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LIFE ESIDIMENI: WHERE WE ARE SIX MONTHS LATER

SECTION27 REPORT TO OUR BOARD AND DONORS

3 August 2017

SECTION27 started working on the issue of the move of mentally ill patients from Life Esidimeni in November 2015 following the termination, by the Gauteng Department of Health, of the contract with Life Esidimeni. We represented families and three mental health organisations in two court actions. In August 2016, one of our clients discovered that her sister had died at Precious Angels NGO, a place that our client had not even heard about. The funeral home owner told our client that he had a number of bodies from the same NGO at his facility.

In September 2016, in response to a parliamentary question coming out of our client's discovery, the MEC for Health announced the deaths of 36 former residents of Life Esidimeni. The Minister of Health then appointed the Health Ombud, Prof Malegapuru Makgoba, to investigate. On 1 February 2017 the Ombud released his report. He found that there had been at least 94 deaths and that the recklessness and negligence of the MEC and her team, together with the unsuitability of the NGOs had led to the deaths and to the suffering of surviving mental health care users. The Ombud made a number of recommendations.

1 August 2017 marked six months since the release of the Health Ombud's report into the deaths of more than 100 mental health care service users following their removal from Life Esidimeni facilities where some of them had lived for over thirty years.

The Ombud's report shook Gauteng and the country. He found that then MEC for Health Qedani Mahlangu took an unjustifiable decision to terminate the contract with Life Esidimeni, leading to a "chaotic" and "rushed" implementation process. Mental health care users were collected from Life Esidimeni by NGOs, sometimes in open bakkies. They went without medical records, without extra warm clothes, sometimes without shoes. They arrived at facilities that were not properly licensed and that were wholly unable to care for them. In the course of a particularly cold winter, many of them died. Some people couldn't get the medicines they had been on for years. Some contracted tuberculosis. Some died of hunger and thirst.

The Ombud made a large number of recommendations, all of which were accepted by the Province and the Department of Health. The recommendations fell into three broad categories.

The first category concerned the living. The survivors of the Life Esidimeni disaster should be moved to safety. The mental health care system nationwide should be assessed. Guidelines should be drawn up for the licensing of community based mental health care facilities and the Mental Health Review Board – a watchdog over the mental healthcare system – should be reconstituted with its independence protected.

The second category was about accountability. The people responsible for the disaster should be held to account – criminally, professionally and disciplinarily.

The final category of recommendations sought to take the steps necessary to make things right. The Ombud recommended an alternative dispute resolution process in which closure is sought and appropriate redress, including financial compensation, is decided on.

In the past six months, many people, from SECTION27 and our clients, the Office of the Premier, and the National and Gauteng Departments of Health, have been working very hard to ensure the implementation of the Ombud's recommendations.

In terms of addressing the mental healthcare system and user safety, Life Esidimeni survivors have been moved out of the NGOs. The process has been far from perfect and some remain in acute facilities including Weskoppies Hospital and Cullinan Care and Rehabilitation Centre but all are out of the danger that they faced in the NGOs. The provincial treasury on 7 March 2017 announced an increase of almost R200 million over the medium term for the budget for mental healthcare services in Gauteng. The Ombud's report, in addition to legal and public pressure, also contributed to a decision by the Eastern Cape Department of Social Development to back away from its plans to shut down frail care centres in that province. Licensing Guidelines were published for public comment and, together with our partners, we made submissions on these guidelines. The South African Human Rights Commission is working on a nationwide assessment of the violations of human rights in the mental health care system. We have tried to work with the Commission to ensure that its investigation is effective and the Commission appears to be making slow progress in moving towards an investigation. The Gauteng Department of Health made calls for nominations for new members of the Mental Health Review Board. New members have been

appointed, but the list of members has not been made public and the process for selection has been far from transparent.

In relation to accountability, MEC Qedani Mahlangu resigned on the eve of the release of the report and has not been seen since. HoD Dr Barney Selebano and Head of Mental Health Dr Makgabo Manamela have been suspended and face disciplinary action. They are both appealing the Ombud's report, in terms of the National Health Act 61 of 2003. SECTION27 is representing the South African Depression and Anxiety Group, the South African Federation for Mental Health, the South African Society of Psychiatrists and the Association of Concerned Families of the Residents of Life Esidimeni in an application to intervene in the appeal of Dr Manamela (SECTION27 filed papers in this regard on 1 August and the matter will be heard on 15 August.) The parties SECTION27 represents may take the same approach in relation to Dr Selebano's appeal. We await a copy of the papers in that matter. Multiple officials and employees of the Gauteng Department of Health have been suspended. The SAPS reports that it is investigating alleged crimes related to the disaster and, linked to these investigations, a number of post-mortems are being performed. We intend to monitor closely the investigation as the SAPS appears as yet to have done little since we first reported deaths to them in August 2016. We are yet to see any health care professionals referred to account to their professional associations.

Finally, the appointment of former Deputy Chief Justice Dikgang Moseneke to head the alternative dispute resolution process was recently announced. SECTION27 currently represents a large number of the families of deceased former residents of Life Esidimeni. Many families, however, cannot be traced or otherwise remain unreachable. The Premier's office will shortly be placing notices in the media to call for families to come forward and participate in the process. SECTION27 is encouraged by the Terms of Reference for the alternative dispute resolution process – which was developed in consultation – and we are hopeful that the process will be fair, transparent and will bring a measure of justice and closure to the families. We expect the commencement of the alternative dispute resolution process to be announced towards the end of August 2017.

Work on the Life Esidimeni matter is far from over and it remains an important component of the work of SECTION27 and the organisations, activists, users and families we work with. We will provide further detailed updates as the various aspects of the matter progress.

For more information: http://section27.org.za/2017/02/ombuds-report-on-life-esidimeni-released/

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