LIFE ESIDIMENI ARBITRATION

HELD AT: EMOYENI CONFERENCE CENTER, 15 JUBILEE ROAD, PARKTOWN, JOHANNESBURG

Date: 26th January 2018

SESSION 1 – 2.

BEFORE ARBITRATOR –JUSTICE MOSENEKE

WITNESSES: PROF. GROBLER

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SESSION 1

ARBITRATOR JUSTICE MOSENEKE: You may be seated. Advocate Ngutshana.

ADV. PATRICK NGUTSHANA: Morning Justice Moseneke. The next witness that we have is Professor Grobler. But, before we get to him there is the SAPS report I spoke about yesterday when we adjourned. I just want to read a certain section into the record so that we have it. The date of the report is 24th of January 2018 and issued under name of the division Commissioner Detective Service. On the status of the investigation, it records that to date the investigation team can account to 144 deaths, a total of 45 inquest dockets and 99 inquiry files. Inquiry files were registered for bodies that were already buried when the investigating team was established. The investigation of these inquest dockets are at an advanced stage. However, during the arbitration proceedings, the investigation team established from certain witness's information that will necessitate for registering other criminal offences. The matter was discussed with the National Prosecuting Authority and the investigation team was advised to await the finalization of the arbitration proceedings. In order to obtain the entire transcripts, audio and visual recordings. The investigation team is working in conjunction with the National Prosecuting Authority on 2018 January 10, all inquest docket files were handed to the NPA for perusal and further directives. All the Inquest dockets and Inquiry files are still with the office of the National Prosecuting Authority. Progress will be reported. That is the end of the status discussion. Thank you justice Moseneke.

ARBITRATOR JUSTICE MOSENEKE: Thank you Counsel. Advocate Hutamo.

ADV. TEBOGO HUTAMO: Thank you Justice, there is a request which we would like to make. We would like to introduce a further witness for next week. We have

communicated this to our learned friends, some of whom do not have any objection. There has been matters which have been raised relating to the finances of the province. We have found it prudent that we should call the MEC for Finance to be able to canvas those aspects which relate to finance. As the Justice has said, there is a need for an explanation of what actually happened to the funds which were allocated to the various NGOs. So, on that basis, we found it necessary that the relevant official in the form of the MEC for Finance should be the appropriate person to be able to canvas those matters relating to the finance of the province in particular in relation to matters concerning the health department. So, with your permission we just wanted to give an indication the order of the witnesses – the order on how we intend to call the witnesses for next week.

ARBITRATOR JUSTICE MOSENEKE: And what would the order be or you are just about to tell me?

ADV. TEBOGO HUTAMO: Yes.

ARBITRATOR JUSTICE MOSENEKE: Okay.

ADV. TEBOGO HUTAMO: We intend calling the MEC for finance on Tuesday, followed by the Premier of the province. We have scheduled 2 witnesses for Tuesday. And then on Wednesday, we will be calling the current MEC for health who will then be followed by the National Minister of Health. That is the order which we intend calling the witnesses. With your permission, we just wanted to alert all the parties of how we intend to run with the matter next week.

ARBITRATOR JUSTICE MOSENEKE: In my part excellent, I think well done. Subject to the views of other Counsel that seems to be highly necessary, prudent and welcome it. Let's hear the views of other Counsel on the matter. And this will be Ms. Barbara Chrissy?

ADV. TEBOGO HUTAMO: It is indeed correct Justice.

ARBITRATOR JUSTICE MOSENEKE: Very well. Counsel.

ADV. LILLA CROUSE: Justice, from our side, we are one of the parties that have not agreed, was not in favour of this. And our line of thinking are just the following: The [indistinct] lies within the MEC of Health, she is best suited to deal with that. If the MEC for Finance feels that there can be a contribution, she can do that via an affidavit. We are concerned, we need to prepare for such a witness and we need the scratch further than going to the NGO money if budgets are placed before us. We will need an expert to advise us how to do that. We are not sitting next week Monday, we are not sitting next week Friday. And this arbitration needs to have an end somewhere. We are not fighting that there were resource constraints within the department. We aren't fighting with what the Minister of Health is saying, there wasn't enough money to care for the mental healthcare patients. The only issue that this court has raised is what happened to the NGO money? And in our submission, to really know the witness and to create new disputes of fact, it is in this case going to prolong because we will have to have a chance to look through the budgets and get expert evidence on that. It will just create new dispute of fact which cannot dispute fact at the moment. And I submit that it might then have the result in having to prolong the arbitration. And that is our objection.

ARBITRATOR JUSTICE MOSENEKE: And how would it prolong it? The 2 days we have set aside will still be used.

ADV. LILLA CROUSE: Yes, but we will need time to look through the evidence because it will be, MEC can't come here and make blanket statements. She will have to get financial statements and we are not qualified to look through financial statements. We are not experts in that. We will need to have the matter stand down and pay an expert to look at that. So, that will cause a delay in the proceedings.

ARBITRATOR JUSTICE MOSENEKE: Well, I hear you. Let me hear other Counsel. I will come back to that. [indistinct] different views to that. I will come back to you once I have heard the views of everybody. Advocate Hassim.

ADV. ADILA HASSIM: Thank you Justice, good morning. First of all Justice, I wasn't aware of this. I am hearing it for the first time now from my colleague. So, I have =not had an opportunity to think it through and what the advantages and disadvantages of this would be. So, from the top of my head, I will say that I have some reservation as far as time goes and preparation as my colleague has herself raised. The Friday in particular next week, the day that we are not sitting is the one day in which we will have clear in order to finalize our witness submissions which we will have to file the very next day. So, the overflow if we were to go into Friday, even though I appreciate that, that day has been kept clear will impact on our ability to at the same time prepare our written legal submissions. And that really is a main concern, it is time and preparation as far as the need to further interrogate the issues of the budget. The MEC for Health is coming. If there is a way to do it in a manner that will not impact on the time that we have available, if that is at all

possible, as I have said I haven't had a chance to think it through. I do think the issue of the budget and how the money was spent is important and it is something we would like to have dealt with in the hearing. We would object to us flowing into the Friday next week.

ARBITRATOR JUSTICE MOSENEKE: Yes, thank you. Counsel, so you were not told until I was told?

ADV. ADILA HASSIM: I was not aware until it was raised now in relation to calling the witness or the impact of the schedule and the proposed schedule.

ARBITRATOR JUSTICE MOSENEKE: Counsel.

ADV. TEBOGO HUTAMO: Justice.

ARBITRATOR JUSTICE MOSENEKE: I will come back to you, let me hear all Counsel. I will be – you have raised the matter so you have got to have the last word. The last word is yours, okay.

ADV. PATRICK NGUTSHANA: Justice Moseneke, in our view, the issues that the MEC for Finance will be bringing into these proceedings are quite limited. We already have heard her budget speech that deals with the issues that she ought to speak to. And if she certainly won't be allowed to traverse other issues which do not fall within her mandate. The MEC can speak that is on the issues that relates to her mandate. And Barbara Chrissy can speak to the issues which have been defined by the budget speech in relation to the budget speeches. So that the MEC will be coming here, there might not be a need for us to cross-examine her. So, to assume that there will be a need to interrogate further the issues that she will be bringing in

here, I think it might not be correct but her participation in this, I think in my view contribute at something in how the finances of the department were used. Whether indeed it is correct they were under financial constraint, whether it is correct that they had to cut the qualifications of services which the patients ultimately received. So, in my view we need that part of evidence. Already we have had the previous MEC, the former MEC who had emphatically said they were under financial constraints. They had to cut services and so on. So, we need to deal with that, interrogate that issue a little further. If that witness is available to assist us Justice Moseneke. Thank you.

ARBITRATOR JUSTICE MOSENEKE: You see Advocate Groenwald, I am coming to you. I would go back and debate the matter with Advocate Crouse. This whole factual trajectory here is premised on, we had no money. And we had to do all of these things because we had no money. Advocate Crousse spent a lot of time yesterday trying to demonstrate the rationality of the decision that [indistinct] this implementation. MEC Chrissy could determine that in a few lines, not hours of cross-examination. She could show that there was money and that reason could fall flat almost instantly. So, if there is anything important in this case is why. I don't know why. And if the big lie is about money, then that is the big lie and she can conclusively get us there.

The 2nd thing, Advocate Groenwald, I want to know what happened to the 90 million. All the other parties were very poor on numbers and somebody came and said here are the numbers. And I want to know about the cost savings that appear to have been anticipated. So, you need somebody who is numbered, not just a politician.

Somebody who sits at the pot. And what did they do with the money? What happened to that 190 million? Where did they use it? On whom? How? To what effect? And why did it effect to save lives? Your submissions.

ADV. DIRK GROENWALD: Thank you Justice. We have indicated to our colleague for the state that we have no objection to calling the witness.

ARBITRATOR JUSTICE MOSENEKE: But why were your colleagues not given due notice?

ADV. TEBOGO HUTAMO: Justice, I just wanted to apologize on that aspect. The time when I was discussing the matter with my colleagues, she was not present at that time. But I had time to discuss the matter -

ARBITRATOR JUSTICE MOSENEKE: Who is she?

ADV. TEBOGO HUTAMO: I was not able to speak to Counsel on behalf of Section 27. However, I had the opportunity to speak to the instructing attorney from Section 27. I took it that the instructing attorney will pass the message to Counsel as she was not present at that time. And I just want to apologize that it is the point which I actually wanted to raise. It was not intentional that I excluded her from my engagements as I did with other colleagues.

ARBITRATOR JUSTICE MOSENEKE: We all know those who have lived long. It always help to ease out things, to give notice and to, if you want your wife to go to the movie with you, you tell her some time early. You don't walk in and say we are going to the movie. When? Now. You are in big trouble. So, it always helps to ease out things.

ADV. TEBOGO HUTAMO: It is for this reason that I just want to apologize for not having had the time to speak to her. But I made effort that the instructing attorney is given notice of what we intended to present before you Justice.

ARBITRATOR JUSTICE MOSENEKE: Very well, I will go back to your colleague. But she has heard you apologize, is there anything else that you want to say on the substance?

ADV. TEBOGO HUTAMO: We stand by the submissions that we have made that it is quite necessary given the issues involved. We have had a lot of testimony relating to financial constraints. So, those are the matters that really need to be cleared and what we want to emphasize is that the current MEC for finance. Ms. Barbara Chrissy, was holding the same position at the relevant period subject to these proceedings. So, in those circumstances, she will be the appropriate person to deal with matters which related to the tragedy. There is nothing further that -

ARBITRATOR JUSTICE MOSENEKE: The current MEC is a doctor? I will say nothing more, I don't know her skills about numbers. I will leave it there. Thank you. Advocate Crousse, I will come back to you because you are probably the most vehement position on the matter. I have expressed my prima farce right upfront. Counsel of the state probably did what they did taking a queue from me because I kept on saying that the MEC must come and explain this. And I think it is quite vital. That was a prima farce view and I think it is now fairly well-formed now. I still don't know why most of the patients here lost their lives given the connection between the deaths and the resources. There is probably the single most important cause of the

devastation on lives of the survivors, on lives of those who lost their lives, and I want somebody to tell me about the money thing.

ADV. LILLA CROUSE: Justice if I may and I know it is very brave to go against the prima farce view of the judge but unfortunately, I have to do what I have to do in these circumstances. I have just quickly looked at the MEC finance, she is also not a finance person. So, she is no better position to advise on finances as the MEC for health.

ARBITRATOR JUSTICE MOSENEKE: That is a very bold statement. It is more bolder than the 1st one you proposed.

ADV. LILLA CROUSE: Justice, we just have her education degree, we looked at it very quickly and it is not the finances.

ARBITRATOR JUSTICE MOSENEKE: People learn very quickly when they are in positions and they qualify themselves. I wouldn't lightly say that about a public official holding a position. I think we need to be a little careful there.

ADV. LILLA CROUSE: Justice, it might be so that she has learned but is she really an expert only on finances or is she going to say well the CFO said this to me and Price Water house Coopers have prepared these papers.

ARBITRATOR JUSTICE MOSENEKE: But we don't know and she is not called as an expert. She is head of finances. So, she has statutory obligations and she should be able to speak to those. And she writes up the budget with her staff. She delivers it, she speaks to it and she should know how the numbers stake up in the budget and above and more importantly here, how the money was used. So -

ADV. LILLA CROUSE: Justice, in terms of money, the money flows from the department of health as I understand it, to the MEC of health. So, the MEC of health gets the money from the national department. So, she is the person that we say should come and account here and we already have the statement of Chrissy. So, I really don't see why we should increase these witnesses just to come and say what she has already told the nation and we accept that.

ARBITRATOR JUSTICE MOSENEKE: No, I need to hear much more than the one-liner that they didn't cut costs around healthcare. I want to know what was the budget at the time. I want to know what was allocated for mental healthcare, I want to know whether it is true, whether they could afford Life Esidimeni or not. I want to know what was the pressure of trying to save the money at that point. Did we make the decision on those totally rationale and totally reckless if in fact it wasn't so? So, I need that evidence so that I understand. And nobody has spoken to those numbers up to now.

ADV. LILLA CROUSE: Justice, but our understanding is that the MEC for health should do that, not the MEC for finance.

ARBITRATOR JUSTICE MOSENEKE: If I take your stance and down that road, she is not even the accounting officer. The HOD is the accounting officer.

ADV. LILLA CROUSE: The Chief Financial Officer.

ARBITRATOR JUSTICE MOSENEKE: She is not the Accounting Officer of the Department. So, on the fine numbers, on the line items, you go and talk to the HOD.

So, I still think the globular understanding of the claimed financial pressure will be dissipated or will be confirmed by the MEC for finance.

ADV. LILLA CROUSE: Justice, it's not for us to tell another party how to receipt with its case. The only issue the we take with this, we don't think this witness is really necessary to put those things on the table and we can do no more than saying it is a waste of resources. And that is the high watermark.

ARBITRATOR JUSTICE MOSENEKE: You are entirely within your argument entirely. If a party has chosen to call a witness in arbitration and that view coincides with the view of the arbitrator that it is a necessary witness, I think you will have a hard swim, you will swim against the current. You are entitled to swim against the current.

ADV. LILLA CROUSE: Yes, Justice. That is my job.

ARBITRATOR JUSTICE MOSENEKE: Absolutely. Do you still want to speak? I see you are raising your – yes, Advocate Hassim. And just before we go to that, the question of time, I think the state Counsel has been clear to say we will be done in the 2 days already reserved. South Africa, I don't see an undue extension of this proceeding. It is kept, and it is defined in that time.

ADV. LILLA CROUSE: Justice, I don't believe that my learned friend is right and that it is going to be accommodated in that time. I was already concerned that we wont finish those witnesses that are before the arbitration at that time. But nobody has crystal ball. But, our prima farce will be -

ARBITRATOR JUSTICE MOSENEKE: Then we stay longer, put more hours to finish. But we are going to finish in the 2 days. Counsel.

ADV. ADILA HASSIM: Justice, I would like to respond to my colleague 1st and say I accept the apology and I don't wish to make a bigger issue out of that at all. I also want to make it clear that we have no objection to MEC Chrissy appearing before the proceedings. We don't have issue with the qualifications to speak on the issues that we would like to hear on. So, we have no objection to MEC Chrissy appearing in order to give us that information. My concern was perhaps mundane one but important to us and that is to stick to the timeframes and if we are able to do that we will be quite happy and a discussion on how to manage time can take place outside of this morning's proceedings with an adjournment with my colleagues.

ARBITRATOR JUSTICE MOSENEKE: Thank you for accepting the apology and your position is understood. I think having heard all the parties and debated the matter, we certainly will have MEC Barbara Chrissy coming on Tuesday next week isn't it? And we are going to start with her in the morning, aren't we?

ADV. TEBOGO HUTAMO: That is correct Justice.

ARBITRATOR JUSTICE MOSENEKE: [indistinct] do so. And the issues are Advocate Ngutshana is quite right, the issues are crisp, they are narrow, they are defined. We are not doing an audit of the province. They are very specific issues we would like to understand in the light of this open-ended claim about money having been the true driver of this inhuman conduct.

ADV. TEBOGO HUTAMO: Thank you Justice and thanks to the colleagues who have acceded to the request as this will assist this process. Thank you.

ARBITRATOR JUSTICE MOSENEKE: Thank you.

ADV. LILLA CROUSE: Justice if I just may interrupt, could you please make a ruling as to when supporting documents will reach us before our cross-examination on Tuesday of this witness.

ARBITRATOR JUSTICE MOSENEKE: Yes, I think that is fair and that would be by Monday. Not later than Monday at 9am. In other words, if the MEC intends to use its Friday today, any documents to use and hand should be made available to you and to the parties not later than 9am on Monday. If earlier all the better and parties can work through them over the weekend. So, if there are any documents she is going top hand in, they must be made available and that will give the parties at least 24 hours in which to look at the documents.

ADV. TEBOGO HUTAMO: Yes, we will do so Justice.

ARBITRATOR JUSTICE MOSENEKE: You will do so. Is that in order?

ADV. ADILA HASSIM: I am indebted to you Justice, thank you.

ARBITRATOR JUSTICE MOSENEKE: Very well. Counsel, is that good?

ADV. LILLA CROUSE: Thank you Justice.

ARBITRATOR JUSTICE MOSENEKE: Advocate Ngutshana, will that work?

ADV. PATRICK NGUTSHANA: It will work Justice.

ARBITRATOR JUSTICE MOSENEKE: So, we have consensus. Very well, we should come back to the business of the day.

ADV. NONHLANHLA YINA: Good morning Justice. Justice, today we have got Professor Grobler.

ARBITRATOR JUSTICE MOSENEKE: It is you and Ms. Stein, I almost thought that you had lost your voices. But, it is very good to hear you say something, I hope she will say something before we adjourn. It is very important to keep one's vocal chords going otherwise they fade like mine over many years of speaking. Yes, Advocate Yina.

ADV. NONHLANHLA YINA: I would like to request that an oath be administered.

ARBITRATOR JUSTICE MOSENEKE: Yes, Professor Grobler, we do apologize. Lawyers do go backwards and forwards as you have heard. We get paid to do exactly that. But thank you for being here. In which language do you want to testify?

PROFESSOR GROBLER: In English Justice.

ARBITRATOR JUSTICE MOSENEKE: In English,

PROFESSOR GROBLER: Would you swear that the evidence you are about to give will be the truth and if so please raise your right hand and say so help me God.

ARBITRATOR JUSTICE MOSENEKE: Very well. Advocate Yina.

ADV. NONHLANHLA YINA: Good morning Professor Grobler.

PROFESSOR GROBLER: Good morning Advocate Yina.

ADV. NONHLANHLA YINA: I will be leading your evidence in chief. Before we start, I would like to request you to please state your qualifications for the record.

PROFESSOR GROBLER: I obtained a degree, a Bachelor's in Medicine and Surgery in 1989, a diploma Occupation Health 1993, I also became a fellow at the college of Psychiatrists in South Africa and obtained the qualification FCPsych in 1997. I did my Master in Medicine in psychiatry in 1997 and I became a doctor in Medicine and Psychiatry in 2013.

ADV. NONHLANHLA YINA: And would you also please state your work experience briefly?

PROFESSOR GROBLER: I have been a psychiatrist now for 20 years Justice. The 1st 6 or 7 years was in private practice and then I went back to public service. I have also worked in Ireland for a year or two and for the past 5 years, 6 years I have been working as the head clinical unit at Elizabeth Donkin hospital in Port Elizabeth. 18 months of those 6 years, I was actually acting CEO of the hospital and for the past 4 years I have been member of the South African Medical Association Human Right Law Ethics Committee.

ADV. NONHLANHLA YINA: Thank you Justice.

ARBITRATOR JUSTICE MOSENEKE: Is there any Counsel who contests the specialist and expert position of Professor Grobler? You accept his expertise and that he is testifying as an expert?

ADV. LILLA CROUSE: Justice, we have perused the qualifications of the expert and we have no objection of his expertise.

ARBITRATOR JUSTICE MOSENEKE: Advocate Groenwald.

ADV. DIRK GROENWALD: We do not dispute that this is an expert witness.

ADV. TEBOGO HUTAMO: Justice, we accept his expertise.

ARBITRATOR JUSTICE MOSENEKE: Very well. Let's then get to the substance of the evidence.

ADV. NONHLANHLA YINA: Thank you Justice. Justice, just before we start I would like to indicate that the report has been handed in as ELLA136 and he also prepared a short affidavit about his qualifications and experience which is marked ELLA 137 and the CV is ELLA138.

ARBITRATOR JUSTICE MOSENEKE: Thank you, these are before me.

ADV. NONHLANHLA YINA: Thank you, I will then proceed to take Professor Grobler through the report which is ELLA136. Professor, I would like us to start from page 3 please.

PROFESSOR GROBLER: I am on page 2.

ADV. NONHLANHLA YINA: Yes, if you could briefly explain to us what you mean when you – if you could briefly give us an explanation of ethical principles in the health profession.

PROFESSOR GROBLER: Justice, if it would please you, I am going to read and going to explain as time goes on. Ethics deals with questions of right or wrong, good or bad and our moral obligation towards others as well as ourselves. The importance of ethics cannot be understated as we make ethical judgments and

decisions every day. These decisions we as individuals or collectively as groups make affect the people and the world around us and for this reason it is important to examine the ethics involved in making such decisions including our own ethics. Why ethics is important in this situation is that there was a lot of mental health professional that were involved in decisions that adversely eventually affected the lives of patients. And all of them are held to certain ethical rules by the nature of the profession that they adhere to. So, ethics ethically I need to understand or try to understand how they reasoned or failed to reason, to come to the decision that they came to as mental health professional and medical professional in this situation.

ADV. NONHLANHLA YINA: Yes, on page 3 you have given examples of ethical principles. Can you just take us through those examples?

PROFESSOR GROBLER: There are 4 ethical principles that are generally viewed as the 4 cornerstones of biomedical ethics. So, when we talk but ethics in medicine, we refer to it as biomedical ethics and these 4 are: autonomy, beneficence, non-maleficence and justice. So, autonomy mean that every person has the right to be in charge of his or her own life and make his or her own decisions. And in other words, the ability of a person to act on his own free will. And you cannot think or reason about autonomy without thinking about informed consent. Informed consent means that you have to explain yourself to the patient. Now doctors have a specific obligation to explain decisions and give patients information about decisions and about their disease. So, when we talk about autonomy in terms of people suffering from mental illness, we have to consider whether they have the capacity to understand the decisions that are being taken. And when I approach this report,

after reading the Ombuds report, I tried to see where in this whole process was the service user, was the patient actually also consulted and I don't know if I missed it but I didn't see where they were consulted. I saw later on that the family started advocating on their behalfs and that is when things started getting hot and also from SASAP And SADAG and Section 27 side. So, when it comes to autonomy, I am wondering why the patients were not ever asked what their opinion was on this intended move because they are surely the people who were going to move. Now again, I have to give some context. So, if my understanding is correct, I read one of the papers by Capri about half of the patients were people with intellectual disability, living with intellectual disability. So, that is a condition where one would assume that the ability to give consent will be fairly static. It wont change over time necessarily. And depending on the level of intellectual disability, there would be a decrease in their ability to give consent. I have to assume the other half suffered from enduring mental illness, illnesses like schizophrenia. Like severe bipolar, modus order, dementia, other mental illnesses. And for patients with illnesses like schizophrenia and bi-polar modus order, their ability to consent may vary overtime. So, you cannot actually use only one point of reference to say this will be the point of reference where I say this person has the ability to consent or not. So, you must have intention. Firstly, you must approach the person with respect, you must respect. You must not accept that this person does not have the capacity to consent. You must go from the premise as a medical doctor that this person possibly will have the capacity to consent and then you will have to make sure that the person understands the concept that which he or she is being confronted. And then there

shouldn't be any manipulation or cohesion involved in this process. So, for these patients, it wouldn't make any sense for me that they should have been approached and asked. Some of them at least and said we intend to relocate you, this is where you are living now and let us go and show you where you are going to live and would you make an informed decision? Can you decide which one of these two would you prefer to live for the life of me I can't think that they could not at least some that could have actually expressed a view on this prior to all of this happen. And I want to give an example of the fact that people even if you have severe enduring mental illness, you don't have the capacity to make certain decisions but you might have the capacity to make other decisions. So, let's say you don't have the capacity to look after yourself in the community by living independent and going out, buying groceries, having a budget, taking care of your personal hygiene. You might not have that capacity but when living in an institution, you might have the capacity to make certain decisions for yourself. If a person I confronted with a choice of would you like an orange or an apple for a snack. The person could make a choice, they have a preference. And I ma sure the family members know that their families had preferences for certain things. So, the person might say then may I would like to have the apple please. But then informed decision comes from the mental healthcare providers side and I don't want to dismiss as simple as that. But, let's say that the apple is rotten, and the apples are old, and oranges are new and fresh. You then inform the person the apple is rotten if you eat it, you will get some nutrients, but you might get an upset tummy, do you still want the apple or would you prefer the orange? And the person will change their mind and say no, in that

case I think I will prefer the orange. So, there are certain decision that a person can take autonomously.

ARBITRATOR JUSTICE MOSENEKE: Are doctors entitled to assume without law whether in the case of intellectual disability or severe enduring mental disorder that the patient is incapable of making a choice or a selection or an informed decision?

PROFESSOR GROBLER: The doctor can never make just make that even the [indistinct] doctor can never make that assumption. Even in my own practice I can name numerous examples of being approached by family members, in one case it was family members that were in hospital and they wanted curatorship for both. And I couldn't assume that either of them had or hadn't and in the end, I had to go in that point in time and do a capacity assessment and make sure that they understand the facts involved. So, from my point of view and in my opinion a doctor can never just assume that a person does not never have capacity. If they need to always have respect for the person's autonomy.

ARBITRATOR JUSTICE MOSENEKE: And Professor Grobler, is there any relationship between the capacity to pay for the services if the doctor and the requirement of autonomy? The fact that the patients here were state patients and did not themselves not the families pay, does that affect reduce or [indistinct] the entitlement to autonomy?

PROFESSOR GROBLER: No Justice, not in my view. I think it is actually 2 different things. So, the fact that they are but paying, I don't think is part of the ethical reasoning when it comes to the person's ability to consent. What can maybe

be construed as part is the fact that they are admitted under the Mental Healthcare Act. And even then, when they are admitted under the Mental Healthcare Act and again, I am going to make an assumption the all of these patients, if they were at Life Esidimeni, there is a statutory route that is followed and there is a high court document that states that they can stay in that facility. Even then, the doctor cannot assume that this person does not have capacity. Sometimes, there are research projects and there is in my affidavit, I refer to an article by Professor Kriar (sp) at the University of Pretoria where he looked at consent for patients with went under the Mental Healthcare Act and their ability to give consent when taking part in research. So, even a person admitted under the Mental Healthcare Act that cannot function independently outside of this institution can in the institution can give an informed consent on whether they would want to participate in research or not. So, I cont think that yah, no.

ADV. NONHLANHLA YINA: Thank you Professor, if you can then take us to the next one which is beneficence.

PROFESSOR GROBLER: The difference between beneficence and non-maleficence is the fact that beneficence is an action and non-maleficence in inaction. So, beneficence is an action that is done for the benefit of others and beneficence actions can be taken to help prevent or remove harm or simply improve the situation of others, Healthcare practitioners are expected to refrain from causing harm, but they also have an obligation to help their patients. All efforts should be made to maximize the possible benefits but keeping the risk at a minimum. The principle of beneficence also bestows upon us the moral obligation to determine

whether any actions would have truly beneficial consequences for our actions. It does not simply imply that our good intentions are sufficient justification to action. Rather that we have a duty to gather sufficient information expertise regarding the possible ramifications our decisions could have on our patients and also that of the future. And again, I hope I am not giving too much context Justice. I have a tendency to do that. So,

ARBITRATOR JUSTICE MOSENEKE: No you are doing fine, we are learning as you speak.

PROFESSOR GROBLER: So, just going back to autonomy. So, a paternalistic approach will be that father knows best if I and put it that way. So, there is the assumption that is made that the father in as head of a household and again, there is an old assumption and I do not want to offend anybody by approaching it in a certain way but that the father knows what is best for the children and the father does not need to consult the children before taking decisions that has an effect of their lives. So, we can also when it comes to beneficence, not just paternalistically assume we know what is best for a person. A person, we still have to go through a logical moral reasoning to come to that point where we say okay, this action will be beneficial to my patient.

And then non-maleficence means do no harm. So, that means no action. So, just by doing nothing sometimes we prevent harm from happening. So, the pertinent ethical issue is whether the benefits outweigh the burdens. First, do no harm is one of the core principles of medical ethics. In every situation, healthcare providers should avoid causing harm to their patients. They should be aware of the principle of

double effect. Where a treatment intended for good unintentionally causes harm. As the case with beneficence, he too has an obligation to determine as far as possible the likely implications of our actions and consequently the risk of possible harm to our patients. And then lastly Justice, it can be divided into 3 categories. Distribution of scarce resources or distributed Justice, respect for people's rights, rights-based Justice and respect for morally acceptable laws, legal Justice. And later on I will explain more about how these were transgressed according to my interpretation of the Ombuds report.

ADV. NONHLANHLA YINA: Yes, thank you Professor. Just before you go there, on page 5, you have highlighted certain guidelines and the books. Can you please explain those? Not necessarily in detail, what are they?

PROFESSOR GROBLER: The majority of people who work in the healthcare professions in South Africa are registered with a professional body and with the exception of nursing who has their own council and pharmacy have their own council. Virtually aligned the allied health professional are registered with the health professions council of South Africa. So, each of these 3 bodies that I referred to and in particular the health professions council then in this case have ethical guidelines for their professions. So, we all by virtue of the fact the you become a certain – take on a cert profession, you have a moral obligation to extend your ethical duties and it has to fit in with the ethics of your profession. And these guidelines are not only for doctors even though they refer mostly to doctors. They are for all, everybody that is [indistinct]with the health professions council should be adhering to these ethical principles.

ADV. NONHLANHLA YINA: Thank you, then we can now move to page 17 where you have applied the principles that you have explained to us before this tribunal.

PROFESSOR GROBLER: Justice through you, may I refer to og 6 please. I would like to just take us through ethical reasoning. Yesterday I was listening to Advocate Crousse trying to follow a logical legal process and I thought to myself that ethically there is a similar process that is followed. It should be logical and it should make everything as clear and concise. So, in one of the booklets, clear guidance is given as to how to resolve ethical dilemmas and suggesting ethical reasoning is needed which precedes in 4 steps. First, you formulate the problem. Determine whether the issue at hand is an ethical one. Once this has been done, it must be decided whether there is a better way of understanding it. Secondly, gather information. All the relevant information must be collected such as clinical, personal and social data. Consult authoritative sources such as these guidelines, practitioner associations, respect colleagues and see our practitioners generally deal with such matters. Three, consider your options, consider alternative solutions in light of the principles and values that they uphold. And four, making a moral assessment. The ethical content of each option should be weighed by asking the following questions, what are the likely consequences of each option, what are the most important values, duties and rights, what are the weaknesses, how would the healthcare profession himself or herself want to be treated in a similar circumstances and how does the healthcare practitioner think that the patient would want to be treated in a particular circumstances?

So, here I would like to come to and refer to the managers involved. The managers that are appointed as director generals and headers of the clinical directors. They are also registered, they are still registered as the health professionals council or with a professions council and what I am trying to understand in this process is there were ample ruling beforehand. So, a decision was taken and then a process followed. During this process at some level, the person taking some of the decisions was not a medical professional. So, in between this person and the patients were a whole range of medical professionals. So, things started happening, letters were written, there were meeting. Letters were written by patient advocacy groups like SADAG, expert groups like SASSOP, court actions were implemented. So, ethical reasoning should tell me that the health profession involved should then say wait, stop, what are we missing, how should we think about this, let's follow a moral ethical reason, what is the problem here, let us gather information. A, people came and volunteered information to us. Let's consult some more. What are the possible consequences of this and then take this information to the next level of authority.

ARBITRATOR JUSTICE MOSENEKE: What is the duty of the healthcare giver? To impose ethical reasoning on himself/herself before conduct? Could you say I was assured or my juniors said for example Dr. Silibano, the HOD said oh my juniors told me it was all fine. Now the inevitable question is, is there a duty to resort to ethical thinking before acting, before providing healthcare or making decisions about patients and so on.

PROFESSOR GROBLER: It sounds like there is 2 questions there, Justice. The one is before instituting healthcare; the answer is yes. And whilst instituting

healthcare and the answer is still yes. So, even after the fact, let's say a certain action has started to take place and you get new information. Immediately, you can change the course of action. Again, if I can use myself as an example. I am a consultant in a psychiatric hospital, I have a multi-disciplinary team around me. Every day we have to take clinical decisions and as psychiatrists it is sometimes very difficult to distinguish what is clinical and sometimes what is ethical or there is a lot of ethical decisions that goes with a clinical decisions like should I send a patient back home because this patient has a history of aggression so we have to consider risk to the patients' family. So, I would say on week 1, I would listen to everybody and everybody will give their opinion. So, everybody meaning the doctor looking after the patient, the psychologists, the social worker, the occupational therapists and the psychiatric nurses. And I would say this is the plan that we are going to take with this patient. Then next week the social worker comes back. So, let us say for example in this situation, I was not aware of the gravity of the danger the patient holds towards other members of the family and the next week the social worker comes in and gives me this information. I have to follow my ethical reasoning and say okay, have we done everything we can? Let us reconsider this decision, do we need more time to make sure that the risk is as minimal as possible before we send this patient out.

ARBITRATOR JUSTICE MOSENEKE: You see Professor Grobler, we were confronted with evidence coming from healthcare users. The decision had already been made. The horse has bolted. So, I can't revise my approach to the healthcare that the user is entitled to or is going to receive. What was the ethical obligations

there? One, was there duty to assess constantly? Two, was there duty to prevent thereafter? Look, a decision was made to move mental healthcare users from one side of treatment to another place of care. And it turned out that the new side has a number of limitations. What ethical issues would arise, what would be the obligation of the healthcare giver?

PROFESSOR GROBLER: When you say healthcare giver, are you referring to the person looking after the patient in the hospital or the person involved in the decision-making?

ARBITRATOR JUSTICE MOSENEKE: Decision-making. The person is either a doctor or other form of healthcare giver.

PROFESSOR GROBLER: Okay. Justice, I really cannot understand why a decision cannot be turned around. If you have new information you should be able to say stop. I mean, here you have a situation where patients are taken care of. They are admitted under the Mental Healthcare Act. There is a multi-professional team looking after them. We know that here they are going to stay in. We don't even know if an equal of them have space that this between here and here this is my understanding that these managers were saying and I don't mean that I am going to state this in a disrespectful way. But, a manager should be saying if a senior manager ask how is things going, they say no, we are going to move them, you said we are going to move them, have you got enough beds here. Maybe, maybe not, we think we have. And have they all been accredited? I am not sure, maybe they are. Make sure it happens. And in this process, so, they are still living here. They are going to live here. External bodies, the families comes and starts worrying about

where this is going. The professional bodies start and SADAG starts and they start giving information. And now my opinion is that this manager has an ethical conflict. Should I listen to my employer or should I listen to my ethical conscience because my ethical conscience here, the evidence should be overwhelming, we should change the course of action. Yes, the decision has been taken and no, they have not been moved out. And it is a simple word that should have been made, stop. Let us just stop what we are doing and say everybody calm down and take this to the higher levels and say listen, something is wrong with this picture. Where they are now and where they are there. Again, in terms of context, when we think as mental healthcare practitioners healthcare is administered, taking a patient from here to here is not merely a matter of a bed and a roof and food to eat and possibly medication. There is so much more involved in this. There is frequent follow-up, there is the input of occupational therapy or occupational therapy assistants, there is psychiatric nursing that has to take place, monitoring of medication, monitoring of side effects, there is follow-up that needs to take place at community mental health clinics or community clinics where the medication can be issued and every time you issue the medication, you should be looking at symptoms of relapse, you shkld be looking for side effects if the medication. So, we are not looking only at a roof over their head. We are looking at whole big picture and this is what SASSOP was trying to say if you read carefully in their documents. This is what they were trying to say, to say that this picture is not here, you should stop. And in spite of that, the logical thing did not happen.

Again, can I use an example of my own experience. There is a wonderful article recently published by [indistinct 0:58:16], I okay we are going to come back to that but we can cover it now. The case of the Eastern Cape. And in that he refers to the mental healthcare policy framework and he also refers to a model calls outreach which he thinks it can be incorporated. And basically, he says that there is no one size fits all for South Africa and I am very well aware of that. So, I work in the Eastern Cape, the area I cover is Nelson Mandela Metropole, Cacadu in parts and Sarah Bartman. I am, as of the Ms. Mahlangu I am the only psychiatrist left in that area, the public service psychiatrist left. I hope to get some help in the near future. So, 2 or 3 years ago I could, since I have been there I have started doing outreach. So, outreach means I take myself and a team of doctors or sometimes just myself, I go to [indistinct 0:59:12] hospital Somerset East Hospital and I drive there in the morning, I dee a number of patients and I drive back in the evening. So, I see patients that we see sometimes, most of them we never see. Then I have sisters, I have a sister Brenda in [indistinct 0:59:30], I don't know where [indistinct] is and I don't know what Sister Brenda look like. But, myself and sister Brenda have ha frequent telephonic contact and by virtue of that, we have been able to keep patients out of hospital. [indistinct 0:59:43] is something like 250 kilometres from [indistinct]. If a patient becomes ill in [indistinct], the patient cannot go to Willowmore hospital because Willowmore is not a listed facility. This patient has to go to [indistinct] Midlands hospital. And thy have to be taken there by the police. From [indistinct], they have to be admitted for 72 hours and then they are transferred to our institution for admission. Nonce they are better they go back to[indistinct]. But

[indistinct] has the only psychiatric support that they have at the moment is my outreach which because of the shortage of doctors I used to do every month, I can now do every 3 months. I go there and that is their support and that is the outreach model. And that was what Dr. [indistinct] was suggesting for the Eastern Cape. So, if you look at the national metropole policy framework strategic plan, the logic and the research behind there, there is nothing wrong, it is a good plan, it will have to be differently implemented. So, I started all of this by saying as mental healthcare professionals, we don't only look at is there a roof over your head and a bed to sleep in. We look at so much more around this person and also the principles involved in the mental healthcare policy framework.

ARBITRATOR JUSTICE MOSENEKE: And throughout that process particularly, there are changes in the site and the manner of how delivery of healthcare, you say ethical reasoning has to begin?

PROFESSOR GROBLER: Yes Justice, that is exactly what I am saying.

ADV. NONHLANHLA YINA: Thank you Justice, if you may then move to page number Professor, we will come back to page 15 where you dealt with the framework policy. Let's start with the application of the -

PROFESSOR GROBLER: So, can I read again Justice. With the aforementioned in mind and considering the rights of the patients involved that is point of departure. The information available to me would indicate that the healthcare providers referred to in the documents through their decisions, actions and omissions may have failed to adhere to the following ethical principles during the time leading up to

and in the aftermath of the Life Esidimeni disaster. The guidance as to how to resolve ethical dilemmas through ethical reasoning as we have just discussed do not appear to have taken place at any stage. And we have already said that it is unimaginable that neither court actions nor the warnings by the experts, nor the concerned voices within the department of health led to some form of introspection on the side of the healthcare practitioners involved in these decisions and review of decisions. And the Ombuds report makes reference to staff members reporting stress and junior officials being put under pressure to do as directed because they did not agree with the decisions. So, in terms of autonomy, a paternalistic approach seemingly assuming that patients were not able to give informed consent and hence not informed of decisions or choices being made that were going to impact on their lives. Either the patients nor their next of kin appear to have been provided with the opportunity to make informed choices or decisions.

ARBITRATOR JUSTICE MOSENEKE: Well, in this case they in essence the response of the managers including managers who are registered healthcare users -

PROFESSOR GROBLER: Healthcare practitioners.

ARBITRATOR JUSTICE MOSENEKE: Yes, healthcare practitioners rather

PROFESSOR GROBLER: They might be users now.

ARBITRATOR JUSTICE MOSENEKE: Yes.

PROFESSOR GROBLER: Sorry Justice, my apologies.

ADV. NONHLANHLA YINA: Was that they had no option, they ha run out of money and they had to change the place and the manner of delivering healthcare.

PROFESSOR GROBLER: So, the ethical reasoning would expect you to reason around the issue of distributive Justice. And again, my logic will tell me, okay, here you have 2 managers that starts to realize that something is wrong with the picture. So, my logic tells me they should go to their superior and say this is not going to work, we don't have money, we can't keep them in there and the understanding is that we need to save money. We have to look elsewhere, we cannot look here because this place, we should be saving money. And then what came afterwards, I mean, the sums don't add up R117 versus R300 versus R1700. That does not make sense. Nothing there was logical to me reading from the findings.

ARBITRATOR JUSTICE MOSENEKE: Assuming that there is substance in the claim that there is no money, how do you deal with the autonomy requirements?

PROFESSOR GROBLER: Again, then the issue is distributive Justice and in my opinion then, they should look elsewhere for saving money. If the choice you have to make is patients are living here, we think that we will save money by moving them there. You haven't done it yet but we think that we might be saving money. So, we don't have enough money to pay for this, we have enough money to pay for this. Ethical reasoning tells us then to consider what the possible consequences should be and the possible consequences considering what we already know about this place is that there will be deaths. I think at that stage it could have been foreseen, it was words like disaster was used if I remember correctly. And then that trumps the money. And then the government has an obligation to say okay, then we

need to move funds to make sure that these patients are looked after. And again, I am not an administrator and I am not a politician. But, that is for me the logical decision to say okay, let's go and look elsewhere to save money.

ARBITRATOR JUSTICE MOSENEKE: Thank you, you may proceed.

ADV. NONHLANHLA YINA: Yes, prof, to the next one. Beneficence.

PROFESSOR GROBLER: Beneficence. The actions and decisions that not consider the best interests of the patients and harm was neither prevented nor was the situation of the patients improved. There was a clear failure to consider whether the proposed actions could have been truly beneficial for the users involved despite clear communication by experts in the field of mental health which indicated that only where the proposed action is not beneficial but they carried a high risk of harm to the users concerned. Non-malefence, expert advice was apparently ignored and a course of action instituted that put patients at serious risk resulting in death for some. So, non-malefence in this stage would have been to say stop, let us just not continue with this because the experts are telling us disaster is coming.

ADV. NONHLANHLA YINA: Even officials within the department.

PROFESSOR GROBLER: Even officials within the department if my understanding is correct, yes.

ARBITRATOR JUSTICE MOSENEKE: And while you are there about officials in the department, where do we draw the line between clinical decisions and ethical decisions? See, Dr. Silibano thought to persuade us that he was no longer a

clinician and therefore his decisions ought not to be but an executive, an administrator. And his decisions not to be tested against any ethical code.

PROFESSOR GROBLER: If he is not registered as a medical practitioner anymore, there might be a way for him to argue that point. If he is still registered, you cannot argue that ways. So, clinical decisions and ethical decisions, you cannot see them apart. They always going to have an influence on each other. Let us take it one step further. Let's look at your institutional duties. So, your institutional duties might sometimes be in opposition to your ethical duties. If you do not follow ethical reasoning, that means you have to get into contact with your superior to say I am not going to do A or B because of my ethical duties to my patient. And the clinician is then in a difficult position because the employer might say, well then you are no longer employed by us. But if the employer – if he listens to the employer and somebody else, the family member takes this person to the HPCSA, ethics even trumps the law. So, you can be found not guilty in a court of law but by your own medical profession if you have broken the ethical rules, you can still be found guilty and held accountable for that. So, coming back to that remark, the only way he can get away from his ethical responsibilities is if he was not registered as a practitioner anymore. If he still was, he has no choice.

ADV. NONHLANHLA YINA: Thank you Prof, you also said that patients were failed in terms of Justice and can you explain that?

PROFESSOR GROBLER: In terms of distributive Justice, scarce resources were not given due consideration and arguments for financial savings does not appear to have any grounds. Arguments towards financial benefits to relocating the users

were short-sighted failing to take into account long-term costs involved in carrying for such users in the absence of adequate community resources. Rights-based Justice, the basic human rights of the patients and the next of kin as enshrined in the constitution of South Africa were not respected and legal Justice. There are a number of references in the Ombuds report alluding to violations of the constitution and contraventions of the National Health Act and the Mental healthcare Act.

ADV. NONHLANHLA YINA: And also, in light of the fact that there is evidence before this tribunal to the fact that the department did not ensure that service level agreements were signed before patients were relocated. As such, no money was to the NGOs on time. Some NGOs had to wait for 3 months to get paid by the department.

PROFESSOR GROBLER: I read that, I saw that in the report, yes, advocate. Can we go on then?

ADV. NONHLANHLA YINA: Yes, please.

PROFESSOR GROBLER: And then I know this has been mentioned a number of times and I values to mention this again. The report of the Ombud refers to a number of human rights violations including the right to human dignity, the right to life, the right to freedom and security, the right to privacy, the right to protection from an environment that is not harmful to their health or well-being, the right to quality healthcare services, sufficient food and water and right to an administrative action that is lawful, reasonable and procedurally fair. Justice, I have to stop here and say something about our mental healthcare users in the field of mental health.

ARBITRATOR JUSTICE MOSENEKE: It is not bad for a doctor, you sounded like a lawyer for a moment.

PROFESSOR GROBLER: I will take that as a compliment Justice. I think I remember going to my 1st psychiatric conference in 1998 as a psychiatrist and expressing an opinion to a colleague of mine saying that there is still stigma involved in mental illness and we should endeavour for the rest of our professional lives to destigmatize mental illness. And unfortunately, this whole disaster, I think at some level has to do with the stigmatization of the mentally ill and the dehumanizing of the mentally ill. And the fact that anybody could have thought that these actions were not right, at some point did not question whether they were right, did not foresee what is going to happen to these patients. I think it is testimony to a society that sees people with mental illness as lesser when in fact we should be taking extra care of the most vulnerable of our society I hope this arbitration process puts that in the spotlight that we really should advocate, it is everybody's responsibility to advocate on behalf of the mentally ill and people living with intellectual disability. Thank you Prof, if you could then go to page 20 on the duties and roles that you would have expected from the officials.

ADV. NONHLANHLA YINA: Thank you Prof, if you could then go to page 20 on the duties and roles that you would have expected from the officials.

PROFESSOR GROBLER: A number of observations in the Ombuds report alludes to possible conflicts between the institution duties, legal duties and professional ethical obligations of involved healthcare practitioners. For example, difficult for us as implementers, it was tough and very stressful, a culture and

climate of fear, no one believed or bought into this rushed approach, time was prioritized over the safety users, haste process with large number of users, timeframe was too short and impossible to do such a project, voices of reason and advice not listened to and such followed instructions blindly.

ADV. NONHLANHLA YINA: Well, that was the excuse that was given.

PROFESSOR GROBLER: These were the excuses that I saw and that I quoted from the Ombuds report. The result appears to have been that healthcare practitioners abandoned their ethical responsibilities to the patients due to a culture and climate of fear and blindly follow the instructions. It is not stated what or whom these managers and junior staff were fearful of. And I am just going to highlight one or two or three of the duties of the patients as referred to in booklet One, they did not apply their minds, number 2, they did not apply their minds in terms of considering the appropriate treatment of the patients, 3, they did not respond appropriately to protect patients from risk or harm, 6, the patients were not listened to. In fact, nowhere in the documentation provided could I ascertain that the patients were at any stage consulted. The concerns of the next of kin were not listened o nor respected, 8, the principle of informed consent as an ongoing process was not applied. The healthcare practitioners seemingly by their own admission according to the Ombuds report did not acknowledge their limits of professional knowledge regarding care treatment and rehabilitation of those with severe mental illness.

ADV. NONHLANHLA YINA: Yes, if we could now go to page 23 were you give an opinion about who are record keeping in particular discharge and supersession of the patients.

PROFESSOR GROBLER: Okay. Poor record keeping, I am going to very quickly refer to that. There are numerous references in the Ombuds report regarding to poor record keeping and data management contributing to poor decision making by healthcare professionals involved. Healthcare practitioners' responsibilities regarding keeping of patient records and alteration of records as described above in the reference to booklet 9.

ADV. NONHLANHLA YINA: Yes, in particular that patients were moved without files. They had no medical records when they moved to the NGOs.

PROFESSOR GROBLER: That is something that I still don't understand Justice. In our province we move patients from our institutions sometimes to institution for [indistinct] Tower. Every transfer takes place with a full history and a full documentation with a report from the doctor, a report from the social worker, a report from the occupational therapist, a report from the psychologist. And we have a life healthcare facility called Kirkwood Care centre in Kirkwood. So, a person goes to these facilities, they stay under the Mental Healthcare Act. So, they are admitted to us under the Mental Healthcare Act and they go there under the Mental Healthcare Act. If we send them home we discharge them from the mental healthcare Act, form 3 is filled out if they are discharged. If they go to these institutions like Kirkwood Care Centre, they need a form 16 which is a high court document. Once they are discharged from Kirkwood, they need to fill out an 03 again. I cannot see and understand from this process how they went from life Esidimeni to these NGOs and what the due process was, what happened to the medical information, what happened to their files, were these people given

medication, where were they going to get the medication. The whole process does not make sense to me.

ARBITRATOR JUSTICE MOSENEKE: Professor, what is the impact of numbers here? You know when you normally do transfers, how many people will be involved? How many patients should be involved? It seems to me there is detailed record keeping and work that has to be done in respect of each patient.

PROFESSOR GROBLER: In general Justice, it is not more than 5 or 6 at any given time. I have to say here there is something that I have expressed my dissatisfaction in our province and it has not happened again. But at some point we were given an instruction and the word that was used was decanting. And I really took exception to the word because it is a dehumanizing word that because of the pressures on beds and there is a long history to that and I am not going to draw the Eastern Cape into this but I have expressed my dissatisfaction with this. There is a long history of not listening to the healthcare professionals even they - at least our managers are engaging with us to say that the problem is not creating more hospitals, the problem is not enough facilities in the community. And then when the pressure starts building up in casualties in the area then everybody starts getting upset and we are forced to send patients out to Kirkwood and to Tower and they call the [indistinct] which is another hospital which is in Queenstown and this was on one Friday we had to transfer between 20 and 30 patients. And then, but then we still followed the process, we had to write reports the whole day, we had to send the information along. And the process then that followed, we will not do this again, this is dangerous. I think there was an instruction.

ARBITRATOR JUSTICE MOSENEKE: Here Professor Grobler nearly 1700 people displaced within like 3 months, between something like March and May. Large numbers. Let's go back to record keeping, how do you properly, proficiently, keep records, discharge as required by the law and have the paperwork done and then move these people to another institution where repetition of the paperwork more or less has to happen? Dis it possible at all and should the managers have anticipated that there will be a real problem in moving large number =s of people from one institution at the same time, i.e. over 2 to 3 months?

PROFESSOR GROBLER: Justice, I agree with you, it is impossible. I think it is human impossible to move that high number of patients and make sure that everybody has the necessary pre-reports that the professional this side was consulted, that they were told about the conditions of the patients, that they had the necessary medication. I don't think it is possible.

ARBITRATOR JUSTICE MOSENEKE: And did they have any chance to move the records with the patients in an orderly systematic way given those numbers?

PROFESSOR GROBLER: My common-sense Justice tells me it would have been impossible. I cannot imagine it.

ARBITRATOR JUSTICE MOSENEKE: And the officials should have known that surely. Any people exposed to mental healthcare or recording keeping in hospitals or facilities should have known that it would have been near impossible to have the records track the patients.

PROFESSOR GROBLER: I think the records and the process of discharge, I think we cannot forget that there is a statutory process that needs to have been followed. And that again for the life of me I cannot think the director of mental health services would not know that.

ADV. NONHLANHLA YINA: Thank you Justice, in actual fact the evidence that was led by the officials before this tribunal was that the process of discharge was not followed. Some tried to say it was not a discharge but it was a transfer, what is your view on that?

PROFESSOR GROBLER: That does not make sense at any level. That is trying to get away with words. These places are not statutory places in my opinion. If my understanding is correct we can admit somebody under the Mental Healthcare Act. So, for them to go from here under the Mental Healthcare Act to here were they are not anymore, it is a discharge. It is not a transfer. If it was a transfer, this place should have been able to give exactly the same services Life Esidimeni and there should the statutory to say that they can admit people under the Mental Healthcare Act.

ADV. NONHLANHLA YINA: Just the last point on that one, also, it would seem that the patients were not assessed in particular by the treating doctors when they left Life Esidimeni. I see that on page 24 of your report, you made reference to an affidavit by Dr. Talatala, can you just read it out please?

PROFESSOR GROBLER: On page 24 in the affidavit of Dr. Talatala who was at the time the President of the Society of Psychiatrists for South Africa, he states that

a foundational principle and care of people with severe mental illness is that only a psychiatrist who has been treating the mental healthcare user should perform an assessment of that mental healthcare user for the purposes of discharge. There should be no circumstances in which a doctor is called in to discharge another doctor's patient. The reason for this is that while there will not be fundamental healthcare users filed, a doctor other than the one responsible for the mental healthcare user does not have sufficient information or background to be able to conduct an assessment of a mental healthcare user for discharge.

We refer to a case of one doctor assessing and discharging another patient as supersession. The guides a clear on supersession. A practitioner shall not supercede or take over a patient from another practitioner if he or she is aware that such a patient is in active treatment of another practitioner unless he or she takes reasonable steps to inform the other practitioner the he or she has taken over the patient at such patient's request and establishes from the other practitioner what treatment such patient received especially what medication if any was prescribed to such patient and in such case the other practitioner will be obliged to provide required information.

In this case, again, what is seemingly is has happened, there were doctors ivn in this side as well at Life Esidimeni. Here, I cannot see where the doctors were involved.

ADV. NONHLANHLA YINA: In of the meetings, the minutes record that the patients should be discharged from Life Esidimeni to the NGOs and that the doctors from the department will follow them and assess them at the NGOs, is that proper?

It is in one of the minutes of the meeting that was held in the department prior to the removal of patients from Life Esidimeni.

PROFESSOR GROBLER: Again, I did not read that Advocate Nonhlanhla through you Justice. But thee people are working for Life Esidimeni, the doctors that were looking after them at that point. What should be happening, they should have been community health clinics around these NGOs were they could have gone and doctor sometimes might be. I don't even know if there would be doctors. So, they seemingly in my opinion went from place where they had access to doctors at a reasonably short you know if they needed it to a place where if they needed a doctor they had to travel.

ADV. NONHLANHLA YINA: It seems like the department was under pressure, so they didn't have time to make sure that the patients were assessed before they leave Life Esidimeni. And therefore, they decided that the doctors from the department will follow them and assess them at the NGOs, would that have been proper?

PROFESSOR GROBLER: The doctors from the department?

ADV. NONHLANHLA YINA: Yes, not from Life Esidimeni.

PROFESSOR GROBLER: Sorry Justice, which doctors from the department?

ADV. NONHLANHLA YINA: The clinicians within the department.

PROFESSOR GROBLER: Which clinicians, I don't understand because the clinicians involved at Life Esidimeni employees if my understanding is correct. I am

not sure which clinicians took them over except if they went to the psychiatric hospitals and again Justice I apologize, I don't know all of the information, I have been trying to follow.

ARBITRATOR JUSTICE MOSENEKE: Your opinion as an expert is sort on whether it was ethically and clinically proper to have patients discharged from Life Esidimeni under the pretext that they will be assessed by provincial clinicians when they arrived at NGOs. Is that something permissible, may it be done that way?

PROFESSOR GROBLER: Well, if they followed due procedure and they discharged them correctly here that means that the doctors in Life Esidimeni thought that they could be discharged, they sign a form and they could be discharged and now they are not under the mental healthcare act. Now there are no doctors looking after them. So, that doctors that they are referred to, I don't know who that will be. I am sure it is not the managers. So, are they referring to the doctors at the community mental healthcare clinics, are they referring to – I know that Gauteng has got community mental health services, I am referring to that psychiatric clinics. But they will have to travel there and they will have to make contact there.

ARBITRATOR JUSTICE MOSENEKE: Of the tragedy Professor Grobler is that when these patients reached the NGOs, there were no doctors, let alone psychiatric nurses. Initially the places there were cleaners, other categories of workers, but forget about psychiatrist, forget about doctors who are not psychiatrist, there was no clinical staff of any note, certainly were at the places were most deaths occurred. Isn't that a clinical violation?

PROFESSOR GROBLER: It definitely is Justice. I cannot begin to say how wrong this looks from the outside looking at this in the inside. Due procedure was not followed and the department didn't put enough thought into what goes into the discharge or what goes into the process of deinstitutionalization. I know that some of them referred to deinstitutionalization and said but that is what the policy says. It is clear that they don't understand what deinstitutionalization means and what it entails.

ARBITRATOR JUSTICE MOSENEKE: You see that Dr. Lebete, Dr. Silibano, Dr. Manamela, certainly the 2, Manamela and Silibano once asked to accept that they had thought the plan through and therefore, they had no reason to anticipate the deaths. This is what we have told you now that is their plan. Is that a safe proof plan, is that a plan that would have ensured lives are not lost, move them from here Life Esidimeni, let us assume they are discharged by doctors because the evidence is that they ordered Life Esidimeni to discharge the patients. Let us assume for a moment that they were properly discharged. All of those patients were taken to places were no clinicians were available to assess and admit. They say that is their plan and that plan makes then not to be culpable. They couldn't anticipate the harm that resulted.

PROFESSOR GROBLER: Forgive me Justice but can they read?

ARBITRATOR JUSTICE MOSENEKE: Well, they share the title doctor with you I think.

PROFESSOR GROBLER: Justice, they were warned and it is not my place to find them guilty or not guilty. But, I am defending my profession here. The psychiatrists told them. So, on what grounds and in what authority could they say that they have thought this through apart from the ethics just in terms of what does deinstitutionalization mean. So, I can't understand you know how could they think they know more or better than the psychiatrist the sent them this letter. It wasn't only SASSOP, it was heads professional departments, it was SADAG, people who are experts. They didn't listen to them. They have Prof. Malvin Freeman, they have the national department right under their noses, they didn't consult them. They are world renowned experts. So, it does not make sense that they say they thought it through.

ARBITRATOR JUSTICE MOSENEKE: But to top it off, the MEC who was in charge was here yesterday and she says she trusted and believed the plan that these clinicians told her that they had put together, was she entitled to trust a plan like this which has just been described to you?

PROFESSOR GROBLER: Justice, that is a very difficult question to know whether she was entitled to trust the plan. She is not a medical practitioner if my understanding is correct. I think she is an educator. But as an educator at some point and again, coming back to myself also as a manager, I am a clinician, but I am also a manager. If new information comes to you, you need to consider the information and if experts come to you saying that there is going to be a disaster, you need to take a step back and consider the evidence. So, if I was in her shoes, if I was to think this through logically and I have two managers coming to me and

saying we have thought this through, one is a doctor, one has a doctorate in nursing but I am not sure how much psychiatric experience they have and here on this side I have got SADAG, SASSOP, Section 27 court action, I need to weigh the two and I can trust as the person responsible. It still does not make sense that she goes through with this plan blindingly trusting the 2 people below you.

ADV. NONHLANHLA YINA: Thank you Justice, just the last point Prof. On page 24 you made reference to patients' rights that you believe were violated. Can you please take us through that?

PROFESSOR GROBLER: In terms of the Patients National Rights Charter, it appears that all the following rights of the patients concerned were violated. The right to a healthy and safe environment, the right to participate in decision-making on matters one's own health, the right to information regarding treatment and rehabilitation to enable the patients to understand such treatments or rehabilitation and the consequences thereof, the right to provision for the special needs of disabled persons, the right to a positive disposition displayed by healthcare providers that demonstrate courtesy, human dignity, empathy and tolerance, the right to health information that includes information on the availability of health services and how to best use such services, the right to be given full and accurate information about the proposed treatment and risks associated therewith and the right not to be abandoned by healthcare professional who or a health facility which initially took responsibility for one's health without appropriate referral or handover.

ADV. NONHLANHLA YINA: And then you have given an example fo a personal experience on dealing with ethical dilemma.

PROFESSOR GROBLER: There was a situation in our hospital where over the years for some reason our hospital was forced to admit patients on the floor. So, even though they were coming from another institution from a bed, we were forced, we were instructed by management – top management, not at the hospital but beyond that, that we have to admit the patients and this came to a boiling point a number of times during my tenure there. And then at some point we were running on an average of 30 patients on floor beds. Basically, an extra ward in our hospital. And then, one day it came to a point we ran out of mattresses and 2 patients had to sleep on blankets on the floor. And the next morning the nurses and the doctors took a stance and we phoned the managers in Bishu and said we shall not continue doing this. And even though they might discipline us. And they never did discipline us for that and other plans were put into place.

ARBITRATOR JUSTICE MOSENEKE: Professor, is there any connection between stigmatization, dehumanization and public service notions of whether resources ought to be spent on mental healthcare? You seem to see a pattern, you only state psychiatric doctor in the Eastern Cape or some area of the Eastern Cape, you must sit and say is there a public service reluctance to use resources on mental healthcare users or is that part of the stigmatization or dehumanization, what is this? Why is that there is a seemingly obviously scarcity of resources on mental healthcare users?

PROFESSOR GROBLER: Justice, I think it has a lot to do with stigmatization and the fact that mental health is not seen as a priority and the mentally ill are not seen as a priority by our managers. I was at a meeting at the beginning of last year were

the National Department of Health came down to the Eastern Cape and they asked what has been done to implement the National Mental Health framework and strategic plan. That is what the meeting was about. So, all the senior managers were there. And they basically had egg on their faces because none of their plans had been instituted in spite of many psychiatrists including what we think should be done and can be done in the province. There is an annexure in moving when it comes to mental health. In fact, I feel that we are regressing. So, this one manager look at Dr. Melutsi from national and said after she said but you haven't done all these things. He asked, but, is it a train smash? And she looked at him and said yes, it is a train smash. They don't see the train smash coming and I agree with you, there is a pattern here and the pattern has to do with stigmatization and looking down on the mentally ill.

ADV. NONHLANHLA YINA: Thank you Justice, that will be evidence in chief.

ARBITRATOR JUSTICE MOSENEKE: Thank you. Advocate Hassim.

ADV. ADILA HASSIM: Thank you Justice, good morning Professor Grobler.

PROFESSOR GROBLER: Good morning Advocate.

ADV. ADILA HASSIM: My name is Adila Hassim and I represent together with my colleague Ms. Stein families of the deceased. I just have some questions, not too many for you. The 1st question is in relation to the letter you referred of SASSOP of June 2015 and you say you agreed with the concerns?

PROFESSOR GROBLER: Yes, I did.

ADV. ADILA HASSIM: And one of the issues that arose -

PROFESSOR GROBLER: Sorry Justice, I don't have that specific letter. I know there were a number of letters and I agreed with the content of all the letters that I saw. I am not sure which one specifically you are referring to.

ARBITRATOR JUSTICE MOSENEKE: We can put it in front of you. If you want we can very quickly get it to you.

ADV. ADILA HASSIM: It is in the exhibit bundle ELLA 2 and it is page 47.

PROFESSOR GROBLER: My ELLA 2 doesn't have a page 47. Yes, I have the letter in front of me.

ADV. ADILA HASSIM: Thank you. So, this letter is addressed to the former MEC for health and it is in relation to the reduction of beds at Life Esidimeni. There were 2 phases to this project. The 1st was a reduction of beds over time, 20% reduction. And then it turned into what the department called a marathon project, what they referred to as decanting mental healthcare users. But if we just start with the 1st phase. You see the letters that come from the clinical heads that you referred to and even from SASSOP were concerned even before the marathon project. They were concerned with the 20% discharge. And the reason they were concerned in, one, the capacity of the communities to absorb, but, that you could also not make these decisions amass. And I would just like to get your view on that.

PROFESSOR GROBLER: Advocate, I agree with you wholeheartedly and again I am making an assumption here. They were worried that they are going to be a 20% reduction in beds. That 20% when you are working in the public service, you are

wondering where these patients are going to go. Are they going to go to the public service hospitals which are up to capacity full, so, there are no beds there? Or are they going to go back to the community where you know there are inadequate resources and inadequate services. So, it is a Catch22 for the clinicians involved and that is what I would assume would have been the consensus. Even the start of the project, they would have been already worried to say okay, this is going to be an extra burden on the community resources and it is going to be an extra burden on acute psychiatric services we do not have a buffer to absorb.

ADV. ADILA HASSIM: So, would it be fair to say that the risk was present even before the marathon project began?

PROFESSOR GROBLER: Yes, it would.

ADV. ADILA HASSIM: The other concern that was raised by the psychiatrists was that this apart from the care and the impact of the individual mental healthcare users was that it would escalate costs. So, I am here referring particularly to your principle of distributive Justice. How does that sense to you? The psychiatrists warned that this will in fact escalate costs.

PROFESSOR GROBLER: Again, I am going to work on the assumption that I think they saw. But, because I am in a similar position, I can make that assumption. They knew that they were not support in the communities. So, what they would have foreseen the risk to be is that these patients are now contained, they are well cared, they are stable on medication. You send them out there where they don't know where they are going to get their medication, where there is a change of

environment, a change of staff, where they wont have the psychological and nursing support that they always had and which will predispose them to relapse. So, they relapsed, they are going to end up in acute psychiatric service. So, here it costs R380 or R370, here it costs R117, there it costs R1700 and that is pretty much the average in our own hospital as well. So, the math is not too difficult. Already from the start, another thing that I don't understand was that from the start of the planning they said they are going to move some other patients back to the state service and the heads of departments expressed their frustration with that decision as well because they knew they didn't have capacity and it doesn't make financial sense either to send them from a place where it is R400 to a place where it is 6 times that amount.

ADV. ADILA HASSIM: So, your reading of their reason is correct and I just want to take you to a specific letter which is a couple of pages before the one you are looking at, the letter of the clinicians page 44 under the heading financial implications.

PROFESSOR GROBLER: Yes, I see it.

ADV. ADILA HASSIM: Have you seen this before?

PROFESSOR GROBLER: Yes, I have.

ADV. ADILA HASSIM: So, the purpose of it is to say let us spell out to you what the financial implications are or could be, readmission, relapse and so on. And you are in agreement with those opinions?

PROFESSOR GROBLER: 100%.

ADV. ADILA HASSIM: I would like to come back to the issue of this decision. But, let us just go to the transfer. Dr. Talatala told us that even the process of transfer of patients has to be very carefully managed? Do you agree and what do you understand by that?

PROFESSOR GROBLER: Yes, advocate. The process of the transfer, it again let us start with the patient. The patient needs to be informed. First and foremost you need to have a conversation with this patient regardless of the level of understanding, to help them understand that they are going to be moved to a different place. And then you have to explain to them the reason for that and what circumstances that they are going to be under. Because you are trying to take away the fear and it is a therapeutic process and you are trying to pre-empt their anxiety because their anxiety will rise and going from place A to place B especially when you have been institutionalized and you are used to the same people, the same routine day in day out month in month out year in year out. So, you have to negotiate, not even negotiate, it will be the wrong word. You have to manage this with the patient itself. Not only the doctor, also the psychologist, also the OT, also the Psychiatric nurse. All of them have a duty in that hospital to start with the patient and explain the reasons and so on, if there is a beneficent reason to move that person. So, even if it is with the best intentions and it is going to be better, you still have to follow that procedure.

Then there is all the administrative responsibilities in terms of writing a report on the history of the case so that the next person accepting this patient understands when did this illness begin, what is the profile, what are the medical conditions, what is the

medication that this patient is on, are there certain medications that are prone to side effects, what should I not use on this patient? So, there is a whole list of medical issues that I can think of that I would like to my colleague taking over this patient know about. And the same for the psychologists, the same for the psychiatric nurse and the OT and so on. And the social worker needs to say this is what I have learnt about this patient's circumstances, otherwise all of this has to be done from the start and we are dealing with patients and again, I am making assumptions but I have been there for years. There is a long history that took them to that point. It is one or 2 lines, we are talking long reports. So, just in terms of of that it is a huge process to move the patient. Then we always involve the family where we live. We go to the family -

ADV. ADILA HASSIM: let me come back to thing in a moment, the issue os=fund the families. At this point I am just talking about the transfer.

PROFESSOR GROBLER: Then you have to arrange the transfer itself. There is a legal process involved there if it is under the mental healthcare act, it is form 11. If they discharge, there is no legal purpose to be involved. But you need to arrange the transport, you need to pre-empt any problems whilst being transport. Again, patients with different illnesses will react very differently to the stress of just being transported. Remember they might not have driven in a car for years before that point. And then once they are there, there is a whole process -

ADV. ADILA HASSIM: On the point of that, on the transportation -

ARBITRATOR JUSTICE MOSENEKE: Well, on that point of that may I interrupt you and Professor Grobler, it is 11:34 I think. Clearly, there are matters to be canvased through with Professor. So, we are going to and yes have some tea given the work that has been done up till now. So, I suggest the tea adjournment now if there is no objection and then we will resume at 12:00 as we always do. As we part, there was a bit of cattle herding. There was nobody, I mean that was part of the tragedy of this inquiry, this arbitration. On the other hand, there was simply nobody to receive these patients forgetting how they were discharged, how they were transported and they got to the other end and there was nothing. There was Siyabadinga, there was Precious Angel, Anchor and what. There was one they got to the other side just about nothing, came with their little few belongings, no proper records, no clinicians, nothing. So, what you are telling us very helpful for us to understand what should have been place. Shall we resume at 12:00? We are adjourned.

SESSION 2

ARBITRATOR JUSTICE MOSENEKE: Thank you, you may be seated. You are under your previous oath Professor.

PROF. GROBLER: Yes Justice.

ARBITRATOR JUSTICE MOSENEKE: Advocate Hassim.

ADV ADILA HASSIM: Thank you Justice. Professor Grobler, we were talking about the transfer of the patients. One of the aspects of this project that was very problematic, was that the patients were going to be transferred not just from Life Esidimeni to another facility, but thereafter from one facility to another. So it was not just a process of one transfer from Life Esidimeni to another facility. There were multiple transfer, so we and the evidence shows that that was understood and that was indeed the plan, that there would be multiple transfers.

PROF. GROBLER: Excuse me, can I just for clarification Advocate. So was that part of the plan? I did not quite understand it, that they are going to go to facility A and then onto facility B?

ADV ADILA HASSIM: Yes. Yes, so the record and part of the minutes of the meetings in which the planning was taking place, and I will just read it for you so that for purposes of your clarity. It says:

"Users from Life Esidimeni may be transferred to NGO and doctors will follow them at the NGO and assess them and replace them to the relevant facility where there is a need."

And the evidence of the families has been to show how their family members, their relatives have indeed suffered this multiple move. What would be the impact on patients of that type of multiple move?

PROF. GROBLER: In brief it is going to, depending on the diagnosis, if it is a mental illness it is going to pre-dispose them to relapse because it is stressful. Every move is stressful and in terms of people living with intellectual disability is going to again make them prone to maybe emotional outbursts and not necessarily a volatile baby, but different behaviour because it is a stressful situation. So it will definitely have an impact on them. Every move will.

ADV ADILA HASSIM: And in each case there would have to be an individual assessment, would there not?

PROF. GROBLER: Yes.

ADV ADILA HASSIM: And so the plan to move 950 patients in three weeks is ... [interjects]

PROF. GROBLER: Absurd.

ADV ADILA HASSIM: Impossible.

PROF. GROBLER: Yes.

ADV ADILA HASSIM: It would be impossible to comply with all the relevant guidelines and precautions.

PROF. GROBLER: I agree.

ADV ADILA HASSIM: And then when it comes to the importance of the families, you spoke about the importance of the families in relation to informed consent and the inability of patients to provide informed consent and we know what the law says about involving families or curators. Both the attempts to involve both, the curator and the families failed as you would have seen from your perusal of the evidence, but is it not so that the importance of the involvement of the families is also because they are able to understand the non verbal cues of the patients.

PROF. GROBLER: Yes.

ADV ADILA HASSIM: The look in their eyes, the sounds they make, how they hold their bodies. Is that not so?

PROF. GROBLER: Yes, absolutely. Ja.

ADV ADILA HASSIM: And that would provide comfort and security to the users, to the patients knowing that people who understand them, the families are with them in the process.

PROF. GROBLER: Yes, absolutely Advocate.

ADV ADILA HASSIM: Now we also know that there was a blanket decision that was taken. In other words it was a decision that was taken for almost 1700 patients. So there could not have been individual assessments, and we have been told by every official who has come to testify that they could not have known that people would die, because they did not have the foresight, the former MEC told us she is not a prophet. But would you agree that it does not take an expert or a medical professional to have foreseen the harm that eventuated. The families

themselves are not experts, but they foresaw the harm. Would you agree that it does not have to be a medical professional?

PROF. GROBLER: I agree with that, because I can understand from a medical professional point of view why they would be worried about the risk and I will explain that in a moment, but both the advocacy groups and the patients and their families, they know what it is like to live with mental illness and people with mental illness and with intellectual disability and the unique challenges involved therein and the unique care that needs to take place. So if you are asking me if you need to be an expert, no. You just need to have compassion and an understanding of the specific challenges related to intellectual disability and people with mental illness. From a mental health care professional point of view a psychiatrist, a social worker, psychologist, occupational therapist, everybody working in mental health, we are always aware of risk, and a risk can take many forms. There is risk for injury to others and also risk of injury to self, and injury to self again can take different forms. So we are trained I think and we are very attuned to seeing risk in the future. It does not make us prophets, it just makes us good clinicians and we have to try and predict as far as possible I think in most medical professions, but specifically in psychiatry and psychology to predict risk. So that does not make you a prophet. But no, you do not have to be an expert to know that there was going to be drama. Whether you could have predicted that somebody would die, I cannot state that for a fact, but I think one could have foreseen that as a possible outcome for some of the patients.

ADV ADILA HASSIM: You see, the importance of the foresight and these denials by the officials that they did not know that this would happen, is linked or what I will be arguing is that it is linked to what you have spoken about in relation to stigma, and the constitution is clear that the state must not discriminate unfairly, directly or indirectly against certain groups of individuals, including individuals with a disability. Would you, what would you say to the position, to this view that the argument on foresight, the claims of lack of foresight, is related to the treatment of a group of people as of less worth?

PROF. GROBLER: That is my impression as well. That there is a lack of understanding that, but apart from that there is a stigmatisation and the constitution takes extra care to state specifically that we need as a society to take more care of people with disabilities, and in terms of that then, the officials can I say that you know, they have no defence to say that they are lesser human beings. The constitution protects them even more than I think the constitution protects the general population. So yes, I think there is a stigma involved, and unfortunately stigma would lead to people looking differently at people with disabilities and people with mental illness.

ADV ADILA HASSIM: These patients were also in the care of the state. They were in the long term care of the state, and they were in the care of the state not because the families did not care for them, but because they were not in a position to provide adequate care, but if these patients are in the care of the state, does it mean that the families no longer have a say in their treatment and in their care?

PROF. GROBLER: No, absolutely not. The families will always stay part of the treatment process of our patients, and in the facility that I work in and I would assume that it is similar in every other psychiatric hospital in South Africa, is that the family stay part of the treatment, and we in fact invite families to ward rounds. To discuss the mental illness. To discuss the treatment options with them, because they know their family members and it gives comfort like you rightfully said to the patients as well. So there need to be a collaboration always, in spite of the fact that the state may be the custodian, but I do not think we as doctors would for one moment believe that the family would not be part of a decision making process. Especially a decision as important as this one.

ADV ADILA HASSIM: Thank you. On a different topic, on the meaning of the term discharge. Dr Tahlatahla, it became a big issue in the course of this process, because the state made representations to court that patients were being discharged in the process of moving them to Thakalani, and the argument was therefore they were well. They needed to be placed in a home, because their families could not care for them. Dr Tahlatahla said that when you use the word discharge, it does not mean that a patient is cured or is now well, it is a term of art.

PROF. GROBLER: It is a term of?

ADV ADILA HASSIM: It is a term of art. It does not mean, you know what was argued in that case is that when you are discharged you are fine.

PROF. GROBLER: Can I use a medical example? When you are discharged from hospital after you have broken your leg, but your leg is still is in a plaster, you

are not well. Mental illness is chronic and severe and enduring. So a discharge does not equate to being well, not in any sense. Neither if you have injured your knee or a mental illness, and even lesser for mental illness. It means you, it can mean different things for different people, but it means that you are able to look after yourself with less support maybe. It can mean that, but it does not mean that the mental illness has gone away and it does not mean that your medical supervision and your medical involvement should be less and the involvement of the family should be less.

ADV ADILA HASSIM: Thank you. My final question is in relation to the psychiatric wards of tertiary hospitals, there were a number of patients and again it was part of the plan for a certain number to be transferred to Sterkfontein and Weskoppies and so on. To the extent that there would be over crowding as a result in those facilities. Would that impact on the care of the patients in those facilities?

PROF. GROBLER: Firstly, it would impact on the wellbeing on the person. So you are taking somebody who is used to a certain level of care, putting them somewhere where there is less privacy possibly. I am making assumptions. There is less privacy, there is less care. It will definitely impact on their wellbeing, their mental wellbeing, and then again I am going to make an assumption that ... [inaudible] from the letter by the heads of departments, they did not really have the capacity. So there may have been wards with space. That does not mean that they are going to get more doctors, more psychiatrists, more nurses, more OT's, more psychologists. There might have been the promise of that, but the reality for them was we know we are going to expect a number of patients and we already stretched

to the limit. How are we going to provide them with better care than they got at Life Esidimeni. That would be my reasoning or understanding of what transpired.

ADV ADILA HASSIM: And certainly should have been something that was taken into account by the decision makers.

PROF. GROBLER: It should have and it was expressed, if I remember correctly by the heads of departments.

ADV ADILA HASSIM: Thank you. Professor Grobler, thank you for your report. It has been enormously helpful. I have no further questions Justice.

ARBITRATOR JUSTICE MOSENEKE: Thank you. On foresight, lawyers call the same thing forseeability. In other words could you see, foresee, reasonably anticipate your unlawful conduct and unlawful consequences? The most common example of course would be murder. If you dropped a baby on a cement floor on its head, it is difficult to say I could not foresee that the baby's scull might crack and God forbid if the baby did not live then we lawyers would ask the question, despite your denial would say could you have reasonably foreseen that if you drop a baby down onto a cement floor, on its head, the baby might not survive. Now let me come back to our situation. Counsel canvassed this well. Each of the officials who made the decision repeat over and over, we could not foresee that they would die. We could not foresee that when we removed them from the health care security of Life Esidimeni to Precious Angel, they might die. Does that make sense to you? Knowing what you know about psychiatry and your experience. What should we make of a response like that?

PROF. GROBLER: It makes ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: Particularly by clinicians or people trained in psychiatric care.

PROF. GROBLER: It makes no sense for me Justice. One gets the impression that a beurocratic decision took preference over clinical decisions. So the clinical people's warning were not heeded. There were democratic decisions, ag beurocratic decisions. So the beurocratic decision we are going to move the patient. The clinicians saying but if you move the patients, something bad is going to happen and the managers caught in the middle between maybe these two opposing poles. So on the one hand the two managers involved is between the MEC and on the other hand they have experts stating something that there are problems coming, and even though they did not, they were not able at that stage to preampt every problem, they knew that there was ... [inaudible] of problems that were coming, and if you look at it from an unlawful conduct, so the first unlawful step for me would have been just the discharge. The issue around taking people who are admitted ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: Ja, I was trying to move to foresee ability.

PROF. GROBLER: Okay.

ARBITRATOR JUSTICE MOSENEKE: I am trying to, ample evidence shows the conduct was unlawful, the conduct was reckless. What I am really probing is if you were to make a decision that somebody must go to a facility where there are none of the good things you told us about clinically, could you sensibly and rightly say I

could not foresee that somebody with chronic or enduring mental disorder might relapse and add a few other things, might die?

PROF. GROBLER: I am trying to put the two together. So you have clinicians and you have managers, and there is a disconnect here. So the clinicians are clearly stating that they are foreseeing disaster. On what grounds does a manager then say they cannot foresee a disaster. It has already been expressed that there is a disaster coming. So again if I take just a little step back behind my colleagues then in terms of trying to understand where they were coming from, so I need to have understood what the levels of care of these 1700 or 3000 patients were. Those with intellectual disability, did they need to be fed, did they need to be dressed? So what was the level of care and involvement needed. The same for patients with dementia and then what are the different risks and so on involved with the other health mental illnesses. So for a manager to say I could not foresee, means that they ignored the opinion of the clinician. So I cannot understand that they say they could not foresee, if they were told to foresee. That just means they did not listen.

ARBITRATOR JUSTICE MOSENEKE: On the facts here, who would you say should have foreseen this? Let us start with for instance the head of department, who is himself a doctor and approves a plan which has been shown to have all of these defects we talked about today. Can he reasonably, credibly say I could not foresee the relapse including the risk to lose life?

PROF. GROBLER: Okay. Justice, let me put myself ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: Even without loss of life, the risk of harm in a variety of ways.

PROF. GROBLER: If I put myself in his shoes for a moment, I would ask myself okay people bring me this document, the mental health policy framework and strategic plan. I look at it, I am a manager and I say this is a wonderful idea. My MEC told me and again I apologise, but I am trying to illustrate the point. My MEC tells me we need to save money. I see there is this document that says if we de-institutionalise we can possibly save money. So I take a decision. So let us say, I am assuming, I am just creating a scenario. I have this document, it is my back up, I am taking a decision, we are going to de-institutionalise, and I do not see the risks, it is because this document looks as if there is no risks involved, even though they do spell out the risks in the document. But okay, I underestimate the risk. Now I start to try and implement this and suddenly all the experts come to me and the families come to me and the advocate groups come to me and says but there is risk involved. Logically you should then stop in your tracks as a medical doctor and say okay well, what did I miss. Should I foresee that there is risk involved. Is there more risk than I initially thought, and even though I had made the decision already, then you need to change the decision because there is new evidence to the contrary that there are lots of risks involved and not as little risk as you expected.

ARBITRATOR JUSTICE MOSENEKE: And what about non clinicians? All we heard from them was things went horribly wrong, and we did not anticipate, did not foresee that things will go horribly wrong. Do you have any comment on that?

PROF. GROBLER: There I would, like referred to the question by Advocate Hassim.

ARBITRATOR JUSTICE MOSENEKE: Yes.

PROF. GROBLER: That it does not take an expert to know, the families are experts with their own family members. They knew. So it does not take an expert to say that things, you do not have to be a medical professional to have known and again I am making the assumption, but I think the families went to the place to see what the places look like and they know what I looks like here, and they, and just by the mere visiting of the facilities and seeing, they could foresee risk.

ARBITRATOR JUSTICE MOSENEKE: And that risk, could that risk be, include death? Would that foresight include the possibility of a patient dying?

PROF. GROBLER: I think so yes, and let me qualify my answer Justice. Again, depending on the level of care. So let us look at a profoundly intellectually disabled person who needs care and fulltime supervision in terms of personal hygiene and feeding and things like that, and the same for somebody with severe dementia. If you go, if I am a family member and I go to a facility and I know what the level of care is here, and I go to a facility and I see at this facility number one that rooms do not look like the other places, number two there are more beds, number three the bedding looks different and maybe not as nice or maybe nicer, number four the carers there are not as many carers as there are at this place, I am going to count the beds and I am going to think all of these patients needs this amount of care because I know what my family member needs and I count the number of carers

and I am asking where is the nurse. No, there is no nurse. Where is the doctor. We do not know he is at the clinic. Is there a psychologist. No, we do not know. As a family member I am going to ask very uncomfortable questions at that point and say but I do not think this is the place for my family member to be ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: But those who made the decision, ought they, should they have foreseen that the risk would include loss of life? That the deterioration in the condition of the patient would result in death?

PROF. GROBLER: If they had investigated and if they had asked the questions that I am logically asking as to what the level of care is that the person need and then go and inspect what can I expect in terms of level of care there, then death should have been foreseen, yes Justice.

ARBITRATOR JUSTICE MOSENEKE: Ja. Because here we have openly unlawful ... [inaudible] conduct and death has ensued in some instances. For the survivors other forms of severe harm, and the central question will always be certainly in criminal courts was death in foresight or other forms of harm in foresight by using their common sense of being reasonable people should they have realised that the patients will relapse. There will be no care that would continue, they will get worse. They will not be able to get food, the medication that is prescribed, and they might die?

PROF. GROBLER: Justice ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: As in fact they did.

PROF. GROBLER: Again my answer comes from a place where I am a medical professional. I am an expert so I will ask different questions. So I think the families are best equipped to answer that question, whether they foresaw that, because if they foresaw that and they told the Managers we are foreseeing that, and not necessarily death. I mean I do not think if you are there you would even think of possibly that your family member would die, because I do not think you would think that the institution or the government looking after your family member would have that intention, but you are worried somewhere that something could horribly go wrong, and you are saying this to another non medical person, and this person does not take it to heart, then something is wrong with this picture. So yes, there should have been foresight. Could it have been with death I think a medical professional could have predicted, depending on the level of care that death could have taken place. Another person, if they know their family members well enough and they know the level of care and they have informed consent or information to compare the two, then even they could have ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: Thank you.

PROF. GROBLER: Had foresight.

ARBITRATOR JUSTICE MOSENEKE: Counsel.

ADV. LILLA CROUSE: Thank you Justice. Dr Grobler, I with my learned friend Mr Skibby appear for the survivors and their families in this project. If I can just put on record, Port Elizabeth being a very small place, we have crossed paths before, is that not so?

PROF. GROBLER: Yes, it is.

ADV. LILLA CROUSE: Yes. Can I just ask you in terms, or maybe before I should go there. I just want to really thank you for your comprehensive report and I jus want to say that it helped us a lot in our preparation. Then can I ask you, you also have ties with the university and teaching experience, is that so?

PROF. GROBLER: Both with Walter Sisulu University as well as Nelson Mandela University.

ADV. LILLA CROUSE: And you have had those ties for some time?

PROF. GROBLER: Yes, I have.

ADV. LILLA CROUSE: Thank you. Can I, I just want to, we have talked about a lot of informed consent before and I am going to try my best not to repeat anything that has already been said. One of the statements that stand out for me, is that the MEC is saying well it is our patients, we will take them. Could the MEC ever form part of the informed consent in respect of a patient?

PROF. GROBLER: No. The simple answer is no. If I can elaborate, it is a very paternalistic way to look at it, say it is my patients. There is an ownership that is taken there that I do not think she has a right to it. It equates her to, these patients are like they belong to the state and I can hence do with them what I want. So no, she is not part of the informed consent process.

ADV. LILLA CROUSE: In terms of the Mental Health Act, a family member of the patient is included in the definition of a health care user. You are aware of that.

PROF. GROBLER: Yes, I am.

ADV. LILLA CROUSE: And you already indicated that in your practice you include the family member, but could you just explain to us how is informed consent obtained by involving the family member?

PROF. GROBLER: It depends on what you are asking informed consent for. So let us for example say a patient is admitted under the Mental Health Care Act in our hospital and he or she develops appendicitis, we would still prefer and it is not that acute, we would still prefer to consult with a family member and say listen, your family member in hospital suffers from appendicitis. We are going to have to send him or her to hospital for an operation. Would you mind com ing in to fill in the informed consent form. So that we can explain to you what the possible complications could be or the surgeon can explain. If the family member cannot be reached or if the family member is unwilling to come, then I as clinical manager can sign the informed consent document. But it, we always prefer to inform the families of any significant changes. Be it special investigations that a person has to go for or an operation, and definitely in the case of transfer of the patient to a different facility.

ADV. LILLA CROUSE: Could you please explain to us how that should have been managed? You now want to move this patient. How do you get informed consent to move the patient?

PROF. GROBLER: I would firstly go to the families. No, I would firstly go to the patient. That is what I said earlier, and every patient needs to be assessed for capacity and understanding and how much understanding they have of this move.

So if I am at ward round for example and I know my patient is going to have to be transferred to Kirkwood Care Centre, it is something I discuss at the ward round when the patient comes in and there is a whole multi disciplinary team there, and I would ask the patient about their understanding and so on, and even their views on it, and then the nurses and the social workers would contact the family and discuss this with the family and the doctors and the psychologists also sometimes, and then they would invite the family to come and discuss it if in most cases to come and sit with the doctors and the professionals involved, and discuss what this entails. The transport entails. So the families are never excluded from the care and treatment of the patient.

ADV. LILLA CROUSE: Thank you. Doctor, we act for the survivors. They are mental health care users in the sense that they can either be intellectually disability or having a mental illness, and although we have consulted with them, we have not called any of them to testify. The opinion that we have received so far, is it could be detrimental to their treatment to appear here. Would you go along with that, that it could be detrimental to their treatment?

PROF. GROBLER: I would go along with that, because I think one should be very cautious there. So I would ask the clinicians involved, and again when I say clinicians I refer to a whole multi disciplinary team who each have an opinion, and like you guys disagreed this morning on something, you can have the same at a multi disciplinary team meeting, where the social workers or the psychologist have reservations and you have to listen to that opinion. So in to put a survivor through this process, I think would again depending on what the illness is, I think would be

very difficult for such a person, and I would be very cautious to ask a person to come and testify here.

ADV. LILLA CROUSE: Thank you. Doctor, if I can then move on to the relapse principle. You have dealt with lots of this already, so again I am goingn to try not to, sorry it is Professor. Not to repeat what has already been said, but what we have in case of most of the survivors were people that has been institutionalised for a long, long period. So if we can go from that backwards, if such a person who had reasonably good treatment with a multi disciplinary team are all of a sudden placed in a place where there are no professional staff, there is not sufficient food, there is not sufficient water or they do not get sufficient water, what would the affect of that be on relapsation?

PROF. GROBLER: On relapse?

ADV. LILLA CROUSE: Yes.

PROF. GROBLER: Again, in a situation like that and reading through all the documents, I can only try and put myself in the shoes of such a person. So when I am in institution A, I may I use the word fairly happy and content, and then suddenly one day, and I am using this, I am explaining it in this way so that everybody in this room I think has the capacity to have this kind of compassion. The next moment a truck or a bus or whatever arrives at the front door, I am told that you have to get on there. I have never seen this place, I do not know how much information has been shared with this person, and then I am taken to a place and suddenly I am out of my routine, the beds are different, I can just imagine gauging from the reports what the

conditions in some of those NGO's might have been. So let us say I am mildly mentally ill and I have to go and stay in a situation like that, that already would have been devastating for anybody and would have been stressful for anybody. Now we put somebody with a severe and enduring mental illness there, and then comes the unimaginable things that we read in the report. Like there is no food, there is inadequate food, inadequate water, inadequate security, protection. That is an extra level of stress that you have from the outside. Inadequate clothing and access to warmth. I mean it is devastating. It would be devastating for a mentally healthy person, even more so for a mentally unhealthy person.

ADV. LILLA CROUSE: Yes, and if we add to that that a mental health care user are not properly identified and getting the wrong medication or not getting medication at all, what effect would that have on the relapse of this person?

PROF. GROBLER: That is something we have not even ... [interjects]

ADV. PATRICK NGUTSHANA: Justice. May I just be allowed to intervene at this juncture? I tried to restrain myself on the aspect which are being canvassed with this witness. The issues relating to relapse of the mental health care users are beyond the scope of this witness, as he is clearly called here to deal with aspects of ethics in relation to those who are in charge of the mental health care users.

ARBITRATOR JUSTICE MOSENEKE: I am startled by the objection. A Professor of psychiatry, qualified as a doctor, has a PHD in psychiatry, work in state institutions for many, many years and is being asked about relapse and his evidence is that clinical and ethical responses are intertwined. They are that tight

and close. Why would a witness not be competent to express an opinion about a relapse of a mental health care user?

ADV. PATRICK NGUTSHANA: My concern is that the report and his purpose before these proceedings is to deal with matters of ethics of the processional who take care of the mental health care users, and he is not here to deal with matters relating to the conditions of the users themselves. I will be in your hands Justice.

ARBITRATOR JUSTICE MOSENEKE: Yes. I do not know how you could talk about ethics without evaluating the kind of care and decisions that were made in relation to the care of mental health care users. Let us look at the report. I mean Professor Grobler goes on to apply the ethics on the conduct of clinicians and non clinicians who were involved. Is that not a legitimate inquiry, whether or not you feed mental health care patients is a clinical and ethical question, not so? The duty not to harm. The duty to do good to patients. The duty to protect their lives. I am not even going to ask the other colleagues to respond. I think the objection is not upheld. Continue.

ADV. LILLA CROUSE: Thank you. Professor, the question was if you then misidentify the mental health care users or give them the wrong medication or no medication at all, how will that impact on a possible relapse?

PROF. GROBLER: Excuse me Justice. It will have devastating consequences. If a person who suffers from epilepsy is not given their medication, they will within days probably start having seizures and that could be life threatening. If a person without epilepsy is given somebody else's medication, that could cause toxicity and

could cause serious harm, and that is only for epilepsy and there are other psycho tropic drugs that have other side effects. So if you are going to give the wrong medication for the wrong person, that will very quickly escalate, or not give patients their medication, that will escalate quickly into a disaster.

ADV. LILLA CROUSE: And anybody working wih these mental health care users should foresee this could result in death. It is just so logic that you not even need to be a mental health care user. We do not even need to treat them to know this, is this not so?

PROF. GROBLER: Justice, yes. I think this is something we have not even touched on. That is just the medication and the transfer of medication. Even when we transfer to a place like Tower Hospital, we provide two or three days for medication, just to make sure that they and they do have access to medication, that they have the same medication available. So if you are going to blindly send somebody elsewhere without knowledge of their diagnosis and the importance of their medication, which medication they are taking, that is a disaster waiting to happen within hours.

ADV. LILLA CROUSE: Yes, and a person would relapse or die. That is the bottom line.

PROF. GROBLER: Death could be possible, yes.

ADV. LILLA CROUSE: Now we also have evidence here in the documents that the local clinics were overloaded, and they could not deal with another overload of mental health care patients. You probably know a little bit about that, and I still want

to speak to you about that in terms of the mental health policy, but if the local clinic is overloaded and that is seen as the primary source of medical attention, what is the logical conclusion to be reached there?

PROF. GROBLER: Again I think this is what the psychiatrist and the concerned groups were trying to highlight. They know what is going on in their community. Some of their patients already live in those communities and they have to take advantage of those clinics available to them. In as much as the professionals in the big hospitals knew they were going to be stretched if they got new patients ... [inaudible] from the reports, I think that they also knew that if you put X amount of patients in a certain area because they are familiar with the area and they know what the level of services is, they are going to know that those persons will be stretched, because it is suddenly a new burden and in a mental health policy framework, one of the things they refer to, is that you have to before you consider de-institutionalisation, you have to first build the services within the community. The support service of the community mental health care teams, the community mental health teams and the health care centres and integrate psychiatry into that and make sure that there is access to medication, and that is a complicated process. So it does not come as a surprise to me that they were not equipped and not ready for this influx of patients.

ADV. LILLA CROUSE: And then you have the fallacy of people thinking that all medicine is available at local clinics and we know in terms of the ... [inaudible] that was already placed before this court in cross-examination, that there is different

levels of medication, and you would not necessarily keep them at a clinic. Do you agree with that?

PROF. GROBLER: I agree with that. Certain medication can only be prescribed by psychiatrists or people working within psychiatry, and that is the case even in our area as well and that is a challenge in our area, because our resources are dwindling, our human resources are dwindling. The community is feeling the brunt, but they have not put things in place to have these prescriptions signed and re-signed. Remember these prescriptions have to be repeated every six months according to law.

ADV. LILLA CROUSE: And see the patient.

PROF. GROBLER: And the patients need to be seen and reviewed and re-assessed.

ADV. LILLA CROUSE: Yes.

ARBITRATOR JUSTICE MOSENEKE: Excuse me Counsel, when you sit in an NGO, there is no doctors and other health care givers, how do you get a prescription? How do you get further medication? How would a patient possibly be medicated?

PROF. GROBLER: My understanding was that the Department of Health expected that the local clinics, the normal primary health care clinics, that the medication will be available there and that they will be available to, for the patients to go and access their follow up and their medication there. That was my understanding of their understanding.

ARBITRATOR JUSTICE MOSENEKE: But Professor, in that scenario, how do you generate a script?

PROF. GROBLER: That is a very good question Justice. If you have no doctor, there should be at one of the clinics at least a doctor. So you should have then a referral document that states which medication you are on. Nobody at the NGO, if there is no doctor there, can prescribe that medication. So this person needs to be taken then with this script to a clinic where there is a doctor and this doctor can then prescribe the medication and see the patient and make sure that the patient gets monthly medication. If the patient came without a script, this doctor will then have to review this patient and a normal psychiatric interview takes about an hour, just the first interview, and that is on average. It is sometimes longer. So this doctor, at this clinic who is already having to look at a primary health care level, having to look at 50, 60 other patients that day, is now suddenly confronted with an extra burden of psychiatric patients whom he or she knows nothing about. So they have to review, find out its expert level medication that they are on. They are going to have to phone the hospital to find out which medication and which dosages they are on. So if there is not access to a specialist in the community, that is another disaster.

ADV. LILLA CROUSE: Thank you Justice.

ARBITRATOR JUSTICE MOSENEKE: Thank you.

ADV. LILLA CROUSE: Doctor, I am going to move off from the relapse now, and I just want to speak to you briefly about the suffering, and this is not only psychiatric. You are also in medical profession. If a person is not given food, and some of the

people die of that, what suffering would you go through even if you do not die at the end? What happens in your body without food?

PROF. GROBLER: Advocate, that is a very good question. I ... [interjects]

ADV. LILLA CROUSE: You have not thought of it in many years.

PROF. GROBLER: I have not thought of that in many years, but just considering if I would put myself in their shoes and I am a mental health care user, firstly wondering why I am not getting the same treatment and then the anxiety that goes with being hungry and not getting the nutrients that you have, and then that is starting to escalate. That you are not getting the nutritions that you need. You are not getting the fluids that you need, and we know that there is a high morbidity between people with severe enduring mental illness and medical illnesses. So they are more prone to medical illness like diabetes and high blood pressure and high cholesterol and kidney diseases, and some of them are on medication that affects their kidneys. So suddenly if you are not given the necessary nutrients and fluids, your electrolytes will start becoming imbalanced and you will start physically suffering as well, and then you can go into what we call a delirium and that is a medical condition.

ADV. LILLA CROUSE: So you are back at relapse with that?

PROF. GROBLER: Then, that is actually a more serious place than relapse. When you are starting to suffer from a delirium that is a medical emergency. Then you need medical attention first before you attend to the psychiatric illness.

ADV. LILLA CROUSE: Yes, and if a person that cannot help themselves to know I am now thirsty, not given water and we have people that has died of dehydration, what suffering will that cause in a person that has not died?

PROF. GROBLER: Again, I do not know what the different diagnosis was of the people involved, but a severe intellectually disabled person might become more and more restless. Might start screaming and acting out more or become aggressive. A menal health care user, most of them should be able to say but I am thirsty, I am hungry.

ADV. LILLA CROUSE: If they can speak.

PROF. GROBLER: If they can speak and if they are not, if they told well we do not have water or you cannot have access to water now, they will become angry and they might have aggressive outbursts and that will be then construed as oh, maybe he is just acting out. Where in fact he has the right to be angry at that point.

ADV. LILLA CROUSE: Yes. We have received evidence of a mental health care user saying I am thirsty and the carer said no, he cannot have water because he wets himself. What would you say in terms of suffering, what would that do to a person?

PROF. GROBLER: That is just unacceptable. I mean that is not care in any way. One cannot construe that as care.

ADV. LILLA CROUSE: Yes. Can I just ask you in, normally a mental health care user has difficulty to adapt in society if he is not institutionalised. Would you agree with that? If he is de-institutionalised there is a problem of adapting.

PROF. GROBLER: Yes. If he is de-institutionalised. So the process, what you are asking Counsel is the process of having lived in an institution for a long time, and then having to go into the community to live there. Is that your question?

ADV. LILLA CROUSE: Yes.

PROF. GROBLER: When I, I worked in Ireland for about two years and I was specifically involved in drawing up in ... [inaudible] in Ireland, in the north west of Ireland. Their plans, helping them with drawing up their plans as to how to de-institutionalise the last of the patients that were still institutionalised in the psychiatric hospital there and there were about, I think if I remember correctly, about 40 patients. It was about three years of planning, just writing it and then they put a team together to do that. They also had other services like day care centres where and half way houses and assisted living centres where a person would go from the hospital. So let us say we are going to de-institutionalise patient X. So this patient tomorrow or this evening is taken by a team to live with other hospitals in assisted hostel.

ADV. LILLA CROUSE: Do you need something to write on or are you fine?

PROF. GROBLER: Am I not making sense?

ADV. LILLA CROUSE: We have something for you to write on if you want to.

PROF. GROBLER: I can write if you want to.

ADV. LILLA CROUSE: I see that you are struggling to do, Justice if I may? We have arranged a board for the Professor to write on.

ARBITRATOR JUSTICE MOSENEKE: Okay.

ADV. LILLA CROUSE: Because he ... [interjects]

PROF. GROBLER: I do not necessarily need it now, I can just quickly mention then the services available. So there would be a building, a house where they are taken this evening. Psychiatric nurses will go and check on them this evening, are they okay. Tomorrow morning a bus will come and take them to the day care centre. There they will get lunch and dinner, and they usually made breakfast if I remember for themselves, but always under supervision. So that is assisted living and every day all those people comes to a day care centre at the hospital. That is the responsible way in going about de-institutionalisation, and I do not think one should go about it any other way than in that way.

ADV. LILLA CROUSE: Yes, because there is social costs involved in putting somebody that is not adopting into society. Do you agree?

PROF. GROBLER: Yes, absolutely.

ADV. LILLA CROUSE: And we have sometimes aggressive people. We have had families testifying we cannot keep them, because they are aggressive. That has a social cost to it. Do you agree?

PROF. GROBLER: I do agree, and what we have seen also and there is an article by Professor Colesky to this effect as well previously that we start seeing if you de-institutionalise in a haphazard way and prematurely, we start to see that psychiatric patients or mentally ill patients are criminalised. So they do not have the access to care and the care that they should have in the community. They commit

crimes, they may become paranoid and throw stones through people's houses or assault people in the community and then they end up in the criminal justice system, which is also wrong and it is because we are not taking care of them in the community.

ADV. LILLA CROUSE: And the person's window that was broken, that is an economic cost.

PROF. GROBLER: Yes.

ADV. LILLA CROUSE: Let me just ask you, we have talked a lot about the stigma. So I am not going to go there, but often between the stigma and the difficulty to adapt, we have people being discriminated against and that discrimination leads to inhumane treatment or to a barrier to human rights. Will you agree with that?

PROF. GROBLER: Sorry, can you repeat that Counsel please?

ADV. LILLA CROUSE: Yes. Often when you are stigmatised and you are not fitting in socially, then there is a barrier to your access in human rights or to you being treated inhumanly in society.

PROF. GROBLER: Yes. There is a barrier to care so you, when you are stigmatised and you feel stigmatised by the community, you would not seek treatment as easily as somebody else would or not find out about the treatment. So there is definitely a barrier to care. I did not quite understand the second part.

ADV. LILLA CROUSE: Yes. It is just that there is inhumane treatment for you then, because people do not want you around them. So they do not treat you humanly good, and often people land up in the street.

PROF. GROBLER: Stigmatisation has that effect that people are de-humanised. They are seen as nuisances in the community because they might do odd things or they behave in an odd manner or they might look odd or dress oddly.

ADV. LILLA CROUSE: The reason I am raising this with you is that there are still as far as we are concerned missing mental health care users which we do not know what happened to them, and being treated in this way there would be terrible suffering for them. Would you not agree?

PROF. GROBLER: I would agree.

ADV. LILLA CROUSE: Also, in just sending people home you are not really having a mechanism to create their atonimy. If there is not a basis for them to receive care, they cannot really be atonimous. Do you agree? Or seek towards the drive towards autonomy.

PROF. GROBLER: Again Counsel, sorry. I am not following quite your ... [interjects]

ADV. LILLA CROUSE: Maybe I should just repeat that. If you want to send people home, there must be necessary infrastructure to help them to be autonomous. You cannot just dump them. Do you agree?

PROF. GROBLER: Yes. To function, I am not sure autonomy would be the right word there, in that sense.

ADV. LILLA CROUSE: Yes, maybe I should say to you the Ombud said it was necessary to promote principles of autonomy in de-institutionalisation. You would agree with that?

PROF. GROBLER: Yes, in the sense that they should have been part of the process and have been consulted in the process.

ADV. LILLA CROUSE: Yes, the Ombud also said that living conditions, there must be improved standards of living conditions for mental health care users in the community before you just de-institutionalise. Would you also agree with that?

PROF. GROBLER: Yes, most definitely.

ADV. LILLA CROUSE: Okay. Do you have the national mental health policy and frame work and strategic planning in front of you, or should we provide you with a copy?

PROF. GROBLER: I have a copy.

ADV. LILLA CROUSE: Justice, that is ELAH124, if I ... we went there yesterday and I know the numbering were different on the ELAH than on the blue cover policy. I am going to refer to page 23 of that policy. It starts by a heading by 2020. Do you have that in front of you doctor?

PROF. GROBLER: I do.

ADV. LILLA CROUSE: Sorry, Professor. Now this says under 1A, B and C, it says:

"Mental health services must be developed further before downscaling of psychiatric hospitals can proceed."

Do you see that?

PROF. GROBLER: Yes, I do.

ADV. LILLA CROUSE: Do you agree with that?

PROF. GROBLER: Yes, I do.

ADV. LILLA CROUSE: Is there sufficient development in the community at present in South Africa in as far as you are concerned?

PROF. GROBLER: In my opinion, no.

ADV. LILLA CROUSE: Do you know of any mental health workers in the field, health care, mental ... [interjects]

PROF. GROBLER: Health assistance.

ADV. LILLA CROUSE: Yes. In the field at all.

PROF. GROBLER: I have never seen one. I know that there is a term for mental health assistance but I have never seen one in our, not in the Eastern Cape.

ADV. LILLA CROUSE: Can you please turn to the previous page in the policy. That is a triangle. You see that?

PROF. GROBLER: I do.

ADV. LILLA CROUSE: Now it seems to me this is the same triangle that the mental, the world health organisation uses and we have just adopted it over from the world health organisation.

PROF. GROBLER: I am going to assume that it is, ja.

ADV. LILLA CROUSE: Now it seems to me that all our patients were in the top op this triangle. Long stay facilities. Would you agree?

PROF. GROBLER: Yes.

ADV. LILLA CROUSE: And then if you could show us perhaps on this diagram, where did they go to from there?

PROF. GROBLER: Can I just show you or do you want me to draw?

ADV. LILLA CROUSE: Do you want to draw?

PROF. GROBLER: Let me draw.

ADV. LILLA CROUSE: I will try to put it on record, yes. As he draws Justice.

ARBITRATOR JUSTICE MOSENEKE: You sensed my concern.

ADV. LILLA CROUSE: You must please just turn your board that the Justice can see. He is the most important person here.

ARBITRATOR JUSTICE MOSENEKE: Thank you.

ADV. LILLA CROUSE: Thank you.

ARBITRATOR JUSTICE MOSENEKE: Counsel is obviously wrong. It should face that way. They are the most important people.

ADV. LILLA CROUSE: Professor, you will have to take your microphone with you as well if you do not mind.

PROF. GROBLER: I do not have enough hands. So this is institutionalised care here where they were ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: Obakeng can hold the mike for you. Obakeng, just hold the mike for the Professor and he can use ... [interjects]

PROF. GROBLER: So this would represent long stay facilities and specialist psychiatric services, and then you would have psychiatric services in general hospitals here and community mental health services. Community mental health services here, and then it goes to primary health care services, informal community care and self care. So by self care we are going to assume, by self care we are going to assume that this person can live independently, but all of these should happen simultaneously. Well, actually all these. So if you are asking what level were they in when they went to the NGO's, in a sense they were inbetween here and here.

ADV. LILLA CROUSE: Inbetween the informal community care and self care.

PROF. GROBLER: Self care.

ADV. LILLA CROUSE: On the triangle.

PROF. GROBLER: Yes, in terms of where they were living.

ADV. LILLA CROUSE: And the logic of taking somebody from the top of this to the bottom, does it make sense?

PROF. GROBLER: It does not. Again I want to qualify here. It depends on how you are going to plan your community mental health services. So if you plan your community mental health services to have day care facilities and assisted living facilities, so this we will call assisted living facilities. So it depends on which model you use, but if you are going to argue that well, this is a community mental health service and it is assisted living, then you are moving them from there to there. What in reality happened is that they moved down there and that this was absent and this was inadequate.

ADV. LILLA CROUSE: Professor, so in terms of what our policy says, before the second tier from the top is not developed, we should not de-institutionalise.

PROF. GROBLER: That is exactly what the policy says, yes.

ADV. LILLA CROUSE: So and in terms of accepted international norms, it is accepted that if you de-institutionalise you will go to the second tier and not down to the bottom. Would you agree?

PROF. GROBLER: Yes, and then have a very good service there with assisted living and day care centres and half way houses.

ARBITRATOR JUSTICE MOSENEKE: The second tier, excuse me. The second tier, does it also consist of institutionalisation?

PROF. GROBLER: Again ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: Or what is the community mental health service?

PROF. GROBLER: I feel quite out of my depth here Justice. I have to admit, because you have one of the experts in the country here, Melvin Freeman, and I am left to explain this and I was not involved in drawing up this. So I am interpreting it in terms of my own experiences. So you might need ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: Professor Freeman must raise hands so that we can identify. His name is all over the record. Hi Professor Freeman. Good to see you sir. Okay.

ADV. LILLA CROUSE: Can I just then continue? So we can say this was not done in terms of the accepted international norms?

PROF. GROBLER: Can I sit down?

ARBITRATOR JUSTICE MOSENEKE: ... [inaudible]. I want to understand. The first step down, what did it constitute of? Will that be institutionalised service?

PROF. GROBLER: Between, is it still working? Again, it depends on the model. So if you have assisted living here and here you have independent living ... [interjects]

ADV. LILLA CROUSE: Can we just put that on record. You are showing the second tier and then you move down to the last.

PROF. GROBLER: Ja, so if you have assisted living there, this is a service that is being rendered. It is not a housing plan or a housing product. So I am assuming you are referring to where they live. So living, going from an institution where they live, to assisted living wat you are referring to, to maybe community living in a half

way house, so again there I am creating my own model now. A half way house, to independent living possibly. That is the process that you are aiming towards for de-institutionalisation.

ARBITRATOR JUSTICE MOSENEKE: ... [inaudible]

PROF. GROBLER: They would probably, no I would consider them as assisted living, because they are still in a sense then institutionalised. They are permanently living in a place where other people are taking care of them on a daily basis.

ADV. LILLA CROUSE: But that can only work if the NGO is up to the standard that it should be.

PROF. GROBLER: Yes, but it is still not, Justice I think you are making the point is it not still institutionalisation? Yes, it would still be institutionalisation in some form.

ARBITRATOR JUSTICE MOSENEKE: What is primary care service for mental health care? What is that?

PROF. GROBLER: Primary health care service have been incorporated in mental health care service. So that is a clinic where you have let us say nurses where a patient can go with any problem. So the person has a mental illness, but they have a cold. Then they go there for their ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: So that does not connote occupancy or institutional living, no?

PROF. GROBLER: Not on my understanding in this.

ARBITRATOR JUSTICE MOSENEKE: Model deals with services rather than where the patients go?

PROF. GROBLER: Yes. This model specifically, yes.

ADV. LILLA CROUSE: But in order to get to the last tier, the previous models must work. Do you agree?

PROF. GROBLER: Yes, absolutely.

ADV. LILLA CROUSE: The previous tiers must work?

PROF. GROBLER: Ja, this is what the policy framework says this and this must be developed.

ADV. LILLA CROUSE: And we know now that the primary care, the clinics, they were already overloaded.

PROF. GROBLER: That seems to be the case, yes.

ADV. LILLA CROUSE: And we know the NGO's, all the patients has been taken away from them.

PROF. GROBLER: Pardon, say that again?

ADV. LILLA CROUSE: All the patients has been taken back to Life Esidimeni after this process?

PROF. GROBLER: I was not aware of that.

ADV. LILLA CROUSE: Thank you Doctor. Can I just ask, how are we going to and I am now talking to the future, because this is ... [interjects]

PROF. GROBLER: May I sit down Justice?

ADV. LILLA CROUSE: Could I ask that somebody just take the barrier between the Justice and the witness away?

ARBITRATOR JUSTICE MOSENEKE: Thank you.

ADV. LILLA CROUSE: Thank you. I want to speak to the future Professor, because one of the things that outlines me, is to make, to be sure that this does not happen again to them. That they are not the next victim if this happens again. So how must de-institutionalisation happen to ensure that a mental health care user will not die?

PROF. GROBLER: We have experts in our country who have been giving this a lot of thought and thought for a long term. Prof Freeman being one and the other being Professor Kriek Lundt and Professor Allan Jay Flisher, and they have written extensively on this topic and I have in front of me an article published in September 2009, and model for community mental health services in South Africa, where they do costing amongst other things, and I am sure that this might have had some, it might have been part of the planning process for the national mental health policy framework as well, and I know that they are involved in that. So I am saying that there are a lot of experts. There are experts in this field that has been studying this for many years. Academics, there are clinicians like myself that has been working in the field that knows what is happening at the grass route level, and as Dr Zikhire said in his article, there is no one size fits all. We need to go about it in a systematic manner. There should be a template for the whole country to follow.

That is what national policy should be about and then different provinces will probably have different needs in terms of the communities that they serve and even in different parts of the same province. But you can change the model here and there, and you need for that you need to know what it is going to cost in terms of human resources, you must know which professionals you want to be part of that model that you are adhering to. So whether it be community mental health teams, which professionals are you going to make part of that community mental health teams, assisted living, primary health care services. Who should be working at which tier of support. It is not rocket science in my opinion to put it together. It is a lot of common sense and there is, where we are in South Africa we are not going to make 2020. Definitely not. Not in the near future.

ADV. LILLA CROUSE: So what you are saying is that by 2020 we will not be at a place where we can de-institutionalise safely? Is that what you are saying?

PROF. GROBLER: Certainly not in the Eastern Cape.

ADV. LILLA CROUSE: Okay.

PROF. GROBLER: So ... [interjects]

ADV. LILLA CROUSE: And the Eastern Cape was part of South Africa the last time I checked.

PROF. GROBLER: So for the, to do something now and I think something should be done now immediately. We have to be pragmatic. We have to think out of the box. We have to consider people with qualifications that are not utilised by the government. People like mental health assistants that you referred to that needs a

two year qualification. That is like, they are on their way to become psychologists, if I can put it that way. Then after, if you do another qualification you become a, what is the next one?

ADV. LILLA CROUSE: Counsellor.

PROF. GROBLER: A Counsellor. Then a psycomotrist. Then a psychologist depending on which masters degree you do there. In occupational therapy they now have occupational therapy technicians, OTT's. In medicine they have clinical associates that has a four year degree. All of these people can be used. In fact, in my province I have been begging for the past two years and say send me ten clinical associates. Walter Sisulu trains clinical associates. Wits trains clinical associates. The University of Pretoria trains clinical associates. Send me ten clinical associates per year and I will turn them into mini psychiatrists all over the province and I can render a service by communicating with them directly. They will not be able to sign scripts, but they can sign scripts together with prescriptions together with professionals out there. In Somerset East for example we trained a doctor in diploma in mental health last year. So she looks after the patients there for me. So we have to be pragmatic and we have all these people with skills, but we are not utilising them in mental health and I definitely think we can use them in mental health. Just as a last remark. I spoke to Prof Jannie Hugo from the University of Pretoria just recently and in Pretoria specifically they have I think he said 11 clinical associates who are running their substance abuse program in Pretoria where they see the substance abuse. I am not sure how it works. I have

very little information on this, but they are using clinical associates there and I can see this, we can do the same in other parts of the country.

ADV. LILLA CROUSE: What you are saying is there is ways to do what we have to do with less money than we want to spend. That is basically what you are saying. There are people around that we can utilise that are not psychiatrists to drive processes?

PROF. GROBLER: We are talking about, there is a nice term for that. I cannot remember the term now, but rescilling or upskilling of ... [interjects]

ADV. LILLA CROUSE: Yes, up scaling.

PROF. GROBLER: Up scaling. You know.

ADV. LILLA CROUSE: Or skilling. Ja, sorry yes.

PROF. GROBLER: So we need to equip other people to do things where we know there will not be a psychiatrist, so and that it is possible to do that.

ADV. LILLA CROUSE: Can I just take you, are you aware that the health professionals council in 2008, you spoke about the mental health assistant, and that they need a qualification of a two year or NQF6. You spoke about that earlier.

PROF. GROBLER: Yes. I am assuming they are at similar level as the OTT's.

ADV. LILLA CROUSE: Yes, and there, but there is no process to accredit these guys as yet. So what can we do about that? Do you know?

PROF. GROBLER: Again I am not a policy maker and there are expert policy makers, even in this room, but we need to think pragmatic and we need to use

these people, and they are going to cost less than what we are spending at the moment and we just need to think smarter. So I think it is doable. I think we can for every province create a different model. Dr Zahire was talking about an outreach model that I was referring to, because we are already using that to some extent in the Eastern Cape. So every province can look at it differently and look at their needs, and an urban area like Gauteng obviously would be very different from where I am working in the Eastern Cape.

ADV. LILLA CROUSE: Yes. The health professional council has a mental health assistant in their framework. They also have a registered Counsellor. But this plan that you, the policy and I take it what you say you did not draw the policy, but both those occupations are absent from the health work policy, so on the one side we have a professional council say these guys could be useful. The policy does not make use of them. So there is, would you say there is a need for these people in mental health care? Assistants and Counsellors.

PROF. GROBLER: Yes, there is a need and I can start using them tomorrow in my, the area where I work.

ADV. LILLA CROUSE: So we have the need on the one side. Then we sit with the fact that there is not a process of registering them. So that is something, who must look to that? The mental health profession or who else? Do you know?

PROF. GROBLER: I ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: I am very close to where ... [interjects]

ADV. LILLA CROUSE: I am very nearly finished.

ARBITRATOR JUSTICE MOSENEKE: Advocate Hutamo was.

ADV. LILLA CROUSE: Yes. I am very nearly finished Justice.

ARBITRATOR JUSTICE MOSENEKE: Yes. You are setting up a whole curriculum of psychiatry about which we can do little but more frankly nothing.

ADV. LILLA CROUSE: With respect Justice, not nothing. We have still a country full that, and I am very close to the conclusion now, if you just give me ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: No, but it is fine. I am saying that in an arbitration award, how much can you write about how the training should be and how those training should be deployed and their characteristics. That is all I am saying. The current purpose, it might be sufficient to say we need mental health care training. We need the experts to go and look again, and to formulate how to build capacity. I do not know whether you want him to go beyond that.

ADV. LILLA CROUSE: If you grant me five more questions Justice, I am done with this.

ARBITRATOR JUSTICE MOSENEKE: Yes, please.

ADV. LILLA CROUSE: What we have, we have a need. We have a clear lack of process, and then on the other side we have university students studying at great expense to themselves and their parents psychology. Do you agree?

PROF. GROBLER: I saw that in the documents that you gave me, yes.

ADV. LILLA CROUSE: Yes. Now we know that about 200 less psychology students than law students qualify per year. Now law students have a career path. But those guys do not have a career path. Is that, would that be true?

PROF. GROBLER: That is my understanding and that is something that the psychologists themselves will have to look into.

ADV. LILLA CROUSE: Yes.

PROF. GROBLER: And in terms of their scope of practice I know that they have been looking to some of that, between clinical psychology and counselling psychology, but they need to look further down the line and the point you are making is that they need to look at mental health assistance and psycomotrists and counsellors as well, and I agree with that.

ADV. LILLA CROUSE: I have asked you before your testimony to look at ELAH90. Do you have that in front of you, and I am stopping with this.

PROF. GROBLER: I do not have .

ADV. LILLA CROUSE: ELAH90, 90.

PROF. GROBLER: I have it in front of me.

ADV. LILLA CROUSE: If you can turn to page 6 of ELAH90. ELAH90 is an affidavit that was placed before the arbitration. The witness was not allowed to testify. If you can just go to paragraph 16 there on page 6. Would you agree when one looks at the Ombud's findings, that there is definitely a need for more skilled resources? You have said that, the Ombud have said that. Do you agree with that?

PROF. GROBLER: I do, yes.

ADV. LILLA CROUSE: Now the conclusion reached by Ms Campbell was that South Africa has a substantial existing skills base from which to be drawn, but graduates have a little opportunity to be formally recognised in the Department of Health and the skills remain inaccessible. Would you agree with that?

PROF. GROBLER: It would appear from the documents and from her career path definitely so.

ADV. LILLA CROUSE: Yes. The problem with having skilled people, not having a place for them to practice create people practicing without the oversight of professional bodies. That is a logical conclusion. So what is the problem to practice in the mental health field without an overarching body to which you are responsible?

PROF. GROBLER: Again we are talking here about a psychologist and I am weary of stepping on any toes, because it is outside of my profession, but I would think that the danger would be that they are going to become entrepreneurs in a way and start rendering some service, maybe a cash service or something of the sort. I suppose that would be one.

ADV. LILLA CROUSE: Or doing harm.

PROF. GROBLER: I suppose that could also be possible yes.

ADV. LILLA CROUSE: Yes. So what you are telling us, you could use more help and so would all state institutions at the moment.

PROF. GROBLER: Yes, and again one has to qualify and then say it has to work according to a very specific plan that was put together prior by academics and clinicians and that it, there is adequate funding to put people in a place and there is a ... [interjects]

ADV. LILLA CROUSE: My last question. It is my last question. So would you agree it is time that the universities, the medical health council, the policy makers start speaking to each other?

PROF. GROBLER: I think it is.

ADV. LILLA CROUSE: Thank you Justice.

ARBITRATOR JUSTICE MOSENEKE: After this hearing if they do not, I would be deeply surprised, but thank you Advocate Crouse. Advocate Groenewald.

ADV. DIRK GROENEWALD: Thank you Justice. We have no questions for the witness.

ARBITRATOR JUSTICE MOSENEKE: Yes. Advocate Hutamo?

ADV TEBOGO HUTAMO: Similarly Justice we have heard the Professor, we have no questions.

ARBITRATOR JUSTICE MOSENEKE: Okay. Re-examination?

ADV. YINA: Thank you Justice, there will be no re-examination.

ARBITRATOR JUSTICE MOSENEKE: You have been quiet for so long, you should be having something to say. But very well. Professor, we have developed a practice and we have been quite consistent. Let me start off first by thanking you

for coming out to this part of our country. You came and helped us with an obvious challenge that happened in the Gauteng province, from which I suspect it might be a national if in some senses not a global challenge. How to provide adequate mental health care in ways that we see in all of these wonderful codes, but thank you for coming out and sharing it with us. It is very, very important, but it is also important for the families who are here. You can see they are all here and listening and those who do not follow English, always gets translated in the language that they hopefully follow. So that is my way of saying thank you and the report is very usefull and will be used. I am sure you will see some, your own sentences in the judgment, in the award.

PROF. GROBLER: Thank you.

ARBITRATOR JUSTICE MOSENEKE: So thank you. We do allow all witnesses at the end of a hearing like this, to express themselves. Obvious it is not obligatory. It is not like a question, but it is something that you might want to say in the light of what you know now about the Life Esidimeni tragedy.

PROF. GROBLER: Justice, if I may then I do not think I am going to say this, but I think I would be amiss not to express my condolences to the families of the patients, the deceased patients and to in a sense say that I have done my part as well as an Advocate for those with mental illness. I recently in last year I published a letter to the editor in a magazine called the South African Journal of bio ethics and law in which I refer to my own brother who I visited the beginning of last year in the UK suffering from ... [inaudible] cancer, and I have to say that I have his permission to, I had his permission to publish this and also the artist. The, what happened is I went

over there and within the first day I realised that he was significantly depressed, suicidally depressed, and it took me five days in the middle of London to get my brother help. I am a psychiatrist myself. I was chased away by psychiatric hospitals, by secretaries at psychiatric hospitals telling me, asking me if I am in the system, if my brother is in the system. Five days before I could get my brother access to mental health care and this is in London. So I think this is a global problem and I am referring to an artist, because an artist friend expressed something about the plight of mental health care users in a painting that I later on bought. So I do want to express from my side my condolences to all the family members and our thoughts and our prayers are with you. Thank you Justice, nothing more.

ARBITRATOR JUSTICE MOSENEKE: Again, thank you. Yes. We are going to have to confront the ... [inaudible] de-humanisation and stigmatisation and look how far it has brought us to a very terrible space where we do not want to be. We thank you again and indeed you are released. We have one or two housekeeping matters we are going to deal with. If you want to sit there, you are welcome. But we are going to thereafter adjourn very shortly. Once more, thank you Professor Grobler.

PROF. GROBLER: I will happily sit here until you are finished.

ARBITRATOR JUSTICE MOSENEKE: Yes, thank you. We have come to the end. It was your witness Ms, Advocate Yina.

ADV. YINA: Thank you Justice. That will be the last witness for today. Thank you.

ARBITRATOR JUSTICE MOSENEKE: It is the last witness for today. That is good news indeed. Would any of the Counsel want to say anything?

ADV. LILLA CROUSE: Justice ... [interjects]

ARBITRATOR JUSTICE MOSENEKE: ... [inaudible] the next two days of sitting which on Tuesday and Wednesday we seem to be agreed. If not agreed, at least it is settled. We know what we are going to do. Is there anything else that we want to say?

ADV. LILLA CROUSE: Justice, from our side I am very sorry that I am going to keep you up for a little bit longer, but I have quite a number of affidavits that I want to hand up, if I might just read them into the record.

ARBITRATOR JUSTICE MOSENEKE: Certainly.

ADV. LILLA CROUSE: As ELAH139 an affidavit by Grace Lea Mohlabi, it is one of the family members. ELAH140 Mosidi Priscilla Ntshangaze. Similarly, all of these affidavits are by family members. ELAH141 Sandra Norita Davis. ELAH142 Lepeo Berth Hassim. ELAH143 Onica Dalasile. ELAH144 Jim Dlamini. ELAH145 Pumla Shahi. ELAH146 Talita Olga Mabisela. ELAH147 Sophie Kanza. ELAH148 Mojalega Sehunya, and those are the affidavits that we will make sure it makes its way to all the necessary files. Thank you Justice.

ARBITRATOR JUSTICE MOSENEKE: Very well. Thank you ever so much. Is there anything else from any of our Counsel? No. We are done. At least for now, and where I come from we say vasbyt, because we are left with two more days of hearing and two days of argument. So the end is in sight Sasha Stevens. You

have been with this thing forever. Almost going to grow old on it girl, be careful. But we are getting there. We are almost there. So I would like to again thank everybody and the family and the media. I have never talked about the media but you have been amazing. Whoever I meet says that they have been watching your coverage's and cross-overs. So it has been quite amazing. So, so many days that you would run this thing live and to tell South Africans about something that might have been ignored about mental health care users. So in many ways it was a very big thing to counteract the stigma to say mental health care users affairs and fate are worth reporting on live on television. So I would like to thank you, and the media houses who have been doing this as well as on You Tube and just about everywhere. Thank you. I hope it will have some value for our nation and for the world. I know BBC and CNN have covered this in a variety of ways. So I hope it was something that will awaken our humanity. On that note I would like to adjourn until Tuesday at 09H30. We are adjourned.