LIFE ESIDIMENI ARBITRATION

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

DATE: 10th NOVEMBER 2017 DAY 18

DAY 18, SESSION 1 – 2.

BEFORE ARBITRATOR – JUSTICE MOSENEKE

WITNESSES:

PROF MALEGAPURU MAKGOBA

ME. CORALIE TROTTER

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10 NOVEMBER 2017

SESSION 1

ARBITRATOR: Thank you, you may be seated. Good morning to you all and I would like to apologise for keeping you waiting and I can assure you that it was not in vein. We had an important meeting in which we had to resolve something quite important and we are starting later than we had agreed yesterday if you all remember. We said 10:00 and it is 11:00 and this is the reason, we have today, in our midst and we welcome them, the advocate and attorneys of MEC Ms Qedani Mahlangu who are here with us and I would like to welcome you Mr Pincus as well as your attorneys. In a short while, Advocate Pincus is going to address this arbitration proceeding out of which you will follow what counsel has to say to you, counsel of the MEC. Advocate Pincus?

ADV PINCUS: Thank you Mr Arbitrator.

ARBITRATOR: If you could just put on record, who, you represent?

ADV PINCUS: I represent Ms Mahlangu, instructed by [Bacari Bolo Mariano]. We are here this morning, we have reached an arrangement which we have put before you and it has also been approved by yourself, that Ms Mahlangu will testify before these arbitration hearings and the dates that are agreed upon, are the 22nd of January next year 2018 running through to the 26th of January 2018, say perhaps for the 23rd, where Mr Arbitrator you are not available. We give an undertaking on our client's behalf, to attend the arbitration during that period and she will definitely attend. She wants to attend and we give this undertaking on her behalf, thank you.

ARBITRATOR: Thank you Mr Pincus. I thought you would add the arrangement in relation to the subpoena that will be served on the attorneys? Would you add that please?

ADV PINCUS: Yes we have also agreed that a subpoena for those particular dates, can be issued and can be served on the offices of my instructing attorneys who are [Bacari Bolo Mariano] and that can be served at 8A Bradford Road, Bedford View, Johannesburg. That has been agreed to and we accept that.

ARBITRATOR: Thank you Advocate Pincus. I am going to start in the normal order that I followed in these arbitration proceedings to get the response of the various counsel to this arrangement. Advocate Hassim?

ADV ADILA HASSIM: Thank you Justice Moseneke, I confirm that we have had a discussion with the legal representatives for the former MEC and that we have agreed to the arrangement that in order to avoid a coercive process, to agree and accept the undertaking of the counsel that the former MEC will be available on 22 January 2018 in these proceedings.

ARBITRATOR: Thank you Counsel, Advocate Crouse?

ADV LILLA CROUSE: Thank you Justice Moseneke, I just want to place on record as well, that we are in agreement with the dates that have been reached. We have tried to secure earlier dates and I am quite sure my learned friend will be happy to place on record why the earlier dates weren't acceptable and couldn't be reached, thank you.

ARBITRATOR: Advocate Groenewald?

ADV DIRK GROENEWALD: Thank you very much Justice, Justice, save for sharing the same sentiments as my colleagues from Legal Aid South Africa, that we invite the representatives of Mrs Mahlangu just to state and to qualify as to why we came to an arrangement only for the 22nd. I think the families are entitled to know why those dates are only available, so we just invite them to clarify that, thank you Justice.

ARBITRATOR: Advocate Ngutshana?

ADV PATRICK NGUTSHANA: Thank you Justice Moseneke. I agree that the arrangement has been arranged by the parties and I agree with the sentiments shared by both legal Counsel for Legal Aid and [inaudible] Attorneys as well as Adila Hassim on behalf of Section 27, thank you Justice.

ARBITRATOR: Thank you Advocate. Advocate Hutamo?

ADV TEBOGO HUTAMO: Thank you Justice, as we have previously indicated that the government has been taking every effort to make arrangements that all relevant officials are in attendance. The appearance of the counsel attending on behalf of the former MEC, has been through that effort and indeed, we have agreed on the dates of the 22nd of January until the 26th of January 2018, with the exception of the 23rd, which is the date on which Justice is not available and that is the arrangement that has been agreed upon. The matter should proceed on that date where the former MEC will present herself before these proceedings, to assist all the family members and to give information to all the interested parties so that this matter can

be brought to finality. We are thankful for the effort that has been made to ensure that an arrangement is made by agreement, thank you.

ARBITRATOR: Thank you. Advocate Pincus, I think it would be fair to the families that you briefly say why we can only do all this in January. You have heard the desire to know why this long, but there is a reason, we know it, but they don't. Would you want to put that reason on record please?

ADV PINCUS: Thank you Mr Arbitrator, we have no difficulty with that. Our client is registered for a Master's of Business Administration at the University of Bedfordshire in London. She has already completed the mergers, acquisitions and private equity model. She at the moment is busy with the strategy and global competitive environmental module which finishes this month November and this month, she starts with the global financial markets and wealth management which is only completed on about the 15th of January next year. In regard to the question relating to our client's suspension from the University of Bedfordshire, we are of the view that that suspension was both wrongful and unlawful and we are taking steps to have it revoked and if necessary, reviewed. That is why notwithstanding that suspension, she is only available from the 15th, well she finishes the module on the 15th of January next year and therefore, the dates that have been suggested, have been agreed upon, thank you.

ARBITRATOR: Thank you. Thank you so much counsel. We are done with this part of the proceedings which we have recorded as we are required and we are going to get to the next phase, so at this stage- it does not mean that you have to agree with it, but that is the arrangement currently and we are going to have to wait

and good things are often worth waiting for. So we are going to wait because we have to get to that evidence and I ask for your patience and your understanding as we continue to do the work we have to do in these arbitration proceedings. Again, I thank you counsel and attorneys who are here and you are indeed, excused, thank you. I do not propose to take a tea-break given the late start, so we are going to go straight ahead until the lunch break and we have important evidence to go through today and that's exactly what we are going to do. Evidence leader?

ADV PATRICK NGUTSHANA: Thank you Justice Moseneke, we would like to call Professor Makgoba to come and provide us with some explanation to certain questions which were raised during his testimony and further enquiries which were directed at him in relation to the numbers of patients who died and other issues which he will come and explain. Before he comes, let me also record that today, I am flying solo, my colleague is outside of town consulting with a witness.

ARBITRATOR: Yes and the Professor, is going to hand in the report formally is it?

ADV PATRICK NGUTSHANA: Correct. It's not a report, or it's not a final report, but a report in which he explains the questions that were raised to him. The final report has been done and dusted some time ago, he had testified on it.

ARBITRATOR: In which language do you prefer to testify Professor Makgoba?

PROF MALEGAPURU MAKGOBA: I will do it in English.

ARBITRATOR: In English. Would you again put your full names on record?

PROF MALEGAPURU MAKGOBA: It's Malegapuru Makgoba.

ARBITRATOR: Do you swear that the evidence that you are about to give, will be the truth and nothing but the truth and if so, please raise your right hand and say so help me God?

PROF MALEGAPURU MAKGOBA: So help me God.

ARBITRATOR: Counsel?

ADV PATRICK NGUTSHANA: Thank you Justice. Professor Makgoba, there is a document in front of you which you have prepared, we have referred to it as ELA57, are you on it?

PROF MALEGAPURU MAKGOBA: Yes I can see it.

ADV PATRICK NGUTSHANA: Yes, can you take us through the document. I see that on the second page, under Introduction, you introduce it by the following, that following my oral evidence on the 9th and 10th of October 2017, I received a number of queries from Advocate Adila Hassim of Section 27 and Advocate Groenewald of Solidarity. It's in fact [inaudible] Attorneys about deceased patients who did not appear on my list. These similar queries were subsequently raised with Dr Kenoshi, Acting Head of Department of Gauteng Department of Health on the 20th of October 2017, I was thus requested by Justice Moseneke to consolidate all the figures and provide a report. Accurate figures are essential to the arbitration process. This is an explanatory report following upon the enquiries directed at you.

PROF MALEGAPURU MAKGOBA: That is correct and again, I want to emphasise that this is not my report. I have already done my final report and my final report has legal requirements that I need to fulfil, so I did this out of a request from what I

testified here, so it can never be my report, but an explanation. Again, I want to go back to what you have just said, that during my testimony here on the 9th and 10th, I received I think a list of deceased patients that were not on my list and I can explain that and I was asked to go and look at this list. I had received about 15 names, I think from Section 27 and I had received 2 additional names from Advocate Groenewald and I went back to Doctor Kenoshi who is the Acting Head of the Department of Health in Gauteng who obviously is the custodian of the patients that were being looked after, who also supervises a data verification team that has compiled the list of patients that were being looked after by the Department. I also took the opportunity to go to the CEO's of the hospitals in which patients were distributed into and all of those people, including Life Esidimeni, I went back to their new CEO to find out, to give me the list and verify the list of the patients that I had received from the 2 advocates and all of them I think cooperated in this matter. I then looked at the terms of reference for the arbitration and they are covered under the title Entitlement Criteria, which under that, is Section 2.1 and 2.2, which marks I think the terms of reference and in short, it says that all people that died before the 30th of June or a month after the relocation process, should be included in the list of those that are eligible and I prepared my report with this in mind and as you remember, the original was to prepare this report and only send it to you confidentially without sending it across and that is what I did, but I actually did indicate that I am prepared I think to put it on the record if that was necessary and that's maybe the reason why I am here. Clearly, I am now going to say how I have prepared the report, because you might have to look at it.

ADV PATRICK NGUTSHANA: Yes let's start on Page 2, under I provide the report organised as follows?

PROF MALEGAPURU MAKGOBA: Ja I have made a summary table of the official figures in accordance to the terms of reference of the arbitration process, that is Section 2.1 and 2.2-

ARBITRATOR: Well before you go far, I am intrigued by a scientist who quotes poets and other writers.

PROF MALEGAPURU MAKGOBA: I will come to that.

ARBITRATOR: Oh you will come to that okay.

PROF MALEGAPURU MAKGOBA: It's just the way I do things. The second table, I have gone to each facility where people have died and I have provided a table for each facility as to the number of people who died, but not only that, I provided that table from the time of the Marathon Project, so for each facility, I went since October and said how many people died here, who died here and it is provided as a table so that for each, you are aware of when did a person die, in which facility, at which month, up until September 2017. So, from about 2015, for each facility, I have done that, per month and the table is included as part of my document.

ADV PATRICK NGUTSHANA: Yes let's get to it.

PROF MALEGAPURU MAKGOBA: Basically I can just summarise it as follows, that if you look at the table which you might have or you might not have-

ADV PATRICK NGUTSHANA: Let me do this for the record that is under A, you make reference to a summary a table of the official figures in accordance with the terms of reference of the ADR. Under B, a summary table of total deaths per facility and period in accordance with the terms of reference of the ADR and C, a detailed spreadsheet of all deceased patients up to 30 June 2017. Then under D, in addition and included, is a list of 4 deceased patients highlighted in yellow up to 1st September that should be end of September.

PROF MALEGAPURU MAKGOBA: Yes end of September yes.

ADV PATRICK NGUTSHANA: The 1st of September is an error.

PROF MALEGAPURU MAKGOBA: Yes it's a typo.

ADV PATRICK NGUTSHANA: So up to the end of September 2017, you will explain that later on.

PROF MALEGAPURU MAKGOBA: Let me summarise it as follows, that in order to start this, we had to study the total number of patients that were at Life Esidimeni at the beginning of the Project and the data verification team went through close to 10 000 names from various data sets that were provided from my office from Life Esidimeni, from social workers, from hospitals, including the Home Office, SASSA and others, so they went through that list to compile the total number of patients that were at Life Esidimeni and we have come-

ARBITRATOR: That would have been around April/May 2015?

PROF MALEGAPURU MAKGOBA: It would have been from the beginning of the Project, it would have been October, so how many people were at the beginning of the Project when the Project started and that number for the record, is 1 711. The total number of people that were at Life Esidimeni, was 1 711. That's where it starts and 270 of these patients were discharged home. Now again, I want the media to report things as they are said, rather than to report things as they are sensationalised. That is why I am going through this trouble, so 270 patients were discharged home, leaving us with 1 441-

ARBITRATOR: Sorry Professor, we are looking at the schedule on?

PROF MALEGAPURU MAKGOBA: It will be Page 3 it's just a summary of the results really.

ADV PATRICK NGUTSHANA: Let's go to Page 3 the results.

ARBITRATOR: I just want to follow you as you say it. If you have a schedule at hand, it makes my life a little easier.

PROF MALEGAPURU MAKGOBA: Maybe I should just say on Page 3, under Results, I just want to summarise it because I don't want to confuse people with the details. So we are starting with 1 711. We discharged 270 and we remained with 1 441. This is arithmetic's and not maths. Now then I am requested to look into the circumstances of the death of mentally ill patients in Gauteng as the Ombud. I did this investigation from October 2016 to the 1st of February 2017 and in that period, I find that there are 118 patients that died and that figure has not changed. That is the terms of reference that I followed, 118 died during the period when I was

investigating. Then I looked at the terms of reference of the arbitration process that says I must then look at the deaths that occurred up to a month after the relocation process, so when I finished my investigations in February, patients were still in NGO's, some patients were in hospitals, but I had made a recommendation that all these patients must be removed from these unhealthy places or unprepared places back into safe places where they could be taken care of, so that process started after I had released my report on the 1st of February. The process started from there and went up to the 31st of May, it was a process of relocating patients from unhealthy, unprepared, unlicensed NGO's back into high quality healthcare places and patients continued to die during that time. Then after that, I would have to count from the 1st of June to the end of June which is the month that is allocated as part of the arbitration. Now what is the figure for that? The figure for that period of arbitration, it's 128 patients that died from Life Esidimeni and 11 patients that died from the associated deaths that I have spoken about in my previous- bringing the total to 139.

ARBITRATOR: And those are items E and F?

PROF MALEGAPURU MAKGOBA: Ja on Page 3, that will be Item H where in total, there will be 139 patients that have died as determined within the RDA arbitration terms of reference. Now again, remember that whatever we count as Life Esidimeni or as per the project, there are always these 11 patients that were associated that died at Siyabadinga, Takalani and even at Precious Angels, they were associated because they didn't originally come from Life Esidimeni, either they

belonged to the Cullinan Care Rehabilitation Centre, but then had to sacrifice their lives in place of Life Esidimeni.

ARBITRATOR: Yes, that is, the category, that, was displaced, from CCRC, but were associated, because they had to give way for those who had been moved from Life Esidimeni?

PROF MALEGAPURU MAKGOBA: Yes, so basically for the period of arbitration, the total number of deaths is 139. For the period of the Ombud, it's 118. Now remember that Dr Kenoshi and his team, have been monitoring patients and we have monitored these patients up until the end of September. Now by the end of September-

ADV PATRICK NGUTSHANA: Which year?

PROF MALEGAPURU MAKGOBA: 2017, there had bene 4 additional deaths which brings the total to 143. Now I want to talk about that, because there is something that I actually want to share with the families and with the lawyers.

ADV PATRICK NGUTSHANA: Before we get to that, that means that you must correct the reference to 1st September under I on Page 3.

PROF MALEGAPURU MAKGOBA: Yes it is 30 September.

ADV PATRICK NGUTSHANA: 30 September.

PROF MALEGAPURU MAKGOBA: I think it must be corrected on the record. Then because I have provided you with a table of facilities and the number of deaths per facilities over the period, I have also given the final figures for some of

the facilities that were identified and I want to place that on the record, that at CCRC, 29 patients had died and remember that CCRC it's a complex that involves Anchor and Siyabadinga and the Cullinan Rehab, so there are 29 in total. At Mosego and Takalani which are also a complex although they are separate, they have the same Director, one has got a licence and the other one is running under the other one, there are 38 people that have died from Takalani in total, so they have now outstripped even Precious Angels which had the highest number which is still 20 and not 23 as I have heard it on evidence, it is 20. Then there is Tshepong which had 13 deaths at the end of what I was doing. In total-

ARBITRATOR: I am a bit confused by those numbers. I am looking at a summary on Page 3 under Item A. Is that where I should look? Are those respective numbers? In other words, CRC, the numbers that follow, are they set out respectively?

PROF MALEGAPURU MAKGOBA: If you go Chief Justice, if you go to this little table here-

ADV PATRICK NGUTSHANA: Professor Makgoba before you go there, let's go back to Page 3. The next column is a summary table of deaths per facility and period showed. Are you making reference to that under A?

PROF MALEGAPURU MAKGOBA: Ja it's under A, it is basically a summary table of deaths per facility and the period that I have shown on Page 3 under Results.

ADV PATRICK NGUTSHANA: The first number 29, you link it to CCRC?

PROF MALEGAPURU MAKGOBA: Ja it's respectively, I left maybe the word respectively. It's 29 for CCRC, 38 for Masego and Takalani and then 20 for Precious Angels and 13 for Tshepong.

ADV PATRICK NGUTSHANA: That is correct.

PROF MALEGAPURU MAKGOBA: Those were the high density places where people died, so out of the 139 patients that died in my investigation, 100 of them had died from these 4 places.

ARBITRATOR: That is where the 72% comes from.

PROF MALEGAPURU MAKGOBA: Yes 72%, but then if you were to add the 11 because they would have died at CCRC, it becomes 79.85%, it is closer to 80%. On B, I have just put a footnote that you must remember all the time that CCRC included the 2 unlicensed and poorly prepared NGO's Anchor and Siyabadinga. So that is the numbers.

ADV PATRICK NGUTSHANA: Then you statistical analysis?

PROF MALEGAPURU MAKGOBA: Now the statistical analysis, as you remember in my report, I had-

ARBITRATOR: You are going a little fast. For details, we should then look at Page 8 of the report. It's a very vital thing I would like to make sure that I get it right. So what you have summarised on Page 3 (a) and (b), in effect, the detail would be found on Page 8 of the schedule that says Total Death Per Facility and Period, is that right?

PROF MALEGAPURU MAKGOBA: Yes it's provided there yes.

ARBITRATOR: Thank you.

ADV PATRICK NGUTSHANA: Perhaps you can finalise your explanation in relation to Page 8?

PROF MALEGAPURU MAKGOBA: I think in relation to Page 8, as I said, I have just put in where patients died, the name of the facility at the top and I have put the period from January 2016 up to the end of June, which will be the arbitration period and I put for each facility, when patients died, so for example, you will see that for CCRC, nobody died in January 2016 up until June 2016. Now all of you know that in June 2016, it was when the major migration was taking place and people were being transferred from Life Esidimeni into the CCRC and the same pattern you can see for each of the facilities, that the deaths almost in numbers, began to follow from June 2016 and that is what it shows there and then it follows for each month up until June for CCRC, for Masego, for Precious Angels, for Tshepong and so on and so on, the list goes on.

ADV PATRICK NGUTSHANA: So according to that list, the first death occurred in January 2016 from Tshepong Care Centre?

PROF MALEGAPURU MAKGOBA: Yes.

ARBITRATORS: The numbers I don't understand are numbers like Life Waverley, for instance in April 2017?

PROF MALEGAPURU MAKGOBA: Ja because people were now being moved back into places like Waverley when the relocation process took people back into Baneng which was part of Life Esidimeni and Waverley, so they had to be counted, because the period of arbitration says that we must go up until June.

ARBITRATOR: So they would have a round trip so to speak to be moved out, go wherever else, escape death and then come back?

PROF MALEGAPURU MAKGOBA: Yes.

ARBITRATOR: To Baneng or Waverley?

PROF MALEGAPURU MAKGOBA: Yes that's correct. So that is that table there and for the sake of clarity, again I have divided it into the period of my terms of reference and then the period of the arbitration where at the end of my period, there were 118, it's there in green and then at the end, it's the final tally which is on Page 9, it's 139 and it tally's, but as I say, it is really the death per facility per period over the time of the arbitration period. So you can go there and say I want to see what happened in Waverley, I want to see what happened in Masego over this particular month and you can see how the deaths are clustering over a particular period.

ADV PATRICK NGUTSHANA: That is where you record the total after the release of the Ombud's report, it equals to 21?

PROF MALEGAPURU MAKGOBA: Ja. So after I released my report, up to the time when patients were relocated, 21 patients died and if you then add them to the-

ARBITRATOR: That is where 139, comes from?

PROF MALEGAPURU MAKGOBA: Yes, but I think the media must be very careful when they report. I think they must report the numbers and qualify them according to the period and the terms of reference, because otherwise the population gets confused and they think that somebody is hiding something. We are not hiding, but there is a time dependent and terms of reference dependent way of reporting.

ARBITRATOR: Sure, but you were quite clear from the beginning that you were still counting?

PROF MALEGAPURU MAKGOBA: Well yes, I was clear about that and there was a reason for that and I have explained it that at the time of my investigation, it was clear to me that the information was coming in and sometimes I was not being given information at the time when I was looking for it and I also had evidence, but I hadn't verified it in the manner that would be satisfactory for me to actually pronounce it as authentic or something like that.

ARBITRATOR: Well let's put it to you this way Professor Makgoba, when in the end 143 died, I know there are 3 stages, 118 and an additional 21 and ultimately an additional 6, that gives you 143, part of the horror, is that you even have to reconcile these numbers in this complicated way, which gives an idea of just how many people have died. There are many bodies aren't there?

PROF MALEGAPURU MAKGOBA: Well I think yes, I would like to agree with that Justice. I just think that this is like a moving train and that's why I want the media to be very cautious because people are coming out of the woodworks in different ways and they appeal to different people. I suspect that it may be that even after what I

have said today, you may find that there are people that need to follow a different process in order to bring this, but that is really not within my gift and within my terms of reference. It is something that maybe the arbitration process needs to sit and discuss, because I followed a particular process with particular terms of reference and there is a particular outcome and I can stand at the rooftop and say this is what I found from the information that I have that is authenticated. As I say, this data here comes from the Home Office. There was a name here that was actually raised by Section 27 where somebody's name was spelt as Legwabe with a G, now that is Pedi and now if you spell it in Xhosa, you can put R and it becomes Legwabe in Sotho, but it will be Legwabe in Xhosa because the R are pronounced as- but it was not only that, but even the dates of death were different, so you had 2 things that actually made it different. We had to go to the Home Office to ask is there such a person in the Home Office register, but we also had to go back to the hospital and ask them did you ever admit, who did you admit who died in your hospital and this was at CCRC.

ARBITRATOR: So the schedule that follows next, you are going to take us there some time right?

PROF MALEGAPURU MAKGOBA: Yes I am going to do that.

ARBITRATOR: Okay let's go there then?

PROF MALEGAPURU MAKGOBA: Okay. Now the final schedule which is on Page- there is a page which-

ARBITRATOR: I'm sorry, just before you go away Professor of course you won't be surprised when the media says the number is now 143?

PROF MALEGAPURU MAKGOBA: Yes.

ARBITRATOR: And that would be borne out by the different stages of counting, that you have so ably done and we are grateful for that.

PROF MALEGAPURU MAKGOBA: Yes.

ARBITRATOR: So clearly, you know you are going to have to expect the media tomorrow to say Professor Makgoba says no, in fact there are now 143.

PROF MALEGAPURU MAKGOBA: I expect them to qualify it Judge, I really think we can't just be banding numbers around. I think the media, must not only inform, it must educate.

ARBITRATOR: Yes, but let's go to the schedules, let's get back to the numbers.

PROF MALEGAPURU MAKGOBA: I think following that, there is a page which is just really a breakdown of the numbers and I think I will leave this to the arbitration team to argue about and so forth, it's not really for me to go through. It just spells out the numbers that I have already said there and I don't think there is an issue around that and then there is a schedule of the names, it's almost like 5 pages of the names of the 143 divided into 3 sections of the 128 which are the Life Esidimeni patients that died in accordance with the terms of reference of the arbitration and then there are 4 additional patients that are put in yellow that died almost towards September and after the period of arbitration and then there are the constant 11 that

have died as associated deaths covered on the last page. So that is really the table and it's the details as far as I can see from what I have. I have given the total breakdown and I have given the names, the list where they died and where they were admitted.

ARBITRATOR: This is very impressive, but as far as you know and with the work that you have done, the detail of this final schedule, the details are reliable?

PROF MALEGAPURU MAKGOBA: As I say, they have been verified by the data verification team in the Department of Health. They have been verified by my office. We have checked this, as I say with the Home Office, I have done that myself and I know that the Department of Health have done it independent of me. They have checked it through SASSA, we have checked it through another team called the Relocation Team that was also monitoring these patients and we have gone back as I said, to the CEO's of the hospitals where these patients were. We have had to make some alterations here and there, but this is where we are. Now there is also just a point that I want to clarify and I am speaking here as a doctor for once, not as an Ombud, when a patient comes to a hospital or is referred to a hospital, the patient belongs to a doctor or they belong to a clinic. Now I say this because the patients we are dealing with here, were patients that came from Life Esidimeni and the decision was that the patients would either be discharged or they will go to a hospital, an institution hospital, or they would go to an NGO. Now you will discover that when you look at the places of death, you will find that somebody would have died at Kalefong-

ARBITRATOR: I see some at Weskoppies?

PROF MALEGAPURU MAKGOBA: At Weskoppies, it's legitimate because that is where people were going to go. You just have to count it as a place where people needed to go, but nobody left Life Esidimeni to go to Kalefong, because Kalefong does not treat long-term mental health, but somebody would have gone to Precious Angels for example and got sick there and then was requested to go to Kalefong. Now in health, the place where you register is the place where you belong and you are tracked through the system. So, if you are treated and you die at Kalefong or, if you get better at Kalefong, you were going to go back, to the NGO, where you came from. You were not going to come out of Kalefong and be discharged, because remember you are a long-term patient, you have a place that you are registered at, so the NGO's where they were registered, would be the place where they belong if they had been treated at a hospital. So this thing should not be confused, that you see somebody at Leratong Hospital and you suddenly think they belonged to Leratong. They went to Leratong for a particular reason, maybe for an emergency for something like that. If they got better, they would have gone to the NGO or the hospital to which they are now registered and that's a tradition in the health system that the place where you are registered, tracks you around. When I was in London, I would see people from Edinburgh and they would be coming from Edinburgh but when I finish with them, they go back to Edinburgh, they don't belong to me, they came to me as a referral and so forth, so I just want people to be cautious, otherwise you will have people all over the place and you don't appreciate- it's a tracking system within the health system that is actually quite classic and traditional.

ARBITRATOR: Professor where the schedule is silent about the location of death, what assumption should I make? That they would have died at the facility registered at?

PROF MALEGAPURU MAKGOBA: Yes they would have died- I mean there is one here that is actually unknown and we have been struggling to find what is this unknown and as I say, out of that whole list, obviously we have one that is unknown and we have tried our best and we have come back- the best way to register it, is to leave it as unknown because we can't assign it.

ARBITRATOR: But look at the location of death on the schedule, you will see there are quite several where the location of death is unspecified, so my question is, is it legitimate to assume that it would have occurred at the facility?

PROF MALEGAPURU MAKGOBA: Yes at the facility, that's a reasonable assumption to make.

ARBITRATOR: Counsel?

ADV PATRICK NGUTSHANA: Professor Makgoba just to finalise on your report, let's go back to your statistical analysis.

PROF MALEGAPURU MAKGOBA: As I indicated in my initial report here, was that one of the problems we had, was we had problems of records, registrations and numbers and therefore, when we went to the Statistician General, to say can we analyse this to find significance to do statistical tests, he said no you can't do this, because this whole thing shows such poor administration, there are no records and you don't know what you are comparing apples with sugar cane or oranges or

whatever it is that you are doing, but basically, we couldn't do robust statistical analysis and part of the reason why one of my first recommendations to the Gauteng Department, was to go back and say let's try and find a way in which we can re-construct the data from scratch and find out who were at Life Esidimeni when we started the Project and that is why we went through this data verification team using computers and going through about 10 000 records and names. In fact, at one stage or another, for the lighter side of it, I had patients who had 2 dates of death. Now I know one thing about South Africa, one of the things which they did which is laughable in the world, is sometimes we confuse genders of babies when they are born, so we are very good at mixing up things, but to have 2 dates of death and you have 28 people, it shows you how corrupt the data was, so we had to go back again to the Home Office, to the various places and say what actually is the actual date of death, because nobody can die twice and then we had people who had several ID's and so forth, I am sure you have heard about that. So we have had to clean up this data to come to where it is right now. So now we are able to do statistical analysis.

ADV PATRICK NGUTSHANA: That is the result of the clean-up?

PROF MALEGAPURU MAKGOBA: Ja that is part of the clean-up and then I just want to share with you, the statistical analysis because I think this just drives home some of the things that you may want to hear. First of all, we looked at the patients who died in 2016 that is from January 2016 to December 2016. The reason for that, is that the Statistician General in the country, compiles an aged adjusted record for the country that in 2016 from January to December, so many people died and so

many people died per 1000, because that is how it is worked out, so out of the population of South Africa, you have a number of people who have died, but you have to calculate it per 1000 of the general population. So in South Africa in 2016, for every 1000, 8 people died. If we take the people who died from this transfer, there were 106 of them and per 1000, if you work it out and compute it, it was 63 per 1000 which is 8X, they were dying 8X higher than the general population, which is very significant. That's the first point in the statistical analysis. The second point is if you then look at the observed death of this group that we are studying and you compare that observed death with the general population, you came to something called a standard mortality ratio and the standard mortality ratio that was able to be computed by the statistician, is 4.9. Now how do you deal with this? We went through the literature and found that there were 203 studies that were done in 29 countries and in 6 continents, looking at the standard mortality ratio and the average for the world is 2.2. So ours of 4.9 is very high. For this population that we studied in 2016 that died-

ARBITRATOR: Is this the standardised mortality ratio of country or of the cohort?

PROF MALEGAPURU MAKGOBA: The cohort that we studied for 2016 that came out of Life Esidimeni comparing it with the international benchmarks of 203 studies in 29 countries.

ARBITRATOR: Okay.

PROF MALEGAPURU MAKGOBA: And then we did other studies statistically that showed that when you were transferred-

ARBITRATOR: This call was 4.9 compared with the international benchmark of 2.2?

PROF MALEGAPURU MAKGOBA: Yes.

ARBITRATOR: Okay I've got that, thank you.

PROF MALEGAPURU MAKGOBA: Now we looked at the risk factors, so what were the risk factors for people to die? We found that there were 3 risk factors. If you were transferred to an NGO, you died faster and earlier than if you were transferred to a hospital. Now let me put it in perspective, if you had to look at patients who were transferred and look at them and say at 92% of survival, 92% of the people would have survived both at NGO's and you ask yourself how many days would they have survived for at the NGO's, it would be about 200 days. If you went to a hospital, about 98% would survive and it would be about 400 days, not only do you die faster, you died earlier if you went to an NGO as opposed to if you went to a hospital. The other one was that if you were older, it was significant. If you were a male or female, although it was consistent to see that females were dying faster and earlier, it was not significantly different, but it was consistent that females died in the study. Now there is a reason for that if you then look at what I've said before. The females in this group were older than the males, so they fell into that risk and proportionately, they were sent to the NGO's and not to the hospitals. It was random, but that is what happened.

ARBITRATOR: You mean more females were sent to NGO's than males?

PROF MALEGAPURU MAKGOBA: As a proportion.

ARBITRATOR: As a proportion of that particular cohort?

PROF MALEGAPURU MAKGOBA: Yes and it wasn't deliberate, it is what comes out and it confirms what we had already said that gender and NGO's versus hospitals, so that is actually very significant also. So the final one on the statistical analysis is that if you had gone to an NGO, you had a 3.5% higher risk of dying than if you went to a hospital, again confirming, that there was something that was not right about the NGO. Now that's really as I say, this is not done by me, it's done by the statisticians. So that is the next point I wanted to put, so if you were older, you were female and you went to an NGO, the chances are you know your survival is cut off and the figures are there.

ADV PATRICK NGUTSHANA: On Page 4, I think we have dealt with this earlier in your evidence.

PROF MALEGAPURU MAKGOBA: Ja we have dealt with it before, but I want to emphasise it because we have spoken about this whole issue of people dying in the winter and I just want to summarise it as follows, that this is nothing clever, but if you were to look at the history of Life Esidimeni and look at the history of the population in general, we know that there are more people dying in the winter, so as it happens by coincidence, the transfer of patients out of Life Esidimeni, the maximum transfer took place between the months of May and June, that was when the maximum happened and that also coincides with the winter. So if you look at the months of May, June and July and study the number of patients who died in Life Esidimeni and then you compared them with the number of patients in this same period who died in the facilities and then you come back in 2017 when you have

relocated them and you have relocated them also coincidentally around the same time, a very interesting picture emerges that over that peak period of 3 months, at Life Esidimeni, you had about 12.8 people dying per month, just between those 3 months. If you then went during the Marathon Project, 22 people died per month in that period. Then you take these people back to good quality care into hospital, 2.7 people die. What does it tell you? It's that look after mentally ill patients properly, professionally at the right places and nobody dies or very few people die, so it is basically the best proof of the pudding, that if we had looked after these mentally ill patients, we wouldn't be sitting here. Now let me put it this way, in 2016, 103 patients died from January to December. In 2017, now, it is the 10th of November and we have only had 29 deaths from January to November. Now this is again arithmetic and not actuary, if you subtract 29 from 106, we have lost about 76 or so patients that should not have died, that would have been here. As I say, if you do actuary, it may be less, but basically, as we sit right now, we have lost about 29 as compared to 106 and the difference is people we should not have lost.

ADV PATRICK NGUTSHANA: Yes I think just explain, I think this would be important as well, Item 7 on Page 5, just explain that for the record?

PROF MALEGAPURU MAKGOBA: Yes I said that during this period of transfer and especially these 3 months and as I say, this is just a snapshot, a window and it follows a number of coincidences that the transfer occurred in May, June, July and Life Esidimeni, deaths were often maximum between May, June and July and we did the relocation during May, June and July, you can measure that as just a snapshot, but it gives you something, that there was a 72% increase in deaths in

the facilities during that period and we also know that during this period, we closed about 6 of the NGO's, they were closed, because people were dying there and both the Minister and the Premier were obviously worried to prevent that we don't suffer more deaths by closing those NGO's and transferring them back into the hospital. So and then after that, we did what we didn't do before, which was to call experts to come and supervise the transfer back into the hospital.

ADV PATRICK NGUTSHANA: That is after the closure of this?

PROF MALEGAPURU MAKGOBA: Ja after the closure of the NGO's and the relocation process. Then we had the death decrease by 98.8%, that's how significant it was.

ADV PATRICK NGUTSHANA: So this will be the period after closure of these supervised relocation of patients back to either-

PROF MALEGAPURU MAKGOBA: To proper places, but all that it tells you, is that if you look after mentally ill patients properly and professionally and give them good care, they are able to live and that is the message here and as I say the proof of the pudding.

ADV PATRICK NGUTSHANA: So this will be a contrast to what occurred when they relocated the patients from LE to the NGO's?

PROF MALEGAPURU MAKGOBA: Yes and there is too much evidence here to suggest that our NGO's were first of all not prepared, they were not properly governed, I mean they had other issues which you might have here when you were sitting and listening, but there were lots of problems, but if you take mentally ill

people and you look after them professionally and well, they are able to live as they have done. Now I just want to basically close up and conclude my thing and this is where I suppose Justice, I come to a little bit of poetry, but let me deal with the facts. First of all, we now know that to have maximum impacts on death in South Africa, we have to target the months of the winter, especially with these mentally ill people because either they get out at night, they just stay outside and we need to target those 3 months properly and I think there is a story at Life Esidimeni that they did that, but for me, the most important message is that unnecessary death can not only be prevented, but can also be stopped through professional quality health care as demonstrated by studies at Weskoppies, as shown by the low death in hospital versus the NGO's because there is professional care there, but as also shown by the dramatic decrease and significant lower death in hospital following the expert guided relocation and professional care. It is all about professional care and where they are being looked after. For me, this is the clearest proof that this was not only unnecessary, but could also have been so easily prevented if we had given them the professional care that they deserved. Again, I repeat that the hospitals such as Weskoppies, Sterkfontein, I think they did a wonderful job, I think in looking after patients, so I have to come back and say I use this quotation for what it's worth and it comes from Shakespeare, it says "now is the winter of our discontent-

ARBITRATOR: So there would have been nearly 4½ X deaths at NGO's than at Weskoppies and Sterkfontein?

PROF MALEGAPURU MAKGOBA: Yes correct – "made glorious summer by the son of York, this was coined by Shakespeare in 1594, but you know the winter of

our discontent, obviously summarises often a period in a country of unhappiness and so forth and it is often also a time for philosophers and others to reflect and see what can we learn from the lessons of such disasters and I think part of what's going on here, is really to see whether out of this unhappiness and I think disaster that we have gone through, whether there is light at the end of the tunnel, as long as it doesn't hit you of this train, so I use that just to remind us that it's not the end of the world, but we are going through a very difficult time. Then I'm saying again, unnecessary and preventable deaths of mentally ill patients occurred in Gauteng as a consequence of reckless and negligent decision making and actions. Now in [inaudible] poem, it says "somebody had blundered", now you must found out who had blundered, but you will deal with that, that is why you are having this process. But also, I also want to emphasise that let's not paint all the NGO's with the same brush. What happened here, I demonstrated to you that 100 out of 139 occurred within 4 or 5 places and we must understand why particularly those 4 or 5 places, so it's not every NGO. I am not saying they don't have problems, but certainly in terms of these deaths, it's not there.

ARBITRATOR: But isn't there also an issue of proportionality? I mean the smaller NGO's, how many warm bodies did they receive? Let's look at your schedule, I just wondered, look at the schedule on Page 8, do we know how many NGO's Tuli Home had received, I mean how patients?

PROF MALEGAPURU MAKGOBA: I don't know this, but I do know that I can say this with certainty. The NGO's where there were generally fewer deaths were NGO's that knew what they were doing and they refused to take more patients.

They would not be seduced to say the more you take, the better your reward would be. They would say no, we are capable of doing this, we are not capable of looking after so many patients they would refuse. That is why I say this Life and others, there must be other reasons that I think you can explore.

ARBITRATOR: So the valley of death coincided with the number of people?

PROF MALEGAPURU MAKGOBA: Yes.

ARBITRATION: The concentration of patients, were taken into facilities?

PROF MALEGAPURU MAKGOBA: Well it coincides with that, but remember that when you take more patients and you don't have professional staff or qualified staff, basically you subject them even to almost, you may call it double jeopardy or something like that, but you are just compounding the problem that you have. You don't have qualified staff, they are not good at what they are doing and then they have got more patients to look after and the problem gets worse rather than gets less. So then I say I think you all have heard this during the course of the arbitration, that during my course of my investigation, many staff from the Department said that they feared what was happening and again, I return back to Theunissen when he wrote the Charge of the Light Brigade and I thought I would read this for this audience "forward the light brigade, was there a man dismayed, not though the soldiers knew someone had blundered, theirs not to make a reply, theirs not to reason why, theirs but to do and die, into the valley of death rode the 600". That's what happened here and again, I can remind you for those of you that are students of history, remember during the TRC, there was a lady called [Kolati

Folati], she testified and she used the word that hers was not to reason why, but hers was to do and die. That's what happens when you operate like that out of fear. Now again, finally, I want to simply say that I think the National Minister, the Premier and all the professionals and the staff that were involved in this relocation process, have provided what I call care and the compliment for I think in bringing back pride and dignity back to South Africans, you remember when Barack Obama was campaigning, he kept on saying yes we can do and I think this relocation process has galvanised people together and has shown that we do have an infrastructure of how to look after mental ill patients, provided we do it correctly and we follow what we have. So I think it's very, very important to think about that, that I think the interventions of the Premier and the National Minister and by galvanising the resources that we have, was able I think to bring people together to focus on the mental ill patients, to actually reduce the death or the valley of death as it's called into small numbers or manageable numbers that we can all deal with and that's why since the relocation, only 7 people have died, 7. I mean it tells you the degree or the magnitude through which by just caring, you can deal with this. Now there are 2 issues here that obviously if you like figures, you would have seen. I have shown you that 12.8 people would have died at Life Esidimeni, 22 died during the Marathon, 2.7% died when we relocated. What it tells you, is that even what was happening at Life Esidimeni, although people were comfortable with it, all of you, I have heard people say, people were being looked after, the quality of care by international benchmarks, is not that good, but nevertheless, in South Africa, we are used to suffering, we are used to being abused and so forth, so our threshold for

what is quality, is problematic and I just want people to- so when we are moving forward, we must be aware of quality and demand more rather than accept that what we get, is adequate.

ADV PATRICK NGUTSHANA: What would be the threshold acceptable?

PROF MALEGAPURU MAKGOBA: The threshold is we have a hospital in South Africa called Weskoppies, if you can go and study their mortality of how they look after mentally ill patients, it's the benchmark. In fact, any mentally ill patient in the world, is much safer at Weskoppies than any other mental institution.

ARBITRATOR: The 2.4% you are talking about is it?

PROF MALEGAPURU MAKGOBA: Ja they would be much comfortable. If I was an American and I had a mentally ill patient, I will send them to Weskoppies, not to Wisconsin or any place like that, so the benchmark is there, Weskoppies. It is has done studies. So if we are going to de-institutionalise as is national policy, we have to bring the NGO's to the standards of a hospital like Weskoppies. At the moment, I think that journey or that gap is too far, but I think on that note Chief Justice, I just want to say and end up with Mahatma Ghandi again, who said the true measure of any society, can be found in how it treats its most vulnerable members in that society and basically I think if we can take that as a benchmark that we had a population of vulnerable people and obviously as the State has already conceded, I think there were things that were not done right, but the only way we are going to measure ourselves in the constitution that we have, one of the best and envied constitutions in the world, is really how we treat and look after the most vulnerable

people. Now obviously I know that the lawyers have not yet studied this and I am very glad that they haven't, because then I won't be asked too many questions, but generally, that is really a supplement to what I was asked to do and to say that I think we can do it. We do have a small infrastructure, let's exploit it, we don't have to do it kicking and screaming like we are doing it right now, thank you.

ARBITRATOR: Well we are going to get onto cross-examination Advocate Hassim? Thank you Professor, I will thank you at the end, there might be, questions, to you and we should get on with that.

ADV ADILA HASSIM: Thank you Justice and thank you Professor Makgoba, I want to say that we are indebted to you for the attention you have paid to this tragedy and to the rigour with which you have approached your task. This is a very important report for the process and to enable us to do what we need to do as representatives of the various parties here. I just have a couple of questions, the first is in relation to the name Legwabe, Motofela Legwabe, as you referred to in your evidence in chief, you went and took some time and effort to double check that entry and it seems to me that it was in fact a double entry, that it was the same person and that has now been corrected, so we are glad to see that.

ARBITRATOR: Where is that on the schedule?

PROF MALEGAPURU MAKGOBA: It was 49 and 90 somewhere like that-

ADV ADILA HASSIM: In the initial and in this one, it is on Page 3 of 6 and it's Number 57. So it's not really a question, I am just confirming that I understand it correctly. The second thing is, you said that where a patient and these were your

words, where a patient is registered, is where the patient belonged. Would you say that once the patients were transferred from Esidimeni, that they belonged anywhere?

PROF MALEGAPURU MAKGOBA: No this is the point I am trying to make. Esidimeni was closing as a health service provider and it had to be decided what do we do with the patients at Life Esidimeni, so it was no longer going to exist and the decision was we do it in 3 ways. The patients that leave Life Esidimeni because they are State assisted patients that are long term patients, we can either assess them as fit to go back to their homes, or we can either say they require medical treatment and then they would go to a hospital, or we say they are fit to go to an NGO. Now that is the 3 areas. Once you have transferred them there, they would be registered there, but remember that there was always an arrangement between the State long term mental hospitals and NGO's, so if somebody was transferred because they were sick to Weskoppies, they would go there and Weskoppies would assess them, whether they were ready to either be discharged home which is what happened I think as part of the process, or it would say maybe they are now fit, let's go and assess an NGO where this person can be put on for the long term.

ARBITRATOR: But what is the short answer Professor? I thought the answer was well then they get registered at Siyabadinga or Takalani?

PROF MALEGAPURU MAKGOBA: Ja they get registered there, provided you are registering them at a place that is properly accessed, properly licenced, you don't register them in a place that takes the constitutional need to have health. When you do that, you are negligent.

ADV ADILA HASSIM: Let me clarify what my question is. Would it be correct to say that even once they were discharged from Esidimeni into other facilities, they were not discharged, the use of the word discharge, is not that they are cured, they remain in the care of the State even if they are at another facility.

PROF MALEGAPURU MAKGOBA: Correct.

ADV ADILA HASSIM: The second complexion of my question was about the use of the word belonging and what I am suggesting to you, is that it is not only belonging in a sense of being, there is a number that follows you and that tracks you, because you are in the care of the State, but also, because you have a sense that there is a place for you that you are not discarded. What I'm suggesting to you, is you use the word belonged and I am saying it wasn't only in the manner and the procedural sense of not belonging because their files didn't go with them and there was no knowing where they were, but in fact, that they were discarded. They felt that there was no sense that they belonged somewhere, a transfer from one place to another, where did they belong?

PROF MALEGAPURU MAKGOBA: No, no I am talking about, there is a patient and there is the professional bureaucracy or the procedures. In terms of the procedures that is what I was trying to talk about, that patients when they enter the health system, are tracked through where they originally registered which is where they belong and of course, it comes with other things, but for the patient, I think it's a different matter whether they feel they belong or they feel discarded. Now that is a separate issue, but nevertheless I take your point.

ARBITRATOR: I'm sorry Counsel let me interrupt you there, these MA numbers, by whom are they allocated?

PROF MALEGAPURU MAKGOBA: They were allocated by the Department of Health and the data verification team and that is a normal thing to anonymise people, because sometimes you don't want people's names to fall into the wrong hands.

ARBITRATOR: I will tell you why I'm asking, I have seen the MA number used in other reports like the report from Cullinan. Is it a number that gets- were these allocated by your verification team, or are numbers that followed the patients to different institutions?

PROF MALEGAPURU MAKGOBA: I think these were given by the verification team and they would have been transferred and transmitted to the various facilities. As I say, it is just to protect the names of the patients when we use the MA number and also when they come to the- for example, when I appointed my team of expert panels, the first thing they needed to do although they had the clinical records, they needed to give patients a code number or a code figure that they could use.

ARBITRATOR: You see at the top you have MHDID, is that the ID that is allocated by the State to each patient? You see your answer has some importance viz-a-viz the question that Advocate Hassim was putting to you, that although people might have been sent to Takalani-

PROF MALEGAPURU MAKGOBA: It's an identification number, it's an MHID ID because it's an identification number ja.

ARBITRATOR: So it would be on the State's health register?

PROF MALEGAPURU MAKGOBA: Yes it would be for example if you went to Dr Kenoshi's department, he would have these numbers.

ARBITRATOR: And would that number ever be allocated to a private patient at a private institution?

PROF MALEGAPURU MAKGOBA: No.

ARBITRATOR: So the number would be indicative of a patient who receives care at a State institution, a public institution?

PROF MALEGAPURU MAKGOBA: Yes correct.

ARBITRATOR: Okay thanks, it helps me. Counsel?

ADV ADILA HASSIM: Sorry Justice I need to follow on from your question now.

ARBITRATOR: Yes please do, it just struck me that as people move around, what is their relationship with the State. It's a vital point that you raised.

ADV ADILA HASSIM: Yes but as far as these numbers go, I just want to clarify then that these numbers, these ID's were provided by the data verification team that it wasn't necessarily an ID number that was ascribed to each patient prior to your process beginning?

PROF MALEGAPURU MAKGOBA: No that's correct.

ARBITRATOR: In other words, when people were moved at Life Esidimeni, they wouldn't have reflected that kind of MHDID?

PROF MALEGAPURU MAKGOBA: No they didn't have that.

ARBITRATOR: They didn't have that okay.

ADV ADILA HASSIM: Professor Makgoba you spoke about winter and the importance of that season and the additional vulnerability that it creates the first time you testified before this hearing and then again today. Do you think that the Gauteng Department of Health apart from everything else that we have heard and that ought to have been taken into account in the transfer, should they also have taken into account the season?

PROF MALEGAPURU MAKGOBA: I think they should because I think all of them when I was interviewing them, they seemed to be aware that it was winter period, but I don't know why they then chose to do it during the winter period, but also to do it at the scale and the magnitude and the speed at which they were doing it, so I think I would agree that they should have taken that into account when they were doing the transfer.

ARBITRATOR: But the question is objectively, should a reasonable decision maker have had regard to the fact that the risk would be higher in winter months?

PROF MALEGAPURU MAKGOBA: Well it's a well-known fact, they should have known that ja.

ADV ADILA HASSIM: Thank you, my final point is this and that is you also spoke about the fact that we can become immune to low standards, we are just tolerant and accept low standards and we shouldn't. So this is not a question to you, but I suppose it's just for the record to say that many of the families that were

represented here and professional organisations, did ask for more once it became known that the transfer would take place and they asked for more in various ways through letters, through meetings, through protest action, through litigation and none of that made any difference. Do you have any view as to why that made no difference? You have suggested that we should ask for more in general. My point is there were many requests for more, yet it happened anyway. I am inviting you to respond to that if you have any view as to why despite all of that, nothing happened?

PROF MALEGAPURU MAKGOBA: Well I think in my report, I captured 2 issues and maybe 3, but let me start with the first. First of all, I think there was a feeling in the staff of the Department in Gauteng, that they were all fearful of as you go up the hierarchy, they became more fearful. The second is, is that there was a feeling, not only in the Department, but generally if you listen to civil society, to the professionals, that they were not being listened to, so it was a question of I don't know want to hear that and I think some people have testified about that. But you know there is also a much bigger fundamental issue that is captured in my report that has not been canvassed which for me is a very deeper philosophical issue. Why do doctors and nurses exist in society? I think people have not asked this. I think it is maybe Chapter 3 of my report, I have drawn it as a little bit of a diagram. The point I was trying to make in that chapter, was that the medical or the health profession stands between life and death, that's our role, whether by omission or commission, the reason why we exist, is that our actions, our decisions, our forgetfulness, leads to consequences that either accelerates the death of people or

delays people's death or even improves their health such that they don't die and that is why there is so much input into my research about longevity and so forth, because this profession stands between life and death. Just like scientists stand behind enlightenment and ignorance. Lawyers stand between justice and order in societies. So there is a fundamental question that people need to ask. If you are looking after patients or people you call patients, remember that whatever you do, writing letters, you are participating in a process that enhances their lives or leads to the deterioration of their life. As I say, I have tried to capture it in one of the chapters in this report and I think people have looked at it because it has got a diagram of somebody going towards a grave, but the philosophy behind it, is that the Health Department for this group of patients, stood between the accelerations of their death or the enhancement of their lives and I think you can pick and choose as to where you think they fell when you have listened to all the evidence.

ARBITRATOR: Well the statistics you gave us show us that there was a significant acceleration towards death.

ADV ADILA HASSIM: I can reassure you that there are other experts that will be coming to testify from the perspective of the ethics and from health professionals, so maybe your challenge as you put it in the report, will be taken up there. I have no more questions for the witness thank you Justice.

ARBITRATOR: Before I call the next Counsel, you know Professor Makgoba, yesterday I was agonising quite loudly about the evidence that tells us that aside from death having occurred in these circumstances, witness after witness from the family, told us how there was nobody there present, to say how their loved one died.

Sometimes there is no one to tell them where, when, of what they died and you know the significance of all that for grieving, but almost every witness that came here, complained about the fact that whether at Takalani or Precious Angels, name it, they get there, there is just nobody appointed accountable just to say what happened. Why is it so, do you know?

PROF MALEGAPURU MAKGOBA: Yes I know. I think this is the difference between professional care and what I call fly by night care. I mean I heard this during the testimony where I mean if you went into hospital, you know this, there are always nurses walking around, they come and take your blood pressure and your pulse and so forth, there is always somebody around to do that. If you went into an NGO, where people don't know, first of all even if you said to them somebody was suffering from epilepsy they don't understand what it means. If you gave them medical records, they don't know how to read it and part of the complaints that people didn't come with records, is that even when they came with a summary of medical they didn't know how to interpret it. So the ignorance in the system compounds the problem and of course, all I can say is the average healthcare only recognises a medical file if it looks like a file. If somebody has written a letter they are not going to be able to interpret that as to what it means, so I think one has to be careful when you hear that there were no clinical records, because clinical notes were made and doctors operate through clinical notes to each other. If you know what it means, you read the clinical notes and you pick up a phone and you say can you explain this to me, but if you have no idea that that is a clinical note, you just look at it as a piece of paper and you go and file it. So there is a conundrum of that,

but I heard that we found somebody dead in the morning. Now I'm asking where were you? I was at home, so as I say, a qualified person would not say that.

ARBITRATOR: But at the point of trying to find the body or to enquire about the death, shouldn't there be a point person, the person who says sorry she died and she died of this and she died here at this time in this way. That's a significant part of closure and I found many witnesses complaining about just the absence of those final rights, that courtesy after the devastation, there was no courtesy to say and some would say, yes there was evidence, get into that room and the family member alone walks into a room to find the corpse of a loved one on the floor, sometimes covered, sometimes not covered. Isn't there a practice that is required to be able to convey this terrible news to a family member within your profession?

PROF MALEGAPURU MAKGOBA: No, no there is a practice and in my profession it gets done, that is why I keep coming back to places like Sterkfontein and Weskoppies, you didn't hear anybody who died at Sterkfontein or Weskoppies where you would not have an explanation. In the NGO, they don't know and I think as soon as they are confronted with that question here, they are scared that you would ask them but what did you do. That question is logical. If somebody says you know you saw my dad dying, did he say anything, you don't want to get involved, the best thing would be to say we just found him dead in his sleep or something like that, then nobody is responsible, but that is the distinction between professional quality care and what we saw in the NGO's and it comes up repeatedly.

ARBITRATOR: Counsel Advocate Crouse?

ADV LILLA CROUSE: Thank you Justice Moseneke. Professor as you know, none of our clients had died, so the questions that I am asking you, is to just and try and see how this could not happen to our clients that are still alive and you have referred to many studies. We haven't studied your report as you well know and I haven't seen those studies at all, but what I have come across in my preparation, is the World Health Organisation in November 2015, bringing out a report on multi-level or the risk in excess mortality in persons with severe mental disorders. Are you aware of that report?

PROF MALEGAPURU MAKGOBA: Yes I am.

ADV LILLA CROUSE: And they divide, I just want to hear your opinion on this, they divide the risk factors into 3 groups. The first would be the individual factors, which is disorder specific or behaviour factors and we are not dealing with those now. Then the second risk factor is the health system factors and I want to deal with them and the third group is the social determents of health and we are also not dealing with those specifically now. I just want to have your view in order to make sure that this does not happen again. Now one of the first risk factors and that would ultimately become then a risk intervention is that of leadership and they specifically list the absence of relevant policies and guidelines. Would you say that that is something that is missing with South Africa with our patients?

PROF MALEGAPURU MAKGOBA: No, no I think we have policies. It is the miss-application of policy. Now let me give you an example in relation to this. The Mental Health Care Act and its strategy says that we must de-institutionalise which means we must take patients from the institutions into the future into their

communities and integrate them into communities. We must place them in a situation which is less restrictive. Those are the basic things and we must obviously still respect the constitution that we must provide healthcare that can be constitutionally justified. What did we do in this situation here? We took patients from a properly licensed institution and took them to places that are not licensed so we didn't fulfil that. Secondly, we took a child from Soweto and placed them in Cullinan. Now which community can that child integrate into if they are in Cullinan instead of maybe somewhere here in Soweto? So we have breached that.

ADV LILLA CROUSE: That is a United Nations principle as well that, you don't do that.

PROF MALEGAPURU MAKGOBA: Yes so that is why I am saying the policy is there, the interpretation of it and then you go and take somebody who was at Life Esidimeni where they had a few gardens here and there and then you put them into a house which is overcrowded, so how less restrictive is that?

ADV LILLA CROUSE: So what you are saying, if I can just summarise Professor, is that you said there are policies which were not applied?

PROF MALEGAPURU MAKGOBA: Yes.

ADV LILLA CROUSE: So the leadership was lacking?

PROF MALEGAPURU MAKGOBA: I think that is an understatement, there is no leadership.

ADV LILLA CROUSE: And then the next risk factor is the financing and they list the low investment in quality care and that goes with what you have said all along. If we have to de-institutionalise there needs to be an injection of finances and that is missing.

PROF MALEGAPURU MAKGOBA: That is correct and I have to repeat this, primary healthcare it is very expensive, it's not cheap. When you use the word primary, they think of themselves at primary school. Primary healthcare is a very expensive business. It must have quality and provide the purpose that it is designed for, it's a very, very expensive thing to do and I think in the few countries where de-institutionalisation has been done, the investment has been very heavy and it takes time before you reap the benefits of those investments. Now in South Africa, sometimes we think we can have an idea and do it on the cheap and it will work and I think that is what happened here.

ADV LILLA CROUSE: The next risk factor is that in service delivery and it says lack of care coordination and management and limited access to services and utilisation and fragmentation of health services and we have seen this in the Marathon Project. People were sent to places, they weren't connected with regional hospitals, they weren't connected or they thought that the primary healthcare system, the clinics would give medicine which they couldn't have given, so you would agree that this is a definite risk?

PROF MALEGAPURU MAKGOBA: Yes it's a huge risk.

ADV LILLA CROUSE: Professor the 4th risk factor is that of human resources and they list poor quality service provision, negative policing, or attitude of the workforce and poor communication. What would be your comment to that in relation to the Marathon Project?

PROF MALEGAPURU MAKGOBA: I don't want to be targeted, but you know I have lived abroad for a very long time and the work ethic in our country, does worry me especially the work ethic around caring for patients. I think that has deteriorated, it needs to be corrected, but that is a national issue rather than maybe a specific, so I think people in the Marathon Project, were just behaving like I would say we all behave.

ADV LILLA CROUSE: Professor if I can then just very quickly go over to our international obligations and you are well aware of the convention of the rights of persons with disabilities, I will start with that one, now Article 3 of that, says that there should be respect for dignity and this didn't happen here, do you agree?

PROF MALEGAPURU MAKGOBA: Well it's there in my report, there was total disrespect for human dignity, it was not there. I mean how can people's loved ones die and the relatives are not informed? How can people be transferred in almost like a legalistic manner, but relatives have not been taken into account, just to inform them that we are going to transfer your mom or your sister, I mean all of these things happened in this Project and the sad part is, it was being done by professionals.

ADV LILLA CROUSE: Professor and then Article 10 says that people with disabilities have an equal basis for their right to live which is logical or should be logical to us, but that didn't happen either?

PROF MALEGAPURU MAKGOBA: No.

ADV LILLA CROUSE: And you have no doubt also looked at the UN principles for the protection of people with mental illnesses and the promotion of mental health when you did your report?

PROF MALEGAPURU MAKGOBA: Yes that's correct.

ADV LILLA CROUSE: And Principle 8 states that the standard of care should be similar to other health institutions. If I am sick, I should get the same treatment as a person with, or the other way around, the person with mental disabilities, must get exactly the same treatment-

ARBITRATOR: You mean the same quality of treatment?

ADV LILLA CROUSE: Yes the same quality thank you Justice. Well that goes without saying actually?

PROF MALEGAPURU MAKGOBA: It goes without saying, but you see what is interesting in this project, is that I think it's both the MEC and the Director of Mental Health, went around telling patients that they would get good quality treatment when they leave Life Esidimeni- it would either be equivalent or even better, I think that is on record in various documents, but in reality, what you are now hearing and what

you are now hearing and what has been the experience, is totally different, so I think as lawyers, you have a name for it. I don't know what it is, but I don't it.

ADV LILLA CROUSE: I am very nearly finished with you Professor, but Principle 10 says that all medication must be recorded on the patient's record. That also goes without saying, but that didn't happen here.

PROF MALEGAPURU MAKGOBA: No there were no records, but the worst part is that the patients didn't get medication. In fact, some of them relapsed and they had to be almost treated physically, because they were not receiving any medication, there was no record they had got and I am sure you will hear it as you carry on here, that people were not receiving medication.

ADV LILLA CROUSE: Or the correct medication.

PROF MALEGAPURU MAKGOBA: Ja, but also the people giving the medication, didn't even know how to read what was to be given, so you had all kinds of issues that relate to professional understanding of what these people needed, as I say fly by night caregivers doesn't work.

ADV LILLA CROUSE: Our clients would want to also know if you have discovered on what basis patients have been sent to NGO's, or to government based institutions. Was there any rational manner in which that had occurred?

PROF MALEGAPURU MAKGOBA: Ja I think there were 5 psychiatrists that were working at Life Esidimeni that I called during my investigation and I think in part of my findings, I actually document what they said. One of the things that they said to me, was that as part of a team to assist in the assessment of where patients should

be, they assess that people who seemed to urgently require medical attention, would go to hospitals and those that were, some of them were frail, but they felt that they were stable, they would go to NGO's, that was the one sort of response. The strongest response that I got, was almost like diametrical. One of the psychiatrists actually said this project is such madness that I am resigning and she resigned because she didn't want to be associated with it. Another one said you know because we knew that this place was closing, we had to do what was best for patients, but we did not send anybody that we thought was dying to an NGO, so as far as they were concerned, people who went to NGO's were reasonably fit enough to survive there. Now that also begs a question why did they then die in such large numbers if they were of that quality, but we now know that I am sure if all these patients had gone to Weskoppies, I suspect most of them would be alive now.

ADV LILLA CROUSE: Can I just clarify the question a little bit further. I hear what you're saying about patients going to hospital, but was there any differentiation between patients going to Siyabadinga and Cullinan for instance? Was there any rationale in placing those?

PROF MALEGAPURU MAKGOBA: As I say, there were 2 clinical teams that were based at Life Esidimeni that was supposed to assess patients as to where they would go, so they did the assessments, but unfortunately, the Director of Mental Health changed that any time she wanted to, so patients arrived at CCRC and she would decide no they must go to Precious Angels.

ARBITRATOR: Ja but Professor the cutting end of the question is, once the initial grading if you like, happened, what was the rationale basis for choosing Precious

Angels or Siyabadinga or Takalani, I think that is where Counsel is going to. Once they had left Life Esidimeni which had been shut down, what was, the criteria for basically sizing up and cutting the cohort remaining?

PROF MALEGAPURU MAKGOBA: I think it's fair to say just as we did not know why Precious Angels was chosen as an NGO, we don't know the criteria that, was used to send patients there. I did try and canvas it with one of the people and you know what, was, the answer? They were better qualified to send patients there.

ADV LILLA CROUSE: Can you just repeat that, I didn't hear that Professor?

PROF MALEGAPURU MAKGOBA: When I asked why did these patients go to Precious Angels and leave CCRC and the answer was that Precious Angels was better qualified to look after them, but the criteria actually for sending the patient to Siyabadinga as opposed to- was never known, just as we did not understand the criteria for licensing or for providing Anchor, taking it from Kalefong and putting it into CCRC and you don't inspect that it deserves to be there. So there were always these things that were almost like ad-hoc.

ADV LILLA CROUSE: Without a rational basis?

PROF MALEGAPURU MAKGOBA: Yes.

ADV LILLA CROUSE: Thank you Justice, I've got no further questions.

ARBITRATOR: Thank you. Counsel, please go ahead?

ADV DIRK GROENEWALD: Thank you Justice, we have no questions for the Professor, save for thanking him for all the work that he has done. We have no questions for the witness.

ARBITRATOR: Advocate Ngutshana I will come back to you last, I must go to the State. Advocate Hutamo?

ADV TEBOGO HUTAMO: Thank you Justice. Good day Professor Makgoba. Is it correct that Sterkfontein and Weskoppies are State institutions?

PROF MALEGAPURU MAKGOBA: That's correct.

ADV TEBOGO HUTAMO: And you have lamented the fact that the general population of our country accept mediocrity due to the history of oppression and suffering.

PROF MALEGAPURU MAKGOBA: Ja as long as you remember that I am not a sociologist, I am trying to explain to myself, what makes us accept mediocracy so easy as a country and maybe I think it has to do with our history rather than anything else.

ADV TEBOGO HUTAMO: Okay and in relation to that, you have identified Sterkfontein and/or Weskoppies as the standard at which the level of care can be measured.

PROF MALEGAPURU MAKGOBA: I have done that. I have not only compared them with ourselves, I have benchmarked them internationally. Weskoppies looked at mortality over a 5 year period in 2010 and their standard mortality rate is the

lowest in the world, it's normal, let's put it that way. in fact, if you had to calculate it, if you were in Weskoppies and you were mentally ill, you would have a normal lifespan, that's how good they are and that is how I have benchmarked them as the standard that we must aim towards, because they are with us, they are doing the work in our own country. Other people are benchmarking themselves against them, but we are benchmarking ourselves against other things.

ADV TEBOGO HUTAMO: And do I understand you to be saying that Weskoppies as a State institution offers the best care even compared to internationally?

PROF MALEGAPURU MAKGOBA: That's what the studies have shown.

ADV TEBOGO HUTAMO: We now know that we have experienced a tragedy that should have been avoided and in your report, the final summary, which has been presented today, in fact, at Page 6, you have mentioned that the National Minister, the Premier, the MEC and all professionals and staff involved in this mammoth relocation project, they have provided care. If I can just start all over again, to read for the record, the National Minister, the Premier, the MEC and all professional staff involved in this mammoth relocation project and staff who have provided care, should be complimented for bringing back dignity and pride to South Africa and towards the end of that paragraph, you have recorded that we stopped the unnecessary death of mentally ill patients and we should now maintain the highest standard of care they deserve and that we are capable of. So do I understand you to be saying that the leadership has managed to arrest the situation and avoid unnecessary deaths of these people?

PROF MALEGAPURU MAKGOBA: Well I am saying that since the release of my report and the galvanising of the Premier's office and the National Minister's and their respective DG's and by assembling all the capacity and the expertise that we have, I think we have been able to go back to basics and do things the right way and that right way is reflected actually at the precipitous death of patients following the relocation and if you were to calculate that number of 2.7 and just multiply it by 12, you will find that you are having maybe about 30 patients or 32 patients of that severity to die. You won't find that in many places in the world at such institutions, so the standard is there and as I say, at Weskoppies, they attain that all the time, so it's not like we must send a delegation to go to Amsterdam or to go to Connecticut to go and study, we have 2 institutions that are doing it and they are doing it, we have had to galvanize them, but people had to do what they are doing in order to get the Minister and the Premier to move, because before that, they were blocked and I am saying that I think the experience over the last 6 months, has shown that we can do things, we can do them properly and I suspect that looking at the number of deaths that are occurring now, I think we are almost close to reaching a point where, remember that you can never stop death completely, but if I was to calculate for example, I told you that if you looked at the cohort of 2016 where 103 patients died okay in that year and then it would have represented an [inaudible] increase above the general population. Now in 2017, you have 30 people die over that year, you have almost reduced that by a third. Now it would translate into 63 divided by almost 3, you have an age adjusted rate of about 20 as opposed to 63 and it almost just twice the general population, so you can reduce it and I can only give you an

example. During the epidemic of Aids, the age adjusted mortality in the country, was about 14, between 13 and 14, so you are not far from something that has happened during a major disaster in our country if you can cut that down to less than 20. In fact, South Africa's neonatal mortality is about 20 per 1000 live births, so we already have such figures here. It is reducing all the time, but if you could cut the death of these mentally ill patients and bring it to something that is acceptable, which is what has happened here, I think that would be good.

ADV TEBOGO HUTAMO: Essentially like you state that since the release of your report, things have been done correctly after the release of your report.

PROF MALEGAPURU MAKGOBA: I think maybe correctly is not something- I haven't gone to evaluate, but people have been busy and there are some good results, but I haven't evaluated them so strictly that I can say correctly. I think let's say we have made an effort and we have been rewarded for that effort.

ARBITRATOR: I think Counsel you want to locate your question within the ADR period, or alternatively, within the Ombud's investigation period. He is rightly reluctant to talk generically about mental healthcare in the country now. Do you want to phrase the question in a way that is more relevant to our arbitration?

ADV TEBOGO HUTAMO: Professor would it be correct that since the release of your report and as per your recommendation, the government has indeed taken appropriate measures to improve the healthcare of mentally ill patients?

PROF MALEGAPURU MAKGOBA: Yes I think I would agree with that. I just hope that when this process finishes, they don't sleep again.

ADV TEBOGO HUTAMO: And in conclusion from what you have just said, I just want to refer to Page 7 of your latest report where you have stated that for deinstitutionalisation to succeed and match the best healthcare standards, community based mental healthcare services must be developed and proper resourced to the level of standard of care existent in our current institutions in South Africa, such as Weskoppies and Sterkfontein. Will it be a correct assessment that if the government commits itself to the standard already set at this institution, the tragedy that we have experienced will never be repeated?

PROF MALEGAPURU MAKGOBA: In medicine, we don't, use the word, never, life doesn't work that way. I can only say that it is less likely to happen, I can never use the word never.

ADV TEBOGO HUTAMO: Would it be unlikely that that tragedy like we have just experienced, will re-occur?

PROF MALEGAPURU MAKGOBA: It's unlikely, but the word never is too strong. Only politicians use the word never.

ADV TEBOGO HUTAMO: Thank you Professor, there are no further questions.

ARBITRATOR: Re-examination?

ADV PATRICK NGUTSHANA: Thank you Justice, nothing in re-exam.

ARBITRATOR: We are appreciative of the work that you have done, most Counsel has said that in appreciation and the family members even in greater appreciation.

PROF MALEGAPURU MAKGOBA: Thank you.

ARBITRATOR: Because we have been set up as a consequence of your report and we are in a journey, we will be talking to psychologists and other experts after you, again progressing the same journey on the one end and on the other indeed, arbitrating the dispute between the parties, being what equitable redress they are entitled to after all this carnage. So that remains a legally valid enquiry that we are going through, so that the soft end issues on the one end, but there are hard end issues also which the law recognises that equilibrium, that scale. If it is tilted the one side, the law tries to tilt the scale back, so there will be attempts to find equitable redress and you have done a lot to help us get there, thank you.

PROF MALEGAPURU MAKGOBA: Thank you and I hope that the families really do find that there is a different commitment that they are seeing and hopefully it will be maintained into the future and you know sometimes we think that the government doesn't listen. I think there are some people in government who do listen and I think we must also recognise that. It's not a monolithic structure, it is, diverse and I think we must appreciate what has been done so far and let's hope they take it into the future.

ARBITRATOR: You are so right and government is a partner in this process. It is a contrite state, trying to do its best to arrest the carnage and to stop it, thank you. You are excused Professor, you may leave.

PROF MALEGAPURU MAKGOBA: Thanks.

ARBITRATOR: Counsel?

ADV PATRICK NGUTSHANA: Justice Moseneke that is it from us for now. We will hand it over to Section 27 to take over.

ARBITRATOR: Very well thank you.

ADV ADILA HASSIM: Justice before we call our next witness, I would like leave to hand in another exhibit. It's not for the purposes of today's testimony, but it will be for the purposes of the testimony of the expert to come on Monday and I thought it best that all parties have a copy before Monday.

ARBITRATOR: Any objection to handing out the summary of the evidence for Monday?

ADV ADILA HASSIM: Sorry this is not a summary of the evidence, it's a document to which the expert will refer that is not currently in his report. We would like to call ADV LILLA CROUSEoralie Trotter.

ARBITRATOR: Ms Trotter, will you put your full names on record?

MS TROTTER: Coralie Ann Trotter.

ARBITRATOR: In which language do you want to testify?

MS TROTTER: English.

ARBITRATOR: You have an option to affirm or to swear to the truth of your evidence?

MS TROTTER: Either is fine.

ARBITRATOR: Okay. Do you swear that the evidence you are about to give, will be the truth and nothing but the truth and if so, please raise your right hand and say so help me God?

MS TROTTER: So help me God.

ARBITRATOR: Very well.

ADV ADILA HASSIM: Thank you Justice. Good afternoon Ms Trotter, we are going to begin with just for the record, reference to your CV and your expertise as a clinical psychologist. Your CV is contained in Volume 11, if you could turn to Page 3635, is that, your CV?

MS TROTTER: It is.

ADV ADILA HASSIM: And according to your CV, you have a Masters in Clinical Psychology, is that correct?

MS TROTTER: That's correct.

ADV ADILA HASSIM: And this was awarded to you in 1995 by the University of Witwatersrand?

MS TROTTER: Correct.

ADV ADILA HASSIM: You also have a BA Honours in Applied Psychology Cum Laude?

MS TROTTER: Correct.

ADV ADILA HASSIM: And you graduated from that degree in 1990 from the University of the Witwatersrand?

MS TROTTER: Correct.

ADV ADILA HASSIM: I am not going to go through all of your-

ARBITRATOR: Let's find out if any of the Counsel contests that Ms Trotter is an expert in the field she is about to testify on?

ADV LILLA CROUSE: Thank you Justice we are not disputing that.

ADV DIRK GROENEWALD: We are not disputing that.

ADV PATRICK NGUTSHANA: No dispute.

ADV TEBOGO HUTAMO: No dispute.

ARBITRATOR: Yes very well, I have looked at the CV and I am satisfied that you are properly qualified. I think we should go ahead to Ms Trotter's evidence.

ADV ADILA HASSIM: Just before we do so Justice, you will also in the same Volume from Page 3639 all the way up to 3731, there are a series of CV's, I am just bringing it to your attention for the record, I will not be referring to them, but there were a number of people who were involved in the preparation of the expert report and consultation with the families, all of whom are experts in their own right and so we have attached the CV's for the record, although we don't need to qualify them for these purposes.

ARBITRATOR: Yes I have seen from her report, that she had several expert collaborators and her report should suffice. If we need to call any of the other

experts, of course we will do so, but I think for now, her qualifications should be good enough.

ADV ADILA HASSIM: Thank you Justice. We can turn then to the report that has been prepared by Ms Trotter which is contained in ELA56. As I pointed out yesterday, some minor amendments had been made to the report and so, we would prefer to use this version rather than the one that has already been included in the bundles, so it's ELA56. It is entitled Expert Testimony for the Alternative Dispute Resolution Process with Justice Dikgang Moseneke and it says led by Coralie Trotter. Was this report prepared by you?

MS TROTTER: Yes.

ADV ADILA HASSIM: And this report is based on the work of the team of individuals that you mention on Page 5 is that right?

MS TROTTER: Correct.

ADV ADILA HASSIM: Can you tell us when the team began its work?

MS TROTTER: The email arrived from Ms [Regege] on the 22nd of August and over the next week, I mobilised a group together and we began about 10 days later. Firstly thinking through how we were going to go about it and then we set up a schedule of interviews.

ADV ADILA HASSIM: What was the objective of your project with the rest of the team?

MS TROTTER: It was to try and understand how the individual members of the families had experienced this entire process from the very beginning and to look at the impact that it had had on them and then also to formulate an argument in terms of why that impact was so devastating. So the information essentially came from the families, but then it was pulled together in a particular way to create an argument.

ADV ADILA HASSIM: Before we go into the findings of the team, can you briefly explain to us, what was the process you followed?

MS TROTTER: With the team?

ADV ADILA HASSIM: Yes.

MS TROTTER: In our first meeting, we spent a considerable amount of time thinking about what this kind of intervention would look like, because the circumstances are very specific and unique and also complex and so one of the things we realised, was that we couldn't see this simply as a means of getting information from the family members for a report, that in fact, these families are so traumatised that we had to approach everything as an intervention and that our priority throughout, had to be the wellbeing of the families and that that had to be taken into account first and foremost and then, we needed to try at the same time, access information. So we developed a model, it's called a single therapeutic interview and really what that means, is that you go through a consultation and it must be complete in itself so that you're not leaving things open-ended, but there must also be the opportunity for follow-up.

ADV ADILA HASSIM: And I noted on Page 7 of the report, the paginated Page 7 Justice Moseneke, Page 5 of the report itself, that you invited independent peer review of the process?

MS TROTTER: Yes.

ADV ADILA HASSIM: Can you explain why you thought that was necessary?

MS TROTTER: Ms [Rajeje's] initial email to me disappeared into virtual reality and then she was very persistent in terms of phoning me and WhatsApp me. The email arrived again and I got the shock of my life when I realised what she was asking for help with. So my concern was that I mean if Ms [Rajeje] had not persisted with that email, I wouldn't have known that it had ever arrived and it would have been another instance of the families being dropped, so what I was worried about while we were going through this, is that that potential was there all the time and so we needed independent review of where we were at, what we were thinking and what we were doing to make sure that we didn't let an organisation an individual or a family down. Ms Jasmine Carrom who is an attorney and Professor Mark Somes both agreed to do that. He is a psycho-analyst and he has just won the award for outstanding scientific achievement internationally and the FEFA prize and they both agreed to read the protocol before we started the interviews, read the report and just basically check that we weren't dropping balls.

ADV ADILA HASSIM: Thank you.

ARBITRATOR: Just before you go ahead, something that I should have asked earlier, how was the team constituted? In other words, from what institution, what place did you draw the team?

MS TROTTER: I run a series of reading groups which study psychoanalysis and there are about 60 psychologists who are active in those groups all the time, 5 groups and then a lot of people who work part and have left but still attend workshops and so originally I sent an email out to that whole group and I have obviously a very good relationship with them and then separately from that, I phoned other individuals.

ARBITRATOR: Are they a group of practising psychoanalysts? Are they a group of academics, I just want to get a feel for the team?

MS TROTTER: They are all mental health professionals, so they all have a registration with a body. They are all practising and they all work psychoanalytically, so they are not all psychoanalysts, people have different qualifications, but the way that they are working, is psychoanalytic.

ARBITRATOR: That's good enough, thank you.

ADV ADILA HASSIM: Thank you Justice. Is there anything else you would like to say about that, about the team and the makeup before we move on to the report?

MS TROTTER: Just in terms of you know the possibility of dropping a ball, the other thing we agreed on, was that 2 clinicians would be in every single interview. Obviously we were managing language, that was one consideration, but we also thought that with 2 people there, it would help in terms of interviewing, intervening,

note-taking because obviously we needed to get the information down, but if we needed to interview and intervene in between that, we were going to do it all, so that was another thing we did and I think that helped a lot. The clinicians afterwards said that they didn't think they would have been able to do those interviews alone, because they were so highly charged and difficult and painful.

ARBITRATOR: On Page 6, you talk about a representative, group of people or families and this boils down to 11 families. Why were these representative, I wondered?

MS TROTTER: Counsel would have to answer that question. Are you meaning in terms of the group of 56 or why those 11 were chosen?

ARBITRATOR: You see your evidence stretches out to all victim families and the conclusions you reach, are premised on talking to 11 families. The rational and logical thing to ask is to say why, were, these families representative. I don't say they are not, I just want to understand in the methodology and the reason why you think it is appropriate to have these families represent a big group?

MS TROTTER: The model that we used, it's a kind of research, it's called qualitative research and really what that's about, is trying to get inside the skin of the person who has had the experience and look at it from their point of view as opposed to standing on the outside and from the outside trying to measure something and with that way of researching and interviewing, you can get much more information, because you can go deeper, you can explore, you can also look at non-verbal behaviour and you're looking for themes, so ideally it doesn't matter if

you are family number 1 or 11 or 54, you would expect to find the same themes if you've done the interviewing skilfully enough and effectively enough.

ARBITRATOR: So you're saying it's not a matter of voting, it's a matter of extracting themes?

MS TROTTER: Exactly.

ARBITRATOR: Themes of experience?

MS TROTTER: Yes and then you can see differences, so there are some differences in the families. There was someone interviewed who was not traumatized, but that was an outlier and for the rest, the themes kept coming back in different words, different ways, but it was all sitting in the report I was given.

ADV ADILA HASSIM: The reports you were given, together with the interviews with these 11 families, was that sufficient for you and the entire team, to draw conclusions in respect of all of the families that were affected by the transfer?

MS TROTTER: We had read the Ombud's report so we had that as an overview, a lot of the affidavits and then we did the interviews and I had all the reports and I could ask the clinicians for more information, so I could go through a report and then send an email to everyone and say I want to know your experience of what it was like or answer this or give me this, so in a way, once you have sat through the consultation, there is a never-ending amount of information that you can access, so that felt for me, absolutely enough to write the report, but then there is not a single moment of this arbitration that I've missed and so, if there were contradictions, I would be well aware of that by now in terms of listening and in fact, what has

happened, it's reinforced what I have written in the report, the process of the arbitration.

ADV ADILA HASSIM: You are saying that all of the findings in this report are applicable to all the families who have been affected?

MS TROTTER: There might be a few where there are variations but I am absolutely convinced that this applies to the families, all of the families.

ADV ADILA HASSIM: And all your colleagues part of the team, agree with you?

MS TROTTER: Absolutely.

ADV ADILA HASSIM: So let's begin with your report. You start off your report with an introduction and in the introduction you refer to the concept of home. Can you explain why you do this?

MS TROTTER: I think what happened here, is complex in terms of trying to make sense of it, so I think what I was trying to do the whole time, is get under what we had observed and try and understand really what went wrong and in my mind, because this was a decanting, a relocation, it had to start with the place that we live in and what it means to live in that place and so that is why I started with the idea of home being so important in our lives, materially, psychologically and that any experience of a home even though it's not ideal, leaves us with a sub-stratum of identity, meaning, humanity, a sense of belonging and it's so fundamental that, that usually it's out of the reach of awareness. The point that I was trying to make is, belonging to a place or having a sense of place is to important, that in war zones, people feel safe if they are attached to a particular place, that is how powerful it is.

So then, if you start disrupting that, it's considered to be one of the most severe social stresses that you can encounter in life, is to lose your home.

ADV ADILA HASSIM: Most severe social stress for anybody, even more so in the case of mental healthcare users?

MS TROTTER: Well that then becomes the point that if you have been institutionalised, you have already lost a home and you have already had to rebuild a sense of place, so once you lose a home, rebuilding that sense of place is absolutely critical and being who we are, we are able to do that, so refugees, people who relocated, as long as they form intimate meaningful relationships in a place that breeds familiarity, they will rebuild a sense of home and there is a psychoanalyst, his name is Anri Ray and what he realised in his work, is that that place, that rebuilding a sense of place for psychiatric patients, is so important that the building itself, comes to be called for him, a brick mother, that the actual building is a brick mother and provides a sense of security, sense of safety, protection, there is involvement in it, so it is actually the building itself that can then hold the patient together. So if you are going to move someone out of a place that for them has become meaningful, a brick mother, where the guard you have a relationship with at the gate for example and with all the other patients and with the staff, if you are going to disrupt that, you have to be very, very careful about it.

ADV ADILA HASSIM: So this is a very important context for the rest of your report?

MS TROTTER: Exactly.

ARBITRATOR: Counsel I am going to interrupt you, because on that note, I want to adjourn for the lunch break from 1:30 to 2:30.

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10 November 2017

SESSION 2

ARBITRATOR, JUSTICE MOSENEKE: Please be seated. Me. Trotter, you are still under your previous oath. Very well. Let's proceed Counsel.

ADV. ADILA HASSIM: Thank you. Justice, when we last left off, we left off at the point of the big mother and the introduction to the report of the expert. Me. Trotter, there are five factors that in your analysis you outlined and you said these are the factors to which to understand the damage that's been done to the families. So I am going to ask you to explain these particular five factors. And the first factor is at page 11 of the paginated report. And it says as factor one, which can also perhaps be described as a finding: "Turning a blind eye to all available, psychological and sociological research, evidence and theory regarding the likely negative impact of relocating institutionalised patients, many of whom were unable to speak, walk and feed themselves and suffered from various impaired mental states." Can you explain what you mean by this and particularly what you mean by all available psychological and sociological research and evidence?

ME. CORALIE TROTTER: So it links to what we were talking about before lunch, which is the underlying concept of the importance of home and there is a huge amount of sociological and psychological experience, research and theory that looks at what it means to lose a home in varying context. So looking for example at children who have been part of human trafficking, people who immigrate, something like forced removals, refugees, people who lose their homes in natural disasters.

So it is really sort of quite extensive in terms of trying to understand what it means to lose a home. And because we have an experience of that in our country, it almost becomes something that is common sense in a way, but it is not just common sense. One can go to the literature and there are volumes and volumes written up about what it means to lose a home and how to manage the loss of a home and prepare for the loss of a home. So that is essentially what I am referring to. And then as we were discussing before lunch, if you then apply that to a population group that is dependent and vulnerable and where people are struggling with different kinds of impairment, it becomes particularly important. So it would be important under any and all circumstances. Just moving into a new neighbourhood is hard. But certainly with this population group, it is a critical thing to take into account.

ADV. ADILA HASSIM: So when you say turning a blind eye, you were referring to the officials who were responsible for the project.

ME. CORALIE TROTTER: Exactly.

ADV. ADILA HASSIM: As having turned a blind eye.

ME. CORALIE TROTTER: Ja.

ADV. ADILA HASSIM: On the same page 11, towards the bottom of the page, you refer to the former MEC. And you say: When asked in an interview why the patients had been transferred against all advice from others, her response was – "how could they know unless they are foretellers?" – That is a quote, those are the words of the MEC. Where does that come from?

ME. CORALIE TROTTER: That is from, I think, one of the very first Carte Blanche interviews done and this is a question that Devi asked the former MEC. And every time Carte Blanche revisits the Life Esidimeni transfers, they replay the ex-MEC saying, how could people know about this unless they are foretellers, unless they are psychic.

ADV. ADILA HASSIM: So you had watched this Carte Blanche documentary.

ME. CORALIE TROTTER: Yes.

ADV. ADILA HASSIM: And that is where you saw this.

ME. CORALIE TROTTER: Yes.

ADV. ADILA HASSIM: So in your view and in the view of your team, there was evidence available and had the officials considered and properly taken into account all that evidence, the move would not have taken place at all or would it not have taken place in this manner?

ME. CORALIE TROTTER: The first factor is to really have registered that moving is serious business and to have taken that on board psychologically. Then if the decision is made to proceed with it, if you fully acknowledged how problematic or how difficult and traumatic moving can be, even if it is a move you desire, if you have taken that on board then you are going to go about it in a particular way. If you denied that at the outset, which is what happened, then all the other factors that become into play become inevitable.

ADV. ADILA HASSIM: Ja.

ME. CORALIE TROTTER: So it is like something that sets the dominos falling to not recognise how important moving is.

ADV. ADILA HASSIM: Right, I understand now.

ARBITRATOR, JUSTICE MOSENEKE: I am sorry to interrupt. I wonder how the translation services are going. Is it all good? Well they are both raising their fingers, I suppose it means good, is it? I just want to make sure people are using earpieces to get what you are saying in their own languages. Very well. But can I ask you a question before Counsel proceed? In the quotation what is "they" referred to? "How could they know" – what is your understanding – "unless they are foretellers?"

ME. CORALIE TROTTER: So the question that Devi asked was, why is it ...intervened.

ADV. ADILA HASSIM: Who asked?

ME. CORALIE TROTTER: Devi, I don't know ...intervened.

ADV. ADILA HASSIM: The interviewer.

ME. CORALIE TROTTER: The interviewer.

ADV. ADILA HASSIM: On Carte Blanche.

ME. CORALIE TROTTER: On Carte Blanche. I don't know what her surname is. The question she asked was, why is it that although the Body of Psychiatrists, the Anxiety and Depression Group and so many different organisations were advising against this, you ignored it. And her answer was, well how could they know unless

they are foretellers. And my argument is, we absolutely know and we are not foretellers and we know from experience and we know from research and theory and lots of it.

ARBITRATOR, JUSTICE MOSENEKE: So "they" refer to psychological and sociological… ja… professionals.

ME. CORALIE TROTTER: Ja.

ARBITRATOR, JUSTICE MOSENEKE: Warned against this. Yes, thank you.

ADV. ADILA HASSIM: Thank you for explaining factor one and how and why it is so fundamental. Factor two, as I understand it, relates to the manner of relocation and your heading for factor two is: Ignoring all available psychological psychiatric and medical expertise and knowledge gained from clinical experience in the manner of relocation. Can you explain that, please?

ME. CORALIE TROTTER: Okay so again, I mean I think this is something that has almost become common sense in a way, but it is also based on an enormous amount of medical research and psychological and psychiatric research. What we know without doubt is that, if any challenges, any change, major change has to be faced in life, the more prepared one is psychologically deliberately prepared and the more detailed, accurate, thorough comprehensive information one is given, the greater the possibility of being able to negotiate that change successfully.

ADV. ADILA HASSIM: And that is in the context of a voluntary change.

ME. CORALIE TROTTER: Voluntary.

ADV. ADILA HASSIM: We are here talking about an involuntary… the patients hand exceeded to this process.

ME. CORALIE TROTTER: So in an involuntary situation it is going to apply even more, but even if something is voluntary, the less preparation there is, the greater the possibility that the person won't mobilise internal resources and prepare themselves for it in advance. When something happens and it is involuntary, that all becomes much more important. And this research has been done across the board in terms of different situations. It even results in people living longer in war. The more prepared they are, the more information they are given, it is associated with the length of time people survived in Vietnam, that is how important it is.

ADV. ADILA HASSIM: And you say ...intervened.

ARBITRATOR, JUSTICE MOSENEKE: But is that consideration the same for the bureaucracy on the one hand and the objects or the victims of the move on the other, are the considerations the same? You are talking about the bureaucrats that must be ready.

ME. CORALIE TROTTER: Ja.

ARBITRATOR, JUSTICE MOSENEKE: What do you say about the victims of the transfer, if it is involuntary?

ME. CORALIE TROTTER: No, I think that is an excellent point. So it applies equally to both groups. If the bureaucrats don't prepare themselves, there is no way they are going to be able to prepare the people on the receiving end of the change. So one of the reasons as a team we've spent so much time sitting and

thinking, was so that we can be prepared as possible for the consultations and for the process that was going to follow. That then allowed us to help the families prepare themselves in the interviews.

ARBITRATOR, JUSTICE MOSENEKE: So you are saying if the bureaucrats were not ready, how could they ever prepare, what I'll call the victims or the patients ...intervened.

ME. CORALIE TROTTER: Exactly.

ARBITRATOR, JUSTICE MOSENEKE: …for what is inherently traumatic.

ME. CORALIE TROTTER: I was saying to Counsel the other day that I saw an example of a three year old who had lost all four limbs through Meningitis and they had built a prosthesis, prosthetic legs for her, and a year before they put it on, they built an exact copy for a baby doll so that she could spend a year playing with these prosthetic legs on a baby doll before they went onto her. That is how important preparation is. And in this situation there was, well we all know it is not that there was nothing, it happened covertly.

ADV. ADILA HASSIM: When you say… Justice has referred to two categories of people, the bureaucracy and then the victims or the patients on the other hand. Where would the families fit into that, as far as preparation goes?

ME. CORALIE TROTTER: So preparing the patients, there is a sort of, how could one say, there is a sort of tower effect in terms of how preparation helps internally. I won't go into the detail unless you want me to, but at the end of those sort of building blocks of the tower, preparation enables primary psychological support

mechanisms. In other words, whoever you in an important relationship with, it enables that person to be prepared and to be there and that becomes absolutely critical. So there is a whole internal process in preparation. But externally… so the families would be preparing internally, the patients would be preparing internally, then that allows the families to be there and support the patients through the process, which is absolutely essential. Because in a situation like this that not having happened, resulted in these patients feeling abandoned and would have contributed to the dire outcome.

ADV. ADILA HASSIM: At page 13 of your report you say: "The manner in which this radical displacement was carried out was such a sudden, vicious shock to the system, both individual and family, that it could not be absorbed and digested." Can you explain what you mean by that, that's another finding, the manner in which the displacement took place? Had this kind of an effect?

ME. CORALIE TROTTER: So without preparation with such an important event… So you've now got two things in relation to each other - this is a very important event and there is no preparation, so that then becomes a shock. This is no longer just a move. This is now a shock to the system. And what happens is that when we are overwhelmed by fear and helplessness, all our neurobiological and psychological mechanisms shutdown. And then you don't have a protective shield in place. So now you've got patients moving without a protective shield in place and then being placed into environments where they are not going to be looked after. There is absolutely no way that these people were not going to die. But equally for

the families what it means is that… for the families this also resulted in it being a shock. So it created a breach in the minds of the families.

ADV. ADILA HASSIM: Yes, I noticed that you used that word, breach.

ME. CORALIE TROTTER: Yes.

ADV. ADILA HASSIM: You say a breach was created in the minds of families and the breach was caused by fright.

ME. CORALIE TROTTER: Fright, yes. so the fright of now having to deal with the situation means that you are in such a state of fright that you are not there to be in the experience and witness it. So it slips into you and then you realise that it is in you and then you've got to manage it, because of the lack of preparation. So it is like something happening but you can't experience it in real time. Psychologically you are not there to witness it and absorb it and find words and dissimilate it into prior experience and then you've got to catch up with yourself.

ADV. ADILA HASSIM: Yes and I have noticed that you've referred to examples to help us understand how that manifested.

ME. CORALIE TROTTER: Ja.

ADV. ADILA HASSIM: The families did try to prepare. The families tried to get information, as did other role players, before the move properly began, which leads to your factor three. You say: "The families were subjected to relentless violation of trust, continual stonewalling and incessant perception." Can you explain that? And

I just want to make sure that we are on the same page, is this related now to the attempt to prepare and to get information?

ME. CORALIE TROTTER: So the more preparation that takes place, the more information we have for something that we are going to have to face. The end result in terms of this tower with blocks is a sense of agency. You adopt a more active role in the whole process and that is empowering. And the families did try, but then there were these violations of trust. the court agreement from the families' point of view being ignored, calls that weren't answered… just a whole long list of things where it wasn't even then a matter of being prepared, which is important, it was then a matter of no one knowing what the truth was. So now you are not prepared and you are trying to get hold of the truth and there is all these sort of detours in terms of what the truth is. So that then adds to not being prepared and undermines a sense of agency even further. so now you are dealing with three things: The enormity of the change, the fact that there has been no preparation and then thirdly the fact that you've got to, almost, for the families, put pieces of a jigsaw puzzle together why you are now going through this experience, it is impossible.

ADV. ADILA HASSIM: Yes. So it is a breakdown of trust and ...intervened.

ME. CORALIE TROTTER: And it shatters the event, which is let's say a gestalt, a hole, it shatters that into tiny little jigsaw pieces and no one know where the jigsaw piece is. You are given a phone number but the number doesn't work, you are not given directions to go to a place that is on the other side of Gauteng. You find out what is happening through the news and your neighbour. So you've got now a

jigsaw puzzle in pieces and you've got to fit them together in the midst of this experience.

ARBITRATOR, JUSTICE MOSENEKE: Well I am worried about the other side of Gauteng. You are speaking like a Jo'burger. If something is not here, it is doer ver… I am getting worried.

ME. CORALIE TROTTER: I am thinking about the family members who had their family members in Randfontein and then they had to go and find them in Hammanskraal. You know that kind of situation. Not nearby, on the other side of Gauteng.

ADV. ADILA HASSIM: And for the Justice's reassurance, it could mean people in the northern part of Gauteng.

ME. CORALIE TROTTER: Exactly.

ADV. ADILA HASSIM: Moving to the other side.

ARBITRATOR, JUSTICE MOSENEKE: Yes. I am from Tshwane, so I am concerned when people speak about Jo'burg… But I understand the point, thank you.

ADV. ADILA HASSIM: And in these pieces, this jigsaw, these fractured, these shards that exist of bits and bobs of information, somewhere in there is a loved one.

ME. CORALIE TROTTER: Exactly.

ADV. ADILA HASSIM: Is that how you understand…?

ME. CORALIE TROTTER: Yes, this is not a jigsaw puzzle, these pieces were people that were loved.

ADV. ADILA HASSIM: In factor four.

ARBITRATOR, JUSTICE MOSENEKE: Well before you go to factor four. On page 15, your page 13, the right bottom corner, 15, let's talk a little about autopsies and their results. Why are they important?

ME. CORALIE TROTTER: That is ...intervened.

ARBITRATOR, JUSTICE MOSENEKE: Families knowing what killed the deceased.

ME. CORALIE TROTTER: That will come up a lot in the final factor, but essentially that is another piece of the jigsaw puzzle ...intervened.

ARBITRATOR, JUSTICE MOSENEKE: You can deal with it then, I just see it, you know, it is obviously under the third factor, midway page 15… Ja, okay.

ME. CORALIE TROTTER: I think what I was trying to demonstrate in terms of the violation of trust ...intervened.

ARBITRATOR, JUSTICE MOSENEKE: I see.

ME. CORALIE TROTTER: …is that across the board, so from the very beginning where there is this court agreement to consult, all the way to the end where there aren't autopsy results, it is a pervasive pattern of not completing things, not doing things properly. It is not just the first part of it, it is the entire process is contaminated because it has been blown into bits and pieces. And we are still

sitting there without autopsy results, we are still sitting with the bits and pieces. Counsel Groenewald said the one day there is a jigsaw puzzle missing and that is exactly right, there is just a whole jigsaw missing because the bits and pieces are still all over the place including the autopsy results.

ARBITRATOR, JUSTICE MOSENEKE: Okay, thank you.

ADV. ADILA HASSIM: I find factor four to be, and I would like you to explain the concept of dehumanisation, because that is what you talk about in factor four. And you refer to quotes from family members and consultations with family members. The heading of factor four, the finding: The terrible dehumanisation of the patients and its impact on the families. And in this part of the report and the quotes there is reference, repeated reference to animal and dog, words like that. Can you explain to us what you mean by this finding?

ME. CORALIE TROTTER: So essentially dehumanisation is a process of identifying a group of undesirable humans and then treating them as if they are not human. And the families over and over and over again spoke about, for example Jabulile said that Sizwe was treated worse than a township dog and township dogs are treated very badly. Stella Mofikeng said that what was so painful for her, she is a domestic worker or… ja, and the dog in the place where she works is treated better than her brother had been treated. So the families had a clear sense that the people they loved had been turned into non-humans, which is why the references to animals come up over and over again. so the dilemma with this is, you've now not only got an untenable psychological and emotional situation in terms of the move, the lack of precreation and the violations of trust, but if people on top of it, had they

not been dehumanised, who knows? But they were dehumanised and so now you've got that next domino block that falls. And that is directly linked to how traumatised the families are, because they have to now sit with all those memories of Sizwe being treated like a township dog in their minds and somehow come to terms with that.

ADV. ADILA HASSIM: You talk about, you use a language of torture in this context of dehumanisation about patients being virtually tortured to death through shocking neglect and cruelty. Is that not… why do you use that word? I imagine you would use it guardedly. It is a very strong term, torture.

ME. CORALIE TROTTER: It is a strong term. I think once you've decided that a group of people is undesirable and you dehumanise them, then actually you are in the terrain of torture. So if you take a group of people who didn't know the move was coming up, weren't prepared for it and they are moved on the backs of trucks, tied with sheets, without supervision, without ID documents, without wheelchairs, without medical files, this is no longer a human endeavour, that in itself is a torture. This is not saying okay you are going to move but we are going to do it in the most humane way possible. This was done inhumanely and so now we are in the terrain of torture. And then that doesn't stop, because the patients are moved into these filthy dangerous environments as if they are not people. And then you know, for example, the Reverend Mabue (spelling) saying that they wouldn't give Billy water because he would pee in his pants. So then you've got the withholding… you know however people were fed or weren't fed, whatever happened in terms of all of that. You've now got something that is a basic human right which is water and food has

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

ADV. ADILA HASSIM: In your long experience, have you had direct experience of counselling victims of torture?

ME. CORALIE TROTTER: Yes.

ADV. ADILA HASSIM: And how does this compare?

ME. CORALIE TROTTER: So my original experience was, I was part of an organisation called Detainees Counselling Service. It was an underground organisation during the 80's and the 90's so that the national party couldn't ban it. We worked in small cells and we met at different places and we worked with people who had been detained and tortured repeatedly. We worked with people who came off death row. We worked a lot with teenagers and young adults in the townships who would be thrown into jail and then released the following day. So that is part of my experience. I worked at the 702 Crisis Centre for 10 years where I was exposed to all kind of crises and traumas. And then I ran the debriefing group at the trauma centre. And of course there I was working with clinicians who were coming out of the prisons, coming back from Rwanda. So my exposure to trauma and torture is pervasive and vast. And I have never seen levels of trauma like this, ever.

ADV. ADILA HASSIM: And when you speak about torture, you are now talking about it as somebody who doesn't understand what torture is and what… Sorry, I just wanted to make it clear that you are not using the word ...intervened.

ME. CORALIE TROTTER: No, I am talking about people who had electric shocks to different parts of their bodies over and over again, who had been beaten every inch of their lives, hung upside down.

ADV. ADILA HASSIM: You've seen torture, you've seen victims of torture, you know what it looks like.

ME. CORALIE TROTTER: Yes.

ADV. ADILA HASSIM: That's all I am… And here this dehumanisation process goes on. And I was about to ask you this and it partly has already been answered is, what the impact of this is on the families.

ME. CORALIE TROTTER: So all of these… these first four factors are going to weave into each other and create for the families an extraordinary situation of trauma. Because remember now they are not prepared, so this experience slips in before they are there to witness it. So it can't be assimilated and made something that is part of the past. Then on top of that there is no way of knowing who can be trusted and you are looking for all these jigsaw puzzles. Then you are left with all these images of how dehumanised people are in your mind. So it is the imagery and dehumanisation is central to that, that becomes part of the trauma. You can't let go of the image, but you also haven't assimilated the image.

ADV. ADILA HASSIM: In your… sticking with this theme and with factor four, you speak about, through the consultation process, the disempowerment of the families and reference to one of the family members being told, well if you don't like it then take it – it was in relation to Jabulile Hlatshwayo

ME. CORALIE TROTTER: If you don't like it, take Sizwe home.

ADV. ADILA HASSIM: Take him home.

ME. CORALIE TROTTER: Well this is all part of the dehumanisation. If you are not happy with our decision, take Sizwe home. And this whole thing of saying to the families, well why did you get rid of them, why did you throw them onto Life Esidimeni in the first place. It is part of a dehumanisation and it plays into stigmatisation. Stigma is, you know it is a very hard and painful part of mental illness. Yes.

ADV. ADILA HASSIM: Because I want to have a follow-up question to that, which is, if you say to a family member who is concerned and you say to the family member well if you don't like it then take your child and go, but the family member is in a position where that is just not possible.

ME. CORALIE TROTTER: Exactly.

ADV. ADILA HASSIM: And so what would the impact of that be to say, well you do something about it if you don't like it, but in fact you can't do anything about it?

ME. CORALIE TROTTER: It is the same as family members who say they wanted to take their loved one home that day when they saw where they moved to and then

were told they couldn't and didn't. These two things are mirrors of each other. Because you land up with this internal situation of massive self-blame. So although it is not true, a lot of these people could not be looked out of some kind of care, it doesn't have to be, you know a massive hospital, but they needed constant care and most of these families couldn't manage that, most of us could not manage that, with all the resources we have and a lot of these families don't have the resources on top of it. So there was no way that they could have made a different decision. But the mind is not just rational. So what happens inside the mind is, I am to blame. I should have done something differently, it was what Anna was saying on the stand yesterday.

ADV. ADILA HASSIM: Anna Mthembu.

ME. CORALIE TROTTER: Mm.

ADV. ADILA HASSIM: And the stigmatisation, there are you referring to the stigmatisation of mental health care users because of their condition, is that what you are talking about? Because you also mentioned it in the context of families and I would just like you to explain if I understood that correctly. How would the families be stigmatised?

ME. CORALIE TROTTER: So we struggle as humans with social stratification and so we sort of generate this idea of like a mythical norm, like Johannesburg is the mythical norm. And then anything outside of that mythical norm, we disqualify, and that is stigmatisation. That has a profound impact separately, psychologically. Because then people land up feeling responsible for their own deficiencies.

Families land up feeling responsible for the person who is deficient. And that… to sort of bear that assault insult negativity takes a toll psychologically and that is called stereotype threat. So people who are stigmatised are at much greater risk for physical illness and disorder. There is a very high level of comorbidity between mental illness and physical illness and stigmatisation is partly why that happens. And the stigma affects the whole family. Stigmas don't just affects the person with disability, because the family has to struggle with internal conflict, trying to look after this person at home. Many of these families tried for years, but then the level of incapacity in terms of language, mobility, impulse control, it just creates a very complicated picture. But nevertheless all of this would have been struggled with internally by the families. So it all boils up when something like this happens.

ARBITRATOR, JUSTICE MOSENEKE: And where does the class issue fit into all this? Would low resources make one even more vulnerable?

ME. CORALIE TROTTER: Exactly. So that is why I say in my report, we are talking here about a group of people who are vulnerable, who struggle with poverty. And it is clear in terms of how the families spoke in the interviews, that's why so many of the families have said at this arbitration, they would go at month-end to visit their loved ones, why, because they have been paid. And that is the struggle of low resources – you don't have the option of just getting in a car and going wherever you want to go. You struggle all the time, every single resource counts in terms of class.

ARBITRATOR, JUSTICE MOSENEKE: And there are private institutions which provide mental health care, but they probably won't be available to families who don't have the resources to ...intervened.

ME. CORALIE TROTTER: Absolutely.

ARBITRATOR, JUSTICE MOSENEKE: To afford those monthly rates. So you have, do you, I don't know, it is your field, you have stigmatisation that you've described so well and then you are stuck with low resources which do not allow you a choice, an option.

ME. CORALIE TROTTER: Exactly.

ARBITRATOR, JUSTICE MOSENEKE: To resist the stigmatisation or the vulnerability.

ME. CORALIE TROTTER: And that is a real thing. I am sure everyone who has listened to the families who have come up here, they are sharp and bright and assertive, they can express themselves. So this is not a function of who they are as people, this is a function of not being as resourced as it is possible to be and then having to cope with someone who has a mental disability.

ARBITRATOR, JUSTICE MOSENEKE: Counsel.

ADV. ADILA HASSIM: And then to add to that, to add to all of what you and Justice Moseneke have been discussing, after a loved one dies in these conditions, to be told why are you crying, why do you really care, you dumped them in any event in our hands.

ME. CORALIE TROTTER: Yes.

ADV. ADILA HASSIM: So that would exacerbate the feelings and the discussion that you've just had.

ME. CORALIE TROTTER: Terribly so. So the trauma of the experience is now going to intersect with the most awful self-blame. And you can see that across the board in the families who were interviewed and the families who have testified. So Maggie Moseane has this dream over and over again about her brother Caswell and he is sitting in a chair and he isn't in his own clothes and he looks hungry and he wants food, and she knows he is saying in the dream, my soul is not at rest, I am not at peace. And she interprets that as, you should not have left me there, you should not have let me die. And she has that dream over and over and over again. So that would be an example of it.

ADV. ADILA HASSIM: Is this Me. Moseane who is also unable to eat meat now.

ME. CORALIE TROTTER: Exactly. That's right.

ADV. ADILA HASSIM: Is it Caswell's sister?

ME. CORALIE TROTTER: Caswell's sister has the dream.

ADV. ADILA HASSIM: It is Caswell's mother who can't eat meat anymore.

ME. CORALIE TROTTER: And it is Caswell's mother who now can't eat meat and is diabetic because of the flashbacks.

ADV. ADILA HASSIM: Why can't she eat meat anymore?

ME. CORALIE TROTTER: So Caswell's face had some kind of a massive blister on it that was filled with a sort of a muddy fluid and when his body was being prepared for burial and they tried to clean it all this blood flowed out. And so what happened with her, every time she sees meat, it reminds her of Caswell's face and she can't eat meat and that is pure trauma.

ADV. ADILA HASSIM: I am going to move off the dehumanisation, I think you ...intervened.

ARBITRATOR, JUSTICE MOSENEKE: Before you move, I just want to canvas one point of indignity. The mortuary and decomposing bodies, you write about that on page 17, the end of the first paragraph. Could you expand a little more about that? Everybody that's been here knows that this is one of the bees in my bonnet. You've probably been watching. About mortuaries which are ill-capped and don't do what they are meant to do and bodies started decomposing. What is all that vis-à-vis the family, vis-à-vis dignity issues?

ME. CORALIE TROTTER: So these different, these five factors were relatively clear, but I kept trying to think what is underneath this and eventually for me that was the issue of dignity. That if you start off and you don't see the other as having inherent dignity, all of this becomes possible, and then you see that across the board from the beginning of the move, all the way to people not being told their family members were dead, never mind whether they had been moved, not being put in proper mortuaries. I mean in Pumzile's example of finding her brother Solly in the butcher mortuary is a typical example of that. It is in a way the evidence of the dehumanisation which is a function of not seeing the other of having inherent

indignity. And you can treat a body as a thing, as a non-human thing, you don't have to treat the body as a person and as someone who was loved. And the problem with the families is that they've got to live with that. They are alive and they've got to live with that knowledge and all those images and memories.

ADV. ADILA HASSIM: It is also a… there are various culture traditions and beliefs in different parts of our society and we do have a very diverse society ...intervened.

ME. CORALIE TROTTER: But if you are not a person anymore, culture doesn't exist, and then you can overwrite all the cultural practices.

ARBITRATOR, JUSTICE MOSENEKE: Ja. Because I think where Counsel comes from is here, many witnesses who came here said in my culture I need to know where my loved one died, where was the last gasp, what did she/he say if anything. And you have a traditional obligation to try and pick up her spirit from there and take it along to the home, going back home. In other words if you've died whatever, there is a little attempt to try and take you back home and then only bury you. And it is done symbolically as though your… and people believe they carry your soul from wherever, you know open veld and take you to where you truly belong before you are laid to rest. And the complaint here was, we couldn't do this.

ME. CORALIE TROTTER: I write at the end of my report about the fact that a relationship with someone you love, doesn't end when that person dies and that is what you are talking about. The person who dies continues to generate messages inside us. Long after death you can have someone alive inside you years after they have died. So the issue of culture is so important here, because the message from

the dead is, where is my soul, what have you done with it, where have you left it. So that is exactly right, that is what the families are having to deal with. Because a relationship goes on with a person, even after they are dead, it doesn't end there.

ARBITRATOR, JUSTICE MOSENEKE: Thanks.

ADV. ADILA HASSIM: And on a similar note. I do think it is quite important because a lot of the hearings have been about what led to the death. But the trauma what we are now discussing with this expert witness goes beyond what led to the death, but also what happened afterwards.

ME. CORALIE TROTTER: Exactly.

ADV. ADILA HASSIM: And the importance culturally of how a dead person's body is handled and the dignity with which it is treated. And we have heard of, and we know of the importance… as I say you can't grow up in this country and not understand the diverse cultural practices, wherever you come from. I mean in the Islamic practice you'd also need to deal with the body in a particular way and cleansing and that ritual is very important. It can't take place when you can't find the body. It can't take place if the body is too decomposed by the time you find the body. And that passage of time has its own separate trauma, post the notification of death.

ME. CORALIE TROTTER: Exactly. So I think almost everyone in this room who has lost someone they loved, will know what it is like to go and say goodbye to that person. And if you then are having to say goodbye to that person six months later when their body has decomposed, it really is horrendous. It is hard enough taking

one final look at someone you love and walking and knowing that you won't see that person in the world again without that body being filled with worms as Nthombi Futi was describing.

ADV. ADILA HASSIM: Yes. Is it correct to say that your world does change, your world is no longer the same, even if it was not in such traumatic circumstances, but especially in such traumatic circumstances that you are no longer the same person you were before?

ME. CORALIE TROTTER: But what helps you is that you find, through mourning you find a way of going on and having a relationship with the person who has died in your internal world. And what has happened in this situation is that all of that has been contaminated.

ADV. ADILA HASSIM: Thank you. And maybe that leads us into factor five, what you call the prevalence of severe continuous traumatic stress disorder, as a result of what the families have witnessed and experienced. Can you explain what that term means? It seems to be a term of art, continuous traumatic stress disorder. I have never heard of it before. I have heard of PTSD. Can you explain that factor for us?

ME. CORALIE TROTTER: So essentially the trauma discourse is about what happens to the body and mind when you experience a shocking, unpredictable, unexpected, horrific event that threatens psychological and physical integrity. And those kinds of events are called traumas and they tend to have the same impact, regardless of the context and regardless of its meaning. So that is what is so

important about the idea of trauma. So you could be looking at the victims of Hiroshima, Los Desaparecidos in South America. You can look at apartheid, you can look at the holocaust, you could look at Rwanda, you can look at what is happening in Aleppo in Syria. And although those people have very different cultures, speak very different languages, the impact of those events would be similar in terms of what happens to the body and mind. So that is post-traumatic stress disorder. When the stress is not finite with a beginning and an end, that is what we call continuous traumatic stress. And continuous traumatic stress is the worst of all. If you go through a trauma and then afterwards you can tray and assimilate it and make sense of it, you can make it part of your past. If you go on being traumatised, which is what happened with these families, that decreases your existence continually. So you become more and more traumatised with continuous trauma and that is what has happened in this situation.

ADV. ADILA HASSIM: You say that, and I am quoting from page 20 of your report, 18 perhaps on your version. "The imprint of the traumatic event comes to dominate the person in that subsequent stressful live events are perceived in the light of the prior trauma."

ME. CORALIE TROTTER: Exactly. So the more you are exposed to the sensory reality of the trauma, the smell, the sight, the sound, the more life threatening it is, the more it results in harm or the death of someone you love, the worse the imprint on the mind, the more florid the imprint. And because the experience hasn't been assimilated, it's now you've got all these imprints and they keep returning in these unbidden ways through flashbacks, intrusive images, dreams. So in a way the

dilemma here is that it is not just the experience you've been through, it is that you've been through an experience that you've missed, but all the imprints are there and your mind is trying to catch up with itself. So these imprints keep on coming back, so that your mind can catch up with the experience – that's trauma. And these images and these memories are so sensory, that generates the worse kind of trauma. So for example Von Van Rooyen.

ADV. ADILA HASSIM: I was about to go to Von Van Rooyen.

ME. CORALIE TROTTER: Yes, who says ...intervened.

ADV. ADILA HASSIM: Can I just take you there? It is page 22 of the paginated report, Justice, and it is about the third of the way down the second paragraph. It says Von Van Rooyen says, and it quotes, "the other day there was a terrible stench of dogs messing in the street and the smell made me" – I think you mean think – "the smell reminded me of Cindy." "The terrible stench of dogs messing in the street and the smell reminded me of Cindy."

ME. CORALIE TROTTER: So that is an example of trauma, where Von's memory is Cindy smelled like the dogs messing in the street, the last time he saw her. And now there is this external queue and in his mind is the image of his sister, Cindy. That is the imprint that now because of this external queue returns in an unbidden way.

ADV. ADILA HASSIM: And that, the other example you'll give in that context is Yvonne Moseane and being unable to eat meat, that is the same kind of concept.

ME. CORALIE TROTTER: It is the same kind of thing. But it can happen, for example, Stella Mofikeng, so she hasn't unpacked her brother's room, she hasn't burned his clothes, which is part of what he should have done in terms of her culture. But she goes shopping and she'll come home and she'll, he is diabetic, and she'll realise that she has bought all this diabetic food and it is as if she has forgotten that he is dead and he doesn't need the diabetic food anymore. And that is partly linked to the carelessness of the staff at the NGO, because she asked one of the caregivers what are they eating and the person… because she said my brother is diabetic, and the person responded very sarcastically and said we are giving them cake and cookies the whole time. So this sort of left this imprint in her mind and now that is unbearable for her. So she goes and buys all this diabetic food, then she sees she's got the diabetic food and then there is the horror of having to realise that he is dead.

ADV. ADILA HASSIM: The second component, as you call it, of this trauma picture, and you say this at page 23, and I am quoting from your report, is that: "The assumptive world of these families has been shattered." What does that mean?

ME. CORALIE TROTTER: So mostly our work as clinicians is to try and help people undo illusion. There is one situation where illusion is healthy and illusion, though these illusions breakdown during trauma, we live with three illusions that help us manage daily life. If we didn't have these illusions, our levels of anxiety would be so high, we wouldn't cope with the ordinary activities of a day. So those three illusions are: Nothing will happen to me today, I will go on living. It is an

illusion. Many busses go through red robots all the time and they can crash into you and we know this and we prepare for it so that we can stay alive. If you thought I could die today, you wouldn't be able to drive on the road. So that is one illusion. A second illusion is, at the end of the day it will work out, the world is a safe place, it is a fair place, it is just place. We absolutely know that is not true, we are sitting here. But you can't live believing that somebody is going to do something unjust today, the world isn't a fair place. The third illusion is, no one will try to harm me or anyone I love. Because again if you walk around every day thinking I am sure somebody is going to harm me any minute now, you would be so preoccupied with that anxiety, you'd be dysfunctional. So those unarticulated beliefs we hold without knowing it and they are part of health. When you go through a trauma that is the assumptive world. When you go through a trauma those three illusions or assumptions are shattered. So part of the work you are trying to do after a trauma is, get the illusions back in place. And if you can't get the illusions back in place, you are in trouble, which is hopefully partly what this arbitration can do for the families.

ARBITRATOR, JUSTICE MOSENEKE: Well I can't resist, that is just wonderful, very informative. Well I can't resist telling you that when I grew up my grandfather always said (vernac).

ME. CORALIE TROTTER: And what does that mean?

ARBITRATOR, JUSTICE MOSENEKE: Where is the interpreter? Can someone tell our expert here? Most days when I went and left the home to go to school and

come back, my grandfather would say, my grandson, all will come right, all will be well.

ME. CORALIE TROTTER: Exactly.

ARBITRATOR, JUSTICE MOSENEKE: Long and behold, he was right. But it is fascinating to hear it that we live through that illusion and when, if he was wrong, of course I won't be here, I would be some messed up person somewhere.

ME. CORALIE TROTTER: Exactly.

ARBITRATOR, JUSTICE MOSENEKE: Because that assurance would have dissipated. But he assured me every day virtually (vernac). And sometimes it is right and sometimes it goes wrong.

ME. CORALIE TROTTER: Ja.

ARBITRATOR, JUSTICE MOSENEKE: Like the people who are with us today.

ME. CORALIE TROTTER: But you believe the illusion and that is what allows you to function, until it is shattered.

ARBITRATOR, JUSTICE MOSENEKE: I hear that. Are you really then telling us that their illusion was then shattered?

ME. CORALIE TROTTER: Ja.

ARBITRATOR, JUSTICE MOSENEKE: Because it was never quite met or fulfilled.

ME. CORALIE TROTTER: And the thing about shattered assumption theory is that, obviously these illusions can be shattered because you are caught up in

Hurricane Katrina. But when the illusion is shattered and it is human induced, it is the most violent of all. We deal better with natural disasters in terms of shattering the illusions than we deal with human induced trauma. So in this situation it is not only human induced, but human induced in the most violent way. And so the shattering of those assumptions for these families is devastating. They now… it is like their illusions have morphed into the opposite. So the families now believe others will harm them, as opposed to having the illusion of mostly people won't try to harm me.

ARBITRATOR, JUSTICE MOSENEKE: I am sure you will be asked questions about what all this means for the survivors. I am not going to ask you the question, I am sure you will be asked. We are talking about shattered illusions of family members, because the deceased are deceased.

ADV. ADILA HASSIM: Yes.

ARBITRATOR, JUSTICE MOSENEKE: But I am sure you will be asked questions about, what about those who survived, in the sense that they didn't die. Where would that level of trauma sit and what would be the origin of that trauma? But I am sure you will deal with that when you are asked. Counsel.

ADV. ADILA HASSIM: Thank you Justice. The third or the fourth, I forgot now which component ...intervened.

ME. CORALIE TROTTER: The third component of ...intervened.

ADV. ADILA HASSIM: It is the aspect in respect of which you say, you talk about central organising fantasies of the self and of the family. I understand this to be

separate now from the assumptive world that you've described. You are now talking about the organising fantasy of the self and the family. Please can you explain what you mean by that and what the impact of that is from the family members?

ME. CORALIE TROTTER: So in this trauma picture you've got firstly a self that has been through something but wasn't able to witness it and that is destabilising. Then the ordinary illusions we all hold in place so that we can manage levels of anxiety, have now been shattered. Thirdly, all individuals and families have a version of themselves, whether that version is accurate or not, there is this central organising version – this is who I am as a person, this is who we are as a family. And often it is false or there are aspects of it that are false and we are attached to these versions of ourselves and of our families. When you go through a trauma, we behave in unexpected ways, and so the fantasy shatters, the organising fantasy shatters. And if people don't know that that's what's happened, they feel as if they are going mad, because they are trying to get back to an old version of the self or an old version of the family and you can't, it's gone, that's what trauma does. But the minute you know that, you can start working with the loss of that version, what, does, it mean, how does that feel, and you can begin to create a new organising fantasy, which might actually be healthier. So what has happened in this situation is those versions of family and self, have been obliterated. And that is part of trauma and if you don't know that, it makes the trauma feel as if you are going crazy.

ADV ADILA HASSIM: Is that why Lucas Mogonane says I am not the person I used to be?

ME CORALIE TROTTER: Exactly and all the families talk in that way, I am no longer myself, Christopher was my treasure, Boitumelo and Sophie saying that their family version now is a black page, that is all it is and they are just falling endlessly into this black page and before, they were just coming to terms with the fact that their mother had vascular dementia and she had been this fierce extraordinary person who was their mother and they are getting used to a new version of their mother and then she dies in this way and so that very fragile new version, is now shattered, thank you.

ADV ADILA HASSIM: You also say that and because I think context is important, I keep referring to our country, our history and our cultural diversity and you speak at Page 25 about an inter-generational scarring. On Page 25, the bottom of the 2nd paragraph, you say most of these families have the legacy of apartheid behind them and now they have this tragedy to integrate, this scenario is likely to result in particularly powerful inter-generational effects. What do you mean by that?

ME CORALIE TROTTER: So this goes back to what Justice Moseneke was asking about before that this situation is not just about death and loss, it is about the disappeared which in Argentina was such a big thing, the loss desapasidos, the problem with the disappeared, is that you can't actually begin a proper process of mourning so you get frozen in some limbo state because you don't have closure, you don't have an explanation, you don't have the jigsaw puzzle and that uncertainty dominates your relationship with the person that has died, so you are suspended in a way in the not knowing, in the untruths, in the autopsy results that aren't there and struggling with your trauma. When that happens and you can't

begin to grieve and mourn and try and get through what has been lost and arrive at a new version of yourself, it affects the next generation and that inter-generational trauma, so that potentially with this, we are not only looking at the people sitting here who are traumatised but their children and usually it's the third generation that expresses that trauma, so that's the point of it.

ADV ADILA HASSIM: You have spoken about the degradation, you used those words, degradation, dehumanisation, what do you, in all of what you are saying, it sounds like this is very unusual, I would hope, what do you and your team take away from that, this particular set of facts and the trauma that you have not you yourself have experienced as a result from your work on this, but the trauma of the families? Where does this lie and I know it sounds callous, but where does it lie on the scale of trauma, of what we know and the terrible- historically we know of examples of trauma of degradation of dehumanisation, where does this lie on that scale?

ME CORALIE TROTTER: If we had to see this as a continuum, it lies at the extreme end of a continuum where it starts to be a crime against humanity. The complexity of this picture and all the factors that are part of it, is unthinkable, so I am a changed person because of this. When I try and explain to people what that means, with all the trauma work that I have done in my life and with all my own losses in life, I feel as if for the first time, I have touched what I would call anti-matter and I am sure people who you know were devastated by apartheid or in the Holocaust, know that, but I now feel like I have touched something that I can only describe as anti-matter. It is unthinkable.

ARBITRATOR: When does continuous trauma end? I am not asking about time, I am asking in which circumstances would it end? In Page 19, you describe it, you tell us what it is and as Counsel was, asking the question, continuous traumatic stress disorder, must it or does it have an end point?

ME CORALIE TROTTER: It can have, so in this situation, there would be a number of things that would help it to have an end point. So one of the things that is a pattern in this entire situation from the very beginning of the Marathon Project to the present, is a disavowal so even in the arbitration, we have had people from the Gauteng Health Department who are representing the government operating in a position of disavowal, everyone is saying no I can't answer that, somebody else must answer that, then the next person can't answer a whole lot of things. So you've got the disavowal of reality during the actual process, we still have it in the arbitration. What will help the families is for the Department of Health to accept responsibility for presenting the full picture to us. Instead we are now having to put another picture together with bits and pieces of evidence, so with that kind of disavowal and maybe we are working towards that, but essentially, unless we have a full picture with explanation, it becomes very hard to move on.

ARBITRATOR: And where is the place of apology in all that? The State has always apologised in regard to every single witness. Where does apology sit in all this?

ME CORALIE TROTTER: It is absolutely essential, because apology and presenting a full picture, is all part of starting to say to the families, you are not non-humans and the people you loved, were not not-humans.

ARBITRATOR: But still the question I put was when does the continuity end, or what would make the continuity end in a continuous trauma situation? I want to understand how the healing is going to come?

ME CORALIE TROTTER: Information such as autopsy results, explanations for what happened, the apology as you say, so if enough information, enough detail, enough explanation is in place, what that means, is the families can't be expected to accept responsibility for this. It is the Gauteng Health Department that must fully accept responsibility and then, that allows the families to begin to focus on their own experience. Up to now, the families with the help of Section 27, have been fighting for who is responsible for this and you can't be working with mourning and assimilating the trauma if you are having that fight in the real world, it uses up all your energy. So when the responsibility is clear and explanations are complete and there is full disclosure and unreserved apologies, then the families can breathe a sigh of relief and then they can begin to focus on what is going on inside them.

ARBITRATOR: And where in all of that, would you place financial accountability, financial responsibility? In other words, where would compensation in a financial form, sit in that matrix?

ME CORALIE TROTTER: I think it's an important part of it, because it's part of an organisation saying we are responsible, we are accountable and this, we are not only going to say we are sorry, but this is how we are going to atone, it is part of a process of atonement, but in terms of the families we interviewed, that has to go along with psychological and emotional genuine memorials ceremonies, that is very, very important to these families, so the money is important as a form of atonement

and also, the families have for example, Vaughn again, it is extremely upsetting for him that his sister Cindy, he names 7 of his children that names that begin with C because he loved his sister so much and she is now buried on top of his uncle, so money is going to help with things like that, proper burials etcetera and it is a form of atonement, but it doesn't replace registering this emotionally and psychologically, so for example again, Boitumelo and Sophie, they kept on saying in their consultation, that woman she was our mother, we want her name called, her name was [Riyasiba Rahab Mangena] it's that over and over, we want her name called and what the families are saying is, we want these people we loved who were turned into non-humans, to be re-humanised and that is critical in terms of the continuous traumatic stress ending.

ARBITRATOR: Thank you, Counsel?

ADV ADILA HASSIM: Thank you Justice, at Page 27 of the report, Ms Trotter sets out the elements of reparative and restorative justice that could be of help in this process and there are 6 parts to it. I don't need to go through it again because Ms Trotter has just summarised that. Ms Trotter that brings me to the end of your report, is there anything that you would like to add that you weren't able to speak to thus far?

ARBITRATOR: Well I can assure you I have seen the love letter all of your professionals have sent to me. In ending, we urge Justice Dikgang Moseneke to pay heed of the following, so I have read every one of them being mentioned by name, but you are going to be asked by rest of Counsel, so there is still going to be quite a lot of talking still to do.

ME CORALIE TROTTER: Last Friday, Counsel asked me to read the [Hillsborough] report and add it which is partly why you got a new report and it's a 122 page report and eventually I decided to end my report with what the Reverend James Jones said because I thought it was so applicable and he says that the bravery and now he is talking about the [Hillsborough] disaster but it absolutely applies in this situation, the bravery dignity and tenacity of families who fight for justice, has a vicarious quality to it, it is of value to the whole nation in that it ensures that the pain and suffering are never repeated.

ARBITRATOR: Thank you very much, I saw that. In many ways, it is true isn't it? Are you done Counsel?

ADV ADILA HASSIM: I am done Justice for now.

ARBITRATOR: Advocate Crouse?

ADV LILLA CROUSE: Thank you Justice Moseneke.

ARBITRATOR: But it also like when we do bad, but if we are in important positions, our deeds that tend to taint the rest. It is like noble deeds, an ethically sound struggle tends to elevate all of us, but horrible deeds tend to diminish all of us.

ADV LILLA CROUSE: We represent the survivors and we would just like to get your thoughts on this. The family members who have lost loved ones, they have been traumatised and you have dealt with that, but the trauma is far more than just losing a loved one, isn't that so?

ME CORALIE TROTTER: Yes.

ADV LILLA CROUSE: For instance, at the beginning you dealt with it, nobody knew where people were moving, would that be a start of the trauma?

ME CORALIE TROTTER: Most of the report would apply regardless of whether people died or survived, so there would be aspects for example that the relationship with someone we love, goes on when they die, which wouldn't apply, but the issues around relocating, lack of preparation, de-humanisation, all of that is going to apply with the survivors. The thing that is going to be very hard for the survivors, I don't talk about this in my report, but I could have added it, is that because home is so important and because this happened in this way, it sets in motion, fantasies, images in the mind of the individual and those are going to be about awful things, not being loved, being abandoned, being forgotten, so the survivors are having to live with that.

ADV LILLA CROUSE: I just want to stop you there. Are we talking about the surviving patients now?

ME CORALIE TROTTER: The surviving patients yes and for the families too.

ADV LILLA CROUSE: I am still with the families, if we can just remain with the families for a moment. The feeling of helplessness, not being heard, what effect does that have on families?

ME CORALIE TROTTER: It is going to be the same. So it's a complex thing when people survive, because I mean death is devastating in terms of the loss, but survival throws all the illusions into question, why did I survive, why me, I shouldn't have survived, so all the conflict around surviving for the families and for their family

members, has to be dealt with. It is not an easy thing to survive, it is a good thing, but it is not an easy thing psychologically.

ADV LILLA CROUSE: Could I just also ask you, we have family members looking for missed healthcare users, they are just missing. What effect would that have on the family?

ME CORALIE TROTTER: That is devastating, so that is the issue of the disappeared, that you are now frozen in a state of uncertainty waiting and looking and so getting on with life, becomes very difficult.

ADV LILLA CROUSE: And you are in a position that you don't have all the resources that other people might have that would also make you feel more vulnerable wouldn't it?

ME CORALIE TROTTER: It would be devastating. I mean if you think of children who go missing in the world and how parents set up whole organisations to look for those children and then in a situation like this, you don't have those kinds of resources, that is devastating.

ADV LILLA CROUSE: Somebody said that being poor is being without choices and the family members have experienced this very badly, because the few choices that they had, were taken away, would you agree with that?

ME CORALIE TROTTER: Yes well I think that is true, but what is extraordinary about these families, is in spite of that, they kept trying to generate choices for themselves.

ADV LILLA CROUSE: After the mental healthcare users have been found, they found them hungry, thirsty, thin, what effect would that have on a family member?

ME CORALIE TROTTER: So all the issues around trauma are going to be there in terms of the return of intrusive images and memories, dreams, but what is going to be very important in that situation, is that at some level, however much relief there is in finding someone, some fracturing has happened in the relationship, so a lot of your work is going to be about relationship repair and it's repairing the actual relationship with the person, even if you love that person, nevertheless that relationship would have been fractured and what is hard about that, is that it generates a lot of internal conflict and then that is hard, because you are alive and you are happy you found the person you love and yet you are filled with all this conflict, anger, violent feelings, murderous rage, feelings of not being loved, so all of that has to be worked through.

ADV LILLA CROUSE: Feelings of guilt of not being there?

ME CORALIE TROTTER: Exactly in terms of repair and it's very hard to do that alone, it is very hard for us in our ordinary lives to do that.

ADV LILLA CROUSE: If I could perhaps move to the patients themselves. They have also suffered through lack of medicine, lack of food, lack of water, what effect would that have on somebody with mental health issues or let me first start, with any person, what effect would that have?

ARBITRATOR: Are we talking about patients who survived?

ADV LILLA CROUSE: We are talking about patients who survived.

ME CORALIE TROTTER: I think the hardest thing is going to be the fact that we are not just rational intellectual beings and so an experience like this, is going to mobilise fantasies essentially am I loved, was I abandoned, why did this happen to me, maybe I am not good enough and that would happen with anyone, where you start to worry inside, you imagine things and you start to worry about what you are imagining, so the survivors are going to be really struggling with that. When you are disabled, that is going to be even worse, because if you are dependent, if you can't walk, if you can't feed yourself, then something like that is life threatening. If you are struggling with someone and you are not disabled, you can think I am so out of here. When you are dependent, you can't think that, so you are trapped in some way in the disability and then these fantasies will be churning inside which you will be having, to deal with. It will be excruciatingly painful inside those people.

ADV LILLA CROUSE: Some of the survivors were moved multiple times, it can't be explained why they would have been moved so many times. We have spoken about the brick mother, how would this affect them having just been moved multiple times?

ME CORALIE TROTTER: It magnifies all the issues, so the more people were moved, the more it magnifies the issues, the more it shatters the assumptions, the harder it becomes to trust what anyone says, so you are going to have a massive erosion of trust in the other and you are dependent.

ADV LILLA CROUSE: Could I just have a moment please Justice?

ARBITRATOR: Yes certainly.

ADV LILLA CROUSE: Could I also just ask you, some of these mental healthcare users, were in facilities where other people died overnight or left in the same wards. What effect would that have on the survivors?

ME CORALIE TROTTER: So that's part of your trauma picture, the more you are exposed to the sensory reality of the event which in this case, would be the sight, the smell of it, the more that results in the possibility of your own life being threatened and the more you witness the death of others, the worse the trauma.

ADV LILLA CROUSE: Thank you Justice.

ARBITRATOR: Well while you are there, talking about survivors, evidence suggests patients which include those who survived, were crowded, were unwashed, they lived in smelly and stinky places, they did not have proper bedding, they were visibly hungry, they would rush to the door every time a visitor came. In some instances, male and female patients were thrown into small wards together or rooms together and on and on it goes. What would that have done for the survivors and of course that they were lucky enough not to die? What does that do to the trauma scenario you have been telling us about?

ME CORALIE TROTTER: I think that is what Counsel was asking, like where on this continuum are we and we are at an extreme end of the continuum of trauma. I mean that set of circumstances, it is like people coming out of the Holocaust and how do they begin to metabolise that experience, to put words to it and sometimes it is actually not possible that is how hard it is.

ARBITRATOR: You know the question of consent has come up in the evidence quite often, even at the end, survivors were basically taken to wherever, even if they were better circumstances, taken back to Life Esidimeni, whether in Randfontein or Waverley or wherever else, but throughout the multiple transfers, I hear no evidence about consent, about talking to them.

ME CORALIE TROTTER: It is very disempowering.

ARBITRATOR: Yes but would that be mitigated by the fact that they were taken back to normalised institutions?

MS CORALIE TROTTER: I think that would help.

ARBITRATOR: I am struggling with the continuity of the stress condition, even in relation to survivors.

MS CORALIE TROTTER: I think going back into I think normalising things and going back into a situation that feels more ordinary, is going to be massively helpful, but I think it has to come with someone sitting with the survivors and saying I know what you have been through, we are back to the illusions, it is all going to be alright now, what your grandfather used to say, this is not going to happen again and working through that over and over and over and not assuming that because people have disabilities, that they don't understand something like that. We can't assume that because people are disabled, they can't register and that they don't get things and so the patients that have survived, need an enormous amount of help to say this will not happen again, it should never have happened and now it will be alright. Of course that might not be true, but that's the work.

ARBITRATOR: And in the restorative justice enquiry, what should I be looking at in relation to survivors?

MS CORALIE TROTTER: I think that ceremonies for survivors are as important as ceremonies for the people who have died, so in other words, it's one thing to have a one on one conversation and try and work through this, it always matters when that is stated publically. So it's like someone saying they love you and then saying at a wedding, they love you in front of everyone and it's that, that somewhere there needs to be some public statement to the survivors, it can't just be private and hidden.

ARBITRATOR: Let's talk about money again and survivors. Okay let's talk about the apology first and other acts that would help stunt continuous stress. What else should we be doing and how do plug in money in all that because they are also entitled to compensation in financial language?

ME CORALIE TROTTER: Absolutely and in this situation, it can really make a difference because the money can help the families to visit the people that they love more and basically just improve the standard of care, so money is essential here, because then at least what you gain from it which also helps with having been let down, is look I am coming every week now, I am not just coming at month-end.

ARBITRATOR: And would it be necessary to make specific orders of psychiatric and psychological intervention, or is it adequate that they are at State institutions that would be able to provide that?

ME CORALIE TROTTER: No this needs to be specific.

ARBITRATOR: You think there should be specific intervention directed at the past trauma around the Marathon Project?

ME CORALIE TROTTER: Exactly, because that also takes it seriously, it is also saying you are not just like one of the other patients, you have been through something very specific and there is going to be a specific intervention to help you with that, plus you will still have access to everything that is available in the institutions. You are going to have more, not just what everyone has because of what has happened.

ARBITRATOR: Ja you are right, the fear to be thrown onto the back of a bakkie again, should still be quite fresh and present. Counsel?

ADV DIRK GROENEWALD: Mam I just have a few questions for you. I have heard your evidence and I would just like to confirm, I understand you correctly that these families, the bereaved families, they are not just simply in the process of grieving, they are in a totally different space, a worse space and if I look at your report, in fact you have diagnosed them with a disorder am I correct?

ME CORALIE TROTTER: The families have not even started grieving, so grieving is not on the map yet. Continuous traumatic stress disorder post-traumatic stress disorder, it has the word disorder in it, but the irony psychologically is that it is considered a normal response to an extraordinary event. So it has got the word disorder in it, because it lands up in the diagnostic and statistical manual of mental disorders, so people can use codes, that logistical stuff, but a traumatic response is considered an ordinary response that almost anyone would respond in the same

way, because it is the event that is shocking, extraordinary, horrific, unexpected and in fact, who didn't respond in these ways, you would wonder what is going on inside this person. But certainly in terms of if you asked it in another way in terms of morbidity, there is a high level of morbidity but it is not that the individual is pathological if that makes sense.

ADV DIRK GROENEWALD: Yes it makes sense.

ARBITRATOR: Yes but the sharp end of the question was, do you consider yourself and your colleagues to have diagnosed the family to be suffering from that disorder?

ME CORALIE TROTTER: Absolutely in a way that I have never seen before.

ADV DIRK GROENEWALD: Thank you very much Mam. Then just a second issue, to what extent would you say that accountability holding those responsible, to what extend would this contribute to the families getting closure?

ME CORALIE TROTTER: Enormously. We get very stuck in relation to each other when the other person doesn't hold themselves accountable or accept responsibility or apologise fully, you can't move, so you will hear in ordinary relationships, people saying that all I wanted, was for you to acknowledge what you did, it's an ordinary common thing and in a situation like this where there has been this de-humanisation, it becomes absolutely essential.

ADV DIRK GROENEWALD: You see I think that in respect of the accountability issue, the families have sat through these proceedings and they have heard that no disciplinary action has been concluded, nobody has been charged criminally, none

of those steps that will tell us that listen here, do not worry, those that are responsible, will be brought to book, we haven't seen that. Now is there any other way that the families can get closure without receiving that confirmation or that evidence or that testimony that here are these individuals and they are now facing criminal charges, or they have now been found guilty in a disciplinary proceeding, what is your alternative to that?

ME CORALIE TROTTER: Look I think all the things that we have been talking about will play their part. The thing that makes us different is that mental health professionals are registered with legal bodies and they have a legal and an ethical responsibility. This is not an ordinary infringement, this is an infringement on the part of people who had legal ethical responsibility and so, disciplinary action not being reported to the HPSCA and I have heard what the advocates have said that there is due process in terms of law, but at the end of the day, if that doesn't happen, it is completely unacceptable and it puts our entire profession into disrepute.

ADV DIRK GROENEWALD: Just a last issue, one of the witnesses testified and she said she was feeling powerless, when we asked her how does it make you feel, magteloos was the word she used, how do we give the people their power back, so that they feel the confidence to trust in the system again?

ME CORALIE TROTTER: This process is part of that, it's the families who pushed and pushed and asserted themselves and then with the help of the advocates sitting here, so this in itself is something that the families have done and they can feel very

proud of that and then all the other things, like accountability, apology come into it. This is an empowering process. It might be frustrating, but it is empowering.

ADV DIRK GROENEWALD: Thank you very much Mam, thank you Justice.

ARBITRATOR: Thank you for those valuable questions, Counsel?

ADV PATRICK NGUTSHANA: Ms Trotter, on Page 13 of the paginated documents, the last paragraph there, you have testified about this already, that it says the manner in which this radical displacement was carried out, was such a sudden vicious shock to the system both individual and family, that it could not be absorbed and digested. What I what to find out from you, is that we have here families who did not know that their loved ones had been moved already to these NGO's. They only learnt later or when they contacted, that they had died and this I understand it to be making reference to the actual implementation of the programme, how it had an impact on them. How would this, that is the impact, on the families of those who had knowledge of the fact of the relocation of their loved ones, later or after the fact?

ME CORALIE TROTTER: Sorry you are going to have to repeat the question, I am not sure what you are asking me?

ADV PATRICK NGUTSHANA: How did the implementation of the project affect those who only learnt of the move after the fact?

ARBITRATOR: That would be?

ADV PATRICK NGUTSHANA: That is families, the survivors.

ME CORALIE TROTTER: That's the whole idea of you've gone through an experience, but actually you have missed it and so now the different parts of your mind, are having to catch up with each other and that is trauma, that is what is so devastating, is you can't undo the experience, you can't get rid of it, because it goes in in such a shocking way, so the sort of physiological experience of it, is intense, so you can't do what we all do and think I am not going to think about that again, you can't do that, but you haven't actually absorbed the experience and made it part of who you are, so now you are torn between a part that has had the experience and a part that hasn't had it.

ARBITRATOR: Making part of it would mean what, learning to live with it?

ME CORALIE TROTTER: Knowing that that is your dilemma, you are not going crazy, that this is what trauma does, so if you start there with okay, I am having to catch up with myself, how am I going to catch up with myself, or what do I need to catch up with myself, then you begin that process and different people will need different things.

ADV PATRICK NGUTSHANA: And the second part to that, the fact that you learnt that the move has already occurred, that is one and then two, you learn that your loved one is dead, what is the level of impact that this would have on the family?

ME CORALIE TROTTER: Look I think a lot of the family members here have spoken about it, that in a situation like that, actually the ordinary response is murderous rage that you want to kill somebody and you can't go and kill somebody and so then you have to push that murderous rage down, but then that doesn't help

you deal with it, so it's a sort of a vicious cycle of a murderous rage and then a helplessness and a disempowerment, very hard to be- I mean that is how we torture people, that is what we do to them.

ADV PATRICK NGUTSHANA: Yes and you had been asked earlier about this continuous traumatic stress disorder, when does it end, I want to know from your practice, you make reference on Page 27 to that is in Paragraph 1 of the reparative and restorative justice, that it will not be possible for these families to do this psychological work without professional assistance. What professional assistance do you make reference to and the level of intervention of that professional assistance I want to know?

ME CORALIE TROTTER: I don't think the families can deal with this without professional help and so I think that every individual and every family has to be assessed and then an intervention designed specifically for that family so that you start to take into account at that level, differences, variations and then design an intervention for individuals and for the family as a whole and that actually needs to go on until it is finished.

ADV PATRICK NGUTSHANA: So the recommendations at the end of this process, should be designed to such that it accommodates that intervention and the frequency of the intervention, would be determined by the professional intervention at the end of the process?

ME CORALIE TROTTER: Exactly so this should not be a default thing, this should be a very specific part of what happens at the end of the arbitration.

ADV PATRICK NGUTSHANA: Yes for example, you had been asked a question whether you had already diagnosed them. You are not able now to assist us with the frequency of the intervention to deal with the diagnosis you can only do that after further interventions through professional help?

ME CORALIE TROTTER: In terms of the families we consulted and in terms of all the oral testimony that I have heard and the fact that the story is the same in the affidavits, I am pretty sure that all these families are going to need psychological assistance, that the level of morbidity is high enough that no one is going to be able to deal with this alone and it is always hard to say how many sessions specifically, but I would use the word it certainly isn't short-term, it certainly isn't 6 sessions and the reason for that is, it is going to be very hard for these families just to put their trust in a mental health professional to begin with. Just that, is going to take time and you can't instruct somebody to trust you and especially in a situation like this, so establishing trust is going to take time and then maybe the work can begin. Sometimes with work like this, it is helpful to take a break, so to have 15 or 20 sessions and have a break and see what the mind has done with it, how much has been metabolised and start again, but it is hard to say because there are children involved, there are adolescents involved, there are families involved, so that is where the variation is going to come in in terms of assessment.

ADV PATRICK NGUTSHANA: Yes and in relation to this professional assistance, we do know that we have public health and private health to assist, what would be your view about what the recommendations should be?

ME CORALIE TROTTER: I don't think it matters whether it's private or public. What matters, is that the person doing the intervention is competent and skilled in terms of trauma and in terms of working deeply and what also matters, is that if it is given over to public health, that it doesn't then disappear in ordinary every day public health life, that this has to be kept separate and be a very specific thing. So it's the competence of the person and their experience and skill that is the most important.

ADV PATRICK NGUTSHANA: So there wouldn't be any difficulty if the recommendations to that, yes this professional intervention must be provided by or under the auspices of the Department of Health that is in your public sector.

ME CORALIE TROTTER: In terms of the ability to do the work, no. In terms of the meaning of that for the families, it makes a difference, so in that situation, in the private sector, it is going to be hard to establish trust. If you put the families into the public sector, you are going to use so much time trying to establish trust just because of this experience. Everyone is too traumatised to just get past that and that will contaminate the intervention.

ADV PATRICK NGUTSHANA: Thank you Justice, I don't have anything further.

ARBITRATOR: Thank you. Counsel for the State?

ADV TEBOGO HUTAMO: Thank you Justice, Ms Trotter good afternoon, let's go to your latest and updated report and in particular, let's go to Page 7, the paginated Page 7, the one written with a marker. Through your testimony, you testified that

the consultations with the family members, was extensive, such that your team had to work in pairs, is that correct?

ME CORALIE TROTTER: Yes.

ADV TEBOGO HUTAMO: And on the second paragraph of the report, you recorded that the consultations took place over a 2 week period, each interview lasted between 2 and 3 hours, do you see that?

ME CORALIE TROTTER: Yes.

ADV TEBOGO HUTAMO: Then you proceeded to state that each meeting was treated as a single therapeutic consultation. What did that entail in respect of an interview of each family?

MS CORALIE TROTTER: The single therapeutic consultation is a form of intervening that arose during the state of emergency during the 80's. The problem during that time, is that when you were working with someone, you never knew whether they would be able to come back or not, either because they had been detained, a whole variety of reasons and so, an intervention was designed that could go on for as long as it needed to go on, so typically we will stop an intervention after a certain amount of time. The point with this intervention, is if it takes 4 hours, it takes 4 hours, you try and arrive at a point of completion before you stop and that is an unusual kind of intervention and the reason we thought it would be appropriate here, is because it was hard for these families to come logistically, so it was pre-empting that it might be difficult to come back again, people might not come back again, so to stay in the consultation for as long as what

was needed and not allow time to be a boundary. That is really the aim of it, but you can then have a second consultation if you need, so it's the best of both worlds. It can be ongoing, but it is as complete as it can be. The other reason for that, was because we anticipated the families would be in distress and we didn't want to stop at a point and leave them in distress, so that the idea was to go on until the point where it felt okay to end. It just so happened, that mostly the team reported that the interviews had taken between 2 and 3 hours.

ADV TEBOGO HUTAMO: That process of consultations, you indicated that the demeanour of the people interviewed, was essential in your assessment of their circumstances? Is that how I understood your evidence?

ME CORALIE TROTTER: When you say the demeanour of the people interviewed, you mean the families?

ADV TEBOBO HUTAMO: The families yes.

ME CORALIE TROTTER: And what is the question?

ADV TEBOGO HUTAMO: The question is like during the consultation with the family members, were you taking into account the demeanour of the responses which were given to you?

ME CORALIE TROTTER: Absolutely. I mean that is the great gain of the model that we used, is you are not standing aside and looking and measuring, you are in it, so you can be watching body language, you can be checking how much emotion there is, you are using that and working with that all the time and that is invaluable.

ADV TEBOGO HUTAMO: So it was quite necessary that those who were conducting the interviews had to pay attention to all those factors?

ME CORALIE TROTTER: Absolutely necessary.

ADV TEBOGO HUTAMO: If I can take you to Page 27 the paginated Page 27, the first paragraph, it would be the 3rd paragraph, but numbered number 1, do you see that?

ME CORALIE TROTTER: Yes.

ADV TEBOGO HUTAMO: I am going to read from the second sentence, which reads that, the individuals in the families, need to be assessed to determine the nature of the psychological intervention required. So that will go along with what you have just said that it is quite important and critical that each family had to be consulted?

ME CORALIE TROTTER: Yes so in other words, are there children in this family, are there adolescents in this family, you would need to take all of that into account to determine what kind of- is it family therapy, is it play therapy, is it couple therapy.

ADV TEBOGO HUTAMO: Like if you look at the last sentence of that paragraph, it says that each family needs therapy so that the family units can heal. Let's then go back to Page 6, it appears to be a very long paragraph, but I just want to refer you to a specific section. It will be about 5 lines from the bottom of that first paragraph, the sentence which starts with the level of rapport do you see that?

ME CORALIE TROTTER: Yes.

ADV TEBOGO HUTAMO: It reads that the level of rapport, disclosure and emotion was high in each consultation and the families reported finding the process helpful and expressed their gratitude. So this was in relation to the interviews conducted in respect of each and every family in order to understand their circumstances of trauma if suffered?

ME CORALIE TROTTER: Correct.

ADV TEBOGO HUTAMO: And would I be correct to say that in order to determine whether a person has suffered trauma, there is an absolute need that such a person should be consulted with?

ARBITRATOR: You've got to say it again? I missed it too?

ME CORALIE TROTTER: I think what you're asking me is-

ADV TEBOGO HUTAMO: Let me repeat the question, will you agree with me that in order for one to be able to determine whether a person has suffered trauma, there is an absolute need that such a person should be consulted and be interviewed?

ME CORALIE TROTTER: No I don't agree with that.

ADV TEBOGO HUTAMO: How will you establish the experience without interaction with the victim?

ME CORALIE TROTTER: So you cannot obviously without interaction with someone, you can't be 100% sure, but the whole trauma discourse, the whole theory of trauma allows you to make predictions, so you could make a very, very

reasonable clinical prediction that somebody having gone through that experience, would be traumatised, then there would be situations or factors in families or in an individual that would mitigate against that, but that would be exceptional.

ADV TEBOGO HUTAMO: Do I understand you to say that you can work on predictions rather than what the person actually expresses himself or herself?

ME CORALIE TROTTER: They interact and the understanding of trauma clinically, will allow you to make a whole lot of predictions about what might have happened to that person, then you are going to find specific things when you interact with that person, then you will get an individual picture, but predicting and anticipating trauma, does not depend on a personal interaction with someone.

ADV TEBOGO HUTAMO: Perhaps let's just go back to the reasons why we are here. I just want to get an understanding from your earlier evidence of the objective why you had to come and give evidence before these proceedings. You had stated that your presence here was to come and make argument to the Justice why certain findings should be found, do you recall that?

ME CORALIE TROTTER: Just say that in another way?

ADV TEBOGO HUTAMO: During the beginning of your testimony, you testified that you were called upon to assist the arbitrator in your argument why certain findings should be made on behalf of the claimants?

ME CORALIE TROTTER: In terms of the outcome of the arbitration.

ARBITRATOR: I think in an expert opinion rather than argument. We have agreed that she is an expert, she is telling us about her field that requires certain expertise that you acquire in a variety of ways, so hence they are not arguments, they are expertise, they are opinions that, is why experts are allowed to express an opinion, because they are skilled and knowledgeable. They have expertise in the area, so I thought you would want to ask the witness why she is here and let her say it in her own words and she might be able to tell you why she is here. I am just changing the argument part. She is not entitled to argue either way, she is an expert who tells us what trauma is likely to ensue in these circumstances, that is in her opinion, in her expert opinion.

ADV TEBOGO HUTAMO: Ms Trotter, on whose behalf are you giving your evidence?

ME CORALIE TROTTER: Section 27.

ADV TEBOGO HUTAMO: Do you know, who are, the, claimants in these proceedings?

ME CORALIE TROTTER: The families who have lost people during the relocation.

ADV TEBOGO HUTAMO: Do you know what, is, the number of those families?

ME CORALIE TROTTER: 56.

ADV TEBOGO HUTAMO: 56 and do you know that there is an aspect relating to redress and compensation in respect of each one of them?

ME CORALIE TROTTER: Yes.

ADV TEBOGO HUTAMO: And do you accept that each one of them will have to make out their case for the relief that they seek in relation to such compensation?

ME CORALIE TROTTER: No I don't accept that, because my argument is that the experience of trauma is outside of context, it can be anywhere in the world and you would be able to anticipate and predict that certain processes would have happened, there would be a certain impact, that is what trauma discourse is about. That is not to say that there isn't variation, but the whole point is that based on the trauma and based on our knowledge of trauma, we can make certain predictions, which would then be refined in a one on one situation.

ADV TEBOGO HUTAMO: You have testified that 11 families of the 56 have been interviewed and consulted with?

ME CORALIE TROTTER: Correct.

ADV TEBOGO HUTAMO: Are their personal circumstances the same?

ME CORALIE TROTTER: No, the families and the constructions of the families were very diverse, in terms of language, in terms of age, in terms of how they had experienced the relocation, so it was a very diverse group of families.

ADV TEBOGO HUTAMO: Is it not the reason why you should went beyond 11 families?

ME CORALIE TROTTER: Look I can't say it in a different way to what I have already said it, that the thing about trauma, is of course there is going to be

individual variation, but the nature of trauma, is that you can make predictions across the families.

ADV TEBOGO HUTAMO: Let's go back to the question and then I will pose another question. Was it not necessary in light of your previous answer that the circumstances of the 11 families varied, my question to you is, was it necessary that in those circumstances, you had to consult more than 11?

ME CORALIE TROTTER: And my answer is no.

ARBITRATOR: No, we had agreed that there would be no heckling here please. Shall we have silence please, we have to go on? It is a legitimate question that Counsel is asking and it requires an answer. I don't think there should be any interruption in that process.

ADV TEBOGO HUTAMO: Still at Page 6, the second paragraph, where you have recorded that the team has consulted with 11 families, can you just indicate of the families referred to in this page, which of the families did you participate in the interviews?

ME CORALIE TROTTER: I didn't participate in any of the interviews.

ADV TEBOGO HUTAMO: And then earlier on you testified that the demeanour of the people who were interviewed, played a role. How would you have assessed their demeanour if you did not interview any of those families?

ME CORALIE TROTTER: So then there are a number of ways of tackling that. So the clinicians after they had done the interviews, would use their notes and they

would write up a report and they would send that report to me and then obviously I could ask further questions that was the one thing. The second thing was that I then asked everyone to write a separate report talking about how the families have presented, the emotional tone for each individual member of the family, but also for the clinician, what was going on inside you and then the third thing, is that we held debriefing groups and in those debriefing groups, the clinicians would talk about their experience. So I had a very intimate sense of what people were going through, plus after most of the interviews, I phoned the clinicians and I spoke to them and then you are right in the moment, how did it go, what happened, what was your experience of it, how are you doing.

ADV TEBOGO HUTAMO: You phoned the clinicians. Would it not have been necessary that someone with first hand exposure, to have been in these proceedings, to express what, they had observed?

ME CORALIE TROTTER: No because I know each and every one of these 20 clinicians and I know them well and I trust them. I trust their skill and I trust their ability and I was there all the time assessing where is everyone at, how they are thinking about this and that is my skill and that is why I led the team.

ADV TEBOGO HUTAMO: But you have never observed the demeanour?

ME CORALIE TROTTER: No but I have a report of that from all the clinicians.

ADV TEBOGO HUTAMO: Is that not hearsay from the other clinicians?

ME CORALIE TROTTER: No because part of our clinical skill, is to be able to empathically get a sense of what is going on inside someone even when they don't

know themselves what is going on inside them, so that is part of our skill, that is what we are trained to do when you work psycho-analytically. That is one of our skills.

ADV TEBOGO HUTAMO: Are you in a position to assimilate the experience of trauma by one family to the other?

ME CORALIE TROTTER: What do you mean assimilate?

ADV TEBOGO HUTAMO: Are you able to generalise?

ME CORALIE TROTTER: I am able to make a prediction that out of these 56 families, this report will be absolutely accurate in terms of most of those families.

ADV TEBOGO HUTAMO: In the absence of an interview?

ME CORALIE TROTTER: In the absence of an interview, because we are not talking about individual pathology here, where what you are saying in terms of an interview becomes absolutely essential, we are talking about a trauma response and there are specific guidelines for trauma responses which allow us to make predictions.

ARBITRATOR: It's a little like asking an aerodynamic expert what would happen to an aeroplane of this size engine if it flew into a storm of this kind, they don't have to be there in person if they are experts in their field to tell you that this will be the likely consequences if an aeroplane of this size engine of this make flew into a storm of this kind. Is that helpful at all in your cross-examination?

ADV TEBOGO HUTAMO: Justice I beg to differ, we are not dealing with mechanics, we are dealing with feelings of individuals, so it becomes very critical that the individual circumstances of those who are affected, need to be considered. It cannot just be done in general.

ARBITRATOR: Put it to the witness that her skill is not sufficient to predict responses to trauma by an individual if you feel that it is different, then put it to the witness and debate it with her. You are entitled to do that.

ADV TEBOGO HUTAMO: Ms Trotter, you have just said that you can use prediction to assess trauma of other family members. You have already testified that of the 11 families, their stories, circumstances, how they have experienced their trauma varied and I therefore put it to you that in light of what you have said, it is not possible to generalise or it is not possible to make a finding of trauma by prediction.

ME CORALIE TROTTER: And I have evidence concrete evidence that it is, so in our very first meeting as a group of professionals, we sat down and we thought okay, that is without having met any family members, I only knew what I knew from the news, what are we looking at here and I wrote up a protocol and that protocol is what was used in the assessments, it's about a 10 page protocol and in that protocol, I predicted what was going to be in this report. What I did not predict, is that it would be much more catastrophic than I had imagined, so I was able to predict it because I wrote it up in the form of a protocol and I have that protocol and as I say, it was more catastrophic than I had anticipated.

ADV TEBOGO HUTAMO: So you were ill-prepared?

ME CORALIE TROTTER: No we were absolutely prepared. Protocol was spot on, that is what I'm saying, when you say that, I can say that I have proof in the form of the protocol where our predictions were correct, but it was catastrophic, so what we had anticipated, was absolutely there, but when you put it all together, it was hard. We were 100% prepared.

ADV TEBOGO HUTAMO: Let's just make some progress, still at Page 6-

ARBITRATOR: Again let me just repeat what we have said earlier. Everybody is allowed into any proceedings provided they allow the proceedings to proceed normally. We cannot witnesses to be heckled or Counsel to be heckled while making cross-examination. You may or may not like the answers of the questions, but you must stay quiet please, so that we can go through the work. The Advocate is entirely within his right to ask the questions and the witness having been sworn in, is obliged to provide answers.

ADV TEBOGO HUTAMO: Thank you Justice. Earlier on you just confirmed that you never interviewed any of the family members. Do you understand what is hearsay?

ME CORALIE TROTTER: Yes it's when someone says that person said it isn't it?

ADV TEBOGO HUTAMO: Yes.

ARBITRATOR: Does the rule apply to an expert, the hearsay rule?

ADV TEBOGO HUTAMO: Well Justice, it should be relevant in the sense that if an assessment of personal circumstances has to be made, then the person who is

supposed to make that determination, has to get first-hand information from the victim.

ARBITRATOR: No I am talking about the hearsay rule as a matter of law. Could you ever say to an expert, you were not at the scene of the accident and you are trying to reconstruct it? I mean or could you ever say to an expert, what you have been told, are the parameters or facts are hearsay and therefore you can't express an opinion. Let's remember in our law, experts are not witnesses to give direct evidence, it's to give an opinion. As a matter of law, I want to hear your submission on that? Can you rely on the hearsay rule in expert testimony?

ADV TEBOGO HUTAMO: My submission is that if the opinion is not based on fact, first-hand fact, then the expert will not be qualified to express such an opinion that is what I'm putting to the witness.

ARBITRATOR: And you say that's a matter of law? Is that what the law says about expert testimony, that witnesses must always be observers of the facts that they are going to express an opinion on? Is that the submission?

ADV TEBOGO HUTAMO: Well it's an argument which I put to the witness in order to verify.

ARBITRATOR: Well for a moment, I wanted us to debate the law we will get back to the witness. The witness is here to take questions. I am asking whether the question you are raising, is a legitimate one as a matter of law, could you say to an expert on Ebola, you must have been in Central Africa before you can tell us about Ebola and it's evolution and it's symptoms and it's likely impact?

ADV TEBOGO HUTAMO: Well Justice what I want to submit is that it is well known that an expert should be able to be of assistance to the Tribunal as in this instance and the assistance from the expert witness, should be based on facts and facts which an opinion should be expressed and what this witness has said, she did not have facts first-hand about what the families have experienced, so the opinion will be of no value and of no assistance to the Tribunal if it is not based on fact. An opinion can't just be based on unfounded facts that is what I am submitting to you Justice.

ARBITRATOR: Let's hear further questions, we will have to debate the law some other time.

ME CORALIE TROTTER: Can I just ask something? Are the reports that clinicians wrote, are those not the facts?

ARBITRATOR: Well I am not going to allow you to debate the law at this stage. This was an exchange between me and Counsel and the other Advocates can of course chip in, particularly the one who called you, can express a view about the legitimacy of the question. Remember it is about whether the question ought to be allowed or not.

ADV ADILA HASSIM: The question and this line of questioning can't be allowed, because it's not permitted. If the line of questioning were allowed, it would mean that no expert who testifies, medical expert, let's stick to medical experts and deal with humans, would be able to testify on the basis of pathology reports, on the basis of medical records, as to what happened, whether it's a scene of a crime, whether

it's a botched operation whatever the case might be. That is the reason why experts provide particular assistance to any Tribunal. It is because they are experts and they are able to interpret what they see. Unless Counsel is suggesting that the clinicians who were part of the team, have manufactured their reports, this team worked together as a whole, unless he is suggesting that, then I suggest that he says so, but he can't continue a line of questioning on the basis of the hearsay rule when it is not applicable.

ARBITRATOR: Do you have any response to that? In essence, it's an objection to the line of questioning, whether it ought to be permitted, whether you are allowed to tell an expert that an expert should be a direct eye witness.

ADV TEBOGO HUTAMO: Justice I persist with my submissions and if it's a matter that has to be argued, we will present an argument in relation to that.

ARBITRATOR: Let's hear the further questions that you are going to put.

ADV TEBOGO HUTAMO: Thank you. Ms Trotter please turn to, Page 27 of your revised report. The third paragraph which is numbered number 1, you recorded that the second sentence, the individuals in the families, need to be assessed to determine the nature of the psychological intervention required and I have read this to you before and the last sentence also records that each family needs family therapy so that the family units can heal. How will you make that determination when you have no knowledge of the individual circumstances of each and every family which is affected by the tragedy?

ME CORALIE TROTTER: Because these families have all been through the same trauma and it's a human induced trauma and that allows me to predict that there will be similar responses across all these families regardless of variations and context and I say in the second sentence, indication is that these individuals affected by the trauma, need long-term psychotherapy, that is the indication from the consultations. You can't separate trauma out of this picture. You are not asking me to look at a group of patients and make a recommendation and someone has got a borderline personality disorder and someone else is schizophrenic where your questioning would apply. You are asking me about a group of people that has been traumatized, it is absolutely specific, you are not asking me about individual pathology.

ARBITRATOR: But more directly, the psychological intervention required, would require one to one consultations with clinicians isn't it?

ME CORALIE TROTTER: Yes so the reason I say an assessment, is because you are going to need to decide are there children, what do the children need, are they ready now, do we need to wait.

ARBITRATOR: Ja but in every family situation or every traumatized person, ultimately as a restorative matter, you are going to have to talk to them personally and tend to their clinical needs personally?

ME CORALIE TROTTER: Exactly.

ADV TEBOGO HUTAMO: I just don't want to repeat this again, but from the exchange that you had with the Justice, you concede that in order to make that determination, there is a need to consult with each family not so?

ME CORALIE TROTTER: No I don't concede in terms of the trauma picture, so I concede in terms of the specifics of should it be play therapy or family therapy, but I don't make that concession in terms of the fact that these families are traumatised and need help.

ADV TEBOGO HUTAMO: So you concede that each and every family will have to be consulted in order to determine what type of therapy they require?

ME CORALIE TROTTER: Yes.

ADV TEBOGO HUTAMO: And you can only do so when you know their circumstances not so?

ME CORALIE TROTTER: But I can-

ADV TEBOGO HUTAMO: Let's just make it simple, is it a yes or a no?

ME CORALIE TROTTER: I am really getting tired and I am not sure what your question is. I am not conceding in terms of the trauma picture.

ADV ADILA HASSIM: The witness has answered the question. The question that was put to the witness was, can she come to the conclusion based on this exercise and the project and the analysis and the teamwork, that the families who were subjected to this project, suffered trauma and the witness answered the question.

ARBITRATOR: Ja but you see Counsel, let's not be at cross-purposes. I understand 2 separate sets of situations, may a witness predict certain pathologies and the remedy that might be required, that's the one set. That's what experts are there for. The other one is if you- the remedy that she is prescribing in 27, will that remedy require personal intervention of clinicians and that will require yet another answer and I thought that was what Counsel was pursuing, so you don't have to collapse Ms Trotter the point you have already made. The current point is about reparation, it is about the curative steps we need going forward and that is how I understand the question to be. It does not diminish the point that you made earlier, so let's not fall back to that. You have been referred to Page 27 and Page 27 is about the curative measures you suggest.

ME CORALIE TROTTER: And for that, you absolutely need an individual assessment, because some families might not want help.

ARBITRATOR: So take questions on that particular point. Counsel you get my point, you should not conflate 2 things. One issue is, may this witness predict what is the likely trauma that family members are to experience, that's the one thing and the other is, what treatment are they likely to need going to forward and Page 27, is about treatment into the future. But continue with the questions?

ADV TEBOGO HUTAMO: Ms Trotter just help us to overcome this lack of understanding, I take that we rely on you as an expert, what we need to establish is, how do you make a determination of the type of therapy without knowing the individual circumstances of each family?

ME CORALIE TROTTER: You would need to have that assessment as I state, but it would be helpful if the person has some understanding of trauma, but you would need to make that assessment and that is a one on one thing.

ADV TEBOGO HUTAMO: So like there is a need to have one on one consultation?

ME CORALIE TROTTER: Yes in order to determine the intervention.

ADV TEBOGO HUTAMO: Okay I feel like that's quite helpful and then you have just confirmed that like you only interviewed 11 families whose circumstances vary, so I am putting it to you that in light of what you have said, you cannot predict what therapy is required in respect of those families that you have not interviewed?

ME CORALIE TROTTER: Correct, I can't predict what therapy is required, but what I can predict is that therapy is required.

ADV TEBOGO HUTAMO: Justice I am just being alerted to time. I am not sure if we should continue or-

ARBITRATOR: As always I am in your hands. Let the respective Counsels tell me what it is, it is 5:00, I would prefer to continue so that I can help the witness away. I wouldn't want this witness to come back on Monday for a few minutes. If you are going to be long and you give us that indication, the witness comes back. If you are going to be winding up, then we wait. There should be no impediment to your cross-examination you shouldn't limit it if you think you want to be longer with the witness. You are entitled to that.

ADV TEBOGO HUTAMO: Well Justice I really don't intend to take too long, I was just asking that in relation to any need for re-examination which might prolong.

ARBITRATOR: I am quite happy to allow you to ask questions. Again I repeat the principle is quite clear, nobody ought to be impeded in cross-examination only because of time. If you feel you can wrap it up soon, we are sitting. If you want more time, the witness will be obliged to come back on Monday.

ADV TEBOGO HUTAMO: Well Justice we really feel pressurized, like there are some issues which we really need to debate with the witness and on that basis, we request that we adjourn for now.

ARBITRATOR: Absolutely you are entitled to and we will ask Ms Trotter your Monday has been pre-planned for you, which means we ask you that you be here available at 9:30 on Monday. Counsel, is there any matter that we ought to canvas before we adjourn?

ADV ADILA HASSIM: Could I get an indication from my colleague as to how much time he expects to be on Monday so that I can advise the witness that was due to arrive on Monday what time he should?

ADV TEBOGO HUTAMO: I should be able to have wrapped up by tea-time.

ARBITRATOR: Very well, so we ask the witness to come here just after tea-time.

ADV TEBOGO HUTAMO: But all will depend on the answers. If the answers are short, we might finish earlier, but if they are longer, they may take a bit of time.

ARBITRATOR: Okay that is fair. Very well, we are adjourned until Monday at 9:30.