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MEDIA STATEMENT
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INVESTIGATION INTO ALLEGATIONS AGAINST RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

The Office of the Health Ombud (OHO) releases a report detailing the findings and recommendations of an investigation into allegations against Rahima Moosa Mother and Child Hospital (RMMCH) in Gauteng Province. The report of the Ombud is issued in terms of Section 81A (11) of the National Health Amendment Act (NHAA), 12 of 2013, which gives the Ombud the powers to consider, investigate and dispose of the complaint relating to breaches of the norms and standards in a fair, economical and expeditious manner.

The investigation was undertaken following a complaint lodged by Hon. Haseenabanu Ismail (Hon. H Ismail), a Member of Parliament's Health Portfolio Committee on 06 April 2022, into allegations of the circumstances relating to the care of expectant mothers at RMMCH. The complaint was risk-rated high.

The complaint was prompted by two main factors, including the media uproar sparked by video footage published by News24 https://www.news24.com/news24/SouthAfrica/News/watch-pregnant-women- sleeping-on-thefloor-at-joburg-hospital-20220402?s=08; and an email from Ms Salma Bhikhoo (Ms S Bhikhoo) relating to the unpleasant conditions found at RMMCH when she took a family member, Ms Nazeerah Ismail (Ms N Ismail), to the hospital for delivery.

In the main, Hon. H Ismail (the Complainant) alleged that:

- Expectant mothers at RMMCH were sleeping on the hospital floor.
- The Hospital's Chief Executive Officer (CEO), Dr Nozuko Precious Mkabayi (Dr NP Mkabayi), was not working full-time to ensure everything ran smoothly at the hospital. Since the CEO was appointed on 01 January 2021, she had only spent 182 days at the hospital.
- Patients' health and dignity, and the well-being of healthcare workers was severely affected.
- RMMCH has seen an increase in patient load, with no concurrent increase in infrastructural development. The hospital has two maternity obstetrics units in its drainage area that refer patients to it.
- The hospital is classified as a specialised hospital, and patients are referred from hospitals in the West Rand, as well as the Community Health Centre (CHC) and clinics in regions B and C of the Johannesburg Metropolitan Council.

On analysis of the complaint and the allegations, the following issues were identified and investigated:

a) Whether expectant mothers at RMMCH slept on the hospital floors.

b) Whether Dr. NP Mkabayi was working full-time at the hospital to ensure everything ran smoothly and whether she only spent 182 days at the hospital since her appointment on 01 January 2021.

c) Whether the health and dignity of patients and well-being of healthcare workers was severely compromised.

Allegations pertaining to an increase in patient load were not identified for investigation as these support the first allegation relating to the problem of overcrowding at RMMCH.

The investigation was conducted through analysis and triangulation of information and documentary evidence received from the health establishment, Gauteng Provincial Department of Health (GDoH), the Health Professions Council of South Africa (HPCSA), onsite visits, and interviews with relevant personnel, application of the relevant legislation and media articles to enable the Ombud to make a decision regarding the resolution of the complaint.

A provisional report was issued on 21 December 2022 in terms of Section 81A (5) of the National Health Amendment Act (NHAA), 12 of 2013, to the following persons: Hon. H Ismail; Dr. A Manning; Dr. NE Mokgethi; Dr. N Nolutshungu; Dr. NP Mkabayi; Ms. LB Baloyi, and Ms. T Goduka. The objective of the report was to afford any implicated person the opportunity to be heard and provide evidence to vary/disprove the Ombud's findings and recommendations. Feedback to the provisional report from all seven individuals indicated that the Ombud's findings were not only confirmed but strengthened by almost all the responses.

The Ombud's investigations established the following:

a) Whether expectant mothers at RMMCH slept on the hospital floor.

i. The allegation that expectant mothers at RMMCH slept on the hospital floor was substantiated and confirmed.

ii. Based on the evidence gathered, pregnant women sitting on chairs and sleeping on the floor were not attended to in a manner that was consistent with the 'nature and severity of their health condition'.

iii. Expectant mothers sitting on the chairs and sleeping on the floor at RMMCH was purportedly due to shortage of space and overcrowding.

b) Whether Dr. NP Mkabayi was working full-time at the hospital to ensure that everything was running smoothly and whether she spent 182 days at the hospital since her appointment on 01 January 2021.

i. The allegation that the CEO of RMMCH was not full-time at the hospital to ensure that everything ran smoothly was substantiated and confirmed.

ii. The investigation considered the question tabled by Mr. Jack Bloom, Democratic Alliance (DA) member, to the Gauteng Provincial legislature on 08 March 2022 and Dr. NE Mokgethi's response to the legislature on 24 March 2022 that Dr. NP Mkabayi had physically spent 182 days at the hospital since her appointment on 01 January 2021. Based on the answers provided, the investigation found that 27 days were unaccounted for, and there were substantive irregularities regarding Dr. NP Mkabayi's leave.

iii. An additional question enquiring about “the latest information about how many days the CEO has been at work since she was appointed” was raised by Mr. Jack Bloom on 26 July 2022. In the response provided by Dr. NE Mokgethi to the Gauteng Provincial Legislature dated 08 August 2022, she indicated that Dr. NP Mkabayi had spent 346 days at RMMCH since she was appointed.’ However, the investigation found that 71 days were unaccounted for.

iv. The investigation further found that the GDoH failed to promote and implement relevant HR policies (e.g. the “work from home” policy based on Circular No. 1 of 2021) in a standardized and transparent manner. This led to so-called “trust agreements”, between supervisors and supervisees where each party “trusted” that the other party was fulfilling their professional responsibilities. It has been demonstrated that this manner of working is not only fraught with pitfalls (once the trust relationship has broken down), but it is also open to abuse, as there is no accountability.

c) Whether the health and dignity of patients, and the well-being of healthcare workers is severely compromised.

i. The allegation that the health and dignity of patients and the well-being of healthcare workers is severely compromised was substantiated and confirmed.

ii. The investigation revealed crumbling infrastructure throughout the hospital, free-flowing sewage between buildings, a pervasive foul-smelling environment, filthy ablution facilities, and leaking steam pipes leading to poor heating in the wards, which does not provide a conducive, healthy, and safe environment for the provision of quality care for patients by healthcare workers.

iii. Due to overcrowding in the antenatal ward, clinical decisions were made based on what was written on the patient file without assessing the patient thoroughly. Most elective patient operations were postponed due to the need to accommodate emergency caesarean sections, leading to a backlog of cases and long waiting times (up to two weeks), which affected patients negatively, as some ended up with complications.

iv. The challenges of overcrowding, staff shortages, and a dire lack of specialised nursing staff compromised the health and well-being of healthcare workers. Significantly, these challenges affect patient safety, by placing patients' lives at risk.

d) Additional findings include issues pertaining to:

i. Human Resources
ii. Infrastructure
iii. Blood Bank (SANBS) and Laboratory (NHLS) Services
iv. Radiology services (CT scan)
v. Hospital Board
vi. Security challenges
vii. Shortage of Nursing Staff
viii. Flouting of Supply Chain Management (SCM) Processes
ix. Infection Prevention and Control
x. Lack of an Intensive Care Unit (ICU) for adults at RMMCH

Breaches of norms and standards

No	Investigation Findings	Related Norms and Standards
1.	The dignity and well-being of pregnant women was compromised as they were expected to sit on plastic chairs in the prenatal ward (ward 15) while awaiting delivery, and sleep on the hospital floor due to overcrowding.	Regulation 5 (1) states that *"the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition*." Regulation 8 (1) provides that "*the health establishment must maintain an environment which minimises the risk of disease outbreaks, the transmission of infection to users, health care personnel and visitors*."
2.	RMMCH Human Resource Department (HRD) failed to ensure proper controls to monitor leave processes at the hospital. RMMCH HRD failed to put measures in place to control and monitor HR files of health personnel	Regulation 19 (1) provides that "*the health establishment must ensure that they have systems in place to manage health care personnel in line with relevant legislation, policies and guidelines."*
3.	The dignity of patients and the well-being of healthcare workers are severely compromised.	Regulation 5 (1) states that *"the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition*." Regulation 19 (1) states that "*the health establishment must ensure that they have systems in place to manage health care personnel in line with relevant legislation, policies, and guidelines."*
4.	RMMCH was built in 1943 and has never received any substantial upgrades. The aging infrastructure and sewage reticulation system are failing, leading to pipe spillages and toilet blockages	Regulation 15(1) provides that: "*the health establishment must ensure that engineering services are in place*". Sub-regulation (2) provides that, for the purposes of sub-regulation (1), "*the health establishment must have 24 hour electrical power, lighting, medical gas, water supply and sewerage disposal system*".
5.	RMMCH security is inadequate. There are no access control measures to monitor hospital entry and exit.	Regulation 17(1) states that*: "the health establishment must have a system to protect users, health care personnel and property from security threats and risks."*

	A case of hijacking within RMMCH premises was reported; most interviewees stated that they felt unsafe within the hospital premises.	Sub-regulation (2) states that "*the health establishment must ensure that security staff is capacitated to deal with security incidents, threats, and risks."*
6.	Severe chronic shortage of nursing staff for over five years. RMMCH is dependent on Nursing Agencies to provide staff and skilled professional nurses. Procurement of these services is through the goods and services budget, leading to over-spending.	Regulation 19 (1) provides that "the health establishment must ensure that they have systems in place to manage health care personnel in line with relevant legislation, policies and guidelines." Sub-regulation (2) (a) states that: "for the purpose of sub-regulation (1) the health establishment must, as appropriate to the type and size of the health establishment, have and implement a human resource plan that meets the needs of the health establishment."
7.	Sporadic incidents of nosocomial infections in the neonatal unit. Use of diluted disinfectant (Povidone-Iodine) solution for skin cleansing pre-operatively led to eleven post-operative 'relook' surgeries between August – September 2022	Regulation 8 (1) provides that "the health establishment must maintain an environment which minimizes the risk of disease outbreaks, the transmission of infection to users, health care personnel and visitors."
8.	Non-functional RMMCH Hospital Board	Regulation 18 deals with Governance and it provides that: "*the health establishment must have a functional governance structure with written Terms of Reference*"

Recommendations

Given the complexity of the findings uncovered by the investigation and following comments to the Provisional Report, recommendations are made to the Gauteng Provincial Department of Health and the acting RMMCH CEO.
These include:

1. **Appointment of a suitable and permanent RMMCH CEO who is 'fit for purpose'**
2. **Transfer of Dr. NP Mkabayi to GDOH Provincial office**
3. **Prioritization of RMMCH for Infrastructure Refurbishment**

   a) Implement Recommendations made in the 2017 report "An Unsafe Hospital" by Prof. A Coovadia and Prof. H Lombaard.
   b) Availability of 24-hour Laboratory and Blood Bank Services
   c) Establishment of an adult ICU at RMMCH
   d) Construction of additional maternity capacity
   e) Security System upgrades

4. **Address Leadership and Governance issues**

    a) Strengthen Gauteng HoD oversight of hospitals
    b) Monitoring of RMMCH Hospital Board

5. **Strengthen Human Resources**

    a) Review Provincial HR processes for the appointment of Hospital CEOs
    b) Development of RMMCH HR capacity
    c) Review RMMCH staff establishment

6. **Gazetting of RMMCH as a Tertiary Hospital**
7. **Disciplinary Inquiry**

The report is available on the ombud website: www.healthombud.org.za.

Issued by Professor Malegapuru W Makgoba

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Health Ombud: Republic of South Africa

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