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MEDIA STATEMENT

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THE HEALTH OMBUD RELEASES FINDINGS OF THE INVESTIGATION INTO THE ALLEGATIONS OF A PATIENT DENIED PROVISION OF CARE AT THE MOTHERWELL NU 11 CLINIC

Pretoria. The Health Ombud Professor Taole Mokoena released the findings of the investigation into the allegations of a patient denied the provision of care at the Motherwell NU 11 Clinic in the Eastern Cape Province who later died at the Motherwell Police Station Community Service Centre (MPSCSC).

The investigation report issued is in terms of the National Health Amendment Act (NHAA), 12 of 2013, in conjunction with the Procedural Regulations pertaining to the functioning of the Office of Health Standards Compliance (OHSC) and handling of complaints by the Ombud to inform the complainant and the health establishment on his/her findings and recommendations. The Office of the Health Ombud (OHO) conducts its investigations in terms of Section 81A (1) of the National Health Amendment Act (NHAA), which gives the Ombud the powers to consider, investigate and dispose of the complaint relating to breaches of the prescribed norms and standards in a fair, economical, and expeditious manner; and in terms of Regulation 42 of the Procedural Regulations, which regulates the powers conferred upon the Ombud.

The report communicates the findings and recommendations by the Ombud, following a complaint lodged by the Democratic Alliance’s (DA) Shadow Minister of Health, the Honourable Michéle Clarke, MP, in September 2022 against the Motherwell NU 11 Clinic. Honourable Clarke alleged that the clinic denied the provision of care, resulting in the death of the patient, Ms Zenizole Vena. The complaint was referred further by the Honourable Minister of Health, Dr Joe Phaahla, MP in October 2022. In the referral, the Minister requested the Ombud to investigate potential negligence and suboptimal care at the clinic.

Primarily, Honourable Clarke, alleged that the Motherwell NU 11 Clinic failed to assist Ms Vena, a 15-year-old who went to the clinic accompanied by an elderly woman seeking healthcare after being sexually assaulted. Ms Vena was instead turned away by healthcare workers at the clinic and later died at the Motherwell Police Station Community Service Centre (MPSCSC) where she sought assistance.

The Health Ombud deployed a team of two Investigators in terms of Section 81(3)(c) of the NHAA to investigate the complaint. Upon analysis of the complaint and allegations, the investigators identified the following issues, to form the basis of the investigation:

a) Whether Ms Vena (the patient) was denied provision of care at the clinic.
b) Whether Motherwell NU 11 Clinic failed to refer Ms Vena to the next level of care.

c) Whether the death of Ms Vena was due to negligence of the healthcare workers at the Motherwell NU 11 Clinic.

The investigation was conducted through analysis and triangulation of information and documentary evidence received from the Motherwell NU 11 Clinic, the Eastern Cape Provincial Department of Health (ECDoH), the Nelson Mandela Bay District Health (NMBDH), onsite visits, interviews with relevant personnel at the affected institutions, and the application of the relevant legislation to enable the Ombud to decide on the resolution of the complaint.

FINDINGS

The investigation sought to establish, and made the following findings:

a) Whether Ms Vena (patient) was denied provision of care at the Clinic

The allegation that Ms Z Vena was denied provision of care at Motherwell NU 11 Clinic was substantiated and confirmed based on the information gathered during the investigation.

The healthcare workers who attended to Ms Vena at the clinic did not touch nor examine her with the belief that every sexual assault case should be referred to the South African Police Services (SAPS). She was instead instructed to go to the Motherwell Police Station Community Service Centre as nurses at the clinic erroneously believed that "nurses are not allowed to touch rape victims to avoid tampering with evidence."

Despite their belief, the two nurses did not arrange transport to take both the escort (an elderly old lady) and victim to MPSCSC nor call the police to come to Motherwell NU11 Clinic to take over the case.

One of the nurses indicated that she only took the patient's vital health data, which was written in a personal diary but not in the approved Patient Administration Record (PAR).

b) Whether Motherwell NU 11 Clinic failed to refer Ms Vena to the next level of care

The allegation that Motherwell NU 11 Clinic failed to refer Ms Vena to the next level of care was substantiated and confirmed by the investigation.

Based on the verbal and documentary evidence gathered and considered, it can be concluded that both healthcare workers concerned failed to refer Ms Vena to the next level of care needed. It was evident that she was not attended to in a manner that was consistent with the nature and severity of her health condition.

The nurses' conduct of failing to refer Ms Z Vena to the next level of care violated the provisions of Regulation 5(1) and (2)(b) of the Norms and Standards Regulations for different categories of health establishments.

c) **Whether the death of Ms Vena was due to negligence of the healthcare workers at the Motherwell NU 11 Clinic**
The allegation that the death of Ms Z Vena was due to the negligence of the nurses at Motherwell NU 11 Clinic was substantiated and confirmed.

Based on the evidence obtained, it can be concluded that Ms Z Vena was not attended to in a manner that was consistent with the nature and severity of her health condition at Motherwell NU 11 Clinic.

d) The investigation further revealed additional findings, such as the failure of the Motherwell Police Station Community Service Centre to assist Ms Vena upon her arrival at the charge office. Ms Vena was told to wait, they only attended to her after she waited for 1h30 minutes. During this time, she experienced seizures and was foaming at the mouth. She was found dead laying on the floor in the charge office.

RECOMMENDATIONS

The Health Ombud made 14 recommendations detailed in the report, which amongst them include:

- The District Manager of the Nelson Mandela Bay District Health should institute a disciplinary inquiry against the two health workers who attended to Ms Vena at the Motherwell NU 11 Clinic.
- Plans should be put in place such that all SAPS employees engaged with the public are trained in First Aid, or if there is an emergency, they have easy physical access to first responders 24 hours a day. This should be implemented within 12 months of the report.

A detailed report is available on the Health Ombud's website www.healthombud.org.za.

Ends.

Issued by Professor Taole Mokoena – South Africa's Health Ombudsman

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