# The Circumstances Surrounding the Deaths of Mentally Ill Patients, Gauteng Province:
# No Guns, 100+ Silent Deaths and Still Counting

Office of the Health Ombud, Professor Malegapuru Makgoba

## Expert Testimony for the Alternative Dispute Resolution (ADR) Process
## with Justice Dikgang Moseneke

led by Coralie Trotter

## This report is written in Memory and Honour of those who Died Silently and the Families who Loved Them

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**PROTOCOL**

The following report will detail how the Gauteng Mental Health Marathon Project under the guidance of Member of the Executive Council (MEC), Qedani Mahlangu, apart from resulting in the deaths of one hundred and forty one individuals to date, has had a traumatic, even catastrophic, impact on the families concerned. The purpose of the report is to present expert testimony regarding the extent to which the families involved in the transfers have been degraded and devastated by this human-induced trauma. The report also emphasises that these families are still having to endure profound, unacknowledged, ongoing mental suffering because of the lack of disclosure and accountability on the part of the Gauteng Department of Health.

The mental health professional team that participated pro bono in the generation of this expert testimony consisted of twenty individuals registered with the Health Professions Council of South Africa (HPCSA) or the South African Council for Social Service Professions (SACSSP).

The curricula vitae of the following clinicians are attached:

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Kathy Krishnan
Vanessa Gaydon

Considerable time and effort was dedicated by the team initially to ensure that the best possible clinical protocol for the consultations with the families of the deceased individuals had been formulated. It was agreed by the team that the process would be a complex one and that, in fact, it had to be viewed as an intervention, as well as a means of obtaining information for the report for the arbitration with Justice Dikgang Moseneke. It was anticipated that there would be apprehension on the part of the family members who participated about opening up old wounds given that they had been repeatedly 'dropped' and their family members allowed to die by those responsible for their care. This proved to be true. The families conveyed how incensed, offended and disappointed they felt subsequent to previous meetings with the Gauteng Department of Health. Nevertheless, initial reservations and doubts were overcome by engaging with the feelings expressed in an honest and direct manner. It was considered important for the clinicians to be psychologically available and to be 'real' in every sense of the word in order to establish a working alliance, facilitate the consultation effectively and provide containment. The level of rapport, disclosure and emotion was high in each consultation and the families reported finding the process helpful and expressed their gratitude. For example, Charles Phoshoko commented: "*This is the first time I have been able to express my true feelings,*" and Lucas Mogoerane said that he appreciated the opportunity to talk because if he didn't talk, he would get sick.

The team conducted consultations with eleven families of deceased individuals. These families constitute a sample for the larger group of families being represented by Section27 at the ADR process. The purpose of the assessments was to obtain clinical information that would contribute towards ascertaining an equitable compensation amount and a constructive reparative process for the larger group.

Those consulted include:

- Christine Theresa Nxumalo and Shanice Machpelah whose sister and mother, Virginia Gwendolen Machpelah, died;
- Reverend Joseph Sponti Maboe whose son, Hendrik Ramthodi Maboe (Billy), died;
- Jabulile Hlatswayo and Moses Hlatswayo whose stepson and nephew, Sizwe Thabang Hlatswayo, died;
- Boitumelo Josephine Mangena and Sophie Mangena whose mother, Raisibe Rahab Mangena, died;
- Vaughan van Rooyen whose sister, Cindy van Rooyen, died;
- Seemole Suzen Phoshoko and Charles Phoshoko, whose nephew, Terence Maphea Chaba, died (they were joined by their children Mamagetho and Motsetse, and, grandchild, Sinotando);

- Lucas Mogoerane whose brother, Christopher Mogoerane, died;
- Stella Thembisile Mofokeng whose brother, Pio Sibusiso Mthombeni, died;
- Christian and Joanna (Jabulisile) Nqgondwane whose son, Vuyo Aaron Nqgondwane, died;
- Phumzile Mirriam Motshegwa and Zandile Mashego whose brother, Solly Nathaniel Mashego, died;
- Yvonne Martha Diababeng Mosiane, Maggie Mosiane and Elisa Moruledi whose son, brother and nephew, Caswell Mosiane, died.

The consultations took place over a two week period; each interview lasted between two and three hours. Most importantly, each meeting was treated as a Single Therapeutic Consultation (Straker, 1987). That is, complete in itself but with the possibility of further engagement. This did happen in certain cases, for example, Boitumelo Mangena indicated that she had not been able to say everything that was on her mind and was given a second opportunity to do so. She expressed deep gratitude for being able to do so. The affidavits were read beforehand, allowing each clinician to adapt the consultation appropriately for a specific family if necessary. The protocol stressed the importance of not creating conditions conducive to the repetition of the trauma as this had characterised previous dealings with The Gauteng Department of Health or The Department as it is referred to by the families consulted. The purpose of the consultation was explored fully at the outset of each meeting to ensure clarity and commitment to what was anticipated would be a painful process. Throughout the consultation the well-being of the individuals and of the family was prioritised to ensure that the intervention as a whole took place with respect and integrity.

During the preliminary discussions the team thought through the possibility of letting an individual or family or organisation down as the process unfolded. It was decided that a solution to this would be to invite independent peer review of the process throughout. Ms Yasmin Carrim and Prof Mark Solms, who has recently received the Outstanding Scientific Achievement Award from the International Psychoanalytical Association (IPA) as well as the very prestigious Arnold Pfeffer Prize, agreed to assist with this. In addition, two clinicians conducted each assessment. This not only facilitated interviewing, intervening and note taking, but was also a source of support and containment for both parties. The feedback from the clinicians subsequent to the consultations was that it would have been difficult to consult the families without a colleague present. Group debriefing sessions were held when necessary to assist in the process of digesting the experience. A high level of cooperation and commitment on the part of the clinicians in the team was evident throughout the process. The information derived from the interviews was then analysed qualitatively by Coralie

Trotter. Finally, the team convened to discuss and ratify the final version of the report which had been written by Coralie Trotter.

## INTRODUCTION

The concept of 'home' is a profoundly important one in our lives, both materially and psychologically (Low & Altman, 1992; Cuba & Hummon, 1993; Bachelard, 1994; Fullilove, 1996; Giuliani, 2003). A home is a dynamic hub which houses not only our memories but the things we have forgotten and wish to forget. A home provides some containment, refuge, rest, satisfaction, continuity and predictability. Of course, in reality no actual home is ideal and each one includes various combinations and degrees of opposites and complexities. Nevertheless, the very fact that one has an experience of a home (regardless of how good or bad, long or brief it may be) forms part of a substratum that contributes to a primary sense of identity, meaning, belonging and humanity (Bachelard, 1994; Scannell & Gifford, 2010; Schaverien, 2011; Papadopoulos, 2002, 2015)). In fact, individuals who are attached to a particular and familiar space experience a heightened sense of safety even when that place is situated in a war zone (Operation Pied Piper, 1938-1944; Billig, 2006).

Ordinarily, this layer is so basic and fundamental that it is outside the reach of our awareness unless it is disturbed (Berger, Berger & Kellner, 1973; Fullilove, 1996; Brown & Perkins, 1992; Akhtar, 2011; Aiello, 2012; Bennett-Murphy, 2012; Brothers, & Lewis, 2012; Papadopoulos, 2002, 2015). The Diagnostic and Statistical Manual of Mental Health Disorders goes as far as stating that the loss of one's home is the most severe of all social stressors and is hard to bear existentially and ontologically (DSMIV-TR American Psychiatric Association, 2000). And, of course, the history of forced removals in South Africa provides direct experience of this. The psychiatric patients in question had already lost a home and negotiated being 'out of place' when they were entrusted to the care of Life Esidimeni. Rebuilding a 'sense of place' in such situations is critical (Brown, Perkins, & Brown, 2003; Bennett-Murphy, 2012; Bhadra, 2012; Brothers, & Lewis, 2012). The experience of home can emerge anew whenever intimate, meaningful relationships and attachments are established over a period of time within the context of a particular space which breeds familiarity (Fulliove, 1996; Akhtar, 2011; Bhadra, 2012; Brothers, & Lewis, 2012; Papadopoulos, 2015). Henri Rey (1994) describes how the actual building that institutionalised patients inhabit can come to symbolise a safe, trustworthy, containing space with secure boundaries. He called this the 'Brick Mother' as it could be experienced as holding the parts of the personality together and providing some sense of 'going-on-being' as a person.

Donald Winnicott (1984) elaborates on this concept of the 'Brick Mother' in his paper, Residential Care as Therapy:

> ***"Therapy was being done in the institution by the walls and the roof, by the glass conservatory which provided a target for bricks, by the cook, by the regularity of the arrival of food on the table, by the warm enough and perhaps warmly coloured bedspreads, by the efforts to maintain order in spite of shortage of staff and a constant sense of the futility of it all."***

Mental health professionals should be particularly sensitive to this phenomenon. It applies even when a clinician moves out of one practice into another, never mind when a population of institutionalised psychiatric patients is relocated. Henry Abramovitch (1997) explores the disruption to continuity that ensues when moving in his paper, Temenos* Lost: Reflections on Moving. The emotional atmosphere, material boundaries and familiarity of a physical setting constitute the vessel within which relationships are free to evolve. Moving out of the space interrupts this continuum. Abramovitch emphasises the importance of the rite of re-entry into a new space. He illustrates this with an account from one of his sessions. His patient, also a mental health professional, is experiencing anticipatory anxiety regarding moving out of her home of many years. She mentions her distress to a neighbour: "There were so many good, happy times here, in this place. Who knows what will be at my new house?" Her wise friend pauses and says: "After the movers have gone, sweep up all the dust that remains in the old house and then distribute it through all the rooms of the new house." The bottom line is that moving is a serious business from a psychological point of view.

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* a temple enclosure, a sacred precinct, a consecrated area

**ANALYSIS**

**This analysis outlines five factors that are central to understanding the damaging impact of the Life Esidimeni transfers on the families. It is derived from a study of the material obtained during the consultations.**

**Factor One: Turning a blind eye to all available psychological and sociological research, evidence and theory regarding the likely negative impact of relocating institutionalised patients, many of whom were unable to speak, walk or feed themselves and suffered from various impaired mental states**

Institutionalised psychiatric care is for a vulnerable minority in society. In this case, the individuals suffered from a wide variety of disorders such as neurocognitive and neurodevelopmental disorders, severe head trauma and disorders on the schizophrenia spectrum. The level of disability in terms of language, mobility, intellect and impulse control should under no circumstances be underestimated. Many of these individuals were literally unable to walk, talk or feed themselves and were entirely dependent on the care of others for their survival and well-being. This does not mean that these individuals were not deeply and profoundly loved by their families. But, institutionalisation was the only reasonable option given the level of care that was required.

Institutionalised psychiatric care for such patients should most definitely provide a holding environment. That is, a consistent, reliable 'Brick Mother' with material support, structure and safety, emotional and psychological involvement and protection from both internal and external impingement. It had taken most of the families considerable effort to find appropriate environments for their loved ones. But, they had all managed to achieve this. Each family consulted commented that their family members had stabilised and improved in the Life Esidimeni institutions. There was a sense of 'being-at-home' in their 'Brick Mothers'. The rupture and dislocation set in motion by the Gauteng Mental Health Marathon Project and the inhumane manner in which this was executed generated a new cycle of 'nowhere-ness' and of not being held in mind. Here the 'Brick Mother' collapsed entirely and the patients, who were dependent on others for care and survival, were thrust into completely inappropriate, in fact, filthy, dangerous, environments in which they died. When MEC Qedani Mahlangu was asked in an interview why the patients had been transferred against all advice from others, her response was: "*How could they know? Unless they are foretellers.*"

**This is the first significant factor of the Gauteng Mental Health Marathon Project:**

**It turned a blind eye to all available psychological and sociological research, evidence and theory regarding the likely negative impact of relocating**

**institutionalised patients, many of whom were unable to speak, walk or feed themselves and suffered from various impaired mental states but, who, nevertheless, had stabilised under the care of Life Esidimeni.**

**Factor Two: Ignoring all available psychological, psychiatric and medical expertise and knowledge gained from clinical experience in the manner of relocation**

The next important factor to unpack concerns the manner in which the relocation was executed. There is a large body of evidence which demonstrates that both deliberate, adequate psychological preparation and the provision of truthful, comprehensive, detailed information are associated with mastery and success in terms of adjusting to any challenge or change in life such as parenthood, emigration, relocating, entering school, undergoing surgery and survival during battle (Solnit, 1984; Birksted-Breen, 1986;. The Menninger Foundation, 1987; Leader's Manual for Combat Stress Control, US Army, 1994; Fullilove, 1996; Rentrop, 2005; Athanassiadou et al, 2012; UNICEF, 2012). Essentially, forewarned is forearmed emotionally and psychologically and this is a determining factor in terms of the outcome of any change.

In his paper, Preparing, Albert Solnit (1984) outlines the details of the argument for the case of provision of information and psychological preparation. The latter enables the individual concerned to mobilise emotional and cognitive resources at the outset. This increases the use of constructive coping strategies and, therefore, tolerance for the strain. It also helps those being subjected to the change to engage in a process of clarification if the facts have been misinterpreted or denied. In addition, it encourages the expression of feelings, fantasies and questions concerning the anticipated event which makes it possible to normalise responses. All this facilitates the adoption of a more active role on the part of the person who is going to have to negotiate the change. Most importantly, it allows others in primary psychological relationships with the individual to provide support, containment and protection. The overall result is that adaptation is enhanced and crisis reactions are averted. The importance of this cannot be overstated in this context for two reasons. The first is that the population concerned consisted of psychiatric patients who were dependent on the State for their well-being and whose care and protection had been entrusted to the State. The second is that this was an involuntary relocation which was being imposed on an already disempowered, vulnerable minority group. For these reasons it was critical and potentially life-saving for both the patients and their families to have been fully informed and prepared for the transfers. The Gauteng Department of Health was solely responsible for taking on this task and failed to do so.

Each family described in detail their experience of not only having to tolerate the withholding of information regarding the relocation but also of having to muddle

through false and contradictory information. Repeated unanswered calls, receiving information inadvertently through neighbours and news broadcasts, misdirection, getting lost finding one place after another because neither addresses nor directions were forthcoming and relying on the internet as the only resource characterise the experience of relocating those handed over. The search took place from one non-governmental organisation (NGO) to another or to hospitals or to the morgue and in Phumzile Motshegwa and Zandile Mashego's case even to the cold storage room of an old butchery. Put bluntly the families had no choice but to engage in a perverse process of 'hide and seek' for weeks in order to locate their loved ones while alive and then their actual bodies after death. There were delays in reporting these deaths of up to a month in most cases which negated various cultural customs in terms of burial rituals and ceremonies. Phumzile and Zandile were not informed that their brother, Solly Mashego, had been transferred in June. In September they were informed that Solly had died in August. Unfortunately, this travesty has never come to an end. The families consulted are still waiting for the cause of death of the individuals they loved. This is something which has been under investigation for months and it has resulted in ongoing mental suffering and lack of closure for these families. What has been outlined here goes against the grain of all available psychological, psychiatric and medical evidence.

The manner in which this radical displacement was carried out was such a sudden, vicious shock to the system - both individual and family - that it could not be absorbed and digested. In situations such as this, extreme fear and helplessness overwhelm neurobiological and psychological adaptive mechanisms. This breakdown impedes the process of assimilating the experience. That is, of integrating it as a personal event belonging to the past (Van der Kolk, 2002). Without protective psychological shields in place, the well-being of the patients declined drastically and dramatically soon after the transfers. Yvonne Mosiane ruminates over the fact that her son, Caswell Mosiane, had only been at the NGO for a week before he died. She still cannot comprehend this emotionally and psychologically and remains preoccupied with it. "*My heart sank when I saw Billy [Maboe]. I wanted to cry. I saw death in his face*" says Reverend Maboe describing his son when he first saw him after the move. Every single family consulted had a similar experience. Equally, the lack of preparation and information is directly linked with this tragedy becoming a traumatic stress for the families. A breach was created in the minds of the family members because of the lack of preparedness to take in an experience that came too quickly (Van der Kolk, 1988, 2002; Caruth, 1995, 1996, 2014). The breach was caused by fright: the experience was so unexpected and overwhelming that 'the words to say it' could not be found. It could, therefore, not be assimilated into previous experience or integrated psychologically. In other words, multiple threats were recognised as such by the minds of the individuals consulted

too late and so the experience slipped in before the recipients were prepared to know and absorb it.

The state of shock these families describe is therefore not simply the direct experience of the threat but precisely the missing of the experience, the fact that not having being experienced in real time it could not be fully known. Or, as Cathy Caruth (1995, 1996, 2014) repeatedly expresses it: deeply traumatic experiences are events without witnesses, experienced a moment too late, before the self was there to mediate it. The family members consulted were able to express exactly this phenomenon. This is how Suzen and Charles Phoshoko describe it: "*The way they treated us was beyond abrupt. I don't have the English word to describe it. At Life Esidimeni the staff would sometimes call because Terence [Chaba] needed to hear the sound of our voices or had hurt his toe. But this very big news they didn't communicate with us.*" As is typical in this Marathon Project, Suzen and Charles found out that Terence had been moved and then had actually died a month after the fact when a hospital official referred to them as the 'family of the deceased': "*The way we were treated on that day was the hardest thing about this experience. We were not treated like human beings. Totally unprofessional! Totally unprofessional! No Ubuntu for Terence or us. Totally unprofessional!*" The trauma for these families remains unprocessed, unsymbolised and unintegrated and therefore, without meaning.

**Once again, all available psychological, psychiatric and medical expertise and knowledge gained from clinical experience regarding considerations to be taken into account when relocating institutionalised patients was ignored. This is the second factor which contributed to this tragedy.**

**<u>Factor Three: The families were subjected to relentless violations of trust, continual stonewalling and incessant deception</u>**

Yvonne Mosiane recounts how the Department said in legal proceedings that, firstly, patients would be assessed and transferred only if they did not need the services of Life Esidimeni and that, secondly, only those who did not have families would be moved. Relocating her son, Caswell Mosiane, was in direct contravention of these statements: "*It appears the Department may have perjured itself in these legal proceedings. This is exceedingly troubling and hurtful to my family.*" Yvonne now has a constant refrain in her mind trying to find a place for Caswell in the row of death: "*Caswell was the sixth one to die. Caswell was the sixth one to die.*" Sophie and Boitumelo Mangena were also told that their mother, Raisibe Mangena, would not be moved due to her critical condition but when Sophie went for her regular fortnightly visit her mother had disappeared. The families believed that the relocation was on hold: "*Mahlangu is the antithesis of a caregiver. She said they'd come back to us before the move. But, behind our back*

*they were transferred*" says Lucas Mogoerane, whose brother, Christopher Mogoerane, died.

The fact that the families still do not have the results of the autopsies is an example of the obstructive, callous attitude they have had to endure on the part of the Gauteng Department of Health. Christian and Joanna Nqgondwane were informed over the phone that their first born son, Vuyo Nqgondwane, was dead. They were told by the nurse: "*All the patients were medicated last night and went to bed in good health. All the patients with the exception of Vuyo woke up in the morning.*" When Christian, in a state of absolute shock, asked how Vuyo had died, the nurse mechanically repeated the story. But, when Christian went to the NGO he found his first born son in a pile of bodies, bleeding. The following words accurately reflect the confusion, disorientation and outrage felt by the families because they have been repeatedly stonewalled and deceived: "*Do they think we are idiots? We are being subjected to the insult of them trying to cover up their mistake!*" says Jabulile Hlatswayo.

**When a person's ability to negotiate the world is already compromised through illness, dependency and poverty, violations of trust have a more debilitating impact and there is clear evidence of this in this human-induced trauma. This is the third factor which resulted in the wrenching pain and psychological damage observed in the families consulted.**

**Factor Four: The terrible dehumanisation of the patients and its impact on the families**

The fourth important factor is that all the families perceived the treatment of their loved ones as terribly dehumanising. There were repeated and continual references during the consultations to their loved ones being treated like animals and being 'decanted', The Department's term, into environments that filled them with disbelief and horror.

Jabulile Hlatswayo sums this sentiment up when she says: "*Sizwe [Hlatswayo] was treated worse than a township dog and township dogs are treated very badly.*"

"*They looked like animals in a caged place*" says Stella Mofokeng whose brother, Sibusiso Mthombeni, died.
Reverend Maboe laments: "*Billy [Maboe] was filthy and unkempt. He was hungry. We sent someone to the store to buy him some snacks - he was so hungry he licked clean the plastic the crisps had come in. They told us he couldn't have water because he would pee in his pants. There was a pit latrine for a toilet.*"

Lucas Mogoerane says: "*Christopher [Mogoerane ] was crying. He had lost weight. I took groceries and fruit. I had to share it with the others. They were saying: 'Uncle, Uncle, we are hungry!' The director, Nolene, told me: 'We told Qedani Mahlangu we were not ready to deliver a service to the patients'. 'Do you want to carry on with this or not?' Nolene asked us.*"

"*Urine welcomes you to this place. It wasn't a place for a human being,*" says Jabulile Hlatswayo.

Vaughan van Rooyen states: "*When I arrived the gates were wide open onto a busy road. The facility looked dirty and neglected. The secretary was surprised to see me as she did not know Cindy [van Rooyen] had family. The matron asked me to fill them in on Cindy's medical condition, the type of care she required and if she needed to take any medication.*"

Dehumanisation is a two-step process. Step one is identifying undesirable humans, in this case, institutionalised psychiatric patients. Step two is turning them into nonhumans (Brenner, 2006). The narratives of the families reveal that this is how The Department went about it. Individual needs and identities were erased at the outset. According to the families, patients were moved without their identity documents or medical files. Now nameless and faceless, these individuals were then treated as if they were cattle: they were loaded onto the backs of trucks without essential items such as wheelchairs and then transported, often without supervision and sometimes tied up with sheets. Many of these patients could not speak, walk or feed themselves and suffered from various mental impairments. Once relocated, there was no way of knowing what medication people were on and, yet, patients were medicated. The wrong individuals were brought to the families when they first went to visit their loved ones. The new environments were filthy and understaffed. They had pulled people off the street to work as caregivers, says Boitumelo Mangena in disbelief. There were sponge mattresses for beds, garages for accommodation and poor facilities, if any.

It appears that the relocated patients were virtually tortured to death through shock, neglect and cruelty. There is no doubt they died in states of abject terror and the families know this. The families have to live with this. Family members describe how their loved ones were shivering with cold and crying, their eyes filled with panic. It is clear that deep disrespect continued after the patients died as even this information was withheld. The families relate how disturbing and agonising it was that they were brought bodies of the wrong gender for identification. In addition, different causes of death were provided as if it did not matter how the individual had died. Phumzile Motshegwa tells us that she and Zandile Mashego were not informed that their brother, Solly Mashego, had been moved to a facility close to their home where it would have been possible to visit. Their experience of the transfers begins with having

to identify his body. He wasn't at the morgue. They went to another place that Phumzile recognised as an old butchery. They walked through blood that was being hosed away. They were brought female bodies to identify. Phumzile kept saying: "*He is a man. Solly is my brother.*" Phumzile finally found Solly herself wedged between other bodies in the cold storage room of the 'butcher mortuary'. She was so horrified by what she had seen that she returned the next day because she could not believe her eyes. Phumzile has still not recovered from the fact that Solly's eyes had shrivelled up from dehydration and there was a yellow film around his mouth. Charles Phoshoko says he didn't recognise his nephew, Terence Chaba, when he went to identify the body: "*I didn't recognise him. I recognised him by his toes.*" Stella Mofokeng arrived at the hospital to visit her brother, Sibusiso Mthombeni, only to find an empty bed; the nurse knew nothing. Stella rushed to Weskoppies thinking Sibusiso had been returned there. She was told that her special Sibusiso, whom only she could communicate with by means of sign language, had been dead for three weeks. The families describe having to plead and bargain for the bodies of their loved ones and even having to field phone calls from social workers asking to speak to the deceased person. Finally, to add insult to injury, the attitude of The Department resulted in burial customs being ignored and funeral arrangements being interrupted and in bodies decaying and decomposing.

Section 10 of our Constitution[1] provides that: "*Everyone has inherent dignity and the right to have their dignity respected and protected.*" Equally, Freud (1920) said that each person dies in their own fashion. The callous, brutal manner in which people were handled in this situation took away even that possibility and certainly the possibility of dying with dignity. Death should not be an event tacked cruelly and meaninglessly on to the end of a person's life as a result of the total empathic failure of others. This aspect is directly linked with the extent and severity of the trauma these families are experiencing in terms of the Marathon Project. They are unable to keep the intrusive images of how their loved ones looked before and after death out of their minds. Once dignity is undermined, it is very hard to maintain a sense of being worthwhile and of being able to author one's life. As a result of the dehumanisation the families have been disempowered and rendered helpless. In their various narratives the families returned over and over again to how their sense of agency has been eliminated and how demoralised they are. A sense of self-determination is central to a robust sense of well-being and effective functioning in life. The families had mobilised themselves and protested by forming a Family Committee and informing the authorities and the public as the tragedy unfolded. This was not only ignored but the families were insulted: "*Take Sizwe home if you don't like it. This is a government decision,*" Jabulile Hlatswayo is told. Phumzile Motshegwa describes how Qedani Mahlangu shouted at them because they went to the press. The families, however, continued to mobilise

1 Constitution of the Republic of South Africa Act 108 of 1996

and organise themselves in the form of reports and complaints. But, all objections were overruled or simply ignored.

These families feel they have not been seen, heard or acknowledged - social workers have put the phone down on them, promises have not been honoured, security guards and nurses have yelled at them for arriving 'late' to see the dead body of someone they loved. As Jabulile Hlatswayo says: "*No matter who we turned to it fell on deaf ears. I don't have the words to say to them. They hurt me in the most, most hurtful way.*" And Moses Hlatswayo adds: "*They didn't listen to the poor people.*" To compound the terrible dehumanisation, these families have been exposed to secondary victimisation and stigmatisation by the Gauteng Department of Health. Human beings have always grappled with the realities of social stratification by creating the 'mythical norm'. Those who fall outside this illusory prototype are then disqualified from full social acceptance and are forced to carry the burden of stigmatisation (Goffman, 1963; Lai, Hong & Chee, 2000; Pachankis, 2007; Campbell, 2011). Stigmatised individuals, in this case institutionalised psychiatric patients, suffer greatly as a result of their diminished social status: they are likely to feel isolated, depressed, anxious, vigilant and aggressive and attribute the negative responses they endure to their own deficiencies (Pachankis, 2007; Campbell, 2011). But, it is not just the individual who has to carry the burden of being stigmatised: stigmas contaminate all members of the family who struggle with guilt, shame, internal conflict and being marginalised and misunderstood. Christine Nxumalo describes feeling judged by her extended family who were suspicious about the circumstances of her sister, Virginia Machpelah's, death until Carte Blanche exposed this tragedy.

The psychic and emotional energy required to run the gauntlet of negativity, assault and insult can take a toll on mental life. Those who are stereotyped are, therefore, at risk, as are their families (Pachankis, 2007; Steele, 2010) The term 'stereotype threat' is used to indicate the high comorbidity between mental and physical disorders (Steele, 2010; Pachankis, 2007; Druss & Walker, 2011). The end result is that this group of psychiatric patients and their families did not simply bear the burden of their disability but also of stigmatisation which adversely affects physical health disproportionately. To compound this burden, The Department subjected the families to secondary victimisation and stigmatisation. Sophie and Boitumelo Mangena recount how Qedani Mahlangu asked the families: "*Why are you crying? Why do you care when you abandoned your families to Life Esidimeni?*" At the official memorial, the pastor complains: "*Why did you throw your families onto Life Esidimeni?*" This heartless attitude has intensified the social isolation, self-blame and distress of already vulnerable families. The deep concern of the mental health professionals who participated in this process is that this modus operandi of disregarding,

disempowering, invalidating and infantilising these families will once again be repeated in the ADR process. If this turns out to be true it is hard to imagine the damage that will be done psychologically and emotionally.

**The terrible dehumanisation that characterised the Marathon Project turned it into a human-induced trauma of the worst kind and was compounded by secondary victimisation and stigmatisation on the part of the Gauteng Department of Health. This is the fourth factor that caused such emotional and psychological distress in this disaster.**

**Factor Five: The prevalence of severe Continuous Traumatic Stress Disorder as a result of what the families have witnessed and experienced**

The fifth factor to consider is that failure to establish a new psychological equilibrium in the wake of a calamity such as the Life Esidimeni transfers has resulted in the mental imprints of the trauma returning in unbidden ways. This is Post Traumatic Stress Disorder, but, unfortunately in this situation the trauma is not 'post' but, rather, Continuous Traumatic Stress Disorder (CTSD) and this is the first component of the trauma picture in this context.

The three central clusters of the symptomatic profile include:

a) re-experiencing the trauma;

b) avoidance of stimuli associated with the trauma; and

c) increased arousal.

There are numerous studies which provide ways of thinking about the impact of traumatic events on individuals such as the Holocaust, Hiroshima, the Vietnam war, 'los desaparecidos' in Argentina, the genocide in Rwanda and the Apartheid regime (Caruth, 1995, 1996, 2001, 2014; Krystal, 2017; Lifton, 1985, 1991, 1992; Van der Kolk, 1987, 2002; Straker, 1987; Garland, 2002; Taiana, 2014). The trauma discourse delineates common features observed in the way the body-mind reacts to sudden, unpredictable, shocking events regardless of the context and meaning of the traumatic event (DSM-VTM, American Psychiatric Association, 2013). Such events are outside the range of ordinary human experience and are unbearable in their horror and intensity because they violate physical and psychological integrity. Essentially, CTSD reflects the direct imposition on the mind neurobiologically and psychologically of the unavoidable reality of agonising events which have been experienced and remembered without mediation and processing. The imprint of the traumatic event

comes to dominate the person in that subsequent stressful life events are perceived in the light of the prior trauma. This can be observed clearly in the families consulted. These individuals are in various states of disequilibrium, disorganisation, bewilderment, desperation, distress, helplessness, rage, terror, hypervigilance and vulnerability. This is clearly depicted in the following example.

Umunyana Rugege recounts the incident that occurred at Section27: "*On the 29th September, 2017, Jabulile Hlatswayo was preparing for her oral testimony. She was very upset. She told us of the grief she feels as a result of the loss of her stepson, Sizwe Hlatswayo. She was especially angry with the government officials who interrupted her preparations for the funeral of her stepson after she had gone to so much trouble to find his body and then bring him back home for burial. She wanted to comply with her culture which requires her to ensure that the deceased sleeps in the house for a specified period of time before the burial. She became extremely emotional and was crying uncontrollably when she related how the government officials failed to bring her son's body by 1pm and that when she called Dr Manamela it was clear that she had not checked with the forensics team to ensure that the body was returned on time as she had promised. Jabulile got up to go to the bathroom but began to fall. I caught her before she hit the ground and placed her in a chair. She said she was cold, had no feeling in her left side from head to toe and had a pain in her chest. While we awaited the ambulance, Jabulile was in distress, she also had trouble breathing. She was hospitalised for several days.*" Jabulile is not the only individual who has broken down during preparation for oral testimony at the ADR process. Anna Mthembu, who now suffers from hypertension and a heart condition, became so upset that she needed oxygen to assist her with breathing. She was advised by Section 27 that she did not need to give oral testimony as this would further negatively affect her health. These incidents illustrate the extent to which the families consulted are still carrying the horror of this human-induced trauma in an undigested and overwhelming way.

Individuals who are most directly exposed to the sensory realities of any aversive event are at the highest risk for developing psychological problems: those who are physically immobile, dependent and helpless, those with first-hand experiences of the sounds, smells, and images of the event, those who directly witness the death of human beings, and those whose lives have been permanently altered by the death or injury of a loved one (Van der Kolk, 2002). Bessel Van der Kolk's assertion could not be more apt than when applied to the individuals caught up in the Life Esidimeni trauma. It explains why the individuals consulted are so traumatised and struggling to such an extent with intrusive sensory recollections in the form of images, smells and sounds associated with the event as well as physical sensations and bodily pain. The symptoms bear witness to an experience that is incomprehensible, unthinkable and unbearable.

Most of the individuals consulted describe significant increases in somatic symptoms such as sleep and eating difficulties, weight loss and gain, ulcers, numbness, high blood pressure, physical pain, exhaustion, loss of energy and recurrent illness. The health of some individuals has deteriorated to the point where hospitalisation has been necessary. Yvonne Mosiane had to be interviewed at home because she had just been discharged from an intensive care unit as a result of cardiac arrest. This was her third hospitalisation in a year. As has been indicated, Jabulile Hlatswayo has only recently been discharged. The individuals consulted are struggling with intense, negative emotional states including fear, horror, anguish, anger, guilt, anxiety, agitation and depression. Some individuals are now on anti-depressants. And suicidal ideation is evident in Phumzile Motshegwa: "*I was Solly's Mimmi as a child; he used to carry me to school on his back when I got tired. I did not expect him to die like this. I have heavy thoughts of killing myself.*"

The most disturbing sign of CTSD in the individuals consulted is that of intrusive symptoms. The individuals are struggling with recurrent, involuntary memories, images and dreams. Sophie Mangena dreams of her mother, Raisibe Mangena, with the dead look of an overmedicated person and feels anguish that she can't dream of her fierce and smiling as she knew her. Maggie Mosiane dreams that her brother, Caswell Mosiane, is sitting on a chair wearing a torn shirt, asking her for food. She can see he is in trouble. Both internal and external cues are causing deep distress for the family members. The families consulted ruminate about the manner of death, the missing autopsy results and the multiple, inconclusive, contradictory death certificates in their possession. The Mosiane family constantly asks themselves: "*How did Caswell fall? They said he had pneumonia. What was the thing on his head? They said he had a seizure. Was it the seizure that caused him to fall? How terrible was the fall that he would die afterwards? What was the thing on his head?*" Similarly, Suzen Phoshoko lies awake at night wondering what happened to Terence Chaba: "*Was he starved to death? Was he dehydrated? Was he poisoned? Did they give him an injection to kill him?*"

On the other hand, the families are also being bombarded by external cues. An example is Yvonne Mosiane who is unable to eat meat since Caswell Mosiane's death. This is directly linked to seeing her dead son's body with the one side of his face covered with a giant blister filled with a strange muddy fluid. When the undertaker tried to wash it off, blood oozed out of Caswell's face. Yvonne sees this in her mind every night. She is reminded of it every time she is offered meat. She feels nauseas and loses her appetite and so continues to lose weight and is now diabetic. Stella Mofokeng has not been able to unpack her brother, Sibusiso Mthombeni's, room. She has left everything as it was when he was alive; and she has not burnt his clothes which is an important practice in her culture. In addition, she displays dissociative responses. For

example, she gets a shock every time she realises that she has once again bought diabetic food for her brother. Persistent negative beliefs and a distorted sense of blame and guilt are apparent in the families. For example, the deaths of other family members subsequent to the transfers are linked in the minds of the families consulted as having been caused by this trauma. Lucas Mogoerane attributes a series of medical ailments suffered by other family members to the trauma. As the families point out, how could they possibly have imagined that their loved ones had been moved to 'Houses of Death'.

Worst of all for the individuals consulted is the prevalence and prominence of the flashbacks. They consist of horrifying images of how their loved ones suffered and how they looked in death: unrecognisable, skeletal, filthy, dehydrated, grotesque, bruised, bleeding, wounded, covered in bedsores. These images haunt the family members. Vaughan van Rooyen says: "*The other day there was a terrible stench of dogs messing in the street and the smell reminded me of Cindy [van Rooyen].*" Christine Nxumalo says: "*If I really thought about Virginia [Machpelah] trying to call out for help I wouldn't want to ever wake up.*" The families have an ongoing sense of anticipatory terror that disaster will reoccur at any moment. Families are suspended in states of waiting for things to go wrong. "*Before there was always enough, now there never is. My husband can't keep his job and there is never enough. Nothing feels right. Nothing is enough,*" says Christine. Many of the individuals in the sample now have difficulty concentrating and maintaining a focus in daily life and feel their capacity to function effectively in the world has been reduced. For some, this includes loss of employment or capacity to work which is reflected in this statement by Lucas Mogoerane: "*Christopher [*Mogoerane*] was part of me - my treasure. His death broke me. This crippled my life. It deteriorated my life. I cannot think properly. I now have to write things down. I can't sleep at night. Energy and interest - I lost it. I cannot do the work I used to do. The torture doesn't come to an end.*" The focus on the past has also robbed the current lives of the family members of a sense of meaning and pleasure and left them with pervasive feelings of emptiness. For the Mosiane family, Christmas was a special time, and, it was also the time of Caswell Mosiane's birthday. Last Christmas, the home with the gnarled apricot tree and gnarled vines that has been in the family for three generations was empty, heavy, quiet, dark and pain-filled.

**The second component of the trauma picture is that the assumptive world of these families has been shattered** (Janoff-Bulman, 1989, 1992). According to shattered assumptions theory individuals develop fundamental yet unarticulated beliefs about the world and themselves that allow for healthy human functioning. This is because levels of anxiety are manageable and self-esteem, feelings of competence and a sense of stability and meaning are promoted.

The core beliefs:

a) "*I will not die today and nor will those I love*" - the illusion of personal invulnerability and immortality: a necessary denial of the finality of our existence;

b) "*It will all work out and make sense in the end and justice will prevail*" - the perception of the world as meaningful, benevolent, just, comprehensible, safe and fair;

c) "*Others will not deliberately try to harm me or those I love*" - the perception of the self and others as positive and benign.

Trauma shatters these assumptions. Traumas involving human-induced disasters such as the Marathon Project are more devastating than natural disasters and cause greater levels of morbidity. The more malignant and self-serving the behaviour of the other in a human-induced trauma, the more intense and distressing the hopelessness, helplessness and sense of disempowerment on the part of the victim.

All three assumptions have been violently shattered in the Life Esidimeni transfers. These family members now have a heightened sense of vulnerability, helplessness, hopelessness, shame and worthlessness. They struggle to trust others and believe that their welfare, dignity and humanity will be disregarded.

In fact, the extent of the dehumanisation in the Marathon Project has resulted in the painful conviction that others will deliberately humiliate, deceive and harm. Lucas Mogoerane says: "*I wouldn't say life is unfair. Some people are unfair.*" Belief in good governance has been eroded: "*We are like in a Mickey Mouse country. I can understand hatred and why people end up in jail for things done in anger*" says Stella Mofokeng. Lucas Mogoerane agrees: "*Motsoaledi said Qedani Mahalangu was a political appointment. Most of the time she would not even inform him. It was as if he had no power. It's difficult to believe him. Politicians! They can't be believed. They change like the weather.*"

Faith in humanity has been undermined and the world is no longer safe, interesting, comprehensible and manageable. As Christine Nxumalo indicates: "*Space and silence are frightening for me now. I'm not ready to face reality.*"

**Trauma also shatters central organising fantasies of the self and of the family and this is the third component of the trauma picture in the families** (Ulman & Brothers, 1988). The meaning of the trauma lies in this shattering of psychological versions the individual and family have held of themselves and the system as a whole and in the

subsequent attempts to restore these fantasies, consciously or unconsciously. These fantasies promote cohesion and coherence and allow for role assignment, affective relatedness and communication. When the homeostatic balance of the system is assaulted, the person and family become orientated to protective mechanisms rather than processing, integration and mastery. A sense of identity, continuity, internal consistency and wholeness has been eroded for many of the individuals consulted. "*I'm not the person I used to be. I'm no more myself,*" says Lucas Mogoerane. It is not just bodies, hearts and minds that are broken but also family constellations. "*Vuyo's [Nqgondwane] death left a hole,*" says Christian Nqgondwane; "*Cindy's [van Rooyen] death left me feeling a sense of emptiness, like a hole in my heart,*" says Vaughan van Rooyen. Sophie and Boitumelo Mangena describe how their family has fallen apart; it is now a black page into which they collapse forever and ever. Ironically all the families describe family cohesion as having been enhanced through the joint task of caring for a mentally disabled family member. Now, the families are fractured and the world is a lonely, dark place. A way of life has imploded to the extent that it has destroyed the possibility of anything that happens having meaning. Christine Nxumalo says of her older sister: "*I found Virginia* [Machpelah] *in the world. She had always been there. How do you stop knowing that? How do you even begin to say goodbye?*"

**The fact that this trauma is not 'post' is severely injurious for these families and is entirely unnecessary.** The families are unable to integrate this experience as a catastrophic event historically unless there is closure. Closure requires truth. The fact that the deaths are still under investigation and that there has been no explanation forthcoming from the Gauteng Department of Health regarding the set of aversive events the families have experienced, means that these families are living in a state of uncertainty.

Multiple traumatisation progressively wears people down as opposed to increasing host resistance. Acceptance of loss cannot be encouraged in this context as it denies the true nature of the uncertainty. Any individual who suggests this becomes part of the political structure of the suppression of information by colluding with its presumption of normality and by maintaining silence (Blackwell, 2009). The implication here is that this experience for the families is not just about loss but also about the phenomenon of 'The Disappeared' or 'los desaparecidos' as the individuals were referred to in Argentina. In the South African context, the patients literally disappeared and then their bodies disappeared. Why the one hundred and forty one died is still unknown. All this tortures the family members.

Essentially, the 'Disappeared' is transformed into a tortured lost soul in limbo and the regulatory and symbolic rites of passage from life to death are annihilated (Brenner,

2006; Korol, 2005). Maggie Mosiane wonders if her dream is telling her that her brother, Caswell Mosiane, is not okay wherever he is and that he is finding it difficult to rest in peace. External reality - the body, the person, the autopsy result - is absent and so the ordinary mourning processes described by Freud (1914) are impeded (Taiana, 2014). These families are, therefore, frozen in their grief work awaiting news that never comes. Death, according to Colin Davies (2009), is a fundamental relation with the other: "Because I am invested with responsibility for the other, the death of the other is necessarily my affair" (p. 114). Davies describes the self as the survivor of the death of the other. And, the self continues to be determined by the relationship with the dead beloved. Why do the dead return? What unfinished business do they have still with us or do we still have with them? Cecilia Taiana (2014) refers to this as the dilemma of the absent-present reality of the other. The other continues to present a message in the mind of the bereaved even though deceased. This is notably apparent in this context. The messages from the dead ones who were virtually tortured to death continue to traumatise the families, as do the outstanding autopsy results. These families understand this very sophisticated concept intrinsically, in their cells and bones. The children and adolescents in this situation are likely to bear the mental scarring for a long period of time if gaps in the family narratives remain. **Most of these families have the legacy of apartheid behind them and now they have this tragedy to integrate. This scenario is likely to result in particularly powerful intergenerational effects.**

**The fifth factor truly reveals the extent of the emotional and psychological wreckage the Marathon Project left in its wake. The individuals consulted are suffering from Continuous Traumatic Stress Disorder, shattered assumptive worlds and shattered central organising fantasies. The fact that this trauma is not 'post' is severely injurious for these families and is an unnecessary compounding factor. The families are not only traumatised but their mourning processes have been impeded because of the silence, uncertainty and lack of closure.**

## SUMMARY

It is clear from the consultations conducted with the family members of the deceased and the analysis provided in this report that the nature of the human-induced trauma the families endured regarding the Gauteng Mental Health Marathon Project under the guidance of Qedani Mahlangu is severe and multilayered.

We summarise the significant features which have contributed to the degradation, decimation and dehumanisation of the families involved.

1. **The Gauteng Mental Health Marathon Project totally ignored and negated all available psychological and sociological research, evidence and theory regarding the likely negative impact of relocating institutionalised patients, many of whom were dependent on the care of others as they were unable to speak, walk or feed themselves and were suffering from various impaired mental states.**

2. **The manner in which the relocation was executed was entirely lacking in empathy and consideration for the welfare of the patients and families alike. It blatantly ignored available psychological, psychiatric and medical expertise and knowledge gained from experience in a wide variety of settings.**

3. **The families were subjected to relentless violations of trust, continual deception and incessant stonewalling and heartlessness on the part of the perpetrators. These individuals have been erased at every conceivable level: symbolic, emotional, psychological, material and literal.**

4. **The families witnessed their loved ones being subjected to the most terrible dehumanisation during the process of relocation. The families themselves were brutally dehumanised after their loved ones died.**

5. **The individuals consulted are suffering from Continuous Traumatic Stress Disorder, shattered assumptive worlds and shattered central organising fantasies. The fact that this trauma is not 'post' is severely injurious for these families and is an unnecessary compounding factor. These families are not only traumatised but their mourning processes are impeded because of the silence, uncertainty and lack of closure in the face of the great unknown surrounding the Marathon Project.**

**REPARATIVE AND RESTORATIVE JUSTICE**

The families were able to articulate their needs in terms of the ADR process clearly and emphatically. **They essentially want (and need) closure and they need to have their dignity and that of their loved ones restored.**

The psychological work that needs to be done by these families is to integrate the Life Esidimeni tragedy as part of their history and identity and to be able to live with that which cannot be forgotten.

**1. It will not be possible for these families to do this psychological work without professional assistance. The individuals in the families need to be assessed to determine the nature of the psychological intervention required. The indication from these consultations is that the individuals affected by this trauma need long-term psychotherapy. This needs to be done by any persons who are able to work psychoanalytically and who have had experience of trauma intervention. In addition, each family needs family therapy so that the family units can heal.**

**2. The families need the truth, the full truth, and nothing but the truth.** Jabulile Hlatswayo says: "*Sizwe was a beloved son and family member. His death and the circumstances of it have been devastating for our family. We love him and what to know the truth about what happened.*" The truth will assist in helping all those involved in the Life Esidimeni transfers to reclaim their dignity.

**3. The families need information regarding all aspects of the transfers and an explanation for the events that took place during the Gauteng Mental Health Marathon Project.** For these families this experience has been like putting the pieces of a jigsaw puzzle together, except that the pieces concerned people they loved. What the families need psychologically is to be presented by the Gauteng Department of Health with the completed jigsaw puzzle. That is, a full disclosure and rationale regarding the transfers with the gaps filled in.

The Gauteng Department of Health must answer the following questions:

a) why the relocations proceeded against all good advice;

b) why their loved ones were sent to NGOs that did not have valid licences and were ill-equipped at every level for the job they undertook to the point of not having food and water;

c) how it is possible that the Gauteng Department of Health selected sixteen NGOs in various parts of the province all of which were going to neglect one hundred and forty seven dependent patients to the point where death was inevitable;

c) why psychiatric patients, many of whom were unable to speak and walk and feed themselves and were suffering from various states of mental impairment, were moved without identity documents, medical files and wheelchairs and without the support and protection of their family members;

d) why the NGO staff watched those entrusted to their care dying brutally through starvation and dehydration and did nothing;

e) how the SASSA cards were used and the fate of the cards;

f) why the families were not informed immediately when their loved ones were moved and, most importantly, when they had died;

g) why the families were given multiple death certificates with contradictory conclusions and why the autopsy results are still outstanding; and

h) whether or not all the NGOs who participated in the Gauteng Mental Health Marathon Project were closed;

Full explanations regarding the above will facilitate a process of achieving closure for the families.

**4. The families need all those who were involved in the Gauteng Department of Health and in the NGOs to apologise unreservedly and accept full accountability. For some families this includes criminal prosecution.** This will also assist in the restoration of the dignity of all those affected by the Life Esidimeni transfers.

**5. All the families express needing an honourable memorial ceremony for the deceased. They want proper burials, graves, tombstones and cleansing rituals.** Vaughan van Rooyen's seven children were all given names beginning with C in honour of his sister, Cindy van Rooyen. It is a source of constant, intense pain for Vaughan that his beloved Cindy is buried on top of his uncle and that she does not have her own grave and tombstone. Sophie and Boitumelo Mangena express this sentiment well when they say repeatedly in their interview: "*That woman, she was our mother. We want her name called. That woman, she was our mother.*" Their mother's name was Raisibe Rahab Mangena.

It is worth considering creating a meaningful memorial in memory of the deceased. A reminder going forward that this should never be allowed to happen again. This will be particularly impactful if it is combined with a new psychiatric facility which many of the families requested. This will not only assist in the restoration of the dignity of all those affected by the Life Esidimeni transfers but will begin to provide some internal peace.

**6. At a material level, the families need equitable financial compensation as a form of redress for this human-induced trauma.**

Mental health professionals know only too well that the denial of a crime will result in its repetition. Of all the difficulties encountered in this process the most serious concern for the professionals involved is that of not being able to protect these families from further trauma, particularly at the hands of The Department. The Department lost its moral and ethical compass in this situation and it continues to psychologically defend itself against the recognition of this fact. The refusal to acknowledge the truth in this matter perpetuates the frozen emotional and psychological states the families are caught in. As the Right Reverend Jones (2017) states in his report on the Hillsborough tragedy: "*A false public narrative is an injustice in itself.*"

The ADR process provides an opportunity for the above to be addressed and for the dignity and peace-of-mind of all those affected to be restored. Perhaps we may use the words of Primo Levi (1989) to express what the Life Esidimeni families need:

> ***"We must be listened to: above and beyond our personal experience, we have collectively witnessed a fundamental unexpected event, fundamental precisely because unexpected, not foreseen by anyone. It happened, therefore it can happen again: this is the core of what we have to say. It can happen, and it can happen everywhere"*** (Primo Levi, 1989, The Drowned and the Saved).

**CONCLUSION**

In ending we urge Justice Dikgang Moseneke to pay heed to the following concluding remarks:

There is a trail of events in this situation that defies comprehension. Vulnerable, dependant, poor people were virtually tortured to death. And, if that did not matter to the officials of The Department, they compounded the matter by treating the victims of their decisions - the families - with the utmost contempt and disregard for their pain, dignity and humanity. As Phumzile Motshegwa says: "*People's loved ones had just been thrown in a cold room as if they did not matter; as if they were less of human and they did not deserve to be treated with dignity after they passed on.*"

To reiterate. Section 10 of our Constitution[2] provides that: "*Everyone has inherent dignity and the right to have their dignity respected and protected.*" This is also reflected in the first statement in the preamble to the 1948 Universal Declaration of Human Rights which refers to the equal and inalienable rights of all members of the human family as well as the recognition of their inherent dignity.

The notion of dignity in the human rights field finds resonance in the psychological arena. All human experience over the centuries bears out the fact that when people are treated badly their psychological well-being is adversely affected. Dignity should be the cornerstone of the mental health profession and field. Thomas Ogden (2005) refers to this as 'the North Star' of the helping professions. All policy makers and clinicians should treat their patients - and all those the patient's life impinges upon - in a humane way, in a way that at all times honours human dignity.

This is particularly true for institutionalised psychiatric patients. "*In short, if dignity matters then it is essential to specify what it is and what is necessary to ensure it. If an institution does not have sufficient resources to promote dignity consistently then it will inevitably be an undignifying institution. And if one believes that dignity is a human priority then undignifying institutions are simply unacceptable*" (Seedhouse & Gallagher, 2002).

The Gauteng Mental Health Marathon Project was an undignifying and life-threatening process and left human wreckage in its wake. Arendt (1958) refers to the erasure of human beings as the most terrible act of all. Jabulile Hlatswayo protests that The Department offered them food parcels - food parcels for a life and silence is how she understood it. When human beings deny their pain and suffering and refuse to see their own propensities towards revenge, greed, power and hatred, they will

1 Constitution of the Republic of South Africa Act 108 of 1996

necessarily create an 'other' to humiliate, colonise, or, at worst, destroy. We have a long and unfortunate history in South Africa of this kind of violent assault in the form of colonisation, the Anglo-Boer war, the atrocities of Apartheid and the recent Xenophobic attacks. In his report on the Hillsborough disaster and its aftermath the Right Reverend James Jones (2017) describes how institutions closed ranks, refused to disclose information, used public money to defend its interests and acted in a way that was both intimidating and oppressive in order to protect the reputation of the organisations in question. He refers to this as the patronising disposition of unaccountable power.

To reiterate. Dehumanisation is a two-step process. Step one is identifying undesirable humans. Step two is turning them into nonhumans (Brenner, 2006). Being seen only as a member of a group is pejorative and depersonalising and it diminishes the dignity of the individual (Mann, 1998). The original brief from the Gauteng Department of Health stated that twenty percent of all psychiatric patients needed to be discharged annually. This statement disregards the severity and extent of the disabilities of many of the individuals in the group who were moved during the period from 2015 to 2016. This dehumanisation resulted in a vulnerable, dependent, minority group being condemned to death by the series of decisions made by The Department. Suzen Phoshoko states: "*The death was a murder. It was planned, intentional murder because they must have known these people couldn't be moved.*" And Sophie and Boitumelo Mangena agree: "*It is one thing to say your mother has passed. It's another to say she was tortured and killed.*"

This is a human-induced trauma which is the most damaging form of trauma. The families were on the receiving end of this and were then treated with absolute contempt and with the utmost disregard for their pain, dignity and humanity. This is the antitheses of what mental health should provide. These families need to be rehumanised.

This expert testimony has delineated the catastrophic and tragic impact of the Gauteng Mental Health Marathon Project on the families involved. It is highly recommended that an equitable compensation amount and sound reparative process psychologically are an appropriate form of redress for this human-induced and avoidable trauma. In this way, the ADR process provides an opportunity to restore the dignity and the humanity and the peace-of-mind of all those affected. As the Right Reverend (2017) points out, the bravery, dignity and tenacity of families who fight for justice has a vicarious quality to it and is of value to the whole nation in that it ensures that the pain and suffering are never repeated.

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