IN THE ARBITRATION BETWEEN:

FAMILIES OF MENTAL HEALTH CARE USERS AFFECTED BY THE GAUTENG MENTAL MARATHON PROJECT

Claimants

And

NATIONAL MINISTER OF HEALTH OF THE REPRUBLIC OF SOUTH AFRICA

GOVERNMENT OF THE PROVINCE OF GAUTENG

PREMIER OF THE PROVINCE OF GAUTENG

MEMBER OF THE EXECUTIVE COUNCIL OF HEALTH: PROVINCE OF GAUTENG

Respondents

BEFORE JUSTICE DIKGANG MOSENEKE

AWARD

Introduction

[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. It is also a story of the searing and public anguish of the families of the affected mental health care users and of the collective shock and pain of many other caring people in our land and elsewhere in the world. These inhuman narratives were rehearsed before me, the Arbitrator, in arbitral proceedings I am about to describe.

[2] It is now undisputed that as a result of their move out of Life Esidimeni facilities after 1 October 2015, 144 mental health care users died and 1418 were exposed to trauma and morbidity amongst other results, but survived. Of the known survivors, the State informs that the whereabouts of 44 mental health care users remain unknown.

[3] The Life Esidimeni Arbitration was established following Recommendation 17 of the Health Ombudsperson's "Report into the circumstances surrounding the deaths of mentally ill patients: Gauteng Province" (Ombud's Report).[1] The parties,[2] referred their dispute to arbitration before a single arbitrator. This they did subject to a written arbitration agreement concluded on 8 September 2017[3] and subject to the provisions of the Arbitration Act[4]. The parties also settled a pre-arbitration minute[5] which regulated the exchange of pleadings; procedural matters; admission of evidence, inclusion of

[1] Discussed below.

[2] Parties are described fully in [13] to [20].

[3] Also referred to as Terms of Reference.

[4] 42 of 1965 as amended.

[5] Signed on 3 October 2017.

extensive bundles of documents and agreed to the role of two advocates appointed by the Arbitrator who would serve as evidence leaders.[6]

[4] The arbitration proceedings started on 9 October 2017 and ended on 9 February 2018. They were open to the affected families, the public and all media. The hearings sat for 43 days and an additional two days on which legal argument was presented. During that time, 60 witnesses took to the stand and gave evidence under oath. Of the 60 witnesses; 12 were senior State officials. They included the former Head of Department of Health: Gauteng Province[7]; the current acting Head of Department[8]; the former member of the Executive Council for Health: Gauteng Province[9]; the current member of the Executive Council[10]; the member of the Executive Council for Finance: Gauteng Province;[11] the Premier: Gauteng Province (Premier)[12] and the National Minister of Health (Minister)[13]. Five witnesses were middle management government employees and one was a senior officer in the South African Police Service. The managing director of Life Esidimeni[14] at the time of the Gauteng Mental Health Marathon Project (Marathon Project) also testified. The witnesses included three managers or owners of non-governmental organisations to which mental health care users were moved, six were expert witnesses, 22 were family members of the deceased persons and nine were family members of the surviving victims. Fifty nine affidavits were submitted by SECTION27[15] in relation to the witnesses who chose

[6] Adv. Nontlantla Yina and Adv. Patrick Ngutshana were appointed as evidence leaders.

[7] Dr Tiego Ephraim Selebano.

[8] Dr Ernest Kenoshi.

[9] Ms Qedani Dorothy Mahlangu.

[10] Dr Gwen Ramokgopa.

[11] Ms Barbara Creecy.

[12] Mr David Makhura.

[13] Dr Aaron Motsoaledi.

[14] Dr Morgan Mkhatshwa.

[15] SECTION27 is a public interest law centre that seeks to achieve substantive equality and social justice in South Africa. Guided by the principles and values in the Constitution, SECTION27 uses law, advocacy, legal literacy, research and community mobilisation to achieve access to healthcare services and basic education. SECTION27 aims to achieve structural change and accountability to ensure the dignity and equality of everyone. Accessed on 19 February 2018 at http://section27.org.za/.

not to testify orally and 42 affidavits were handed in by Legal Aid South Africa. In addition to the arbitration record which runs into 3000 pages, a total of 173 documentary exhibits were admitted to the record.

Issues

[5] The core dispute to be determined by the Arbitrator is the nature and extent of the equitable redress, including compensation due to mental health care users and their families who were negatively affected by the Marathon Project[16] that led to the closure of Life Esidimeni mental health care facilities after 1 October 2015.

[6] A prominent feature of the reference to arbitration is the unqualified admission by the State that it is liable to recompense the affected mental health care users and their families individually or as a group. On this aspect, the arbitration agreement reads:

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[16] Paragraphs 6.3 of the arbitration agreement provides:

> "The [alternative dispute resolution] process is intended to facilitate closure and redress for affected mental health care users and families. As set out in recommendation 17 of the Ombud's Report ─ and as discussed in various meetings between the State, affected families and their representatives ─ 'closure and redress' includes but is not limited to:
>
> 6.3.1 appropriate compensation for affected families, whether on a group or individual basis;
>
> 6.3.2 where possible, the provision of information to affected families regarding the circumstances and cause of death of their loved ones as well as the location of the final resting place of their loved ones;
>
> 6.3.3 the provision of appropriate counselling and support services, at Government expense, to affected [mental health care users] and families;
>
> 6.3.4 appropriate apologies to and acknowledgement of the suffering of affected [mental health care users] and families by relevant parties;
>
> 6.3.5 the provision at Government expense of an appropriate monument, in an appropriate location such as before the Gauteng Department of Health, to commemorate the suffering and loss caused by the [Gauteng Mental Health Marathon Project] and to serve as a reminder to future generations of the dignity and vulnerability of [mental health care users]; and
>
> 6.3.6 facilitate any other form of equitable redress the parties deem appropriate."

"2. The following groups will be entitled to the equitable redress arising from the [Alternative Dispute Resolution]:

2.1 The family members of [mental health care users] who were moved out of Life Esidimeni on or after 1 October 2015 as part of the [Gauteng Mental Health Marathon Project] and who subsequently died, provided that they died during the period between the move out of Life Esidimeni and one month after they were again moved to an appropriate facility following the de-establishment of the [Gauteng Mental Health Marathon Project];

2.2 The family members of the 13 [mental health care users] whose deaths were counted by the Ombud but were described as not 'Life Esidimeni-associated' and 'non-Life Esidimeni-related' on page 40 of the Health Ombud's Report; and the family members of [mental health care users] who were accommodated at [non-governmental organisations] established or utilized for the purpose of the [Gauteng Mental Health Marathon Project] and who subsequently died, regardless of whether the deceased individuals came from Life Esidimeni, provided that they died during the period between 1 October 2015 and one month after they were again moved to an appropriate facility following the de-establishment of the [Gauteng Mental Health Marathon Project]; and

2.3 [Mental health care users] from Life Esidimeni, and their families, who survived the [Gauteng Mental Health Marathon Project], but for whom the [Gauteng Mental Health Marathon Project] caused trauma and morbidity, amongst other results.

2.4 Annexures A, B and C contain the names and other particulars of the parties referred to in paragraphs 2.1, 2.2 and 2.3 respectively."

[7] By agreement amongst the parties, the final versions of Annexures A, B and C containing the respective claimants entitled to compensation determined by the

Arbitrator were duly submitted to me before the end of the proceedings. There is thus, before me, no contest about the identity of the people entitled to equitable redress in respect of each affected mental health care user who was represented in and were part of the arbitration.

[8] The arbitration agreement also records that the deaths of the mental health care users were "not natural but caused unlawfully and negligently" by the employees of the Government and that "liability for the loss of the affected families falls to the Government." . . . "The liability of the Government is not an issue to be determined or contested in the [Alternative Dispute Resolution] process."[17]

[9] Following in the footsteps of the arbitration agreement, the pre-arbitration minute again records emphatically that the liability of the State is admitted and is not in issue. From the foregoing, it is plain that all the elements of delictual liability and of the entitlement of all claimants to equitable redress are admitted in so many words.

[10] For its part, the Government contends that it is liable to compensate the families of the deceased and the mental health care users who survived the Marathon Project or their families for estimated funeral expenses and common law general damages arising from pain, suffering and emotional shock and nothing else. To that end, the Government tendered a globular amount of R200 000 which some claimants accepted. For their part, all claimants, in slight variations, were emphatic that beyond the general damages for which the Government is obviously liable, the pervasive, egregious, uncaring and wanton violations of the constitutional rights of all mental health care users affected and their families, call for equitable redress which must include

[17] Paragraph 6.7 of the arbitration agreement provides:"The parties accept, for the purposes of the [Alternative Dispute Resolution] process, the findings of the report of the Ombud in their totality, including that deaths were not natural but caused unlawfully and negligently and that liability for the loss of the affected families falls to the Government. The Ombud found that the 'conditions and circumstances at non-governmental organisations made these deaths other than 'natural'' (at page 43). The liability of the Government is not an issue to be determined or contested in the [Alternative Dispute Resolution] process."

constitutional damages. The Government resists this claim. After all said and done, that is the residual but intractable difference and dispute I am called upon to resolve.

[11] The arbitration process, albeit unusual, was also intended to achieve related objectives of "closure". These were to uncover the full circumstances of the death or survival of affected mental health care users; to afford the affected families the space to mourn or grieve as they related what they knew about the demise or survival of their loved ones; to give the State decision-makers an opportunity to account for the deaths and torture of the mental health care users who were in their care; to grant an opportunity to the political representatives of the State to tender public apologies and hopefully facilitate emotional closure on the part of the affected families of mental health care users who died in and those who survived the ordeal of the Marathon Project.

[12] Whilst the oral and documentary evidence is truly vast, it is important that I, at the outset, caution against an expectation of an excessive rendition of evidence which is readily available on the audio recording and its transcript. Given limitations of space and time, that would not be practicable. Only evidence strictly related to the remaining crisp dispute between the parties will be considered.

Parties and their claims

[13] Having introduced the broad character of these proceedings, it is convenient to describe the parties to the arbitration and their claims. Their description one naturally finds in their arbitration pact.[18] In broad terms there are two sets of parties. They are the claimants made up of families of the affected mental health care users who died or survived during the Marathon Project. They may be divided into three parts.

[18] Paragraph 1.3 of the arbitration agreement provides:

> "The parties to the [Alternative Dispute Resolution] are:
>
> 1.3.1 the Government represented by the Premier of Gauteng, the National Minister of Health and the member of the Executive Council of the Gauteng Department of Health; and
>
> 1.3.2 the affected [mental health care users] and families, which group incorporates bereaved families and surviving and their families."

[14] First are 63 claimants listed in Annexure A[19] whose loved ones were moved out of Life Esidimeni into hospitals, non-governmental organisations or their homes as part of the

[19] Annexure A:

	NAME OF THE DECEASED	DATE OF BIRTH	DATE AND PLACE OF DEATH	PARTICULARS OF THE FAMILY MEMBER AND RELATION TO DECEASED
	Adams, Felicity	1969-02-14	2016-10-18 Soweto	Gabriel Adams (8803175163086 – son)
	Botha, Diederik Johannes	1964-06-16	2016-12-09 Atteridgeville	Gerrit Huyter Kirst Botha (6102175004082 – brother)
	Chaba, Terence Maphea	1988-02-03	2016-08-15 Pretoria	Seemole Suzen Phoshoko (7504110762089 – aunt)
	Colitz, Fredrick	1955-04-04	2016-08-07 Krugersdorp	Maria Colitz (5802200010084 – wife)
	Dekker, Frans	1968-09-10	2016-11-07	Magdelena Delange (6702020024084 – sister)
	Dlamini, Thembesile Lillian	1964-10-01	2016-08-20 Mamelodi Hospital	Vusumuzi Dennis Dladla (brother 5809175752087)
	Dubree, Mehmona	1979-10-19	2016-12-24 Takalani Home	Daphne Mausley Margret Dubree (4309030110085 – grandmother)
	Du Toit, Nellie Johanna	1968-12-03	2017-04-12 Mamelodi	Bertha Stina Luies (7101070105084 – sister)
	Golden, Joseph William	1961-07-26	2016-11-04 Pretoria	Winnie Annie Golden (3801310068083 – stepmother)
	Gumede, Joseph	1957-05-03	2016-07-24 Cullinan	Ntombifuthi Olga Dhladhla (6407050286088 – sister)

	Hlatshwayo, Sizwe Thabang	1987-11-21	2016-09-10 Cullinan	Jabulile Hlatshwayo (6908090590082 – stepmother) Moses Hlatshwayo (6904165461085 - uncle)
	Jannik, Nicholas Anthony	1948-10-04	2016-07-27 Mosego Home	Mariana Antoinette Jamnik-Schmidt (4708080170081- sister)
	Janse Van Rensburg, Jacobus Johannes	1952-12-28	2016-06-15	Jo-Anne Janse Van Rensburg (9101020197080- daughter)
	Josiah, Daniel Charles	1974-01-08	2016-09-08 Pretoria	Monomong Welheminah Thejane (5809030921083 – sister)
	Khunjwa, Maureen	1954-10-20	2016-10-24 Soweto	Luleka Lorraine Khunjwa (5907070330080 – sister)
	Kozwale, Masweet	1970-07-14	2016-11-17 Soweto	Sindile Anna Masombuka (5503060330089 – mother)
	Lale, Christina	1935-10-03	2016-06-06 Pretoria	Sophie Goitsemang Mahlatsi (3306150191086- aunt)
	Leroabe, Mothofela	1971-05-10	2016-08-15 Pretoria	Lesiba Johannes Legwabe (5609175635088 – brother)
	Maboe, Hendrick Ranthopi	1964-05-04	2016-07-22 Hammanskraal	Joseph Maboe (3707135225081 – father)
	Machpelah, Virginia	1966-01-08	2016-08-15 Atteridgeville	Christine T Nxumalo (7403180264086 – sister)
	Mahloko, Matsobane John	1954-06-21	2016-11-10 Krugersdorp	Madimetja Juda Mahloko (4810205234089 – brother)
	Makhoba, Christopher	1970-09-06	2016-07-03 Pretoria	Elizabeth Phangela (5601240744086 – sister)
	Makhubela, Happy	1970-02-02	2016-07-01 Mamelodi	Busisiwe Maria Makhubela

				(4403070445087 – mother)
	Mangena, Raisibe Rahab	1959-05-24	2016-06-06 Soweto	Boitumelo Josphine Mangena (9303240401082 – daughter)
	Maretele, Maria Mpabane	1972-05-25	2017-01-29	Daniel Maretele (7807295406087 – brother)
	Mashigo, Nathaniel (Solly)	1962-02-15	2016-08-06 Pretoria	Phumzile Mirriam Motshegwa (6507310413081 – sister)
	Mashiloane, Mangana Eric	1943-10-11	2016-07-18 Pretoria	Zenzele Lincorn Mazibuko (7010035425083 – son)
	Mhlongo, Josephina	1959-03-09	2016-08-04 Orange Farm	Fortunate Mkhabela (7505260572087 – daughter)
	Mnisi, Jabulane Godfrey	1957-11-17	2016-10-15 Pretoria	Yamie Miriam Mnisi (4212010337084 – mother)
	Moatshe, Sedumedi Solomon	1949-09-20	2016-05-29 Krugersdorp	Kefalotse Abram Sedumedi (5010055851080 - brother)
	Modise, Lucky Jeremiah	1966-05-13	2016-07-25 Pretoria	Anna Kgomotso Modise (4804080545081 – mother)
	Mogwerane, Christopher	1960-12-21	2016-06-15 Tshwane	Lucas Mogwerane (461305514085 – brother)
	Mokaneng, Bernika	1959-02-14	2016-07-01 Soweto	Mojanilu Selina Klaas (6302230730081 – cousin)
	Mokgethi, Ntswelengwe	1957-06-30	2016-08-01 Krugerdorp	Dipuo Elizabeth Mokgethi (4709220326088 – sister)
	Molefe, Sophia Manyana	1993-08-05	2016-09-12 Krugerdorp	Bertha Molefe (5903160921086 – mother)
	Mosalo, Mameisi Sina	1955-05-12	2016-07-18 Leratong Hospice	Vinolia Annah Mosalo (7409080452085 – daughter)
	Mosiane, Caswell	1975-12-28	2016-07-10 Soweto	Magdeline Alice Mosiane (7612270744084 –

				sister)
	Motsoahae, Matlakala Elizabeth	1944-09-12	2016-08-26 Kalafong Hospital	Maud Gaonyadiwe Motsoahae (8109210407087 – daughter)
	Msimanga, Siyabulela Roger	1983-09-18	2016-09-09 Jubilee District Hospital	Lindiwe P Msimanga (6501180524085 – mother)
	Mthembu, Emily	1966-10-22	2016-09-21 Cullinan	Thamsanqa Phillip Mthembu (6201215621085 – brother)
	Mthombeni, Pio Sibusiso	1960-03-12	2017-04-05 Pretoria	Stella Thembesile Mofokeng (5711010873088 – sister)
	Mvundla, Peter	1958-10-13	2016-06-22 Mosego	Agnes Mozibonele Mvundla (5810135558085 – brother)
	Nelson, Frederik Stefanus	1955-09-18	2016-09-18	Abram Jacobus Nelson (6210165073080- brother)
	Nqgondwane, Vuyo Aaron	1985-10-11	2017-02-07 Cullinan	Christian Nqgondwane (6010035663080 – father)
	Petersen, Julian Anthony	1964-07-25	2016-12-06 Pretoria	Amber Janet Absalom (6203170074086 – sister)
	Phetla, Deborah	1970-05-25	2016-03-26 Takalani Home	Zimbi Maria Phehla (4509100474085 – mother)
	Pilane, Seipati Janet	1943-11-22	2016-07-22 Cullinan	Edith Pilane (6611120754088- daughter)
	Ratsotso, Charity	1968-09-26	2016-07-11 Mamelodi Hospital	Maureen Racoco (4903230402084 – mother)
	Rontoese, Jean Banana	1944-12-24	2016-10-28 Vereeniging	Joyce Rontoesa, (7404141263084 – daughter)
	Senekal, Dawid Johannes	1958-09-27	2016-08-06 Leratong Hospital	Desiree Chaves (8401220059085- daughter)
	Shabalala, Busisiwe	1964-01-01	2016-07-25 Cullinan	Anna Thokozile Mthembu (6003090234087 – sister)

	Shariff, Moegmamad Adiel	1995-04-20	2016-11-27 Soweto	Rudaiba Jones (7007130202086 – aunt)
	Simamane, Joy Nomsa	1961-09-03	2016-11-17 Sterkfontein	Jacob Molale Simamane (4702165204089- brother)
	Sithole, Alfred	1975-06-27	2016-07-27 Jabulani	Elizabeth Sibiya (6205240718089 – aunt)
	Sithole, Bhekumuzi	1958-05-02	2016-07-18 Mamelodi	Bongane Sithole (6112085651088 – brother)
	Stewart, Charles	1955-07-11	2017-06-11 Florida	Yvonne Muhammad (7004080163087 – sister)
	Thabethe, Siphiwe	1975-11-30	2016-11-13 Pretoria	Cynthia Thembi Thabethe (8510201082088- sister)
	Tholoana, Isaac	1965-04-04	2016-07-21 Mamelodi	Paulina Tholoana (5303200340084 – sister-in-law)
	Tladi, Johanna	1957-10-16	12016-10-26 Chris Hani Baragwanath Hospital	Sarah Tladi (6206040759083 – sister)
	Tlholwe, Motshabisi Michael	1958-10-24	2017-02-12 Cullinan	Baatseba Tlholwe (9207040119085 – daughter)
	Tshawe, Julia Kedibone	1947-08-18	2016-07-13 Kalafong Hospital	Rosy Tshabalala (6504060642084 – daughter)
	Van Rooyen, Cindy	1983-06-12	2017-04-12 Chris Hani Baragwanath Hospital	Vaughan Van Rooyen (7903035165081 – brother)
	Visser, Sanet	1973-01-16	2016-08-23 Chris Hani Baragwanath Hospital	Nimeckqe Visser (9311120338084 - daughter)

Marathon Project, and then died. From the inception of the Marathon Project and throughout the struggles of these families to resist the government plan to move their loved ones out of Life Esidimeni and during the arbitration they were represented by SECTION27. In these proceedings Adv. Adila Hassim and Adv. Nikki Stein appeared for them.

[15] They seek the following relief in the arbitration:

(a) Compensation for funeral expenses in the amount of R20 000;

(b) Compensation for emotional shock and psychological injury in the amount of R200 000;

(c) Compensation for constitutional damages in the amount of R1 500 000 of which R1 000 000 is claimed for each claimant and R500 000 is claimed to be paid into the mental health system in Gauteng as a donation by the families in memory of each deceased, to improve the care of mental health care users in the province;

(d) Counselling and support services for each claimant and up to three members of each claimant's family, the nature and duration of the services to be determined through an individual and or family assessment by a psychologist.

(e) Other equitable redress including directives requiring:

(i) the Recovery Plan to address the systemic failures in the Department, referred to by member of the Executive Council Ramokgopa to be made public and requiring government to work with civil society in its implementation;

(ii) the establishment of training for government officials on constitutional rights and ethics; and

(iii) the Government to make public the outcomes of the various investigations into the officials and bodies involved in the Marathon Project.

[16] The second set of claimants is four family members[20] whose loved ones[21] died during and as a result of the Marathon Project. They are represented by Hurter Spies Attorneys[22] and for them in the proceedings appeared Adv. Dirk Groenewald appeared for them in the proceedings.

[17] They claimed:

(a) Funeral expenses in amounts ranging from R4000 to R40 000

(b) General damages of R150 000 under the common law for the emotional shock and psychological injury the claimants have suffered.

(c) Constitutional and punitive damages of R1 500 000 to vindicate the fundamental rights of the claimants and their families, who have died and to deter and prevent future infringements of the fundamental rights. Of the amount claimed, R1 250 000 is to be paid directly to each of the claimants who each in turn donate R250 000 to be paid to the Office of the Health Ombud subject to the money being used; for the investigation of complaints lodged by the public, and that the Ombud makes public, within a year of the Award being made, how the donated amount has been utilised.

(d) In another form of equitable redress, the claimants ask that the Award require the Government to submit the record of the proceedings to the

[20] Sandra de Villiers: Sister of Jaco Stols. Merriam Monyane: Mother of Thabo Monyane. Lillian Mpofu: Grandmother of David Mpofu and Sarah Mhlongo: Mother of Jabulani Mhlongo.

[21] These are the contents of Annexure B

"1. Jabulani Mhlongo, 23, Male died on June 2016 at Siyabadinga

2. Thabo Monyane, 33, Male died on 12.08.2016 at Mamelodi Hospital

3 David Kgotso Mpofu, 21, Male died on 03.08.2016 at Mamelodi Hospital

4 Jaco Stols, 51, Male, died on 14.10,2016 at Mamelodi Hospital"

[22] Hurter Spies Inc. is a law firm specialising in property law, family law, law of contracts, civil rights and deceased and insolvency estates. Accessed on 19 February 2018 at http://hurterspies.co.za/en/home/

South African Police Service and the Specialised Investigation Unit to assist in their investigation; and that the Gauteng Department of Health (Department) must make public a plan and or strategy, within three months of the Award, through which its employees must be made aware of their constitutional, statutory and ethical obligations toward patients and mental health care users, in particular.

[18] The last category of claimants is 68 in number and their particulars are listed in Annexure C[23]. They are mental health care users who were *inter alia* "*caused trauma and*

[23] Annexure C:

	Patient's Name	Next of Kin Name	Contact No.
1.	Agnes Sitale	Sibongile Baloyi	0732337053
2.	Anthony Singh	Sandra Davids	0810330707
3.	Asyha Boswell	Agnes Quanita Mlotshwa	0826774660
4.	Bhekumuzi Ntshanghase	Mosidi Ntshangase	0725066317
5.	Bongani Selest Mokoena	Lulu Mitchildes Mokoena	0792271545
6.	Brenda Mofokeng	Mohlaba Mofokeng	0724984888
7.	David Chauke	Washington Chauke	0781451386
8.	David Mapela	Puleng Muller	0849284059
9.	Edward Mofokeng	Matshidiso Mofokeng	0763569417
10.	Elizabeth Zwane	Lipuo Bertha Hassim	0762976438
11.	Francinah Motlhabi	Grace Motlhabi	0766446634
12.	Francois Bezuidenhout	Gerhardes Bezuidenhout	0733509819
13.	Frans Chester	Elizabeth Chester	0728386478
14.	Freddy Yaka	Thandi Selina Silinda	0835819195
15.	Gabrie Lucas Monaheng	Itumeleng Tshabalala	0835755885
16.	George Shai	Phumla Shai	0714169720
17.	Guy Daniel Kanza	Sophie Kanza	0749117676
18.	Hendon Namba	Sonwabo Namba	
19.	Jabulile Mackenzie	Priscilla Mackenzie	0761683204
20.	Jerry Mmowa	Sarah Bayeni	
21.	Johanna Dhladhla	Johannes Dhladhla	0837416247

22.	Julia Kgatle	Lesego Baloyi	0729422611
23.	Julian Holoane	Marry Fletcher	0846948540
24.	Kabelo George Mokatsi	Lucky Albertina Molatsi	0762818238
25.	Kathy Reid	Mannerin Reid	0826825581
26.	Khutso Maditsi	Madinyane Maditsi	0833216214
27.	Lazarus Moleleki	William Moleleki	0735436545
28.	Lehlohonolo Francis	Mary Osopeng	
29.	Lindi Mokoatlo	Solomon Mokwatlo	0837537999
30.	Lord Michael Setou	Mapo Setou	0725319263
31.	Maggie Joyce Dlamini	Jim Dlamini	0728926855
32.	Mandla Radebe	Nomsa obo Malintle Radebe	0789768283
33.	Maspiriti Mofokeng	Moelo obo Dikeledi Mofokeng	0712439073
34.	Mathews Moloi	Mojalefa Sethunya	0631870645
35.	Mcmillan Makhosezwe Nkosi	Christine Nkosi	0630996787
36.	Mduduzi Sikhakhane	Sibusiso Sikhakhane	0837375108
37.	Mercy Motsoasile	Onica Dalasile	0847012735
38.	Michael Mabizela	Patience Chiloane	0742237743
39.	Michael Siphiwe Tshabalala	Elizabeth Malgas	0735055903
40.	Mkhanyiseli Mangqasana	Lungiswa Banzi	0781747733
41.	Moffat Lukhele	Ivan Lukhele	0723417386
42.	Moses Molobi	Anna Molobi	0794651235
43.	Mzwandile Elliot Mphambo	Mordicai Mphambo	0824277013
44.	Nkahlululeng Ntsobe	Thalitha Mabizela	0731383029
45.	Nonjabe Khayakazi	Nomvula Nonjabe	0782459011
46.	Norah Thebe	Nthabiseng Mokale	0736969846
47.	Ntombikayise Zanele Magaga	Fakazile Dibetsoe	0823060655
48.	Ofentse Nkuna	Steven Mahlangu	0823911915
49.	Phillemon Ramakgapola	Thabiso Ramakgapola	0720552695
50.	Phillip Theys	Lenah Theys	0824867721
51.	Reginald Thomas Zamisa	Sussan Kuni	
52.	Samson Mokoena	Selina Leruma	0836197780
53.	Seyabulela Dlamini	Sandiswa Ndaba	
54.	Shadrack Emkula	Yvonne Nemkula	0824789800
55.	Sizwe Nkosi	Nompilo Nkosi	0727265000
56.	Skhumbuzo Hlatshwayo	Phumzile Dlamini	0825583791
57.	Solomon Mokwatlo	Lindi Mokwatlo	0837537999
58.	Sphiwe Nkosi	Joyce Mokgoea	0827848757
59.	Stephanus Hoffman	Marinda Myburg	0829533186
60.	Steven Mano	Jacob Lucas Mokone	0733814568

morbidity" but survived the Marathon Project and their families.[24] They were represented by Legal Aid South Africa and for them in the hearing appeared Adv. Lilla Crouse and Adv. Nzame Skibi.

[19] The claimants seek:

(a) R1 000 000 in respect of general damages for shock, pain and suffering for each of the mental health care users.

(b) For special damages of the family of each mental health care user:

(i) R5 000 for specific damages for the replacement of clothing and other valuables lost during the Marathon Project;

(ii) R50 000 for future medical, psychotherapy and counselling expenses;

(iii) R1 000 for costs incurred to locate mental health care users after they were discharged from Life Esidimeni facilities;

(c) R1 000 000 for constitutional damages.

[20] The respondent, against whom the claims are made, is the Government of the Republic of South Africa represented by the National Minister of Health, the Premier of Gauteng and the member of the Executive Council of the Gauteng Department of Health. They are represented by Werksman Attorneys[25] and for them in the proceedings appeared Adv. Tebogo Hutamo. I have intimated earlier that the Government has tendered to pay all claimants up to the amount of R200 000 for funeral expenses and general damages under, they put it, the common law. All claimants barring

61. Themba Mtetwa	Sipho Mthethwa	
62. Victor Truter	Andrew Peterson	0749271420
63. Vusi Maphisa	Patience Sithole	0604132892
64. Vuyani Phakathi	Sphiwe Phakathi	0832415347
65. Welani Petrus Ngcwatywa	Mzwandile Patrick Ngcwatywa	0761166021
66. William Ramakgapola	Thabiso Ramakgapola	0720552695
67. Zelda Pamela Lebopo	Olga Nkisa	0836937945
68. Zibusiso Ngwenya	Joseph Ngwenya	0635295160

[24] See paragraph 2.3 of the entitlement criteria in the arbitration agreement.

[25] Werksman Attorney is Corporate and Commercial Law Firm.

the survivors and their families have accepted this offer. What is plain is that the claimants seek, in addition, constitutional damages, a head of damages the Government has resisted strenuously.

[21] It seems plain that in order for me to reach a just and equitable redress including compensation, and in particular whether the claimants have made out a case for compensation because of constitutional breaches, I must examine the facts surrounding the termination of the contract with Life Esidimeni, followed by a description of the extraordinary context of the deaths that occurred and the morbidity, trauma and suffering endured by the survivors. Immediately thereafter I will be required to identify the applicable law as I search for equitable redress.

[22] It is to that task that I now turn.

Factual background

Termination of the contract

[23] The genesis of this terrible tale of death and torture of mental health care users was the termination of the contract between the Gauteng Department of Health (Department) and Life Esidimeni. The contract, which had been in operation for over 30 years, was ended on 29 September 2015 by a formal notice authorised and signed by the Head of Department, Dr Tiego Ephraim Selebano (Dr Selebano). On 21 October 2015, then member of the Executive Council, Ms Qedani Mahlangu (Ms Mahlangu) announced the formal end of the contract of service. In her evidence before me, Ms Mahlangu was adamant that the decision to terminate the contract was taken by a "collective". In contrast, Dr Selebano claimed that he signed the notice ending the contract only because he feared his political principal, Ms Mahlangu, on whose instructions he terminated the contract.

[24] The contract was ended on a six-month notice. This meant that all mental health care users would be moved out of Life Esidimeni facilities by 31 March 2016. Random and mass discharges of patients on the orders of the Department started immediately. The

date for the closure of the facilities was later extended to 30 June 2016. The end of the contract precipitated the move of 1711 mental health care users out of Life Esidimeni between October 2015 and the end of June 2016. Mental health care users were moved to hospitals, to non-governmental organisations handpicked by the Department or to their family homes.

[25] Before and after the termination of the contract, the families of mental health care users, civil society, professional bodies and clinicians within the Department made attempts to persuade the Department to devise a plan that would protect the rights and meet the needs of the mental health care users being moved out of Life Esidimeni. 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 torturous conditions after their forced displacement from Life Esidimeni facilities.

[26] 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. To this important matter I revert later.

[27] Ms Mahlangu, Dr Selebano and Dr Manamela, gave three reasons for the termination of the contract with Life Esidimeni: the policy requirement to deinstitutionalise mental health care users; the Auditor-General's concern regarding the duration of the contract with Life Esidimeni; and budgetary constraints.

[28] Unsurprisingly, the reasons are neither cogent nor rational. I deal with each only briefly. This is so because towards the end of the hearing, the testimony of the Minister, Premier, member of the Executive Council for Health and member of the Executive Council

for Finance convincingly demonstrated that all three reasons put up by the leaders of the Department were false, disingenuous and advanced in order to conceal the true reasons for ending the contract and moving the patients.

[29] The Department claimed that the termination of the Life Esidimeni contract was in line with the National Mental Health Policy Framework and Strategic Plan 2013-2020 (Policy Framework). It is so that the Policy Framework envisages the deinstitutionalisation of mental health care users following the development of community-based services. The virtues of properly curated community or home based health care seem self-evident even to me as a lay person. But the Marathon Project was not the deinstitutionalisation the Policy Framework imagined. First, placing mental health care users outside institutions is neither inexpensive nor easy. Professor Makgoba, the Health Ombud, pointed out that only Italy and France have successfully deinstitutionalised mental health care users and that doing so is expensive. Put plainly, deinstitutionalisation may not be and ordinarily is not a cost saving measure. Professor Melvyn Freeman develops the same theme, pointing out that global experience and numerous research studies had shown that displacing patients from institutions should not be used to save money as this inevitably results in people with mental illnesses being further abused, increased hospital admissions and early mortality.[26]

[30] The claimed deinstitutionalisation was riddled with several defects. The money supposedly saved by the Department did not follow the mental health care users. Instead, there was an increase in the allocation to psychiatric hospitals and paltry transfers to district mental health services and the facilities that were supposed to care for the Life Esidimeni mental health care users.

[31] Moreover, neither the mental health care users nor the non-governmental organisations to which they were transferred were adequately prepared for the move. Instead, the move was rushed, with non-governmental organisations accepting mental health care users without having the resources or infrastructure to do so. Mental health care

[26] Professor Freeman is the Cluster Manager: Non-Communicable Diseases at the National Department of Health. See page 18 of the Annexures to the Health Ombud's Report.

users were not appropriately assessed by clinicians let alone multidisciplinary teams of health care practitioners. Their move from Life Esidimeni was coercive and thus did not follow normal clinical protocols of discharging patients and their placement into non-governmental organisations appeared to be random. Mental health care users were not assisted to integrate into their communities and to retain access to the health care services that they require. The new living environment at non-governmental organisations was no less restrictive than a hospital but significantly more disadvantageous. Most mental health care users were moved to non-governmental organisations far from their family homes, removing them from the communities into which they were supposed to be integrated. Some of the non-governmental organisations were far from any community. Mental health care users were, therefore, isolated from other people.

[32] Both Ms Mahlangu and Dr Selebano claimed that a reason for termination of the contract with Life Esidimeni was the need to comply with the Auditor-General requirements concerning "evergreen contracts". None of the two provided evidence to support this ostensible reason. To the contrary, member of Executive Council for Finance Ms Barbara Creecy (Ms Creecy), told the hearing that she reviewed the Auditor-General's management letters to the Health Department for the years 2013/14 to 2016/17 and was unable to find any reference to or concern over the Life Esidimeni contract. It is in the management letters that any instruction to review contracts would appear. Both Ms Mahlangu and Dr Selebano called the name of the Auditor-General in vain.

[33] The third reason given for the cancellation of the contract with Life Esidimeni was resource constraints. But the decision to end the contract in order to save costs ran at complete odds with a report commissioned by the Department from the Health Advanced Institute, in which the Health Advanced Institute found that the Life Esidimeni contract provided good value for money, a finding Dr Selebano remembered well and accepted, although he noted concerns with the level of certain clinical services provided at Life Esidimeni facilities. As for Ms Mahlangu, she claimed, rather surprisingly and unconvincingly that the Department had kept the Health Advance Institute report away from her. She could not explain why the Department she headed would conceal a diagnostic

report of this importance given its relevance to the looming cancellation of the Life Esidimeni service level agreement. Her stance begs the question: Why did she not demand a diagnostic report before pulling such a big trigger? Did she not care to make a decision which is evidence-based?

[34] The decision disregarded the provincial instruction to cut only non-core costs. Ms Creecy explained and produced documentary evidence to show that the provincial directive was to cut only non-core costs and to fight corruption. She stated that "[t]reasury has never demanded that any department cut core services". She emphasised that the delivery of health care was a "core service" not liable to cost containment measures. Of particular importance is that the evidence shows that the Department was not under budgetary pressure. Ms Creecy explained that the Department's allocated budget was increasing in the years before and after the transfer of patients. The current member of the Executive Council Dr Gwen Ramokgopa (Dr Ramokgopa) confirmed, however, that the mental health budget was in particular, at the relevant time, decreasing, as was the proportion of the provincial department's budget allocated to mental health.

[35] I readily accept that on all accounts, the Department, like the rest of the State, faced financial constraints. Its allocated budget seemed to fall short of its actual expenditure and the Department experienced annual overruns that were rolled over to subsequent financial years. Dr Selebano and Ms Mahlangu were at pains to explain that the overruns were due to the ever-increasing health expenditure triggered by an ever-growing population and health care users in the Gauteng province. In so doing, they sought to show an obvious need for cost containment that in turn justified their decision to shut down the Life Esidimeni services to mental health care users.

[36] However, both of them told the hearing nothing about what emerged from Ms Creecy's evidence and records that the budgetary and financial crisis within the Department was mainly due to mismanagement, incompetence and possible fraud. Financial mismanagement appears to have been rife, with increasing accruals and significant irregular expenditure up to R6.8 billion, R1.6 billion of which was referred to

the Special Investigating Unit for investigation. The Department asserted a need for cost containment and yet over the relevant period its actions breached the cost cutting directives of the National Treasury, spending huge sums of money on consultants.

[37] Despite her claim that cost containment was a major driver for terminating the contract, Ms Mahlangu testified that she did not see the actual numbers of the budget for moving mental health care users from Life Esidimeni and did not know how the R190 000 000 budget for mental health was spent. She could not say whether actual savings were realised. At Life Esidimeni, the Department paid around R320 per mental health care user per day. And yet those transferred to other state health care facilities were to incur a substantially higher cost for care. On the Department's own version most mental health care users were meant to be transferred to state facilities at a rate almost six times more than the cost of care at Life Esidimeni. Was cost-saving the true reason for terminating the Life Esidimeni contract?

[38] In the end, the largest majority of mental health care users were transferred to non-governmental organisations and this move was meant to cut costs to R112 per day. At non-governmental organisations, mental health care users were expected to obtain medication from state health facilities and to be attended to by health care workers in state facilities. The R112 was supposed to be used to cover accommodation, meals, toiletries, clothing and health care workers and care workers required for the day to day care of mental health care users. Non-governmental organisations were also expected to collect mental health users South African Social Security Agency grants and to get donations. Dr Selebano acknowledged that the subsidy that the Government paid to non-governmental organisations was insufficient. Despite the insufficient subsidy, the actual amount paid to non-governmental organisations was significant, totalling R47 531 997,97 on Ms Creecy's evidence and of which Dr Ramokgopa acknowledged that some payments were made to non-governmental organisation to which the non-governmental organisations were not entitled, including payments to non-governmental organisations long after they had been closed.

[39] The mental health care users and their families, and the Department, ended up paying a much higher price for the termination of the contract with Life Esidimeni. Apart from the loss of at least 144 lives, the project itself and the need to return mental health care users to Life Esidimeni and Selby facilities after the release of the Ombud's Report was costly. Director-General of the National Department of Health Ms Precious Matsoso rightly observed that cost savings cannot be the real reason behind the Marathon Project.

[40] The reasons that Ms Mahlangu and Dr Selebano and their Department have advanced for terminating the service contract with Life Esidimeni have been shown to be untrue. Also, the reasons are not properly related to the outcomes they claim they were pursuing. In short, besides the reasons being untruthful, the decision on which the reasons are based are irrational, and in blatant breach of the law and the Constitution.

[41] In any event, resource constraints cannot constitute an acceptable justification for the failure to protect and realise constitutional rights if the organ of state concerned has budgeted according to a mistaken understanding of its constitutional and statutory obligations.[27]

Non-governmental organisations

[42] An indispensable starting point in understanding the role of non-governmental organisations in the Life Esidimeni death and torture is the Ombud's Report. The Ombud found that all 27 non-governmental organisations to which the mental health care users were moved operated with invalid licences. More than 95 % of the deaths happened at non-governmental organisations. The highest number of deaths occurred at five non-governmental organisations. These were Precious Angels,[28] Cullinan Care and

[27] Compare *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd and Another (CC)* [2011] ZACC 33 at para 74.

[28] Precious Angels Home, 194 Bergattillerie Street, Danville Extension 5 and 17 Mosalo Street, Atteridgeville. Both facilities were managed by Ethel Ncube.

Rehabilitation Centre (Cullinan Centre)[29] Siyabadinga[30]/Anchor,[31] Mosego/Takalani,[32] Tshepong[33]/ Hephzibah[34]. These non-governmental organisations more than others turned out to be sites of death and torture of mental health care users under their care. According to the Ombud, these non-governmental organisations had neither the basic competence and experience, nor the managerial capacity nor the fitness for purpose and were often poorly resourced and overcrowded. Below I detail some of the treacherous features of non-governmental organisations that the State chose to entrust with the lives of mental health care users.

[43] The plan was not always to move mental health care users into new non-governmental organisations. Once the contract was terminated, Dr Manamela formulated a plan for the move of all of the mental health care users by 31 March 2016. Then, the plan was to use renovated hospital wings and non-governmental organisations. The renovation of unused hospital wings never came to fruition due to the projected expense of undertaking such renovations. As such, there was, as Dr Selebano described it, a deviation from the plan. Despite this deviation, a plan on paper to build 900 beds was finalised only in November 2016, after at least 90% of the deaths had occurred. Simply stated, Ms Mahlangu, despite her claim that she was ignorant of the fact, Dr Selabano and Dr Manamela, without a proper plan or beds, ordered the mass discharge of affected mental health care users from Life Esidimeni to non-governmental organisations where many died and others survived torture.

[29] Zonderwater Rd, Cullinan, managed by Chief Executive Officer Ms Nyatlo and Acting Chief Executive Officer Ms Malaza, during the Gauteng Mental Health Marathon Project.

[30] Siyabadinga was based at Cullinan Care and Rehabilitation Centre, Centre Manager: Ms Dianne Noyile.

[31] Anchor Centre was based at Cullinan Care and Rehabilitation Centre, Centre Manager :Ms Dorothy Franks

[32] Mosego Home 114 Ockerse Street Krugersdorp1740 Centre Managers: Dr Dorothy Sekhukhune and Ms Maletsatsi Mokgojoa and Takalani Home Centre Administrator: 7947 Zone 6 Diepkloof Soweto Dr Dorothy.

[33] Tshepong Centre, 351 Klipspringer Street Atteridgeville, Centre Manager: Ms Karina Moralo.

[34] Hephzibah Home Care, 7979 Cnr Segaetsho/Kent Masire Street, Mohlakeng Ext 5 Randfontein Centre Manager: Ms Masekolo Mashego.

[44] Dr Selebano also looked into the possibility of the Department buying the Life Esidimeni facilities. He said that the Department had sufficient funds to buy and was provided with three options for payment terms but he did not pursue the idea. He could not say why he did not proceed with the purchase option which was well within his power. Given the lack of available hospital beds, and the failure to pursue the option of buying Life Esidimeni facilities, the Department engaged non-governmental organisations.

[45] There was no open procurement process for the services required. Instead, non-governmental organisations were first invited to a meeting in September 2015 which was chaired by Dr Manamela and were told that the Life Esidimeni contract would be terminated by the end of the 2015/16 financial year. When meetings with non-governmental organisations were called, they would be called by the districts and included "the old non-governmental organisations and any other person who might listen". The non-governmental organisations were told that the Department would "welcome" expansion of old non-governmental organisations. Professor Makgoba explained that people were told at these meetings that "this is an opportunity to provide empowerment to people who can . . . modify their homes in order to accommodate patients". He thought that people were "excited" by this prospect. Professor Makgoba observed correctly that the non-governmental organisations were "mysteriously selected". There were never any clear selection criteria. There seemed to be no requirements for premises, staff, qualifications or experience. The second is that there were already other non-governmental organisations in the province that would have had the experience to look after these patients, but new ones were brought in instead.

[46] Professor Makgoba's findings were spot on. Ms Jacobus, the deputy director of mental health services, reported to Dr Manamela. She candidly testified that the normal assessment processes of conducting pre-audit visits and then non-governmental organisations audits were not completed during the Marathon Project and instead alternative processes were introduced, on Dr Manamela's instruction. Ms Jacobus was aware that the non-governmental organisations did not comply with the licensing requirements. Prior to issuing the licences, she told Dr Manamela who ignored the warning and instructed her to

finalise the licences, citing the instructions "from above" that had to be followed. This is after Dr Manamela had testified that her team, under the leadership of Ms Jacobus, assessed all non-governmental organisations and prepared licences for her signature. She even claimed to have seen all of the assessment reports before issuing licences, including a check list to show that the non-governmental organisations met all of the requirements, but she did not request to see financial statements.

[47] To cut to the chase, Ms Jacobus told the hearing that there were no assessment reports of aspirant non-governmental organisations; that the licensing process connected to the Marathon Project was unlawful and knowingly fraudulent and that much she admitted in the course of her testimony. According to Ms Jacobus' evidence and indeed it seems plainly so, her boss, Dr Manamela, knew of the fraud in the licensing process but went ahead to issue licences to non-governmental organisations where ultimately death and torture occurred.

[48] Aside the licensing fraud and unlawfulness at the point of issue, the licences had many other defects. They reflected incorrect addresses, incorrect mental health care user classifications, and were all backdated to 1 April 2016 regardless of the date of signature. All licences were issued by Dr Manamela despite her not having legal authority to do so and at least some, if not all, licences were re-issued by Dr Selebano following his interview with Professor Makgoba and were backdated to 1 April 2016. Dr Selebano admitted to having re-issued and backdated licences after he had closed the non-governmental organisations concerned. Non-governmental organisations were licensed for their planned number of beds and not for beds actually available. Other non-governmental organisations did not even have premises let alone beds at the time they received a licence from the Department for 150 beds. Some of the non-governmental organisations were not licensed. Some non-governmental organisations were licensed for more people than they could accommodate, whilst others, accepted more people than they were licensed for.

Mass transfer under Marathon Project

[49] Sadly, even in the face of vacuous and irrational reasons for terminating the Life Esidimeni service level agreement, the inadequate assessment of non-governmental organisations and the unlawful and fraudulent issuing of licences, Dr Manamela and her Directorate with the knowledge and under the direction and support of Ms Mahlangu and Dr Selebano went ahead to carry out the mass transfer of patients out of Life Esidimeni facilities.

[50] The "success" of the Department in the High Court litigation of March 2016 between itself and South African Depress and Anxiety Group[35] emboldened it to carry out the mass transfers of mental health care users to non-governmental organisations. Between October 2015 and April 2016 about 16 patients per month were transferred from Life Esidimeni to non-governmental organisations. Resolutions from a meeting in the member of the Executive Council's office on 8 April 2016 show that 950 mental health care users needed to be moved to non-governmental organisations by the end of that month. Even given this resolution, the "big migration" was between May and June 2016. When 500 and 800 patients were transferred respectively. The Ombud named this a "stampede".

[51] On 2 June 2016, in the middle of the "stampede" South African Depression and Anxiety Group sent a letter to Dr Selebano, Mr Mosenogi, the Project Leader of the Marathon Project, and Dr Manamela raising desperate concerns about the move of mental health care users without the knowledge of their families; non-governmental organisations 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 Cullinan Centre; adult users being moved en masse to Baneng; non-governmental organisations not being paid; mental health care 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". 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". South African Depression and Anxiety Group received no further response to this letter. And the mass transfers were not stopped. They continued regardless. How could Ms Mahlangu, Dr Selebano and Dr Manamela be believed when they told the claimants and indeed our nation that they could not reasonably foresee the imminent torture and death of mental healthcare users that they and the Government they worked for were duty bound to care?

[52] The move was described as "chaotic", with mental health care users left unattended outside Life Esidimeni facilities and multiple non-governmental organisation personnel were "picking" patients and vehicles sent to collect them. While support from a family is important to ensure that a mental health care user is able to settle into a new environment, many families testified that they had not been informed of the moves. Some were told that the transfers would happen but not when or where their loved ones would be moved. Life Esidimeni was not informed where individual mental health care users would be taken to. All this meant that tracking mental health care users when family members contacted Life Esidimeni was very difficult.

[53] Mental health care users were transported from Life Esidimeni to non-governmental organisations in Departmental vehicles or in vehicles owned by the non-governmental organisations. There was no written plan for the transportation of patients but Mr Mosenogi said that Mr Malotana from the provincial emergency services handled the logistics. A document submitted by Ms Mahlangu during her testimony shows that many of the non-governmental organisations in fact used their own transport. In one instance, people from non-governmental organisations arrived at Life Esidimeni to collect mental health care users in a bakkie. Dr Mkhatshwa instructed that the bakkie be turned away. Dr Mkhatshwa, complained to the Department that it was unacceptable for non-governmental organisations to arrive at Life Esidimeni facilities to "choose" mental

[35] *The South African Depression and Anxiety Group and Others v Member of the Executive Council for Health, Gauteng and Others*. The applicants in this matter launched an urgent application at the High Court of South Africa, Johannesburg Gauteng Division, under case number 08904/16, seeking an order interdicting the State from discharging mental health care users from the Life Esidimeni Facilities, either to their families or to alternative facilities. On 15 March 2016, the Court, in a judgment delivered by Vally J, dismissed the applicants' application.

health care users and instructed Life Esidimeni facility managers that non-governmental organisations must not be permitted to come and choose mental health care users. His instruction was to no avail because the Department persisted in sending non-governmental organisation personnel to come choose and cart away patients.

[54] Here is one disturbing example of arbitrary, randomised and mass discharge and transfer of mental health care users. Cullinan Centre facility staff were instructed by their chief executive to go to Life Esidimeni in Waverley to collect 10 mental health care users who they were to assess to determine whether Cullinan Centre was the appropriate facility for the patients in question. They had not been provided with the identity of the patients that they were to collect. Cullinan Centre staff erroneously drove to Life Esidimeni in Randfontein. When they arrived there, they were met by a group of 26 mental health care users and were instructed by departmental officials to bus them to Cullinan Centre, on the basis that they had arrived with a 27-seater bus. On the evidence, none of the patients were assessed individually and discharged or transferred by an authorised clinician.

[55] Apart from mass moves out of Life Esidimeni, many mental health care users had to suffer the trauma and anxiety of being moved from place to place and from one non-governmental organisation to another. For instance, mental health care users who were moved to Cullinan Centre were again moved out of Cullinan Centre to one of its resident non-governmental organisations and then to Precious Angels. Ms Franks, the owner of Anchor, testified that 30 Anchor patients were transferred to Precious Angels, without any identity documents, within two weeks of their transfer from Cullinan Centre. She said she knew this was wrong but said she was under instructions from the Department. Mr Charity Ratsoso was moved from Life Esidimeni to Cullinan Centre and then to Anchor House. Mr Sizwe Hlatshwayo was moved from Life Esidimeni to a non-governmental organisation in Hammanskraal, to Cullinan Centre and then to Anchor House. Ms Daphne Ndlovu testified that Cullinan Centre took 21 mental health care users from Precious Angels when it was closed down. The mental health care users came after a short stay at Kalafong and Pretoria West Hospitals.

[56] Clinical records, medication and other belongings did not move with the mental health care user. Dr Manamela blamed Life Esidimeni for the move of mental health care users without their medical records. Dr Mkhatshwa testified, however, that when mental health care users left Life Esidimeni facilities, they had a file with a picture of the mental health care user, their identity document and a discharge summary. They did not hand over the full medical records as the volume of files would have made this impossible, but offered for the Department to attend the facilities and photocopy the medical records. The Department did not take them up on this offer. Professor Makgoba corroborated this evidence, finding that the mental health care users were transferred with summary notes and records that could have been interpreted by a "health related qualified person". Also, various non-governmental organisations reported to families that their loved ones had arrived without any records.

[57] The evidence reveals severe problems in accessing medication once the patients had been moved. Dr Mkhatshwa testified that Life Esidimeni gave patient medication for between seven and 28 days depending on whether they were going to a state facility or a non-governmental organisation. He explained that Life Esidimeni was unable to provide the amount of medication that they would ordinarily provide for each mental health care user due to the large numbers of mental health care users being moved at once. Dr Manamela claimed that the transfer plan was that the non-governmental organisations would be linked with local health facilities for sourcing medication, but, she said, the clinics and the managers in some areas were "not so much supportive" and that this may explain problems in accessing medication. The more sensible and candid explanation is by Mr Mosenogi who observed that the former Life Esidimeni patients' medication would need to be prescribed at a psychiatric hospital and would not be accessible at clinics.

[58] The overall evidence, reveals not only problems in accessing medicine, but also serious breaches in clinical protocols for identifying, labelling and storing medication for multiple patients in non-governmental organisations. There were no competent health care givers to prescribe, identify or provide appropriate medicines, if any, to patients. There were no records tracking each patient's dosages of medication, if any. In addition, patients

at non-governmental organisations who did not have identity documents had problems accessing care at hospitals if they became sick. There were no resident or visiting clinicians at all non-governmental organisations. Mental health care users had no access to doctors, let alone psychiatrists, except when taken to a nearby hospital.

[59] The damning point is this. Dr Manamela and Mr Mosenogi, with the instruction, knowledge and support of Ms Mahlangu and Dr Selebano, devised the plan for the mass displacement of mental health care users from Life Esidimeni. This they did, without prior and proper notice to and the consent of the patients or their families. On their instructions, the patients were loaded on busses or open trucks and driven to non-governmental organisations unknown to the patients of their families. Patients tightly held their meagre personal belongings. The evidence suggests that the patients were visibly harassed or anxious and some were conveyed with their hands or feet or both tied. On all accounts the conveyance was cruel, inhuman and in a degrading manner. All this without prior and continuous clinical assessment of the patients; without useful or any medical records; without access to clinical and other medical care and without access to appropriate or prescribed medication.

[60] 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. I now look at briefly at the conditions of the non-governmental organisations.

Conditions at non-governmental organisations

[61] The chaotic process of moving mental health care users to non-governmental organisations; the lack of appropriate assessment to ensure sufficient, qualified staff, decent infrastructure and programmes; and the late payment of non-governmental organisations meant that conditions at the non-governmental organisations were poor and entirely unsuited to the care and medical needs of mental health care users.

[62] Family members who testified at the hearing and those who submitted affidavits found that the food at some non-governmental organisations was of bad quality, insufficient, and in some instances had to be provided by family members. Many non-governmental organisations appeared to have problems in accessing the medication that mental health care users required – for both psychiatric and physical conditions. There was significant understaffing or inappropriate staffing at some non-governmental organisations. Some non-governmental organisations had insufficient security, both putting mental health care users at risk and increasing the likelihood of patients absconding. Several non-governmental organisations were very overcrowded with low levels of hygiene, dirty facilities and unwashed mental health care users. Many of the mental health care users had insufficient clothes and blankets to protect them from the cold. Abuse or suspected abuse was reported at some non-governmental organisations.

[63] Only a few examples of non-governmental organisations that served as places of death and torture should suffice. Takalani Home was overcrowded when Ms Boitumelo Mangena's brother went there to find his mother. He was asked to wait for her to be brought to him but the first person who they brought was the wrong person although she was wearing his mother's name tag. He was then told to walk through the hall to find his mother. He reported that the circumstances were "extremely devastating". The place was overcrowded and some people were sitting on the floor. The patients were still in their Life Esidimeni uniforms. Ms Mangena's brother did not recognise his mother at first because of the amount of weight she had lost. He had to walk around the hall a second time before he found her. She was sitting in a corner shivering, without any socks or jersey. Her feet were swollen and she was extremely hungry. The nurse with whom Ms Mangena's brother spoke was new and had no experience caring for mental health care users. The patients at Takalani were receiving the same medication despite having different mental health conditions. If mental health care users could not walk or talk for themselves they would not get what they needed, including their food and medication. Ms Mangena's brother insisted on seeing where his mother slept. There were no enough beds for all of the patients. Some of the mental health care users slept on benches or on the floor without

mattresses. He was taken to a bed, but he knew that it was not his mother's bed because there were pictures of another person's family on the wall by the bed.

[64] The outbreak of typhoid at Takalani Home was reported in July 2016 to Chief Directors, Directors, Deputy Directors, Public Health Specialists and Health Programme Managers. It appears that the steps that would have been necessary to keep mental health care users at Takalani safe from this notifiable disease were not taken. Certainly, mental health care users were not moved out of Takalani. One of the deceased, Ms Joanna Tladi, is mentioned as a suspected case. She died on 26 October 2016. Ms Mahlangu claimed not to remember any of the details of the typhoid outbreak or the deaths at Takalani. She offered to revert to the Arbitration on this subject, but did not.

[65] Reverend Maboe told the hearing that at Bophelong non-governmental organisation, construction was ongoing, with fences being erected at the time of his visit. He said 40 beds were lined up in a garage, with no privacy and no washing basin. His son, Billy, was so hungry that after eating a bag of chips that his father bought for him, he licked the packet clean. There was also a pit toilet on the grounds. Shortly after his visit, Reverend Maboe received a call from Bophelong with the news that Billy had been admitted to Jubilee Hospital. He had to organise transport from Randfontein to Hamanskraal. By the time he got there, Billy had died.

[66] Mr Lucas Mogwerane testified that the manager of Rebafenyi Home, Noeline, repeatedly said she had not been ready to take on mental health care users but she had been forced to do so. When he visited his brother at Rebafenyi Home on or about three weeks after he had last seen him at Life Esidimeni, his brother had lost a lot of weight. He noticed that the roof was leaking and doors were falling off their hinges. Mental health care users were not dressed appropriately for winter as they only had oversized overalls on, but did not have shoes. The other mental health care users surrounded him, as he tried to give them bananas one by one. They grabbed these bananas and ate voraciously, without peeling. Mr Mogwerane testified that Noeline acknowledged that Rebafenyi had not received its subsidy and was therefore unable to source food for the mental health care users in its care.

[67] Ms Franks testified that Anchor still had to do renovations such as installing air conditioners. Anchor also did not have hot water for the duration of the project (which took place in the winter months), did not have sufficient furniture, did not have incident reports, and did not have policies related to first aid procedures. Even a long established State facility like Cullinan Centre had admitted from Life Esidimeni categories of mental health care users who they were not equipped and had no experience to care for including patients with psychosis. Cullinan Centre was insufficiently staffed to deal with these mental health care users.

[68] Ms Ethel Ncube had planned to establish Precious Angels as a facility for children. She claims she was asked to provide residential accommodation for adults. She occupied residential houses in Atteridgeville and Danville. She was brought mental health care users in large groups and she personally went to Life Esidimeni to choose and fetch mental health care users accompanied by an auxiliary nurse. She had no medical staff and had expected the Department to send medical professionals but they never did. She was not paid for three months and the only support she received from the Department was in the form of a once off donation of groceries and nappies. Ms Ncube said that the Department was aware of everything that happened at the facility, including all the deaths, and still allocated more mental health care users to her.

[69] Mosego Home was made up of a number of houses along one street. Mrs Maria Colitz testified that when she visited her husband Frederick, he could not eat. He was not receiving his medication, he had lesions on his face and heels, and, although he was clearly ill, the staff refused to take him to the hospital. He passed away while she was making a desperate plea to them to take him to the hospital.

[70] Mr Jaco Stols had been a patient at Cullinan Centre for 18 years prior to being transferred to Siyabadinga, a new non-governmental organisation within the premises of Cullinan Centre. His sister, Mrs de Villiers narrated the circumstances at Siyabadinga.

They included the lack of food, medicine, proper care and the failure of the Department to inform and consult her on the decisions to close Siyabadinga and to transfer Mr Stols back to Cullinan Centre.

[71] His physical condition deteriorated to such an extent that they had to take him to a private doctor who instructed the nurses at Cullinan Centre that he needed to be admitted to hospital if his condition did not improve. Medical records show that he was vomiting a brownish colour substance for four weeks, and had lost 14 kilograms in just two weeks' time. During cross examination, Mrs Manaka, a nurse at Cullinan Centre, confirmed that Mr Stols displayed symptoms of internal bleeding and the urgent need for such a patient to be admitted to hospital immediately. Mrs de Villiers received no sympathy from the staff when she enquired about her brother's wellness. She said that she was physically prevented from entering the ward where her brother slept. When she phoned to enquire about her brother's condition she was told that there was no patient by the name of Mr Jaco Stols. She explained how she had to intervene to ensure that her bother was admitted to hospital and how she was informed that he was severely dehydrated and underfed and that his condition was critical. An autopsy was performed but that she never received the findings nor did the South African Police Service in Cullinan revert to her over the formal charge she had laid at the Cullinan Police Station.

[72] Mr Thabo Moyane had been a patient at Cullinan Centre since 2005, his mother testified how his condition deteriorated since his transfer to Siyabadinga. She testified how she was telephonically informed that he was not well but that the nurse could not tell her since when he fell ill. When she went to fetch him from the hospital on the same day, he was unable to speak and could not walk and when she took him to the hospital the following day they informed her that he would not make it. No one informed her that her son was transferred back to Cullinan Centre after Siyabadinga was closed, nor did any one inform her of the fact that her son became ill. Her son died within two days of being admitted to hospital.

[73] Mr David Kgotso Mpofu was admitted at Cullinan Centre on 9 May 2011. His grandmother testified that she was never informed of the fact that he was to be transferred to Siyabadinga, nor his transfer back to Cullinan Centre. She observed marks on his body and later found out that he fell and was hospitalised. She was however never informed about the fall. She only learned of his passing when Mr Mpofu's uncle phoned her. She testified that the staff at Cullinan Centre had her details and that she did not know why they could not have phoned her. She further related that she was never informed that he was hospitalised and received no reasons for the cause of death and that they only learned from the medical records that he was vomiting a brownish substance. According to Mrs Mpofu, her grandson did not receive his medication for epilepsy.

[74] Mr Jabulani Mhlongo was admitted to Cullinan Centre in January 2008 and transferred to Siyabadinga on 19 May 2016. His mother told the hearing that the affairs at Siyabadinga were disorganised and they had a shortage of food and medication. Her son was taken to hospital and shortly thereafter she was informed that her son had passed away. She testified that after they had enquired about the cause of her son's death she was only provided with a report that simply stated that on 26 June 2016 at 12h45 her son had an epileptic seizure, and that he was taken to Mamelodi Hospital but was only admitted at 21h00 that evening. She testified that they pleaded with the staff of Cullinan Centre that her son not be moved to Siyabadinga but were informed that the decision was final. She approached the Health Ombud for assistance in light of the fact that they received no further information and or assistance from the Government.

[75] One of the causes of the continued poor conditions at non-governmental organisations appears to have been significant delays between the arrival of and the payment of subsidies. This delay was predictable because service level agreements were only signed after the mental health care users were moved and the Department would not have been able to pay in the absence of a service level agreement. Dr Manamela blamed the late signature of the Service Level Agreements on the non-governmental organisations. Another reason provided for late payment was that the non-governmental organisations did

not have tax clearance certificates. In some cases, non-governmental organisations did not have bank accounts.

[76] No steps were taken by Dr Manamela and the Directorate to ensure prompt payment until it was too late. Only once problems arose did Dr Manamela liaise with the finance department. Ms Jacobus testified that her attempts to ensure that non-governmental organisations received their subsidies were thwarted by Dr Manamela. She said that when she contacted the non-governmental organisations coordinators in the different districts and advised them to submit the paperwork necessary for them to be paid, two of the non-governmental organisations coordinators came back to her and informed her that Dr Manamela had instructed them to stop that process as it could be done afterwards. Dr Manamela stated that the non-governmental organisations should not, in any case, be relying solely on the subsidy from the Department and that the non-governmental organisations were expected to claim South African Social Security Agency grants and to raise funds independently. She stated, in addition, that the non-governmental organisations had assured the Department that they had independent funds.

[77] In response to complaints by non-governmental organisations regarding non-payment, the Directorate referred the non-governmental organisations to companies that could help with dietician services, clothes, and linen on credit. The Directorate also provided a letter to allow non-governmental organisations to go to nearby shops to get food donated. Despite late payment and a small subsidy per mental health care user being paid to non-governmental organisations, the amount of money involved was substantial, particularly for non-governmental organisations licensed to care for large numbers of mental health care users. Ms Franks testified that after a few months she received back pay of R539 000 and thereafter R150 000 per month from the Department. She testified that after Anchor was closed, she continued to pay the workers, ran Anchor remotely, and eventually paid the surplus of approximately R46 000 back to the Department.

[78] Five of the non-governmental organisations were closed before the release of the Ombud's Report. Various role players claim credit for the closure of these

non-governmental organisations. A total of 14 non-governmental organisations, including all of the unlicensed non-governmental organisations, have been closed. What is clear is that none of the non-governmental organisations was closed soon enough and payments continued, even after they were closed.

[79] The Ombud concluded that all the patients died under unlawful circumstances. The Ombud was indeed correct and the State so admits. The admission is properly made. The patients were placed at non-governmental organisations at the instance, request and authority of the State. The non-governmental organisations were willing agents of the State who were required to care for patients against payment of subsidies and other remuneration. In doing so the State and the non-governmental organisations acted in a reckless and uncaring manner and contrary to statutory prescripts directed at protecting mental health care users. The State continued to owe a duty of care and other constitutional duties to the affected mental health care users and their families. In a blatantly unlawful and life threatening way, the State purported to outsource its constitutional and statutory duties to ill-equipped and ill prepared non-governmental organisations and devastation of multiple deaths and torture ensued.

Uncaring response to the deaths

[80] One of the first mental health care users to die was Ms Deborah Phetla. She died on 26 March 2016 at Takalani. The post-mortem report revealed that she passed on with brown paper and plastic in her stomach. After Ms Phetla at least 142 more mental healthcare users died. The Ombud found that 72% of the deceased had been at or died at only five non-governmental organisations. Professor Makgoba has found that of the mental health care users transferred from Life Esidimeni to hospitals, 2.4% died, as compared to a death rate of 10.4% of the mental health care users who were transferred from Life Esidimeni to non-governmental organisations.

[81] A major attribute of the months following the first deaths is the misinformation on the part of the Department about how many deaths there were and the circumstances in

which the deaths had occurred. The progress reports compiled by the project team did not deal with the deaths. What is clear, however, is the attempt to obfuscate.

[82] By 1 August 2016, 51 people had already died and yet the on the 11 August 2016, Ms Mahlangu's response to a question in the provincial Legislature did not mention deaths because, as Dr Manamela testified, the question was not specifically asked. This is significant because we now know that Dr Manamela compiled the legislative response. Were the deaths of 51 patients, out of their pet project, the Marathon Project, not of sufficient gravity to be reported to the Legislature when the treatment of mental health care users was specifically probed in the legislature? Asked the same question during the hearing, 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.

[83] The deaths were reported to the Department as well as to numerous other people and bodies. SECTION27 wrote to Ms Mahlangu informing her of several deaths on 1 September 2016. SECTION27 received no substantive response to the letter, having received an initial response from Ms Mahlangu that she would look into it. Ms Mahlangu testified that she responded to SECTION27's letter of 1 September 2015 by referring it to the relevant officials ─ Dr Selebano and Dr Manamela ─ even though she had undertaken to revert to SECTION27. This, she said, was her practice.

[84] A little over a month later, on 13 September 2016, Ms Mahlangu answered another legislative question and announced that 36 deaths had occurred. The Ombud found that, by this point, 82 people had in fact died.

[85] The Ombud acknowledged in his report that at that point he was still counting deaths because he had been unable to obtain accurate information from non-governmental

organisations and the Department. Professor Makgoba interviewed Dr Selebano and Dr Manamela one after the other on 23 November 2016. Dr Selebano told him that there had been 36 or 40 deaths and Dr Manamela said that there had been 48 deaths. Three days later he asked Ms Mahlangu and she said that there had been 36 deaths. When Professor Makgoba asked Ms Mahlangu why the numbers she reported on 13 September 2016 were so low, she responded that the numbers had become a political game. At that stage, he told Ms Mahlangu that there had been 77 deaths and "she just kept on saying, but you know if I released such numbers, it would have been a political game". It is indeed remarkable that in the face of such carnage of patients under their direct care, none of the three top leaders, architects and implementers of the Marathon Project and their enormous project team, had no grasp of the number of deaths. Did they choose not to know or were they downright untruthful? On the totality of the evidence, I conclude that Ms Mahlangu, Dr Selebano and Dr Manamela falsely claimed ignorance of the actual number of deaths at non-governmental organisations even as they were responding to Professor Makgoba's enquiry and when Ms Mahlangu addressed the provincial Legislature. She was seemingly concerned more about the "political game" than the truth and the plight of the dying mental health care users that the Departmental plans had displaced.

[86] Another misinformation that emanated from Ms Mahlangu, Dr Selebano and Dr Manamela was that the deaths that occurred were not related to the move but ought to have been expected given the mental health status of the deceased. All three of them, 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.

[87] The circumstances of all of the deaths were questionable and indicated, at the very least, cruel, inhuman and degrading treatment. The causes of death as reflected on the death certificates varied but include pneumonia, neuroglycopenic brain injury, chronic hepatitis which caused liver failure, septicaemia, and severe dehydration. Despite the circumstances

of the deaths, most were classified as being due to "natural causes". The result was that post-mortem examinations were not conducted in the vast majority of the deaths.

[88] Mrs Maria Phetla testified that the post mortem conducted on her daughter, Deborah, revealed that she had plastic and brown paper in her stomach. She also testified that Deborah had been kept in solitary confinement in a small room and she suspects that the care givers at Takalani Home probably forgot to give her food, water and warm clothing.

[89] Ms Luleka Kunjuwa told how her sister, Maureen, had lost a lot of weight, looked dehydrated and could not support her own weight. Maureen had unexplained bruises on her body and her hip. Ms Maureen Kunjuwa's death notice states that sepsis may have contributed to her death.

[90] Reverend Maboe found Billy at Bophelong in a filthy state and clearly disoriented. He appeared hungry. Reverend Maboe testified that Billy said he was thirsty but the nurse refused him water, saying that he will urinate on himself. Ms Nono Maditse testified that her brother had bruises on his wrists, as if his hands had been cuffed or tied together to restrain him. Mr Sizwe Hlatshwayo's body was restrained with a straight jacket. Mr Frederick Colitz had lost so much weight that his trousers had to be tied with shoelaces. This was more or less induced by lack of food and starvation. He had marks on the back of his ankles from being dragged and marks on his forehead and nose. He was very weak. He could not eat or drink anything on his own. He was not receiving his medication. Mrs Colitz requested that her husband be taken to hospital but the staff refused. After she left Mosego Home she phoned to repeat her request but was told to wait until the next day. Mr Frederick Colitz died the next day. The post-mortem report of Mr Vuyo Ngqondwane shows that there was a large piece of orange plastic sheeting in Vuyo's stomach, resembling what could be part of a plastic bag.

[91] Professor Makgoba observed that mental health care users transferred from Life Esidimeni died at a rate eight times higher than the general population. Evidence from various studies indicates that for mental health care users one would expect a death rate of

2.2 times higher than the general population. The death rate was, therefore, much higher than would be expected. Professor Makgoba identified three key risk factors for the Life Esidimeni cohort to be: transfer to non-governmental organisations rather than transfer to hospital; advanced age; and being female.

[92] The findings of Professor Makgoba as well as the causes of death identified on death certificates, belie the claim of Dr Manamela that side effects of treatment, co-morbidities, lower life expectancy, prolonged use of psychotropic medication and deformities would be the factors that caused deaths. Although, under cross-examination she had to concede that malnutrition, dehydration and exposure to cold would also have hastened death.

[93] SECTION27 sent a dossier of information on the deaths to Professor Makgoba and several other state institutions. The approach of all parties, however, appeared to be not to take any action, other than the closure of a handful of non-governmental organisations, until the finalisation of Professor Makgoba's report. Between September 2016 and the release of the Ombud's Report on 1 February 2017, an additional 42 people died.

[94] Mercifully and rightly, in these proceedings, the wrangling about the cause of death does not arise. The State has conceded that the deaths of the concerned mental health care users were not natural deaths but caused by the unlawful and negligent omission or commissions of its employees ─ starting with Ms Mahlangu, Dr Selebano and Dr Manamela ─ and of the personnel of non-governmental organisations who were agents of the State and who bore the same duty of care and the same statutory and constitutional obligations as the State towards the mental health care users and their families.

Searching for the living and the dead ─Indignity even after death

[95] The lack of dignity accorded to the mental health care users when they were alive continued after their deaths. About this Professor Makgoba testified:

> "There was a total disregard I think for human dignity and human respect in terms of the patients and even after death. Many patients, many relatives, did not know where their

> loved ones were and many I think are still somewhere looking for them and not having received answers proactively, they had to dig, they had to go knock at many doors and I think that was traumatic and frustrating over time."

[96] A recurring theme throughout the evidence of families is that although some knew of the intended closure of Life Esidimeni facilities, they were not provided with the final details relating to the transfer of their loved ones, including which non-governmental organisation they would be transferred to and when. After the moves, most families were not informed and some spent months searching for their loved ones. Many family members were not told of the whereabouts of their loved ones and had to call many of the non-governmental organisations and conduct a long search to establish their whereabouts. Some of the non-governmental organisations were far from families, making visiting difficult specifically because of long distances and high costs of travel.

[97] Dr Manamela's claim, that families who were accessible knew, is contradicted by many families whose contact details were in the files of their loved ones at Life Esidimeni but who did not receive notification of the move. Also, her assertion that families were offered transport to visit their relatives is also disputed by families. In any event, if Dr Manamela's claims were true there would not have been so many unclaimed deceased bodies in the hands of non-governmental organisations. Her claim in most instances is plainly false.

[98] I again resort to a few anecdotal examples of gruesome disrespect in life and even in death.

[99] Mr Ngqondwane found out in December 2015 that Life Esidimeni was closing and that mental health care users would be moved to other facilities. Although his son, Vuyo, was moved to Cullinan Centre, the family was told that he had been moved to Takalani. They went to Takalani and could not find Vuyo. They went back to Randfontein and received a number to call. They called the number and discovered that Vuyo was in Cullinan Centre. Mr and Mrs Ngqondwane went to Cullinan Centre on 2 July 2016 and

found Vuyo there, looking thin, sickly and unhappy. The record of transfers and deaths at Cullinan Centre record that Vuyo was at Anchor and then transferred to Cullinan Centre in January 2017. However, Anchor had already closed down in October 2016. Mr Ngqondwane did not know anything about this.

[100] Ms Ntombifuthi Dhladhla testified that she searched for her brother, Mr Joseph Gumede, in the non-governmental organisations for more than four months and she could not find him. When she approached the Department of Health on 20 January 2017, the officials were not forthcoming with the information. She was told that her brother was still alive and laboured under that impression for another month. Someone at the Department put her in contact with a social worker, Ms Daphne Ndlovu, who made appointments to visit her and give information about her brother, but Ms Ndlovu never kept her commitments. Eventually, Ms Dhladhla was informed on 10 February 2017 that her brother had died on 24 July 2016.

[101] Ms Dhladhla found the body of her brother, decomposed in a hospital mortuary. She testified that the decomposed state of the corpse presented difficulties when it was time to take the corpse home. They could not use a normal trailer for the corpse. It attracted flies and the smell was overwhelming. The undertaker could not prepare and clothe her brother for burial. Instead, his family wrapped the deceased in a blanket.

[102] Many families, came to know of the deaths of their loved ones days, weeks or months after their death. Ms Ndlovu of Cullinan Centre told the hearing of her search for families to inform them of their loved one's death. Ms Ncube of Precious Angels also claimed that she did not have contact details of many families and that the Department coordinator, Dr Sophie Lenkwane, helped to trace families, including when mental health care users had died and notification had to be made.

[103] Employees at both Cullinan Centre and Mamelodi Hospital who were responsible for operating and ensuring the maintenance of the mortuaries concerned each denied that the decomposition of the bodies under their care was due to the dysfunction of their

mortuaries. Instead they shifted blame to each other. Their evidence exposed significant deficiencies in the operation and maintenance of the mortuaries at Cullinan Centre and Mamelodi Hospital. In particular, there were serious doubts about the system for the daily monitoring of the temperature of the mortuaries.

[104] Whatever the discrepancies in the evidence or in the operations of the mortuaries, one intolerable fact remains: deceased bodies of mental health care users in the care of the State became decomposed before they were handed over to their families. This must have caused acute distress, agony and a sense of disrespect to the families who bore the brunt of disposing of the remains of their loved ones. Apart from the causes of death and the conditions of the bodies, the families of the mental health care users were themselves subjected to cruel, inhuman and degrading treatment.

[105] Ms Thejane testified that she was pressured into using African Queens of Africa Co-op to transport her brother's body to the Northern Cape. Mrs Masondo, then Chairperson of the Mental Health Review Board (Review Board), had a funeral undertakers business that is a member of African Queens of Africa Co-op and her name and contact details appear on the stamp on Mr Daniel Josias's Notice of Death form. Ms Thejane testified that she was unable to obtain a death certificate from Home Affairs as the funeral undertaker had completed a form indicating cause of death as natural causes, whereas the doctor had indicated that the cause of death was under investigation. This delayed the funeral in the Northern Cape. Dr Manamela said that Mrs Masondo was asked by the chief financial officer of the Department and the member of the Executive Council to transport the body to the Northern Cape.

[106] The Department had devised no scheme to dispose of the bodies that piled up at the non-governmental organisations. In order to get rid of the many deceased bodies, non-governmental organisations shunted the bodies from one funeral parlour to another without the consent or knowledge of family members concerned. In many instances the non-governmental organisations did not even have the contact details of families of their deceased patients and no budgets to dispose of the deceased bodies. They sought storage

at funeral parlours that in turn hoped for burial business or storages fees when the bodies were fetched. Bodies at Precious Angels were sent to Kotelo Funeral Parlour. Kotelo then appears to have moved some bodies to PutU2Rest Funeral Parlour, which did not have its own storage for bodies despite this being a requirement of licensing.

[107] An example would be the body of Virginia, Ms Nxumalo's sister, who without consent or knowledge of the family had been taken to PutU2Rest Funeral Parlour from Kotelo Funeral Parlour. She could only get the body released by pretending that she was considering using their services for the funeral. Some bodies sent to PutU2Rest Funeral Parlour were stored in a facility that was a disused butchery in Atteridgeville. Director-General Matsoso investigated the facility upon hearing of it, and found that PutU2Rest was receiving bodies and transferring them to other facilities. The team also learned about another facility called Royal Funeral Parlour, and they found out about more mortuaries that were involved in this scheme as the investigation continued.

[108] Some of the mental health care users did not get to see their families before they died. Ms Elizabeth Phangela last saw her brother, Mr Christopher Makhoba, on 16 May 2016 at Life Esidimeni. On 15 July 2016, she received a call from Ms Ethel Ncube of Precious Angels informing her of Christopher's death and asking if she could go ahead and bury his body. Ms Anna Mthembu last saw her sister Ms Busisiwe Shabalala in February 2016 at Life Esidimeni. She was not informed that Busisiwe would be moved to Cullinan Centre. The next she heard, Busisiwe had died.

[109] Ms Boitumelo Mangena described having to wait most of the day to be told about the circumstances of her mother's death. Ms Raisibe Mangena's body had already been moved to a funeral parlour without the family's consent. Ms Trotter recalled an experience relayed by Mr van Rooyen for whom the smell of dog faeces reminded him of the smell of his sister Cindy's dead body. "The terrible stench of dogs messing in the street and the smell reminded me of Cindy".

[110] These mental health care users and others were deprived of the comfort and certainty that their families could have provided and were moved from the place they had lived for a long time to facilities where they died. Mental health care users were dehumanised and they and their families treated callously.

[111] At the close of the scornful tale of every deceased body, were distraught families who had to find the remains of their loved ones and bury them out of their meagre means.

Survivors

[112] Besides 144 mental health care users who died as a result of their move out of Life Esidimeni facilities after 1 October 2015, 1418 other patients were exposed to torture, trauma and morbidity amongst other results, but survived. They have been returned to Life Esidimeni facilities for continued care. Of the known survivors, the State was unable to ascertain the whereabouts of 44 mental health care users. They remain missing persons. Short of death, the survivors and so too their family members were exposed to the trauma, morbidity and torture, to which the deceased mental health care users succumbed.

[113] Families of several survivors found their voice and came before the hearing to narrate the ordeal of their loved ones and their own pain and suffering. The accounts that follow are a mere glimpse of the torture the survivors lived through and are additional to the conditions at non-governmental organisations where most of mental health care users died.

[114] Ms Banzi spoke to us about her brother, Mr Mkhanyiseli Banzi, who was a mental health care user since he was a baby. Mr Banzi was admitted to Life Esidimeni in 2014, which is located nearer to the family home. Due to the Marathon Project, he was moved to Cullinan Centre, which initially misidentified him. Cullinan Centre was far from the family home and entailed travelling cost of about R600 for a single visit. At Cullinan Centre Ms Banzi found her brother unwashed, inappropriately dressed, and very hungry to the extent that he had even eaten the meat bones. Even in the few days he was there, he had

already lost weight. He was given medicine which numbed him, but he was not given the correct epileptic medicine. Whilst at Cullinan Centre, his shoulder was hurt to the extent that he had to be hospitalised.

[115] Ms Nkosi relayed the story of her brother Mr Sizwe Nkosi who was a mental health care user at Life Esidimeni since 1997. Mr Nkosi cannot speak as he is autistic, but he hums when he is happy. He was taken to Cullinan Centre in May 2016 appropriately dressed. Dr Manamela, somewhat cynically, said that Cullinan Centre is like a five-star hotel, but none of this proved true when Ms Nkosi went back 10 days later. Mr Nkosi was non-responsive, cold, curled into a bundle and had lost weight. He was inappropriately dressed. He was unkempt and smelly, to the extent that his mother took him to the bathroom to check whether he had not perhaps dirtied himself. He had not. Mr Nkosi has not yet reached the state of health he was in before the move. As a result of her role of activism opposing the Marathon Project, Ms Nkosi lost her business as a make-up artist, as she was not available to attend to business engagements. She described with agonising detail her pain and suffering and that of her brother, Sizwe.

[116] Mr Ngwenya is the father of Mr Sibusiso Ngwenya, who for most of his life was institutionalised. Since 2014 he was cared for as a mental health care user at Life Esidimeni. During the Marathon Project, the Department moved his son to Cullinan Centre without the family's knowledge or consent. When Mr Ngwenya found his son after two weeks of the move. He did not even recognise because he had lost so much weight. Sibusiso was hungry, he smelled and was very dirty, as he put it, like someone sleeping in the bush. Cullinan Centre was not close to their family home. At some stage Sibusiso fell ill and was admitted to Tembisa Hospital. He was left unattended and dirty in a hospital bed without a mattress, and was bound to the sides of the bed. On the bed next to him lay a corpse. Sibusiso is now receiving care at Weskoppies Hospital. He is gaining weight and his complexion is improving, but his move out of Life Esidimeni has affected the whole family adversely. His sisters' academic progress was hampered and his mother fell ill as a result of a stress-related illness. Mr Ngwenya became unemployed as he was caring for his son.

[117] Ms Nonjabe testified that her younger sister Ms Khayakazi Nonjabe is a survivor of the Marathon Project. In 2009, Khayakazi who was then in grade 10, fainted at school. Ms Nojabe related how her sister "was seeing things that did not exist" and as a result she dropped out of school. She was diagnosed with schizophrenia. Khayakazi was placed at Weskoppies Hospital and subsequently in 2015 was admitted to Life Esidimeni. When Khayakazi was at Life Esidimeni Ms Nonjabe was able to sleep knowing that her sister is well taken care of. In May 2016, Khayakazi was moved from Life Esidimeni to a non-governmental organisations known as Goitsemodimo in Fochville, some 60 kilometres away from their home. Ms Nonjabe found Khayakazi in a corrugated iron house. Her sister was distressed. Within a week she had lost a lot of weight and her complexion changed. Ms Nonjabe testified that the Marathon Project had taken an emotional and financial toll on her and her grandmother. Her work performance dropped sharply. She had to seek help from a psychologist after an emotional breakdown at work.

[118] Ms Baloyi's older sister, Ms Malinzwi Hlatle, had been at Life Esidimeni since 1983. She was moved to Takalani without the family being informed. Takalani was far away from their home. During the first visit, they found Ms Hlatle inappropriately dressed and hungry. During subsequent visits, she was still inappropriately dressed and hungry, but also dirty and smelly. She had lost a lot of weight and had relapsed. The family was deeply traumatised and could not cope emotionally and desperately needed counselling to manage what had happened. As they heard about the death of other patients at Takalani they became even more stressed and fearful. The family members would phone each other to pray over the phone. Out of desperation, Ms Baloyi also bought a car on instalments just to be available at night in case something happened to her sister.

[119] Ms Radebe told us about her brother Mr Mandla David Radebe who was a mental health care user at Life Esidimeni since 2014. Mandla was imprisoned for the death of his friend when he was 16 years old and was only released from prison in 2008 as a result of his mental illness. He was moved without the knowledge of the family to a non-governmental organisations known as Bophelong which was more than 100 kilometres from their home. When they eventually found him, Ms Radebe screamed and cried as her

brother was very smelly, skinny. He went from a size 40 to a size 28 clothing and was dirty and had long hair and beard. He was hungry. The other mental health care users around him were also hungry and they fought over the food which Ms Radebe's family brought for them.

[120] Mr Maditsi related the awful story about his ill sister's child, Ms Kgotso Maditsi, who had been at Life Esidimeni since 2005. The Department never consulted the family for permission to move her. When they ultimately traced Ms Maditsi at Takalani, she had lost weight, was hungry, smelling badly and was dirty. She was thinly dressed for the cold day. They were unhappy with the care she received and decided to take her home as they feared for her life. No one was able to care for her in Gauteng and they had to pay a family member R3 000 to care for her in Limpopo from October 2016 to December 2017. She was re-admitted to Life Esidimeni in December 2017.

[121] Mr Sibusiso Sikhakhane told us that his younger brother Mr Mduduzi Sikhakhane was a mental health care user at Life Esidimeni. He was diagnosed with bipolar disorder in 2002. During May 2016 Mduduzi was transferred from Life Esidimeni to a non-governmental organisation known as Rebafenyi in Pretoria without the knowledge of his family. Mr Sikhakhane did not know where Rebafenyi was situated and had to search for it. He found his brother hungry and dirty. Mr Sikhakhane heard from his brother that Mr Christopher Mogwerane, a mental health care user with whom he had shared a room, died at Rebafenyi. When Mr Sikhakhane visited Mduduzi for the second time at Rebafenyi he had shed a lot of weight. In a short time Mduduzi relapsed and was moved to Jubilee Hospital in Hammanskraal about 100 kilometres away from Soweto, where their family home was. Mduduzi was thereafter moved to another non-governmental organisation Rebafenyi 2 near Hartbeespoort. Mduduzi was later moved to different hospitals as his conditions worsened since he was relocated from Life Esidimeni. Mduduzi is now at Sterkfontein since the intervention of the National Minister of Health, and is doing well there. Mr Sikhakhane wants Government to look after the mentally ill patients.

[122] Mr Andrew Petersen recounted the journey of his uncle, Mr Victor Truter, aged 69, who had been a mental health care user at Life Esidimeni since 1979. Mr Truter was diagnosed with chronic schizophrenia. During the Marathon Project Mr Truter was moved from Life Esidimeni but his family was never told where he was transferred to. Government officials told Mr Petersen that Mr Truter was either moved to Sterkfontein or Baneng. Mr Petersen could not find Mr Truter at either of these two places. Mr Truter was found at a non-governmental organisation known as Mosego after he had been missing for two months. He had lost weight, and his complexion had changed. He was hungry, thirsty and very dirty. Mr Truter was not receiving his medication at Mosego. On 5 April 2017 he was moved to Selby Care Centre where he is receiving medication and good nutrition. He is much better now. Mr Petersen was appointed as a family representative. He sacrificed a lot of his time to attend family meetings, organise marches with civil society organisations and present memoranda to the Department. He explained that he acted in the interest of his uncle and other mental health care users but the Department ignored their voices which were attempting to stop the transfer. He lost a lot of business during this time.

[123] Ms Mofokeng testified that her younger sister Ms Maggie Mofokeng was a mental health care user at Life Esidimeni since 2010. Maggie was three years old when she sustained a head injury. Doctors discovered brain damage. She had been in various hospitals before she was admitted at Life Esidimeni. In 2003 she was raped by another patient at Takalani. At the time she tested HIV negative. Maggie was ill thereafter and was taken to Chris Hani Baragwanath Hospital for treatment. Once discharged, she returned to Takalani. It was then discovered that she was HIV positive. In May 2016, as part of the Marathon Project, the Department moved Maggie from Life Esidimeni to a non-governmental organisation called Anani in Vereeniging. Maggie was far from the family home and without knowledge of her family. Ms Mofokeng went to Anani and found Maggie there. She was dirty, smelly and had lost weight. She was not given any medical file. Maggie was moved again from Anani to Baneng and was further moved back to Life Esidimeni in April 2017. Ms Mofokeng testified that they spent more or less R3 000 buying Maggie clothes because her clothing often went missing. Ms Mofokeng spent some money travelling to visit her sister after she had been moved from Waverley but cannot say

how much she spent. Ms Mofokeng also related the family's pain and trauma, as well as Maggie's own torturous circumstances.

[124] Ms Lucky Albertina Mokatsi's son, Mr Kabelo George Mokatsi, was moved by the Department from Life Esidimeni in June 2016. Ms Mokatsi learned about her son's move when she went to visit him and found the Life Esidimeni Centre closed. A security guard advised her that patients had been moved to non-governmental organisations in Atteridgeville, Cullinan, Soshanguve and Soweto. After looking for Mr Mokatsi in the mentioned areas to no avail, she ultimately found him at Weskoppies Hospital after two months of looking for him. While Mr Mokatsi was found relatively well in Weskoppies, his clothes and shoes were missing and Ms Mokatsi was forced to buy him new clothes and shoes.

[125] Ms Elizabeth Chester's son, Mr Frans Chester, was moved from Life Esidimeni in June 2016 to a non-governmental organisation in Pretoria whose details are unknown to Ms Chester. The move happened without Ms Chester's knowledge. While Mr Chester was relatively well when he was found, he had lost weight. Since Ms Chester does not have a car she was forced to incur costs of transport for several trips to Pretoria. Mr Chester lost clothing items in the process of him being moved and Ms Chester had to spend money to replace the lost items.

[126] Ms Agnes Quanita Mlotshwa's sister, Ms Aysha Boswell, who was a patient at Life Esidimeni since July 2004, was moved to Saint Mitchells Clinic in Brakpan on 16 May 2016. Although Ms Mlotshwa was informed of the impending move a week before it happened, she was not informed of the exact date of the move and the move consequently occurred without her knowledge. When the family visited Ms Boswell at Saint Mitchells, they found her well and were satisfied with the conditions at the facility.

[127] Ms Grace Motlhabi's sister, Ms Francinah Motlhabi, was a patient at Life Esidimeni for about 47 years. The Department moved Francinah to Cullinan Centre in July 2016. The move occurred without the Motlhabi family's knowledge. They heard about the patients

being moved from someone whose family member was also a patient at Life Esidimeni. When Ms Motlhabi called Life Esidimeni Waverley to enquire about her sister, she was informed that she had been moved either to Cullinan Centre or Weskoppies. Ms Motlhabi then asked a relative that lives in Atteridgeville to go and check if her sister was not in Cullinan Centre. When the relative went to look for Francinah in Cullinan Centre, she was informed that she was not there. However, after insisting on looking for her before leaving, the relative found her there. Ms Motlhabi went to visit her sister a few days after hearing that she was in Cullinan Centre and found her fine. However, she was not happy with the environment as it looked like wards were being renovated. When Ms Motlhabi visited her sister a month later, she found her having lost weight and her behaviour had changed drastically in that she was aggressive, restless and was using foul language, contrary to her quiet personality.

[128] Ms Mosidi Priscilla Ntshangase's brother Mr Bhekumuzi Ntshangase, who had been a patient at Life Esidimeni since 2012, was moved to Rebafenyi non-governmental organisations in Pretoria in or about June 2016. Ms Ntshangase visited her brother after he was moved to Rebafenyi and found him wearing the same clothes he was wearing when he left Life Esidimeni. He was dirty, barefoot and disorientated. On enquiring about his state from a certain Noni who was in charge of Rebafenyi, Ms Ntshangase was informed that he arrived at Rebafenyi in that state. Noni further informed Ms Ntshangase that her brother and the group of patients he arrived with at Rebafenyi were moved from Life Esidimeni to another care centre whose name cannot be recalled. However, when that centre refused to admit them, the Department officials took them to Rebafenyi against Noni's will. Visiting as often as Ms Ntshangase would have liked was very difficult as it was very far from her home. When Ms Ntshangase visited Mr Bhekumuzi Ntshangase in July 2016, she found him even worse off. He was dirty, stinking of urine, had lost weight and was looking like a zombie.

[129] Ms Sandra Ronita Davids' brother, Mr Anthony Singh, was moved to Odirile Care Centre in Hammanskraal around the end of May 2016. Before Mr Singh was moved, Ms Davids' sister, Ms Shereen Jelley, received a call from a Department official informing

her that Mr Anthony Singh was being moved that day. However, when she enquired if she would be allowed to escort the bus that would be transporting him, the official suddenly became unsure of whether the bus was to depart that day or the following day. Instead, the official gave Ms Jelley, Odirile Care Centre's telephone numbers to confirm the move with them. On or about 4 June 2016, Ms Davids and her sister went to Temba, Hammanskraal to visit Mr Singh. Having arrived in Temba, they spent two and a half hours looking for Odirile as their phones' Global Positioning System could not pick up Odirile's physical address. When they ultimately found Odirile, their initial impression was that it was a decent and clean place and they were relieved. They found Mr Singh wearing pants that were about three sizes too big for him and a pair of fluffy pink ladies' slippers. They were extremely distressed to find him like that. On enquiring about his state from Odirile's staff, they were informed that Odirile normally cares for children, and never had adults before. They accepted Odirile's explanation and their main concern was that Odirile was about 114 kilometres from where they lived. In October 2016, Ms Davids and her sister made arrangements to take Mr Singh home to spend a weekend with him and asked for medication he would take while at home. They were informed that Odirile was still waiting for his medication from Life Esidimeni in Waverley. At home, they noticed that he had a scar with a scab on the left side of his forehead. They could not get answers from the staff as to what caused the scar.

[130] Ms Lipuo Bertha Hassim's sister, Ms Elizabeth Peggy Zwane, was moved from Life Esidimeni to Takalani non-governmental organisation in about June 2016 without her knowledge. She came to know of the move when she went to visit her sister at the Life Esidimeni in June 2016. On her arrival she was informed that patients had been moved to different places around Johannesburg and Pretoria and was given telephone numbers to call and enquire about Ms Zwane's whereabouts. Hearing about her sister's move in the manner that she did and not knowing where she was deeply distressed Ms Hassim. She then made countless telephone calls enquiring about Ms Zwane's whereabouts, to no avail. The only indication she received from the telephone calls was that many patients were moved to non-governmental organisations around Pretoria. She then focused her search for her sister around Pretoria. She ultimately found her sister at nearly three months later, in

September 2016, at Takalani in a terrible state. Ms Zwane had a big scar on her forehead and also on her knee. In the process of looking for her sister, Ms Hassim was forced to rent a car as it would have been difficult to use public transport. Consequently, she spent money on transport, telephone calls and clothing. The prolonged anxiety, pain, discomfort and trauma for Ms Zwane and her family is obvious.

[131] In or about July 2016, the Department moved Ms Mercy Motsoasile, from Life Esidimeni, without her family's knowledge or consent. Ms Onica Dalasile, and her family found out about Ms Mercy Motsoasile's move when they were trying to make arrangements to take her home for a weekend. Ms Dalasile was informed that her niece was moved to Cullinan Centre. She then went to Cullinan Centre in the company of family members and did not find her there. She called the Department to enquire about Mercy's whereabouts and was informed that she was at Takalani non-governmental organisation. The family went to Takalani to look for her and found her there. Sadly, the state they found her in was very bad as she was thin, dirty and unkempt. On enquiring about her state, they were informed that she had fallen ill on her arrival at Takalani and had to be taken to Chris Hani Baragwanath Hospital. Ms Dalasile's impression was that patients were not adequately taken care of, as they were grouped together almost like sheep in a kraal, with some laying on the ground while others roamed around aimlessly.

[132] The Department moved Ms Maggie Joyce Dlamini from Life Esidimeni to a non-governmental organisation known as Mosego in April 2016. Her son, Mr Jim Dlamini, was notified that his mother was being moved to Mosego. When he visited his mother at Mosego, he found her well, but she was a bit untidy. Although he was somewhat concerned, he let that pass. Mr Dlamini visited his mother two weeks later and found her to have lost weight, untidy and unkempt. On that occasion his mother informed him that they were using cold water to wash. After raising his concerns about his mother's condition with management, Mr Dlamini decided to bring his clippers when visiting his mother and used it to cut her hair. Apart from Mr Dlamini's mother's unsatisfactory physical condition, her mental state was negatively affected as well, and as a result she relapsed. One day when Mr Dlamini visited his mother, he found her with wounds on both her ears.

[133] In April 2016, Mr George Shai was moved from Life Esidimeni to a non-governmental organisation in Atteridgeville known as Tshepong without the knowledge of his sister Ms Phumla Shai. Ms Shai received a call from someone from Tshepong advising that her brother was there. She was given a list of things to bring when visiting him. They included clothes, pyjamas and slippers as Tshepong did not have any available for the patients. Ms Shai then bought Mr George Shai clothes, pyjamas, underwear, a pair of sneakers and a pair of slippers. When she went to visit her brother, she found him with his mood downcast, but this did not bother her as that was not unusual. Sometime in May 2016, he fell sick and was admitted to Kalafong Hospital. When Ms Shai visited her brother there, she found him heavily sedated and seriously ill. Later on Mr Shai was transferred to Weskoppies and Ms Shai was present during the transfer. When Ms Shai went to Tshepong to fetch her brother's belongings, most were missing. Her brother's condition improved greatly at Weskoppies. She was forced to hire a car numerous times in order to visit her brother.

[134] Ms Thalita Olga Mabizela's brother, Mr Nkahluleng Hosia Ntsobe, was a mental health care user at Life Esidimeni since May 2013. Ms Mabizela was informed of the pending closure of the facility in or about March 2016 and was given an option of taking her brother home or letting him be moved to a non-governmental organisation. She elected to take him home and did so in or about April 2016. Ms Mabizela tried her best to look after her brother, but he kept on relapsing, resulting in him being admitted to Thelle Mogoerane Hospital.

[135] Ms Sophie Kanza's father, Mr Guy Daniel Kanza, was a patient at Life Esidimeni since 2009. The Kanza family are asylum seekers from the Democratic Republic of Congo and arrived in the country in 1995. In or about November 2015, they received a call from Life Esidimeni advising that the facility was going to be closed at the end of March 2016 and that the patients would be moved to a non-governmental organisation. However, since Mr Kanza was not a South African national and was not receiving a social grant, he would not be eligible to be moved to a non-governmental organisation. Sadly, it was not explained

to the Kanzas that Mr Kanza was welcome to remain there until the end of March 2016. Consequently, they were forced to take him home in December 2015. Ms Kanza and her siblings were forced to bear the burden of looking after their father as their mother had abandoned them. While Mr Kanza was at Life Esidimeni, a semblance of normality and stability had been created in their lives. At some point he was admitted to Helen Joseph Hospital and was released in the custody of his friend after three days, without his next of kin's consent, and is currently missing. Ms Kanza and her siblings do not know their father's whereabouts and their desire is for their father to be traced and returned to Waverley, if located.

[136] In 2016, the Department moved Mr Mathews Moloi, a mental health care user at Life Esidimeni since 1993. He was moved without his family's knowledge. Mr Mojalefa Sethunya, his brother only became aware that Life Esidimeni was closed and that patients had been moved in January 2017. While looking for his brother at care centres, orphanages and old age homes, he was referred to Selby Hospital. Officials from Selby Hospital put Mr Sethunya in touch with the family committee. It was through the family committee's assistance that Mr Sethunya found his brother at Weskoppies Hospital. He remains at Weskoppies Hospital. Mr Sethunya's challenge is that it is costly to travel by taxi to Weskoppies Hospital. Mr Sethunya therefore wishes that his brother be moved closer to home.

[137] Mr Thabiso Ramakgapola's uncle, Mr Philemon Ramakgapola, was a mental health care user at Witpoort since 2012 and was moved to Life Esidimeni, Waverley in or about May 2016. A few days after being moved to Waverley, Mr Philemon Ramakgapola was moved to Tshepong non-governmental organisation in Atteridgeville without his family's knowledge. The family heard about the move when they received a call from Tshepong advising that Mr Philemon Ramakgapola was there. The family visited him a few days after hearing about his move. On arrival at Tshepong, the family's impression was that the place was not ideal for people in need of care as the premises were dirty with some patients basking in the sun while others were roaming around. Apart from that, they found Mr Philemon Ramakgapola in a bad state – he was dirty, untidy and wearing other people's

clothes. In or about July 2017, Mr Philemon Ramakgapola was moved from Tshepong to Baneng where he currently remains.

[138] Mr William Makama Ramakgapola, was a mental health care user at Life Esidimeni since 2013 and was moved to Cullinan Centre in or about May 2016 without the Ramakgapola family's knowledge. Mr Thabiso Ramakgapola, the cousin to William and the family got to know that William had been moved two days after he was moved. Mr Thabiso Ramakgapola visited his cousin at Cullinan Centre a few days after hearing about the move and found him wearing dirty clothes, torn shoes, looking as though he had not had a bath since arriving there and in distress. The family noticed an improvement in William's condition after Professor Makgoba had released his report about Life Esidimeni. About May or June 2017, William was moved back to Life Esidimeni and his condition has improved greatly.

[139] Since 2014, Mr Michael Siphiwe Tshabalala, was a mental health care user at Life Esidimeni. Mrs Elizabeth Malgas, his sister, heard reports on the radio and television that Life Esidimeni facilities were being closed and patients were being sent to non-governmental organisations close to their homes. Mrs Malgas's expectation after hearing the media reports was that someone from Life Esidimeni would call and inform the family about her brother's move. However, when that call was not forthcoming, in June 2016 Mrs Malgas and her siblings went to the facility to establish whether their brother Michael was moved. They were informed that the care centre had been closed and that patients had been moved to non-governmental organisations. The nearest non-governmental organisation they knew was Takalani. They went there to look for Michael. He was not there. They resorted to the Department. Its officials told them that Michael was at Weskoppies Hospital. They went to Weskoppies but Michael was not there. They were told that he was at Bophelong non-governmental organisation in Pretoria. The family went to Bophelong, but Michael was not found there. They called a certain Mr Lehau who seemingly was responsible for patients at the non-governmental organisations. He pointed the family to a non-governmental organisation which the family called. Mrs Malgas insisted that if Michael was at the non-governmental organisation he be put on the phone

so that she could hear his voice. When Michael came on the phone Mrs Malgas heard that the voice was indeed her brother's. They were relieved that Michael was still alive, having looked for him for about two months. They visited and found Michael fine and relatively well looked after at that non-governmental organisation. In April 2017, Mr Michael Siphiwe Tshabalala was moved to Selby Park, where he remains.

[140] Mr Mordicai Mphambo's brother, Mr Mzwandile Elliot Mphambo, has been a mental health care user at Life Esidimeni since 20 November 2002. About 26 May 2016, Mwandile was moved to a non-governmental organisations in Atteridgeville named Tshepong. A few days after learning of his brother's move, Mr Mphambo visited him at Tshepong. Mr Mphambo's impression of Tshepong was that it was not conducive for mental health patients as it was cluttered. His brother was wearing light clothes on a cold winter's day, he was dirty and had shed a lot of weight. Mr Mphambo was told that the non-governmental organisation was unable to provide clothes, shoes and blankets as it was not receiving money from the Government. Consequently, Mr Mphambo had to buy his brother clothes, underwear, shoes and blankets. On 30 March 2017, Mr Mzwandile Elliot Mphambo was moved from Tshepong to Life Esidimeni, Baneng Care Centre. During June 2017, he was admitted to Helen Joseph Hospital after falling ill and was discharged back to Baneng after three weeks. He was admitted to Helen Joseph Hospital again in July 2017 and sadly passed away on 18 August 2017.

[141] The circumstances of the mental health care users who survived the Marathon Project are expectedly many, varied and uneven. There are indeed differences on the kind, extent and impact of the morbidity, trauma and even torture the patients, on the one hand, and their families, on the other, had to be withstand. Equally, there are strong and stubborn common contours that are traceable across the experiences of mental health care spawned by the Marathon Project.

Government's obligations towards mental health care users

[142] There is no rift between the parties over the obligations of the Government towards mental health care users. They are sourced first and foremost from our Constitution, applicable domestic legislation and policy; all understood in the light of our country's international obligations.[36] Our Constitution leaves no doubt that we are bound by our properly assumed international obligations[37] and when interpreting domestic legislation we must prefer a construction that is consistent with international law.[38] Despite the pre-eminence of our Constitution, it is more convenient to dispose of international obligations first.

International law obligations

[143] The starting point must be the Universal Declaration of Human Rights[39]. Its preamble restates the "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family" and warns that "disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind". For now, let it suffice to record a few pointed provisions of the Universal Declaration of Human Rights that are here apposite and have found their way into our Constitution. They are:

> "Article 3: 'Everyone has the right to life, liberty and security of person'.
>
> . . .
>
> Article 5: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.'
>
> . . .
>
> Article 25(1): 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.'"

[36] Our Constitution lays down that a court, tribunal or forum must consider international law when interpreting

[144] The next important piece of international law is the African Charter on Human and Peoples' Rights (African Charter).[40] It guarantees protection of conventional fundamental human rights as well as peoples' rights within the African context.
Article 4 roundly proclaims that:

> "Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right".

[145] The African Charter proscribes all forms of human degradation including torture, cruel, inhuman or degrading punishment and treatment. Of immediate relevance is Article 16. It provides:

> "(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.
> (2) States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."

[146] The Convention on the Rights of Persons with Disabilities (Convention) is of immediate relevance.[41] Its primary mission is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.[42] Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which upon interaction with various barriers may hinder their full and effective participation

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the Bill of Rights.

[37] Section 231(2) of the Constitution.

[38] Section 233 of the Constitution.

[39] Adopted by the United Nations' General Assembly resolution 217A (III) on 10 December 1948.

[40] Adopted by the General Assembly of the Organisation of African Unity (OAU) on 27 June 1981 and entered into force on 21 October 1986. South Africa ratified the African Charter on 10 October 1997.

[41] South Africa signed this Convention together with its optional protocol on 30 March 2007 and ratified these on 30 November 2007.

[42] The Preamble of the Convention on the Rights of Persons with Disabilities.

in society on an equal basis with others.[43] A core principle of the Convention is respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.[44]

[147] The Convention targets several vital interests of people who have long-term physical, mental or intellectual impairments. These include the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability;[45] freedom from torture or cruel, inhuman or degrading treatment or punishment[46]; prevention of all forms of exploitation, violence and abuse; ensuring that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities;[47] and promoting the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse.[48]

[148] Even closer home, is the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.[49] The Principle on basic rights covers the right to the best available mental health care within the health and social care system. The right to be treated with humanity and respect for the inherent human dignity and the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.[50]

[149] The standard of care must be appropriate to the patient's health needs and in accordance with the same standards as other ill persons. Every patient must be protected

[43] Article 1 of the Convention on the Rights of Persons with Disabilities.

[44] Article 3 of the Convention on the Rights of Persons with Disabilities.

[45]Article 25 of the Convention on the Rights of Persons with Disabilities.

[46] Article 15 of the Convention on the Rights of Persons with Disabilities.

[47] Article 16(3) of the Convention on the Rights of Persons with Disabilities.

[48] Article 16(4) of the Convention on the Rights of Persons with Disabilities.

[49] Adopted by the UN General Assembly on 17 December 1991 as Resolution 46/119.

[50] Principle 1 of the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

from harm, including unjustified medication, abuse by other patients, staff or other acts causing mental distress or physical discomfort.[51]

[150] All medication must be prescribed by a mental health practitioner authorized by law and must be recorded in the patient's records. Medication must meet the best health needs of the patient; must be given to a patient only for therapeutic or diagnostic purposes and must never be administered as a punishment or for the convenience of others[52]. Mental health practitioners must only administer medication of known or demonstrated efficacy.[53]

[151] The Principle on treatment stipulates that every patient must be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.[54]

[152] On ethics, one Principle requires that mental health care must always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards. The treatment of every patient must be directed at preserving and enhancing personal autonomy. Mental health knowledge and skills must never be abused.[55]

[153] Another vital Principle sets the necessity of consent to treatment.[56] No treatment shall be given to a patient without his or her informed consent, save for recognised

[51] Principle 8 of the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

[52] Principle 10 of the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

[53] Id.

[54] Id.

[55] Principle 9 of the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

[56] Principle 11 of the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for

exceptions. A patient may request the presence of a person or people of the patient's choosing during the procedure for giving consent. A patient must never be invited or induced to waive the right to informed consent. Should a patient seek to do so, it must be explained to the patient that the treatment cannot be given without informed consent except if the patient is, at the relevant time, held as an involuntary patient or lacks the necessary capacity to consent or an independent authority has after the prescribed process granted consent on behalf of the patient. All treatment must be immediately recorded in the patient's medical records, with an indication of whether it has been given voluntarily or not.[57]

[154] The Principles recognise that a patient or his or her personal representative, or any interested person, must have the right to appeal to a judicial or other independent authority concerning any treatment given to the patient.[58]

Our Constitution

[155] Our Constitution binds all organs of state and every state official entrusted with public power.[59] All public office bearers and State officials who made decisions on the Marathon Project were bound to observe constitutional dictates. By parity of reasoning, when organs of State, as the facts here show entrusted non-governmental organisations with and in turn, non-governmental organisations assumed duties of an organ of the State in relation to the affected mental health care users, the non-governmental organisations acquired related constitutional obligations.[60] The non-governmental organisation exercised delegated public power. The non-governmental organisations acted in the name, place,

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the Improvement of Mental Health Care.

[57] Principle 10 of the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

[58] Principle 11 of the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

[59] Section 8(1) of our Constitution reads that:

> "The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state."

[60] *Allpay Consolidated Investment Holdings (Pty) Ltd and Others v Chief Executive Officer of the South African Social Security Agency and Others (No 2)* [2014] ZACC 12 at paras 52-59.

stead and authority of the State whose duty it was to provide adequate care to the mental health care users. As the non-governmental organisation voluntarily assumed the care of the affected mental health care users they were bound to exercise their mandate lawfully and in a reasonable manner.[61]

[156] The concerned state organs and indeed non-governmental organisations were obliged to respect, promote and protect constitutional entitlements of mental health care users. These include their inherent human dignity[62] right to life[63]; freedom and security of the person, especially the right not to be tortured in any way; and not to be treated or punished in a cruel, inhuman or degrading way.[64] Mental health care users were entitled to have access to adequate health care services and sufficient food and water.[65] In turn, their families and interested parties acting on their behalf or in the public interest were entitled to demand that the fundamental rights of mental health care users should not be infringed or threatened.[66]

[157] The Constitution goes further to impose overarching duties on wielders of public power. As elected office bearers and so too those in the public service go about their duties, they must first and foremost be faithful to the law. They must act within the stricture of the law and eschew unlawfulness. They may not elevate their personal or arbitrary or political or other preferences above or in a breach of binding law. That is a bare minimum of the constitutional tenet of the rule of law.[67] And embedded in our democratic practice are founding values of openness, responsiveness and accountability in the exercise of public

[61] *Rail Commuters Action Group v Transnet Ltd t/a Metrorail* [2004] ZACC 20 at para 87 held that :

> "This standard strikes an appropriate balance between the need to ensure that constitutional obligations are met, on the one hand, and recognition for the fact that the bearers of those obligations should be given appropriate leeway to determine the best way to meet the obligations in all the circumstances".

[62] Section 10 of the Constitution.

[63] Sectionn11 of the Constitution.

[64] Section 12 of the Constitution.

[65] Section 27 of the Constitution.

[66] Section 38 of the Constitution.

[67] Section 1 of the Constitution.

power that affects all people in our land, and certainly that impinges on defenceless mental health care users and their families.

[158] Our democratic project sets admirably high principles for officials in the public service. Public administration must occur within the precincts of set values and principles. These include a high standard of professional ethics[68] using public resources in an efficient, economic and effective manner;[69] providing services impartially, fairly, equitably and without bias;[70] and being responsive to people's needs and engaging and encouraging the public to participate in policy-making.[71] In addition, public administration must be accountable[72] and transparent by providing the public with timely, accessible and accurate information.[73]

[159] Here, it is useful to record that the Constitution expressly, albeit self-evidently, imposes duties of fidelity to the law, transparency and accountability on the member of the Executive Council. To cut to the chase, Ms Mahlangu, was responsible for the executive function related to health care in the province as assigned by the Premier.[74] She was obliged to act in accordance with the Constitution.[75] She was "accountable collectively and individually" to the legislature for the performance of her functions and duties[76] and she bore the duty to give full and regular reports to the Legislature.[77]

Domestic legislation

[68] Section 195(1)(a) of the Constitution.

[69] Section 195(1)(b) of the Constitution.

[70] Section 195(1)(d) of the Constitution.

[71] Section 195(1)(e) of the Constitution.

[72] Section 195(1)(f) of the Constitution.

[73] Section 195(1)(g) of the Constitution.

[74] Section 133(1) of the Constitution.

75 Section133(3)(a) of the Constitution.

76 Section 133(2) of the Constitution.

77 Section 133 of the Constitution.

[160] The key pieces of applicable domestic legislation are National Health Act[78] and Mental Health Care Act[79](the Act). Both, in theory, are animated by and seek to give effect to the progressive realisation of the constitutional right of access to health care services; to an environment that is not harmful to the health or well-being of people and to the protection of vulnerable groups including women, children, older persons and persons with disabilities.

[161] I single out only a few relevant provisions of each of the statutes. The National Health Act requires the person in charge of a health establishment to ensure that a health record containing such information as may be prescribed is created and maintained at that health establishment for every user of health services.[80] It is significant that a health establishment includes a private institution, facility or building, whether for profit or not, that is operated or designed to provide any of the health care services of a wide spectrum.[81] There is no doubt that the non-governmental organisations that were used in the Marathon Project were health establishments as defined and bore the duty to keep a health record of every user of health care services in their care.

[162] The National Health Act prescribes duties of the member of the Executive Council and head of the department[82] and requires that provincial health plans must conform to national health policy.[83]

[163] The germane national policy to mental health care is the National Mental Health Policy Framework and Strategic Plan[84] (Policy Framework). Its vision is as bold as it is

78 61of 2003.

79 17 of 2002.

[80] Section 13 of the National Health Act. The duty is subject to National Archives of South Africa Act 43 of 1996 and the Promotion of Access to Information Act 2 2000.

[81] Section 1 of the National Health Act.

[82] Section 25(1)-(3) of the National Health Act.

[83] Section 25(4) of the National Health Act.

[84] 2013-2020 - the Policy Framework became national policy after extensive consultation and the adoption of The Ekurhuleni Declaration on Mental Health in April 2012.

ambitious and what is more, it is time bound: "Improved mental health for all in South Africa by 2020".

[164] Its mission is equally aspirational:

> "From infancy to old age, the mental health and well-being of all South Africans will be enabled, through the provision of evidence-based, affordable and effective promotion, prevention, treatment and rehabilitation interventions. In partnerships between providers, users, carers and communities, the human rights of people with mental illness will be upheld; they will be provided with care and support; and they will be integrated into normal community life."

[165] The objectives of the policy are to be welcomed and well in line with our constitutional and international treaty obligations. They include the objective to promote and protect the human rights of people living with mental illness; to increase decentralized integrated primary mental health services, which include community-based care, primary health care as part of clinic care, and district hospital level care; to reduce stigma and discrimination associated with mental illness; to empower local communities, especially mental health service users and carers; to promote mental well-being and recovery within their community and to establish a monitoring and evaluation system for mental health care.

[166] Whilst the Policy Framework places considerable hope on community-based care into the future it also candidly warns of the high risk of rapid and pre-mature use of community based mental health care:

> "Deinstitutionalisation has progressed at a rapid rate in South Africa, without the necessary development of community–based services. This has led to a high number of homeless mentally ill, people living with mental illness in prisons and revolving door patterns of care."[85]

[85] Paragraph 2.5 (12) of the Policy Framework.

[167] The Policy Framework envisages that the provincial departments of health will license and regulate the provision of community-based mental health services by non-governmental organisations and for-profit organisations, such as community residential care, day care services, and halfway houses. This, the Policy Framework says, is in keeping with regulation 43 of the General Regulations of the Mental Health Care Act.[86] The provisions authorise the Minister or Director-General in the national department or the member of the Executive Council or head of the department in the provinces to be signatories to licences to non-governmental organisations.

[168] Only a few observations on the Act should suffice. It is the principal legislation that regulates mental health care. The Act carries wide and far reaching meaning of a "mental health care user"[87] and "mental health care providers"[88]. A mental health care user includes "next of kin" or family of the user if below 18 years or is incapable of taking decisions. Equally important is that, a mental health care provider includes any person providing health care to a user. It is enough to note that patients and their families who were affected by the Marathon Project were mental health care users. On the evidence virtually all patients affected by the Marathon Project were incapable of taking decisions. Also the non-governmental organisations that assumed their care were health care providers under the Act and thus bound by its requirements.

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[86] General Regulations under the Mental Health Care Act. Published under Government Notice R1467 in Government Gazette 27117 of 15 December 2004 and amended by:GN R98 GG 27236 of 11 February 2005 and GN 1590 GG 40515 of 23 December 2016.

[87] The Act defines a mental health care user as:

> *"*A person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, State patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions, and in certain circumstances may include─
>
> (i) a prospective user;
>
> (ii) the person's next of kin;
>
> (iii) a person authorised by any other law or court order to act on that persons behalf;
>
> (iv) an administrator appointed in terms of this Act; and
>
> (v) an executor of that deceased person's estate,
>
> and 'user' has a corresponding meaning."

[88] A mental health care provider is "a person providing mental health care services to mental health care users and includes mental health care practitioners".

[169] The objects of the Act divulge no surprises. They are consistent with international and domestic norms on the purpose of mental health care. The main ones are to "make the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interests of mental health care users within the limits of the available resources"; to co-ordinate and regulate access to mental health care and to clarify the rights and obligations of mental health care users and the obligations of mental health care users and the obligations of mental health care providers.[89]

[170] The Act locates the responsibility to provide mental health care, treatment and rehabilitation services at primary, secondary and tertiary levels and health establishments to "[e]very organ of State responsible for health services".[90] The organ of state must advance the rights and interests of mental health care users and when exercising any powers or duties under the Act must have regard to what is in the best interests of the mental health care user.[91] The Act provides for recognition of health establishments[92] that must provide mental health care to any person requiring it, within its professional scope of practice or refer the person to a health establishment that provides the appropriate level of mental care.[93]

[171] The Act echoes the human rights imperatives in mental health care. It embraces a definition for health as being "a state of complete physical, mental and social well-being", and states that mental health is therefore an essential element of health and is crucial to the overall well-being of individuals and society.[94] It restates the prescript that human dignity and the privacy of every mental health care user must be respected. The care must seek to

[89] Section 3 of the Act.

[90] Sections 4 and 5(1) of the Act.

[91] Section 7(2) of the Act.

[92] In terms of the Act, "health establishment" means institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals.

[93] Section 6 of the Act.

[94] The definition borrows from the World Health Organisation's definition of health.

improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life. The care must be proportionate to his or her mental health status and may intrude only as little as possible to give effect to the appropriate care.[95] The legislation seeks to screen the patient from unfair discrimination[96] and from exploitation and abuse[97] by imposing a stringent requirement of informed consent before submitting to treatment[98].

[172] The legislative scheme boasts of an internal review mechanism. It is the Mental Health Review Board (Review Board) that must provide an independent oversight role.[99] Its members are appointed and may be removed by the member of the Executive Council on specified grounds but only after an enquiry. For purposes of this arbitration the most useful attribute of the Review Board is the power and obligation to consider appeals against decisions of the head of a health establishment.[100]

[173] Relevant here, is that a decision by the head of a health establishment to transfer a patient is susceptible to review and reversal by the Review Board. But the evidence tells us that in the Marathon Project, Dr Manamela ordered heads of health establishments concerned to discharge or move users gratuitously and contrary to the detailed prescripts of the legislation. The chairperson and members of the Review Board knew about the en masse discharge of mental health care users from Life Esidimeni facilities and did absolutely nothing about this. They raised not even a finger to protect the users. In her evidence, the chairperson, Mrs Masondo, a multiple qualified nursing sister and a psychiatric nurse of vast experience, admitted that she and members of the Review Board were pleased to draw handsome monthly salaries from the Department and yet they neither apprised themselves of their statutory tasks nor performed them.

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[95] Section 8 of the Act.

[96] Section 10 of the Act.

[97] Section 11 of the Act.

[98] Section 17 of the Act.

[99] Sections 18-24 of the Act.

[100] Section 19(1)(a) of the Act.

[174] Also the Review Board may set its own procedure for accomplishing its mandate. In other words it was within its gift to take reasonable steps to fulfil its independent oversight role in order to advance or protect vital interests of mental health care users and their families.

[175] The Ombud correctly described the Review Board as "moribund" during the torturous and murderous Marathon Project. Its chairperson admitted that the Review Board did not fulfil any of its statutory obligations during the Marathon Project. This because, she claimed, she believed that she worked for and reported to Ms Mahlangu who hired and paid her. She thought the Review Board had no power to countermand the decision to move or transfer users. She claimed that she was unaware of her statutory obligations to review and where appropriate set aside the decisions to transfer or move patients in order to advance and protect the vital interests of mental health care users and their families. One fleeting reading of the legislation regulating the Review Board will show that Mrs Masondo was less than truthful when she pleaded ignorance of the duties of the Review Board. She and her Review Board chose to bend over and comply with what the Department wanted to do in order to protect her appointment and remuneration at the expense of mental health care users and their families. The Review Board deserted its statutory duties for personal convenience and fear of retribution from the leadership of the Department.

[176] I have spelled out the regulatory regime in considerable detail. In my view this was necessary given the vast human tragedy, in the form of death, torture and survival of defenceless mental health care users. Also because since 1994 our State has erected a globally admirable and compliant regulatory regime for the care of mental health care users. Its provisions are by and large in sync with international human rights and mental health care norms of a very high order. But what stands out is the breadth and depth and frequency of the arrogant and deeply disgraceful disregard of constitutional obligations, other law, mental health care norms and ethics by an organ of state, its leaders and employees.

[177] The final questions are what would be just and equitable redress including compensation and what form should the arbitration Award assume. To that end I quickly look at the constitutional breaches underlying the claim for compensation higher than the amount the Government has tendered.

Breaches of constitutional obligations

[178] The claimants contend that severe constitutional breaches against the mental health care users who have died and those who have survived and their families have occurred. Thus their claims are for damages beyond common law damages and flow from severe breaches by the Government of the constitutional rights of the claimants. Well, the breaches are self-evident. I nonetheless record them.

[179] The primal genesis of the torture and death of mental patients and torture of the survivors is the termination of the service level agreement with Life Esidimeni. I have already found, after an extensive evaluation of the evidence, that reasons that Ms Mahlangu and Dr Selebano and their Department have advanced for terminating the service contract with Life Esidimeni are untrue and false. As I have already found, the evidence of National Minister, the Premier and the member of the Executive Council for Finance have shown that the reasons are fabricated and patently false. More so, the reasons are not properly related to the governmental purpose they claim they were pursuing. In short, besides the reasons for the termination being untruthful, the decision to terminate the contract was irrational and in blatant breach of the law and the Constitution.

[180] The requirement of rationality in decision making is a subset of the rule of law, a founding value of the Constitution. It compels a person who exercises public power to pursue only a lawful governmental purpose and that the means she chooses must be properly related to the outcomes she seeks. A decision-maker wielding public power may not act arbitrarily, without a good or for no reason. Least still a decision-maker may not act for an ulterior purpose, particularly when she makes a decision that impinges adversely on the rights of other people. Absent rationality in the use of public power, arbitrariness and

tyranny will flourish. The death and torture in the Life Esidimeni tragedy stemmed from the irrational and arrogant use of public power.

[181] I invited Ms Mahlangu and Dr Selebano several times to explain the true reason why they ended the contract. They failed to do so. They diverted responsibility, so they thought, by saying it was a "decision of the collective". Both admitted that each had the power to stop the termination of the contract but never explained why they did not. None could explain why it was urgent to cancel the contract. Here is the point. Their irrational and thus unconstitutional decision was the reason for the death and torture that ensued. And yet the claimants and indeed the nation knows not the true reason why the triggering decision was taken by powerful Government Officials against defenceless mental health care users and their families. Absent the truth, closure for the claimants is only hardly possible.

[182] This wanton, arbitrary and unaccounted decision has caused so much pain and suffering, stress, trauma and morbidity, and in my view, is a very serious breach of the constitutional obligations by the State and its servants. Such a breach, together with other considerations will weigh heavily on the character of the just and equitable redress.

[183] The right to human dignity is critical to a meaningful departure from the oppression of the apartheid era. Colonialism and apartheid were the antithesis of human dignity. The recognition of the self-worth of each individual, regardless of their circumstances, is a prerequisite to the achievement of our constitutional values and therefore our democratic project.

[184] In *NM*, Madala J stated that:

> "While it is not suggested that there is a hierarchy of rights it cannot be gainsaid that dignity occupies a central position. After all, that was the whole aim of the struggle against apartheid ─ the restoration of human dignity, equality and freedom."[101]

[101] *NM and Others v Smith and Others* [2007] ZACC 6*;* at para 50. Compare*: Everfresh Market Virginia (Pty) Ltd v Shoprite Checkers (Pty) Ltd* [2011] ZACC 30*;* at para 71. *S v Makwanyane and Another* [1995] ZACC 3 at para 224 the following was said:

[185] Every element of the Marathon Project trampled: on the human dignity of the mental health care users when they were still alive, the dignity of the mental health care users after they had passed away, and the dignity of their family members who watched their loved ones waste away and die, powerless to do anything to prevent it.

[186] The violations of the right to dignity here are as many as they are plain to see. Not only were the mental health care users stripped of their dignity, in life and in death, but their families were also treated as sub-human and devoid of any worth. Their entitlement to participate in the decisions about the health care of their loved ones was disregarded, as was their right to information. Their grief was brushed off. Their emotional distress arising from the trauma they went through was undermined and used to marginalise them.

[187] The evidence shows the effort of many family members who took to search for their loved ones. The indignity of being confronted with dehydrated, emaciated and unwell mental health care users in dingy and unkempt non-governmental organisations seem a fairly obvious indignity. As I have recorded earlier, the families finding their loved ones deceased and in some instances decomposed was a hurtful affront to their human worth and to the value of *Ubuntu* that teaches us caring, communal sharing and human solidarity.

[188] I find that the claimants, in the extended sense, of mental health care users and their families or next of kin were stripped of their dignity in the way that the Government treated them. Before their death, mental health care users were owed a duty of protecting and upholding their dignity. The Government failed them dismally. In fact the Government proactively invaded their multi constitutional guarantees despite warnings and protests from organised clinicians, psychiatrists, psychologists and formation of families.

> "A person's status as a human being, entitled to unconditional respect, dignity, value and acceptance from the members of the community such person happens to be part of. It also entails the converse, however. The person has a corresponding duty to give the same respect, dignity, value and acceptance to each member of that community. More importantly, it regulates the exercise of rights by the emphasis it lays on sharing and co-responsibility and the mutual enjoyment of rights by all."

[189] The right not to be treated in a cruel, inhuman or degrading way is a self-standing right in the Constitution.[102] It is related to the right to dignity but its reach travels further. It does not only require that people be treated in a respectful and dignified manner and in accordance with their human worth but also targets proactive and systematic acts that are not only unkind but also hateful and directed at bodily and psychological hurt and harassment. All the facts here point to cruelty ─ an antithesis of empathy and caring.

[190] Our Constitution promises everyone not to be tortured in any way.[103] During argument before me, the State readily conceded that the ordeal of all mental health care users amounted to torture. That concession is well-made. That view is one held by at least three of the expert witnesses: Dr Mvuyiso Talatala[104], Ms Coralie Trotter[105] and Professor Ames Dhai[106].

[191] About torture Ms Trotter explained:

> "It is a strong term. I think once you've decided that a group of people is undesirable and you dehumanise them, then actually you are in the terrain of torture. So if you take a group of people who didn't know the move was coming up, weren't prepared for it and they are moved on the backs of trucks, tied with sheets, without supervision, without identity documents, without wheelchairs, without medical files, this is no longer a human endeavour, that in itself is a torture. This was done inhumanely and so now we are in the terrain of torture. And then that doesn't stop, because the patients are moved into these filthy dangerous environments as if they are not people. And then you know, for example, the Reverend [Maboe] saying that they wouldn't give Billy water because he would pee in his pants. So then you've got the withholding . . . you know however people were fed or weren't fed, whatever happened in terms of all of that. You've now got something that is a

[102] Section 12(1)(e) of the Constitution.

[103] Section 12(1)(c) of the Constitution.

[104] Dr Talatala, MBCHB (Natal), FCPsych(SA) (UKZN), MMed (Psychiatry) UKZN). Dr Talatala is Psychiatrist in private practice.

[105] Ms Coralie Trotter MA (Psych) (RAU), Hons BSc (Psych) (UNISA), Psychology (UNISA), H.Dip.Ed.(P.G) (UNISA), BSc(Hons)(Chem) (Wits). Ms Trotter is Psychoanalyst and Psychologist in private practice.

[106] Professor Ames Dhai MBCHB (Natal), FCOG (Colleges of Medicine of South Africa), LLM (Natal) PG Dip Int Res Ethics (UCT), PhD (Wits). Professor Dhai is a Director Steve Biko Centre for Bioethics, Faculty of Health Sciences, at University of the Witwatersrand.

> basic human right which is water and food has become complex – that's torture. When you torture people, that's what you do, you play around with food, you play around with water, you deprive them at a sensory level, you overcrowd them. And all of those features of actively torturing people are in this situation.

[192] In oral evidence Dr Talatala was asked to explain the impact of dehydration and hunger on psychiatric patients. Below he explains the torturous impact of hunger on patients:

> "Similar to dehydration, if people do not eat, even if they do not have a mental illness, they are likely to have complications related to not eating, their blood sugar will decrease and they may die as a result. But with psychiatric patients, at the beginning if they are not getting enough food, before they even get these complications from lack of food, they become restless because their medication increases apetite. If there is no adequate provision of food, you will think that maybe their psychiatric illness is getting worse when they actually just want food. Then as the blood glucose goes down they could also go into delirium confusion and you as a lay person may think that, even a junior doctor, maybe they are getting mentally ill and yet it is the confusion due to hypoglacemia which is low blood sugar."

[193] Professor Dhai characterised the conditions as "inhuman", "cruel" and "degrading", noting that for her, the evidence of the bereaved families brought back to her memories of the manner in which people were mistreated during the apartheid era. Her expert report reflects the following:

> "The entire project is a sad reminder of Steve Biko, the leader of the Black Consciousness movement in South Africa and an opponent of the Apartheid regime who died in detention on 12 September 1977. His death raised grave moral questions regarding the conduct of various medical practitioners who were implicated in the affair and are relevant even now in the Gauteng Mental Health Marathon Project. Biko was left lying on a mat, soaked in urine on the cement floor of the cell. On the night of 11 September, he was placed on cell mats on the floor of a Land Rover, semi-comatose naked and handcuffed and driven to

> Pretoria Central Prison. No medical records were sent with him. Neither was he accompanied by any medical personnel during the journey."[107]

[194] Indeed, the State breached the protection of mental health users against torture of any kind.

[195] The right to family life is an associational right that flows from a collection of other interrelated rights such as right to dignity, equality, freedom and the right of a child to family and parental care.[108] In *Dawood* the Court explained that *"human beings are social beings whose humanity is expressed through their relationship with others."*[109] The family unit is an important source of security, support and companionship, and any action that violates the integrity of the family unit therefore violates the right to dignity, freedom and sometimes parental and family care as well.

[196] The family life to which the claimants are entitled is more nuanced. The claimants entrusted the Government with the care of their loved ones. They did so because most of them were previously disadvantaged, poor and did not have the material and professional means to provide their loved ones with the health care and dignity that they required. The claimants who testified said that they visited their loved ones whenever they were able to do so. Those whose loved ones were moved without their families' knowledge spent weeks, and sometimes months, searching for them. All this came at great cost to people with limited finances. They continue to seek answers on how and why the State excluded them from participation in decisions about their loved ones' care, and how and why their loved ones lost their lives. The right to family life has been breached by the deprivation of the opportunity to take decisions in the best interests of their loved ones' health. Not only did they lose their loved ones in this tragedy, but they also lost their power to ensure that their needs would be met.

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[107] Opinion on Ethics and Healthcare with Specific Reference to the Circumstances Surrounding the Deaths of Mentally Ill Patients in Gauteng Province by Professor Ames Dhai at page 17.

[108] Section 28(1)(b) of the Constitution.

[109] *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* [2000] ZACC 8 at para 30.

Responsiveness and accountability

[197] Our Constitution requires public officials to be responsive to the plight and reasonable requests and demands of the citizenry.[110] Ms Mahlangu and Dr Manamela insinuated that they were entitled to "empty" Life Esidimeni facilities because families had abandoned their loved ones and had no one to give notice of the closure of Life Esidimeni. There may have been family members who had not visited their loved ones at facilities over an extended period. In fact claimants in the arbitration relate to a fraction of the total number of users who died or survived the ordeal. However, that can hardly be true of claimants in these proceedings. That charge against present claimants is without purchase and falls to be rejected.

[198] The claimants are the ones who took rigorous and persistent steps to procure these arbitration proceedings. The evidence showed that families protested over the planned mass transfers of their loved ones from the first day they met with Ms Mahlangu at the Waverly facility of Life Esidimeni around May 2016. They formed an activist and representative family committee. They negotiated and pleaded with the Department including with Ms Mahlangu, Dr Manamela and Mr Mosenogi not to move their loved ones in vain. The families succeeded to delay the mass transfer but only for three3 months. They engaged public interest attorneys from SECTION27 to intercede on their behalf who in turn wrote tomes of letters of demand and pleading to Ms Mahlangu, Dr Selebano and Dr Manamela and to the Department before and after the Marathon Project had started. Families organised public protest marches. The tendered memoranda of protest to Ms Mahlangu, Dr Selebano and Dr Manamela. They alerted print and electronic media to their plight and that of their loved ones. After the blind transfers of their loved ones, families went to search for them at far-flung non-governmental organisations. After the death of some, concerned families went out to retrieve the bodies of their loved ones and buried them at their own costs without Government assistance.

[110] Sections 1 and 195.

[199] The point here is less about what the families did but rather about what Ms Mahlangu, Dr Selebano and Dr Manamela refused to do. They refused to stop the mass transfer of mental health care users to non-governmental organisations not fit for purpose. They chose, knowing all the facts and risks, not to be responsive to the reasonable and lawful request and demands of the claimants. Their attitude was perhaps summarised by Ms Mahlangu who on one occasion retorted that: "If I was a prophet Justice, I would have had foresight."

[200] Our Constitution hopes for public servants who listen to the genuine and reasonable grievances of citizens and other people within our borders with concern and a readiness to respond to and alleviate their concern and certainly protect and promote the rights the law affords them. This did not happen here. The public service motto of *Batho Pele* was ignored.

[201] That is just as true about the requirement of accountability. I have already recorded how Ms Mahlangu's answers to question in the Provincial Legislature on deaths in the Marathon Project were objectively inaccurate and misleading. She explained that she was fed inaccurate and inadequate information on deaths of mental health care users by Dr Manamela who prepared her answers to the Legislature.

[202] Lastly there is the larger question of accountability for the entire Marathon Project and its toxic aftermath. In their testimony, Ms Mahlangu, Dr Selebano and Dr Manamela, each acknowledged the pain caused to families by the death of users or the torture of survivors. For that, each apologised in a tearful or near-tearful way. And yet despite their obvious position of authority and power, each refused to take on full responsibility for the administrative and political decision that led to a tragedy of this proportion.

[203] Dr Manamela played the victim. Yes, she was the head of the Directorate but she acted on instructions "from above". Once the decision to terminate had been taken she had to plan and implement the mass removals of users. She was ordered by Dr Selebano and Ms Mahlangu to move the patients and she simply carried out orders. She knew that the

removal was not in accordance with the law but the order was from above. When confronted in cross-examination, she said she knew that she was not obliged to carry out an unlawful instruction but carried it out nonetheless and it led to the death and torture of many helpless patients under her care. She also claimed that she could not reasonably foresee that patients under the care of her Directorate might lose their lives or be subjected to extended degrading treatment and torture. Dr Manamela was integral to the decision to end the Life Esidimeni contract. She was not a victim and dutiful servant but a leader and principal decision-maker. The evidence shows that she produced a plan to transfer the patients en masse. She was physically present at removal sites. She visited non-governmental organisations and must have known of their parlous conditions. She could reasonably foresee that some patients will be exposed to health care inferior to the one they enjoyed at Life Esidimeni and that some will suffer and others might die. And they did. After her evidence she resigned before internal disciplinary processes were completed.

[204] Dr Selebano was the Head of Department at all relevant times. He signed the termination agreement and had the power to revoke that decision. He repeatedly said he was accountable as head of the department. He says he was opposed to the Marathon Project. He asked Mr Mosenogi to write a letter to Ms Mahlangu pleading for an extension of the contract because he could not. He was afraid of Ms Mahlangu. He implemented the Marathon Project out of fear. Ms Mahlangu was his political principal and he had to follow even her unlawful instructions. This is indeed an extraordinary tale. A medical doctor turned a government chief executive of provincial health pleads fear in decision making. I am unable to accept that he did not make a conscious albeit unlawful decision to terminate the contract. The documentation shows that he directed and chaired meetings on the project and its implementation. His claim that because he was perched at the top of the departmental activities, he knew nothing about the transfers, torture and deaths of patients is plainly untrue. He denied, wrongly in my view, that he was bound by his professional code as a medical doctor because he is no longer an active clinician. All facts point to him having chosen to go along with and lead the Marathon Project. He must have foreseen that death and torture might ensue and he nonetheless allowed the project to go on

and death and torture did indeed ensue. After his evidence he resigned from his post before facing disciplinary processes.

[205] Ms Mahlangu too denied that she was administratively responsible for the mass death and torture related to the Marathon Project. She mentioned the Department's plan to terminate the contract in a planning meeting in which the Premier presided. She said that the cancellation decision was of the "collective" and not hers alone. She testified that the decision was by her and all senior people in her Department. She said she knew nothing about the implementation of the Marathon Project and Dr Manamela and Dr Selabano lied to her about the transfers, the conditions at non-governmental organisations and the death and torture that ensued. She further said that Dr Manamela gave her false and inaccurate figures of death and told her that the care at non-governmental organisations was adequate when supported by district offices. She could not say why her senior colleagues would lie to her about the Marathon Project.

[206] I must say that Ms Mahlangu resigned from her position as member of the Executive Council as soon as she had seen the findings of the Ombud. In my view she took political responsibility for the horrid failing in the Department she was in charge of. However, on all accounts she was at the helm of the Marathon Project. She was the ultimate leader and commander of the project. Dr Selebano, Dr Manamela and Mr Mosenogi testified about how she ordered them to ensure that the project is pursued relentlessly. One such example is when Mr Mosenogi pleaded for the postponement of the project, Ms Mahlangu turned to him and asked whether he worked for Life Esidimeni. That was enough to stop all of them in their bid to postpone the project. Dr Manamela testified repeatedly that she implemented the Marathon Project on firm orders of Ms Mahlangu. On the other hand, Dr Selebano repeatedly said that he was afraid to contradict Ms Mahlangu. As the ultimate leader of the project and member of the executive council, she failed to explain why she allowed so many lives of defenceless mental health care users to be placed at risk for no good reason. She was aware of the full risks of implementing the Marathon Project. She ignored and indeed brushed aside the warnings at many levels that death might ensue and it did.

[207] Her plea of ignorance and that Dr Selebano and Dr Manamela lied to her about the facts related to the Marathon Project is patently untrue. It is a response of convenience in the face of an ominous tragedy. Her overall conduct in relation to the Marathon Project, was irrational, inexplicable, highly reckless and led to the death of at least 144 mental health care users and 1418 survivors of the torture at non-governmental organisations. Her stance that she could not reasonably foresee that death might ensue or that mental health care users might be subjected to torture is untenable and cannot be believed. She acted with impunity thinking that she will get away with murder because the users and their families were vulnerable and poorly resourced. She acted with an ulterior motive that remains concealed even after many days of evidence before the hearing.

[208] All we can hope for is that one day, the true reason for the conception and implementation of the Marathon Project will see the light of day.

Equitable redress

[209] This is an arbitration. The jurisdiction of an arbitrator stems from the arbitration agreement and subsequent pleadings.[111] The parties have stipulated that, absent an agreement on the quantum of compensation, the arbitrator must make a binding award on equitable redress and on measures to facilitate closure.[112] The redress, the agreement explains, includes appropriate compensation for affected families whether on a group or individual basis[113]. The Arbitrator may determine any further form of redress he deems appropriate.[114]

[111] *Gutsche Family Investments (Pty) Ltd and Others v Mettle Equity Group (Pty) Ltd and Others* (115/2011) [2012] ZASCA 4.

[112] Paragraph 6.4 of the arbitration agreement.

[113] Paragraph 6.3.1 of the arbitration agreement.

[114] Paragraph 3.5 read with paragraph 6.3.6 of the arbitration agreement.

[210] On closure the arbitration agreement pre-sets measures that are likely to facilitate closure.[115]

[211] At the end of the hearing, the Government tendered a globular amount of R200 000 per claimant family as full and final settlement for estimated funeral expenses and common law general damages arising from and psychological injury and emotional shock. Some of the claimants accepted the tender. All claimants, in slight variations, were emphatic that beyond the general damages for which the State is obviously liable, the pervasive, egregious, uncaring and wanton violations of the constitutional rights of all mental health care user affected and their families, call for equitable redress which must include constitutional damages. To the extent that this head if damages is settled I am obliged to include it in the award I will made, as the arbitration agreement commands.

[212] The Government resists an Award for what the claimants call "constitutional" damages in the region of R1 000 000 to R1 500 000. The core reasoning of the Government seems to be twofold. First, once a claimant has been compensated under the common law, she or he may not rely on the Constitution to seek equitable redress. All civil claims, the argument ran, must be brought only under the rubric of the common law. On this reasoning the stratagem of the Government was to settle "common law'' damages and then contend that the claimants may no longer rely on the Constitution for equitable redress. For this proposition Government developed the following argument.

[213] First it relied on *Mboweni*[116] where the Supreme Court of Appeal was seized with an appeal in which the High Court had found that a child whose parent had died because of unlawful conduct of a third party could claim constitutional damages for infringement of the right to parental care. The Supreme Court of Appeal held that the question of remedy can only arise after the relevant right has been properly identified and the pleaded or

[115] See above n 15.

[116] *Minister of Police v Mboweni and Another* (*Mboweni*) [2014] ZASCA 107.

admitted facts show that the right has been infringed. An inquiry into damages cannot take place in the air. It must be an inquiry into the damages arising from an identified wrong.

[214] The Government went on to submit that once the constitutional right alleged to be breached has been identified, there remains a further issue of whether constitutional damages are appropriate constitutional remedy for that breach. I find no fault in this submission. But the difficulty with this submission is this. In this arbitration there can be no doubt that a legion of constitutional rights have been breached and each has been meticulously identified and proven by uncontested facts.

[215] In *Mboweni* the Supreme Court of Appeal concluded that the claimant could have vindicated the loss of parental care under the common law claim of loss of support. In doing so the Court relied on two cases of the Constitutional Court in which I wrote for the Court[117].

[117] The Government relied on *Dikoko v Mokhatla* [2006] ZACC 10 at paras 90-1, the Court held that:

> "It seems to me that the delict of defamation implicates human dignity (which includes reputation) on the one side and freedom of expression on the other. Both are protected in our Bill of Rights. It may be that it is a constitutional matter because although the remedy of sentimental damages is located within the common law, it is nonetheless "appropriate relief" within the meaning of section 38 of the Constitution. In *Fose v Minister of Safety and Security* this Court assumed but stopped short of deciding whether "appropriate relief" in section 7(4)(a) of the interim Constitution includes an award for damages where the award is required to enforce or protect rights in the Bill of Rights. The Court however made it clear that
>
> '[T]here is no reason in principle why 'appropriate relief' should not include an award of damages, where such an award is necessary to protect and enforce [Chapter] 3 rights. Such awards are made to compensate persons who have suffered loss as a result of the breach of a statutory right if, on a proper construction of the statute in question, it was the Legislature's intention that such damages should be payable, and it would be strange if damages could not be claimed for, at least, loss occasioned by the breach of a right vested in the claimant by the supreme law. When it would be appropriate to do so, and what the measure of damages should be will depend on the circumstances of each case and the particular right which has been infringed.'
>
> Although these remarks in *Fose* were directed at the remedy provision of the interim Constitution, it seems to me that the same considerations apply to the "appropriate relief" envisaged in section 38 of the Constitution when an award of damages is necessary to vindicate, that is to protect and enforce rights, which aside their common law pedigree are also enshrined in the Bill of Rights. There appears to be no sound reason why common law remedies, which vindicate constitutionally entrenched rights, should not pass for appropriate relief within the reach of section 38. If anything, the Constitution is explicit that subject to its supremacy, it does not deny the existence of any other rights that are recognised and conferred by the common law. (footnotes omitted)"

[216] In effect the Government is arguing that the claimants should have converted all their claims to common law claims and if not they would be non-suited. Neither the Constitutional Court cases relied on nor *Mboweni* is authority for that proposition. The cases simply state that a remedy under section 38 of the Constitution may be vindicated by common law mode of pleading and claim. The cases do not mean that a party is barred from relying on the Constitution where the breaches defy common law formulation. It would be strange if not bizarre if a claim under the supreme law would be denied vindication simply because it could not fit into the common law framework. If that were so, the constitutional remedies would be granted only subject to the common law. That would be remarkably retrogressive understanding of the hierarchy of sources of law. It is important to restate that the common law is subservient to the Constitution and not the other way around.

[217] More importantly, the claim of the claimants in this arbitration for compensation arising from invasive and pervasive violation of constitutional guarantees by the Government cannot readily be couched in common law terms. What is the common law equivalent of a claim based on the State's breach of the right of access to healthcare; right of access to food and water; freedom from torture; protection from cruel degrading and inhuman treatment? Similarly what is the common law equivalent of a claim against the State for breaching the rule of law, for disregarding protections provided by legislation that is meant to give effect to constitutional guarantees or a claim arising from a breach of international obligations on Mental Health care? And on the facts here all these breaches together led to agonising devastation for families of the deceased, survivors and their families.

The Government also relied on *Law Society of South Africa and Others v Minister for Transport and Another* [2010] ZACC 25, at para 74, where the Court held:

> "It seems clear that in an appropriate case a private law delictual remedy may serve to protect and enforce a constitutionally entrenched fundamental right. Thus a claimant seeking 'appropriate relief' to which it is entitled, may properly resort to a common law remedy in order to vindicate a constitutional right. It seems obvious that the delictual remedy resorted to must be capable of protecting and enforcing the constitutional right breached."

[218] In effect the Government has invited me to squeeze this pervasive and reeking violation of our Constitution and many valuable laws into psychological injury and shock for which R180 000 might be the going rate in trial courts under the common law. I decline that invitation. This is a matter of massive proportion for the utterly defenceless mental health care users who deserve every care in the world and every protection and vindication a tribunal like this can afford them.

[219] The parties have agreed that the Arbitrator must determine equitable redress in the form of compensation. In their wisdom, they have allowed the Arbitrator discretion to determine other forms of equitable redress. I can find no hint that the parties sought to leave their fate in the narrow and dated strictures of the common law only. The full complexity and uniqueness of the facts here were well known to the parties, when they concluded the arbitration agreement. The parties did not seek to restrict the Arbitrator's power only to common law claims. I will have regard to all the circumstances that I have sketched in great detail earlier in order to reach what I trust is to be equitable redress and will help achieve closure to all concerned.

[220] In the Award I will make, I will not differentiate amongst classes of claimants. No party has argued that I should do so. Such a differentiation would be treacherous, difficult to make and impracticable given the high number of claimants and the variety of circumstances under which some users died and other users who are survivors of torture. The other risk is that such a differentiation may be uneven and lead to an unjust outcome. I propose to make a uniform award in favour of each claimant who is a party to this arbitration.

[221] I am not unmindful of the fact that many other potential claimants are not before me in these proceedings. I am aware of many public announcements and media advertisements that invited potential claimants. Not all have joined the process. When they find their voice or way I trust that the Government would choose to meet their claim in terms identical to the Award than to set up new litigation of another arbitration process.

[222] The Award I intend to make will heed the pre-set elements which the parties believe will bring the mental health care users and their families nearer to closure. However, I have declined to order the establishment of a trust in which claimants would contribute part of their Award amount, as the claimants suggested. The claimants are free to do so at their election. In any event the order I will have to make will be long, complex and difficult to enforce. I have declined to order the South African Police Service to investigate criminal charges that obviously arise from the facts of this arbitration. My Office has furnished the South African Police Service with full record of proceedings. They must do their work as the law requires of them and not at my direction.

[223] Whilst I have a voice let me thank the families of the claimants and the National Minister of Health and the Premier of Gauteng Province and the member of the Executive Council for Health: Gauteng, who stayed the course to bring this arbitration to fruition. The logistical and material support to families and the arbitration staff was considerable. They represented a contrite, responsive and accountable Government that readily came along to help heal gaping and personal wounds of so many in our nation. More so they publicly apologised. In my Award I will require them to do it again in a manner I will specify.

[224] All expert witnesses who appeared for the parties did so without a qualifying fee. I am grateful for their selflessness. I have been suitably encouraged to donate all my arbitrator's fees to chosen law schools that will hopefully help nurture young women and men committed to the high values of our Constitution and to the calling to defend the vulnerable against the abuse of the high and mighty.

[225] I will like to express a word of gratitude to all attorneys and counsel who participated in these proceedings. I would like to thank the Health Ombud, Professor Makgoba. Without whom, the completion of the arbitration proceedings would not have been possible. And lastly and certainly not least, I am grateful to Obakeng Terence Van Dyk[118] and Aviwe

[118] Head of the Office of the Arbitrator.

Sivuyile Ralarala[119], for their remarkable loyalty and professionalism they brought in support of my role as the Arbitrator.

The Award

[226] I make the following binding Award:

1. The Government of the Republic of South Africa as represented by the National Minister of Health, the Premier of Gauteng and the member of the Executive Council of Health: Gauteng Province (Government) is ordered to pay the agreed amount of R20 000 (twenty thousand rand) to each of the claimants listed in Annexures A and B in respect of funeral expenses.
2. The Government is ordered to pay R180 000 (one hundred and eighty thousand rand) to each of the claimants listed in Annexures A, B and C in respect of general damages for shock and psychological trauma.
3. The Government is ordered to pay R1 000 000 (one million rand) to each of the claimants listed in Annexures A, B and C as appropriate relief and compensation for the Government's unjustifiable and reckless breaches of section 1(a), (c) and (d), section 7, section 10, section 12(1)(d) and (e), section 27(1)(a) and (b) and section 195(1) (a), (b), (d), (e), (f) and (g) and multiple contraventions of the National Health Act 61 of 2003 and the Mental Health Care Act 17 of 2002 that caused the death of 144 mental health care users and the pain, suffering and torture of 1418 mental health care users who survived and their families.
4. As required by the arbitration agreement, the amounts in paragraphs 1, 2 and 3 must be paid by the Government in lump sum not later than 3 months from the date of the publication of this Award and in any event not later than 19 June 2018.
5.

[119] Assisted the Head of the Office of the Arbitrator.

(a) Within 30 days of the date of the publication of this Award, the Government must make available the services of qualified mental health care professionals who must assess the counselling and support needs of each of the claimants listed in Annexure A, B and C and up to three members of each claimant's family require.

(b) The assessed counselling and support services must be provided immediately and in any event not later than 30 days after the assessment of the counselling and support services; except if any of the claimants or their family in writing decline the counselling and support.

6. Pursuant to the arbitration agreement between the parties, the Government is directed to construct at its exclusive expense and within 12 months from the date of the publication of the Award a monument at an appropriate and prominent location to commemorate the suffering and loss caused by the Gauteng Mental Health Marathon Project (Marathon Project) and to serve as a reminder to future generations of the human dignity and vulnerability of mental health care users

7.

(a) Pursuant to the undertaking, by the member of the Executive Council for Health, Gauteng Province, Dr Gwen Ramokgopa, the Government is ordered to provide to the Health Ombud (appointed in terms of section 81 of the National Health Act 61 of 2003) and the claimants listed in Annexures A, B and C or their representatives the recovery plan whose purpose is to achieve systemic change and improvement in the provision and delivery of mental health care by Department of Health in the Province of Gauteng. The parties to these proceedings are permitted to share the recovery plan with interested members of the public.

(b) The Government is ordered to report to the Health Ombud and to the claimants within 6 (six) months of the publication of this this Award,

and thereafter every six months until the conclusion of the recovery plan.

8.

(a) The Government is directed to take prompt and reasonable steps to report or cause to be reported to the Health Professions Council of South Africa and to The South African Nursing Council, whichever is applicable, the conduct of the health care practitioners that fell under its jurisdiction and who were involved in the Marathon Project. These include Dr Tiego Ephraim Selebano, Dr Makgabo Manamela, Mrs Dumi Masondo and Ms Hannah Jocobus.

(b) The Government must give notice of the steps it has taken to the Health Ombud and the claimants listed in Annexure A, B and C or their representatives within 30 days of initiating the steps.

9. The Government is ordered to pay the party and party legal costs of all claimants and in each case including the cost of one counsel.

JUSTICE DIKGANG MOSENEKE