Mob assault victim fatalities admitted at a forensic pathology laboratory in a South African rural province

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Background. Community-based assault is a phenomenon carried out worldwide, which contributes to the rise in unnatural deaths due to violence. In South Africa (SA), this is often referred to as mob assault or vigilantism. There is a paucity of literature on the prevalence and epidemiology of this phenomenon in SA.
Objectives. To profile fatal mob assault victim cases admitted at the Polokwane Forensic Pathology Services Laboratory, Limpopo Province. For this to be achieved, the study determined the demographic characteristics of the victims, examined the circumstances of the incidents and noted whether or not victims were hospitalised prior to death.
Method. A quantitative, descriptive cross-sectional study was conducted using a sample of 141 community assault death victims that were selected using consecutive sampling of such victims admitted to Polokwane Forensic Pathology Services Laboratory over 5 years (2018 - 2022).
Results. The study revealed that black adult males residing in townships suffered fatal mob assault. All victims were black men, mostly South African, from the Polokwane subdistrict (75.9%), with a median age of 28 years, and only 33.3% were hospitalised before their death. Within the Polokwane subdistrict, the majority of cases (59.6%) were from the two largest townships (Seshego (31.9%) and Mankweng (27.7%)). A higher proportion of victims (39.7%) had lower levels of education and were mostly unemployed (76.6%). The main causes of death included multiple injuries, head injuries and severe soft-tissue injuries.
Conclusion. This study highlighted the complex dynamics of community assault and its impact on public health. The high incidence of multiple injuries and elevated fatality rates prior to hospital admission can be primarily attributed to the violent conduct of communities and mobs. These groups often engage in aggressive confrontations that escalate quickly, leading to severe injuries and fatalities. Addressing community assaults requires a multifaceted approach, including community engagement, conflict resolution programmes and preventive measures aimed at reducing the occurrence of mob assaults.

Keywords: community assault, mob assault, interpersonal violence, South Africa

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Globally, violence has become a health issue and a human rights challenge.[1] According to the World Health Organization (WHO), there are ~1.6 million violent deaths annually.[2] As an upper-middle income country,[3] South Africa (SA)'s injury burden is very high and mostly consists of violence and road traffic collisions as the leading causes of premature death.[2] The burden of morbidity and mortality continues to rise due to violence, and the homicide rate is six times higher than the global average.[1,4]

With the alarming rate at which violence takes place, people have resorted to defending themselves against these crimes. One such defence mechanism is through a phenomenon called mob assault, which is carried out against suspected perpetrators of crime accused by the community with or without evidence or at times lack of official charges by the police.[5-8] This happens widely across diverse cultures, in various historical settings and as an internationally recognised phenomenon.[6,7]

Mob assault fatalities fall under unnatural causes of death and their investigation is carried out at medicolegal laboratories as mandated by the Inquests Act 58 of 1959.[8] There has been a significant number of mob assault fatalities at Polokwane Forensic Pathology Services Laboratory, which serves large parts of the Capricorn district in Limpopo Province, SA. As seen in other neighbouring medicolegal laboratories,[4,9] pressure is put on the forensic pathology services physical and personnel resources as the need for rendering the services rises significantly.

Other scholars have described mob assault as a symptom of a society where ignorance, an incompetent justice system and human rights violations hinder access to justice.[7] The root cause of this occurrence is the lack of trust in the legal system to justly and timely handle and convict suspected criminals.[7] Some of the reasons stated as justification for this phenomenon are that people believe the justice system to be lenient or insufficient in punishing

perpetrators of crime.[4,7] The perpetrators of mob assault believe they are sending a message to the authorities on how to deal with perpetrators of crime.[5,6]

The traumatic witnessing of a mob assault, the possible loss of innocent lives or breadwinners and the overall lack of faith in the justice system are concerning, as these could render the health and mental wellbeing of the nation at risk.[6] There is a call for mob assault perpetrators to be punished and to encourage them to leave crime for authorities to deal with legally.[10]

There is a paucity of literature that reviews or profiles mob assault internationally and in SA. This study aimed to profile the victims of fatal mob assault cases admitted at the Polokwane Forensic Pathology Services Laboratory.

Critical feedback from this study will be handed over to the SA Police Service (SAPS). SAPS personnel will be made aware of risk areas within their jurisdiction for which they need to evaluate their community-police liaison programmes or protocols. Stakeholders such as the SA national and provincial health departments will receive results from this study, which it is hoped, will help them to evaluate, plan and dispense relevant public healthcare measures. Community leaders in the hot-spot areas could seek effective management and leadership skills after receiving the findings of this research.

Methods

Research design

This was a quantitative, descriptive cross-sectional study.

Study setting

The study was performed in the Polokwane Forensic Pathology Services Laboratory. The facility services the largest catchment area in the Capricorn district, one of five districts in Limpopo (Fig. 1). The Capricorn district has four subdistricts (Blouberg, Molemole, Polokwane and Lepelle-Nkumpi). Although the Aganang subdistrict was de-established after the 2016 local government elections and incorporated into neighbouring subdistricts (primarily Polokwane), this study continues to refer to Aganang to reflect the predominantly rural areas from where victims were referred. It is also important to note that Polokwane is both the city and the subdistrict within the Capricorn district. Unless otherwise specified, this study refers to the city. Of the estimated 1 300 medicolegal examinations/investigations performed at this laboratory annually, an estimated 2 - 5% of cases are of mob assault fatalities. These victims would have been fetched from the scene of crime or referred from the hospitals at which medical help would have been sought before the victims succumbed to their injuries or complications thereof.

Study population and sampling

Population

The study population considered all fatal mob assault cases in the Capricorn district that were referred to the Polokwane Forensic Pathology Services Laboratory for postmortem examination. A convenient sample of cases seen over 5 years between 1 January 2018 and 31 December 2022 was selected owing to ease of availability and accessibility of records. Approximately 94% of the population comprises black Africans; a significant portion of the population is young, with 22% aged 0 - 9 years, 20% aged 10 - 19 years and 21% aged 20 - 29 years; and 53% of the population being women. There is high overall unemployment, with actual figures a subject of debate.

Sample size and technique

Consecutive sampling of all cases seen over the 5-year period was undertaken. Although anticipated to be a small population, the study met a minimum sample size for statistical purposes. The sample size was calculated using the equation $n = \frac{p(100-p)z^2}{d^2}$, where n represented the minimal sample size; p represented the proportional distribution of victims of mob assault in Capricorn district as 50%, because the true proportions were unknown; d represented the desired precision (10%); and z was a constant (1.96) under the 95% confidence interval (CI) and the 5% level of significance.[3] This yielded a minimum

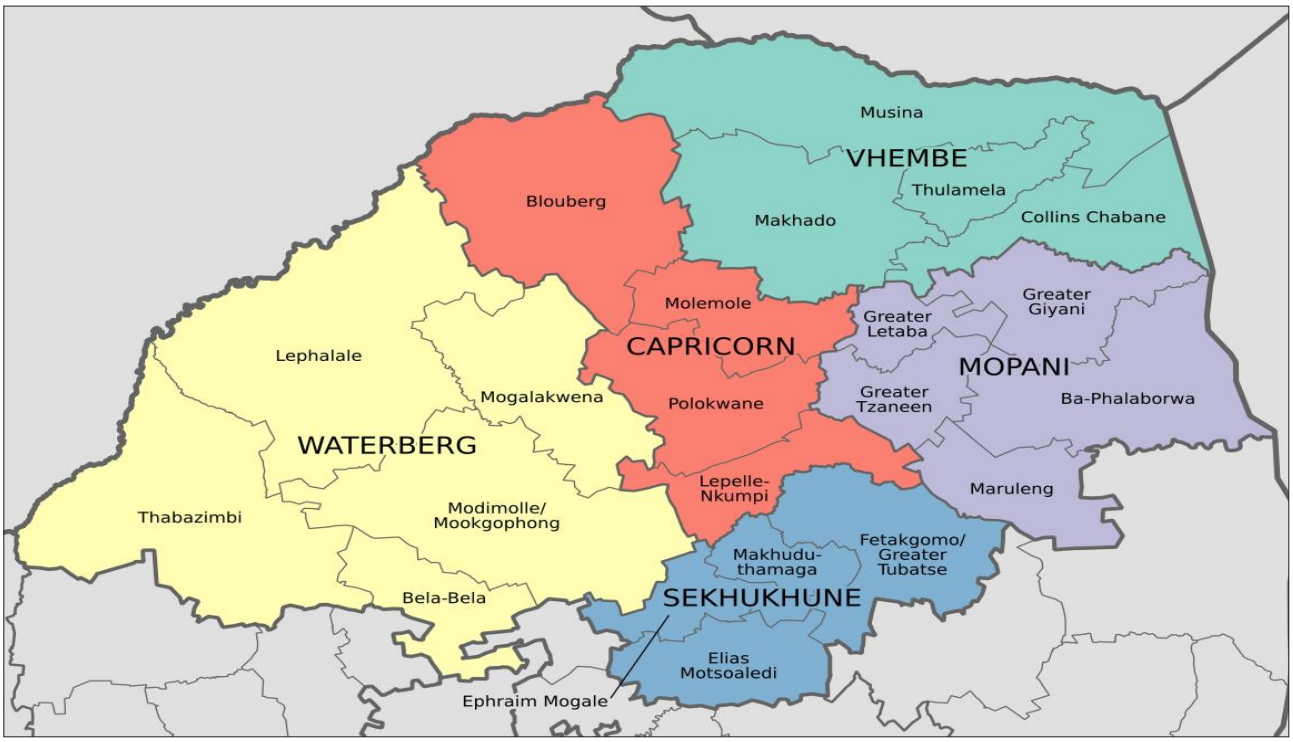

Fig. 1. Map of study setting – Limpopo Province and the different districts and subdistricts.[1]

sample size of 96. Because of data entry errors, a further 10% (n=~10) was added, resulting in a minimum sample size of 116 deceased persons that were targeted. A total of 141 records were retrieved.

Inclusion criteria

All mob assault deaths autopsied between 1 January 2018 and 31 December 2022 were included in the study.

Exclusion criteria

Cases with incomplete data that affect answering of the key objectives were not included in the study.

Data collection

The study was record based and used secondary data. A data collection tool was used. The researcher developed this tool after a review of the relevant literature.

Documentary sources for these data included the forensics pathology registry, where relevant case files that contain all necessary information pertaining to studied cases were obtained. In these case files some of the reviewed documents included SAPS 180 forms (the notification-of-death form, which is issued by SAPS when a person dies due to natural causes after thorough investigation by SAPS), forensic pathology services scene form, Department of Home Affairs form 1663 (a notice of death/stillbirth form) and postmortem reports of mob assault deaths. Where the deceased had been to a hospital, the D28 form (completed by a medical practitioner to record a patient's hospital stay, particularly in cases where an autopsy is required) and/or a GW7/24 form (an SA form used to document and report deaths that occur during or as a result of medical procedures, including those involving anaesthesia) containing the necessary hospitalisation information was perused.

The study objectives were to determine the demographic characteristics of the victims (sex, race, age and employment status); examine the circumstances of the incidents (such as season, time of day and day of the week); note whether or not victims were hospitalised prior to death; and document the types of injuries. Junior high school was defined as the period between Grade 8 and Grade 9. Senior high school was defined as the completion of Grade 10 and Grade 11, but not going beyond matric. Seasons were defined based on the solar equinox (spring (22 September - 20 December), autumn (21 March - 20 June)), when the sun is above the Tropic of Capricorn (summer (21 December - 20 March)) and when the sun is above the Tropic of Cancer (winter (21 June - 21 September)). Weekdays were defined as Monday (05h00) - Friday (15h59), and weekends were defined as being between Friday (16h00) and Monday morning (04h59). Night was defined as the period spanning from 18h00 in the evening to 05h59 the next morning. Day was defined as the 12-hour period from 06h00 to 17h59.

Data analysis

Data collected were captured and coded in Microsoft Excel (Microsoft, USA) and exported to Stata version 17 (Stata Corp., USA) for analysis. Numerical data were explored for normality using the Shapiro-Wilk test and box-and-whisker plot. Numerical data were summarised using the median and interquartile range (IQR 75th percentile (p75) - 25th percentile (p25)) as they were not normally distributed. Categorical data were summarised using frequencies, percentages and graphs. The Wilcoxon rank sum test or the Kruskal-Wallis test was used to compare the medians of categorical variables. Contingency tables were used to compare binary (2) and nominal (>2) categorical data. The χ^2 test or Fisher's exact test was used for comparison of categorical data, depending on the value of the expected frequencies. The two-sample t-test of proportions was used to compute the proportions of victims who were hospitalised and those who were not. The prevalence ratio (PR) was used to determine a factor associated with being assaulted at night. The 95% CI was used to demonstrate the precision of estimates, and the level of statistical significance was set at $p \leq 0.05$.

Ethical considerations

Prior to commencement of the study, ethical clearance (ref. no. TREC/1652/2023:PG) was sought through the Turfloop Research Ethics Committee, University of Limpopo. Permission to conduct the study (ref. no. LP_2023=11-025) was obtained from the Limpopo Health Research Committee via the National Health Research Database.

For access to records, authorisation was granted by the Pietersburg Tertiary Hospital management and the Department of Forensic Pathology. Informed consent was not required, as case records of deceased persons were used. Data were anonymised and we abided by the four ethical principles of autonomy, beneficence, non-maleficence and justice.

Results

Demographic characteristics and contextual factors

Of 6 601 postmortems performed in the 5 years of assessment, 141 records were retrieved, of which all were for black African males; a third (n=47) were hospitalised before their death (p<0.0001). With an overall median age of 28 years (p25=25; p75=35), the youngest individual was 18 and the oldest 74 years old. Even though 29.1% (41/141) of the individuals had at least a matric qualification, 39.7% (56/141) had either suspended their education in primary school or had not gone beyond Grade 9. Only 17.7% of the individuals were employed or self-employed, and this difference (between employed and unemployed) was statistically significant (p=0.020). Individuals' characteristics are summarised in Table 1.

Geographical location and contextual factors

Fig. 2 shows that cases were from Seshego (31.9%, n=45); Mankweng (27.7%, n=39); Polokwane (9.2%, n=13); Matlala (8.5%, n=12); Senwabarwana (7.8%, n=11); Sebayeng (5.0%, n=7); Botlokwa (2.8%, n=4); Westenburg, Mashashane and Mogwadi (2.1%, n=3); and Morebeng (0.7%, n=1).

Viewed differently, three-quarters (75.9%, 107/141) of victims were from the Polokwane subdistrict; 10.6% (n=15) from Aganang or Blouberg; and 2.8% (n=4) from Molemole subdistrict (Fig. 3).

Table 2 summarises other contexts such as the subdistrict, season, time of day and week period, grouped by hospitalisation status. Seshego, Mankweng, Haenetsburg, Polokwane, Sebayeng and Westernburg police stations are in the Polokwane subdistrict; Mashashane and Matlala in the Aganang subdistrict; Senwabarwana, Malebogo and Botlokwa in the Blouberg subdistrict; and Mogwadi and Morebeng in Molemole subdistrict. However, Haenetsburg and Malebogo police stations had no records of deceased mob assault victims. There were statistically more victims from the Polokwane subdistrict in the group who were hospitalised than in those who were not (p=0.018). Furthermore, those who were assaulted at night were 70% more likely to have been hospitalised before their death, which was statistically significant (PR 1.7; 95% CI 1.0 - 2.7; p=0.031).

Causes of death among the mob assault victims

While most individuals had a single cause of death, in two individuals causes of death were unclear – burns and another cause of death. Victims mostly succumbed to multiple injuries (65.2%, 92/141) or head injuries (22.0%, 31/141) (Fig. 4).

Table 1. Victims' demographic characteristics

Caracteristics, *n* (%)†		Hospitalisation		Total	*p*-value
		Yes, *n* (%)	No, *n* (%)		
Hospitalisation		47 (33.3)	94 (66.7)	141 (100.0)	<0.0001*
Sex					
	Male	47 (33.3)	94 (66.7)	141 (100.0)	<0.0001
Race					
	Black African	47 (33.3)	94 (66.7)	141 (100.0)	<0.0001
Age, years (median) (p25 - p75)		28.0 (25 - 35)	28.5 (24 - 35)	28.0 (24 - 35)	0.849**
Age, years					
	<20	4 (40.0)	6 (60.0)	10 (100.0)	0.317
	20 - 29	27 (37.0)	46 (63.0)	73 (100.0)	
	30 - 39	7 (20.6)	27 (79.4)	34 (100.0)	
	40 - 74	9 (37.5)	15 (62.5)	24 (100.0)	
Nationality					
	South African	42 (33.6)	83 (66.4)	125 (100.0)	0.362
	Zimbabwean	3 (23.1)	10 (76.9)	13 (100.0)	
	Other‡	2 (66.7)	1 (33.3)	3 (100.0)	
Highest education					
	Unknown	4 (57.1)	3 (42.9)	7 (100.0)	0.336
	Primary school	8 (28.6)	20 (71.4)	28 (100.0)	
	Junior high school	9 (32.1)	19 (67.9)	28 (100.0)	
	Senior high school	9 (24.3)	28 (75.7)	37 (100.0)	
	Matric	16 (44.4)	20 (55.6)	36 (100.0)	
	Tertiary	1 (20.0)	4 (80.0)	5 (100.0)	
Employment					
	Student	3 (42.9)	4 (57.1)	7 (100.0)	0.020
	Unemployed	29 (26.9)	79 (73.1)	108 (100.0)	
	Employed	9 (52.9)	8 (47.1)	17 (100.0)	
	Self-employed	5 (62.5)	3 (37.5)	8 (100.0)	
	Pensioner	1 (100.0)	0 (0.0)	1 (100.0)	

(Continued)

Fig. 5 shows that those hospitalised accounted for 34.8% (32/92) of multiple injuries, 35.5% (11/31) of head injuries, 25.0% (2/8) of severe soft-tissue injuries, 33.3% (1/3) of burns, 20.0% (1/5) of crush injuries and 50.0% (1/2) of abdominal injuries.

Table 3 shows that none of the contextual characteristics was statistically associated with the occurrence of multiple injuries ($p>0.05$).

Discussion

This study aimed to profile mob assault victim fatalities admitted at Polokwane Forensic Pathology Services Laboratory in Limpopo. This laboratory services most of the police stations in the Capricorn district of the province.

The study found that all victims were black African males, mostly South Africans from the Polokwane subdistrict, with a median age

Table 1. (Continued) Victims' demographic characteristics

Caracteristics, *n* (%)†		Hospitalisation		Total	*p*-value
		Yes, *n* (%)	No, *n* (%)		
Year of incident					
	2018	8 (33.3)	16 (66.7)	24 (100.0)	
	2019	6 (33.3)	12 (66.7)	18 (100.0)	
	2020	7 (31.8)	15 (68.2)	22 (100.0)	0.987***
	2021	9 (30.0)	21 (70.0)	30 (100.0)	
	2022	17 (36.2)	30 (63.8)	47 (100.0)	

p25 = 25th percentile; p75 = 75th percentile.
*Two-sample test of proportions; **Wilcoxon sum rank test; ***χ^2 test; all other *p*-values computed using Fisher's exact test.
†Except where indicated otherwise.
‡2 Mozambican and 1 Ugandan national.

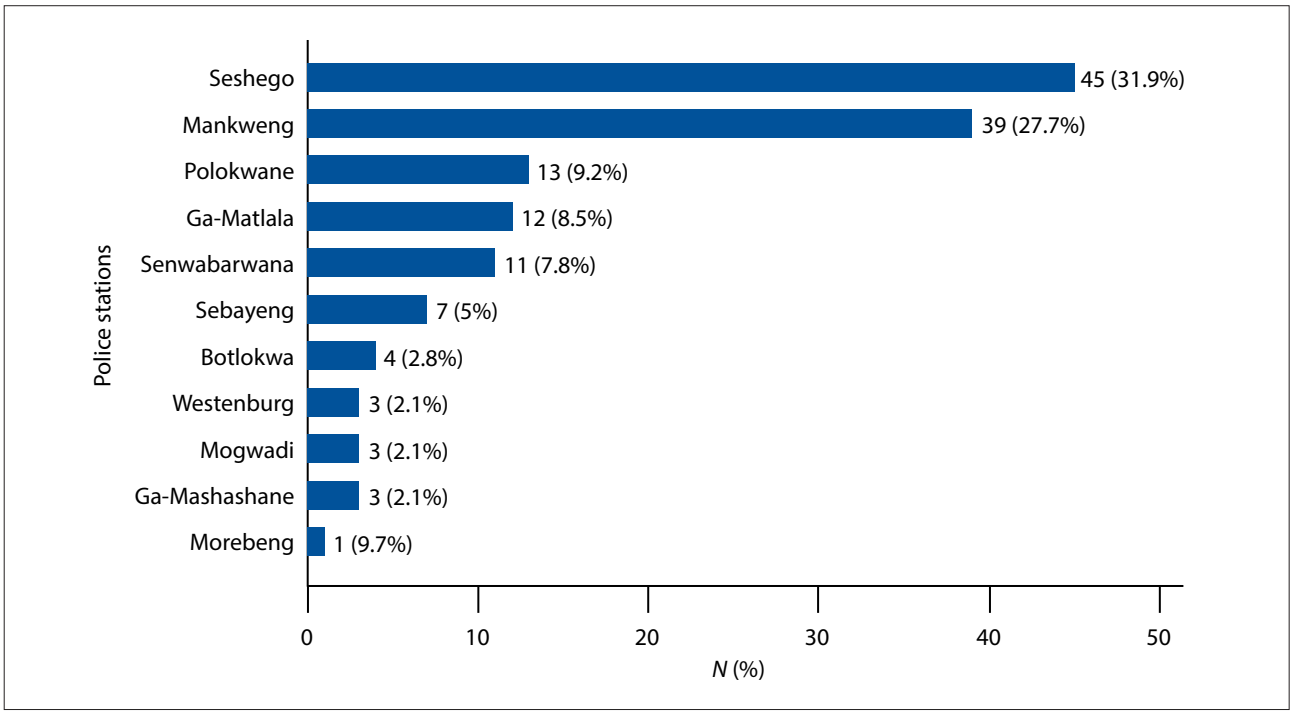

Fig. 2. Police stations where cases were reported.

of 28 years, and only 33.3% were hospitalised before their death. A higher proportion of victims had lower levels of education and were mostly (76.6%) unemployed. To the researchers' knowledge, this is the first study of its kind to characterise the epidemiology of mob assault victims in the Capricorn subdistrict in SA. The study will not only contribute to addressing and reducing the dearth of literature on the subject in this area, but will also help planners to devise targeted solutions based on the victims' profiles presented in this study. Due to the dearth of literature from the province of study, it was not possible to compare the study victims' demographic characteristics with those described in the literature. Furthermore, it was not possible to find literature that compares the prevalence of mob assaults in SA between the various provinces.

Victims mostly had low literacy levels, which is consistent with other studies elsewhere in SA and Tanzania.[7,8] A study by Chalya *et al.*[7] previously reported a higher likelihood for victims to have either had primary school or no formal education. The literature[8,10,11] has also previously associated community-based assault victims with higher probabilities of being unemployed at the time of the incident. Reasons for these are multi-pronged. First, these individuals are likely to be known suspects of opportunistic crimes in their communities and are therefore stigmatised (presumed guilt).[7-9] Second, because these individuals are unemployed, there is loss of trust that they could have any meaningful possessions. They could therefore distance themselves, fearing reputational damage or safety concerns, thus exposing them to attacks.[7-9] Third, victims may be isolated, making it difficult to access job networks or community support, and could end up committing opportunistic crimes to survive.[7-9]

Two-thirds of the victims died at the scene or before arrival at the hospital, which could be an indication of the severity of the incident, a reflection on the inefficiency of the health system (e.g. delayed ambulances if they were called), or inefficiency of the police (if they delayed arriving at the scene to save the victim). These findings are consistent with those in another study[10] done in Johannesburg, SA,

where 50% of the victims died at the scene. However, these findings contrast with those reported in Cape Town, SA, where it was found that 8.5% had died at the scene.[8] A high proportion of deaths at the scene can possibly be attributed to the severity of injuries and/or the efficiency of paramedics and the police. Similarly, the association of increased deaths at the scene among victims who were assaulted during the day could be associated with a lower number of perpetrators during the night than during the day.

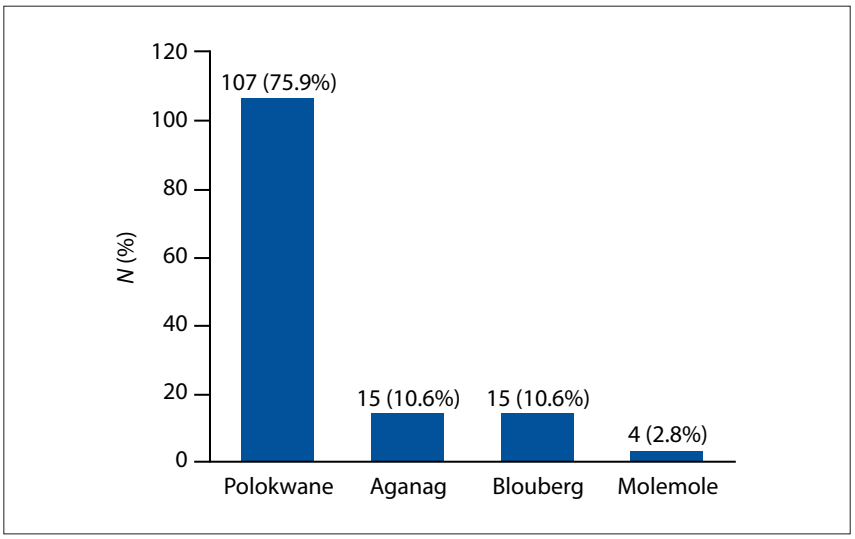

Fig. 3. Subdistricts where cases were reported.

Overall, the Polokwane subdistrict reflected a majority of reported cases at 75.9% of the total. Within the Polokwane subdistrict, the majority of cases (59.6%) were from the two biggest townships (Seshego (31.9%) and Mankweng (27.7%)) included in this study.[9] This is consistent with literature findings that a higher proportion of victims are found in townships.[8,12] It was further established in the local and international literature that crime concentrates in space (specific geographical locations), and that there is stability in spatial crime concentrations.[13-20] This phenomenon occurs where criminal activity is disproportionately clustered in specific geographical areas.[13-20] It is further known that these concentrations are remarkably consistent over long periods of time.[13-20] This theory could further explain the uneven distribution of statistics between the peri-urban settlements (townships), urban and rural settlements.[13-20]

Table 2. Other contexts of victims

		Hospitalisation			
Characteristics, *n* (%)		**Yes, *n* (%)**	**No, *n* (%)**	**Total**	***p*-value**
Hospitalisation		47 (100.0)	94 (100.0)	141 (100.0)	
Subdistrict					
	Aganang	1 (2.1)	14 (14.9)	15 (10.6)	0.018*
	Blouberg	7 (14.9)	8 (8.5)	15 (10.6)	
	Molemole	3 (6.4)	1 (1.1)	4 (2.8)	
	Polokwane	36 (76.6)	71 (75.5)	107 (75.9)	
Season					
	Spring	12 (25.5)	36 (38.3)	48 (34.0)	0.481**
	Summer	13 (27.7)	20 (21.3)	33 (23.4)	
	Autumn	14 (29.8)	23 (24.5)	37 (26.2)	
	Winter	8 (17.0)	15 (16.0)	23 (16.3)	
Day of week					
	Mon - Thu	24 (51.1)	54 (57.4)	78 (55.3)	0.472**
	Weekend	23 (48.9)	40 (42.6)	63 (44.7)	
Time of day					
	Night	27 (57.4)	36 (38.3)	63 (44.7)	0.031**
	Day	20 (42.6)	58 (61.7)	78 (55.3)	

Mon = Monday; Thu = Thursday.
*Fisher's exact test; **χ^2 test.

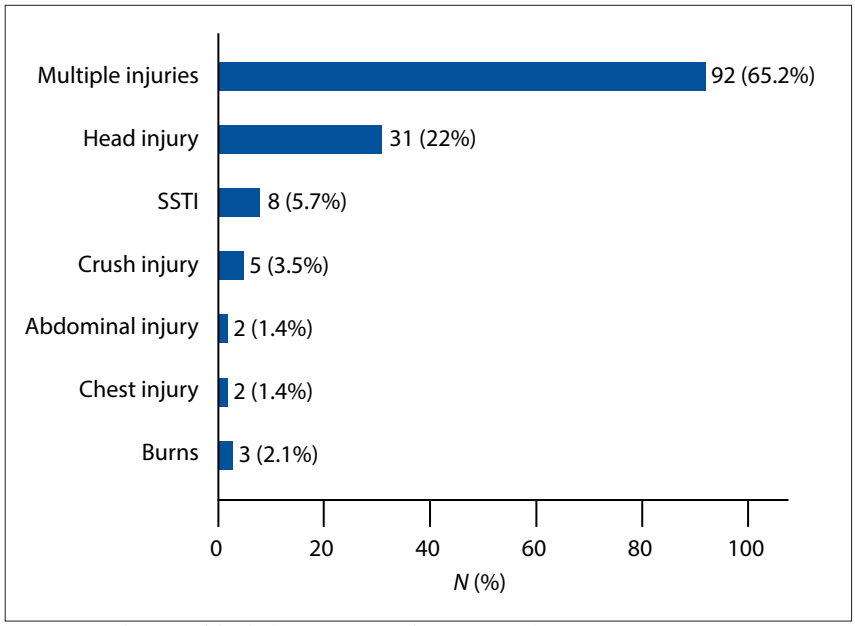

Fig. 4. Victims' causes of death. (SSTI = severe soft-tissue injury.)

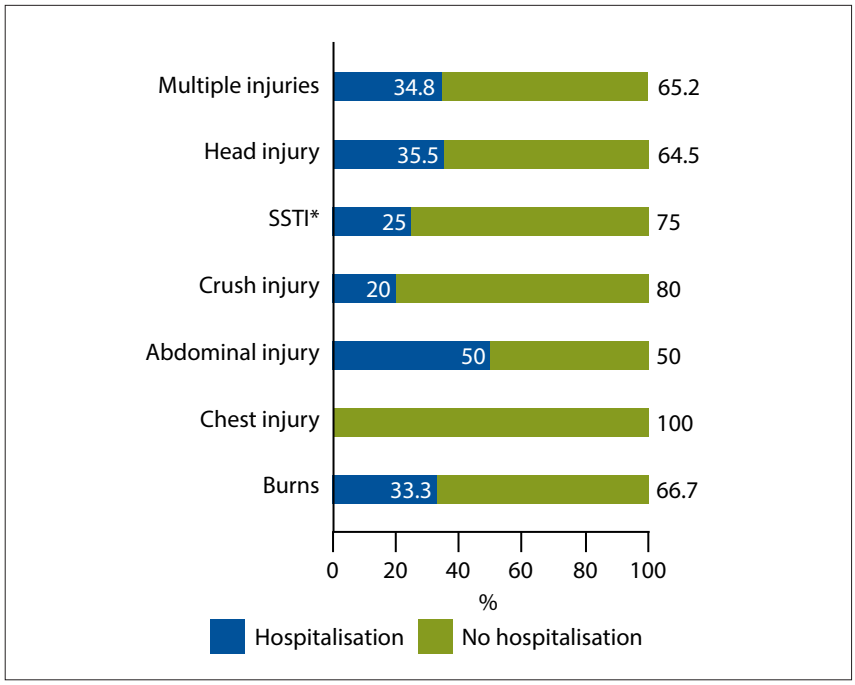

*Fig. 5. Causes of death and hospitalisation status. (SSTI = severe soft-tissue injury.) *Two individuals had both multiple injuries and burns.*

The findings for causes of death are consistent with those in the literature – nationally and internationally. The three major causes of death included multiple injuries, head injuries and severe soft-tissue injuries.[8,10] Victims with multiple injuries could succumb to their injuries owing to the possibility of having been attacked by several individuals simultaneously, leading to widespread trauma across the body; use of unconventional weapons (e.g. bricks, rods, blunt objects); and lack of restraint, as the perpetrators are not regulated and this action could be prolonged.[10,12]

Study limitations

Limitations included that the study comprised retrospective research, and therefore some case files could not be retrieved. Other cases were excluded from the study owing to incomplete information contained in the case files. These limitations reduced the sample size. Even though the calculated minimum sample size was met and exceeded, the missing files could introduce bias and, as such, there might have been over-presentation or under-presentation of findings. The study was performed only in the Capricorn district, and therefore the findings cannot be generalised to the entire Limpopo Province or SA with confidence or certainty. Furthermore, this study could not determine the variables in each of the geographical locations, which resulted in differences in the frequencies of multiple injuries or the absence thereof.

When determining the causes of death, researcher bias could have been introduced. Postmortems are conducted by different pathologists who use a variety of terminology. There is no universal or national code of guidance on how to formulate the causes of death in mob assault victims. As such, different medical personnel record their findings in various ways. At times, the findings on the postmortem reports were left to the researcher's own interpretation and understanding as a trained pathologist.

The study identified that the victims of fatal mob assault were young males who were mostly unemployed. The data on these demographics may be disseminated to the national and provincial health department offices, the Department of Social Services and other relevant government entities such as the Presidency, the Office of the Premier, Limpopo Economic Development and Tourism, small businesses and the Sector Education and Training Authority. The relevant authorities may use the information to formulate, prioritise and implement preventive strategies that could help curb mob assaults.

The majority of the cases were reported in the Capricorn subdistrict; Seshego and Mankweng SAPS recorded a significantly high number of these cases. On publication of these research findings, the SAPS areas in question could look into methods of reducing the criminal activities of mob assault. The police might need to determine ways of working with the affected populations via community liaison schemes.

The study highlighted that most victims who were assaulted at night were initially hospitalised prior to their death. The Limpopo Department of Health could undertake a study to determine whether they have efficient treatment approaches, resources and modalities for trauma victims after hours. Furthermore, they could check whether they are adequately equipped to service victims of mob assault at night or early in the morning. Further qualitative studies could be undertaken to establish possible reasons why communities take the law into their own hands and commit the crime of mob assault.

Conclusions

This study researched and profiled the mob assault victim fatalities admitted at the Polokwane Forensic Pathology Services

Table 3. Contextual factors associated with multiple injuries

Characteristics, *n* (%)		Multiple injuries: Yes, *n* (%)	Multiple injuries: No, *n* (%)†	Total	*p*-value
Multiple injuries		92 (65.3)	49 (34.8)	141 (100.0)	
Hospitalisation					
	Yes	32 (68.1)	15 (31.9)	47 (100.0)	0.617
	No	60 (63.8)	34 (36.2)	94 (100.0)	
Subdistrict					
	Aganang	12 (80.0)	3 (20.0)	15 (100.0)	0.141*
	Blouberg	4 (100.0)	0 (0.0)	4 (100.0)	
	Molemole	7 (46.7)	8 (53.3)	15 (100.0)	
	Polokwane	69 (64.5)	38 (35.5)	107 (100.0)	
Season					
	Spring	36 (75.0)	12 (25.0)	48 (100.0)	0.354
	Summer	20 (60.6)	13 (39.4)	33 (100.0)	
	Autumn	23 (62.2)	14 (37.8)	37 (100.0)	
	Winter	13 (56.5)	10 (43.5)	23 (100.0)	
Days of week					
	Mon - Thu	51 (65.4)	27 (34.6)	78 (100.0)	0.970
	Weekend	41 (65.1)	22 (34.9)	63 (100.0)	
Time of day					
	Night	49 (62.8)	29 (37.2)	78 (100.0)	0.501
	Day	43 (68.3)	20 (31.7)	63 (100.0)	

Mon = Monday; Thu = Thursday.
*Fisher's exact test.
†Inclusive of burns, unless patient also had multiple injuries.

Laboratory in the Capricorn district of Limpopo Province. The demographics of the victims were determined, the geographical locality where these mob assaults occurred was identified and the causes of death were reported. It is the opinion of the researchers that more needs to be done to ensure the employment of educated persons. The hotspot areas need to determine the reasons why communities commit mob assault and also need to find strategies to minimise these occurrences. Hospitals must evaluate their effectiveness and efficiency in treating victims of mob assault. Subsequent studies, both qualitative and quantitative, should be undertaken to strengthen findings that could help with implementation strategies by various stakeholders to curb the practice of mob assault.

Data availability. All data used in this study are available from the corresponding author upon reasonable request.

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