

**AN ASSESSMENT OF THE MENTAL HEALTH CARE LAW IN
SOUTH AFRICA WITH SPECIFIC REFERENCE TO THE *LIFE
ESIDIMENI* TRAGEDY**

by

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ABSTRACT

The history of mental illness and its treatment reveals apart from each other the mentally-ill have had few advocates and have suffered confinement and neglect. The treatment of persons with mental illness occupies a dark place in the pages of history.

South Africa's new democratic order ushered in by the 1993 Interim Constitution¹ was confirmed with the signing by President Nelson Mandela of the 1996 Constitution² at Sharpeville on 10 December 1996. These developments brought to a close a long and bitter struggle to establish democracy in South Africa. In South Africa after the introduction of a democratic constitution there was an evident awareness that mental health had been neglected and that the transition to democracy requires it be given more attention. The Mental Health Care Act of 2002 and read with the Bill of Rights are key documents to regulating mental health care in South Africa.

This study investigates where accountability lies following tragedies such as the *Life Esidimeni* incident. It examines the findings of the Ombudsman and the evidence that came out of the arbitration process to determine what should happen next. A particular focus in the study is on legal liability and accountability, as well as on issues of negligence and the law regarding obedience to the orders of superiors. The dissertation critically examines the Mental Health Care Act and its alignment with the South African Constitution and other international, regional and national human rights law instruments.

Key words: mental health; human rights; Mental Health Care Act 17 of 2002; National Health Act 61 of 2003; Constitution of the Republic of South Africa Act 108 of 1996; Bill of Rights; Life Esidimeni; ombudsman; right to access health care; assisted mental health care user; legal liability; criminal liability; superior orders.

¹ The Constitution of the Republic of South Africa Act 200 of 1993.

² Constitution of the Republic of South Africa, 1996.

List of Abbreviations

GDoH	Gauteng Department of Health
HHE	Head of Health Establishment
HPCSA	Health Profession's Council of South Africa
ICESCR	United Nations International Covenant of Economic, Social and Cultural Rights
ICCPR	United Nations International Covenant of Civil and Political Rights
MEC	Member of the Executive Council
MHA	Mental Health Act
MHCA	Mental Health Care Act
MHCU	Mental Health Care User
NGO	Non-governmental Organisation
NHA	National Health Act
SADAC	South African Depression and Anxiety Group
SAJHR	South African Journal on Human Rights
SAMJ	South African Medical Journal
SAFMH	South African Federation for Mental Health
SASOP	South African Society of Psychiatrists
UDHR	United Nations Declaration of Human Rights
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

1.1 Introduction

South Africa was witness to a national tragedy when the Gauteng Department of Health (GDoH) in terms of a plan called the Gauteng Mental Health Marathon Project moved 1 711 mental healthcare users out of facilities managed by a private company, *Life Esidimeni*. In a rushed and flawed process between October 2015 and June 2016 these mental healthcare users living with severe mental illness or severe and profound intellectual disability were removed. They were moved mainly into the care of non-governmental organisations (NGOs). A total of 144 people died and the whereabouts of another 44 remain unknown. The report of an extensive arbitration process, released in March 2018, raises important ethical, moral, political, legal, governance, accountability and clinical issues.

1.2 Background to the events

1.2.1 Termination of the contract

The termination of the contract between the Gauteng Department of Health and *Life Esidimeni* can be viewed as initiating the problems that led to the torture and deaths of these mental healthcare users. The contract that had been in operation for over 30 years was terminated on 29 September 2015 by formal notice authorised and signed by the Head of the Department, Dr Tiego Selebano. Dr Selebano claims he signed this notice only because he feared his political principal, MEC (Member of the Executive Council) for Health, Qedani Mahlangu.³

Ms Mahlangu cited three reasons for the termination of the contract with *Life Esidimeni*: policy requirements to deinstitutionalise mental health-care users; the Auditor General's concern regarding the duration of the contract and budgetary constraints.⁴

³ Arbitration between families of mental health care users affected by the Gauteng Mental Marathon project and National Minister of Health of the Republic of South Africa, Government of the Province of Gauteng, Premier of Gauteng and Member of the Executive Council of Health Province of Gauteng before Justice Moseneke (Arbitration Report) 19 March 2018, para 23.

⁴ Arbitration report, para 27.

Between October 2015 and June 2016 patients were discharged randomly and in large numbers. A total of 1711 mental health-care users were removed from the care of *Life Esidimeni* to hospitals, to NGOs handpicked by the Department or to their homes. As a result 144 of these patients died and, discounting the missing patients, about 1400 patients survived the barbaric conditions of their displacement.⁵

1.2.2 Attempts to avert the tragedy

Family members, civil society organisations and professional associations attempted to stop the GDoH from removing patients from the care of *Life Esidimeni* and placing them in institutions that could not provide them with adequate care. Ultimately, these persons and groups instituted legal action against the Department of Health.⁶

The South African Society of Psychiatrists (SASOP) wrote to the former Gauteng Member of the Executive Council (MEC) for Health, Qedani Mahlangu, about the risks associated with the transfer project. This letter seemingly was ignored and in October 2015 the former MEC terminated the contract with *Life Esidimeni*. In November 2015 the South African Depression and Anxiety Group, SASOP, the South African Federation for Mental Health and families of the patients again pleaded in vain with the GDoH to ‘slow down and follow the correct procedure to ensure proper care for the patients’.⁷

In December 2015 litigation was instituted against the GDoH. The Department was presented with documents citing that patients needed specialised psychiatric healthcare that the NGOs could not provide. This litigation was withdrawn when the GDoH ‘committed to a consultation and a safe process, in the best interests of the mental healthcare users’. It promised that no patient would be moved until all parties involved agreed on the process and facilities. The Department reneged on this agreement and in February 2016 announced that all *Life Esidimeni* residents would be removed from the facility.⁸

In response to the Department’s announcement, in March 2016, the NGO, Section 27 and others instituted renewed litigation against the GDoH to stop the transfer of 54 people to a

⁵ Arbitration report, para 25.

⁶ Section 27 *The Life Esidimeni Case Fact Sheet* Available at <http://section27.org.za/wp-content/uploads/2017/02/Life-Esidimeni-Fact-Sheet-1.pdf> (accessed 1 October 2018).

⁷ As above, 1.

⁸ As above, 6.

NGO. Many of these were adult patients with severe mental disabilities such as schizophrenia, which requires specialised care. The GDoH argued that patients had been assessed and it had been concluded that they no longer needed professional care. The department claimed they were not obliged to consult and had decided to remove them. The Johannesburg High Court ruled in favour of the GDoH, which continued 'with its plans to discharge and place those who still need medical care to different facilities'.⁹

1.3 Problem Statement, research question and research objectives

1.3.1 General problem statement of the mini-dissertation

Human rights abuses and tragedies, such as the example of *Life Esidimeni*, would be prevented by strict implementation of the laws that regulate all aspects of mental health care.

1.3.2 Research objectives

Specific research aims are:

- a) Compiling a comprehensive and detailed discussion of selected current mental-health legislation and policy in South Africa, as well as an account of criminal law and procedure that apply to mentally-disturbed persons.
- b) Identifying problems in the implementation of mental-health legislation in the *Life Esidimeni* case.
- c) Detailing a framework of national and international laws and human rights' standards and principles which must be complied with.
- d) Presenting findings as to where the legal liability lies following the *Life Esidimeni* tragedy and identifying what steps further need to be taken.

1.3.3 Research methodology

The approach taken in this mini-dissertation is holistic, critical and mainly rights-based. It advocates firmly respect for human rights.

Data was gathered by systematic keyword searches relating to *Life Esidimeni*, mental health legislation and policies, human rights and criminal procedure. The search was productive of journal articles, textbooks, dissertations and theses, local and foreign legislation, policy

⁹ Section 27 *The Life Esidimeni Case Fact Sheet* available at <http://section27.org.za/wp-content/uploads/2017/02/Life-Esidimeni-Fact-Sheet-1.pdf> (accessed 1 October 2018).

documents and government publications and reports, which were analysed. An analysis of legislation alone it was felt does not offer an accurate account of the lived experience of the mental healthcare users at *Life Esidimeni*, thus a desktop study of the implementation of mental health legislation and criminal procedure was undertaken. Of particular significance in this vein is the review of the Mental Health Care Act and the Criminal Procedure Act as they are viewed as the foundation in establishing legal liability in this case.

1.4 Chapter Outline

Chapter 1

This chapter provides a general introduction to the study, the background to the study, the problem statement and its substantiation, the aims and objectives of the study, the research question and the research methodology.

Chapter 2

This chapter examines mental healthcare law in the context of the South African legal system. In exploring the legislative environment the Constitution and the Bill of rights are first examined and then mental healthcare law in general. Both repealed and current legislation in the form of the Mental Health Care Act are discussed. The chapter pays close attention to the Health Care Act as well as to the provisions of the Health Professions Act, and concludes by examining regional and international instruments that seek to protect and assist a variety of persons in specific circumstances who suffer mental ill-health.

Chapter 3

This chapter gives an account of legal liability. It discusses the criminal and personal liability that the former MEC of Health in Gauteng and senior public health officials in Gauteng incur as a result of their actions in the *Life Esidimeni* tragedy. It further discusses negligence and the concept of vicarious liability.

Chapter 4

This chapter presents the findings of this study and indicates specific contraventions of the Constitution, mainly of the Bill of Rights, of the NHA, certain sections of the MHCA, and determines contract and fiduciary responsibilities.

The following chapter examines legislation applicable to the care of mental healthcare users in South Africa.

CHAPTER 2

LEGISLATION, POLICIES AND GUIDELINES

2.1 Introduction

The human rights of every person in South Africa are guaranteed by the Constitution, inclusive of those living with mental illness. All issues relating to the treatment of mentally-ill patients are governed by law in terms of which the mentally ill have rights. These rights are protected in the Constitution, in various domestic regulations and in international instruments that seek to protect persons with mental illness.

This chapter examines the domestic legal framework and international instruments that govern the care of mental healthcare users.

2.2 The Constitution of South Africa, 1996

The impact of the Constitution of the Republic of South Africa, 1996 on our law is threefold:

- 1) The Constitution is supreme law in South Africa and any legislation that conflicts with its provisions is invalid to the extent of the conflict.
- 2) According to section 39 of the Constitution the Bill of Rights is applicable to all laws.
- 3) The Bill of Rights instructs the state to apply the power the Constitution grants it in a manner that does not violate fundamental rights.

2.2.1 Responsibilities of state organs

The Constitution is binding on all organs of state and on each state official entrusted with the exercise of public office.¹⁰ All public office-bearers and state officials who took the decisions in the *Life-Esidimeni* case and the Marathon Project were bound by the provisions the Constitution dictates. Logically, when, as the facts of the case demonstrate, the organs of state entrusted the care of patients to NGOs the non-governmental organisations assumed the duties of an organ of state in relation to the mental healthcare users and took

¹⁰ Sec 8(1) Constitution of the Republic of South Africa, 1996. "The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state".

on the corresponding constitutional obligations.¹¹ Thus the NGOs exercised delegated public powers;¹² the NGOs acted in the name, place, stead and authority of the state whose duty it is to provide adequate care to mental healthcare users. As the NGOs voluntarily had assumed their care they were bound to exercise their mandate lawfully and in a reasonable manner.¹³

The concerned state organs and, indeed, the NGOs were obliged to respect, promote and protect the constitutional entitlements of mental healthcare users. The primary entitlement is the right to life¹⁴ and state organs must comply with measures that ensure its effective enjoyment by persons with disability on a par with every other person.¹⁵

2.2.2 The Bill of Rights

Health is indispensable in the realisation of other human rights, such as life and dignity. Therefore, each person should be assured of the implementation of the highest attainable standard of health that is conducive to living a life of dignity.¹⁶ Mental healthcare users are entitled to access adequate healthcare services and, at a minimum to be provided with sufficient food and water.¹⁷ Their families and interested parties acting on their behalf or in the public interest are entitled to insist that the fundamental rights of mental healthcare users are not infringed or placed under threat.¹⁸

The notion of dignity is often closely linked to the concept of social justice. Social justice generally equates to an idea of fairness in society's treatment of individuals, especially the

¹¹ *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 at paras 52-59.

¹² The Life Esidimeni Arbitration report; Judge Moseneke at page 64 para 155.

¹³ *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 at paras 52-59.

¹⁴ Sec 11 the Constitution of the Republic of South Africa, 1996.

¹⁵ Sec 8 & 9 Constitution of the Republic of South Africa, 1996.

¹⁶ Art 16 African Charter on Human and Peoples' Rights.

¹⁷ Sec 27 Constitution of the Republic of South Africa, 1996.

¹⁸ Sec 38 Constitution of the Republic of South Africa, 1996.

most vulnerable.¹⁹ The dignity of each human being is achievable if every member of society is regarded as equal.²⁰

2.3 Legislation: The Mental Health Care Act

2.3.1 Repealed legislation: The Mental Health Act 18 of 1973

South Africa has had various mental health statutes; our discussion commences with the 1973 Act. The Mental Health Act 18 of 1973 (MHA 1973) is the consequence of a “public panic” that ensued after the assassination of Prime Minister, Dr Hendrik Verwoerd,²¹ by a mentally-ill man. A commission inquiring into the incident concluded that many assassinations ‘are committed by mentally disordered persons’.²² The commission’s conclusions led to a proposed amendment and culminated in the MHA, 1973. Scholars and psychiatrists have noted that MHA, 1973 did not encompass a concern with individual rights, its primary focus was on patient control and treatment in parallel with the protection of the “welfare and safety” of society.²³

This Act, enacted by the Nationalist government, exhibits the fact that the human rights of the patients were not necessarily a priority. Specifically, MHA, 1973 was criticised²⁴ because it required only a reasonable degree of misgiving for someone to be certified and placed in a mental institution²⁵; it was a possibility that individuals could be denied their freedom and be placed in a mental facility based on prejudice and as a result of a vendetta. People were declared mentally incapable for political reasons at this time. Political opponents could be silenced by being placed in a mental facility.²⁶ Once they were deemed

¹⁹ Ferlito BA and Dhali A “The Life Esidimeni tragedy: A human-rights perspective” (2017) *S Afr Med J* 52-54, available at <http://10.7196/SAJBL.2017.v10i2.611> (accessed 1 October 2018).

²⁰ Maiese M *Human Rights Violations. Beyond Intractability* 2003 <http://www.beyondintractability.org/essay/human-rights-violations> (accessed 29 October 2018).

²¹ Dr Verwoerd was the Prime Minister of South Africa. He was stabbed to death by Demetrio Tsafendas, who later claimed he was told by a giant tapeworm inside him to kill the Prime Minister. He was declared insane by state psychiatrists.

²² Cheetham RWS “Commission of inquiry into the Mental Disordered Act in relation to the problems of today” (1970) *SAMJ* 1371-1372.

²³ Burns, JK “Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice” (2008) *S Afr Med J* 46-49.

²⁴ As above, 23.

²⁵ As above.

²⁶ As above.

mentally ill and certified, patients were deprived of the assistance of the law and could spend a considerable amount of time in mental institutions against their will.²⁷ The patients did not have a significant right of appeal or representation.²⁸

According to the South African Federation for Mental Health the MHA, 1973 permitted disproportionate mental healthcare based on race, Blacks receiving the least amount of care. The provisions of MHA, 1973 did not promote personal autonomy, dignity or justice for individuals with mental illness. Instead, it relied on a paternalistic principle which allowed mentally-ill patients to be alienated, stigmatised and disempowered²⁹ by restraining patients in institutions against their will.

It was apparent that the MHA, 1973 needed to be revisited.

2.3.2 Present legislation: The Mental Health Care Act 17 of 2002

The Mental Health Care Act 17 of 2002 (MHCA) ushered in a new era for South African psychiatry in repealing and replacing the Mental Health Act of 1973. The Act was assented to on 28 October 2002, and commenced on 15 December 2004. As a consequence of the Constitution of the Republic of South Africa, 1996 it was incumbent on law-makers to ensure that all acts of parliament were amended and rewritten so as to accord with its provisions.³⁰

The foundation of MHCA, 2002 rests on ten basic principles set out by the World Health Organization (WHO) in relation to mental healthcare law.³¹ In essence the act signalled the arrival of an era of a human rights-driven ethos in patient care. Previously, human rights may have been a consideration, but the revised act incorporated a raft of changes, not least of which is an explicit orientation towards a more 'patient-centred' approach to psychiatric care.³²

In effect the MHCA, 2002 seeks to:

²⁷ As above.

²⁸ As above.

²⁹ Haysom N, Strous M, & Vogleman L "The Mad Mrs Rochester Revisited: The involuntary Confinement of the mentally ill in South Africa" (1990)6 *SAJHR* 31, 33.

³⁰ Constitution of the Republic of South Africa, 1996.

³¹ WHO/MNH/MND/96.9 'Mental health care law: ten basic principles', Division of Mental Health and Prevention of Substance Abuse, World Health Organization, Geneva, 1996.

³² Szabo CP and Kaliski SZ "Mental health and the law: A South African perspective" (2017) 14(3) *BJPsych Int* 69-71 available at <http://creativecommons.org/licences/by-nc-nd/4.0/> (accessed 1 October 2018).

- (1) Shift the system from a custodial approach in the past to one encouraging community care.
- (2) Ensure that appropriate care, treatment and rehabilitation are provided at all levels of the health service.
- (3) Underline that individuals with mental disability should not be discriminated against, stigmatized or abused.³³

The promulgation and implementation of the MHCA represents a new era in mental health-care in South Africa. A human rights-based orientation in support of the Constitution reflects an intention to ensure humane care with appropriate accountability.³⁴

2.4.1.1 Key provisions of the Act

In terms of the act mental illness is defined as a 'positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria' as made by a mental healthcare practitioner authorized to make such a diagnosis.³⁵

The act outlines the rights of mental health patients and the duties of carers,³⁶ and highlights that human dignity and privacy must be respected.³⁷ They should not be discriminated against because of their mental status³⁸ and are to be protected against 'exploitation, abuse and any degrading treatment'.³⁹

2.4.1.2 Involuntary treatment

People in need of care, of treatment and rehabilitation for mental illness, in truth, are likely to be the least willing to ask for or receive it. In certain circumstances it may be necessary to provide services to persons without their consent. The provision of services without consent constitutes an invasion of basic human rights, that is, the rights to dignity, autonomy, and freedom or liberty. The MHCA regulates the circumstances in which these rights may be infringed as well as the manner and extent to which they may be infringed. Special

³³ See https://www.natlawreview.com/article/approvals-process-slows-development-hydrokinetic-power-michigan#_edn11 (accessed 1 October 2018).

³⁴ Szabo and Kaliski (n 29 above) 69-71.

³⁵ Sec 1 MHCA, 2002.

³⁶ Sec 7(1) MHCA, 2002.

³⁷ Sec 8(1) MHCA, 2002.

³⁸ Sec 10(1) MHCA, 2002.

³⁹ Sec 11(1)(c) MHCA, 2002.

measures and safeguards have been introduced which protect the rights of persons who are admitted, cared for, treated and rehabilitated on an involuntary basis.

The MHCA authorises two streams for the provision of involuntary care, treatment and rehabilitation. One stream is through the criminal justice system and the other is via a civil route which permits certain persons to apply for the provision of a health intervention in the case of people incapable of making an informed decision owing to their mental health status and who refuse intervention but require such services for their own protection or for the protection of others. The criminal justice route is beyond the scope of this study, but, regardless of whether the involuntary user has entered the mental healthcare system through the criminal law or the civil route, no distinction is made regarding the services provided.

In terms of the general rule, subject to a section 9(1)(c) emergency situation, a user may not be provided with services at a health establishment as an outpatient or inpatient without consent.⁴⁰ Section 32 provides for involuntary services in certain circumstances.

Section 32 of the act⁴¹ states that in order to commence a proceeding to have someone involuntarily committed “an application must be made in writing on form MHCA 04 to the Head of a Health Establishment (HHE)⁴² by a spouse, next of kin, partner, associate, parent or guardian”,⁴³ who must have seen the person within the past seven days.⁴⁴ If the user is under the age of 18 on the date of the application, the application must be made by his/ her parent or guardian.⁴⁵ Once the application is received the HHE must have the person examined by two mental healthcare practitioners who perform independent assessments of the patient in accordance with s 33(4) (a) of the MHCA⁴⁶ and report their findings and recommendations. If the assessments of the two practitioners differ, then the HHE must have the patient assessed by a further practitioner.⁴⁷ The HHE can approve an application

⁴⁰ Sec 26 MHCA, 2002.

⁴¹ Sec 32 MHCA, 2002.

⁴² Reg 10(1) MHCA, 2002.

⁴³ Sec 33(1)(a) MHCA, 2002.

⁴⁴ Sec 33(1)(b) MHCA, 2002.

⁴⁵ Sec 33(1)(a)(i) MHCA, 2002.

⁴⁶ Regulation 10(3) MHCA, 2002.

⁴⁷ Sec 33(6) MHCA, 2002.

only if the two mental healthcare practitioners agree that involuntary care is necessary.⁴⁸ MHCA is clear that only individuals suffering from mental illness are eligible for involuntary care.⁴⁹

According to the act an involuntary mental healthcare user ‘must be provided with care, treatment and rehabilitation at a health establishment if at the time of application, there is a reasonable belief that the mental health care user has a mental illness’, and is likely to cause serious harm to their person or to others.⁵⁰

If the HHE recommends involuntary care, treatment and rehabilitation, the patient must be admitted to a health establishment within 48 hours.⁵¹ The HHE must then arrange for the assessment of the patient’s physical and mental health status over a period of 72 hours.⁵² After the 72-hour assessment period and based on the medical healthcare practitioners’ reports the HHE must decide if the patient requires further involuntary care, treatment and rehabilitation services as an inpatient. If the HHE determines that the patient does not require further treatment, care or rehabilitation, the patient must be discharged immediately, unless the patient gives consent to further care. Invariably, depending upon the HHE’s determination, the patient can be discharged or have their status changed to a voluntary inpatient or outpatient.⁵³

2.4.1.3 Voluntary treatment

The MHCA directs that an individual who voluntarily submits to a mental health facility for care and treatment and who consents to such care is “entitled” to care and treatment or to a referral.⁵⁴

⁴⁸ Sec 33(7) MHCA, 2002.

⁴⁹ Sec 32 MHCA, 2002.

⁵⁰ Sec 32 MHCA, 2002.

⁵¹ Sec 33(9) MHCA, 2002.

⁵² Sec 34 MHCA, 2002.

⁵³ Sec 3(3) MHCA, 2002.

⁵⁴ Secs 25 & 26 MHCA, 2002.

2.4.1.4 Procedural protections and precautions

The MHCA incorporates several procedures and precautions to ensure that patient's rights are fully protected. As a precaution persons directed by the HHE to examine the prospective patient must be qualified mental health practitioners.⁵⁵

The establishment of the Mental Health Review Boards, which are to be constituted in every province,⁵⁶ provides another layer of protection. The primary aim of the Board is to ensure that the rights of the prospective patients are not violated. The Boards comprise of a magistrate, an attorney and a mental health practitioner.⁵⁷ In the case in which the HHE subjects an involuntary patient to the 72-hour assessment period and concludes that the patient should receive further involuntary care, treatment and rehabilitation, the HHE must submit a report within seven days of the expiration of the 72-hour assessment period which requests the Board to approve further involuntary care.⁵⁸

The Act requires that while the Board considers the HHE's decision to continue involuntary treatment all concerned (the applicant, the mental health providers) except for the reluctant patient, are afforded the opportunity to submit representations to the Board.⁵⁹ It is noted in the Act that decision letters should be sent to the HHEs and the applicant who requested that the patient be treated.⁶⁰ Once the Board agrees with the HHE's assessment that the involuntary patient should continue to be so treated, the Board must submit their decision for judicial review and send all documentation to the High Court for consideration of the matter. The Court has a month to consider the matter.⁶¹

The Act provides that mental health-care users have a right to legal representation and to appeal to the Board over the decision of the HHE to continue involuntary treatment.⁶² However, it is problematic that the HHE's decision in favour of involuntary care is not

⁵⁵ Sec 27(4), Sec 33(4) MHCA, 2002.

⁵⁶ Sec 18 MHCA, 2002.

⁵⁷ Sec 20 MHCA, 2002.

⁵⁸ Sec 34(3)(c) MHCA, 2002.

⁵⁹ Sec 34(7)(a) MHCA, 2002.

⁶⁰ Sec 34(7)(b) MHCA, 2002.

⁶¹ Sec 34(7)(c) MHCA, 2002.

⁶² Sec 15, Sec 35 MHCA, 2002.

submitted to the patient but to the applicant. Since the reluctant patient is not notified of the HHE's decision in the first place, it is difficult for the patient to submit an appeal. If the Board finds for the reluctant patient, s/he must be released immediately. If the Board finds in favour of the HHE's decision, the Board must submit their decision to the High Court for judicial review.⁶³

Another important procedural protection applicable to both voluntary and involuntary mental patients is that their condition periodically is reviewed and annual reports must be submitted to the Board for review.⁶⁴

2.4 Legislation: The National Health Act 61 of 2003

2.4.1 Provisions of the Act

The objectives of the National Health Act⁶⁵ (NHA) are to regulate national health and to provide uniformity in respect of health services across the nation by:

- (a) establishing a national health system which:
 - (i) encompasses public and private providers of health services; and
 - (ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;
- (b) setting out the rights and duties of healthcare providers, health workers, health establishments and users; and
- (c) protecting, respecting, promoting and fulfilling the rights of:
 - (i) the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;
 - (ii) the people of South Africa to an environment that is not harmful to their health or well-being;
 - (iii) children to basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution; and

⁶³ Sec 35(3) & 35(4) MCHA, 2002.

⁶⁴ Sec 30 & 37 MHCA, 2002.

⁶⁵ Sec 2 National Health Act 61 of 2003 (NHA).

(iv) vulnerable groups such as women, children, older persons and persons with disabilities.

2.4.2 Rights and duties of health care users

The NHA provides that every healthcare provider must inform a user of their health status except in circumstances where there is substantial evidence that the disclosure of the health status would be contrary to the best interests of the user, and that the practitioner, where possible, must inform the user in a language that the user understands and in a manner which takes into account the user's level of literacy.⁶⁶

A health service may not be provided to a user without the user's informed consent, unless the user is unable to give informed consent and such consent is given by a person mandated by the user in writing to grant consent on his or her behalf or is authorised to give such consent in terms of any law or court order.⁶⁷

A user has the right to participate in any decision affecting his or her personal health and treatment. If the informed consent is given by a person other than the user, if possible, that person must consult the user before giving the required consent. If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest.⁶⁸

2.4.3 Compliance and monitoring

The relevant member of the Executive Council is responsible for ensuring the implementation of national health policy and its norms (which include the provision of health services, including social, physical and mental health care)⁶⁹ and standards in his or her province. The head of a provincial department, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province, must provide specialised hospital services; plan and manage the provincial health information system; plan, manage and develop human resources for the rendering of health services; control

⁶⁶ Sec 6 National Health Act, 2003.

⁶⁷ Sec 7 National Health Act, 2003.

⁶⁸ Sec 8 National Health Act, 2003.

⁶⁹ Sec 21(2)(b)(v) National Health Act, 2003.

and manage the cost and financing of public health establishments and public health agencies and consult with communities regarding health matters.⁷⁰

2.4.4 Policy guidelines for the licensing of residential and /or day-care facilities for persons with mental illness and /or severe or profound intellectual disability

The act⁷¹ promotes the provision of community-based care, treatment and rehabilitation services. It obliges persons who provide care, treatment and rehabilitation services to offer such services in a manner that facilitates community care of mental healthcare users. The General Regulations to the Act published in Government Gazette 27117, Notice R1467 of 15 December 2004 further defines which organisations should be licensed, how it should be done and the conditions attached to licensing.

2.4.4.1 Guiding principles

Facilities and services providing mental health care, treatment and rehabilitation should ensure the protection of the basic human rights of mental healthcare users. Mental healthcare users should receive care, treatment and rehabilitation in an environment which is safe, therapeutic and less restrictive. The care, treatment and rehabilitation programmes provided in these facilities or services must promote the physical, spiritual, emotional and social well-being of mental healthcare users. A multi-disciplinary approach must be followed to provide care, treatment and rehabilitation programmes. Psycho-social rehabilitation programmes must be sensitive to culture and must be evidence-based. There must be collaboration with stakeholders that have a role in the provision of community-based mental healthcare services, including non- governmental organizations, departments of Labour, Social Development, Basic Education, Human Settlement and Local Government. Facilities and services must aim at improving social competence by enhancing an individual's social skills, and psychological and occupational functioning. The programmes and services should be planned in conjunction with mental healthcare users as far as is possible. The environment in which residential and day-care services are provided should be accessible and equitable to all regardless of geographical location, economic status, race, gender or social condition, and mental healthcare services should have parity with general health services.

⁷⁰ Sec 25 National Health Act, 2003.

⁷¹ Sec 3 National Health Act, 2003.

All organisations which provide residential and day-care services to mental healthcare users should be accountable for the delivery of appropriate, effective and efficient intervention. Residential and day-care services should be offered in the context of the community environment and should offer capacity building and support to communities. Residential and day-care services should offer a wide range of services and programmes that are specific to each mental healthcare user's developmental and therapeutic needs. Residential and day-care services should be holistic, intersectoral and delivered or supported by a multi-disciplinary team. Residential and day-care facilities should meet all infrastructure requirements as set by the South African Bureau of Standards, municipal by-laws, relevant legislation and policies'.⁷²

2.4.4.2 Rights of mental healthcare users

The rights to equality, non-discrimination, dignity, respect, privacy, autonomy, information and participation should be upheld in the provision of mental health care, treatment and rehabilitation. The rights to education, healthcare services, sufficient food, water and social security should be upheld. The proprietor and manager of a residential or day-care facility, and any healthcare practitioner and service provider rendering services at any such facility or service, must obtain informed consent for admission and treatment from a voluntary mental healthcare user. The proprietor, manager, healthcare practitioner and service provider must ensure that a mental healthcare user incapable of making an informed decision (an assisted or involuntary mental healthcare user) is admitted for care, treatment and rehabilitation only as approved by the responsible Mental Health Review Board in terms of sections 27 and 33 of the NHA.

The proprietor, manager, health care practitioner and service provider must ensure that all the rights of a mental healthcare user under the act are respected and upheld in accordance with the requirements of the NHA. The proprietor and manager of the relevant residential facility or day-care facility must ensure that mental healthcare users at the facility and their families are provided with adequate information with regard to (a) the health care services available at that facility and (b) accessing the services in accordance with the Norms and Standards Regulations Applicable to Different Categories of Health Establishments.

⁷² 41498 GOVERNMENT GAZETTE, March 2018 para 6.

The proprietor and manager must ensure that the mental healthcare users

(a) are attended to in a manner which is consistent with the nature and severity of their health condition as prescribed in the Norms and Standard Regulations Applicable to Different Categories of Health Establishments and (b) have appropriate access to medical and other healthcare services.⁷³

2.5 Other regulations and considerations

2.5.1 Health Professions Council of South Africa: Core ethical values and standards for good practice

Everything ethically required of a professional to maintain a good professional practice is grounded in the core ethical values and standards; the latter being directives that follow the core values.⁷⁴

The core ethical values and standards required of healthcare practitioners include the following:

- (a) Respect for persons: healthcare practitioners should respect patients as persons and acknowledge their intrinsic worth, dignity, and sense of value.
- (b) Best interests or well-being - non-maleficence: healthcare practitioners should not harm or act against the best interests of patients even when the interests of the latter are in conflict with their self-interest.
- (c) Best interest or well-being - beneficence: healthcare practitioners should act in the best interests of patients even when the interests of the latter are in conflict with their personal self-interest.
- (d) Human rights: healthcare practitioners should recognise the human rights of all individuals.
- (e) Autonomy: healthcare practitioners should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.

⁷³ As above, para 15.

⁷⁴ HPCSA *Guidelines on Ethical rules: Ethical rules, regulations and policy guidelines Booklet 1*.

- (f) Integrity: healthcare practitioners should incorporate these core ethical values and standards as the foundation for their character and practice as responsible healthcare professionals.
- (g) Truthfulness: healthcare practitioners should regard truth and truthfulness as the basis of trust in their professional relationships with patients.
- (h) Confidentiality: healthcare practitioners should treat personal or private information as confidential in professional relationships with patients unless overriding reasons confer a moral or legal right to disclosure.
- (i) Compassion: healthcare practitioners should be sensitive to and empathise with the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.
- (j) Tolerance: healthcare practitioners should respect the rights of people to have different ethical beliefs as these may arise from deeply-held personal, religious or cultural convictions.
- (k) Justice: healthcare practitioners should treat all individuals and groups in an impartial, fair and just manner.
- (l) Professional competence and self-improvement: healthcare practitioners should continually endeavour to attain the highest level of knowledge and skills required within their area of practice.
- (m) Community: healthcare practitioners should strive to contribute to the betterment of society in accordance with their professional abilities and standing in the community.

2.5.2 International legislation and policies

In assessing the international element to healthcare the bioethical principles of autonomy, beneficence, non-maleficence and justice provide a useful framework.⁷⁵ The principle of autonomy recognises the duty of the healthcare professionals to respect the freedom of patients to make their own decisions. The principle of beneficence recognises the duty of health professionals to do good for their patients.⁷⁶ Non-maleficence is a principle which recognises the duty on the part of health professionals not to harm patients.⁷⁷

⁷⁵ TL Beauchamp and JF Childress *Principles of Bioethics* (1994) 67-113.

⁷⁶ Beauchamp and Childress (n 73 above) 194-249.

⁷⁷ As above, 120-184.

These elements are expressed in documents such as the International Bill of Rights and the African Charter of Human and Peoples' Rights (African Charter). The International Bill of Rights consists of the Universal Declaration of Human Rights (UDHR);⁷⁸ the International Covenant of Economic, Social and Cultural Rights (ICESCR)⁷⁹ and the International Covenant on Civil and Political Rights (ICCPR).⁸⁰

2.5.2.1 International Bill of Rights

Autonomy is recognised in the following provisions of:

- (a) The UDHR regarding the right to life, liberty and security of the persons;⁸¹ privacy;⁸² freedom of movement⁸³ and the right to freedom of thought, conscience and religion.⁸⁴
- (b) The ICCPR regarding the right to life,⁸⁵ liberty and security of the person;⁸⁶ liberty of movement⁸⁷ and the right to freedom of thought, conscience and religion.⁸⁸

Beneficence is recognised in the following provisions of:

- (a) The UDHR regarding the right to social security⁸⁹; the right to a standard of living adequate for a person's health and wellbeing and that of his or her family⁹⁰.
- (b) The ICSECR provides for the right to an adequate standard of living⁹¹; the right for everyone to enjoy the highest attainable standard of physical and mental health by requiring state parties to improve all aspects of environmental and industrial hygiene and create conditions which assure to everyone medical service and medical attention in the

⁷⁸ United Nations Declaration of Human Rights, 1948.

⁷⁹ United Nations International Covenant of Economic, Social and Cultural Rights, 1966.

⁸⁰ United Nations International Covenant on Civil and Political Rights, 1966.

⁸¹ Art 3 UN Declaration of Human Rights, 1948.

⁸² Art 3 UN Declaration of Human Rights, 1948.

⁸³ Art 13.1 UN Declaration of Human Rights, 1948.

⁸⁴ Art 18 UN Declaration of Human Rights, 1948.

⁸⁵ Art 6.1 UN International Covenant on Civil and Political Rights, 1966.

⁸⁶ Art 9.1 UN International Covenant on Civil and Political Rights, 1966.

⁸⁷ Art 12.1 UN International Covenant on Civil and Political Rights, 1966.

⁸⁸ Art 18.1 18.3 of the UN International Covenant on Civil and Political Rights, 1966.

⁸⁹ Art 22 UN International Covenant on Civil and Political Rights, 1966.

⁹⁰ Art 25.1 UN Declaration of Human Rights, 1948.

⁹¹ Article 11.1 UN International Covenant of Economic, Social and Cultural Rights, 1966.

event of sickness.⁹² The ICSECR also states that everyone has a right to receive information.⁹³

Non-maleficence is recognised in the provisions of:

- (a) The UDHR which states that nobody shall be subjected to cruel, inhuman or degrading treatment⁹⁴ or to arbitrary interference with their privacy.⁹⁵
- (b) The ICCPR provides that nobody may be deprived of their liberty;⁹⁶ be subjected to unlawful interference with their privacy;⁹⁷ be subjected to cruel, inhuman or degrading treatment. In particular, nobody may be subjected without their free consent to medical or scientific experimentation.⁹⁸

Justice and fairness are recognised in the provisions of:

- (a) The UDHR which states that everyone is born free and equal in dignity and rights⁹⁹ and entitled to all the rights and freedoms in the UDHR without distinction of any kind such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.¹⁰⁰
- (b) The ICCPR which provides that all persons are equal before the law and are entitled, without any discrimination, to the equal protection of the law. This means that the law prohibits discrimination and guarantees to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.¹⁰¹

2.5.2.2 The African Charter of Human Rights and Peoples' Rights

Autonomy is also protected in the African Charter which recognises the right to:

- (a) Respect for life and integrity of one's person.¹⁰²

⁹² Art 12.1 United Nations International Covenant of Economic, Social and Cultural Rights, 1966.

⁹³ Art 19 United Nations International Covenant of Economic, Social and Cultural Rights, 1966.

⁹⁴ Art 5 United Nations Declaration of Human Rights, 1948.

⁹⁵ Art 12 United Nations Declaration of Human Rights, 1948.

⁹⁶ Art 9 United Nations International Covenant on Civil and Political Rights 1966.

⁹⁷ Art 17.1 United Nations International Covenant on Civil and Political Rights 1966.

⁹⁸ Art 7 United Nations International Covenant on Civil and Political Rights 1966.

⁹⁹ Art 1 United Nations Declaration of Human Rights, 1948.

¹⁰⁰ Art 2 United Nations Declaration of Human Rights, 1948.

¹⁰¹ Art 26 United Nations International Covenant on Civil and Political Rights 1966.

¹⁰² Art 4 African Charter of Human Rights and Peoples' Rights, 1981.

- (b) Liberty and security of the person.¹⁰³
- (c) Freedom of conscience and free practice of religion.¹⁰⁴
- (d) Freedom of movement.¹⁰⁵

Beneficence is found in the provisions of the African Charter dealing with:

- (a) the right to receive information;¹⁰⁶ and
- (b) the right to attain the best available state of physical and mental health.¹⁰⁷ In this regard state parties are required to take the necessary measures to protect the health of their people and ensure that they receive medical attention when they are sick.¹⁰⁸ The state must also take care of the family's physical and moral health¹⁰⁹ and take special measures to protect the aged and disabled in keeping with their physical and moral needs.¹¹⁰

In the African Charter examples of non-maleficence are found in the following provisions:

- (a) the prohibition of all forms of exploitation and degradation, including cruel, inhuman or degrading treatment;¹¹¹
- (b) the provision that nobody may be illegally deprived of the right to liberty or security of the person.¹¹²

The justice principle is recognised by providing that:

- (a) Everyone shall be entitled to enjoy the rights and freedoms in the Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.
- (b) Everyone shall be equal before the law and entitled to equal protection of the law, and all peoples shall be equal and enjoy the same respect and equal rights.

¹⁰³ Art 6 African Charter of Human Rights and Peoples' Rights, 1981.

¹⁰⁴ Art 8 African Charter of Human Rights and Peoples' Rights, 1981.

¹⁰⁵ Art 12.1 African Charter of Human Rights and Peoples' Rights, 1981.

¹⁰⁶ Art 9.1 African Charter of Human Rights and Peoples' Rights, 1981.

¹⁰⁷ Art 16.1 African Charter of Human Rights and Peoples' Rights, 1981.

¹⁰⁸ Art 16.2 African Charter of Human Rights and Peoples' Rights, 1981.

¹⁰⁹ Art 18.1 African Charter of Human Rights and Peoples' Rights, 1981.

¹¹⁰ Art 18.4 African Charter of Human Rights and Peoples' Rights, 1981.

¹¹¹ Art 5 African Charter of Human Rights and Peoples' Rights, 1981.

¹¹² Art 6 African Charter of Human Rights and Peoples' Rights, 1981.

The next chapter examines the potential legal liability of the officials involved in the transfer project.

CHAPTER 3

LEGAL LIABILITY

3.1 Criminal liability

The straightforward definition of the crime of murder is the intentional and unlawful killing of another human being.¹¹³ The elements in declaring a murder that have to be proved beyond reasonable doubt are (i) that the accused person had the intention to kill; (ii) the person's act or omission was unlawful; (iii) the person caused the death of the other person and (iv) the other person was a human being.¹¹⁴

3.1.1 Intention

The element of 'intention' in murder takes the form either of 'actual intention' or 'eventual intention'. A person who directs their will to kill a particular person and knows that their act or omission is unlawful he or she is guilty of 'actual intention'.¹¹⁵ If he or she does not mean to kill a person, but subjectively foresees the possibility that a person may die as a result of their act or omission and continues with such conduct regardless, he or she is guilty of 'eventual intention', in Latin, *dolus eventualis*.¹¹⁶ The question arises as to whether in the *Life Esidimeni* case the MEC for Health, the head of the provincial DoH and any other public health officials involved in the decision not to renew the contract with *Life Esidimeni* and to transfer them 'like cattle on the back of open bakkies, to ill-equipped and unlicensed NGOs, where unqualified staff had no idea how to care for them'¹¹⁷ had "actual" or "eventual intention" to cause the death of mental healthcare users.

Self-evidently, they did not have 'actual intention' to kill the patients, which clearly would result in a murder charge. The question that needs answering is whether they had 'eventual intention' to do so. The answer involves deciding if they subjectively could foresee that by not renewing the service contract that the patients would receive sub-par treatment or that

¹¹³ Burchell J *Principles of Criminal Law* (2006) 667.

¹¹⁴ Same as 113.

¹¹⁵ Burchell 461-463.

¹¹⁶ As above, 115.

¹¹⁷ Kotze A, Gonzalez L & Malan M "Life, death and political gain" *Mail & Guardian* 2018 January 26-February 1:15.

alternative arrangements had to be made. As soon as they knew that there were no viable alternatives they had a legal duty to act expeditiously to have the patients re-institutionalised. According to the Ombudsman's report¹¹⁸ they had been warned of the consequences and subjectively must have foreseen that such a lengthy period without the necessary treatment could result in the deaths of the patients. Therefore, legally they had the 'eventual intention' to let the patients die.

3.1.2 Unlawfulness

Whether or not the conduct of a person accused of murder is unlawful depends upon the legal convictions of the community¹¹⁹ as informed by the provisions of the Bill of Rights in the South African Constitution.¹²⁰ The Bill of Rights clearly declares that everyone should have access to healthcare services¹²¹ and that the state must 'take reasonable legislative and other measures within its available resources to achieve the progressive realisation' of this right.¹²² Furthermore, children have the right to 'basic healthcare services'¹²³ and not merely access to such services. In addition, everyone has a right to life.¹²⁴ Clearly, any breach of these provisions that results in the death of patients is unlawful. In terms of the *Life Esidimeni* case, the question that needs answering is whether the MEC for Health, the head of the provincial DoH and any other public health officials involved in the decision not to renew the contract with *Life Esidimeni* acted unlawfully. The former MEC offered as justification that she had been forced to end the contract because of pressure from the Auditor General, claiming that the department 'had been subject to tender and budget constraints'.

However, the MEC for finance in Gauteng declared during arbitration hearings that there was no evidence to support this claim.¹²⁵ Clearly, the state officials could not argue that they

¹¹⁸ Ombudsman Report 29.

¹¹⁹ *Minister van Polisie v Ewels* 1975 (3) SA 590(A).

¹²⁰ *S v Makwanyane* 1995 (3) SA 391 (CC).

¹²¹ Sec 27(1)(a) Constitution of South Africa, 1996.

¹²² Sec 27(2) Constitution of South Africa, 1996.

¹²³ Sec 28(1)(c) Constitution of South Africa, 1996.

¹²⁴ Sec 11 Constitution of South Africa, 1996.

¹²⁵ Van Dyk J "Life Esidimeni. Officials could face culpable homicide charges" *Mail & Guardian* 2018, February 16-22:22-23.

did not have the 'available resources' to renew the contract with a competent, designated health establishment.

3.1.3 Causation

The last question to be answered in deciding criminal liability in a murder charge is whether the conduct of the accused person caused or contributed to the death of the deceased person.¹²⁶ In law the alleged murderer must factually and legally have caused or contributed to the death of the deceased.¹²⁷ The test for factual causation is that had it not been for the act or omission of the accused person the deceased would not have died.¹²⁸ In this context is it possible to determine that 'but for' the failure of the MEC for Health and public health officials to renew the *Life Esidimeni* contract scores of patients would not have suffered from neglect and mistreatment at unregistered NGOs and would not have died. Answering these questions in the affirmative satisfies the element of factual causation.

What needs to be decided is whether the MEC for health, the provincial head of health or other public health officials involved legally caused the death of the deceased. Previously, the tests for legal causation were the foreseeability test,¹²⁹ the direct-consequence test¹³⁰ and the adequate-cause test.¹³¹ The foreseeability test provides that if a person reasonably could have foreseen the likelihood of death resulting from their act or omission and persisted with such conduct, the accused person is regarded as having legally caused the death of the person.¹³² The direct-consequence test states that a person is liable for the direct consequences of their act or omission unless some new act intervened between such act or omission and the death of the deceased.¹³³ According to the adequate-cause test a person causes the death of another if such a death is 'adequately connected' to the act or omission of the accused person.¹³⁴ The above three tests are now regarded as 'subsidiary

¹²⁶ Burchell 209.

¹²⁷ Lee v Minister of Correctional Services (2013) SA 144 (CC).

¹²⁸ *S v Daniels* 1983 (3) SA 275 (A).

¹²⁹ J Neethling, J Potgieter, PJ Visser *Law of Delict* (2001) 202-204.

¹³⁰ *S v Goosen* 1989 (4) SA 101 (A).

¹³¹ Neethling, Potgieter, Visser 190-191.

¹³² Neethling, Potgieter, Visser 202-204.

¹³³ As above, 130.

¹³⁴ Neethling, Potgieter, Visser 190-191.

tests'¹³⁵ and the courts apply a 'flexible approach' based on policy considerations such as whether it would be reasonable, fair or just to regard the consequences of a person's conduct as not being too remote from the conclusion.¹³⁶ On this basis the courts determine 'whether or not a sufficiently close connection exists between conduct and its consequences'.¹³⁷ The 'subsidiary tests' may be used to assist the court in making such a determination but themselves are not decisive.¹³⁸

Whether one applies the three 'subsidiary tests' or the flexible test for the reasons set out below it seems that in this case the MEC for Health and her colleagues can be said to have legally caused the deaths of the deceased patients. Under the foreseeability test a reasonable person in the position of the former MEC and other senior public health officials would have foreseen that the deaths of the patients in these circumstances were a direct consequence of the contract not being renewed and patients being transferred to incompetent and unregistered NGOs. Also, there is an 'adequate connection' between the failure to continue the service contract and the deaths of the patients. Finally, in terms of the 'flexible approach' it would be reasonable, fair and just to find that there was a 'sufficiently close connection' between the decision by the MEC for Health and senior public health officials to discontinue the service contract with authorised service providers and the resulting deaths.

3.2 Personal Liability

Public officials in South Africa who are incompetent, indifferent or negligent, and who cause harm to others do not have immunity from prosecution. They can be held personally liable provided that the injured person can prove that their conduct either was negligent or was intentional. In a situation where several public officials are responsible for causing harm all of them may be held personally liable.¹³⁹

¹³⁵ *S v Mokgethi* 1990 (1) SA 32 (A).

¹³⁶ As above, 136.

¹³⁷ As above, 136.

¹³⁸ As above, 136.

¹³⁹ Apportionment of Damages Act 34 of 1956, Sections 1(1) (a) and 2(13).

3.2.1 Negligent conduct

Incompetence and maladministration often are the result of negligence. Negligent conduct means that a reasonable person in the position of the wrongdoer ought to have foreseen the likelihood of harm and would have taken steps to guard against it.¹⁴⁰ It was stated that many attempts were made by civil society organisations, family members and professional associations to stop the GDoH from removing patients from the care of *Life Esidimeni* and placing them in institutions that could not provide them with adequate care. The state also may be held vicariously liable for their misconduct.¹⁴¹ Public officials who negligently harm patients can be sued for damages such as loss of income, medical expenses, pain and suffering, reduced life expectancy and loss of support for the dependents of patients¹⁴².

3.2.2 Intentional misconduct

Intentional misconduct occur when, as a result of indifference, persons deliberately refrain from acting because they do not care or they intentionally engage in malpractice which harms patients, and when their will is directed to do or fail to do things knowing they are acting unlawfully.¹⁴³ The former MEC and senior public health officials were informed of the likely harm to patients should they be transferred to ill-equipped and unlicensed NGOs,¹⁴⁴ despite resources being available. They may be held personally liable for harm caused to patients.¹⁴⁵ Public officials who intentionally harm patients are liable for damages to be awarded that can be measured in monetary terms as well as ‘sentimental’ damages (i.e., damages for hurt feelings).¹⁴⁶

3.2.3 Misconduct by more than one public official

If several public officials (e.g., the public hospital manager, procurement officer and chief executive officer of the relevant department of health) are found personally liable for harming a patient, the damages may be apportioned among them and each will be liable for a

¹⁴⁰ See *Kruger v Coetzee* 1966 (2) SA 428 (A).

¹⁴¹ D McQuoid-Mason “Practising medicine in a resource-starved environment: Who is liable for harm caused to patients – the health care administrators or the clinicians?” (2010) 100(9) *S Afr Med J* 573- 575.

¹⁴² As above.

¹⁴³ Mc-Quoid-Mason (n 133 above) 579-575.

¹⁴⁴ Section 27 *The Life Esidimeni Case Fact Sheet* Available at <http://section27.org.za/wp-content/uploads/2017/02/Life-Esidimeni-Fact-Sheet-1.pdf> (accessed 1 October 2018).

¹⁴⁵ McQuoid-Mason (n 133 above) 573-575.

¹⁴⁶ McQuoid-Mason (n 133 above) 573-575.

proportion of the damages to the patient.¹⁴⁷The courts usually hold joint wrongdoers 'jointly and severally liable' which means that any one of them can be made to pay all of the compensation awarded, and the person who pays may then claim a contribution from the others in proportion to their fault.¹⁴⁸ If a public health official who is held personally liable by the court cannot afford to compensate the harmed patient in full, the patient may always cite the relevant provincial MEC for health or Minister of Health as a joint wrongdoer as vicariously liable to pay the balance. The parties will be 'jointly and severally liable' but the court may order each to pay a proportion of the damages.

3.3.4 Vicarious liability

In common law vicarious liability refers to situations where one person is liable for another's unlawful conduct irrespective of fault by the first person.¹⁴⁹ Vicarious liability usually refers to the employer-employee relationship. An employer will be held liable for the harmful, negligent or intentional wrongful acts or omissions of their employees if: (i) there was an employer-employee relationship; (ii) the employee committed an unlawful act or omission and (iii) the employees acted in the course and scope of their employment, even if this was in an improper way.¹⁰² These principles apply to both the public and private sectors.¹⁰¹

The state is in the same position as private employers, and the State Liability Act provides that the state is vicariously liable for the wrongful acts or omissions of state employees.¹⁵⁰ Thus, the MECs for health and provincial Departments of Health may be held vicariously liable for the wrongful acts of their employees committed within the course and scope of their employment,¹⁵¹ even if they intentionally failed to carry out or obey instructions.

It is claimed that where there is a shortage of resources a health department or hospital cannot be expected to exercise a standard of care that is beyond its financial resources.¹⁵² However, where the shortage arises as a result of intentional or negligent harmful acts or omissions by public health officials or hospital management patients have a valid claim

¹⁴⁷ Secs 1(1)(a) and 2(13) Apportionment of Damages Act 34 of 1956.

¹⁴⁸ Secs 1(1)(a) and 2(13) Apportionment of Damages Act 34 of 1956.

¹⁴⁹ *Minister of Police v Rabie* 1986 (1) SA 117 (A).

¹⁵⁰ Sec 1 State Liability Act 20 of 1957.

¹⁵¹ *South African Liquor Traders' Association v Chairperson, Gauteng Liquor Board* 2009 (1) SA 565 (CC) paras 47, 49.

¹⁵² See *Collins v Administrator, Cape* 1995 (4) SA 73 (C).

against them for any harm suffered. The state is vicariously liable for such conduct by public health officials or hospital administrators. However, even where the state is vicariously liable for the conduct of its public officials the latter still are personally liable.¹⁵³ Such public officials may be personally sued, or may be cited as joint wrongdoers together with the state.

Where the state is held vicariously liable for the conduct of public officials the latter may be required to reimburse the state for any damages paid out to injured or harmed patients. It remains to be seen if the courts are prepared to impose personal liability on public servants. The courts have realised that shaming of public officials 'no longer works', and that 'even the strongest exhortation of our highest courts' for public officials to be held accountable has fallen 'on deaf ears'.¹⁵⁴ It has been proposed that 'individual public responsibility, in contrast to nominal responsibility, could be enhanced by forcing individual public officials to explain and account for their own actions, as parties to the litigation'.¹⁵⁵

The sense of individual responsibility among public servants would improve if they were sued in their personal capacity in addition to the state being sued vicariously. Several cases have made public servants personally liable for wasted costs incurred in indefensible matters,¹⁵⁶ but the same principles apply to holding them personally liable for harming patients. In deciding whether or not to impose personal liability on public servants acting in the course and scope of their employment the courts have recognised that 'to err is human', but 'indifference', 'incompetence' and 'not caring' have not been sanctioned by the courts, for instance by awarding costs against public officials in their personal capacity.

The courts have observed: 'The public should not have to suffer this complete indifference and incompetence at the hands of public servants.'¹⁵⁷ The state is bound to 'respect, protect, promote and fulfil the rights' contained in the Bill of Rights.¹⁵⁸ The state must act so that these fundamental rights are realised and the Constitution requires constitutional obligations 'be performed diligently and without delay'.¹⁵⁹ Furthermore: 'Incompetence undermines the

¹⁵³ See *Feldman (Pty) Ltd. v Mall* 1945 AD 733.

¹⁵⁴ *Feldman (Pty) Ltd. v Mall* 1945 AD 733.

¹⁵⁵ *Kate v MEC for Department of Welfare, Eastern Cape* 2005 (10) SA 141 (SE) para 11.

¹⁵⁶ *Lushaba v MEC for Health, Gauteng* 2015 (3) SA 616 (G) para 90.

¹⁵⁷ As above, paras 70, 71.

¹⁵⁸ Sec 7(2) Constitution of the Republic of South Africa 1996.

¹⁵⁹ Para 14 *Mlatsheni v The Road Accident Fund* 2009 (2) SA 401(E).

Constitution and with it the social contract underlying it. If personal accountability among public officials does not come naturally it must be inculcated. Somehow these officials must be taught that their actions (or lack thereof) have consequences'.¹⁶⁰ The courts have observed further that 'the taxpayer also has an interest in these matters, as public funds are at risk in matters where damages against the Minister are claimed'.¹⁶¹ MECs of provinces have been held individually liable where they have been personally involved in decisions and have also been held vicariously liable in their representative capacity for the wrongdoing of their employees.¹⁶²

¹⁶⁰ *Lushaba v MEC for Health, Gauteng* 2015 (3) SA 616 (GJ) para 88.

¹⁶¹ *The Minister of Safety and Security v G45 International UK Ltd.* Case 07/12735 South Gauteng High Court, para 14. www.saflii.org/za/cases/ZAGPPH/2015/844.pdf (accessed 28 October 2018).

¹⁶² *South African Liquor Traders' Association v Chairperson, Gauteng Liquor Board* (2009) (1) SA 565 (CC).

CHAPTER 4

CONCLUSION

4.1 Conclusions

Based on the factual findings by the Ombudsman¹⁶³ and the arbitration report of Judge Moseneke¹⁶⁴ it is evident that several human rights that enjoy protection under our Constitution and which also are protected under international human rights treaties to which South Africa is party have been violated.

Everyone has a right to a standard of living adequate for the well-being of himself and of his family, including food, clothing, housing and medical care.¹⁶⁵ In addition, everyone has a right to the enjoyment of the highest attainable standard of physical and mental health.¹⁶⁶ This right to access healthcare services includes the obligation on the state to refrain from denying healthcare to any individual and that particular types of healthcare should be provided to all on a non-discriminatory basis if every individual is to enjoy access to the best attainable state of physical and mental health.¹⁶⁷ There has been an infringement of all these rights when the mental healthcare users (MHCU) were denied such rights in the course of the *Life Esidimeni* tragedy.

South Africa is a party to the Convention on the Rights of People with Disability (CRPD) and in terms of this Convention all persons with disability are entitled to all fundamental rights, especially persons with intellectual and psycho-social disabilities.¹⁶⁸ Also, the Constitution¹⁶⁹ recognises a right of access to healthcare, food, water, and social security.¹⁷⁰ Given that these rights are interrelated the protection of the right to health is central in

¹⁶³ Ombudsman report, 2.

¹⁶⁴ Arbitration report.

¹⁶⁵ Art 25 Universal Declaration of Human Rights.

¹⁶⁶ Art 12 International Covenant on Economic, Social and Cultural Rights Handbook, August 2015.

¹⁶⁷ Art 16 African Charter on Human and Peoples' Rights.

¹⁶⁸ Art 14 Convention of the Rights of People with Disability (CRPD).

¹⁶⁹ Constitution of the Republic of South Africa, 1996.

¹⁷⁰ Sec 27 Constitution, 1996.

upholding the right to life.¹⁷¹ It also guarantees the rights to freedom and security,¹⁷² and the right to bodily and psychological integrity.¹⁷³ A violation of these rights ultimately violates the right to human dignity.¹⁷⁴ The MHCU were denied the right to an environment conducive to their health and wellbeing, a right to food and nutrition, as well as the right to freedom and security.

The contravention of the rights of the MCHU extends to rights provided for in the National Health Act (NHA) too, which provides for the protection of the constitutional right to healthcare, including the right to participate in decisions regarding their health.¹⁷⁵ However, MHCU and their family members were not granted the opportunity to participate in decisions regarding their health. Also, the NHA requires that healthcare should be provided to the population in an efficient and equitable manner. The insistence on the protection, promotion and respect with regard to this right not only is a duty to progressively realise the constitutional right to healthcare, but also requires the application of a minimum standard of care. The healthcare users were denied this right.¹⁷⁶ They were denied the standard of care envisaged in both domestic and international frameworks. The direct provisions in the NHA on consent and the discharge of patients were not complied with.

Several Regulations to the Mental Healthcare Act (R17-23) regarding patient movement processes were violated. The National Core Standards domains 1-7 on aspects of rights, safety, care management and accommodation were violated.

The Ombudsman found that there had been no screening criteria applied to the NGOs and there were no service-level agreements¹⁷⁷. Contract law and procedure were ignored.¹⁷⁸ There were no signatures to the contracts, and no suitability criteria were in place.¹⁷⁹

¹⁷¹ Sec 11 Constitution, 1996.

¹⁷² Sec 12(1) Constitution, 1996.

¹⁷³ Section 12(2) Constitution.

¹⁷⁴ Section 10 Constitution.

¹⁷⁵ Section 8 National Health Act of 2003.

¹⁷⁶ Sec 21(b) Constitution.

¹⁷⁷ Ombudsman report 49.

¹⁷⁸ As above.

¹⁷⁹ As above, 52.

It emerged during the inquiry that the NGOs violated the rights of MCHU. They were not provided with adequate food, warm clothing, blankets, warm water to bathe and medicine.¹⁸⁰ The patients were completely neglected. Poor and ineffective leadership was displayed during the process of transfer of these patients to the NGOs.¹⁸¹ They were transported in “batches”¹⁸² and were “transported like cattle” with no regard for their human dignity.¹⁸³ The Ombudsman found that the process was ‘chaotic or a total shamble’.¹⁸⁴

Given the sequence of events that took place in the *Life Esidimeni* case and the gross infringement of rights which led to the MCHU being subjected to risk, the head of the GDoH, the MEC for Health and the officers in the GDoH who allowed the termination of the *Life Esidimeni* contract and displacement of patients should be subject to civil and criminal sanctions, as well as the doctors who allowed this tragedy to take place. The doctors who acquiesced violated the HPCSA Code of Ethics and should be referred to the Council for disciplinary processes.

Clearly the criminal law elements in the definition of the crime of murder are present. When it became clear that the lives and wellbeing of these patients were at risk following the displacement it can be argued that the failure to act displays an ‘eventual intention’ for these patients to die. On these grounds murder or culpable homicide charges are a consideration. At a minimum the law of contract has been ignored, creating a case for a charge of fraud.

4.2 Recommendations

The study has revealed that there have been gross violations of human rights and in that light recommends the following:¹⁸⁵

¹⁸⁰ Ombudsman report 6.

¹⁸¹ Ombudsman Report, 37.

¹⁸² As above, 51.

¹⁸³ As above, 2.

¹⁸⁴ As above, 1.

¹⁸⁵ Ombudsman Report, 54-55.

- (1) The National Minister should consider a systematic review of human rights compliance nationally related to mental health.
- (2) Licensing regulations and procedures need to be reviewed to ensure that they comply with the NHA and MHCA. The certification of NGOs needs to be overhauled.
- (3) In the future projects must not be undertaken without clear policy guidelines and proper ministerial oversight.
- (4) Deinstitutionalisation must be undertaken professionally with the involvement of multidisciplinary teams.
- (5) The Mental Health Review boards should be strengthened so that they work efficiently.

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