

CASE STUDY · MENTAL HEALTH · SOUTH AFRICA

The Life Esidimeni Tragedy

A short companion to the main article — on what happened when deinstitutionalisation was pursued without the capacity to deliver it, and what it tells us about the systems meant to protect South Africa’s most vulnerable.

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Companion piece

4 min read

Between October 2015 and June 2016, the Gauteng Department of Health transferred approximately 1,700 mental health care users from a long-term provider, Life Esidimeni, to a network of unlicensed and unprepared non-governmental organisations. At least 144 patients died. A further 1,418 survivors were exposed to torture, neglect and trauma. The transfers were ordered to save costs and to advance a policy of deinstitutionalisation. They were carried out without the workforce, infrastructure or oversight required to keep patients alive.

Why this case matters. *Life Esidimeni is not a suicide case, but it is the clearest recent demonstration in South Africa of what happens when mental health policy outruns the capacity to implement it — and of how invisible institutionalised patients can be, even when they are dying in plain sight.*

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The scale

144

confirmed deaths

1,418

survivors exposed to torture & trauma

~1,700

patients forcibly relocated

27

receiving NGOs — all unlicensed

95%

of deaths in NGO facilities

44

patients still unaccounted for

Timeline

- OCT 2015

Gauteng MEC for Health Qedani Mahlangu announces the termination of the province's 40-year contract with Life Esidimeni, citing cost-saving and a policy of deinstitutionalisation.
- MAR – AUG 2016

Mass transfer of approximately 1,700 mental health care users to unprepared NGOs. Patients were loaded onto trucks; medical records were lost; many families were not notified.
- SEP 2016

The MEC tells parliament that 36 patients have died. The actual number is already substantially higher. The National Minister of Health requests an investigation by the Health Ombud.
- FEB 2017

Health Ombud Prof. Malegapuru Makgoba publishes a damning report. Mahlangu resigns from the Executive Council.
- OCT 2017 – MAR 2018

A 45-day arbitration led by retired Deputy Chief Justice Dikgang Moseneke concludes; government is ordered to pay R1.2 million per bereaved family.
- JUL 2021

A judicial inquest opens in the Pretoria High Court to establish criminal liability for individual deaths.
- JUL 2024

Judge Teffo rules that Mahlangu and Dr Manamela negligently caused nine of the deaths — the first time senior officials face possible criminal charges.
- 2025

The NPA confirms it will proceed with prosecution. Families and civil society continue to advocate for accountability.

How patients died

The Health Ombud's 2017 report and subsequent inquest evidence documented a consistent pattern of preventable causes of death in the receiving NGOs. The receiving facilities were paid roughly R112 per patient per day, against the R320 paid to Life Esidimeni for the same care.

CAUSE	CONDITIONS IN RECEIVING NGOS
Severe malnutrition & starvation	NGOs received R112 per patient per day vs R320 at Life Esidimeni
Dehydration	Inadequate water and hydration care
Pneumonia	Cold, cramped, overcrowded conditions
Gangrene & bedsores	Immobile patients left unturned and unattended
Aspiration (choking)	Lack of supervision; patients ingested foreign objects
Medication withdrawal	Medical files lost in transit; prescriptions not continued

04

Why it matters for the suicide argument

COMPANION TO THE MAIN ARTICLE

Three failures the main article identifies

Life Esidimeni demonstrates, in concentrated form, three of the failures the main article documents: a workforce too thin to absorb policy change, a research and surveillance system unable to track patient outcomes in real time, and a policy — deinstitutionalisation pursued for cost reasons — that ran ahead of the capacity to implement it.

If the system can lose 144 institutionalised patients in plain sight, it is reasonable to ask how many of the estimated 14,000 annual suicides — most of them men outside institutional care — are being lost to a system that has never been built to see them.

The patients who died had diagnoses including schizophrenia, bipolar disorder, intellectual disability, cerebral palsy, epilepsy and dementia. The Ombud report and inquest did not publish a comprehensive demographic breakdown, but the patient population broadly reflected Gauteng's demographics — predominantly Black African. Some named victims include Virginia Machpelah, Deborah Phehla, Frans Dekker, Charity Ratsotso, Koketso Mogoerane, Daniel Josiah and Lucky Maseko.

Further reading

[SECTION27 — Life Esidimeni case archive](#)

[Health Ombud full report \(PDF\) — SAHRC](#)

[Bhekisisa — Life Esidimeni special report & timeline](#)

[The Conversation — Lessons from the inquest judgment \(2024\)](#)

[Health & Human Rights Journal — Ombud accountability analysis](#)

[University of Pretoria — Human rights perspective \(2025\)](#)

[Wikipedia — Life Esidimeni scandal](#)

RETURN TO

Suicide in South African Boys and Men

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