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Health Ombud

MEDIA STATEMENT

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To All Editors/Health Journalists

THE HEALTH OMBUD RELEASES INVESTIGATION FINDINGS INTO THE TREATMENT, COMPLICATIONS AND DEATHS OF PSYCHIATRIC PATIENTS IN THE NORTHERN CAPE HOSPITALS

Pretoria - The Health Ombud, Professor Taole Mokoena, has released the findings of an investigation into the treatment, complications, and deaths of psychiatric patients at the Northern Cape Mental Health Hospital (NCMHH) and the Robert Mangaliso Sobukwe Hospital (RMSH). The investigation revealed that two patients died, and another underwent craniectomy and remains bedridden.

The investigation was initiated following a complaint filed by the Honourable Minister of Health, Dr. Aaron Motsoaledi (MP), regarding the Northern Cape Mental Health Hospitals in October 2024. The reported incidents took place in July and August 2024, during which it was alleged that two patients died at NCMHH, and two others were admitted to RMSH in critical condition.

In response to the Minister's request, the Health Ombud deployed a team of two investigators in accordance with Section 81(3)(c) of the National Health Amendment Act (NHAA). This investigation report is issued based on Section 81A (11) of the NHAA, 2013 (Act No. 12 of 2013), pertaining to the functions of the Office of Health Standards Compliance and the handling of complaints by the Health Ombud. The report is intended to inform both the complainant and the health establishments as well as the general public of the findings and recommendations derived from the investigation.

ISSUES INVESTIGATED

The investigation was carried out through a detailed analysis and triangulation of information and documentary evidence obtained from the NCMHH and RMSH, as well as through on-site visits. The following issues were identified for investigation based on the analysis of the complaints, allegations, and engagement with both health establishments:

- The circumstances surrounding Mr Cyprian Mohoto's care at NCMHH and his subsequent death at RMSH;
- The circumstances surrounding Mr Petrus De Bruins's care at NCMHH and his admission to RMSH;
- The circumstances surrounding Mr Tshepo Mndimbaza's care and death at NCMHH; and
- The circumstances surrounding Mr John Louw's care at NCMHH and his admission to RMSH.

The investigation revealed that, at the time of the incidents, NCMHH and several neighbouring health facilities were facing challenges with their electricity supply due to cable theft and vandalism at their power substation. This power loss impacted the

communication infrastructure, leaving the hospital without telephone lines.

Electricity supply was restored within days at two of the neighbouring hospitals; however, it took an entire year for the electricity to be restored at NCMHH. The investigation found that the delay in repairing the electricity supply to NCMHH was due to dysfunctional Supply Chain Management processes within the Provincial Department of Health. This delay rendered the hospital's Heating, Ventilation, and Air Conditioning (HVAC) system nonfunctional, exposing patients and staff to extreme weather conditions during the summer and winter. Additionally, because of the lack of electricity, the available resuscitation equipment was not operational, as it could not be charged, and other necessary equipment was unavailable for use. NCMHH procured poor quality pyjamas and blankets which were inadequate to provide warmth to patients during the severe winter's cold, especially at night.

It was established that the Clinical Manager at NCMHH had written a complaint letter to the Acting Head of the Provincial Department of Health, detailing the adverse conditions which patients at NCMHH were being subjected to. These circumstances negatively impacted their health and violated their human rights.

FINDINGS

The investigation uncovered several findings regarding the medical care of four patients:

1. **Circumstances surrounding Mr Cyprian Mohoto's care and admission to RMSH:** The investigation revealed gross mismanagement surrounding Mr. Mohoto's care, which ultimately led to his death. He was admitted to RMSH on 13 July 2024, with a suspected abdominal or bowel obstruction following complications at NCMHH on 12 July 2024. Admission abdominal X-rays ruled out bowel obstruction while the chest X-ray revealed multi-lobar pneumonia. The pneumonia was never treated during the 3 days that the patient stayed in the Surgical Recovery Unit until his death. His deteriorating clinical status was never attended to by either the nursing personnel nor the doctors. Mr. Mohoto died on 16 July 2024, in the Emergency Centre at the Surgical Recovery Unit at RMSH.

2. **Mr. De Bruin was transferred from NCMHH to the Emergency Centre at RMSH on 30 July 2024,** after collapsing and being unresponsive in Ward M2 at NCMHH. He was stabilised and later admitted to the RMSH Medical Recovery Unit for hypoglycemia, the medical care and investigations conducted in the Emergency Centre were appropriate. However, the monitoring by nursing personnel was found to be inadequate.

3. **The Circumstances Surrounding Mr. Tshepo Mdimbaza's Death:** Mr. Mdimbaza was discovered unresponsive in his bed on 3 August 2024, at NCMHH. The resuscitation process was delayed due to the unavailability, malfunction, or unpreparedness of resuscitation equipment. There was also a lack of monitoring of the patient's vital signs before and during resuscitation by medical or nursing personnel. Mr. Mdimbaza did not survive the resuscitation attempt. The post-mortem report indicated that he died due to "exposure to the elements" at NCMHH.

4. The investigation into the **circumstances surrounding the care and admission of Mr John Louw** to RMSH revealed that he had an acute subdural haemorrhage. An emergency craniotomy and craniectomy were successfully performed on 07 July 2024 and 23 July 2024, respectively, and he was discharged back to NCMHH on 28 October 2024. Mr Louw remains bedridden.

5. The investigation also established **additional findings**, including leadership instability in the Northern Cape Provincial Department of Health, which negatively affected service delivery, safety, and the quality of patient care at NCMHH and RMSH.

6. Northern Cape Mental Health Hospital was found to have poor governance and systemic lack of leadership and poor management at all levels, unpreparedness for emergency cases, crumbling infrastructure, poor pharmacy and medicine control management, shortage of staff, poor quality assurance management, non-compliance with patient record keeping, and poor laundry services.

7. Robert Mangaliso Sobukwe Hospital was found to be experiencing critical staff shortage across the board; lack of oversight with nursing supervision; communication breakdown of reporting systems, non-compliance with guidelines on principles of good record keeping and overcrowding at the hospital emergency centre, aggravated by the absence of a district or regional hospital.

8. The investigation concluded that the general care provided at the Northern Cape Mental Health Hospital and the Robert Mangaliso Sobukwe Hospital to the patients was substandard, and patients were not attended to in a manner consistent with the nature and severity of their health condition, as required by Regulation 5 (1) of the Norms and Standards Regulations Applicable to Different Categories of Health Establishments, 2018 (Norms and Standards Regulations).

RECOMMENDATIONS

The Health Ombud made clear, actionable recommendations to address the systemic failures observed at both health establishments to improve the overall safety and quality of patient care. Key recommendations include; the Provincial Head of Department of Health must immediately appoint a Task Team to monitor the implementation of the recommendations as outlined in the report, hold accountable officials found to be in breach through formal disciplinary processes, the National Department of Health should initiate a forensic investigation into the procurement processes for the NCMHH, priority should be given to the development, reinstatement, and implementation of an effective and efficient reporting system for continuity of care and effective communication, and the development of comprehensive Standard Operating Procedures (SOPs)/Protocols/Guidelines to guide healthcare personnel in providing healthcare services. The complete set of recommendations is included in the report.

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

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Issued by the Health Ombud.

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