ethel Ncube statement, Vol 005, page 1467.
[555] Ethel Ncube statement, Vol 005, page 1468.
[556] Ncube written statement, Vol 013, page 3289.
[557] Patient record waiting time, Vol 013, page 3294.
[558] Inquest transcript, 4 August 2022, Vol 413, page 48223.
[559] Josiah post-mortem exam, Vol 013, page 3317.
[560] Josiah patient observations, Vol 013, page 3318.

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 associated intellectual disability."[561] He explained that the fact that Mr Josiah had cerebral palsy 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 staff may not have been familiar with the level of mental illness he had.[562] 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[83] and had at least two cleaners turned careworkers, untrained in medical care providing care to MHCUs.[84] Dr Talatala concludes that Mr Josiah was inappropriately placed at Precious Angels.[563]

<u>The legal cause of Mr Josiah's death</u>

378 Mr Josiah's death was unnatural.

379 He was moved from Life Esidimeni in a big group of MHCUs to Precious Angels. He died of necrotising pneumonia and was underweight. His illness would have made it difficult for him to articulate his needs and he died in Ms Ncube's car on the way to the hospital.

380 Precious Angels was found, three weeks before Mr Josiah's death, to be wholly inadequate for care of MHCUs. The report was given to Dr Manamela but she failed to take action to remove MHCUs.

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[561] Inquest Transcript, 16 March 2022, Vol 413, 44550.

[562] Inquest Transcript, 16 March 2022, Vol 413, page 44338.

[563] Dr Talatala report, Vol 412, page 37512.

381 He was the 12th person to die at Precious Angels and one of seven to die with pneumonia.

382 Ms Mahlangu and Dr Manamela created the circumstances in which Mr Josiahs's death was inevitable. He should never have been sent to an NGO and yet he was sent to one where the conditions were known but nothing was done to prevent deaths. Ms Ncube failed to act to prevent Mr Josiah's death by taking him to hospital when needed, ensuring that his health was monitored, and ensuring that he had sufficient food. They should each be held to have caused Mr Josiah's death.

The death of Matlakala Motsoahae

383 Matlakala Motsoahae (docket 16) was born on 12 September 1944 and died 26 August 2016 at Kalafong Hospital,[564] at the age of 72. The docket does not contain any records from Life Esidimeni.

384 However, according the Kalafong Hospital clinical records, Ms Motsoahae had Alzheimer Dementia[565] and was bedridden[566]. Ms Ncube says Ms Motsoahae was not on treatment[567], but hospital records note that the background information provided to them state that she was on Ridag[568] and according to her

[564] Matlakala notice of death, Vol 048, page 8063.

[565] Patient progress report, Vol 048, page 8074.

[566] Patient nursing report, Vol 048, page 8077 and Affidavit of Motsoahae, Vol 200, page 21222.

[567] Ethel Ncube statement, Vol 048, page 8059.

[568] Matlakala patient information, Vol 048, page 8079.

daughter, Maud Motsoahae, had previously been on medication at Life Esidimeni.[569]

385 Ms Motsoahae's death can be attributed to the recklessness of Ms Mahlangu, Dr Manamela and Ms Ncube.

386 Ms Motsoahae had been at Life Esidimeni Randfontein for two years[570] before she was moved to Anchor home and then Precious Angels.

Ms Motsoahae's transfer

387 Ms Motsoahae was transferred to Precious Angels on 29 June 2016[571]. According to Ms Ncube, on arrival she was stable and was not on medication.[572] Her medical files were brought by Mr Mogale from the Department a couple of days after Ms Motsoahae's arrival.[573]

Ms Motsoahae's death

388 Ms Motsoahae was admitted to Kalafong Hospital on 10 August 2016.[574] She was brought in by paramedics in a stretcher and a health care worker informed the nurses of Kalafong that Ms Motsoahae had a history of vomiting. It was observed that Ms Motsoahae had deep bed sores on the hip, presented with

[569] Memo to the families of patients, Vol 200, page 21225.

[570] Affidavit of Motsoahae, Vol 200, page 21221.

[571] Ethel Ncube statement, Vol 048, page 8059.

[572] Ethel Ncube statement, Vol 048, page 8059.

[573] Ethel Ncube statement, Vol 048, page 8059.

[574] Nursing notes, Vol 048, page 8077.

decreased level of consciousness[575], she had lower respiratory tract infection, a septic hand, renal impairment, and hypernatremia.[576] Ms Motsoahae died two weeks after her admission to hospital on 26 August 2016.[577]

389 Dr Talatala testified that it is unlikely that Ms Motsoahae would have developed bed sores if she was up and about. Therefore, this gives the impression that the NGO could not cope with the mental health care user care needs. Ms Motsoahae would need direct care and to have been turned every two hours.[578] Dr Talatala concluded that "I would not place a mental health care user who is bedridden with Alzheimer's dementia in an NGO unless I wanted to hasten their death".[579] Ms Motsoahae was inappropriately placed at Precious Angels resulting in her not receiving adequate monitoring – leading to the development of bed sores and other complications ultimately resulting in her death.[580]

<u>The legal cause of Ms Motsoahae's death</u>

390 Ms Motsoahae's death was unnatural.

391 She was moved from Life Esidimeni in a big group of MHCUs to Anchor Home and then to Precious Angels. She had Alzheimer's dementia and was bedridden. Such a person should not be moved to an NGO.

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[575] Nursing notes, Vol 048, page 8077.

[576] Clinical records, Vol 048, page 8074.

[577] Nursing notes, Vol 048, page 8087.

[578] Inquest Transcript, 16 March 2022, Vol 413, page 44342.

[579] Inquest Transcript, 16 March 2022, Vol 413, page 44342.

[580] Dr Talatala report, Vol 412, page 37513.

392 She had deep bedsores, a decreased level of consciousness, a lower respiratory tract infection, a septic hand, renal impairment and hypernatremia. She died in hospital.

393 Precious Angels was found, three weeks before Ms Motsoahae was taken to hospital, to be wholly inadequate for care of MHCUs. The report was given to Dr Manamela but she failed to take action to remove MHCUs including Ms Motsoahae.

394 She was the 15th person to die at Precious Angels.

395 Ms Mahlangu and Dr Manamela created the circumstances in which Ms Motsoahae's death was inevitable. She should never have been moved to an NGO but she was and the conditions of the NGO were known and nothing was done to prevent deaths. Ms Ncube failed to act to prevent Ms Motsoahae's death by ensuring that her health was monitored and she was turned to prevent bedsores. They should each be held to have caused Ms Motsoahae's death.

The death of Deborah Phehla

396 Deborah Phehla (docket 96) was born on 25 May 1970[581] and died on 26 March 2016[582] at Takalani Home at the age of 46, just three days after her transfer on 23 March 2016. She had been institutionalised for 38 years before her move to Takalani. She was profoundly mentally retarded[583] and epileptic[584] and according

[581] Zimbi Phehla written statement, Vol 031, page 6575.

[582] Forensic letter on death of Deborah Phehla, Vol 031, page 6599.

[583] Patient progress notes, Vol 412, page 3743.

[584] Patient progress notes, Vol 412, page 37432.

to a 2013 periodical report that was provided to Takalani on transfer, was totally dependent on staff for her basic needs and was known to eat rubbish. She was also unable to talk or to follow instructions.[585] Ms Phehla's required treatment, according to a 2013 periodical report, was Modecate, Largactil, Tegretol, Prexum and Adalat.[586]

397 Ms Phehla's death can be attributed to the recklessness of Ms Mahlangu and Dr Manamela.

Ms Phehla's transfer

398 Ms Phehla had been an assisted mental health care user since 1978[587] and was living at Life Esidimeni Witpoort before being moved to Takalani.

399 Ms Phehla was moved to Takalani just eight days after the judgment[588] in the matter challenging the Department's decision to move 54 MHCUs to Takalani. Ms Phehla was not, however, one of the MHCUs on the list of 54,[589] bringing into question how it was decided that she should be sent to Takalani.

400 Shortly before the court application, a presentation dated 18 February 2016 reflected that Takalani was a facility licensed for residential care for severe and profound intellectually disabled children.[590] There had been no indication that

[585] Patient progress notes, Vol 412, page 37432.

[586] Patient progress notes, Vol 412, page 37432.

[587] Patient progress notes, Vol 412, page 37431.

[588] *SADAG and Others v MEC for Health, Gauteng and Others*, Vol 200, page 18916.

[589] List of MHCUs to be moved to Takalani in March 2016, Vol 200, page 18949.

[590] City of Johannesburg NGO list, Vol 200, page 18672.

Takalani had been assessed as being suitable to cater for adults with the psychiatric and physical illnesses of the Life Esidimeni MHCUs. SECTION27, on behalf of its clients, informed Ms Mahlangu and Dr Selebano of this fact in a letter dated 11 March 2016.[591] With nothing on record to support this confidence, Dr Selebano, in an affidavit defending the litigation, stated "I am confident that Takalani home which is part-financed by the Government, has adequate facilities to give access to quality mental health care to all users in their care including those which are currently accommodated at the Life Esidimeni facilities"[592]

401 Ms Phehla was among the first six MHCUs moved to Takalani. She arrived at Takalani before the organisation had been licensed to care for 200 people with severe to profound intellectual disability (the license is dated 1 April 2016 although most licenses were signed later).[593] By the time Ms Phehla arrived, the Memorandum of Agreement[594] was signed by the district (in April 2015). However, the Memorandum of Agreement provided for Takalani caring only for 80 people with severe and profound intellectual disability.[595]

402 There is no audit or inspection report in the record for Takalani.

403 There is very little information on the record, and it is not clear what information was before the Department of Health, about the state of Takalani at the time of

[591] Letter from SECTION27 to MEC Health, 11 March 2016, Vol 200, page 18622.

[592] Dr Selebano Answering Affidavit in *SADAG and Others v MEC for Health, Gauteng and Others*, Vol 200, page 18727.

[593] Takalani Home Mental License Vol 200, page 20333.

[594] Memo of agreement between Department of Health and Mosego Home, Vol 200, page 19648.

[595] Memo of agreement between Department of Health and Mosego Home Annexure D1, Vol 200, page 19688.

Ms Phehla's move, other than that the agreement with the Department at the time was that Takalani was a residential facility for children. Dr Selebano acknowledged[596] in the arbitration that the evidence included in the report on typhoid at Takalani in July 2016[597] (including insufficient space, a pungent foul smell in the dining hall, a very dirty kitchen) made it clear that, in March 2016, it was not a suitable facility. Prof Robertson, not long after, raised concerns about problems with management, workers being on strike since 3 March, and the impact of an unhappy environment on MHCUs.[598]

404 Levy Mosenogi attached to his general statement presentations on NGOs that appear to be from a 13 May 2016 meeting with the MEC.[599] By this time, Takalani had received 117 people and the report notes five deaths and that management underestimated the ramifications of the transfers, and that the facility is not "geared up in terms of human resources and systems to ensure that these users received and recorded their daily medication and were medically monitored in respect of daily blood pressures, blood glucose etc. The facility is also not equipped to deal with emergencies."[600] It was also noted that the facility was congested, there were insufficient toilet and ablution facilities, there had been a recent case of typhoid, and there was insufficient space for rehab and entertainment.[601]

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[596] Evidence of Selebano, 6 December 2017, Vol 300, page 27831.

[597] Letter informing of Typhoid outbreak, Vol 300, page 30739.

[598] Email from Lesley Robertson to Dr Manamela, Vol 412, page 37635.

[599] Minutes of 13 May 2016 meeting, Vol 405, page 34859.

[600] Takalani Masego report, Vol 005, page 1134.

[601] Takalani Masego report, Vol 005, page 1135.

Ms Phehla's death

405 Ms Phehla died of asphyxia due to aspiration of blood[602] at Takalani. A post-mortem was conducted on Ms Phehla's body by Dr Morule. He found foreign bodies including plastic and brown paper[603] (which he described as being the type of cardboard that would be used to make a cardboard box)[604]. The plastic was described by Dr Morule as "2 bottled up plastics which are [the] size of a fist.[605] The upper part of the larnyx was perforated and contused and the lungs had a leopard skin appearance.[606] The perforation would have been caused by a hard object inside the larynx.[607] Dr Morule stated that "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"[608] In oral testimony, Dr Morule posited that something like a staple used to form a cardboard box could have caused this type of damage,[609] as could hard cardboard from a box itself. He noted that she could have coughed up whatever damaged her larynx causing the bleeding and asphyxia as this would be a natural reaction, although she could also have swallowed it. Dr Morule said that it was likely that the object did the damage when it was coughed up. He also thought it

[602] Forensic pathology report of Deborah, Vol 031, page 6599.

[603] Forensic pathology report of Deborah, Vol 031, page 6599.

[604] Inquest Transcript, 16 March 2022, Vol 413, page 44546.

[605] Deborah death register, Vol 031, page 6578.

[606] Forensic pathology report of Deborah, Vol 031, page 6599.

[607] Inquest Transcript, 24 May 2022, Vol 413, page 45761.

[608] Forensic pathology report of Deborah, Vol 031, page 6599.

[609] Note, the Inquest transcript is missing this testimony. See the recording of the hearing on 24 May 2022 at https://www.youtube.com/watch?v=i12Oaa6ItK8 at timestamp 2 minutes 41 seconds.

most likely that she swallowed the paper/cardboard at Takalani due to the speed with which paper/cardboard degrades in the stomach.[610] This places the action that caused her death at Takalani.

406 Dr Morule noted that death is a slow process and Ms Phehla's death would have taken time.[611] The process was akin to drowning as the spaces in the lungs that should have been filled with air were filled with blood.[612] Dr Morule suggested in his addendum to the post-mortem report that the autopsy findings are suggestive of management and care at the place where Ms Phehla was living not being adequate, appropriate and professional enough to cater to people with Ms Phehla's incapacity.[613]

407 A nurse (Matron Christinah Mkhasibe) at Takalani reported to the police that Ms Phehla had vomited on 25 March 2016 (the evening before her death) after supper but was then stable. She told the police officer that Ms Phehla was found unconscious in the morning of 26 March 2016 by a staff nurse doing rounds. The relevant people were then informed, and private undertakers were called.[614] Matron Mkhasibe was not herself at Takalani either when Ms Phehla is reported to have vomited on 25 March 2016 or when she died. She reports that she received a call at home from Staff Nurse Virginia Maduma to inform her of the death and the vomiting the night before.[615] Dr Sekhukhune also testified that she

[610] Inquest Transcript, 24 May 2022, Vol 413, page 45783.

[611] Inquest transcript, 24 May 2022, Vol 413, page 45798.

[612] Inquest transcript, 1 March 2022, Vol 413, page 45923.

[613] Morule Addendum, Vol 031, page 6599.

[614] Duma statement, Vol 031, page 6569.

[615] Christina Mkhasibe statement, Vol 031, page 6573.

was not present when Ms Phehla died[616] but repeated the version of the other staff.

408 The version of Ms Phehla's death on Takalani's death report is different – it says that Staff Nurse Maduma went into Ms Phehla's room and found her "gasping". Artificial respiration was applied, and oxygen was administered but Ms Phehla died.[617] This is a vastly differing version of Ms Phehla's death and put into question the various hearsay statements by Ms Mkhasibe and Dr Sekhukhune, neither of whom were present.

409 Further, while there was no report of further vomiting after 25 March 2016 from the staff at Takalani, the post- mortem report notes "bloody fluid in the nose and mouth"[618] The fact that there was blood on the nose and mouth is confirmed by Ms Phehla's mother [619] and by photographs from the post-mortem.[620]

410 The room in which Ms Phehla died was described by her mother in a statement as a small room that "looked like it was used a very long time ago because it was dirty, had spiderwebs and was smelly. It had couches (sofas), [a] wooden cabinet with old files and two beds."[621]

411 Dr Sekhukhune testified that there was a camera in front of Ms Phehla's room but that there was no 24-hour monitoring of the cameras inside – the manager

[616] Inquest transcript, 8 June 2022, Vol 413, page 46549.

[617] Statement of Zanele Moses Duma, Vol 031, page 6569.

[618] Death register notes, Vol 031, page 6577.

[619] Zimbi Phehla statement, Vol 031, page 6592.

[620] Patient progress notes, Vol 412, page 37438.

[621] Zimbi Phehla statement, Vol 031, page 6592.

could rewind the video to see what happened earlier.[622] There is, therefore, no evidence to contradict Dr Morule's opinion that Ms Phehla swallowed something hard, while at Takalani, and then slowly died through aspirating her own blood. She was alone in a room when she died.

412 Dr Talatala testified that given that Ms Phehla was known to be at risk of swallowing inedible objects, an institution taking care of her would have to ensure that there are no loose objects lying around. She would need close supervision.[623] His report finds that while nurses at Life Esidimeni knew about this risk and would have managed it, at Takalani she was being looked after by staff who were not familiar with her and her risks. The move from one facility to another put her at risk of swallowing objects and her death resulted.[624]

413 The conditions at Takalani and lack of sufficient supervision caused Ms Phehla's death in that 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 on blood. Takalani had received the periodical report that said that she eats rubbish and yet she was insufficiently supervised to prevent her from doing so. She survived for 38 years in mental health institutions but died within a few days of being moved to Takalani.

<u>The legal cause of Ms Phehla's death</u>

414 Ms Phehla's death was unnatural.

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[622] Inquest Transcript, 8 June 2023, Vol 413, page 46557.

[623] Inquest transcript, 16 March 2022, Vol 413, page 44348.

[624] Inquest Transcript, 16 March 2022, Vol 413, page 44546.

415 She was moved from Life Esidimeni to Takalani Home. She had been institutionalised for 38 years but died within three days of moving to Takalani. Her periodical report said that she was totally dependent on staff for her basic needs and was known to eat rubbish.

416 Two months after Ms Phehla's death, a report indicated the significant problems that Takalani Home was facing. Prior concerns about Takalani's new life as a facility for adults, and the labour issues that would make it a stressful environment for MHCUs who need a "predictable, safe and secure environment",[625] were not heeded.

417 Ms Phehla died of asphyxia due to aspiration of blood. She swallowed a cardboard box and plastic and perforated her larynx. Her death would have taken some time and yet she was insufficiently supervised for her dying to be noticed.

418 Ms Mahlangu and Dr Manamela created the circumstances in which Ms Phehla's death was inevitable. She should never have been moved to an NGO given her periodical and yet she was and the place she was moved to was untested as a facility for adults. They should each be held to have caused Ms Phehla's death.

The death of Frans Dekker

419 Frans Dekker (docket 56) was born 10 September 1968[626] and died on 7 November 2016 at Kalafong Hospital.[627] He had dementia and was wheelchair

[625] Inquest Transcript, 25 May 2023, Vol 424, page 54060.

[626] Frans Dekker identification card, Vol 023, page 4751.

[627] Notice of death Frans Dekker, Vol 023, page 4597.

bound due to an earlier motor vehicle accident. He was on Epilim, Carbamazepine, Clopixol Depot and Orphenadrine at Life Esidimeni.[628]

420 Mr Dekker's death can be attributed to the recklessness of Ms Mahlangu and Dr Manamela.

421 He had been at Life Esidimeni since 2003 before he was moved to Tshepong. This is despite a periodical on 3 August 2015 recommending that he is not suitable for an NGO or for discharge[629] and stating that he had cognitive impairment, behavioural issues, and "needs supervision of treatment in a structured environment."[630] Mr Dekker had had bedsores at Life Esidimeni and had received treatment for them.[631] Rochelle Gordon said that an NGO should not receive someone who is prone to bedsores.[632]

About the facility: Tshepong

422 As CEO and Board member, Carrina Morale had applied to use Tshepong to care for MHCUs in 2011[633] but only received an operating certificate and license in March 2016. She amended[634] the constitution of the organisation to cater for MHCUs, although the objectives[635] have very little relevant detail, merely mentioning supporting institutions that are against the abuse and stigma of the

[628] Medication prescription, Vol 023, page 4777.

[629] Frans Dekker periodical report, Vol 023, page 4756.

[630] Frans Dekker periodical report, Vol 023, page 4756.

[631] Frans Dekker forensic pathology report, V023, page 4808.

[632] Inquest Transcript, 11 February 2022, Vol 413, page 43112.

[633] Carrina Morale statement, Vol 005, page 547.

[634] Constitution of Tshepong Health Centre, Vol 054, page 8912.

[635] Constitution of Tshepong Health Centre, Vol 054, page 8903.

mentally challenged and recruiting companies to send employees to clinic for early intervention on diseases, including the mentally disturbed.

423 She received three licenses. One was for 170 people with “severe and profound disability”, signed by Dr Manamela;[636] on for 186 people (51 geriatric and 135 adult) with “chronic psychiatric disability”, signed by Dr Manamela[637] and one for 186 people (60 geriatric and 126 adult) with ”severe psychiatric disability”, signed by Dr Selebano.[638] All three licenses were ostensibly signed on 1 April 2016. She was told she should be ready to operate from 1 April 2016.[639] Ms Morale says that Dr Manamela herself gave Ms Morale a license in March 2016.[640] Hanna Jacobus said that if the proper process had been followed, Tshepong would not have been licensed for with the number or the category of MHCUs that they received.[641]

424 Frans Thobane had visited Tshepong on 8 December 2015 and Rochelle Gordon came on 9 December 2015 and provided her with the guidelines and tariffs.[642] An audit report dated 8 December 2015 and signed by Rochelle Gordon suggests that the physical environment was, on the whole, good but almost all aspects of administration of care and care of users were marked as non-

[636] Tshepong Centre Mental Health license, Vol 200, page 20316.

[637] Tshepong Centre Mental Health license, Vol 059, page 9423.

[638] Tshepong Centre Mental Health license, Vol 059, page 9424.

[639] Carrina Morale statement, Vol 023, page 4786.

[640] Carrina Morale statement, Vol 053, page 8694.

[641] Inquest transcript, 9 January 2022, Vol 413, page 41776.

[642] Carrina Morale statement, Vol 005, page 547.

compliant.[643] Ms Gordon testified that she completed this audit in the presence of Hanna Jacobus while in Dr Manamela's office.

425 On 22 January 2016, a team from Gauteng Department of Health and Tshwane visited Tshepong for an inspection. The team included Rochelle Gordon, Hanna Jacobus and Dr Manamela.[644] A team member inspected the buildings and informed Ms Morale that the centre was suitable for the care of MHCUs.[645] However they did not audit and inspect the building as usual and make a recommendation to province - they were just accompanying province on the visit, according to Ms Morale.[646]

426 Ms Morale states that they did not have enough beds.[647] Dr Manamela promised 150 beds[648] in lieu of the starter kit,[649] but Ms Morale states that the beds did not materialise.[650] In fact, Dr Manamela told Ms Morale in March 2016 at a meeting at the Department of Health that the department would not provide beds and the NGO would need to fundraise.[651]

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[643] Audit report for Mental health facility, Vol 200, page 20380.

[644] Carrina Morale statement, Vol 005, page 548.

[645] Carrina Morale statement, Vol 005, page 548.

[646] Carrina Morale statement, Vol 005, page 549.

[647] Carrina Morale statement, Vol 005, page 548.

[648] Carrina Morale statement, Vol 053, page 8694.

[649] Carina Morale explains the starter kit as items to supplement the facilities. These were items that the facility was short of but needed to operate - Carrina Morale statement, Vol 137, page 17296.

[650] Carrina Morale statement, Vol 005, page 549.

[651] Carrina Morale statement, Vol 053, page 8694.

427 On 22 February 2016, Dr Manamela, Frans Thobane and Hanna Jacobus came to Tshepong to meet with the board members and to discuss the project.[652] In minutes of a meeting on the same day, chaired by Dr Manamela, Tshepong is listed as having capacity for 170 (150 adults and 20 children) and 40 beds for adults and 20 for children were reflected as being available, with two registered nurses and 22 care workers.[653] There was an inspection that included Dr Manamela, Hanna Jacobus and Rochelle Gordon in March 2016.[654]

428 After the 8 December 2015 audit, the next documented audit visit was on 14 July 2016 and found that there was old furniture and sharp objects lying around all over the centre, no ramps between some rooms, no form of reliable mental health care user identification, no assistive devices like rails and ramps, no activity schedule, no formalised duty allocation list or even a supervisor per unit, no individual progress reports per mental health care user.[655] Furthermore, the staff complement was recorded as consisting of the manager, one professional nurse, two enrolled nurses, one auxiliary nurse and eight caregivers.[656] This is far fewer than the staff complement described by Ms Morale in her oral testimony. In addition, the care givers also had a daily cleaning responsibility.[657] The audit also reflects that there is no equipment to monitor vital data and no first aid box, no hand washing soap at basins and ”MHCUs shared a toothbrush”[658] At an 18 July

[652] Carrina Morale statement, Vol 053, page 8693.

[653] Minutes of meeting with NGOs and Department of Health, 22 February 2016, Vol 200, page 20696.

[654] Carrina Morale statement, Vol 053, page 8694.

[655] Tshepong Centre Audit checklist, Vol 200, page 20376 and 20377.

[656] Tshepong Centre Audit checklist, Vol 200, page 20377.

[657] Tshepong Centre Audit checklist, Vol 200, page 20377.

[658] Tshepong Centre Audit checklist, Vol 200, page 20377.

2016 meeting of the Mental Health Directorate (neither Dr Manamela nor Hanna Jacobus were present), the significant problems at Tshepong and the fact that it has not received payment are discussed.[659]

429 Ms Morale signed the SLA in April 2016.[660] Despite the 14 July 2016 audit showing the extent of the problems at Tshepong, the SLA was signed by the Department on 10 August 2016,[661] long after the MHCUs had arrived.

430 A further audit was conducted on 18 September 2016 or 5 October 2016 (the audit checklist document includes two dates) by Nonceba Sennelo,[662] as part of the Adopt an NGO programme, which reported improvement, although number and payment of staff remained a problem.[663] Ms. Morale explains in her facility report that one of the issues was absenteeism, which resulted in the facility not being cleaned due to having only four workers on duty. During Ms. Morale's second visit, there was only one care worker per block, and these care workers were expected to both care for patients and perform cleaning duties.[664]

431 Ms Sennelo also recommends that 51 males be moved out of the NGO.[665] On 21 October 2016, Morale signed a written commitment that reflected that staff

[659] Minutes of Mental health directorate, 18 July 2016, Vol 200, page 20715.

[660] Carrina Morale statement, Vol 053, page 8694.

[661] Carrina Morale statement, Vol 005, page 549.

[662] Audit checklist, Vol 005, page 967.

[663] Audit checklist, Vol 005, page 978.

[664] Audit checklist, Vol 005, page 978.

[665] Gauteng Health information on NGO, Vol 005, page 961.

had been paid for September but money had only been received on 12 October 2016.[666]

Mr Dekker's transfer

432 The transfers to Tshepong were among the first mass transfers, despite the lack of an acceptable audit at this time.

433 Ms Morale was told to come and collect MHCUs and on 12 May 2016, she hired two busses and travelled with a professional nurse, enrolled nurses and care workers to Life Esidimeni. She was on the way to Waverley when she was called by Dr Manamela and told to also send a bus to Rand West.[667] She received a total of 185 people from Waverley and Rand West facilities. Dr Wadvalla stated that they had prepared 70 ambulant, male, intellectually disabled people for transfer to Tshepong but Ms Morale called on 11 May 2016 to advise that she could not have the intellectually disabled male MHCUs and the staff had to prepare male and female psychiatric MHCUs not older than a specified age. This caused disruption as the newly identified people needed physical examinations, records, medication and prescription.

434 Dr Manamela was present and went into the wards during this process.[668] Nonceba Sennelo testified that Morale asked for extra people over and above those prepared for her on the day of collection, which caused problems. She wanted to receive many people on the day because of the number of people she

[666] Commitment from Tshepong, 21 October 2016, Vol 005, page 966.

[667] Carrina Morale statement, Vol 053, page 8695.

[668] Affidavit of Dr Wadvalla, Vol 005, page 1516.

was licensed for.[669] Ms Sennelo said that she complained to Dr Manamela about this but Dr Manamela said they must prepare the additional people for Ms Morale.[670] Tshepong would end up receiving 85 people that day.[671] Ms Morale stated in oral testimony that Gauteng Department of Health officials would call the names of people who were meant for Tshepong, but they did not respond. This is how MHCUs were identified.[672]

435 Frans Dekker was among the people she collected on 12 May 2016 and while Morale said he looked unwell and had 'dots' on his body, it was only in October that he was taken to Kalafong Hospital for treatment of bedsores.[673] Indeed, on 9 May 2016, Mr Dekker was examined by a doctor and there was no reference to bedsores at this time.[674] Dr Talatala confirmed that the doctor would have included reference to bed sores in the space on the form allocated for 'skin'.

436 Both Nonceba Sennelo and Rochelle Gordon testified that Mr Dekker should not have been moved.[675] Zanele Buthelezi also said that there were some people who were moved to Tshepong on 12 May 2016 who should have gone to

[669] Inquest transcript, 23 November 2021, Vol 413, page 40481 and Inquest transcript, 29 November 2021, Vol 413, page 40951.

[670] Inquest Transcript, 22 November 2021, Vol 413, page 40670.

[671] Inquest Transcript, 22 November 2021, Vol 413, page 40671.

[672] Inquest Transcript, 20 July 2022, Vol 413, page 47617.

[673] Carrina Morale statement, Vol 023, page 4787.

[674] Patient periodical report, Vol 023, page 4775 and 4776.

[675] Inquest transcript, 26 November 2021, Vol 413, page 40769 and Inquest transcript, 11 February 2022, Vol 413, page 42946.

hospital.[676] Dr Talatala confirmed that if Mr Dekker had to be moved, it should only have been to a place that could cater for people with frail care needs.[677]

437 Nomsa Zikalala, a care worker at Tshepong states that Mr Dekker had medication when he arrived at Tshepong and she ensured that he took the medication, bathed him, made sure he was fed and that his personal hygiene was taken care of.[678] In a scheduled inspection document dated 8 December 2015, a document clearly completed by the NGO, it is stated in respect of bed sores ”bedridden clients to be changed position frequently. Sheepskin and other equipment for preventing bed sores must be available. Changing of positions must be recorded in the position chart.”[679] It seems that these plans were not complied with.

438 Morale stated in oral testimony that the NGO expected to and was able to cater to the mental health care needs of MHCUs but not to their physical health needs.[680] She states further that on 1 September 2016, her staff did not come to work due to non-payment and while she arranged with the department for staff from Weskoppies and brought in some care workers from the community, during this period, MHCUs became weak and lost weight.[681] It is doubtful that Tshepong would ever have been able to cater to the physical health needs of its 185 MHCUs, including Mr Dekker. In the 14 July 2016 audit the staff complement was

[676] Inquest Transcript, 13 September 2021, Vol 413, page 39276.

[677] Inquest Transcript, 18 March 20221, Vol 413, page 44595.

[678] Nomsa Zikalele written statement, Vol 023, page 4587.

[679] Facility inspection, Vol 200, page 20391.

[680] Inquest Transcript, 20 July 2022, Vol 413, page 42629.

[681] Carrina Morale statement, Vol 005, page 551.

recorded as consisting of the manager, one professional nurse, two enrolled nurses, one auxiliary nurse and eight caregivers[682] In the 18 September 2016 audit report, the staff complement was 2 professional nurses, 4 enrolled nurses, 1 admin, 4 cooks, 6 security officers, 22 care workers, 4 people assisting with rehabilitation.[683] Given that staff was only paid in October 2016,[684] and given specific reference to absenteeism due to non-payment,[685] there would not have been sufficient suitably qualified staff.

439 At the time of Mr Dekker's move, the only information before Dr Manamela was that the NGO was new to the care of MHCUs, and the December 2015 audit follow up visits suggested that only the physical environment was appropriate, but care levels were not. Despite this, the NGO received 185 MHCUs in two large groups,[686] itself putting MHCUs at risk.

440 By 14 July 2016, Dr Manamela and the team knew that the NGO was in dire straits. The audit report is clear in this regard. When Nonceba Sennelo returned to Tshepong on 5 October 2016, staff remained an issue.

Development of septic bedsores

441 Mr Dekker was presented at Kalafong with a swollen eye from falling on 19 June 2016.[687] There is no mention in the hospital notes of bedsores at this stage.

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[682] Tshepong audit checklist, Vol 200, page 20377.

[683] Tshepong audit checklist, Vol 005, page 972.

[684] Written commitment from Tshepong NGO, Vol 005, page 966.

[685] Tshepong audit checklist, Vol 005, page 978.

[686] Butsi Carina Morale statement, Vol 053, page 8695.

[687] Frans Dekker nursing report, Vol 023, page 4621.

442 Mr Dekker was at Tshepong for five months before he was taken to Kalafong Hospital on 9 October 2016 for treatment for his bed sores. A care worker states that was not admitted but Tshepong was given treatment of the bedsores. He was returned to Kalafong on 18 October 2016 and was admitted.[688] Registered Nurse Patrick Khumalo confirms this.[689] The referral form from Tshepong states that he was dehydrated with sores all over the body especially on both hips and buttocks appearing as pressure sores"[690] Marven Thabang Malele said that Mr Dekker's sister could not come to give consent for Mr Dekker to undergo debridement surgery, although this consent was provided telephonically on 19 October 2016 and on 22 October 2016, Mr Dekker underwent debridement surgery.[691]

Mr Dekker's death

443 He died from septic decubitus ulcers complicated by sepsis on 7 November 2016 at Kalafong.[692] Dr Makhoba, the pathologist stated that his death should be considered to be unnatural because of the nexus between a motor vehicle accident in 1999 and the development of ulcers through incapacitation.[693] He also stated that there appeared to be "prima facie grounds from which inferences of negligence can be drawn concerning the management of this mental health care user at the Tshepong Health Centre. It appears that the aforementioned

[688] Nomsa Zikalele written statement, Vol 023, page 4588.

[689] Nomsa Zikalele written statement, Vol 023, page 4589.

[690] Frans Dekker referral form, Vol 023, page 4604.

[691] Prof. Abel Pienaar report on Frans Dekker, Vol 023, page 4804.

[692] Frans Dekker post-mortem report, Vol 023, page 4738.

[693] Frans Dekker forensic investigation report, Vol 023, page 4807.

centre was not an ideal centre for the management of the conditions Mr F Dekker [was] suffering from."[694] He elaborated in oral testimony that Mr Dekker needed surgical, medical and ICU care and management.[695] He also said that bed sores were caused by pressure and the relevant factor is not whether someone had a history of bedsores but whether they have been immobilised in a certain position.[696]

444 Dr Talatala testified that Mr Dekker was not suitable for placement in an NGO and that this resulted in him getting insufficient nursing care, putting him at risk of the pressure sores and emaciation that, complicated by sepsis, caused his death.[697]

445 Prof Pienaar states in his report that given his mental condition, the fact that he was wheelchair bound, and that fact that he was on psychotropic medication, Mr Dekker needed pressure relief and night bed turning to prevent bed sores.[698] Given that bed sores are caused by the absence of such care, Prof Pienaar concludes that there was negligence and incapacity on the part of the NGO.[699] In oral testimony he comments on the staff complement at Tshepong (as per the audit report)[700] and noted that it was wholly insufficient for 185 users and that the lack of emergency equipment including oxygen, a BP machine, a first aid box)

[694] Frans Dekker forensic investigation report, Vol 023, page 4808.

[695] Inquest Transcript, 24 February 2022, Vol 413, page 43390.

[696] Inquest Transcript, 25 February 2022, Vol 413, page 43794.

[697] Dr Talatala report, Vol 412, page 37509.

[698] Prof Pienaar report, Vol 023, page 4804.

[699] Prof Pienaar report, Vol 023, page 4804.

[700] Audit checklist for Tshepong Health Centre, 14 Juny 2016, Vol 005, page 1430.

would make it impossible to provide basic nursing care, especially physical care.[701]

446 Ms Morale says that during November 2016 when Mr Dekker died, “many MHCUs were dying”.[702]

447 Tshepong was clearly never in a position to care for people in Mr Dekker’s position. They were not prepared for physical incapacity and never had the staff or expertise required to care for people with physical as well as mental illnesses. Mr Dekker’s physical and mental illness was clear at the time of his transfer, as was his need for vigilant nursing care. Tshepong was never going to be able to provide such care and this was clear to the Gauteng Department of Health officials transferring him and was clearly stated on his most recent periodical report. The experts all point to lack of nursing care as being the cause of the bed sores that ultimately became septic and killed Mr Dekker.

<u>The legal cause of Mr Dekker’s death</u>

448 Ms Dekker’s death was unnatural.

449 He was moved from Life Esidimeni to Tshepong in a group of 85 MHCUs who all arrived on the same day. Dr Manamela approved additional people being included in the group that went to Tshepong that day.

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[701] Inquest Transcript, 14 March 2022, Vol 413, page 44229.

[702] Carrina Morale statement, Vol 053, page 8696.

450 A periodical report recommended that he was not suitable for discharge as he needed supervision of treatment in a structured environment. He was prone to bedsores, had dementia, was on a complicated series of medication and was wheelchair bound.

451 The first check on the facility after MHCUs were moved in happened four months before Mr Dekker died and found that it was not suitable. Subsequent audits, both before Mr Dekker's death, recommend moving some MHCUs out of the facility and improvements in the staff complement.

452 While Mr Dekker did not have bedsores when he left Life Esidimeni, he developed and died from septic decubitis ulcers complicated by sepsis. The nursing care that would have prevented and cared for the bedsores was not present at Tshepong.

453 When Mr Dekker died, many other MHCUs at Tshepong were dying, according to Ms Morale.

454 Ms Mahlangu and Dr Manamela created the circumstances in which Mr Dekker's death was inevitable. He should never have been moved to an NGO and the conditions of the NGO were known and yet nothing was done to prevent deaths. They should each be held to have caused Mr Dekker's death.

The death of Charity Ratsotso

455 Charity Ratsotso (docket 73) was born on 26 September 1968[703] and died on 11 July 2016 at Mamelodi Hospital[704]at age 48. He was epileptic with severe mental retardation and was on chronic treatment.[705] A prescription from CCRC shows that he was on Chlorpromazine, Zuclopenthixol, Clonazepam, Orphenadrine and Oxazepan.[706]

456 Mr Ratsotso's death can be attributed to the recklessness of Ms Mahlangu and Dr Manamela.

Mr Ratsotso's transfer

457 Mr Ratsotso was institutionalised from early childhood.[707] He had been at Life Esidimeni Waverly since 2002.[708]

458 After 14 years at Life Esidimeni, Mr Ratsotso was transferred to CCRC from Life Esidimeni Waverley on 12 May 2016. According to CCRC's clinical notes, he had severe mental retardation or profound intellectual disability, was unable to care for himself and a danger to others and was destructive to property. He needed constant supervision.[709] The Discharge Report says that he is going to CCRC

[703] Charity Ratsotso discharge report, Vol 028, page 6180.

[704] July Maseko written statement, Vol 028, page 6281.

[705] Medication prescription, Vol 028, page 6213.

[706] Medication prescription, Vol 028, page 6211.

[707] Ratsotso patient particulars, Vol 028, page 6297.

[708] Ratsotso patient file, Vol 028, page 6351.

[709] Medication Prescription, Vol 028, page 6202.

and provides a prescription.[710] Daphny Ndlovu testified that on the date of Mr Ratsotso's discharge from Waverly, he lay down on the floor of the bus with his hands crossed on his chest. The Life Esidimeni staff explained that he liked to sleep this way.[711]

459 After just over a month at CCRC, Mr Ratsotso was transferred to Anchor on 23 June 2016 through a discharge form signed by Prescilla Nyatlo.[712] This transfer of MHCUs happened to make space for other MHCUs who were being moved from Life Esidimeni to CCRC and occurred on Dr Manamela's instruction.[713] He was reported to have been transferred in a satisfactory condition on CCRC's clinical notes,[714] and with discharge documents.[715]

460 Dorothy Franks maintained that she did not receive any information on Mr Ratsotso's identity,[716] although this is disputed. Either way, it is clear from the evidence that Charity's identity was not known at Anchor Home.

<u>About the facility: Anchor Home</u>

461 Anchor Home was a new NGO registered after a November 2015 meeting at which Hanna Jacobus encouraged Dorothy Franks to open a new NGO despite

[710] Ratsotso transfer report, Vol 028, page 6357.

[711] Inquest Transcript, 21 April 2022, Vol 413, page 45256.

[712] Ratsotso discharge report, Vol 028, page 6180.

[713] Hanna Jacobus statement, Vol 005, page 1507 and Transcript Inquest, 31 January 2022, Vol 413, page 42109.

[714] Nursing notes, Vol 005, page 6201.

[715] Hildah Kgwete statement, Vol 028, page 6365.

[716] Inquest Transcript, 14 June 2022, Vol 413, page 46891.

her not having experience in caring for MHCUs.[717] Ms Jacobus knew that she only had experience with children.[718]

462 According to the audit checklist[719], Anchor Home was established on 12 April 2016.[720] Dorothy Franks confirmed that she registered Anchor Home.[721] However, on 22 February 2016, at a meeting that Dr Manamela chaired, and Ms Jacobus attended, Dorothy Franks presented that it had a capacity of 150 beds, 2 registered nurses, 2 enrolled nurses and 18 care workers.[722] This was untrue as Dr Manamela and Hanna Jacobus knew that Anchor had no premises.[723] In April 2016, both Dr Manamela and Hanna Jacobus knew that the place that they had identified for Anchor House (unused wards Kalafong Hospital) had been declared unsuitable for human habitation.[724] Despite this, Anchor Home was licensed by Dr Manamela for 150 children with severe to profound intellectual disability at Kalafong Heights from 1 April 2016.[725] It never received children and never operated at Kalafong Heights. It was also never capacitated for 150 users. It was only sometime in June 2016, that Hanna Jacobus took Dorothy Franks to CCRC and arranged for her to set up her NGO there.

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[717] Evidence of Dorothy Franks, 30 October 2017, Vol 300, page 24540.

[718] Inquest Transcript, 19 January 2022, Vol 413, page 41527.

[719] Anchor Centre checklist, Vol 005, page 920.

[720] Anchor Centre checklist, Vol 005, page 930.

[721] Inquest Transcript, 15 June 2022, Vol 413, page 46756.

[722] Minutes of meeting between NGOs and Department of Health, vol 005, page 657.

[723] Dorothy Franks statement, Vol 005, page 359.

[724] Hanna Jacobus statement, Vol 005, page 1506-7.

[725] Anchor house Mental Health License, Vol 200, page 20314.

463 The ordinary process for inspecting and auditing the NGO did not take place. In fact, Hanna Jacobus said “There was not any process followed”.[726]

464 On 20 June 2016,[727] there was a meeting that involved Dianne Noyile and Dr Selebano and Ms Noyile had the impression that Dr Selebano knew about Anchor and Siyabadinga and instructed Dr Manamela and Hanna Jacobus to ensure payment happened.[728]

465 The first mention of Anchor Home in an official progress report to the MEC was on 21 June 2016, two days before Mr Ratsotso’s transfer.[729] Ms Mahlangu handed a copy of this presentation at the arbitration.[730] It showed that 64 MHCUs had been placed at Anchor Home (this was not true). But it is important that the first reference to the NGO is when people have purportedly already been moved there, despite it being a new NGO. The presentation also notes as a ‘low light’, “death and absconds”, showing that the MEC was aware of deaths and abscondments associated with the project before Mr Ratsotso was transferred.[731]

466 Dorothy Franks received 30 MHCUs on 23 June 2016 from CCRC, which was trying to make space for Life Esidimeni MHCUs. She only had space for 25

[726] Inquest Transcript, 19 January 2022, Vol 413, page 41671.

[727] Dianne Noyile statement, Vol 005, page 496.

[728] Inquest Transcript, 14 June 2022, Vol 413, page 46664.

[729] Life Esidimeni contract termination project, 21 June 2016, Vol 200, page 20643.

[730] Qedani Mahlangu exhibit file, Vol 300, page 31826.

[731] Life Esidimeni contract termination project, 21 June 2016, Vol 200, page 20646.

MHCUs at this point[732] and was expecting to receive children.[733] Hanna Jacobus and Dr Manamela were both aware of her having received more people than she had space for and Dr Manamela told Hanna Jacobus that the placement of adults was temporary.[734] Daphney Ndlovu confirmed that the instruction to move people from CCRC to Anchor Home came from Dr Manamela.[735] Dr Talatala confirmed that moving MHCUs at 6pm from CCRC rather than from Life Esidimeni, as expected, was negligent.[736] Dr Manamela also came to Anchor Home and moved some of the MHCUs from Anchor into wards used by Siyabadinga in time for Anchor to receive a further 40 MHCUs from Life Esidimeni.[737]

467 One of the first 30 MHCUs transferred from CCRC was Mr Ratsotso.

468 There had been no audits or inspections of Anchor Home at this time, despite transfers having taken place and so we do not know what the NGO looked like at this time. Dorothy Franks said they had one professional nurse at the beginning.[738]

469 Dorothy Franks testified that the clinics that they were supposed to be able to rely on were overcrowded and did not have additional budget to assist their MHCUs. They had problems with medication and with staff who were not being

[732] Dorothy Franks statement, Vol 005, page 360.

[733] Hanna Jacobus statement, Vol 005, page 1507.

[734] Hanna Jacobus statement, Vol 005, page 1507-8.

[735] Inquest Transcript, 21 April 2022, Vol 413, page 45053.

[736] Inquest Transcript, 18 March 2022, Vol 413, page 44543.

[737] Hanna Jacobus statement, Vol 005, page 1508.

[738] Inquest Transcript, 14 June 2022, Vol 413, page 46670.

paid.[739] They got occasional help from the Department of Health when they complained (eg with bedding and food) but the NGO had to pay the suppliers for this.[740] Hanna Jacobus confirmed that the necessities were not yet in place when MHCUs were transferred to Anchor Home.[741]

470 The NGO was first audited on 19 September 2016[742] by Rochelle Gordon. This was long after Mr Ratsotso died. That audit found that the furniture was insufficient, there was one professional nurse, the centre did not always have access to running water, the staff was not trained in first aid, and there were no seats on the toilets. Anchor Home was audited again on 6 October 2016 by Nonceba Sennelo.[743] At that time the NGO had two professional nurses but no other professional staff.[744]

471 Dr Talatala notes that the medication that Mr Ratsotso was on included an antipsychotic that may have been used to control abnormal behaviour, a drug to treat the side effects of the antipsychotic, and two drugs probably used to calm him down but that could, if used for prolonged periods, have put him at risk of seizures if they were suddenly stopped rather than being tapered. Given that his name was not known means that this was a distinct risk. This risk would make transfer with good communication essential, although he states that moving Mr Ratsotso to a less specialised facility was in any case not appropriate.[745] Dr

[739] Inquest Transcript ,14 June 2022, Vol 413, page 46811.

[740] Inquest Transcript, 14 June 2022, Vol 413, page 46814.

[741] Inquest Transcript, 19 January 2022, Vol 413, page 41612.

[742] Anchor centre audit checklist, Vol 200, page 20558.

[743] Anchor centre audit checklist, Vol 005, page 920.

[744] Anchor centre audit checklist, Vol 005, page 924.

[745] Dr Talatala report, Vol 412, page 37507.

Talatala emphasised that the fact that Mr Ratsotso could not himself communicate further increases his risk of harm if he is unknown at a facility. It is unacceptable for a transfer to happen in these circumstances.[746]

472 Prof Pienaar notes that Mr Ratsotso's diagnosis and the medication that Mr Ratsotso was on meant that he needed "total direct care 24 hours a day, seven days a week (24/7) and under no circumstances can cope with indirect care".[747] He explained this to mean that because the person is compromised on several levels, they need care for every facet of life. This kind of care is impossible where there is a low staff to mental health care user ratio.[748] He also notes that difficulty swallowing, caused by Mr Ratsotso's illness and exacerbated by his medication, would put a person at greater risk of drooling and aspiration. This in turn requires higher levels of supervision.[749]

Mr Ratsotso's death

473 On 30 June 2016, Mr Ratsotso was transferred to Mamelodi Hospital as an unknown mental health care user and was diagnosed as having continuous seizures.[750] He remained in Mamelodi Hospital until his death in the early hours of 11 July 2016.[751] Mr Ratsotso's identity was established on 8 July 2016, three days before his death, through a call between the social worker at Mamelodi and

[746] Inquest Transcript, 16 March 2022, Vol 413, page 44415.

[747] Ratsotso Mental health assessment, Vol 028, page 6370.

[748] Inquest Transcript, 14 March 2022, Vol 413, page 44043.

[749] Inquest Transcript, 14 March 2022, Vol 413, page 44044.

[750] Ratsotso patient progress report, Vol 028, page 6221.

[751] Ratsotso patient progress report, Vol 028, page 6231.

Tshepiso Mmola[752] of Anchor.[753] Mmola says that he informed Dorothy Franks that the unidentified person at Mamelodi was Mr Ratsotso, because he had seen Mr Ratsotso's ID book at Anchor.[754] However, Dorothy Franks maintained that Mr Ratsotso remained unknown long past his death, until he was identified by Daphney Ndlovu on 17 January 2017.[755]

474 Dr Makhoba notes that Mr Ratsotso was admitted with continuous seizures but that he appeared to be stable after admission.[756] He states that "aspiration, resulting in aspiration pneumonia, is a well-known complication of generalised tonic colonic seizures and is caused by the aspiration of secretions as airway protective reflexes are inhibited by seizure."[757] In oral evidence he said that food would have entered Mr Ratsotso's lungs while he was having a seizure and the immune system would have fought the food, resulting in inflammation and then infection.[758] The cells in the lungs then die.[759] The pneumonia could take hours or days to develop.[760] The lack of notes from Anchor Home make it difficult to know when the seizures started.

[752] Phone number in social worker report matches that on Mmola's general statement, Vol 018, page 3909. Mmola confirms this in their written statement, Vol 028, page 6341.

[753] Medication Prescription, Vol 028, page 6242.

[754] Tshepiso Mmola's written statement, Vol 028, page 6342.

[755] Dorothy Franks statement, Vol 028, page 6284.

[756] Ratsotso forensic investigation report, Vol 028, page 6337.

[757] Ratsotso forensic investigation report, Vol 028, page 6337.

[758] Inquest Transcript, 24 February 2022, Vol 413, page 43520.

[759] Inquest Transcript, 24 February 2022, Vol 413, page 43510 This was in reference to Daniel Josiah, but both Charity and Daniel died of necrotizing pneumonia and Dr Makhoba was providing a general explanation about the condition.

[760] Inquest Transcript, 24 February 2022, Vol 413, page 43521.

475 Dr Makhoba conducted a post-mortem on Mr Ratsotso's body and found the cause of death to be "in keeping with food aspiration complicated by necrotising pneumonia".[761] Mr Ratsotso weighed 42kg when he died and appeared underweight.[762]

476 Dr Makhoba said further that there is a need for a smooth transition between institutions, with the adequate documents, so that adequate treatment can be provided.[763] This did not occur in this case. The seizures would have required early intervention and miscommunication on transfer wastes time.[764] Dr Makhoba added that not everyone who is exposed to sub-optimal care would necessarily die but it puts a person in a category that, if you are one of the most vulnerable, you can be predisposed to death.[765] The conditions in which the person is placed will then be a factor in the outcome of a mental health care user.[766]

477 Mr Ratsotso should never have been transferred to a facility with a lower level of care (CCRC) and his further transfer to a facility that was known not to have an appropriate staff to mental health care user ratio or staff capacity put him at serious risk. The loss of his identity, either in his transfer to Anchor or in his transfer to Mamelodi (but likely in his transfer to Anchor) meant that he could not be appropriately medicated and facilitated his death. He died weighing just 42kg, having been admitted to hospital for continuous seizures without evidence of his

[761] Ratsotso post-mortem report, Vol 028, page 6261.

[762] Ratsotso post-mortem report, Vol 028, page 6262.

[763] Inquest Transcript, 24 February 2022, Vol 413, page 43511.

[764] Inquest Transcript, 24 February 2022, Vol 413, page 43546.

[765] Inquest Transcript, 24 February 2022, Vol 413, page 43546.

[766] Inquest Transcript, 24 February 2022, Vol 413, page 43546.

identity. He aspirated food which caused an infection in his lung that was not noticed by Anchor caregivers, until he died of pneumonia.

The legal cause Mr Ratsotso's death

478 Mr Ratsotso's death was unnatural.

479 He was moved from Life Esidimeni to CCRC and then to Anchor Home. He was a difficult to manage MHCU and his discharge report places him at CCRC. He was moved when Dr Manamela sought to make room for more MHCUs in CCRC.

480 Mr Ratsotso was moved to Anchor Home, at night, and in a group of 30 MHCUs when there was only space for 25.

481 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 be stopped abruptly at the risk of causing seizures. Doing so was inevitable when his identity was not known, however.

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

483 Anchor Home was first audited long after Mr Ratsotso died and was found to be unsuitable to care for MHCUs.

484 Ms Mahlangu and Dr Manamela created the circumstances in which Mr Ratsotso's death was inevitable. He should never have been moved to an NGO

and the conditions of the NGO were unsuitable to provide for his care. They should each be held to have caused Mr Ratsotso's death.

The death of Koketso Mogoerane

485 Koketso Christoper Mogoerane was born 21 December 1960[767] and died on 15 June 2016 at Rebafenyi[768] at age 55. He had schizophrenia. The docket does not contain any records from Life Esidimeni.

486 Mr Mogoerane's death can be attributed to the recklessness of Ms Mahlangu and Dr Manamela.

Mr Mogoerane's transfer

487 According to his brother, Mr Mogoerane had been institutionalised since age 26[769] and had been at Life Esidimeni (most recently at Waverley since 2014) for many years before he was moved to Rebafenyi on 26 May 2016.[770] He had thus been safely institutionalised for almost 30 years. He died within 19 days of being moved to Rebafenyi.

488 Dr Talatala clarified that while some people with schizophrenia are able to live a normal life, if a person with schizophrenia is institutionalised it would mean that they are on treatment, but the symptoms are not sufficiently dealt with. The person may have some psychotic features remaining and would be unable to

[767] Lucas Ramasike written statement, Vol 083, page 12952.

[768] Nonhlanhla statement, Vol 083, page 12957.

[769] Lucas Mogoerane statement, Vol 083, page 12942.

[770] Lucas Mogoerane statement, Vol 083, page 12942.

look after himself, requiring shelter, supervision with eating and drinking and provision of medication, and ensuring safe behaviour.[771]

489 Mr Mogoerane was moved to Rebafenyi as a group of 61 male MHCUs.[772] Hanna Jacobus admitted that this would be a huge burden even for an experienced NGO and would result in poor treatment of users. The NGO was on a small holding[773] and was fairly remote. At the time of his move until his death, there was no professional nurse at Rebafenyi. A professional nurse only started mid-July when Rebafenyi was paid by the Department.[774] Tiisetso Malebe had received a call from Nonceba Sennelo the same day to instruct him to arrange transport to fetch the users that day.[775]

490 When his brother visited Mr Mogoerane at Rebafenyi, he found that he had already lost weight, was distressed, and was very hungry.[776] Dr Talatala stated that the medication used to treat schizophrenia increase appetite and if the NGO was not able to provide sufficient food, this would have cause hunger and distress.[777]

491 Dr Talatala further noted that Mr Mogoerane would have been familiar with his environment at Life Esidimeni and a move may cause adjustment disorder,

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[771] Inquest transcript, 16 March 2022, Vol 413, page 44381.

[772] Nonhlanhla statement, Vol 083, page 12956.

[773] Tiisetso Malebe statement, Vol 005, page 393.

[774] Nonhlanhla statement, Vol 083, page 12956.

[775] Tiisetso Malebe statement, Vol 005, page 394.

[776] Lucas Mogoerane statement, Vol 083, page 12943.

[777] Inquest Transcript, 16 March 2022, Vol 413, page 44378.

sadness and anxiety.[778] This needs to be managed because he has limited abilities to care for himself.[779] The new caregivers would not know how he communicated and any further stressor such as a lack of food could make him more distressed, particularly given his limited emotional resources to deal with distress.[780] Tiisetso Malebe admitted that "due to the fact that Rebafenyi staff had no experience to deal with mental health care patients their lives were put in danger."[781] Rebafenyi did not have a dietician, occupational therapists or social workers and the menu was introduced later.[782] Nonceba Sennelo confirmed the inadequacy of staff at Rebafenyi,[783] she testified that Mr Mogoerane's fall at night and no one finding him until morning demonstrated the lack of sufficient staff and should never have happened.[784]

492 Tiisetso Malebe confirmed in evidence that Rebafenyi did not know how to care for MHCUs until Salome Mashile was assigned to the NGO (which occurred after Mr Mogoerane died).[785] While Hanna Jacobus testified to having visited Rebafenyi and finding it compliant,[786] she also said that she was just checking structure, not paperwork and protocols.[787] Furthermore, a 21 July 2016 inspection report[788] finds that certain essential requirements for an NGO were

[778] Inquest Transcript, 16 March 2022, Vol 413, page 44379.

[779] Inquest Transcript, 16 March 2022, Vol 413, page 44380.

[780] Inquest Transcript, 16 March 2022, Vol 413, page 44380.

[781] Tiisetso Malebe statement, Vol 005, page 395.

[782] Tiisetso Malebe statement, Vol 005, page 396.

[783] Inquest Transcript, 22 November 2022, Vol 413, page 40448.

[784] Inquest Transcript, 22 November 2022, Vol 413, page 40692.

[785] Inquest Transcript, 26 May 2022, Vol 413, page 46331.

[786] Inquest Transcript, 18 January 2022, Vol 413, page 41489.

[787] Inquest Transcript, 21 January 2022, Vol 413, page 42061.

[788] Rebafenyi Audit checklist Vol 200, page 20398.

not met, MHCUs were not receiving medicine for long periods. Hanna Jacobus acknowledged that the findings of the inspection illustrate that the NGO was not properly capacitated.[789] Another audit of Rebafenyi House 1 is dated 17 September 2016.[790] This audit found that even at this late stage, there was insufficient furniture, broken toilet seats, inadequate food storage, inadequate assistive devices, no professional nurse, basic equipment like a blood pressure and a glucose monitor missing. Despite this, Rebafenyi was licensed.[791]

Mr Mogoerane's death

493 The report from the NGO indicates that Mr Mogoerane died after falling at night as there was no care in the upper level of Rebafenyi at night. His body was only found in the morning. While a person with schizophrenia does not need constant monitoring at night, Dr Talatala said that he would have had periodical monitoring at night at Life Esidimeni and that this should have continued, at least until he was adjusted to his new environment.[792]

494 Dr Talatala indicates that death at night without care and without a known cause should have been investigated[793] and yet, not only did a post-mortem not get performed, but the police failed to collect any evidence relating to the death.[794]

[789] Inquest transcript, 19 January 2022, Vol 413, page 41490.

[790] Rebafenyi Audit checklist, Vol 200, page 20496.

[791] Rebafenyi Mental Health license, Vol 200, page 20317.

[792] Inquest Transcript, 16 March 2022, Vol 413, page 44383.

[793] Dr Talatala report, Vol 412, page 37479.

[794] This is also despite a specific request for a judicial inquest, with reference to Mr Mogoerane's death, on 16 September 2016, at Vol 200, page 19040.

495 Mr Mogoerane should never have been moved to a place without professional staff to take care of his basic and medication needs. He had survived decades in institutionalised care but died when everyone else was asleep, completely unsupervised, and in a place, he was not familiar with. He was hungry and distressed, as was inevitable given his illness and medication. There was no professional nurse to prepare and assist to administer his medication and we do not know whether it was provided appropriately.

The legal cause Mr Mogoerane's death

496 Mr Mogoerane's death was unnatural.

497 He was moved from Life Esidimeni to Rebafenyi. He was moved in a large group of 61 MHCUs.

498 From when he arrived until the time of his death, there was no professional nurse at Rebafenyi. The NGO was not audited until after Mr Mogoerane's death.

499 Mr Mogoerane had lost weight when he saw his brother. Mr Mogoerane fell at night and died. He was only discovered in the morning.

500 Ms Mahlangu and Dr Manamela created the circumstances in which Mr Mogoerane's death, alone, hungry and in a place he was unfamiliar with, was inevitable. Mr Mogoerane needed care and supervision to adapt to a new location but the conditions of the NGO were unsuitable to provide for his care. They should each be held to have caused Mr Ratsotso's death.

The death of Vuyo Aaron Ngqondwane

501 Vuyo Aaron Ngqondwane (docket 71) was born on 11 October 1985 and died on 7 February 2017[795] at age 31 at the Cullinan Care and Rehabilitation Centre[796]. He was epileptic,[797] had cerebral palsy[798] was intellectually disabled and was confined to a wheelchair. Mr Ngqondwane was on sodium valproate and lamotrigine.[799]

502 Mr Ngqondwane's death can be attributed to the recklessness of Ms Mahlangu and Dr Manamela.

Mr Ngqondwane's transfer

503 Mr Ngqondwane had been institutionalised since he was six years old.[800] He had been at Life Esidimeni Randfontein since he was 24 years old[801] and was moved at age 30.

504 Mr Ngqondwane was moved to Anchor Home from Life Esidimeni on 29 June 2016.[802]

[795] Letter from SECTION27 requesting judicial inquest, 16 September 2016, Vol 200, page 6054.

[796] Vuyo Ngqondwane forensic investigation report, Vol 027, page 6067.

[797] Vuyo Ngqondwane prescription and admin information, Vol 027, page 6077.

[798] Vuyo Ngqondwane prescription and admin information, Vol 027, page 6077.

[799] Vuyo Ngqondwane prescription and admin information, Vol 027, page 6079.

[800] Johannah Ngqondwane written statement, Vol 027, page 6048.

[801] Johannah Ngqondwane written statement, Vol 027, page 6048.

[802] Transfer of Mental health patients form, Vol 027, page 6075.

505 There had been no audits or inspections of Anchor House at this time, despite transfers having taken place and so we do not know what the NGO looked like at this time.

506 Mr Ngqondwane was transferred in a satisfactory and well-nourished condition with 28 days of medication.[803] Dorothy Franks reports that he could not eat, dress or wash himself and relied on staff for help.[804] Similarly, a leave of absence form filled in at CCRC records that he needs help with personal care, feeding, pressure point care and that he must not be left alone.[805]

507 Prof Pienaar was of the opinion that caring properly for Mr Ngqondwane would require a professional nurse and auxiliary/assisted nurses under the professional nurse's direct supervision. This would also be needed for the appropriate use of the medication that Vuyo was on.[806]

508 Mr Ngqondwane did not get the care he needed at Anchor House. Dorothy Franks testified that the clinics that they were supposed to be able to rely on were overcrowded and did not have additional budget to assist their MHCUs. This was confirmed by Prof Robertson.[807] They had problems with medication and with staff who were not being paid.[808] They got occasional help from the Department of Health when they complained (eg with bedding and food) but the NGO had to

[803] Patient progress notes, Vol 027, page 6076.

[804] Dorothy Franks statement, Vol 027, page 6045.

[805] Patient leave of absence form, Vol 027, page 6146.

[806] Inquest Transcript, 14 March 2022, Vol 413, page 44028.

[807] Inquest Transcript, 25 May 2023, Vol 424, page 54043 and 54071.

[808] Inquest Transcript, 14 June 2022, Vol 413, page 46917.

pay the suppliers for this.[809] Hanna Jacobus confirmed that the necessities were not yet in place when MHCUs were transferred to Anchor.[810]

509 Mr Ngqondwane's mother reported that he lost weight and his complexion changed while he was at Anchor House.[811]

510 The NGO was first audited on 19 September 2016[812] by Rochelle Gordon. That audit found that the furniture was insufficient, there was one professional nurse, the centre did not always have access to running water, the staff was not trained in first aid, and there were no seats on the toilets. Anchor was audited again on 6 October 2016 by Nonceba Sennelo.[813] At that time the NGO had two professional nurses but no other professional staff.[814]

511 On 31 October 2016, Anchor was closed and CCRC staff took over care of the MHCUs. Dorothy Franks was asked to leave the following day but continued to be responsible for paying for suppliers.[815]

512 On 31 December 2016[816] Mr Ngqondwane was taken home for a leave of absence and returned on 15 January 2017[817] to CCRC.

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[809] Inquest Transcript, 14 June 2022, Vol 413, page 46919.

[810] Inquest Transcript, 19 January 2022, Vol 413, page 41483.

[811] Johannah Ngqodwane written statement, Vol 027, page 6049.

[812] Anchor House Checklist, Vol 200, page 20558.

[813] Anchor House Checklist, Vol 005, page 920.

[814] Anchor House Checklist, Vol 005, page 924.

[815] Dorothy Franks statement, Vol 005, page 361.

[816] Nursing report, Vol 027, page 6040.

[817] Christian Ngqodwane written statement, Vol 027, page 5993.

513 The nursing notes are inconsistent and sometimes contradictory, both in the period when he was at Anchor House and when he was at CCRC.[818]

Mr Ngqondwane's death

514 Mr Ngqondwane died from aspiration pneumonia[819] according to Dr Stuart who performed a post-mortem on his body. She found a large piece of orange plastic sheeting in his stomach[820] and photographed it.[821] It was around 50/60cm by 20cm.[822] Dr Stuart notes that there is also nothing in the notes to indicate that the staff was aware of Mr Ngqondwane having swallowed plastic, which would have resulted in likely nausea, vomiting and abdominal pain.[823] Swallowing something this size would not have been easy according to Dr Stuart – it would have been a long drawn out process.[824]

515 Mr Ngqondwane weighed only 36kg at death.[825] Dr Stuart characterised this as being very severely underweight and a sign of malnutrition.[826]

516 When Mr Ngqondwane's father identified his body, he had a sponge in his mouth that was full of blood.[827]

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[818] Forensic investigation report, Vol 027, page 6068.

[819] Forensic report, Vol 027, page 6056.

[820] Forensic report, Vol 027, page 6056.

[821] Photo evidence of orange plastic found in stomach, Vol 412, page 37461.

[822] Inquest Transcript, 23 February 2022, Vol 413, page 43382.

[823] Forensic investigation report, Vol 027, page 6068.

[824] Inquest Transcript, 23 February 2022, Vol 413, page 6068.

[825] Leratong Hospice intake register, Vol 054, page 6057.

[826] Inquest Transcript, 23 February 2022, Vol 413, page 43384,

[827] Christian Ngqodwane written statement, Vol 027, page 5994.

517 Dr Talatala notes in his report that the use of both sodium valproate and lamotrigine to treat convulsions is indicative of difficult to control epilepsy or abnormal behaviour or both.[828] He is of the opinion that transferring Mr Ngqondwane to another facility of equal competence would be difficult and would need to be done with extreme caution because he would be familiar with his surroundings and the personnel in Randfontein and the personnel in Randfontein would know how to communicate with him.[829] He finds that the fact that Mr Ngqondwane either swallowed the plastic and aspirated on his vomit, or swallowed the plastic and aspirated during an epileptic seizure are indicative of the fact that he needed close supervision.[830] A facility should be able to pick up at the point of aspiration and not wait for it to get to pneumonia - it could take hours or days to progress from aspiration to pneumonia.[831]

518 Dr Talatala also notes with concern the presence of clozapine in his blood and stomach contents. Clozapine was not prescribed to Mr Ngqondwane and needs to be used with caution in MHCUs with epilepsy as it lowers seizure threshold. He may have swallowed an unprescribed medication or was given such a medication, both of which indicate poor quality care.[832] Dr Talatala argues that Mr Ngqondwane's psychosocial disabilities made him unsuitable for placement in an NGO and that doing so put him at risk.[833]

[828] Expert report of Dr Talatala, Vol 412, page 37504.

[829] Expert report of Dr Talatala, Vol 412, page 37505.

[830] Expert report of Dr Talatala, Vol 412, page 37505.

[831] Inquest transcript, 17 March 2022, Vol 413, page 44465.

[832] Expert report of Dr Talatala, Vol 412, page 37505.

[833] Expert report of Dr Talatala, Vol 412, page 37505.

519 The conditions at Anchor and then at CCRC clearly caused Mr Ngqondwane's death in that while he was very dependent on care, he lost significant weight, to the extent that he was very severely underweight and malnourished, swallowed a large piece of plastic, and aspirated on his vomit. His stomach contained non-prescribed medication and what would have been a slow process of death was not noticed by staff at CCRC.

The legal cause Mr Ngqondwane's death

520 Mr Ngqondwane's death was unnatural.

521 He was moved from Life Esidimeni to Anchor Home and then to CCRC. He was confined to a wheelchair and could not communicate. He was moved to Anchor Home in a large group of MHCUs.

522 By the time of his death, Mr Ngqondwane weighed only 36kg.

523 Mr Ngqondwane died from aspiration pneumonia with a large piece of orange plastic in his stomach. The plastic would have resulted in nausea, vomiting and abdominal pain but there is nothing in the notes to suggest that staff at CCRC noticed. It would have taken several days for the disease to progress to pneumonia but again, this was not noticed.

524 Mr Ngqondwane's stomach was also found to contain a medication for which he had no prescription.

525 Ms Mahlangu and Dr Manamela created the circumstances in which Mr Ngqondwane's death was inevitable. Mr Ngqondwane needed care and

supervision to but the conditions of the NGO and then CCRC were unsuitable to provide for his care. They should each be held to have caused Mr Ngqondwane's death.

F. RESPONSE TO EVIDENCE LEADERS' SUBMISSIONS

526 As per this Court's directives, the Evidence Leaders filed Heads of Arguments on 28 July 2023. The Heads in the main provide a summary of the testimony provided by various witnesses before this Court. We address certain critical aspects of those submissions. Our submissions will also be limited to submissions made in relation to Ms Mahlangu, Dr Manamela and Ms Ncube. In particular, we focus on:

526.1 The standard of proof used by the Evidence Leaders;

526.2 Causes of death in terms of section 16(2)(b); and

526.3 Criminal responsibility.

Incorrect standard of proof

527 The Evidence Leaders, on a number of occasions, refer to a failure to prove beyond reasonable doubt. This appears in a number of places, we refer to the following examples:

527.1 In a section dealing with factual causation, the Evidence Leaders state that:

> *"In an inquest where possible criminal liability must be established, the evidence must beyond reasonable doubt show that a person's death was*

brough about by any act or omission involving or amounting to an offence on the part of any person".[834]

527.2 In a section dealing with whether legal causation has been established against Dr Manamela, the Evidence Leasers submit that:

"It is thus submitted that it cannot be proved beyond reasonable doubt that the placement of these users in Precious Angels legally caused their death."[835]

…

"it will be argued that the state cannot prove beyond reasonable doubt that she had known or that a reasonable person in her position should have known that the deceased would face starvation (the factual cause of death) if placed in Precious Angels."[836]

…

527.3 In a section dealing with Ms Ncube, the Evidence Leaders again submit that:

"The evidence is not as such that the court, beyond reasonable doubt, can find that Ms Ncube was either responsible for the precipitating factors, or partake in causing them or knew about them and neglect her duty of care by not timeously taken appropriate steps to prevent further consequences."[837]

528 These examples are just three occasions where the Evidence Leaders refer to the incorrect standard of proof. As far as we are able to determine, this is done at least 18 times. This error is important.

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[834] Evidence Leader Heads of Argument, Vol 426, page 54758.

[835] Evidence Leader Heads of Argument, Vol 426, page, 54791, para 6.4.2.3.

[836] Evidence Leader Heads of Argument, Vol 426, page 54791, para 6.4.2.4.

[837] Evidence Leader Heads of Argument, Vol 426, page 54792, para 6.4.3.1.

529 In ***Goniwe and Others***[838] the court held that the standard of proof required to make a finding in an inquest is not that as applied in a criminal trial. The test is less stringent in inquests. The court explained this rationale as follows:

> *"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 Inquest Act is whether the judicial officer holding the inquest is of the opinion that there is evidence available 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 an act or omission which involves or amounts to the commission of a criminal offence on the part of some person or persons."*[839]

530 Similarly, in ***Padi v Botha***[840] it was held that –

> *"section 16(2)(d) of the Act did not require proof beyond a reasonable doubt: a judicial officer was not required to make his finding with reference to the credibility and acceptability of the evidence before him as in a criminal trial."*

531 More recently, in ***Todd v Magistrate, Clanwilliam and Others***[841]

> *"The standard of proof applicable in inquest proceedings is poles apart to the standard of proof applicable in criminal matters. In criminal matters the state must proof its case beyond reasonable doubt. … While in inquest proceedings the question is whether a judicial officer holding the inquest is of the opinion that there is evidence available which could 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 an act or*

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[838] *In Re Goniwe and Others (2)* 1994 (2) SACR 425 (SE).

[839] *Ibid* at 428D – E.

[840] *Padi en 'n Ander v Botha No en Andere* 1995 (2) SACR 663 (W) at 665G.

[841] (19247/19) [2022] ZAWCHC 15; 2023 (1) SACR 481 (WCC) (23 February 2022).

> *omission which involved or amounted to the commission of a criminal offence on the part of some person or persons."*[842]

532 We submit that based on the abovementioned case law, the Evidence Leaders relied on the incorrect standard of proof and thus evaluated the evidence before this Inquest on a higher standard than that required in inquest proceedings.

Causes of death in terms of section 16(2)(d)

533 In broad terms, this section of the Evidence Leader's heads deal with the deceased MHCU's causes of death, in particular, whether the deaths could be proven to have been unnatural.

534 In relation to Christopher Makhoba (docket 4), the Evidence Leaders conclude that:

> *"Specific evidence was introduced regarding Christopher Mokaba(4) – he had died shortly after his transfer to Precious Angels. All the available evidence shows that he was an uncooperative patient. Nothing indicates that he was maltreated in any way. No surrounding evidence exists to indicate an unnatural death as the only reasonable possibility."*[843]

535 We respectfully disagree with this submission for the following reasons:

535.1 We submit that is incorrect to state that Mr Makhoba was an "uncooperative patient". This is a misunderstanding of the nature of the MHCU and their particular vulnerability as was dealt with extensively during the hearing of this inquest. Mr Makhoba was epileptic,

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[842] Id at para 35.

[843] Evidence Leaders Heads of Argument, Vol 426, page 54767, para 6.1.2.

intellectually disabled and wheelchair bound.[844] On assessment by Dr Wadvalla, it was recommended that he not be discharged to an NGO because he is “frail, disabled and vulnerable” and needed 24 hr care.[845]

535.2 The evidence before this Inquest is that Mr Makhoba started to not eat well a few days after his arrival at Precious Angels and was fed using a syringe.[846] Further, that during that time, Precious Angels did not have enough food and the type of food available did not follow a special diet. Further, there was no medical equipment like blood pressure machines, wheelchairs and thermometers[847] which would be needed to assess patients like Mr Makhoba.

535.3 Dr Talatala explained that the fact that Mr Makhoba needed feeding meant that he had to be under some sort of supervision. Without supervised feeding, Mr Makhoba may not eat and may die of hunger. Additionally, Mr Makhoba’s his blood sugar levels should have been monitored, because there is no other way to tell that he is hungry as it is unlikely that Mr Makhoba would communicate that he had not eaten enough.

535.4 We submit that it was also not correct to state that “Nothing indicates that he was maltreated in any way”. The evidence before this inquest is that when Mr Makhoba’s condition deteriorated a few days after his

[844] Christopher Makhoba notice of death, Vol 041, page 7617.

[845] Department of Health Transfer Document of Christopher Makhoba, Vol 041, page 7632.

[846] Transcript of Dr Sekukune, Vol 413, page 45961.

[847] Affidavit of Julia Mamatshele Vol 041, page 7696.

arrival at Precious Angels, Ms Ncube was informed several times that he needed medical attention.[848] Ms Ncube called a private doctor, but he was never taken to hospital. On the evening of 2 July 2016, Nontlantla Ndlovu found Mr Makhoba lying on ground and took him back to bed. Around 2am the following morning, she found him on the ground again, gasping for air and placed him on a sponge mattress.[849] He was found cold and unresponsive in the early morning hours of 3 July 2016.[850]

535.5 Dr Talatala testified that Mr Makhoba was a complicated mental health care user who needed specialised care. He was being treated for mental retardation with epilepsy, and from the combination of the medication he had been prescribed, it appears to have been difficult to treat the epilepsy.[851]

535.6 Dr Talatala concluded that the care at the NGO was of below expected standard or that the NGO did not have the care that Mr Makhoba needed as he was not matched to the right NGO.[852]

535.7 Lastly, we submit that it is not so that “No surrounding evidence exists to indicate an unnatural death as the only reasonable possibility”. The evidence before this inquest is that while a cause of death was not determined as there was no post-mortem, the pathologist (Dr

[848] Discharge report of Christopher Makhoba, Vol 041, Page 7684.

[849] Affidavit Nontlantla Eunice Ndlovu, Vol 041, page 7695.

[850] Transcript of Mahlatse Theophilus Nofile, Vol 413, page 45963.

[851] Transcript of Professor Pienaar, Vol 413, page 44313.

[852] Transcript of Professor Pienaar, Vol 413, 44323.

Rossouw) deduced that the likely cause of death was linked Mr Makhoba's mental condition and questions whether his feeding was adequate since it was managed with a syringe.[853]

536 In relation to Matlakala Motsoahae (docket 16), the Evidence Leaders conclude that:

> *Although Mathlakala Motsoahae (16), according to the evidence of Dr Talatala, was apparently not well looked after and should not have been placed with an NGO, the evidence available does not, beyond reasonable doubt show an unnatural death.*

537 We again respectfully disagree with this submission for the following reasons:

537.1 As stated above, the Evidence Leaders relied on the incorrect standard of proof. There is no requirement to find evidence, beyond reasonable doubt to show an unnatural death.

537.2 The evidence shows Ms Motsoahae was admitted to Kalafong Hospital[854] after she was brought in by paramedics. Ms Motsoahae had deep bed sores on the hip, presented with decreased level of consciousness,[855] she had lower respiratory tract infection, a septic hand, renal impairment, and hypernatremia.[856]

537.3 Dr Talatala testified that it is unlikely that Ms Motsoahae would have developed bed sores if she was moved frequently and able to walk

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[853] Pathology report of Christopher Makhoba, Vol 041, page 7650.

[854] Progress report of Matlakala Matsoahae, Vol 048, page 8077.

[855] Ibid.

[856] Curriculum Vitae of Dr.Abel Pienaar, Vol 412, page 37482.

around. The existence of these sores suggests that the NGO could not cope with the mental health care user care needs and did not care for the MHCUs as they ought to have. Ms Motsoahae needed direct care and to be turned every two hours.[857] Dr Talatala concluded that Ms Motsoahae was inappropriately placed at Precious Angels resulting in her not receiving adequate monitoring – leading to the development of bed sores and other complications ultimately resulting in her death.[858]

538 In relation to Frans Dekker (docket 56), the Evidence Leaders conclude that:

> *It is suggested that, in the absence of specifics in this regard and the fact that the deceased had arrived at Tshepong having had bedsores, no evidence is available to indicate beyond reasonable doubt that the death of the deceased was in any way unavoidable and thus natural."*[859]

539 We again respectfully disagree with this submission for the following reasons:

539.1 As correctly stated by the Evidence Leaders, the evidence is that Mr Dekker died from septic decubitus ulcers complicated by sepsis on 7 November 2016 at Kalafong.[860]

539.2 Dr Talatala testified that Mr Dekker was not suitable for placement in an NGO and that this resulted in him getting insufficient nursing care, putting him at risk of the pressure sores and emaciation that, complicated by sepsis, caused his death.[861]

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[857] Transcript of Dr. Pienaar, Vol 413, page 44342.

[858] Curriculum Vitae of Dr. Abel Pienaar, Vol 412, page 37482.

[859] Evidence Leader Heads of Argument, Vol 426, 54776, para 6.2.19.

[860] Medio- legal postmortem report of Frans Dekker, Vol 023, page 4738.

[861] Curriculum Vitae of Dr Abel Pienaar, Vol 412, page 37479.

539.3 This is supported by Prof Pienaar. He states in his report that given his mental condition, the fact that he was wheelchair bound, and that fact that he was on psychotropic medication, Mr Dekker needed pressure relief and night bed turning to prevent bed sores.[862] Given that bed sores are caused by the absence of such care, Prof Pienaar concludes that there was negligence and incapacity on the part of the NGO.[863]

540 While we agree that the evidence prima facie indicate that the deaths of Virginia Machapelah (7), Terrence Chaba (9) and Manyane Sophie Molefe (97) appear to be unnatural,[864] we would add the deaths of Christopher Makhoba, Daniel Josiah, Matlakala Motsoahae, Debrah Phehla, Frans Dekker, Charity Ratsotso, Koketso Mogoerane and Vuyo Ngqondwane.[865]

Criminal Responsibility

541 The Evidence Leaders start with criminal liability as it relates to both Ms Mahlangu and Dr Selebano. We limit our submissions in response to Ms Mahlangu.

542 The Evidence Leaders in essence conclude that there was no act that can lead to criminal responsibility on the part of Ms Mahlangu because she was not involved in the practical implementation of the decision. She became further involved when the deaths started to take place.[866] Further, while factual

[862] Professor Pienaar opinion on Frans Dekker, Vol 023, page 4804.

[863] Ibid.

[864] Evidence Leader Heads of Argument, Vol 426, page 54786, para 6.3.3.

[865] Evidence Leader Heads of Argument, Vol 426, at pages 54766- 54784.

[866] Evidence Leader Heads of Argument, Vol 426, 54787, para 6.4.1.1.

causation is acknowledged, they submit that there is no legal causation as cannot be said that they knew that it would or can happen during the initial stages of the implementation of the decision.[867] Lastly the Evidence Leaders find no fault because a "reasonable head of state department should rely on the decisions and actions of the personnel in the department".[868]

543 We respectfully disagree with the Evidence Leaders for the following reasons:

543.1 The evidence shows that Ms Mahlangu terminated the contract with Life Esidimeni and pressured the Gauteng Department of Health staff to fulfil that decision, continuing to make project decisions for months. She did so knowing the hazards of project termination and continuing implementation and heedless about the inadequacy of mitigation measures.

543.2 Ms. Mahlangu was sufficiently informed of the contract termination and transfer of MHCUs en masse. She did nothing to reduce these hazards.

543.3 Ms. Mahlangu received the project report after the transfers, which lists some deaths as "lowlights" as well as a range of other problems.[869] In her testimony, Ms. Mahlangu recognised the report's "lowlights" were severe. Ms. Mahlangu did nothing about project flaws.

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[867] Ibid, para 6.4.1.3.

[868] Ibid, para 6.4.1.4.

[869] Problems included users were not grouped according to needs, lack of assistive devices, lack of individual progress reports, expired food, lack of cleanliness, a shortage of medical equipment, insufficient staff due to non-payment, clinical staff, blankets, ARVs, overcrowded condition, unsuitable and unsafe infrastructure, and security concerns.

543.4 But for Ms Mahlangu's decision to terminate the LE contract, we submit that MHCUs would not have perished at the rate and manner they did.

544 In relation to Dr Manamela, the Evidence Leaders conclude that while there is factual causation, there is no legal causation because it cannot be proved beyond reasonable doubt that the placement of users in Precious Angels legally caused their death.[870] In relation to fault, the Evidence leaders find that it cannot be proven "beyond reasonable doubt that she had known or that a reasonable person in her position should have known that the deceased would face starvation (the factual cause of death) if placed in Precious Angels".[871]

545 This is simply incorrect. We discuss Dr Manamela's criminal responsibility in detail at above in these submissions. In short:

545.1 This is so because there were many warnings that the mass transfer of MHCUs to NGOs within a short timeframe would be disastrous. This was expressed prior and during the mass transfer process.

545.2 Dr Manamela was the lead implementer and was appointed as such given her wide experience with mental health. We submit that her conduct, and lack of conduct, fell short of what is required of a reasonable state official in her position.

545.3 Dr Manamela was told by her team of the many challenges faced by the NGOs including Precious Angels but failed to act. The challenges

[870] Evidence Leader Heads of Argument, Vol 426, page 54790, para 6.4.2.3.

[871] Evidence Leader Heads of Argument, Vol 426, page 54791, para 6.4.2.4.

included the lack of staff, food, space and skill across the various NGO's. This we now know resulted in the deaths of the MHCU.

546 In relation to Ms Ncube, the Evidence Leaders conclude that "*the evidence is not as such that the court, beyond reasonable doubt, can find that Ms Ncube was either responsible for the precipitating factors, or partake in causing them or knew about them and neglect her duty of care by not timeously taken appropriate steps to prevent further consequences".*[872] Further that Ms Ncube cannot be held criminally liable for deeds committed by her personnel.[873]

547 Again, this is not correct. We discuss Ms Ncube's criminal responsibility in detail above. In short:

547.1 Ms Ncube had no knowledge or experience of dealing with people with severe to profound mental illness. She accepted them into her care knowing that she was only skilled to care for children, and that she did not have experience operating a 24-hour care centre.[874] Further she had no professional or trained staff to take care of the MHCUs.

547.2 Ms Ncube knew that at all material times Precious Angels had no resources to admit and care for the MHCUs transferred to it.

547.3 Ms Ncube knew her facilities were operating without proper licenses.

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[872] Evidence Leader Heads of Argument, Vol 426, page 54792, para 6.4.3.1.

[873] Ibid, para 6.4.3.1.

[874] Transcript of Ethel Ncube, Vol 413, page 48203.

547.4 Ms Ncube was informed about various patients' conditions, but she failed to act. This includes Mr Chaba and Mr Makhoba who required urgent care but Ms Ncube, who bore a responsibility, failed to act.

G. CONCLUSION

548 It is said that the true measure of any society can be found in how it treats its most vulnerable members. In this case, our most vulnerable members were failed by those who were put in positions of power and authority and who were responsible for their care.

549 The deaths of the 10 MHCUs who died while under the care of the State did not happen in a vacuum. They died because they were removed from a place of care where they were fed, cared for and given the correct medications, to places where they were neglected, tortured, starved, and deprived of medication and proper care. This took place under the instructions and direction of Ms Mahlangu, Dr Manamela and Ms Ncube as we have described above in these submissions. The evidence from pathologists, psychiatrists and administrators shows that the deaths of the 10 MHCUs listed above in these submissions were a direct consequence of the actions and omissions of Ms Mahlangu, Dr Manamela and Ms Ncube.[875]

[875] Ms Ncube's responsibility extends only to the death of five MHCUs who are listed above and who were transferred to Precious Angels.

550 For all the reasons set out in these submissions, we respectfully submit that both the evidence led in these proceedings as well the law set out in these submissions support a finding by this Court that Ms Mahlangu, Dr Manamela and Ms Ncube are *prima facie* guilty of culpable homicide in relation to the deaths of the 10 MHCUs we list above.[876]

ADILA HASSIM SC

NASREEN RAJAB-BUDLENDER SC

THABANG POOE

Chambers, Sandton

22 September 2023

[876] In these submissions we have emphasised that our case is focused on holding Ms Ncube responsible for the deaths of the five MHCUs listed above in these submissions, who were transferred to Precious Angels and placed in her care.