



**INVESTIGATION OF TREATMENT,
COMPLICATIONS AND DEATHS
OF PSYCHIATRIC PATIENTS AT NORTHERN CAPE
MENTAL HOSPITAL AND ROBERT MANGALISO
SOBUKWE HOSPITAL**



SAFEGUARDING QUALITY HEALTHCARE

REPORT OF THE HEALTH OMBUD IN TERMS OF SECTION 81(A) OF THE
NATIONAL HEALTH ACT, 2003 (ACT NO 61 OF 2003) (as amended).

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ACKNOWLEDGEMENTS

The Health Ombud acknowledges and extends his sincere gratitude to all those who contributed to the successful completion of this investigation. Special thanks to the staff and managers of both Northern Cape Mental Health Hospital and Robert Mangaliso Sobukwe Hospital, as well as the Northern Cape provincial officials who generously shared their time and insights into the matters being investigated. The Health Ombud also acknowledges the Northern Cape SAHRC for their involvement in assisting with this investigation.

LIST OF ACRONYMS AND ABBREVIATIONS

A & E	Accident & Emergency
AHoD	Acting Head of Department
BE	Basal Excess
CCTV	Closed-circuit television
CDP	Continuous Development Programme
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CNS	Central nervous system
CVS	Cardiovascular
DID	Department of Infrastructure Development
DDG	Deputy Director General
DoH	Department of Health
DPSA	Department of Public Service and Administration
DR	Doctor
EC	Emergency Centre
EU	Emergency Unit
ECT	Electroconvulsive therapy
ED	Emergency Department
EN	Enrolled Nurse
ENA	Enrolled nursing assistant
ETC	Et. Cetera
HB	Haemoglobin
HE	Health Establishment
HO	Health Ombud
HoD	Head of Department
Hon	Honourable
HPCSA	Health Professions Council of South Africa
HR	Human Resource
HRD	Human Resource Department
HRM	Human Resource Manager
HVAC	Heating, Ventilation, and Air Conditioning

KHC	Kimberly Hospital Complex
ICT	Information and Communication Technology
ICU	Intensive Care Unit
MEC	Member of the Executive Council
MHCU	Mental Health Care User
MI	Medical Intern
MO	Medical Officer
NCHRC	Northern Cape Human Rights Commission
NCMHH	Northern Cape Mental Health Hospital
NDoH	National Department of Health
NHA	National Health Act
NHAA	National Health Amendment Act
OHSC	Office of Health Standards Compliance
PDoH	Provincial Department of Health
PFMA	Public Finance Management Act
PN	Professional Nurse
POC	Physician on Call (Medical Recovery)
PTB	Pulmonary Tuberculosis
RMSH	Robert Mangaliso Sobukwe Hospital
SAHRC	South African Human Rights Commission
SANC	South African Nursing Council
SASTG	South African Standard Treatment Guidelines
SCM	Supply Chain Management
SLA	Service Level Agreement
SOC	Surgical on Call (Surgical Recovery)
SOP	Standard Operating Procedure
SR	Sister
WCC	White Cell Count
WHO	World Health Organisation

DEFINITIONS

- **Constitution:** means the Constitution of the Republic of South Africa, 1996
- **'Ex post facto' payment:** means retrospective approval of payment for work already done without prior approval.
- **Health Establishment:** means a whole or part of a public or private institution, facility, building, or place, whether for profit or not, that is operated or designated to provide inpatient or outpatient treatment, diagnostic or therapeutic intervention, nursing, rehabilitative, palliative, convalescent, preventative, or other health services.
- **'In loco' inspection:** means on-site inspection of where an incident connected with the complaint being investigated occurred.
- **Minister of Health:** means the Cabinet member responsible for Health.
- **National Health Act:** means the National Health Act, 2003 (Act No.61 of 2003)
- **National Health Amendment Act:** means the National Health Amendment Act, 2013 (Act No. 12 of 2013).
- **Norms and Standards Regulations applicable to different categories of health establishments:** means the Norms and Standards Regulations published on 02 February 2018.
- **Office of Health Standards Compliance (OHSC):** means a regulatory body established in terms of section 77 (1) of the National Health Act.
- **Health Ombud:** means a person appointed as the Ombud in terms of Section 81 (1) of the National Health Act.
- **Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud:** means the Procedural Regulations published on 02 November 2016.

EXECUTIVE SUMMARY

- (i) This is the final report of the Health Ombud (the Ombud) in terms of Section 81A (11) of the National Health Amendment Act (NHAA), 2013 (Act No. 12 of 2013), read with Regulation 48 (a) of the Procedural Regulations Pertaining to the functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud (Procedural Regulations), 02 November 2016, to inform the complainant and the health establishment of his findings and recommendations.
- (ii) The investigation was conducted by the Health Ombud through the assistance of the Investigators, Ms. Petunia Kekana and Mr George Senyolo, who are designated and seconded by the Office of Health Standards Compliance with the concurrence of the Ombud, in terms of Section 81 (3)(c) of the NHAA, pursuant to an investigation into a complaint lodged by Honourable Minister of Health, Dr Aaron Motsoaledi, against the Northern Cape Mental Health Hospital (NCMHH) in Kimberley on 10 October 2024.
- (iii) The complaint was based on information he received, alleging that two patients died at NCMHH, and two others were admitted to Robert Mangaliso Sobukwe Hospital (RMSH) in a critical condition. The incidents occurred in July/August 2024. This investigation was conducted jointly with the members of the South African Human Rights Commission (SAHRC) based in the Northern Cape.
- (iv) The investigation established that three patients were admitted to RMSH: Mr Cyprian Mohoto (Mr Mohoto), Mr Petrus De Bruin (Mr De Bruin), and Mr John Louw (Mr Louw). Mr Mohoto died on 16 July 2024 at RMSH, in the Surgical Recovery Unit. Mr Tshepo Mdimbaza (Mr Mdimbaza) died in Ward M5 at the NCMHH on 03 August 2024.
- (v) At the time of the incidents, NCMHH was experiencing challenges with the electricity supply. The NCMHH's lack of electricity was due to cable theft and vandalism of its electricity power substation. The absence of electricity also affected the communication infrastructure, and the hospital was functioning without telephones. The electricity cable theft also affected the Emergency Medical Service College, Gariep Mediclinic Hospital, and Careline Clinic Private Psychiatric Hospital. Electricity supply was restored within a month at these two private hospitals, whilst it took a year to restore electricity at NCMHH. The delay in restoring the electricity supply to NCMHH was found to be due to dysfunctional Supply Chain Management in the provincial office.
- (vi) The Heating, Ventilation, and Air Conditioning (HVAC) system was nonfunctional. Patients and hospital personnel were subjected to extreme summer and winter weather conditions. One patient died due to hypothermia, and two other patients were admitted to RMSH, one of whom died from **double pneumonia**, possibly from exposure to severe cold, and another sustained permanent neurological damage from stroke and is permanently dependent on nursing personnel for basic care.

- (vii) NCMHH lacked emergency resuscitation equipment and drugs. Due to a lack of electricity, the available resuscitation equipment was non-functional, as it was not charged, and the other equipment was not ready for use. This delayed commencement of resuscitation contributed directly to Mr Mdimbaza's death.
- (viii) There was insufficient linen and patient clothing. Blankets and pyjamas were of poor quality. Patients were continuously exposed to extreme cold conditions. At the time of the incidents, laundry was being washed at RMSH. It was difficult to consistently provide clean laundry. The NCMHH laundry staff had to wait for the RMSH staff to finish their own patients' laundry before doing the NCMHH patients' laundry.
- (ix) NCMHH is experiencing a gross staff shortage, especially professional nurses. Although it was commissioned for 287 beds, the current occupancy is at one hundred and fifty-three (153) beds (53%). The nurse and doctor to patient ratio per shift is inadequate. Both NCMHH and RMSH operated some shifts without professional nurses due to the staff shortage. Enrolled nurses and enrolled nursing assistants are made to take charge of "high acuity" units at RMSH.
- (x) Both nursing and medical personnel failed to manage patients appropriately due to a lack of vital signs monitoring, poor record keeping, lack of continuity of care, and no follow-up. Patients' conditions deteriorated in their presence without them noticing or taking appropriate action.
- (xi) There is a lack of professional leadership, and management was inefficient. NCMHH and RMSH did not have protocols, standard operating procedures, or guidelines for managing patients. Therefore, the care provided at NCMHH and RMSH was unsupervised, unstructured, non-standardised, unsafe, and altogether substandard.
- (xii) The NCMHH has poor infrastructure, and the building is breaking down. Broken windows were not repaired, posing a security and safety risk through which patients can and do escape, and patients use broken glass as weapons. The electromagnetic doors were not working, posing a safety and security risk for all building occupants. Should they close, especially during a fire, occupants will be trapped inside and unable to escape. Sewage was coming out of the shower drains. There was also general neglect of the buildings and the environment.
- (xiii) Poor leadership was evident at both the provincial health department and hospital levels, especially in respect of finance, supply chain, and human resource management. Leadership instability in the Provincial Health Office, which has been headed by acting HoDs for several years, has negatively affected service delivery, safety, and the quality of patient care, including avoidable deaths of some patients.

- (xiv) Of major concern is that two days before the Health Ombud's interviews with the Provincial Office and NCMHH senior officials, NCMHH and RMSH Managers were summoned to the HoD's office and told to "adopt a given stance in response to the Health Ombud's interviews." This conduct is tantamount to interference, hindrance and obstruction of the Ombud in the performance of his functions and violation of Section 89(1)(h) of the NHAA.
- (xv) The investigation found gross mismanagement of a patient, Mr Mohoto, in the Emergency Centre and the Surgical Recovery Unit at RMSH, which resulted in his death.
- (xvi) Mr Mohoto was admitted to RMSH on 13 July 2024, with a suspected "**abdominal or bowel obstruction**" for further management after his condition had complicated at the NCMHH on 12 July 2024. He was received by the General Surgery Department and examined by a medical intern in the Surgical Recovery Unit. Blood investigations, chest and abdominal X-rays were performed. Abdominal obstruction was ruled out following the abdominal X-ray. The chest X-ray revealed "**multi-lobar pneumonia.**"
- (xvii) A medical officer later reviewed Mr Mohoto and discharged him back to NCMHH on Lactulose without treating the lobar pneumonia with intravenous antibiotics or referring him to the Internal Medicine Department for further management.
- (xviii) Mr Mohoto spent three days in a Surgical Recovery Unit awaiting to be transported back to NCMHH without being reviewed by doctors from the General Surgery Department. Although he was reviewed at RMSH by two doctors from NCMHH, his condition was deteriorating, and no appropriate action was taken. There was a lack of monitoring and nursing management. The discharge of Mr Mohoto back to NCMHH, albeit not executed, resulted in his death on 16 July 2024. Mr Mohoto died without any attempt to resuscitate him, which was patently clinical mismanagement. According to the senior clinical manager and the head of surgery of RMSH, if Mr Mohoto's "lobar pneumonia" had been actively managed when he presented on 13 July 2024, his death could have been avoided.
- (xix) Mr De Bruin from NCMHH was received in EC at RMSH on 30 July 2024, after he had collapsed and was unresponsive in Ward M2 at NCMHH. He was stabilised before being admitted to the Medical Recovery Unit for hypoglycaemia. The medical care provided, and the investigations conducted in EC were appropriate. However, monitoring by the nursing personnel was inadequate. Mr De Bruin spent approximately 24 hours in the Medical Recovery Unit and was discharged after his blood sugar had normalised. The care provided to Mr De Bruin in the Medical recovery unit was substandard, and vital signs monitoring was inadequate. The cause of hypoglycaemia was not determined. Mr De Bruin was discharged back to NCMHH on 31 July 2024.
- (xx) The investigation into the circumstances surrounding the care and admission of the third patient, Mr Louw, to RMSH revealed that he had an **acute subdural haemorrhage** resulting from his chronic disease progression and side effects from the chronic medication he had been receiving. Subsequently, emergency craniotomy and craniectomy were successfully

performed on 07 July 2024 and 23 July 2024, respectively. Mr Louw was discharged back to NCMHH on 28 October 2024, and he remains bedridden.

- (xxi) Mr Mdimbaza was discovered unresponsive in his bed at 07h30 on 03 August 2024, after he had been handed over to the day duty personnel in Ward M5 at NCMHH. He was hypoglycaemic and hypoxic with a blood sugar of 1.1 mmol/l, and the oxygen saturation of 57% on room air, further dropping to 41%. His skin was cold due to the extremely cold conditions in the ward.
- (xxii) Mr Mdimbaza's resuscitation was delayed as the resuscitation equipment was not available, not functional, or not ready for use. There was no monitoring of his vital signs before and during resuscitation by the medical or nursing personnel. Mr Mdimbaza died after a failed resuscitation. The postmortem report revealed that Mr Mdimbaza died due to *"exposure to the elements"* at NCMHH.
- (xxiii) The general care provided at NCMHH and RMSH to all 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).
- (xxiv) The NCMHH Clinical Manager, in a complaint letter dated 19 July 2024 and addressed to the Acting Head of Department (HoD), detailed the adverse circumstances to which patients in NCMHH were subjected, which resulted in the death of Mr Mohoto and Mr Louw's admission to RMSH. Exposure to extreme weather conditions, lack of warm clothes and bedding for patients, patients nursed in the dark, and erratic availability of psychotropic drugs were some of the adverse circumstances referred to by the clinical manager.

1. INTRODUCTION AND BACKGROUND

- 1.1 This final report of the Health Ombud is issued in terms of Section 81A. (11) of the National Health Amendment Act (NHAA), 2013, to inform the complainant and the health establishment of his findings and recommendations.
- 1.2 The investigation was conducted following a complaint (ANNEXURE A) from the Hon. Minister of Health, Dr Motsoaledi, on 10 October 2024, regarding allegations of the death of two Mental Health Care Users (MHCUs), hereafter referred to as patients, Mr Mohoto and Mr Mdimbaza, in July and August 2024 at Robert Mangaliso Sobukwe Hospital, and Northern Cape Mental Health Hospital in the Northern Cape Province, respectively.

2. SUMMARY OF THE COMPLAINT

- 2.1 The complaint was lodged by the Honourable (Hon) Minister of Health, Dr Aaron Motsoaledi (Hon. Dr A. Motsoaledi), and captured on the Health Ombud Case Management System on 10 October 2024. It was risk-rated **high** and allocated Reference No: **50343**.
- 2.2 The Hon Minister, Dr Aaron Motsoaledi, referred a complaint after he was provided with information that in July and August 2024, two psychiatric patients died at NCMHH, and two others were admitted to RMSH during the same period, in a critical condition.
- 2.3 Furthermore, deaths and illnesses occurred when NCMHH was experiencing electricity supply problems due to theft and vandalism of electricity infrastructure, and the health establishment received its electricity supply from a diesel-powered generator. The postmortem of one of the two deaths indicated that the cause of death was **“consistent with cold exposure.”**

3. POWERS AND JURISDICTION OF THE HEALTH OMBUD TO INVESTIGATE

- 3.1 The Ombud derives his/her powers in terms of Section 81A. (1) of the NHAA, 2013 (Act No.12 of 2013). The mandate of the Ombud stipulates that: *“the Ombud may, on receipt of a written or verbal complaint relating to norms and standards, or on his or her initiative, consider, investigate, and dispose of the complaint in a fair, economical and expeditious manner,”* and Regulation 42 of the Procedural Regulations, regulates how the power conferred upon the Ombud by section 81A(1) of the NHAA maybe exercised.
- 3.2 Section 81B (2) of the NHAA provides that: *“When dealing with any complaint in terms of this Act, the Ombud including any person rendering assistance and support to the Ombud - (a) is independent and impartial; and (b) must perform his or her functions in good faith and without fear, favour, bias, or prejudice.”*

- 3.3 The Ombud, Professor Taole Mokoena (Prof Mokoena), was assisted by Investigators Ms Petunia Kekana (Ms Kekana) and Mr George Senyolo (Mr Senyolo), who are designated and seconded by the Office of Health Standards Compliance with the concurrence of the Ombud, in terms of Section 81 (3)(c) of the NHAA. The Investigation was conducted in collaboration with the Northern Cape Human Rights Commission delegation, Mr Uzair Adams (Provincial Manager), Mr Nduduzo Majozi (Research Officer), and Ms Nozipho Ntshangase (Human Rights Monitor).
- 3.4 NCMHH and RMSH are public health establishments, and their investigation falls within the scope of the Ombud's mandate.

4. ISSUES IDENTIFIED FOR INVESTIGATION

- 4.1 On analysis of the complaint and the allegations, and engagement with the health establishment, the patients involved were identified. The following issues were identified and investigated:
- 4.1.1 Circumstances surrounding Mr Cyprian Mohoto's care at NCMHH and RMSH, and his death at RMSH.
- 4.1.2 Circumstances surrounding Mr Petrus De Bruins's care at NCMHH and his admission to RMSH.
- 4.1.3 Circumstances surrounding Mr Tshepo Mndimbaza's care and death at NCMHH.
- 4.1.4 Circumstances surrounding Mr John Louw's care at NCMHH and his admission to RMSH.

5. INVESTIGATION

5.1 Scope of Investigation

- 5.1.1 The scope of the investigation covered the death of two patients, Mr Mdimbaza and Mr Mohoto, who died at NCMHH and RMSH in July and August 2024, respectively, and the admission of three patients to RMSH, including Mr Mohoto. Both NCMHH and RMSH were investigated. The investigation was limited to the period between July and August 2024.
- 5.1.2 After reviewing Mr Cyprian Mohoto's RMSH medical records, the Ombud saw it necessary for further in-depth investigation of RMSH because Mr Mohoto died under their care.

5.2 Methodology

- 5.2.1 The Report of the Health Ombud (the Ombud) in terms of Section 81A. (11) of the National Health Amendment Act (NHAA), 2013, requires him to inform the complainant and the health establishment of his findings and recommendations.
- 5.2.2 The Health Ombud, in terms of Section 81A. (3) (a)(b)(i)–(iv) of the National Health Act, 61 of 2003, authorised the Investigators, Ms Petunia Kekana and Mr George Senyolo, to investigate the complaint against NCMHH and uncover the circumstances which led to the death of the two patients, and the admission of the other two patients at RMSH in a critical condition.
- 5.2.3 During the investigation, 68 witnesses (ANNEXURE B) from both NCMHH and RMSH were interviewed between November 2024 and March 2025. The Ombud interviewed the Acting HoD, Mr Mlatha, the NCMHH CEO, Mr Links, Dr A. Kirimi, and Mr Riet at NCMHH. Dr B. Hammer, Dr A. Kantani, Mr Tsholo, and Mr Chipungu were interviewed via Microsoft Teams. Mr O. A. Tabi, Dr X. Mathunda from NCMHH, and Dr E. Olivier from RMSH were interviewed twice by the Investigators.
- 5.2.4 Relevant legislation was applied as appropriate to arrive at findings and provide recommendations.

5.3 Evidentiary Material Analysis

- 5.3.1 The investigation was conducted through analysis and triangulation of information and documentary evidence received from NCMHH and RMSH, as well as on-site visits that included taking rounds at key areas of interest. Possible witnesses were identified during the medical records analysis, and interviews were conducted accordingly. Some further witnesses were identified from the information gleaned during interviews.
- 5.3.2 Preliminary investigation established that three patients, Mr De Bruin, Mr Louw, and Mr Mohoto, were admitted to RMSH. Mr Mohoto died after three days there, while Mr De Bruin and Mr Louw were treated and discharged back to NCMHH. A fourth patient, Mr Mdimbaza, died at NCMHH during the period under investigation. This formed the basis for the substantive investigation.

5.4 Northern Cape Mental Health Hospital:

- 5.4.1 Mr Mxolisi Mlatha (Mr Mlatha), the Northern Cape Department of Health Head of Department (HoD) and NCMHH CEO, Mr Albert Links (Mr Links), were served with a Notice of Complaint On 23 October 2024, (ANNEXURE C), in compliance with Section 81A(3)(b)(iii) of the National Health Amendment Act, 2013 (Act 12 of 2013) (NHAA), read with Regulation 36 (1) of the Procedural Regulations Pertaining to Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, 02 November 2016 (Procedural Regulations) to solicit submissions regarding the complaint.

5.4.2 Thereafter, on 29 October 2024, a Notice of Investigation (ANNEXURE D) was issued notifying them of the on-site investigation scheduled for 18–22 November 2024. Four more follow-up on-site investigations were conducted between December 2024 and March 2025. All on-site investigations were jointly conducted by the Office of the Health Ombud and the Northern Cape Human Rights Commission Team, joining the November 2024 and March 2025 on-site investigation visits.

5.5 Robert Mangaliso Sobukwe Hospital:

5.5.1 On 27 November 2024, the RMSH CEO, Mr Joseph Sandt (Mr Sandt), was notified of the investigation against NCMHH involving three patients, Mr Petrus De Bruin (Mr De Bruin), Mr Cyprian Mohoto (Mr Mohoto), and Mr John Louw (Mr Louw), who were also admitted to RMSH. Two of these patients, Mr De Bruin and Mr Louw, were treated and discharged back to NCMHH. Mr Mohoto died at RMSH after spending three days in Surgical on Call (SOC), commonly referred to as the Surgical Recovery Unit, which is the extension of the Accident and Emergency (A&E) Department.

5.5.2 The HOD, Mr Mlatha, was issued a letter (ANNEXURE E) requesting that he provide the Health Ombud with the RMSH medical records of all three patients who were admitted and treated in the facility.

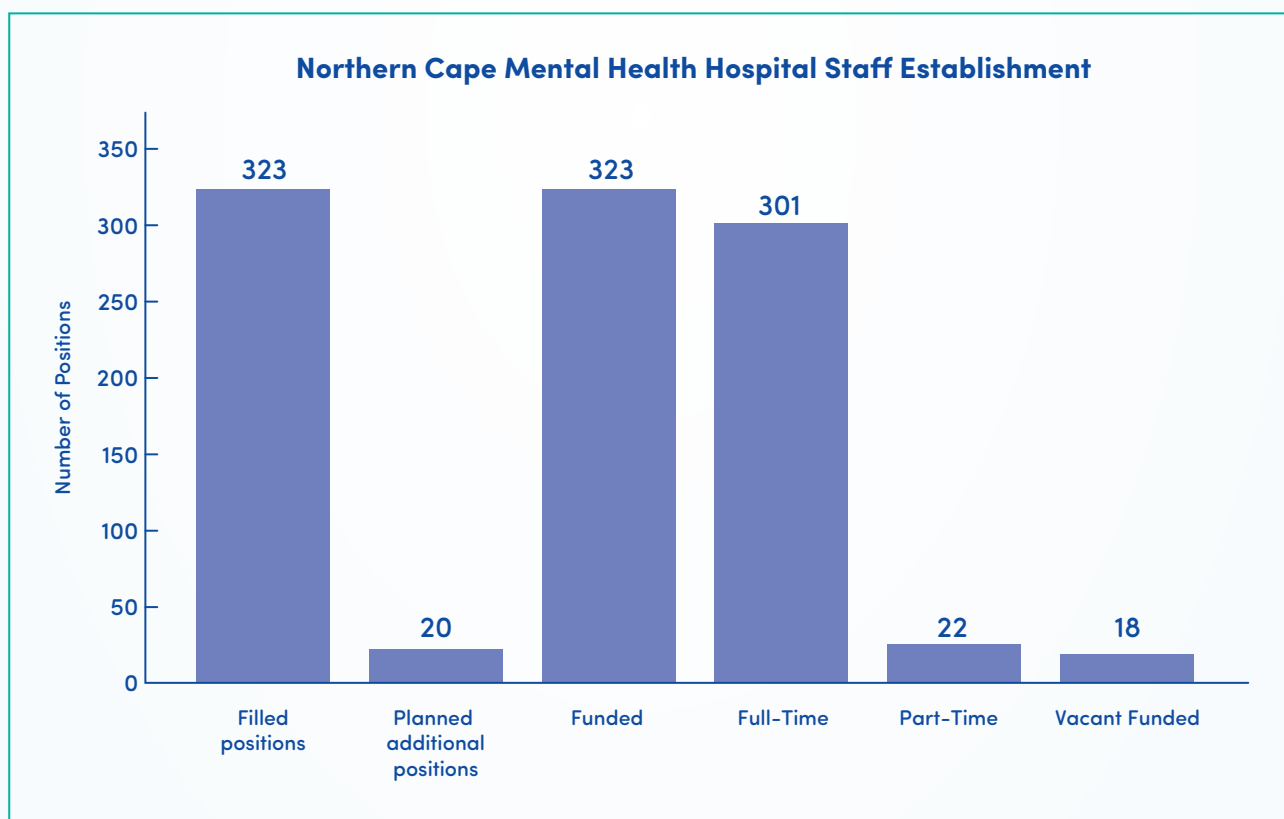
5.5.3 The requested medical records were received from RMSH on 10 and 11 December 2024. Mr Mohoto's records did not include any nursing notes. Following the analysis of Mr Mohoto's RMSH medical records, a need was identified to extend the investigation to RMSH to uncover the circumstances surrounding his death on 16 July 2024.

5.5.4 A repeat visit was conducted from 03 to 07 March 2025, and a follow-up visit from 24 to 28 March 2025, with the Northern Cape Human Rights Commission members joining the investigation for two days.

5.6 Northern Cape Mental Health Hospital (NCMHH):

5.6.1 The NCMHH is a specialised mental health hospital located at Portion 84, Bultfontein Farm, Number 80 on the R31, Barkly Road, Kimberley. The hospital commenced its operations on 30 September 2019 following its separation from the Old West End Hospital. It specialises in the diagnosis, treatment, and rehabilitation of mental health patients for the whole of Northern Cape Province. Services include inpatient and outpatient care, crisis intervention, and community outreach programmes aimed at promoting mental health and reducing the stigma associated with mental illness.

- 5.6.2 NCMHH plays a pivotal role in supporting the Northern Cape’s mental health services. With a multidisciplinary team of doctors, including psychiatrists, psychologists, social workers, and nurses, the hospital provides care tailored to each patient’s unique needs.
- 5.6.3 At the time of the four patients’ incidents under investigation, NCMHH was experiencing challenges with the electricity supply, resulting in a lack of communication infrastructure. Diesel-powered generators were used to supply electricity. However, planned electricity rationing was necessary so as not to overburden the generators, as they could not run continuously for 24 hours. The generators could not power all the hospital’s electricity needs, including the HVAC system. There were instances when patients were cared for in the dark at night. The wards were extremely cold, and the blankets, clothing, and pyjamas used by patients were of poor quality, further exposing them to cold weather.
- 5.6.4 There is a severe shortage of nursing personnel, where wards were managed by one professional nurse, one enrolled nurse, or one enrolled nursing assistant on each shift for at least 27 users, which was grossly inadequate. According to the World Health Organisation (WHO), the recommended ratio is 1:4 to 1:6 in acute units and 1:8 to 1:10 in long-term or chronic care units. Below is a graph depicting NCMHH’s overall staff composition.



- 5.6.5 The Northern Cape Mental Health Hospital’s staffing establishment reflects persistent systemic human resource challenges, compounded by fiscal constraints and strategic scale-up planning.

- 5.6.6 The hospital currently employs 323 personnel, all of whom are funded, signalling stable retention and payroll coverage for the current financial year. However, deeper analysis guided by insights from the CEO, Mr. Links, reveals significant structural limitations affecting the facility's trajectory toward full operationalisation.
- 5.6.7 The column reflecting "*planned additional*" positions refers to positions identified during the 2024/25 financial year as part of a formal submission to enhance services in the State Patients ward. These 20 posts are critical for staffing an additional 18 beds to meet increased demand. Interviews for these roles have already been concluded, but the final appointment processes remain stalled due to the broader departmental financial pressures experienced during the 2025/26 budget cycle.
- 5.6.8 This administrative bottleneck underscores the disconnect between strategic planning and implementation caused by recurring fiscal austerity. The 18 posts listed as "Vacant Funded" span both clinical and non-clinical categories and initially signalled opportunities for immediate filling. However, following recent communication from Executive Management, only posts vacated from 1 April 2025 onward are considered actionable funded vacancies.
- 5.6.9 This revised interpretation reflects a policy shift that further limits the hospital's agility in replacing critical staff lost to attrition, thereby reducing the facility's responsiveness to operational needs.
- 5.6.10 A broader concern lies in the long-term vision for the hospital's full-scale activation. Mr. Links confirmed that the total staffing requirement to fully operationalise the hospital is 593 posts, inclusive of both current and anticipated personnel. This establishes a shortfall of 270 posts, encompassing critical clinical disciplines, specialist nursing staff, allied health professionals, and essential administrative support. The gap is substantial and presents a formidable challenge to service readiness, especially in the context of growing mental health needs in the province.
- 5.6.11 Despite maintaining a strong core of 301 full-time staff, the reliance on 22 part-time employees introduces concerns regarding continuity of care and sustainability in high-dependency units. The fragmented presence of part-time personnel, although helpful in managing workload fluctuations, is not a long-term substitute for a fully capacitated workforce.
- 5.6.12 While the hospital's leadership has demonstrated proactive planning through the identification of required posts and ongoing recruitment efforts, actual progress remains impeded by financial and policy limitations. The urgent need for Treasury support, expedited approval of planned appointments, and a phased staffing implementation strategy remains central to the hospital's ability to deliver comprehensive, equitable, and dignified mental health care in line with national norms and professional standards.

5.6.13 The hospital has 287 commissioned beds. However, the current occupancy is at one hundred fifty-three (153) beds (53%), as illustrated in Table 1. Between 2019 and 2024, NCMHH experienced growth in bed occupancy from 133 to 153 beds.

Table 1: NCMHH Bed Occupancy

2024/25 BED OCCUPANCY (NCMHH)			
MHCU CLASSIFICATION	FORMER WEST END BED UTILISATION	COMMISSIONED BEDS	CURRENT BED UTILISATION
STATE PATIENTS	39	80	59 (74%) Males
FORENSIC OBSERVATION	3	10	3 (30%) Males
ACUTE PSYCHIATRIC INVOLUNTARY	Males = 28 Females = 10	92	28 (30%) Males 10 (11%) Females
ACUTE PSYCHIATRIC VOLUNTARY	Males = 11 Females = 10	20	5 (25%) Males 5 (25%) Females 5 (25%) CAMHS 5 Parents of Child and Adolescent Mental Health Services (CAMHS)
CHRONIC/ LONG STAY	Males = 18 Females = 10	38	28 (74%) Males 10 (26 %) Females
CHILD & ADOLESCENT	0	17	(0%)
CO-MORBID	0	7	(0%)
WELLNESS	0	7	(0%)
PRIVATE	0	16	(0%)
TOTAL	130	287	153 (53%)

5.6.14 Based on Table 1, the Chronic and Long-Stay ward accommodating male patients is fully utilised. State patients' and Acute psychiatric voluntary patient beds are adequately utilised at 74%, which are males, and 75% respectively. However, 25 % of beds in the Acute psychiatric voluntary ward are being used by parents of child and adolescent mental health patients.

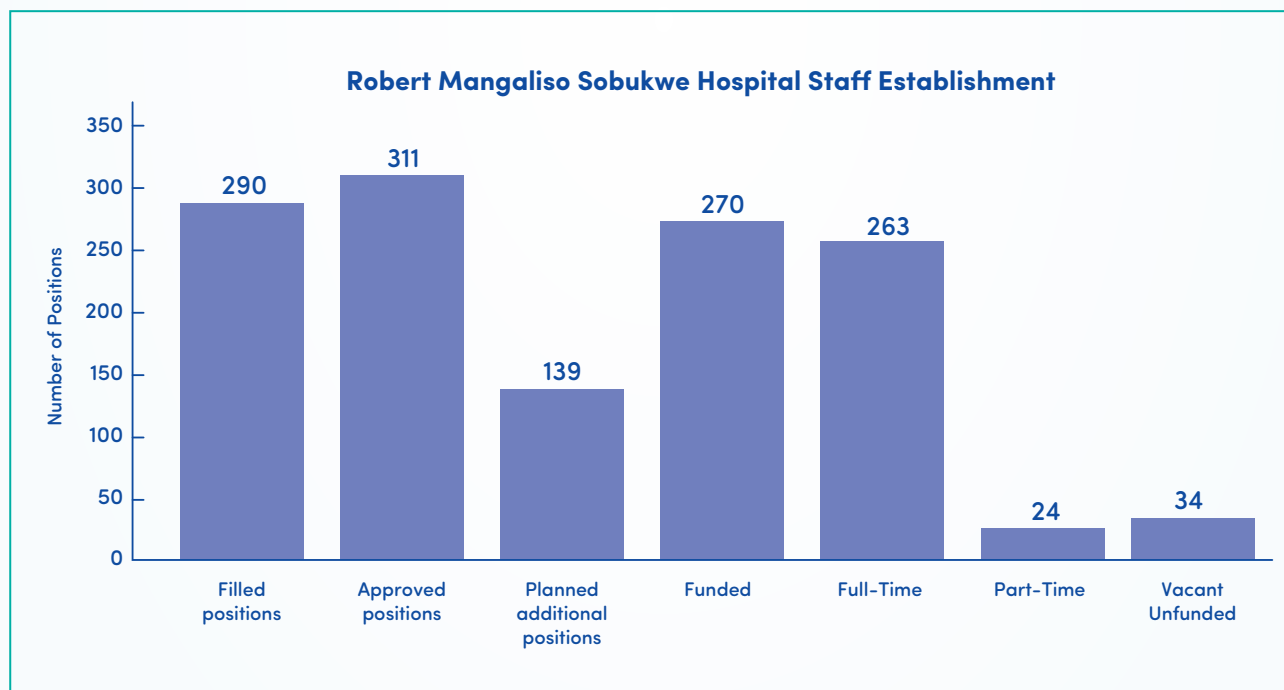
5.6.15 There is underutilisation of the forensic observation beds at 30%, and 41% of Acute psychiatric involuntary beds for both males and females. Comorbid, Wellness, and Private beds are not utilised. A total of 53 % of the commissioned beds are being utilised.

5.6.16 The underutilisation of the beds at NCMHH is attributed to the staff shortage and the crumbling infrastructure, which makes it impossible to accommodate patients in some wards.

5.7 Robert Mangaliso Sobukwe Hospital:

- 5.7.1 Robert Mangaliso Sobukwe Hospital (RMSH), formerly known as Kimberly Hospital Complex (KHC), is the only Provincial Tertiary Hospital in the Northern Cape. RMSH is situated at 114 Du Toitspan Road, Belgravia, Kimberley.
- 5.7.2 The hospital was established in the 1800s. It has 604 approved beds and 612 usable beds. RMSH is headed by an Acting CEO, Mr Joseph Sandt, supported by a team of Managers. Currently, RMSH does not have a functional Hospital Board. The procurement, supply chain management, and financial decisions for RMSH are centralised at the Northern Cape DoH Provincial Office.
- 5.7.3 The services offered at RMSH do not include all specialities, such as cardiology, radiation therapy, paediatric oncology, and specialised obstetrics. Due to lack of such specialised services, RMSH refers patients to Universitas Hospital in Bloemfontein.
- 5.7.4 RMSH serves approximately 1,324,270 people, and its catchment area covers the whole of Northern Cape Province over a 700-kilometre (km) radius. The Northern Cape's geographic landscape is predominantly rural, urban, and peri-urban.

5.8 Robert Mangaliso Sobukwe Hospital Staff Establishment



- 5.8.1 The staffing structure at Robert Mangaliso Sobukwe Hospital reveals a dynamic yet strained human resource profile. The facility currently holds 290 total positions, while the approved establishment sits higher at 311 posts, indicating a shortfall in actual filled positions relative to planned capacity. This discrepancy may impact the hospital's ability to fully implement its service delivery mandate.

- 5.8.2 Out of the approved positions, 270 are funded, and 263 are filled with full-time staff, showing commendable alignment between funding and permanent staffing. However, this still leaves a gap between approved and filled posts, with 24 part-time positions supplementing the workforce. While part-time roles can offer operational flexibility, an overreliance on them may challenge continuity of care and patient satisfaction.
- 5.8.3 Of concern are the 34 vacant unfunded positions, which highlight structural budget constraints and may indicate difficulties in recruiting or retaining staff due to financial limitations. These vacancies risk overburdening the existing workforce, possibly compromising the quality and timeliness of services rendered.
- 5.8.4 Encouragingly, the information received shows 139 posts planned for creation, suggesting future strategic intent to bolster the workforce. This expansion, if properly funded and implemented, can significantly improve the hospital's capacity to meet growing health demands, especially in specialised and critical care areas.
- 5.8.5 While Robert Mangaliso Sobukwe Hospital effectively utilises its funded posts and maintains a stable full-time staffing base, the gap between approved and funded positions, together with a substantial number of planned posts yet to be established, underscores the need for targeted investment in health workforce expansion and budget allocation.

6. INTERVIEWS WITH OFFICIALS

6.1 Mr Mxolisi Mlatha (Acting Head of Department)

- 6.1.1 Mr Mlatha, Acting HoD since December 2023, was interviewed by the Health Ombud on 12 December 2024. He outlined the following concerns, which negatively impact mental health service delivery at NCMHH:
- 6.1.1.1 **Clinical Governance:** Understaffed healthcare practitioners, failure to follow protocols, including note-taking and proper record-keeping.
- 6.1.1.2 **Electricity:** There have been power outages due to theft and vandalism of cables and the power substation. These have prevented the hospital from functioning properly and caused adverse effects to patients, including exposure to the elements. The patients' blankets and clothing were also "substandard."
- 6.1.1.3 **Infrastructure:** Challenges with ablution facilities. The building is malfunctioning, despite its being relatively new.
- 6.1.1.4 **Security:** NCMHH lacks security personnel and adequate security arrangements. Security personnel were not trained in handling mentally ill users. The hospital was built without burglar guards, and some windows are broken, allowing patients to escape.

- 6.1.1.5 **Equipment:** NCMHH lacks emergency and resuscitation equipment.
- 6.1.1.6 **Maintenance:** Only one artisan, a plumber by trade, is on secondment from RMSH. He is responsible for all maintenance needs and is utilised as an electrician.
- 6.1.2 Mr Mlatha did not refute any of the concerns raised by the Health Ombud, such as electricity and clinical governance, and further stated that:

6.2 Clinical Governance

- 6.2.1 He acknowledged that the provincial office has serious systemic and leadership issues that contribute to these challenges. He also expressed a concern that it becomes a challenge with the supply chain when people are appointed to positions without the necessary skills or experience.
- 6.2.2 The previous HoD and the Chief Financial Officer (CFO) were relieved of their responsibilities due to charges pending against them. An official on secondment from RMSH occupies the supply chain position.
- 6.2.3 Mr. Mlatha emphasised accountability and learning from past mistakes, particularly in procurement. He mentioned that he was aware of the procurement of advanced beds that were not suitable for a psychiatric institution. The Ombud mentioned to Mr Mlatha that the procurement of an electroconvulsive therapy (ECT) thymatron machine several years ago has yet to be commissioned, hampering service delivery and not providing the crucial primary treatment for acute mental illness.
- 6.2.4 He further told the Ombud that he is investigating the purchase of expensive golf carts. Mr Mlatha stated that the system must be held accountable, noting that addressing these issues is challenging due to their long history.
- 6.2.5 NCMHH lacked a proper staff complement and the necessary capacity to manage financial delegations. Mr Mlatha reported that the Department is working on HR delegations and issuing delegations to properly capacitated executive managers and directors.
- 6.2.6 Regarding the staff shortage, he acknowledged that the relocation of NCMHH from West End Hospital saw an increase in operational requirements, but staffing and resources have not kept pace. He reported that attempts have been made to fill vacancies, although not to the desired level, and he also required additional funding. Mr Mlatha indicated that incremental capacity expansion of the facility was intended, but this has yet to occur. Budget constraints and difficulty attracting personnel to the mental healthcare industry have also been causing difficulty in providing these services.

6.2.7 He added that the hospital had advertised psychiatric posts twice in the last year without receiving suitable responses and recently advertised forty psychiatric nurse posts, receiving only four responses. Mr Mlatha noted that these challenges hindered the hospital's operationalisation, including the inability to fully staff the state patient ward, which was intended to be fully operationalised to decant eighteen patients from prison. Mr Mlatha stated that budget constraints have hindered the filling of certain posts, including those of psychiatrists.

6.3 Electricity

6.3.1 Mr Mlatha told the Ombud that the power substation supplying electricity to NCMHH had been repaired at a cost of approximately R1.2 million in November 2022, only to be damaged again in November 2023. Subsequent sporadic damages, costing around R33 million, occurred during the stage 6 load-shedding period. The electricity was restored in September 2024 after the tender was advertised for a shortened period, while adherence to the normal procurement process ensured transparency.

6.3.2 Telephone connectivity has been a challenge, including issues with telephone connections or other technical problems, and a solution is being sought. Mr Mlatha pointed out that telephones are part of the facility's infrastructure projects and are linked to electricity issues. He informed the Ombud that the Department is in the process of distributing mobile phones to staff, starting with doctors and nurses, to enhance communication.

6.4 Emergency Equipment

6.4.1 Mr Mlatha indicated that the Deputy Director General (DDG) for Primary Health Care and Hospital Management Systems from the National Department of Health (NDoH), Ms J. Hunter, had indicated that there were funds available to procure emergency equipment during a visit to NCMHH. She said that the Northern Cape should submit its list of emergency needs. However, there was a slow and unresponsive submission of those needs by different institutions in the Province.

6.5 Unavailable Medication

6.5.1 A concern was raised about the unavailability of medication and the limited formulary in the province. Mr Mlatha indicated that he did not have information about this issue. What he was aware of was that the national and provincial heads of pharmacy were responsible for the psychiatric medicine formulary, unless a specific doctor wanted the medicine outside the list, and it was expensive when a cheaper alternative was available.

6.6 Patients' clothing and linen

6.6.1 Mr Mlatha confirmed that two consignments of pyjamas and blankets, each worth R 2 million, were procured in 2023 and 2024. The pyjamas did not last even six months due to poor quality, and the blankets disappeared. He pointed out that no investigation was conducted to probe this unethical purchase.

6.7 Infrastructure

6.7.1 Mr. Mlatha indicated that projects were stopped to recalibrate the budget and prioritise spending. He stated that the department is underfunded but is working to implement systems and optimise resources. The non-functional ablution facilities, HVAC system and magnetic doors were due to the electric supply as a result of theft and vandalism of the electrical supply infrastructure. The damaged electrical points needed to be replaced and installed high up, out of easy reach for the patients. Therefore, the primary reason for the lack of infrastructure maintenance is due to budget constraints.

6.8 Security

6.8.1 Mr Mlatha agrees with the assessment that the facility's perimeter poses a security risk due to its design and stated that the facility's location and layout require additional security measures. He acknowledged that the security personnel lack specific training on the handling of a mentally ill patient.

6.8.2 Mr Mlatha acknowledged that the incident of a patient absconding highlighted the need to secure the windows and ensure that they provide full proof prevention of patient escapes. He added that measures can be taken to mitigate the risks and that alternative solutions need to be found to secure the facility, such as changing to manually operated doors. However, the security risk posed by the design of the windows cannot be easily changed.

6.9 Artisan

6.9.1 Mr Mlatha stated that the facility advertised for artisans, but the appointment process was halted due to changes in submissions, including the names of appointees. He acknowledged that a submission for electricians was made, but the facility's needs weren't met. He also mentioned that the selection panel made changes, and the process is ongoing.

6.10 Mr Albert Links (NCMHH CEO)

6.10.1 Mr Links is also the Acting CEO for the Specialised TB Hospital, also known as Westend Hospital, which is approximately six km from NCMHH. Regarding the four patients' incidents under investigation, Mr Links told the Ombud on 12 December 2024 that Dr Hammer and colleagues from the clinical governance committee had reviewed the cases and identified unfortunate oversights in clinical interventions. These oversights included gaps in monitoring patient vital signs, missing care plans, and delayed medical interventions,

such as drawing blood. He stated that the clinical governance committee had developed a quality improvement plan (ANNEXURE F) on 19 September 2024 to address identified gaps.

- 6.10.2 He stated that burglaries had occurred at the power substation, resulting in power outages and disruptions to patient care, including patient security from the nonfunctioning of the electromagnetic locks. He also stated that the facility had relied on generators for almost a year due to the delay in repairing the power substation, which had caused challenges, including diesel shortages.
- 6.10.3 Mr Links further stated that the generators had never supplied 100% power, and many areas, including offices and apartments, had not been supplied by the generators, a situation that persisted at the time of the investigation. Efforts were made to get a service provider, Max Electrical, to repair the damage. However, despite the MEC's intervention, there was a delay in the appointment due to logistical challenges.
- 6.10.4 He also confirmed that environmental factors, in this case, **extreme cold** due to a lack of power supply and the non-function of the heating system, had contributed to the patients' incidents.
- 6.10.5 Concerning the lack of medical and resuscitation equipment, Mr Links said that he believed the provincial supply chain office's delays in procuring health technology equipment were due to inadequate staffing, procurement failures, and ineffective procurement management. He conceded that delays in procurement negatively impacted patient care. However, requests for medical equipment submitted in 2019 to the previous HoD had yet to be received by NCMHH. NCMHH did not have a health technology department. He further revealed that the budget allocated for health technology was inadequate, with R21m in the 2020/21 financial year, significantly cut to R6 m during the 2023/24 financial year.
- 6.10.6 Mr Links told the Health Ombud that NCMHH was served with a Contravention Notice by the Department of Labour for the dilapidated state of the infrastructure. Also, the NDoH, the Municipal Advisory Committee and the Office of the DDG, led by Ms J. Hunter from NDoH, visited NCMHH in 2022 and 2023. During these two visits, infrastructural problems were identified, and directives were given to address them. However, no progress had been made at the time of the investigation. Mr Links further stated that his attempts to solicit infrastructure maintenance support from the provincial office were unsuccessful.
- 6.10.7 Mr Links confirmed to the Ombud that NCMHH was operating without telephones, which negatively impacted patient care and service delivery, but stated that the process of providing cellphones to nurses and doctors was underway.

6.11 Dr Keith Kirimi (NCMHH Head of Clinical Medical Department)

- 6.11.1 In his interview with the Health Ombud, Dr Kirimi echoed the difficult and unacceptable conditions under which healthcare personnel provided healthcare to patients. Patients were cared for in the dark; the environment was extremely cold in winter and hot in summer. When these incidents occurred, the hospital was extremely cold. Due to the erratic and absence of electricity and lights, patients were not monitored at night.
- 6.11.2 In his view, all the patients' incidents and the resultant deaths were directly linked to the extremely cold conditions to which the hospital subjected them. In addition, the hospital experienced a TB outbreak, which affected both patients and healthcare personnel because of the extreme cold conditions.
- 6.11.3 Also, the lack of electricity and the non-functional HVAC system affected the storage of medication in the pharmacy, and pharmacy services were moved to Westend Specialised TB Hospital until the electricity was restored.
- 6.11.4 Despite his writing to the HoD about these adverse circumstances, his letter was never acknowledged or responded to. He also revealed that he had engaged the NCMHH Review Board regarding the challenges, which the Board was aware of.
- 6.11.5 Eight high-tech beds, unsuitable for a psychiatric environment, were delivered to the hospital a day before the Health Ombud's visit. NCMHH operated without emergency equipment, and ECT services were not rendered because not all necessary equipment and healthcare personnel were made available. Instead, expensive furniture was prioritised and procured at the expense of critical healthcare equipment for care and service delivery.
- 6.11.6 Doctors were performing outreach duties as far as a thousand kilometres away from Kimberley without phones to communicate and request assistance in case of an emergency. Three doctors had a tyre burst whilst travelling to Namaqua to render outreach services without a work phone.
- 6.11.7 Also of importance is that two days before the Health Ombud's interviews with the Provincial Office and NCMHH senior officials, NCMHH and RMSH Managers were summoned to the HoD's office for *"adopting a stance in response to the Health Ombud's interviews."* This conduct is tantamount to interference, hindrance and obstruction of the Ombud in the performance of his functions and in violation of Section 89(1)(h) of the NHAA.
- 6.11.8 Dr Kirimi attributed these challenges to systemic failures within the Hospital and at the Provincial Office.

6.12 Dr Alastair Kantani (Clinical Manager, Hospital Services Northern Cape)

- 6.12.1 Dr Kantani was the Acting HoD from September to November 2023, when the electricity infrastructure was vandalised (cable theft) for the first time, leaving NCMHH without an electricity supply. A lack of security led to further vandalism of the power station. This plunged the hospital into darkness in the winter months, due to the absence of the heating system and a lack of hot water. Patients and healthcare personnel were exposed to extreme cold, resulting in the death of a patient due to hypothermia.
- 6.12.2 Before he vacated a HoD position, plans were put in place under his leadership to swiftly restore the electricity. However, a deviation from the normal processes of securing a service provider he advocated for to replace the cable was not implemented. Instead, a normal bidding process was followed, and it took a lengthy period to secure a service provider, resulting in a delay in restoring electricity.
- 6.12.3 Subsequent intervention to restore the HVAC system was not executed, and the head of finance pleaded a lack of finances.
- 6.12.4 Challenges in the Northern Cape hospitals and provincial office are systemic, and there is a lack of accountability at all levels.

7. DETERMINATION OF ISSUES INVESTIGATED IN RELATION TO THE EVIDENCE OBTAINED

7.1 Circumstances surrounding Mr Cyprian Mohoto's care at NCMHH and RMSH and his death at RMSH

Northern Cape Mental Health Hospital

- 7.1.1 Mr Cyprian Mohoto (Mr Mohoto), a 37-year-old male, was admitted to NCMHH in Ward B1 on **29 October 2020**, and he died on 16 July 2024 at RMSH. He was diagnosed with Bipolar Disorder, Schizophrenia, Substance Use Disorder and Intellectual Disability.
- 7.1.2 During interviews with the Health Ombud and the Investigators on 12 December 2024, Dr Hammer and Dr Kirimi, both Psychiatrists, told the investigating team that Mr Mohoto had developed **Resistant Schizophrenia**, which needed multidrug intervention, and adjustment of antipsychotics from time to time.
- 7.1.3 Over the four years Mr Mohoto was admitted to NCMHH, he was treated with Clozapine (antipsychotic) 12 hourly, the dose of which was adjusted from time to time, Senekot 2 tablets (stimulant laxative) at night, Orphenadrine 50 mg (muscle relaxant and anticholinergic) 12 hourly, Largactil 100 mg (antipsychotic and anti-emetic) 12 hourly, Pantoloc 40 mg (gastric acid suppression for gastroesophageal reflux) once daily, and Epilim 1g (antiepileptic) 12 hourly all orally. Additionally, he was on Ativan (sedative) 2mg - 4mg orally or intramuscularly,

Etomine 40mg - 80mg (antipsychotic and sedative) intramuscularly, when necessary, Clopixol 200 mg (long-acting antipsychotic) intramuscularly monthly, and Depo Provera 300 mg (testosterone suppressor) intramuscularly monthly.

- 7.1.4 The investigation established from the medical record that between July 2023 and July 2024, Mr Mohoto's Full Blood Count blood investigation was conducted to monitor the White Cell Count (WCC) and Differentials (Diff) as Clozapine can cause a severe drop in white blood cells (Neutropaenia and Agranulocytosis), which could be fatal if not diagnosed and managed. This necessitates rigorous blood monitoring for which local and international protocols exist.
- 7.1.5 According to the South African Standard Treatment Guidelines (SASTG) and the Essential Medicines List for South Africa, 2017, WCC monitoring was required to be conducted monthly since Mr Mohoto was on Clozapine treatment beyond 52 weeks. However, between July 2023 and July 2024, WCC was not monitored consistently according to protocols. During this period, WCC ranged from 3.26 to 7.90. According to Ampath, the normal value is from 3.92 to 9.88 x 10⁹ /L. The investigation established that NCMHH did not have a specific protocol or a standard operating procedure (SOP) on Clozapine to guide both the nursing and medical healthcare providers in the management of patients on Clozapine regarding haematology and vital signs monitoring.
- 7.1.6 Due to his unstable psychotic mental health condition, Mr Mohoto was receiving more than three antipsychotic drugs, all with sedative side effects, and he required close vital signs monitoring. Additionally, he regularly received sedations such as Ativan and Etomine IMI when necessary, during his episodes of aggression and violent behaviour. Therefore, Mr Mohoto's treatment regime made him susceptible to an increased risk of central nervous system (CNS) depression and adverse cardiovascular (CVS) conditions such as hypotension, or tachycardia, respiratory depression, and seizures, hence requiring frequent vital signs monitoring.
- 7.1.7 Overall, Mr Mohoto's vital signs were not adequately monitored, as they were measured once in the morning. There was no recorded evidence of any vital signs monitoring between 13 June 2024 and 02 July 2024 (ANNEXURE G). An opportunity to identify any deterioration or danger signs, such as hypothermia or hypotension, was missed.
- 7.1.8 According to the NCMHH standard operating procedure (SOP) for "Vital Signs of the Patient" (ANNEXURE H), effective from January 2024, guiding the nursing personnel on when to take the vital signs of mental healthcare users specifies that vital signs should be done once daily, and in line with the user's clinical condition. The investigation established that the standard operating procedure was not complied with as necessitated by Mr Mohoto's condition, and the nursing personnel failed to monitor his vital signs as prescribed by the doctor. There was no evidence that between July 2023 and July 2024, monthly monitoring of blood glucose, weight, height, haemoglobin (HB), and urine tests was done as stipulated in the SOP.

- 7.1.9 All the nursing personnel interviewed in Ward B1 at the time of the incident told the Investigators that they were unaware of a standard operating procedure for vital signs monitoring, including guidelines or protocols for a mental healthcare user on Clozapine or Ativan. Ms Agnes Mintor (Ms Mintor), the Nursing Service Manager, could not provide investigators with evidence to the contrary. Therefore, the investigation found that NCMHH failed to communicate critical documents that guide and enable nursing personnel to provide safe and quality healthcare services.
- 7.1.10 Furthermore, the nurses' clinical notes were grossly inadequate. They mainly consisted of handing and taking over reports between shifts. They were void of progress reports and any nursing management that was done. There were shifts and days when clinical notes were not recorded completely. The investigation established that ENs and ENAs mainly recorded nurses' clinical notes. Professional nurses' records of assessments, findings, and evidence of nursing management instituted on Mr Mohoto were unavailable.
- 7.1.11 Between July 2023 and July 2024, Mr Mohoto was reviewed by the doctors and the multidisciplinary task team once a month on average, and medications were adjusted regularly. Given the multiple drug treatments with associated serious side effects, Mr Mohoto was at high risk of developing serious side effects and complications. However, monthly medical reviews were not consistent with the risks posed by the medication he was receiving, as physical assessments and vital signs monitoring were not done. The investigation found that Mr Mohoto was not managed holistically. Emphasis was placed on his mental state and behaviour, neglecting his physical state.
- 7.1.12 On 08, 09, 12 and 13 July 2024, according to the duty roster, PN O. White (PN White), ENA, M. Mkhabele (ENA Mkhabele), and ENA S. Pieterse (ENA Pieterse) were on duty in Ward B1 from 07h00 – 19h00. The handing-over reports on 08 and 09 July 2024 at 09h00, respectively, were recorded by ENA Pieterse. There was no evidence that PN White had assessed and recorded any notes on Mr Mohoto's medical record during these two days.
- 7.1.13 According to the progress notes, on 12 July 2024, at 11h45, PN White administered Ativan 2 mg orally to Mr Mohoto to manage his aggressive behaviour. There was no recorded evidence that PN White, ENA Mkhabele, and ENA Pieterse monitored Mr Mohoto's vital signs or the level of sedation. Vital signs were measured at 08h59 before Ativan was administered. During the interview with the Investigators, PN White acknowledged that her failure to monitor Mr Mohoto and to keep records was an omission. An opportunity was missed to identify deterioration in condition, which resulted in his referral to RMSH.
- 7.1.14 The investigation established that on 08, 09 and 12 July 2024, PN Tabi did not document the clinical condition of Mr Mohoto on the nurses' notes. Instead, there was a documentation by ENA Randwezi on 08 July 2024 at 20h00. Additionally, there was no record reflecting the vital signs monitoring during the night on 12 July 2024.

- 7.1.15 PN White and PN Tabi failed to fulfil their duties according to the SANC Regulations Regarding the Scope of Practice For Nurses and Midwives, R.2127 of 2022 (SANC Scope of Practice, R.2127) Regulation 2 (1) states that *“The professional nurse takes responsibility and accountability for the following: ... (b) providing safe and quality comprehensive nursing care in a scientific, integrated and evidence based approach, in all healthcare settings,... (d) facilitating the attainment of optimum health for the individual, the family, groups and the community,...(f) assessing and interpreting the health information needs of individuals and groups so as to plan and respond accordingly, (g) diagnosing and prioritising individual health and nursing care needs based on a comprehensive analysis and the interpretation of data,...(p) creating and maintaining a concise complete and accurate nursing record for individual healthcare users, and (q) referring a healthcare user timeously and appropriately to other members of the multidisciplinary team.”*
- 7.1.16 Similarly, ENA Chweu, ENA Pieterse, ENA Mkhabele, and ENA Ranwedzi also failed to execute their nursing duties according to SANC Scope of Practice, R.2127. Regulation 5(1) of the SANC Scope of Practice states that *“(b) providing basic nursing care in accordance with a standardised plan of care, ... (i) adhering to relevant protocols and guidelines, and (j) maintaining concise, complete, and accurate nursing records for individual healthcare users.”*
- 7.1.17 According to Dr Mathunda’s notes, medication was omitted on the evening of 12 July 2024. ENA Ranwedzi confirmed this when interviewed, which strongly suggests that PN Tabi was aware of Mr Mohoto’s clinical condition but neglected to monitor him accordingly. PN Tabi failed to notify Dr Mathunda, who was on call, about Mr Mohoto’s condition.
- 7.1.18 During the interviews, it also emerged that on the morning of 13 July 2024, Mr Tabi handed over the ward to ENA Pieterse because PN White was late and only reported to work at 07h30. ENA Pieterse failed to document the state in which he found Mr Mohoto. There was also no record of how the handover was conducted. The Investigation noted that at the time of the incident and investigation, NCMHH did not have a valid SOP for “Handover in ward/unit”, as the one provided was not reviewed in October 2023 (ANNEXURE I).
- 7.1.19 It was revealed that at the time of Mr Mohoto’s referral to RMSH, NCMHH was experiencing an electricity blackout due to vandalism of the electricity substation supplying the health establishment. On the evening of 12 July 2024, there was no electricity supply to Ward B1, and the electronic vital signs monitoring device’s battery was flat. Nursing personnel did not have the medical equipment necessary to monitor patients’ vital signs and thus ensure their safety. PN Tabi stated that he used his cellphone torch intermittently as a light source, could only administer medication and could not make clinical notes for all patients, including Mr Mohoto.
- 7.1.20 Patients, including Mr Mohoto, did not have warm clothing or warm pyjamas; the blankets used were very thin and of poor quality, and patients were exposed to extremely cold winter conditions.

- 7.1.21 PN White told the Investigators that on the morning of 13 July 2024, she reported late for duty at around 07h30, and she met PN Tabi in the corridor on his way out, who informed her that *“all patients were fine”*, which was not the case with Mr Mohoto when he was discovered by ENA Pieterse, soon after PN Tabi left. According to PN White’s clinical notes, at 07h30, she discovered that Mr Mohoto was *“very drowsy, cold, muttering, swollen right hand and face. Black/brown vomit on patient’s pillow.”* No explanation was provided to the investigators of what caused the swelling. Vital signs recorded were blood pressure (BP) of 89/61 mmHg, pulse rate (P) of 46 beats/minute (b/min), O₂ saturation (Sats) of 94% and Visidex (HGT) of 4.7 mmol/l. Mr Mohoto was hypotensive with bradycardia and needed urgent medical attention. Although Mr Mohoto was cold, no temperature or respiratory rate was recorded. PN White incorrectly stated in her clinical notes that she noticed **“during the handover”**. During the interview, she admitted that she was not present at the handover. The investigation, therefore, found that PN White’s notes were misleading and untruthful and amounted to **forgery**, which is a serious offence.
- 7.1.22 Subsequently, PN White notified Dr Mathunda about Mr Mohoto’s condition, who requested the insertion of a Ringer’s Lactate drip, which was done, and he later came to see him. The investigation established that there were no telephone lines to communicate with other healthcare providers internally and externally. Personnel were using their personal cell phones for official purposes.
- 7.1.23 The investigation revealed that there was only one PN per shift in Ward B1, which had 27 patients. According to PN White and PN Tabi, the workload was immense, making it difficult to record progress notes for everyone. Furthermore, NCMHH was operating without a night supervisor to oversee and supervise the provision of care and support to the nursing personnel.
- 7.1.24 The investigation found that the absence of electricity was a major contributory factor to the nursing personnel’s failure to fulfil their nursing obligations, monitor Mr Mohoto, or make any notes on the night of 12 July 2024.
- 7.1.25 According to the medical record, Dr Mathunda arrived in Ward B1 at 08h20 after he was called by PN White at 07h30 and informed that Mr Mohoto was drowsy, vomited, and had a 2/7-day history of constipation. Additionally, medications were omitted the previous night.
- 7.1.26 On examination, the respiratory and cardiovascular systems were recorded as having no abnormalities. However, at 07h30 and 09h00 respectively, vital signs were BP 89/61 mmHg and 83/53 mmHg (hypotension), P 46 b/min (bradycardia) and 62 b/min, O₂ Sats 97% and temperature (Temp) of 35,2°C (hypothermia). The investigation noted that the respiration was not assessed, and there was no indication whether Mr Mohoto was breathing spontaneously in room air or was supplemented with oxygen therapy. Glasgow coma scale (GCS) was 14/15, with normal and reactive pupils. The GCS assessment sheet was not available in the medical record. The abdomen was non-tender and moderately

distended, with suprapubic hardness, most likely secondary to stool. There was no active vomiting during examination. Per rectal examination, no stool was found in the rectum. The sphincter was normal. Ringer's Lactate was running on the left arm.

- 7.1.27 Following the examination, Dr Mathunda diagnosed **severe constipation secondary to Clozapine**. He recorded a plan for a fleet enema x 3, Ringer's Lactate 8 hourly, and a nasogastric tube. The enemas were administered by PN Sehularo, who came to assist PN White before Dr Mathunda arrived. Blood investigations for Full Blood Count and Differential (FBC and Diff), Liver Function Tests (LFTs), calcium, magnesium, and phosphate (CMP), and Urea and Electrolytes (U&E) were drawn. Dr Bhyat, a specialist surgeon and Head of Surgery at RMSH, told the Investigators that prescribing and giving three (3) enemas whilst suspecting bowel obstruction and before conducting appropriate investigations and confirming the absence of obstruction or presence of mechanical perforation was dangerous and unsafe. The investigation, therefore, found that Dr Mathunda's management was incorrect and unsafe. Dr Mathunda conceded during the interview with the Investigators that, on hindsight, prescribing and giving the fleet enema before conducting investigations was incorrect and unsafe.
- 7.1.28 Dr Mathunda discussed Mr Mohoto with Dr U. Anjum (Dr Anjum), a Medical Officer (MO) at RMSH General Surgery Department, who accepted the referral for further management. Dr Mathunda handed him over to Dr Beukes at 08h40 as he was post-call. Dr Beukes saw Mr Mohoto but omitted to record the time of the consultation. When asked about her management of and interventions on Mr Mohoto, she told the Investigators that she did not need to do anything as Dr Mathunda had done all that needed to be done and the patient was awaiting transport to RMSH.
- 7.1.29 The investigation found that while awaiting the EMS, Mr Mohoto spent approximately three hours in the ward. Still, he was not monitored closely in line with the severity of his condition. Vital signs were measured once at 12h35, his BP had improved to 129/84 mmHg, and his pulse was 47 b/min. The temperature was 35.2°C, and his Ringer's Lactate drip was running. At 12h58, Mr Mohoto was taken to RMSH by EMS with a referral letter.
- 7.1.30 The investigation found that failure by PN White, PN Tabi, ENA Mkhabele, ENA Pieterse, and ENA Ranwedzi to monitor Mr Mohoto as required by the SANC Scope of Practice was a lapse in care, was substandard and contributed directly to his condition deteriorating to the point of requiring hospitalisation at RMSH. Mr Mohoto was not attended to in a manner consistent with the nature and severity of his health condition, as required by Standard 5 (1) of the Norms and Standards Regulations. If Mr Mohoto had been monitored, the deterioration would have been identified, and he would have received appropriate intervention.

7.1.31 Furthermore, nursing personnel in Ward B1 acted inconsistently with SANC Acts or Omissions, R767 of 2014, Regulation 5, which provides that *“failure to maintain the health status of the healthcare user under his/her care through – (a) assessing the health status of a healthcare user and the response of the body, ... (c) preventing accidents, injury or trauma, ... (f) providing specific care and treatment of the ill and the vulnerable and high-risk healthcare user, (g) monitoring vital parameters, including vital signs of the healthcare user, and (h) keeping clear and accurate records of all actions performed on the healthcare user”, is an omission.*

Robert Mangaliso Sobukwe Hospital

7.1.32 On 13 July 2024, at 13h30, Mr Mohoto was triaged at the Emergency Centre in the Accident and Emergency unit at RMSH by ENA I.M. Bulling (ENA Bulling). Vital signs were incomplete as the temperature and respiratory rate were not recorded. When questioned about the failure to record the temperature and the colour coding, ENA Bulling informed the Investigators that EC had been operating without a thermometer for some time, but she could not account for why she did not record the triage colour coding, and she acknowledged that it was an omission. ENA Bulling did not show a full understanding and insight of triaging and its purpose, as she rated the temperature a “0” in the triage form, suggesting that the temperature was within normal ranges even though it was not measured, and amounts to a fraudulent entry.

7.1.33 The investigation viewed ENA Bulling’s overall triage score as **“false,”** misleading, and a serious clinical professional offence. There was no recorded evidence that Mr Mohoto was reviewed by the PN Moleele, who was in charge of the shift, or a doctor before he was rerouted to Surgical Recovery.

7.1.34 During the interview, PN Moleele informed the Investigators that he did not have contact with Mr Mohoto. PN Moleele also told the Investigators that it was common in the Emergency Centre (EC) for a patient to be attended to by a nurse and be rerouted to another unit without his knowledge due to the high influx of patients and a severe shortage of staff, especially professional nurses. When asked about what he did about the unavailability of a thermometer in EC, PN Moleele told the Investigators that *“he was unaware, and nobody informed him; in fact, he always carried his thermometer, and he could have availed it if ENA Bulling had asked.”*

7.1.35 The Investigators view how EC is managed as unsafe for healthcare users and nursing personnel. The investigation found that EC lacked the critical equipment to provide safe, quality care. PN Moleele further told the Investigators that he was the only PN on 13 July 2025 on duty from 07h00 – 19h00, and the unit was busy. The investigation noted that record-keeping at EC was poor, making it difficult to ensure continuity of care, hampering safe and quality care. In essence, RMSH allowed ENA Bulling to function unsupervised, and she made decisions that fell outside the scope of her training, thus practising contrary to the SANC Scope of Practice, R.2127.

- 7.1.36 At 14h11, Mr Mohoto was seen and examined by Dr F. Conradie (Dr Conradie), a Medical Intern at SOC. On examination, he was found to be confused, restless, and shivering throughout his body. GCS was 14/15. The abdomen was soft and non-tender, with mild distention and bowel sounds present. On arrival, Mr Mohoto passed a pebble-like hard stool mixed with soft stool. Vital signs were not measured in the Surgical Recovery Unit.
- 7.1.37 According to the radiology report, abdominal obstruction was ruled out, but there was **multilobar pneumonia** (ANNEXURE J) of the right lung. Based on her clinical notes, Dr Conradie was aware of the chest X-ray results, but there was no evidence that she acted on them, sought advice, or received guidance in any way.
- 7.1.38 During the interview with the Investigators, Dr. Conradie stated that she prescribed an antibiotic on a script as treatment to take out. The investigation found that the antibiotic was not administered, and the prescription was not in the medical record or at the pharmacy to confirm her statement. There was, therefore, no evidence that the antibiotic was prescribed. Prescribing treatment to take out antibiotic treatment for a multilobar pneumonia is a gross error.
- 7.1.39 The blood gas results (ANNEXURE K) revealed CO₂ of 7.28 kPa, above the normal ranges of 4.7 – 6.0 kPa, which was an indication of severe respiratory acidosis. The sO₂ was 67.7%, which was severe hypoxia, below the normal ranges of 90% – 100%. Basal Excess (BE) was 7.4 mmol/l (high), and the normal ranges are -2 to +2, HCO₃⁻ - 29.1 mmol/l (high) and the normal values are 22 to 26 mmol/l, both revealing compensating metabolic alkalosis. Despite a normal pH of 7.383, Mr Mohoto was presenting with **compensated respiratory acidosis and severe hypoxia**. It emerged during the interviews that the blood gas results depicted as **arterial** were, in fact, a **venous** blood sample, thus making the interpretation invalid. Also, the temperature recorded was 37 °C, which was not measured on arrival, yet it was 35.2 °C when Mr Mohoto left NCMHH.
- 7.1.40 There was no evidence in the medical record that the blood gas results were acted upon or that a follow-up blood gas investigation was done if Mr Mohoto's clinical picture was not aligning with the results, and also to exclude poor blood sampling or any error that might have influenced the results.
- 7.1.41 The investigation noted that Dr Anjum, with whom Dr Mathunda discussed and accepted Mr Mohoto's referral, did not see him. Dr Anjum did not provide guidance and missed an opportunity to provide on-the-spot mentoring to Dr Conradie, a Medical Intern. He agreed when interviewed that, in hindsight, he realised he should have availed himself and guided Dr Conradie. Dr Conradie informed Investigators that after examining Mr Mohoto, she presented him to her seniors, Dr Nieuwoudt and Dr Anjum.

- 7.1.42 Later, Dr Nieuwoudt saw Mr Mohoto but did not indicate the time of consultation, her name and surname, but only attached her signature (ANNEXURE L). There was no evidence that Dr Nieuwoudt, as a senior doctor, referred to the referral letter from NCMHH, nor conducted her own assessment and made her own findings, nor reviewed the chest X-ray and blood gas results. Dr Nieuwoudt discharged Mr Mohoto on Lactulose but omitted to write the dose, frequency, and route. Blood gas results were recorded as normal, and she failed to act on the chest X-ray results. Mr Mohoto remained in Surgical Recovery while awaiting transport back to NCMHH.
- 7.1.43 The investigation found that Dr Nieuwoudt did not treat Mr Mohoto holistically, did not consider the history contained in the referral letter, the patient's clinical condition and investigation results. She also failed to prescribe antibiotics and refer him to Internal Medicine for further management. The investigation found that Dr Nieuwoudt acted contrary to the HPCSA Guidelines, Booklet 1 Rule 5 on Duties to Patients, 5.1 patient's best interests or well-being, which states that in 5.1.8 *"Apply their mind openly when making diagnoses and considering appropriate treatment. 5.1.9 Respond appropriately to protect patients from any risk or harm."* Booklet 9, Rule 3 on Content of Patient Health Records also states that 3.1 *"The patient health record should where appropriate consist of, 3.1.1 All relevant clinical findings, including (but not limited to): - Who is making the notation in the patient health record (this is particularly important when multiple healthcare professionals are responsible for a patient health care record); The times of consultation and other clinical interactions; The full clinical history; The clinical examination; The differential diagnosis". 3.2, The compulsory elements of a patient's health record are " the date, time and place of consultation, the assessment of the patient, the proposed management of the patient; the medication and dosage prescribed; Details of referrals to specialists and other healthcare professionals."* The investigation found that Dr Nieuwoudt's clinical notes lacked integrity and were not attributable in compliance with HPSCA Booklet 9, 2022 Guideline 4 (4.2 and 4.3).
- 7.1.44 Dr Anjum and Dr Nieuwoudt did not thoroughly check Dr Conradie's work, review the investigation results or take appropriate action in managing Mr Mohoto's clinical condition. Therefore, the investigation found this to be contrary to Rule 10 of the HPCSA Handbook on Internship Training Guidelines for Interns, Accredited Facilities and Health Authorities, 2024, which provides *that "Medical Interns should be supervised by a registered medical practitioner with at least three (3) years (post-internship training) of clinical experience in that specific domain of training."* Rule 13 also states, *"Interns must be aware of their limitations, both in knowledge and skills and not hesitate to seek advice from senior colleagues."*
- 7.1.45 According to the medical records, Mr Mohoto's condition deteriorated whilst awaiting transport in Surgical Recovery. He was not reviewed by doctors from General Surgery until he died on 16 July 2024. Therefore, the investigation found that Dr Nieuwoudt, Dr Anjum, and the General Surgery Department clinically mismanaged Mr Mohoto.

- 7.1.46 Investigators established that Surgical Recovery is an extension of the EC. It receives multidisciplinary, **high-acuity** patients who need to be managed by a professional nurse. Because of the hospital's severe shortage of professional nurses, it has become usual practice for ENs and ENAs to manage Surgical Recovery. The Emergency Department statistics (ANNEXURE M) showed that in seven months between April 2024 and March 2025, Surgical Recovery had **nineteen (19) deaths**, six of which occurred in September 2024. The Surgical Recovery Unit, which admits high acuity patients, should not continue to operate without a professional nurse on a shift.
- 7.1.47 During the day shifts of 13 and 14 July 2024, from 07h00 – 19h00, Surgical Recovery was managed by EN N. Marney (EN Marney), who was in charge of the shift, and was with ENA P. Ramakgobedi (ENA Ramakgobedi). ENA Ramakgobedi confirmed during the interview that she received Mr Mohoto from EMS personnel. However, there was no evidence of the nurses' notes indicating the time he was received, monitoring of vital signs, intake and output chart, as he had a Ringer's Lactate drip inserted at NCMHH, medication administered, and any nursing care provided until the end of the shift at 19h00. When ENA Ramakgobedi was asked in what condition Mr Mohoto was when she received him from EMS personnel, she said she could not remember. The Investigators further asked her why she did not measure vital signs or write any notes. ENA Ramakgobedi said it is the practice that when a patient's vital signs are measured at EC, they would not be done on receiving the patient at the Surgical Recovery. Regarding the patient's condition, she could not explain why she did not document it. Vital signs measured on 14 July 2024 at 08h10 did not include the respiratory rate and temperature. ENA Ramakgobedi recorded Mr Mohoto's condition as unstable but failed to report to EN Marney or any doctor. There was no evidence that Mr Mohoto received food on either 13 or 14 July 2024.
- 7.1.48 The investigation found that Mr Mohoto was not managed according to the severity of his condition, and his basic needs were not cared for. Both EN Marney and ENA Ramakgobedi raised a concern with the Investigators that they were working under seriously adverse conditions without proper supervision. They expressed that the unit is abnormally busy with a high turnover of patients who are very ill. The investigation found that EN Marney and ENA Ramakgobedi acted contrary to SANC Acts or Omissions, R767 of 2014, which provides that, 4 *"failure to carry out such acts in respect of assessment, diagnosis, treatment, care, ... collaboration, and advocacy as the scope permits"*, and 5 *"failure to maintain the health status of the healthcare user under his/her care through – (a) assessing the health status of a healthcare user and the response of the body, ... (c) preventing accidents, injury or trauma, ... (f) providing specific care and treatment of the ill and the vulnerable and high-risk healthcare user, (g) monitoring vital parameters, including vital signs of the healthcare user, and (h) keeping clear and accurate records of all actions performed on the healthcare user"*, is an omission.

- 7.1.49 During a walkabout, the Investigators were shown two rooms outside the Surgical Recovery where doctors performed non-surgical and minor surgical procedures. Two junior nurses are expected to assist the doctors when performing these procedures. Investigators were informed that patients in Surgical Recovery sometimes receive blood products, and they must be monitored by the two nurses who are not adequately supervised, exposing them to practice outside their scope of practice.
- 7.1.50 During the night shifts of 13 and 14 July 2024, from 19h00 – 07h00, Surgical Recovery was managed by EN F. Langa (EN Langa), who was in charge of the shift, and she was working with ENA B. Chakela (ENA Chakela). ENA Chakela received Mr Mohoto from the day staff for the two (2) nights and measured vital signs. On 13 July 2024, at 20h00, BP was 133/102 mmHg, P was 99 b/min; at 04h35 on 14 July 2024, before the end of the shift, it was 147/118 mmHg, P was 68 b/min. Mr Mohoto was having **Stage 2 Hypertension**, was at risk of a cardiovascular accident (CVA), and needed urgent medical attention (ANNEXURE N). At 20h00 on 14 July 2024, BP had subsided to 104/68 mmHg, and P was 58 b/min. On 15 July 2024, at 04h05, BP was 108/70 mmHg, and P was 54 b/min. The saturation ranged between 89% (hypoxia) and 93% on room air, except for one episode of 98%. Mr Mohoto was hypoxic and was being nursed on room air. Temperature and respiratory rate were not measured. Mr Mohoto's vital signs were unstable. There was no evidence that these vital signs were reported to anybody senior, or a doctor, or that urgent medical care was provided. ENA Chakela could not provide the Investigators with the reasons why EN Langa or a doctor was not alerted. Investigators found that the care provided to Mr Mohoto was substandard, and he was not managed in line with the severity of his condition.
- 7.1.51 EN Langa was asked about her interaction with Mr Mohoto and the care she provided. She told the Investigators she could not remember anything except that she saw Dr Mathunda review him on 15 July 2024, at 07h00. She further informed the Investigators that she had raised a concern with Dr Mathunda about Mr Mohoto's deteriorating condition and the action plan. Dr Mathunda responded that he needed to discuss Mr Mohoto with the Internal Medicine doctors. EN Langa failed to record Mr Mohoto's deteriorating condition, the nursing care she provided, and Dr Mathunda's consultation. The investigation found that EN Langa and ENA Chakela's failure to report Mr Mohoto's condition and keep clear records were serious omissions, and they acted contrary to Regulations 4 and 5 of the SANC Acts or Omissions, R767 of 2014, stated above.
- 7.1.52 On 14 July 2024, Mr Mohoto was seen by Dr Mathunda at Surgical Recovery while awaiting his referral back to NCMHH; the time was not recorded. Dr Mathunda left without examining Mr Mohoto and recorded that he was sleeping, and for mental state examination (MSE) the following morning. There was no evidence that Mr Mohoto was reviewed by any doctor from General Surgery. Dr Nieuwoudt confirmed to the Investigators that Mr Mohoto was not reviewed by the doctors from the General Surgery Department for the entire period he spent in Surgical Recovery until he died.

- 7.1.53 On 15 July 2024, at 07h00, Dr Mathunda reviewed Mr Mohoto and recorded decreased lung volume on the right with crowding on the right ribs. He further noted a deviated trachea to the right with circumscribed consolidation on the right and left lobes. Dr Mathunda planned that the patient should not be transferred back to NCMHH and advised sonar/ CT abdomen to exclude TB, as he suspected PTB or Abdominal TB. There was no evidence that Dr Mathunda spoke to anyone in General Surgery, or that Mr Mohoto was formally referred to the Internal Medicine Department.
- 7.1.54 Later, at 12h38, Dr Zanab Abrahams (Dr Abrahams) from NCMHH reviewed and examined Mr Mohoto. His oxygen saturation was 83% (hypoxia) on room air. A respiration rate record of 89 br/min (severe tachypnoea) was cancelled and replaced with RR 20, and oxygen saturation of 94% on room air, but cancelled "room air" without recording the reason(s) or indicating if Mr Mohoto was on oxygen therapy or not. Dr Abrahams did not follow the HPCSA Booklet 9, 22, Rule 5 on Record Keeping, regarding Alteration of Patient Health Record, which states in 5.2 that *"the reason for an amendment or error must be specified on the record."* The blood gas (ANNEXURE O) recorded by Dr Abrahams did not reflect the oxygenation, respiratory or metabolic status, except for a pH, which was within the normal range. When questioned on why she did not record complete blood gas results, she did not provide a response. The original printout was not in the medical record. Mr Mohoto was confused, with a GCS of 14/15 and cold peripherally. Dr Abrahams recorded that the restraints be removed. There was no evidence that Dr Abrahams discussed Mr Mohoto with anyone from the Internal Medicine Department, even though she planned to.
- 7.1.55 During the interview, Dr Abrahams told the investigators that she went to the Medical Recovery Unit (POC) and found Dr Oss busy with resuscitation, and she left a message with a junior doctor. Dr Abrahams admitted that she never made a follow-up to ensure that Mr Mohoto was indeed seen by a doctor from Internal Medicine. When questioned why she did not manage Mr Mohoto by prescribing antibiotics or intubating him, she could not account. The investigation found that Dr Abrahams acted contrary to the HPCSA Booklet 1, Rule 5 on Duties to Patients, 5.1 patient's best interests or well-being, which states that health care practitioners must ... *"5.1.8 Apply their mind openly when making diagnoses and considering appropriate treatment. 5.1.9 Respond appropriately to protect patients from any risk or harm, ...5.1.13 In emergency situations, provide healthcare within the limits of their practice and according to their education and/or training, experience and competency under proper conditions and in appropriate surroundings. If unable to do so, refer the patient to a colleague or an institution where the required care can be provided; 5.1.14 Provide emergency interventions when required: In an emergency, where there is threat to life or limb (including a perceived threat) and where no appropriately trained healthcare professional is available, then the practitioner must intervene to the best of their ability."*

- 7.1.56 The investigation noted that on 15 July 2024, Mr Mohoto was not reviewed by the General Surgery Department doctors. It is a common cause in medical practice that if a patient is discharged but still in the ward, the doctor who discharged the patient is still responsible and should see the patient regularly and record in the medical record. This was echoed and confirmed by Dr Oliver, the Clinical Manager, and Dr Bhyat, the Head of Surgery from RMSH. Dr Nieuwoudt was responsible for providing care to Mr Mohoto or handing him over to the next incoming doctor, but failed to do so.
- 7.1.57 On 15 and 16 July 2024, PN V. Moima (PN Moima) and ENA T. Moloji (ENA Moloji) were on duty from 07h00 to 19h00. Only EN Moloji recorded nursing notes. Mr Mohoto had a mechanical restraint applied. He was sedated and not restless. Vital signs at 09h30: BP was within normal range, P was 107 b/min (tachycardia), and O₂ Sats were 94% on room air. Temperature and respiration rate were not recorded. At 12h38, when seen by Dr Abrahams, Mr Mohoto's condition had worsened. A note was made that Dr Abrahams was to discuss with Internal Medicine for review. Mr Mohoto was not reviewed. Oxygen therapy at 40% and 10L/min flow was commenced per oxygen mask. At 14h00, Mr Mohoto was still restrained, and there was no evidence that the restraint had been removed despite Dr Abrahams' request. The investigation noted that vital signs were not repeated before the end of the shift. There was no recorded evidence that EN Moloji reported Mr Mohoto's condition to PN Moima, as she had not made any notes. The investigation found that there was nursing and medical mismanagement of Mr Mohoto. He was not treated in line with the severity of his condition.
- 7.1.58 During the interviews, it was revealed that on 15 July 2024, EC had a crisis, and no nursing personnel had reported for duty. Mr G. Shong (Mr Shong), the Night Supervisor, removed ENA M. Peleho (ENA Peleho) from the Surgical Recovery Unit, leaving PN T. Mahlati (PN Mahlati) to work alone from 19h00 to 07h00 on 16 July 2024. PN Mahlati informed the Investigators that on 15 July 2024, during the night, Surgical Recovery had about 10 patients inside the unit on the beds, and approximately 25 patients were seated on chairs outside the unit, some with intravenous infusions. Mr Shong confirmed during the interview with the Investigators that he removed ENA Peleho and left PN Mahlati alone, and Surgical Recovery was overflowing.
- 7.1.59 There was no record of Mr Mohoto's condition when he was taken over from day staff the evening of 15 July 2024 and handed over to day staff the following morning. There was also no evidence of vital signs measured, medications administered, or any nursing care provided during the 12 hours PN Mahlati was on duty. This implies that due to the situation PN Mahlati was faced with, she never made contact with Mr Mohoto.
- 7.1.60 Mr Shong informed the Investigators that on the same evening, he left RMSH at 01h00 by the authority of the Acting Assistant Nursing Service Manager, Ms R. Lotz, as he was scheduled to attend a short-listing of interview candidates on 16 July 2024. He added that he was standing in for someone who could not come to work that evening. In essence, RMSH functioned without a night supervisor from 01h00 till 07h00 on 16 July 2024 in the

area that Mr Shong was responsible for. PN Van der Linde, the Operational Manager for A&E, mentioned that she did not remember receiving a handover report on the situation at night when she came on duty in the morning.

- 7.1.61 The investigation views this action as irresponsible and a lack of accountability by RMSH Nursing Management to leave nursing personnel without leadership and support when the situation was dire. Mr Shong could have assisted PN Mahlati, but she was left alone in a crisis situation. The investigation views PN Mahlati's failure to provide care to Mr Mohoto as beyond her control, and she did not wilfully neglect him, except that she failed to identify his serious condition, provide care, notify the doctor, and keep clear records. RMSH must, therefore, take full responsibility for the adverse conditions under which the nursing personnel practised and are still practising their profession, failure to provide care to Mr Mohoto, and his resultant death.
- 7.1.62 On 16 July 2025, EN Moloi recorded at 08h00 that Mr Mohoto was in a critical condition, appeared to be gasping and unresponsive, on a 40% 10L/min flow oxygen per mask. Vital signs measured, BP was 65/43 mmHg (hypotension), P was 35 b/min (bradycardia) and Sats of 94%. EN Moloi failed to alert PN Moima and any doctor, as evidenced by a lack of recording. At 09h20, PN Moima recorded that she informed Dr Abrahams about Mr Mohoto's condition, who informed her that she discussed him with an Internal Medicine doctor, but the name is not provided.
- 7.1.63 PN Moima continued to record that she went to POC and informed Dr P. Mwenze (Dr Mwenze), an MO, about Mr Mohoto. He responded that Mr Mohoto was not discussed with him, maybe with another doctor. He did not go to Surgical Recovery to see Mr Mohoto.
- 7.1.64 Dr Muwenze, when interviewed by the Investigators, refuted PN Moima's narrative, stating that he did not remember discussing a patient with a sister as explained. He questioned PN Moima's reporting if it did happen, and looking at his alleged response, it did not appear that he was provided with the patient's actual condition and the situation's urgency. He agreed that he never saw Mr Mohoto, as evidenced by the absence of his notes in the medical record, which he would have otherwise recorded. Investigators were provided with the call list, which showed that Dr Mwenze was post-call for POC on 16 July 2024, and the same was confirmed by Dr Penä, the consultant for General Surgery. The investigation found that it was highly likely that PN Moima informed Dr Mwenze about Mr Mohoto.
- 7.1.65 The investigation found that Dr Mwenze failed to respond to PN Moima's plea for assistance, and Mr Mohoto was left without help. There was no evidence that PN Moima returned to Mr Mohoto to provide emergency care within her scope of practice or tried to find other doctors to assist Mr Mohoto.

- 7.1.66 At 10h00, EN Moloi repeated the vital signs, and the findings revealed a BP of 53/45 mmHg, P of 25 b/min, Resp of 22 br/min and gasping, with Sats of 95%. They were all critically low and not compatible with life, except for the respiration and saturation. It was evident from these values that Mr Mohoto's condition deteriorated further. Mr Mohoto was not connected to a monitor for continuous monitoring. EN Moloi told Investigators that she used a mobile vital signs monitor that she connected to Mr Mohoto intermittently at the time she was measuring the vital signs. There was a need to attach Mr Mohoto to a monitor for continuous monitoring, and it was not done. Surgical Recovery was not equipped with the critical equipment necessary to care for the type of patients under its care.
- 7.1.67 On 16 July 2024, at 13h11, Dr Abrahams reviewed Mr Mohoto in SOC. According to the clinical notes, Mr Mohoto's condition had deteriorated with decreased consciousness and cold peripheries. Blood gas results (ANNEXURE P) with pH of 7.301, PO₂ of 8.85 kPa, and sO₂ of 59.9%. Electrolyte, K⁺ was 2.9. The metabolic status was not reflected. Dr Abrahams discussed Mr Mohoto with Dr L. Oss, a Community Service Doctor, from Internal Medicine, who promised to review him. Dr Oss advised Dr Abrahams to start Rocephin 2 g IVI, administer double-barrel oxygen, and that she would come later, which she did not do. Dr Oss, when asked about the reason she did not prioritise assisting Mr Mohoto, she could not provide a response but added that it was a common experience for medical doctors in the department to not be able to reach other departments due to the overwhelming workload in POC. After speaking to Dr Oss, Dr Abrahams attempted to insert a second intravenous line but was unsuccessful. There was no recorded evidence that Dr Abrahams activated an emergency response for assistance. At 14h45, Dr Abrahams recorded that Mr Mohoto was not responding, pupils fixed and dilated, peripherally cold.
- 7.1.68 There was no evidence that cardiopulmonary resuscitation was attempted, and any emergency drug such as Adrenaline was not administered, even though there was a five (5) hour lapse between when he was discovered gasping at 08h00 by ENA Moloi and when he was reviewed by Dr Abrahams at 13h11 and subsequently died at 14h45.
- 7.1.69 The investigation found that if Mr Mohoto had been reviewed daily by doctors from General Surgery, the serious medical problems he presented would have been identified and managed promptly. Dr Olivier and Dr Bhyat told the investigators that they believed Mr Mohoto's death was avoidable had appropriate actions been taken from the moment the initial blood gas and chest X-ray results were reviewed, acted upon and further referred to the Internal Medicine Department.
- 7.1.70 In view of the above, the investigation found that Dr Mathunda, Dr Abrahams from NCMHH, RMSH doctors, Dr Anjum and Dr Nieuwoudt from General Surgery, who knew about Mr Mohoto, Dr Muwenze and Dr Oss's failure to provide care to Mr Mohoto, was a serious omission and an opportunity missed to manage his condition. Doctors failed in their **"moral and institutional duties"** in contravention of the HPCSA, Regulation 4.6 on the Healthcare Practitioner Role, 4.6.2 healthcare practitioner's duty to provide healthcare, relieve pain, ... and 4.6.3. duties imposed upon healthcare practitioners working in specific institutions,

which must be consistent with the ethical and legal duties of healthcare practitioners. Furthermore, regarding Duties to Patients, 5.1 patients' best interests or well-being, states that "5.1.1 Always regard concern for the best interests or well-being of their patients as their primary professional duty,5.1.9 Respond appropriately to protect patients from any risk or harm."

- 7.1.71 A report compiled by Dr Nieuwoudt, the Medical Officer (MO) (ANNEXURE Q), was submitted to the Health Ombud on 20 February 2025. In her report dated 22 July 2024, Dr Nieuwoudt confirms that Mr Mohoto spent three days in the Surgical Recovery Unit without being monitored and reviewed by doctors from the General Surgery Department and referred to internal medicine. She also confirmed that Mr Mohoto was reviewed by two doctors from the NCMHH and only referred to internal medicine on 16 July 2024, shortly before he died. However, his condition began to deteriorate on 15 July 2024.
- 7.1.72 The report is void of the recorded evidence of active clinical management provided to Mr Mohoto following the chest X-ray and blood gas results. Dr Nieuwoudt's report confirms that Mr Moloto did not receive medical intervention congruent with his condition, and, therefore, the investigation found that all the doctors under whose care Mr Mohoto was did not provide him with care in line with the severity of his condition until he died on 16 July 2024.
- 7.1.73 Dr E. Olivier (Dr Olivier), currently a senior clinical manager, was the acting CEO in July 2024 when Mr Mohoto was admitted to the Surgical Recovery Unit until he died. She submitted a report dated 23 July 2024 (ANNEXURE R) to the Health Ombud, in which she stated the sequence of events from when Mr Mohoto was received at RMSH and attended to at the Surgical Recovery Unit on 13 July 2024 until he died on 16 July 2024. Dr Olivier's report is based mainly on the medical record of the doctors' clinical notes, vital signs, and investigation results. The report also refers to hearsay, as the information was not recorded in the medical record. The investigation also noted that the role of nursing care, or lack thereof, was not considered when compiling this report.
- 7.1.74 Dr Olivier's report outlines Mr Mohoto's history, the clinical investigations conducted, and the fact that he was seen at the Surgical Recovery Unit before he was discharged from the General Surgery Department, despite the chest X-ray results showing multiple lobar pneumonias, which were not managed. According to Dr Olivier, doctors from the General Surgery Department did not consult with doctors in Internal Medicine to manage Mr Mohoto's respiratory condition due to a low **CURB-65 Score of 1/6**. The Curb-65 score is a clinical tool to assess the severity of pneumonia. Mr Mohoto was kept in the unit while awaiting transport back to NCMHH.

- 7.1.75 In the report, Dr Olivier acknowledges that the severity of Mr Mohoto's respiratory condition was not identified and managed. Also, antibiotics were not prescribed. Doctors from the General Surgery Department failed to follow up on Mr Mohoto, who was still under their care. She further stated that the Internal Medicine doctor failed to review Mr Mohoto following a verbal discussion on 15 July 2024 with the psychiatric doctor. However, there was no evidence that the referral happened, as there was no record of which doctor Mr Mohoto discussed with.
- 7.1.76 The investigation found that Dr Olivier's report is merely a narration of the sequence of events leading to Mr Mohoto's death. While the report reflected what is in the medical record, the investigation found that RMSH missed the opportunity to conduct an internal investigation to obtain facts and identify gaps to improve quality.
- 7.1.77 During the interview, Dr Olivier told the Investigators that Mr Mohoto was still a responsibility of the General Surgery Department while he was occupying the hospital bed and was not handed over to the Internal Medicine. She added that changes have been introduced since the incident to ensure that no patient occupying the hospital bed is missed and not seen by a doctor. Dr Olivier revealed that in July 2024, the General Surgery Department implemented a morning handover round for discharged patients who were still in the Surgical Recovery Unit. She also mentioned that Internal Medicine implemented a similar system, where referrals are handed over to the next shift to prevent miscommunication.
- 7.1.78 Dr Olivier stressed that proper handover and communication are crucial to ensure continuity of care, especially when doctors are on call and may not be present the next morning.
- 7.1.79 The investigation found that all the doctors who had contact with Mr Mohoto from 13 – 16 July 2024, Dr Conradie (MI), Dr Nieuwoudt, Dr X Mathunda, Dr Z. Abrahams, all medical officers, and Dr Muwenze, who failed to assist PN Moima, acted contrary to the Health Professions Council of South Africa (HPCSA), Booklet 1 General Ethical Guidelines for the Healthcare Professions, Regulation 4, "**DUTY TO CARE**". There was a failure on their part as RMSH employees and professionals in their moral obligation and professional duty "*to provide health care*". HPCSA, Booklet 3 on National Patients' Rights Charter, Regulation 2, states, "*2.11 No one shall be abandoned by a healthcare professional who or a health facility which initially took responsibility for one's health without appropriate referral or handover.*" Additionally, they acted contrary to the HPCSA Guidelines on Keeping Patient Health Records, Booklet 9.
- 7.1.80 Dr Bhyat, currently the head of the Department of General Surgery at RMSH, was asked about his involvement with Mr Mohoto's management. He explained that he was not directly involved but learnt about Mr Mohoto during the department's morning meeting, where they discussed admissions and patients seen in SOC.

- 7.1.81 The Investigators solicited Dr Bhyat's view as the head of the unit on who was primarily responsible for treating Mr Mohoto and what should have happened. Dr Bhyat pointed out that the doctor in EC should have referred to the referral letter from NCMHH, conducted a proper assessment and identified the seriousness of Mr Mohoto's condition. Also, the General Surgery Department doctors missed an opportunity to act on the chest X-ray and blood gas results. Mr Mohoto should have been referred to the Internal Medicine Department for further management of the multilobar pneumonia revealed on the chest X-ray. Also, doctors from the General Surgery Department were responsible for monitoring Mr Mohoto in the Surgical Recovery Unit daily, whilst he was still in the unit, regardless of his discharge. According to Dr Bhyat, doctors from the General Surgery Department did not treat Mr Mohoto as a whole person but treated a surgical problem while his respiratory condition was ignored.
- 7.1.82 Based on the above, the investigation found that Mr Mohoto died as a result of:
- (a) Exposure to extreme cold at NCMHH.
 - (b) The general Surgery Department doctors failed to manage and/or refer him to the Internal Medicine Department.
 - (c) Failure by General Surgery Unit nursing personnel to inform doctors about the patient's condition and provide care in accordance with their scope of practice.
 - (d) Doctors from NCMHH failed to manage his respiratory condition following their examination findings on 15 July 2024.
 - (e) Failure by the doctor from the Internal Medicine Unit to respond on 16 July 2024 when he was asked for assistance.
 - (f) Failure to resuscitate Mr Moloto on 16 July 2024, when he was presenting with bradycardia of 25 b/min, and a BP of 53/45 mmHg.
- 7.1.83 Considering that there was no record that Mr Mohoto's temperature was measured, IV fluids were monitored, he was fed and/or bathed, the restraint was removed, and active cardiopulmonary resuscitation was performed, the investigation found this to be consistent with substandard care and poor record keeping.
- 7.1.84 If Mr Mohoto had been properly managed from the initial consultation and referred to the Internal Medicine Department in a timely manner, his life might have been saved.
- 7.1.85 The investigation found that failure by RMSH to treat Mr Mohoto's respiratory condition, monitor and manage vital signs, and resuscitate him resulted in his death, which was avoidable.
- 7.1.86 Therefore, the allegation that Mr Mohoto's death resulted from exposure to elements at NCMHH is **substantiated**, but he died as a result of **clinical mismanagement of pneumonia** at RMSH.

7.2 Circumstances surrounding Mr Petrus De Bruin's care at NCMHH and admission to RMSH

- 7.2.1 Mr Petrus De Bruin (Mr De Bruin), a 51-year-old, was admitted to NCMHH, Ward M5 on 30 July 2024 with **Treatment-Resistant Schizophrenia, Paranoid Subtype**, and a past diagnosis of **Substance Abuse Disorder**. Mr De Bruin was treated with antipsychotic Clozapine 100 mg (morning), 200 mg (at night), antiepileptic Epilim 700 mg (twice a day), laxative, Senekot 2 tablets at night, Folate 5 mg daily (B vitamin, B9), and hormone replacement therapy for hypothyroidism with Eltroxin 25 mg daily, all orally. On a few occasions, he was also administered Ativan to sedate him when he was showing aggressive behaviour.
- 7.2.2 From January 2024 until 30 July 2024, the day Mr De Bruin collapsed, the doctors reviewed him once a month, except in January and June 2024, when they reviewed him twice. The reviews concentrated on Mr De Bruin's mental state, behavioural patterns, and social or family issues.
- 7.2.3 During this period, evidence of a physical examination was recorded only on 27 January 2024. However, it was not a complete physical examination, as only a negative JACCOLD was reflected.
- 7.2.4 In view of the fact that Mr De Bruin was receiving medication such as Clozapine, known for its serious risks, such as bowel obstruction or perforation, severe hypotension, and reflex tachycardia, his physical condition was not monitored frequently enough to be able to identify and manage side effects and prevent complications promptly. There was no record of monthly assessment of vital signs such as blood sugar, urinalysis, and weight. According to the standard operating procedure on vital signs monitoring, such vital signs should be monitored at least once a month (ANNEXURE S). The investigation found that the nursing and medical management provided to Mr De Bruin lacked a comprehensive approach and concentrated on his mental status, neglecting his physical health.
- 7.2.5 On 26 January 2024, Mr De Bruin was diagnosed with pulmonary tuberculosis (PTB) through a Gene-Xpert, and it was Rifampicin sensitive. Mr De Bruin was sent for chest and abdominal X-ray investigations at RMSH. The X-ray results were suggestive of PTB and constipation, respectively. A telephonic prescription of Rifafour 3 tablets daily and Pyridoxine 25 mg tablet was given as advised by the doctor from Internal Medicine at RMSH. Mr De Bruin was thus commenced on anti-TB treatment. In addition, Mr De Bruin was put in isolation until 18 February 2024 and finished the course of PTB treatment in July 2024.
- 7.2.6 Mr De Bruin was reported to be taking and retaining his breakfast and night snacks well, including on 29 July 2024, the night before he collapsed. However, the night nurses did not record Mr De Bruin's condition before handing him over to the day staff.

- 7.2.7 PN Lekwene informed the Investigators during the interview that on 30 July 2024, at 07h55, Mr De Bruin collapsed and was unresponsive, with pinpoint pupils which were non-reacting to light, and vomited coffee ground vomitus. His BP was 120/100 mmHg; P was 100 b/min, Sats of 84%, and HGT was 3 mmol/l. Temperature, and the respiration rate were not recorded. Dr Jacobs was called, and she responded immediately. She was joined by Dr Melakeco. Mr De Bruin was treated with intravenous 50% Dextrose, Normal Saline infusion, a nasogastric tube was inserted, and oxygen therapy was administered via nasal cannulae.
- 7.2.8 According to Dr Jacobs' examination findings, GCS was 5/12 (Eyes -1, Verbal -1, Movement-3), mouth slightly deviated to the left, with increased tone and reflexes. Pupils were poorly constricted and reacting poorly to light. His skin was cold and clammy. Later, his vital signs improved. BP was 122/63 mmHg and 128/71 mmHg, P was 76 and 105 b/min, Sats of 98% on oxygen and 93% - 96% in room air, and HGT was 5.4 mmol/l and 6.5 mmol/l. Subsequently, arrangements were made with Dr Celliers at the Emergency Centre at RMSH, who accepted the referral and advised that Mr De Bruin be intubated.
- 7.2.9 According to Dr Jacob's notes, Mr De Bruin could not be intubated due to the unavailability of resuscitation equipment and drugs. Mr De Bruin's symptoms were suggestive of opioid overdose, organophosphate poisoning, or stroke, which are all medical emergencies, and intubating him was imperative to save his life should the condition deteriorate further. The unavailability of resuscitation equipment was confirmed by Dr Hammer during the interviews with the Health Ombud and Investigators on 12 December 2024.
- 7.2.10 The investigation found that NCMHH was not adequately prepared to handle medical emergencies and, therefore, posed a serious danger to the safety of Mr De Bruin and other patients in its care. Therefore, the immediate care provided to Mr De Bruin before referral to RMSH for further management was inadequate and would have resulted in his death had his condition worsened. At 09h50, Mr De Bruin was taken to RMSH by the EMS officials, accompanied by an NCMHH nurse.
- 7.2.11 On the same day at 10h50, Mr De Bruin was received at RMSH EC by PN M. Ngubane, who conducted a triage and allocated a Red colour code. Mr De Bruin was examined by Dr P. Lombard at 10h55. On examination, Mr De Bruin's nutritional status was "**wasted.**" Vital signs, BP was 101/67 mmHg, P was 107 b/min, Resp was 16 bpm, Temp was 36.2 °C, HGT was 4.3 mmol/l, Hb was 12.0 g/dl, and Sats of 87% on room air. Mr De Bruin was vomiting with hypersalivation and had involuntary, fine and fast muscle twitches (muscle fasciculations). 40% oxygen was administered with a face mask, and his O² saturation improved to 98%. GCS deteriorated to 3/15. The cardiovascular and abdominal examination did not reveal any abnormalities. There were bilateral expiratory crepitations with transmitted sounds on chest auscultation. Following the assessment, Dr Cillier's provisional diagnosis was **Suspected Brainstem/Midbrain CVA, Organophosphate Ingestion, Aspiration or Neuroleptic Malignant Syndrome (NMS).**

- 7.2.12 Following a treatment plan, the following interventions were carried out: Intravenous Ringer's Lactate was put up, a urinary catheter size 18 was inserted, and a urine dipstick was done. The oropharyngeal airway was inserted, and Mr De Bruin was suctioned. A nasogastric tube was replaced, and an O2 face mask was used to maintain Sats > 91%. Atropine 1mg and Midazolam 2.5mg x 2 doses were administered. Chest X-ray, CT brain, and blood investigations for FBC, U&E, ALT & AST(liver injury markers), Creatine Kinase (CK), Epilim Level, and Cholesterol were done. HIV rapid test was done, and the results were negative. Mr De Bruin was treated with Midazolam 2.5 mg and Atropine 1mg intravenously at 11h05 and 11h10, respectively.
- 7.2.13 There were no intracranial infarct areas, haemorrhage, or lesions on the CT Brain. The chest X-ray showed fine streaky infiltrates and was clear of aspiration. Only blood results for FBC were available in the medical record, and there were no significant deviations.
- 7.2.14 At 13h00, after the CT scan, GCS had improved to 11/15, BP dropped to 97/64 mmHg, P was 99 b/min, and Sats were 100%. The chest X-ray showed fine streaky infiltrates, aspiration was ruled out, and the CT brain was normal. Midazolam 2.5 mg intravenously was repeated at 13h10.
- 7.2.15 At 14h30, Dr Kantani (medical intern) re-examined Mr De Bruin, who appeared chronically ill and wasted. GCS had further improved to 12/15, and Hgt was 3.0 mmol/l. BP had improved to 101/67 mmHg. Venous blood gas results and repeat Dextrose 50% were ordered. There was no evidence that the dextrose was administered. At 15h30, Mr De Bruin was reviewed by Dr Penă, medication was prescribed, and he was placed on a fluid diet, intravenous fluid, and for a venous blood gas investigation. There was no evidence in the medical record that all the blood investigations conducted were reviewed and acted upon for any abnormality detected. The investigation found that vital signs monitoring was done after every two hours in the EC, which was inadequate for a patient with his clinical presentation and provisional diagnosis. The investigation reckoned that the staff shortage and high patient influx in the EC would make it difficult for patients to be monitored adequately.
- 7.2.16 At 17h48, Mr De Bruin was admitted to Medical Recovery (POC) for further management and blood sugar monitoring. Dr Naidoo, a medical intern, and Dr Van Zyl, a medical officer, both from NCMHH, reviewed him and discussed his condition with Dr Essop, a medical officer from RMSH. Mr De Bruin had improved, was fully awake, and was calm.
- 7.2.17 During his admission to POC, his condition gradually improved. However, there was no recorded evidence that the nursing personnel monitored his blood glucose levels four (4) hourly as prescribed until he was discharged, except at 7h30 on 31 July 2024, when it was 5.8 mmol/l. Vital signs were recorded only three times during the 24-hour admission period, which was inadequate based on his condition. The investigation found that the care provided to Mr De Bruin by the nursing personnel during his admission on 30 and 31 July 2024, both during the day and night shifts in POC, was substandard.

- 7.2.18 On 31 July 2024, at 16h50, Mr De Bruin was discharged and referred back to NCMHH after he was reviewed by Dr P. Lombard, a medical officer, with Dr Penă, the consultant from Internal Medicine, and Dr Mathunda, a medical officer from NCMHH.
- 7.2.19 The investigation established that following the admission and investigations, no final diagnosis was provided, and the possible cause of the hypoglycaemia and unresponsiveness was not determined.
- 7.2.20 The investigation found that Mr De Bruins's admission to RMSH was a result of hypoglycaemia and unconsciousness (unresponsive). However, the cause was not determined at RMSH.
- 7.2.21 Therefore, there was no conclusive final diagnosis, and Mr Debruin was fully recovered and referred back to NCMHH.

7.3 Circumstances surrounding John Louw's care at NCMHH and admission to RMSH

- 7.3.1 Mr John Louw (Mr Louw) is a 66-year-old patient who was declared a state patient in 2010 and admitted to West End Hospital on 18 May 2012. According to the medical records, Mr. J Louw is a known Schizophrenic, Epileptic, Hypertensive patient with neurocognitive disorder due to different aetiologies. His epilepsy was poorly controlled. He had a long-standing psychotic disorder with fixed delusions, which was possibly diagnosed around 1992, and an unsteady gait, requiring long-term institutional care.
- 7.3.2 Mr Louw was treated with long-acting injectable antipsychotic Clopixol depot 200mg, Rivotril/Clonazepam (antiepileptic), Sodium valproate (antiepileptic), Epanutin (antiepileptic), and Fluoxetine (antidepressant). According to the medical records, Mr Louw was observed to be experiencing neurocognitive decline, which was suggestive of possible neurodegenerative progression or medication side effects.
- 7.3.3 On 05 July 2024, PN Motlhole was on duty at night in Ward M2, where Mr Louw was admitted. The investigation established that the nursing notes at 20h00 stated that Mr Louw was in a "stable condition, no cough or problems raised," and were recorded by ENA K. Neels. During the interview, PN Motlhole told the Investigators that Mr Louw was at risk of "falling." When asked about the care she provided to Mr Louw that evening, Sr Motlhole informed the Investigators that she conducted **two hourly** checks on Mr Louw, the evidence of which was not recorded. There was no evidence of monitoring vital signs or a record of his clinical condition. Sr Motlhole attributed her failure to record Mr Louw's clinical condition and the care she provided to the high workload demand of administering medication to all the patients in the ward. She told the investigators that she delegated the task of writing nursing progress notes to the ENA.

- 7.3.4 Since nothing was recorded, Sr Motlhole was also asked about the morning routine on 06 July 2024 pertaining to Mr Louw. She told the Investigators that Mr Louw did not want to drink his morning tea at 05h00 and did not respond when she called him out. She checked on him again and saw that he was unresponsive but did not think it was serious. The investigation found that PN Motlhole proceeded to hand him over to the day staff without having investigated why Mr Louw was not responding. PN Motlhole also failed to notify the doctor on call about Mr Louw's condition. Therefore, the investigation further found that Mr Louw was not treated in line with the severity of his condition, and the care provided to him was substandard.
- 7.3.5 Additionally, the investigation found that Sr Motlhole acted contrary to the SANC Acts or Omissions, R767 of 2014, Regulation 5, which states that *"failure to maintain the health status of the healthcare user under his/her care through – (a) assessing the health status of a healthcare user and the response of the body... (g) monitoring vital parameters, including vital signs of the healthcare user, and (h) keeping clear and accurate records of all actions performed on the healthcare user", is an omission.*
- 7.3.6 On 06 July 2024, at 07h10, Mr Louw was unresponsive when taken over by Sr Mulaudzi from night staff. According to Sr Mulaudzi, at 07h45, Mr Louw was breathing spontaneously on room air, unresponsive to voice commands and pinching, with a decreased level of consciousness. Vital signs were measured: Temp was 36.1 °C, P was 82 b/min, Resp was 21 breaths/min, BP was 115/78 mmHg, and HGT was 7.4 mmol/l. The blood oxygen saturation was, however, not recorded. These vital signs were noted to be within normal limits despite his being unresponsive.
- 7.3.7 At 08h00, Sr Mulaudzi informed Dr Abrahams about Mr Louw's condition. Dr Abrahams came two hours later at 10h30, examined Mr Louw, and recorded the following findings: decreased consciousness and right-sided weakness, querying CVA. GCS was **9/15**. Right and left pupils were 1 mm and 2 mm in size, respectively. Quetiapine and Etomine were stopped. Blood for investigations, i.e. FBC, phosphate (PHS), U&E, C-reactive protein (CRP), Epilim levels, Treponema Pallidum Hemagglutination Assay (TPHA), and Vitamin B12, was drawn.
- 7.3.8 Mr Louw was subsequently referred to the RMSH Neurosurgery Department for a CT scan and further management. Arrangements were made with EMS at 10h40 to transport Mr Louw to RMSH. However, it took six hours and fifteen minutes for the EMS to collect Mr Louw. The reason for the delay was reported to be the unavailability of ambulances as they were all out responding to calls. While waiting for the ambulance, Mr Louw's vital signs were monitored thrice, with BP ranging from 125/74 mmHg to 138/82 mmHg, P from 74 b/min to 82 b/min, Resp was 18 br/min, and Temp was within normal parameters. The investigation noted that Mr Louw's condition did not deteriorate despite the long wait. Though his BP was increasing, it remained within normal parameters. Sr Mulaudzi recorded that at 16h00, Mr Louw started responding to voice commands and was moving his arm. Mr Louw was finally transported to RMSH at 16h55 by EMS.

- 7.3.9 Upon arrival at RMSH, a computed tomography (CT) brain scan was done, and a **large left acute subdural haemorrhage** was diagnosed. He subsequently underwent an emergency craniotomy on 07 July 2024 for Evacuation of Acute Left Subdural Haematoma. Postoperatively, Mr Louw was admitted to the intensive care unit (ICU) and received organ and ventilatory support. Mr Louw was nursed under neuroprotective sedation. A tracheostomy was performed in the ICU on 12 July 2024.
- 7.3.10 On 16 July 2024, Mr Louw's condition worsened due to re-bleeding at the surgical site. On his neurology assessment, his GCS was 2/10, and he was intubated. A CT Brain scan revealed an *"acute left parietal extra-axial haemorrhage, with mass effect demonstrated. There was an impression of complicated extra-axial haemorrhage, with associated collection within the area of haemorrhage, and left Middle Cerebral Artery (MCA) and Posterior Cerebral Artery (PCA) territory subacute infarcts"*. A Decompressive Craniectomy was performed, and the tying off of Vessels (MCA vv), as there was suspected Aneurysm. Postoperatively, he remained in the ICU but gradually improved and was transferred to a general ward. However, he developed hospital-acquired pneumonia, leading to respiratory distress and requiring a tracheostomy re-insertion.
- 7.3.11 On 23 July 2024, a CT Brain Scan was done, and it showed cerebral herniation, residual subdural haemorrhage, and superficial fluid collection; no aneurysm was demonstrated. Mr Louw remained in the ICU and made good progress; the GCS improved to 9/10, and he was intubated. Mr Louw was discharged from the ICU to the step-down in Ward A4 on oxygen via T-piece, where he received extensive rehabilitation.
- 7.3.12 On 02 September 2024, Mr Louw was decannulated. However, he developed Hospital-Acquired Pneumonia, resulting in respiratory distress. A tracheostomy was re-performed, and he was put back on a ventilator. Despite the complication, Mr Louw was weaned off ventilation and successfully decannulated on 18 September 2024. During the hospitalisation, Mr Louw was treated with Paracetamol 1g orally qid, Keppra 500mg orally bd, Clexane 40mg subcutaneously daily, and Piptaz 4.5g intravenously tds and completed a 14-day course.
- 7.3.13 From 02/10/2024, he remained stable but was aphasic and had residual right-sided hemiparesis. No further surgical interventions are planned, and he was recommended for continued rehabilitation.
- 7.3.14 On 28 October 2024, Mr Louw was discharged back to NCMHH on antiepileptic drugs, wound care on the tracheostomy site and for follow-up at the Neurosurgery Outpatient Department on 15 October 2025. At the time of the investigation, Mr Louw was bedridden and fully dependent on nursing staff for care.

- 7.3.15 Based on the evidence gathered from the medical records and the interviews, the investigation found that the nursing and medical care provided to Mr Louw at RMSH were of a good, expected standard. Mr Louw's admission to RMSH was a result of an **acute subdural haemorrhage** diagnosed on a CT Brain scan. Although Mr Louw was exposed to extremely cold conditions at NCMHH, "**exposure to elements**" was not focused on, and there was no finding for or against it at RMSH.
- 7.3.16 The investigation found that Mr Louw's exposure to extreme cold at NCMHH contributed to his neurological complications, which resulted in his being admitted to RMSH and undergoing cranial surgery twice.

7.4 Circumstances surrounding Mr Tshepo Mdimbaza's care and death at NCMHH

- 7.4.1 Mr Tshepo Mdimbaza (Mr Mdimbaza), 33 years old, was admitted to NCMHH as a state patient from Tswelopele Correctional Centre in Kimberley on 16 August 2022. He was diagnosed with **schizoaffective disorder, polysubstance abuse, and neurocognitive disorder**. He had a history of epilepsy, aggressive behaviour, and fighting. His initial treatment included medications for epilepsy, anxiety, and muscle relaxation, along with a topical treatment, and his medication was adjusted periodically to manage his condition.
- 7.4.2 He also had a chronic right ear infection due to **Proteus mirabilis** growth, which was treated with Ciprofloxacin ear drops. Despite initial improvement, his condition later worsened, leading to a change in treatment to oral Augmentin and acetic acid ear drops. He was booked for ENT assessments and a brain CT scan at RMSH, which revealed chronic otomastoiditis and cerebral atrophy but no signs of acute haemorrhage or infection. According to the medical staff and occupational therapist, his cognitive function declined over time, and he experienced epileptic fits frequently.
- 7.4.3 On 01 August 2024, Ms Shanda De Wee (Ms De Wee), a physiotherapist, told the Investigators that she observed Mr Mdimbaza being unable to hold a spoon while eating due to loss of strength and suspected that he might be having muscle weakness or motor retardation. Sr Rhodes informed the Investigators that Mr Mdimbaza presented with significant slowness in his daily activities, including eating and walking. The investigation established that despite his struggle to feed himself, his basic needs checklist plan for August 2024 did not include feeding. Also, professional nurses recorded no nursing notes about Mr Mdimbaza's clinical condition. Nursing notes were primarily written by the enrolled nurses and enrolled nursing auxiliaries.
- 7.4.4 According to the medical records, Ms De Wee informed Dr Melakeco about Mr Mdimbaza's inability to lift the spoon. However, Dr Melakeco did not examine Mr Mdimbaza or record clinical notes. She promised to conduct a medical workup the following day, which was not done. The investigation viewed this failure as a missed opportunity. Had Dr Melakeco examined and reviewed Mr Mdimbaza, she would have promptly identified any abnormalities and acted on them. In response to the missed opportunity, Dr Melakeco

stated that she may have missed reviewing the blood tests and doing a medical workup due to other commitments.

- 7.4.5 The investigation found that Dr Melakeco acted contrary to the HPCSA Booklet 1 General Ethical Guidelines for the Healthcare Professions, Regulation 4, "**DUTY TO CARE**". She failed in her moral obligation and professional duty "*to provide health care*". Furthermore, Dr Melakeco acted contrary to the HPCSA Guidelines on Keeping Patient Health Records, Booklet 9.
- 7.4.6 The investigation established that Sr Molaulu and ENA J. Mosikare were on duty in Ward M5 on 02 August 2024. However, there was no record of Mr Mdimbaza's clinical condition for the night, including upon taking over from day staff and handing over to the day staff the following morning on 03 August 2024.
- 7.4.7 On 03 August 2024, Sr Molaulu handed the ward over to ENA E. Chweu (Mr Chweu) by doing a headcount and not ensuring that patients, including Mr Mdimbaza, were awake. ENA Chweu told the Investigators that Sr Molaulu informed him that "*everything was fine*". It emerged during the interviews that Sr E. Rhodes (Sr Rhodes) was late for duty and did not take over the report from Sr Molaulu. At 07h30, Mr Mdimbaza was discovered unresponsive by Mr Chweu, contrary to Sr Molaulu's report. He measured his HGT, which was **critically low at 1.9 mmol/l** (severe hypoglycaemia). Upon her arrival after 07h30, Sr Rhodes was informed about Mr Mdimbaza's condition. Sr Molaulu and ENA Mosikare were called back to the ward.
- 7.4.8 Sr Rhodes confirmed that she had notified Dr Gadzama through a WhatsApp message. The Investigators were informed that Dr Gadzama was officially on leave. He then contacted Dr Liandri Van Zyl (Dr Van Zyl) at 08h05. Dr Van Zyl, in turn, requested Dr Kiasha Naidoo (Dr Naidoo), the medical intern, to go to the hospital and assist with the emergency and stated that she had not been informed about the nature of the emergency.
- 7.4.9 PN Molaulu and PN Rhodes attempted to secure an intravenous line but failed until Dr Naidoo, a Medical Intern on call, arrived at 08h30, followed by Dr Van Zyl, the MO on call, approximately 10 minutes later. According to Sr Rhodes, Dextrose 50% was administered, and the HGT improved to 3.4 mmol/l. The actual volume was not recorded. However, the nurse's notes reflected that Dextrose 50% x 2 was administered, which was unclear.
- 7.4.10 Dr Naidoo, the first doctor to arrive in the ward, informed the Investigators during the interview that she felt a faint pulse upon arrival and immediately assisted Sr Rhodes in securing an intravenous line, but they struggled until Dr Van Zyl arrived after 10 minutes at 08h40. Furthermore, only chest compressions were performed, and manual breaths were not administered as there was no ambubag. Also, Mr Mdimbaza was dehydrated and very cold to the touch. That there was no ambubag contradicts what Dr Van Zyl told the investigators about the ten (10) CPR cycles, including manual breaths.

- 7.4.11 According to the clinical notes, Dr Van Zyl arrived at 8h30, which was unlikely according to Dr Naidoo's account. Dr Van Zyl found Mr Mdimbaza unresponsive, HGT 1.1 mmol/l. The intravenous line appeared infiltrated, and she commenced CPR. ENA Chweu told the Investigators that the oxygen cylinder that was available in the ward was empty, and he had to get one from another ward, which took him six to seven minutes. When he arrived with the oxygen cylinder, it lacked the connection for the oxygen tubing. He stated that he had to look for the connection. The investigation found that this caused further delay for O₂ provision to Mr Mdimbaza.
- 7.4.12 Furthermore, Dr Van Zyl informed the Investigators that when she requested a defibrillator, she was told that it was not charged. She left the resuscitation scene to collect a defibrillator from the next ward. Upon returning and after 10 CPR cycles, a faint pulse was felt. CPR was continued, and further attempts were made to secure the intravenous line. There was no account of whether the defibrillator was used to administer shocks, except that it was used for electrocardiogram (ECG) tracing. Furthermore, there was no evidence of an attempt to intubate Mr Mdimbaza.
- 7.4.13 The investigation noted that no vital signs were recorded for Mr Mdimbaza before and during the resuscitation, except for a saturation of 57% in room air, which further deteriorated to 41%. Sr Rhodes told the Investigators that Mr Mdimbaza's BP could not be measured as the BP monitor's battery was flat due to a power outage on the morning of 03 August 2024. No other vital signs were recorded, such as temperature, heart rate, or respiration rate, which could be measured manually and did not require a monitor.
- 7.4.14 At 09h28, Mr Mdimbaza had fixed and dilated pupils, no pulses, and no breathing efforts. Dr Van Zyl certified Mr Mdimbaza dead with the diagnosis of **Hypoglycaemia** (query cause) and **Hypothermia**.
- 7.4.15 Following Mr Mdimbaza's death, a postmortem was performed on 05 August 2024. Both lungs were congested, and the kidneys were swollen on the cut section. According to the report, Mr Mdimbaza was found dead on 03 August 2024, at 09h28. This narrative is consistent with what Dr N. Kantani, the Northern Cape Provincial Head of Psychiatry, told the Ombud during an interview on 14 January 2024, that Mr Mdimbaza was "**found dead and was not resuscitated.**" However, none of the nurses and doctors revealed that to the Investigators. The investigation found this to be a severe discrepancy and contradiction, casting doubt on the truthfulness of the information provided during the interviews and submitted written statements. The cause of death was recorded as "**Consistent with exposure.**"

- 7.4.16 The investigation noted that Sr Molaulu, Sr Rhodes, ENA Chweu, and Dr Naidoo's versions were based on the interviews and their written statements, as nothing was recorded in the nursing notes, including the resuscitation sequence of events. All the statements by nurses and doctors were written and submitted between 28 August 2024 and 31 October 2024, a month or more after the incidents occurred, except Dr Naidoo, who did not write or submit a statement.
- 7.4.17 The investigation found the information to be unreliable as it could not be verified against recorded notes. It should be noted that the investigation found several contradictions. According to Dr Van Zyl, the initial HGT measured at 7h30 was 1.1 mmol/l and was managed with Dextrose 50%.
- 7.4.18 Dr Naidoo told the Investigators that manual ventilation breaths were not administered as the ambubag was unavailable, contrary to Dr Van Zyl, who, when specifically asked about the delivery of manual breaths, asserted that they were administered. The investigation attributed these contradictions to inadequate record-keeping and the failure by all those involved to write the incident reports at the time they occurred, when the facts of what happened were still fresh in their minds.
- 7.4.19 Based on the above, Mr Mdimbaza's death is found to have resulted directly from exposure to extreme cold and failed resuscitation due to a lack of resuscitation equipment at NCMHH.

8. FINDINGS

Following the investigation, the Health Ombud established the following findings:

8.1 Circumstances surrounding Mr C. Mohoto's care and admission to RSMH

- 8.1.1 Mr Cyprian Mohoto, a 37-year-old male, was admitted to NCMHH on 29 October 2020 with bipolar disorder, schizophrenia, substance abuse disorder and intellectual disability.
- 8.1.2 He was managed with polypharmacy for his unstable mental illness. He had developed resistant schizophrenia. His treatment during the latter part of his hospital stay was characterised by a litany of errors, misdiagnosis, mismanagement and unprofessional treatment or neglect by both nursing and medical healthcare personnel.
- 8.1.3 On the morning of 13 July 2024 at 07h30, Mr Mohoto collapsed on the ward with BP 89/61 mmHg, Pulse 46 bpm, O₂ saturation 94% on room air and HGT 4.7 mmol/L. The patient was cold with a temperature of 35.2°C. Dr Mathunda (medical officer) ordered that a Ringer's Lactate drip be infused while *en route* to see the patient. The patient had vomited black/brown vomitus.

- 8.1.4 During this period, the hospital experienced a lack of electricity supply due to damage to the electricity substation and electricity cable theft. Consequently, the HVAC system was not working. Furthermore, there were no warm pyjamas or blankets to warm patients during the bitterly cold winter months (including this July). The patient was, therefore, exposed to extreme cold.
- 8.1.5 Dr Mathunda examined the patient and diagnosed severe constipation secondary to clozapine, which the patient was on. Dr Mathunda ordered a fleet enema, drip and suction. He discussed and referred the patient to Dr Anjum, a medical officer at the RMSH General Surgery Department. At NCMHH, Dr Mathunda handed the patient to a colleague, Dr Beukes, while awaiting transport to RMSH. The patient's BP improved on Ringer's Lactate drip to 120/84 mmHg, but he remained bradycardic at 47 bpm and hypothermic at 35.2°C by 12h35.
- 8.1.6 The patient arrived at the Emergency Centre (EC) at RMSH at 13h30. Vital status of the patient was not fully determined at the EC. The patient was referred to the SOC Surgical Recovery Unit, where a medical intern, Dr Conradie, examined the patient and noted that the patient was confused, restless and shivering with GCS 14/15. The abdomen was soft and non-tender but mildly distended, with bowel sounds present. Patient passed pebble-like hard stools mixed with soft stool (patient had earlier received an enema at NCMHH). The chest X-ray showed multilobar pneumonia, for which the intern prescribed oral antibiotics as TTO, as the patient was being referred back to NCMHH.
- 8.1.7 The patient was presented to senior doctors from the Surgery Department, Dr Anjum, who had accepted the referral from Dr Mathunda and Dr Nieuwoudt. Dr Nieuwoudt examined the patient and discharged him on Lactulose. She did not manage or treat the multilobar pneumonia demonstrated on the chest X-ray. The patient was not formally referred or discussed with the Internal Medicine Department regarding his pneumonia either. The patient remained in SOC while awaiting transport back to NCMHH. He stayed for three days without being managed or examined by any doctor from the Surgery Department, but Dr Mathunda from NCMHH did a cursory review of the patient on 15 July 2024 at 07h00 and noted signs of right lung pneumonia but did nothing about it.
- 8.1.8 The patient's condition deteriorated while in SOC. Later that day, at 12:38, Dr Abrahams from NCMHH reviewed the patient. She reported that she attempted to discuss the patient with the Internal Medicine doctor, Dr Oss, who was busy with a resuscitation and never got to discuss the patient.
- 8.1.9 The patient died on 16 July 2024. He started gasping at 08h00 and was unresponsive with BP 65/43 mmHg, Pulse 35 bpm and saturation of 40% on a 10L/min Oxygen mask. Dr Mwenge, a medical officer at POC Internal Medicine, was summoned for help but failed to assist. The patient was declared (certified) dead by Dr Abrahams at 14h45 after failure to resuscitate from 13h11 when she started to review the patient at SOC.

- 8.1.10 During this acute episode of illness, the patient's medical records from both nursing and medical staff were woefully inadequate. There was no communication or proper handover between nurses, between doctors and between nurses and doctors, thus compromising continuity of care. There was a severe shortage of nursing personnel, resulting in junior nurses taking sole charge of service units and working unsupervised in both hospitals. The nursing shortage at the acute care/reception units at RMSH was very dire, resulting in many patients, including Mr Mohoto, remaining unmonitored despite the critical nature of their conditions.
- 8.1.11 There is generally a lack of supervision of junior doctors in both hospitals, and junior doctors, including interns, are left to make final decisions on patients, including inappropriate discharges.
- 8.1.12 Mr Mohoto's death could have been avoided if the attending doctors had appropriately and timely managed his pneumonia, which was evident on chest X-ray. The patient's exposure to extreme cold, owing to the non-functioning of the HVAC system and a lack of warm clothing and blankets at NCMHH, predisposed the patient to pneumonia. This again is a needless exposure which could have been avoided by diligent repairs to the electricity supply and appropriate procurement of warm clothing and blankets.
- 8.1.13 Therefore, NCMHH and RMSH should take full accountability for Mr Mohoto's death.

8.2 Whether the death of Mr T. Mdimbaza was consistent with exposure to cold conditions.

- 8.2.1 Frequent power outages affected the heating system, and Mr Mdimbaza was cared for in an extremely cold environment without proper clothing and blankets to keep warm.
- 8.2.2 Mr T Mdimbaza required close observation as he had motor retardation and needed assistance with feeding. He had reached a point where he could no longer lift a spoon to eat, and there was no documented evidence that he was assisted during the period before his death.
- 8.2.3 Alarming, nursing personnel failed to measure Mr Mdimbaza's vital signs on 03 August 2024, shortly before his death. Furthermore, the investigation found that staff did not develop a tailored care plan to address Mr. T Mdimbaza's specific needs. Mr Mdimbaza was not managed in line with the nature and severity of his condition. Nursing personnel acted contrary to Regulation 5 of the SANC Acts or Omissions, R767 of 2014.
- 8.2.4 Resuscitation was delayed as the resuscitation equipment was not ready, and some equipment was unavailable or not functional. This was not compliant with the Norms and Standards Regulations.

- 8.2.5 The postmortem examination of Mr Mdimbaza revealed congestion in the lungs and kidneys, consistent with the pathophysiological changes associated with hypothermia. Research indicates that hypothermia can lead to pulmonary oedema characterised by interstitial and alveolar oedema (Hleşcu, Grigoraş, & Amalinei, 2024). The kidney congestion may be attributed to the systemic hemodynamic perturbations and microvascular bed lesions associated with hypothermia.
- 8.2.6 Dr Kirimi's complaint letter, dated 19 July 2024 and addressed to the Acting HOD, detailed the adverse circumstances under which patients in NCMHH were subjected to, which negatively impacted their health and violated their human rights. He mentioned that all four patients were cared for in a "freezing environment" and that Mr Mdimbaza died of **hypothermia**. The postmortem findings corroborates Dr Kirimi's assertion.
- 8.2.7 Mr Mdimbaza's cause of death, according to the postmortem report, was "**consistent with exposure**." Therefore, the investigation found that the allegation that Mr. Mdimbaza's death was "**consistent with exposure**" and **hypothermia** is substantiated.
- 8.2.8 Thus, NCMHH should take full accountability for Mr Mdimbaza's death.

9. ADDITIONAL FINDINGS

- 9.1 The investigation found that the leadership instability in the Northern Cape Department of Health Provincial Office has negatively affected service delivery, safety, and the quality of patient care at NCMHH and RMSH. Therefore, the provincial office should take full accountability for the deaths of Mr Mdimbaza and Mr Mohoto.
- 9.2 NCMHH and RMSH failed to provide some supporting documents, such as policies and standard operating procedures, to assist the investigation.

9.3 Northern Cape Mental Health Hospital Governance

- 9.3.1 The four incidents resulted from serious systemic deficiencies with regard to leadership, communication, sound financial stewardship, accountability, supply chain and procurement processes. These had a bearing on the substandard care provided at NCMHH and the adverse working conditions under which healthcare personnel carry out their duties.
- 9.3.2 The investigation found a systemic lack of leadership and poor management at all levels, including the CEO, the Quality Assurance Manager, Nursing Service Manager, and Operational Managers of the wards where the patients' incidents occurred. It was also noted that there was a lack of consequence management; hence, there were challenges with chronic late arrival on duty amongst nurses and managers.

- 9.3.3 NCMHH functions without finance, supply chain management, and Infrastructure (maintenance) departments. These functions are managed centrally at the Provincial Office, which causes delays in procuring supplies and services to address challenges at the hospital.
- 9.3.4 The NCMHH CEO's office lacks good financial stewardship and fails to demand quality service from service providers, as witnessed by the poor quality of pyjamas and blankets that did not meet the specifications, and inappropriate furniture and equipment, e.g., new specialised beds and golf carts. The process of awarding the tender was not revealed to the Investigators.
- 9.3.5 The investigation gathered that there is a lack of transparency regarding decision-making, poor communication, and a lack of synergy among the executive management team at NCMHH.
- 9.3.6 The Investigators established that the NCMHH had significant governance shortcomings, particularly regarding formulating standard operating procedures (SOPs) and protocols for nurses and doctors.
- 9.3.7 The investigating team found no evidence that doctors and nurses at NCMHH and RMSH have access to SOPs/protocols to guide their work and instead relied on verbal instructions. Interviews revealed that nurses were unclear about the SOPs governing night supervision and lacked clear guidance on taking vital signs.
- 9.3.8 The investigation revealed that professional nurses at NCMHH were assigned night supervision on an *ad-hoc* basis, with no clear protocol or consideration for seniority or experience. In some cases, junior registered nurses were tasked with night supervision.
- 9.3.9 In essence, no supervision took place except to conduct a roll call and receive night reports. The NCMHH Nursing Management team noted that this lack of formal protocols and accountability made obtaining clear answers regarding incidents that occurred during night shifts difficult.
- 9.3.10 The Investigators also found that the NCMHH did not conduct clinical audits. The Acting Quality Assurance Manager, Sr V. Nero, told the investigators that medical records clinical audits were not conducted due to staff shortage. Sr Nero acknowledged the negative impact this has on the safety and quality of care rendered.

- 9.3.11 Additionally, the investigation established that the Acting Quality Assurance Manager was not formally appointed in accordance with prescribed quality assurance management protocols within a tertiary or specialised facility. Instead, it was a verbal delegation from the CEO, Mr Links, who asked her to assist with quality assurance matters. Additionally, she had not formally accepted the delegation by signing any document and did not have a job description.
- 9.3.12 Furthermore, the investigation found that the Quality Assurance Unit was inefficient and ineffective. The Quality Assurance Manager lacked guidance and stated that she was unsure of what was expected of her most of the time. She demonstrated little understanding of the National Guidelines for Patient Safety Incident Reporting and Learning. She also expressed concern that her unit lacked the human resources to adequately manage the quality assurance responsibilities.
- 9.3.13 The investigation found that professional nurses did not document patient progress in nursing progress reports. Only enrolled nurses and enrolled auxiliary nurses wrote in the patients' progress notes. Moreover, no care plans were made to manage the challenges experienced by all patients under investigation, which indicated a significant gap in quality patient care.
- 9.3.14 It emerged during interviews that despite the staff shortage, managers spend a lot of time in meetings instead of carrying out their management and supervisory duties.
- 9.3.15 The oversight for doctors was lacking, as there were serious gaps identified in clinical management and record-keeping.
- 9.3.16 The Ombud was informed that doctors were performing outreach assignments without being supplied with telephones, and some destinations were about 700 kilometres away from base. When they encountered emergencies, they would be stranded with no form of communication to seek help, putting their lives and safety in danger.

9.4 Emergency Preparedness:

- 9.4.1 The investigation found that NCMHH lacked suitable stretchers and emergency beds, so patients were resuscitated on the floor and on mounted patient beds, which were not suitable for resuscitation. The available emergency rooms were far from the patient care areas, not equipped with resuscitation equipment and could not be utilised. Oxygen cylinders, defibrillator and Ambu bags were not ready for use, putting patients who require emergency management at risk due to delays.

- 9.4.2 Dr Jacobs told the Investigators that she could not intubate Mr De Bruin before sending him to RMSH due to the unavailability of the resuscitation equipment and drugs. It also emerged that NCMHH healthcare providers were not trained in Basic Life Support (BLS), which poses significant risks to patient safety and the provision of quality care. Therefore, healthcare personnel lacked the necessary skills to conduct successful resuscitations, and NCMHH was non-compliant with the Regulated Norms and Standards requiring that professional nurses be trained in BLS.
- 9.4.3 There was no evidence that disaster and fire drills were conducted with all personnel; therefore, the NCMHH staff were not trained in disaster management and would be unprepared if a disaster were to occur. These findings highlight significant concerns regarding the hospital's ability to provide timely, safe, and quality patient care.

9.5 Infrastructure

- 9.5.1 NCMHH was built in 2005 and has not received substantial upgrades or refurbishment since its commissioning in 2019. The poor workmanship in the construction has resulted in infrastructure and sewage reticulation systems failures, leading to pipe spillages and toilet blockages. Sewage was found coming out of one of the wards' showers, indicating significant plumbing problems, and the shower could not be used (ANNEXURE T). Although hospital staff reported that the shower was not in use, this finding raises concerns about the facility's overall sanitation and hygiene. Despite the allocation of budget and personnel, maintenance needs of the hospital infrastructure do not appear to be addressed on an ongoing basis.
- 9.5.2 An *in-loco* inspection by the Ombud investigators confirmed crumbling infrastructure in most areas of the hospital, including damp-soaked walls, corroded flooring, damaged ceilings in various departments due to the leaking roofs, blocked toilets, broken windows and doors, exposed electric wires (ANNEXURE U), filthy, foul-smelling ablution facilities, and a non-functional HVAC system. The investigators were told that the non-functional HVAC system left the wards unbearably hot in summer and extremely cold in winter. Broken windows remain unfixed for an extended period, thus posing a security breach, and patients abscond. Mr Links, in a letter dated 08 November 2024, wrote to the HOD appraising him of the challenges NCMHH is facing regarding the patient accommodation and crumbling infrastructure (ANNEXURE V). The Investigators were shown a broken office door in T Block, risking the danger of a fatal accident should the door fall onto someone.
- 9.5.3 All the electromagnetic doors were not functioning because of a lack of electricity supply and were kept open by placing rocks or heavy objects. This poses a security risk in case of a disaster such as fire. Should the doors close, workers and patients will be trapped without a possibility to escape. The investigation found that NCMHH was a "**death trap**" unless this **situation was attended to** and fixed as a matter of urgency. The grounds were observed to be unkempt with long overgrown grass and weeds providing ground for snakes and other pests, which are reportedly common on the premises.

- 9.5.4 NCMHH operates at only 53% capacity, with just 153 out of 287 commissioned beds in use. This reduced capacity is due to infrastructural issues, staff shortages, and financial constraints, all of which hinder the hospital's ability to deliver quality care and result in underutilisation of the facility amid high demand in the Province. Mr Riet, the Chief Director for Infrastructure and Dr Alastair Kantani attested that there was no maintenance plan in place to address maintenance issues.
- 9.5.5 NCMHH experienced frequent electricity shortages caused by repeated cable theft from the local power substation, which forced the hospital to rely on a generator. The HVAC system was nonfunctional owing to a lack of electricity and could not be powered by the generator. s Nursing staff and doctors said that patients were subjected to bathing with cold water, and the wards were "freezing cold." All interviewed clinical personnel told the Investigators in no uncertain terms that NCMHH becomes unbearably cold in winter.
- 9.5.6 During winter months, this situation was worsened by a lack of proper warm clothing and shoes for patients. In addition, Investigators were informed that personnel bought bath tubs (ANNEXURE W) for patients with their own money for them to be able to bathe, and on many occasions, personnel found themselves having to provide basic necessities such as "food" for patients when NCMHH failed to provide this.
- 9.5.7 Investigators were informed that NCMHH has been operating without telephones since 2020. Healthcare providers were not provided with cellphones for official use, which placed a financial burden on them to use their own personal airtime and data for official purposes.

9.6 Pharmacy

- 9.6.1 The investigation revealed that the NCMHH pharmacy is headed by Dr Malgas, a psychologist. During the interview, Ms Carla Schoeman, the pharmacist, cited challenges such as communication breakdowns and a lack of support.
- 9.6.2 The investigation established that NCMHH has only one pharmacist, Ms Schoeman, who works with a community service pharmacist. At the time of the onsite investigation on 23 January 2025, Ms Schoeman stated that the community service pharmacist's contract was ending, and the appointed Intern could not resume duty due to work permit challenges.
- 9.6.3 The investigation found that the pharmacy had a staff shortage. During interview, Ms Schoeman reiterated that the pharmacy was severely understaffed, with only two staff members. As a result, her management functions suffered. She further informed the Investigators that the NCMHH pharmacy dispenses medication to Correctional Services under OPD and covers West End Hospital as well, which is approximately six kilometres away.

- 9.6.4 The NCMHH pharmacy was experiencing challenges with transport, which resulted in delays in receiving supplies. Furthermore, the medicine depot was allegedly not adhering to the delivery schedules, often delaying supplies by a week or more.
- 9.6.5 The investigation established that NCMHH pharmacy uses the RX Solution System for stock control management. However, Ms Schoeman informed the Investigators that the system was not working consistently and was therefore unreliable. She further stated that it took too long to fix it. This negatively impacts the smooth running of the pharmacy and medicine control management.

9.7 Shortage of staff at NCMHH

- 9.7.1 NCMHH has 153 operational beds and is currently experiencing significant shortages in key positions, which negatively impact service delivery and operational efficiency. Table 2 below depicts the ward capacities, their occupancy and the type of patients accommodated.

Table 2: Ward Capacity and Occupancy (NCMHH)

Ward No.	Number of beds	Type of patient	Capacity
B1	28	Male Chronic Patients	100%
B2	10	Female State Patients	100%
B3	10	Acute Involuntary Female Patients	100%
B4	15	Voluntary Assisted & CAMHS	75%
B6	11	Acute Involuntary Male Patients	39.2%
M2	26	Male State Patients	100%
M3	15	Male State Patients	100%
M5	18	Male State Patients	100%
Forensic Observation Unit	10	Male Forensic Patients	50%

- 9.7.2 Ward B6: This acute involuntary male ward is a 28-bed unit, but due to infrastructure challenges, it is currently using only 11 beds.
- 9.7.3 Ward B4: Voluntary, Assisted, and Child and Adolescent Mental Health Service (CAMHS), 20-bed unit, using only 15 beds to accommodate admissions.
- 9.7.4 Forensic Observation Unit: This is a 10-bed unit using only 5 beds, without a professional nurse on duty at night. The unit accommodates one gender of patients at a time, as it does not mix genders.
- 9.7.5 The Investigators interviewed Sr Mintor, a Senior Nursing Service Manager, to obtain an overview of the hospital's nursing coverage. The team also reviewed relevant documents and records to verify the information provided. Table 3 below shows the nursing staff complement that covers the entire hospital.

Table 3: Nursing Staff Complement

Category	Permanent Posts	Contract Posts
Nursing Service Manager	1	None
Quality Manager	1	None
Operational Managers	5 (3 with advanced psychiatry)	None
Professional Nurses with Advanced Psychiatry	2	None
Professional Nurses with Basic Psychiatry	29	None
General Professional Nurses	4	None
Enrolled N	8	5
ENA	33	13

9.7.6 Of the 29 professional nurses, one has been granted a paid study leave for advanced psychiatry.

9.8 Staffing Ratio

9.8.1 The investigation established that during day shifts, the hospital operates with one professional nurse per shift, working with two nurses, either two ENs or one ENA or one EN. At night, a PN is allocated either one EN or one ENA.

9.8.2 The forensic observation unit does not have a professional nurse working at night, which is a serious safety risk.

9.9 Quality Assurance Management

9.9.1 The investigation revealed that Ms V. Nero, a professional nurse who was assigned by the CEO without a formal appointment or job description, heads the Quality Assurance Unit.

9.9.2 Ms Nero told the investigators that she had not received any formal training since occupying the role of the Quality Assurance Manager in April 2023. She stated that she was also responsible for Infection Prevention and Control, Complaints Management, the Ideal Hospital Framework, and the District Hospital Information System (DHIS) for the health establishment and supervising the clerks. She stated that she feels overwhelmed and undervalued in her role.

9.9.3 The investigation established that the four incidents were reported as Patient Safety Incidents and were captured in the Patient Safety Incidents Register. However, NCMHH did not comply with the National Guidelines for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa Version 2 – 2022 (National Guideline for PSI Version 2 – 2022). The Patient Safety Incident Reporting forms were not completed within 24 hours as stipulated in the National Guideline for PSI Version 2 – 2022, except for the social worker, Ms R. Humampe, who informed Mr Mdimbaza’s family about his death.

9.9.4 Ms Nero confirmed that no formal investigations had been conducted for all the incidents, and investigation reports with findings, contributory factors, recommendations, and evidence of implementation could not be provided. Thus, NCMHH missed an opportunity to use the incidents to learn for all personnel.

9.10 Patient Record Keeping

9.10.1 The investigation found that the analysed patients' records did not comply with guidelines on principles of good record keeping. When writing clinical notes, doctors did not consider the HPCSA Guidelines on keeping the Patient Health Records Booklet 9, clauses 3 and 4 regarding all the information to be maintained after consulting a patient. Also, the nurses failed to comply with the SANC Acts or Omissions, R767 of 2014, Regulation 5, which states that *"failure to maintain the health status of the healthcare user under his/her care through – (a) assessing the health status of a healthcare user and the response of the body... (g) monitoring vital parameters, including vital signs of the healthcare user, and (h) keeping clear and accurate records of all actions performed on the healthcare user"*.

9.10.2 The following non-compliance were identified:

9.10.2.1 Clinical notes pages were not identified with the patient's name or hospital number. The numbering of pages was not done (ANNEXURE X). The times of consultations were not consistently recorded. There was excessive use of abbreviations, some of which were not clear. Clinical notes were ambiguous, and some symbols were not internationally recognised. Handwriting and signatures were illegible, and the culture of writing a full name and surname before attaching a signature was not practised. Nurses' clinical notes were written mainly at the change of shifts, and the patients' clinical condition was not documented.

9.10.2.2 Professional nurses rarely made entries, except for medication administered. ENs and ENAs made entries, focusing on taking over from the previous shift. The reports did not show clinical condition of patients and monitoring data.

9.10.2.3 No notes were taken when the doctors reviewed patients during rounds, and the doctors round book was not used. The investigation found that poor record-keeping negatively affected the continuity of care and the safety of patients.

9.11 Laundry and Patient Clothing

9.11.1 The investigation established that the NCMHH laundry department had three (3) supervisors between 2019 and 2024. The store manager, Mr Modise, told the Investigators that he started supervising the laundry team by mid-August 2024.

- 9.11.2 The interviews with the laundry staff revealed that there were no systems in place regarding linen management processes at NCMHH. Linen inventory was non-existent, and there was no record of the number of linen items and patients' pyjamas, nightdresses, or gowns in the laundry. Furthermore, a concern was raised that linen was disappearing, and that available linen was insufficient to service all the patients. The absence of a linen management system made keeping track of the linen stock impossible.
- 9.11.3 The investigation established that there were times during winter when there was no power supply, the laundry staff could not distribute and supply all the wards, and patients would have to go without blankets. During this period, laundry was done off-site at RMSH.
- 9.11.4 The investigators were told that patients were supposed to have three blankets each. However, they sometimes did not have any since linen and clothing could not always be washed and delivered on time. Ms B. Van Zyl informed the Investigators that she had witnessed instances where Mr Mohoto had soiled himself and would be left in wet pyjamas because no clean ones were available. This exposes patients to ill health and violates their right to **human dignity**, in terms of Section 10 of the Constitution, which provides that *"everyone has inherent dignity and the right to have their dignity respected and protected"*.
- 9.11.5 The Investigation established that two consignments of patients' clothing procurements were made in 2022 and 2023. However, the first order, which was procured in 2022, was of poor quality (ANNEXURE Y). The pyjamas were torn, the sizes were small, and they did not last six months. Mr Modise attributed the poor quality to the lack of precise specifications provided to the supplier. As a result, the hospital had to undertake another procurement in 2023 to replace the substandard pyjamas.
- 9.11.6 Ms Mintor brought to the attention of the Investigators that on 15 December 2022 and 19 December 2022, she was summoned to witness a consignment of patients' pyjamas and gowns received at the laundry, which were of poor quality. Ms Mintor requested Ms Z. Jones (Acting Assistant Director, Finance) to come and witness. In letters addressed to Dr A. J. Malgas (Acting CEO) (ANNEXURE Z), dated 22 December 2022, Ms Mintor and Ms Z. Jones bemoaned the state of the patients' clothing and linen, which was of poor quality and poor workmanship. The pyjamas and gowns were poorly stitched, sizes were small, and they were not fit for use.
- 9.11.7 Ms Mintor told the investigators that Dr Malgas had not responded to their communication. When the matter was brought to Mr Links' attention, he advised that Ms Jones procure a sewing machine to mend the pyjamas, to which Ms Mintor and Ms Jones objected, instead of sending them back to the service provider.
- 9.11.8 Despite the poor quality of the patient's clothing, the Investigators learned that pyjamas were distributed to the wards. Use of poor-quality pyjamas and insufficient blankets exposed patients to extreme cold temperatures. Hence, Mr Mndimbaza's post-mortem report revealed that he died due to **"exposure."**

- 9.11.9 Mr Modise, the store Manager, acknowledged that there were insufficient blankets to meet patient needs and that staff members sometimes had to use their discretion to allocate available blankets. The investigators were also informed that there was a delay in distributing the blankets to the patients because they needed to be branded.
- 9.11.10 Mr Modise told the Investigator that when procuring patients' clothing, a team that included Ms Mintor, Ms Nero, and Ms Visagie (Housekeeper) were responsible for providing specifications. The first procurement was done without consultation with them, and no specifications were provided, contrary to Mr Modise's account. Ms Visagie refuted Mr Modise's claim and told the Investigators that she was only approached to advise on sizes and was not involved in other specifications. According to the specification document dated 03 June 2024, with VA2 SEQ. NO. 181, signed by Mr Links and Mr Modise (ANNEXURE AA), the type and quality of the material were not mentioned. Unsurprisingly, the material the supplier "**Tropical Enterprise**" used was of poor quality.
- 9.11.11 The Investigators were informed that the pyjamas did not last six months. This is wasteful expenditure; NCMHH did not receive value for the money, and the service provider was not held accountable for the poor workmanship. NCMHH Management failed to advocate for the vulnerable patients in their care and did not show accountability for the financial resources provided. The investigation found that the then HoD, Mr Riaan Strydom and Mr Links acted contrary to the Public Finance Management Act, No. 1 of 1999 (PFMA Act). Section 38 on General responsibilities of accounting officers states that—(1) "*The accounting officer for a department, trading entity or constitutional institution—... b) is responsible for the effective, efficient, economical and transparent use of the resources of the department, trading entity or constitutional institution.*"

9.12 Furniture

- 9.12.1 During the walkabout, the Investigators observed that NCMHH had excessive new furniture lying in different areas. Mr Modise told the Investigators that some of the furniture was delivered incorrectly, as it did not meet the specifications. The supplier was delivering this furniture in bits and pieces. The furniture could not be used as it could not serve the purpose for which it was ordered.
- 9.12.2 On 04 April 2025, during a later telephone conversation with the investigators, Mr Modise said that to resolve the matter, NCMHH Management met with the supplier "**Reagile Kitso**" and reached an agreement to collect the furniture and re-do it according to the original specifications. This will be done in consultation with the Provincial Supply Chain Manager, Mr Chipungu.

9.13 Robert Mangaliso Sobukwe Hospital

9.13.1 Staff Shortage

- 9.13.1.1 Robert Mangaliso Sobukwe Hospital is experiencing a critical staff shortage across the board, i.e. medical personnel, allied and support staff. Nursing Operational Managers are overstretched, and their span of control is very wide, making it impossible to perform their supervisory duties and support their staff. Investigators were informed that the nursing night supervisor in the surgical department, for instance, oversees eleven units, including the theatre, the Accident and Emergency Department and the Intensive Care Unit.
- 9.13.1.2 During the interviews with personnel, it was revealed that many units are managed by enrolled nurses and enrolled nursing auxiliaries, as there are not enough professional nurses to cover all shifts. Mr Van Wyk, the Assistant Director for A&E, told the investigators that there is no replacement when a professional nurse goes on leave.
- 9.13.1.3 During the walkabout, Dr A. Nair, Head of Family Medicine, informed the Investigators that the Gateway Unit did not have a professional nurse and relied on the ENAs, whose scope of practice is limited and who could not administer medication. This led to an unfair workload for doctors, who had to take on additional responsibilities. The Gateway Unit accommodated patients on oxygen therapy and intravenous infusion and required close monitoring. This is contrary to the purpose it was established for, which was to manage patients triaged green and yellow and expected to be discharged home or to a local clinic.
- 9.13.1.4 The shortage of nursing staff is further exacerbated by high absenteeism due to illness and overtime limitations. The investigators requested the absenteeism statistics from Ms Alexander, the nursing services manager, who informed the investigators that the statistics were unavailable as no one could compile them due to the staff shortage in the human resource department. In essence, RMSH did not have systems to monitor staff movement.
- 9.13.1.5 The investigation established that the night before Mr Mohoto died (15 July 2024), there was a crisis in EC as all the nursing personnel failed to turn up for duty. SOC had only one professional nurse, PN Mahlathi, as the ENA she was allocated to work with was removed to cover the gateway unit, which did not have any staff. PN Mahlathi had more than 25 patients to manage, most of whom were seated on the chairs outside the unit due to the unavailability of beds and the unit itself accommodating about eight to ten beds. It was revealed that the same night supervisor, Mr Shong, left the hospital at 01h00 due to a shortlisting process which he needed to attend on 16 July 2024, with his supervisor's permission, thus leaving the hospital unsupervised. The investigation views this act as irresponsible and not supportive of the personnel on duty and patients. RMSH Management allowed the EC unit to run on "autopilot" from 01h00 until 07h00, a dangerous situation for personnel and patients.

- 9.13.1.6 The Investigators were informed that porters transport patients between departments without being accompanied by nurses, a potential danger for patients should an emergency arise. This practice puts the safety of patients at risk. In addition, Investigators witnessed a doctor wheeling a patient on a bed alone without assistance (ANNEXURE BB). In another instance, a doctor carried a heavy oxygen cylinder while the mother was walking and holding a baby on oxygen therapy, besides her.
- 9.13.1.7 Dr Bhyat, Clinical Head of General Surgery, provided Investigators with a submission (ANNEXURE CC) that was sent to the HoD regarding staff shortage, motivating for the hiring of more healthcare personnel. Ms Alexander also wrote to the HoD about staff shortage (ANNEXURE DD).

9.13.2 Nursing Supervisors' Lack of Oversight

- 9.13.2.1 PN Bezuidenhout, PN Fanampe, and Mr Shong, who were hospital supervisors from 13 – 15 July 2024, told the investigators that due to their high workload and very wide span of control, they are often not able to conduct proper rounds in the units with the nursing staff and often miss important information about the patients and even serious incidents encountered by nurses.
- 9.13.2.2 During the night and on weekends, the supervisors oversee the A&E Department, ICU, theatre, surgical units, and the 72-hour psychiatric unit located at the NCMHH and supervise porters and cleaners. Ms Van der Linde, the Operational Manager in the A&E department, informed the Investigators that Surgical Recovery is a high-demand ward with multiple surgical disciplines (gynaecology, orthopaedic, neurosurgery and general surgery) and a heavy patient load subunit. She added that A&E and RMSH were operating under severe staff shortages, with shifts operating without professional nurses. She expressed concern that the hospital's allocation of only an enrolled nurse and an enrolled nursing assistant to Surgical Recovery is inadequate and poses a serious risk to patient safety and the provision of quality care.
- 9.13.2.3 The investigation established that Ms Van der Linde had to work physically in EC due to staffing shortages and often failed to conduct proper ward rounds. She recalled a specific incident where she had to work in SOC over a weekend due to a staff shortage. Ms Van der Linde also had to work at the gastroscopy unit to assist doctors with the procedures.
- 9.13.2.4 Ms Bezuidenhout confirmed to the Investigators that she worked night duty on 13 and 14 July 2024. She explained that due to the busy nature of the night shift and the pressure in EC, she would often not conduct proper patient rounds when on duty during weekends as the hospital supervisor, whether on day or night duty. She further stated that she depended mainly on the information the staff would provide. She frequently took hands-on tasks, especially in critical care areas like ICU, EC and Surgical Recovery, where she had to administer blood transfusions as there would be no professional nurse.

- 9.13.2.5 Ms Fanampe, the Operational Manager for the surgical ward, confirmed during the interview that she worked on 13 and 14 July 2024, overseeing the A&E Department, ICU, theatre, surgical units, the 72-hour psychiatric unit located at the NCMHH, and supervising porters and cleaners. Ms. Fanampe described that upon reporting for duty, she checks if there are any staff challenges or critical patients or new patients, updates the bed status, and informs the doctors about bed availability. Due to the ongoing staff shortage, it is common for her not to conduct patient rounds but to be involved in direct patient care, leaving her with no time to fulfil her supervisory functions.
- 9.13.2.6 When Ms Fanampe was questioned about what she knew about Mr Mohoto during the two days she worked, she replied that she remembered that Mr Mohoto was discharged and awaiting transport. Ms Fanampe conceded that she did not conduct a bed-to-bed round and did not review Mr Mohoto's medical record. In essence, Ms Fanampe was unaware of Mr Mohoto's sick condition.
- 9.13.2.7 On 15 July 2024, Mr G. Shong, the OPM of the General Surgery Ward, was working night duty supervising the surgical part of the hospital. Mr Shong told the Investigators that the workload of the supervisory role was overwhelming due to a staff shortage, which contributed to his inability to fulfil his role adequately.
- 9.13.2.8 Mr Shong informed the investigators that when he reported for duty on 15 July 2024, there was a staffing crisis in EC. His efforts for the night in question concentrated on the administrative function of ensuring that all A&E units were covered, although staffing remained grossly inadequate. He reshuffled staff around, leaving Surgical Recovery with one professional nurse, PN Mahlati.
- 9.13.2.9 When asked by the Investigators about his interaction with Mr Mohoto, Mr Shong mentioned that he did not have any specific recollections about him but noted that the patient was already on oxygen therapy when he saw him. However, he continued to state that he did not conduct bed-to-bed rounds on 15 July 2024, review Mr Moloto's medical record, or receive a report about his condition.
- 9.13.2.10 Mr Shong told the Investigators that he left the hospital at 01h00, with the permission of the Acting Nursing Service Manager, Ms Loots, as he was scheduled to be part of the team tasked with shortlisting the interview candidates. He left without any supervision or support for the staff, further revealing challenges with oversight at RMSH.
- 9.13.2.11 Mr Shong confirmed what was already expressed by other OPMs: The A&E Department did not submit a formal comprehensive report for the patients, leaving supervisors without information about the actual status of patients and other challenges. The investigation found that this further hampered the dissemination of critical patient information and the effective oversight by managers.

9.13.2.12 Furthermore, the investigation found that staff shortages and a lack of a consistent, efficient and effective reporting system are major contributors to the lack of oversight on both day and night duty.

9.13.3 Communication Breakdown

9.13.3.1 The investigation found that the reporting system for the Emergency Department between shifts, by the units to the supervisors and between the supervisors was not documented or formalised. Investigators were informed by operational managers that the system of the “Matron’s Report” submitted at the end of each shift was stopped by the A&E Department Assistant Director, Mr Van Wyk, because he allegedly said, *“the report was not serving any purpose and was a waste of time”*. This decision was implemented without the knowledge and approval of Ms Alexander, the Nursing Service Manager. This shows a lack of understanding of the importance of reporting and handing over for continuity of care and ensuring safety and quality care.

9.13.3.2 Ms Alexander confirmed that she did not approve of such a decision and acknowledged that this decision was erroneous and had a negative impact on the safety and quality of care.

9.13.3.3 Mr Van Wyk, when questioned about this decision, agreed that it was his unilateral decision and, in hindsight, realised that it was incorrect to stop the submission of the Matron’s Report.

9.13.3.4 Ms Van der Linde expressed a concern to the Investigators that the communication book (ANNEXURE EE) introduced to substitute the Matron’s Report was inadequate. It did not provide a comprehensive overview of patients and important incidents that transpired during the shift, but rather just administrative matters.

9.13.3.5 The investigation also uncovered that a doctor’s round book was not used in SOC, and the doctor’s orders/requests were not documented in the clinical notes. This hampered the continuity of patient care and adversely affected the standard of care. The care provided to Mr Mohoto in SOC was found to be substandard, and there were times when care was not provided at all.

9.13.3.6 The investigation found a serious communication challenge at RMSH on all functional levels. Ms Alexander told the Investigators that she became aware of Mr Mohoto’s death and the circumstances of his death when the patient was discussed at the Clinical Complaints Review Committee meeting in September 2024, while Mr Van Wyk, the Head of Nursing for A&E, became aware in December 2024, four months after the incident. Ms Van der Linde, the A&E Operational Manager, stated that she became aware of Mr Mohoto’s death in March 2025 when she was informed about the Health Ombud’s investigation.

This pointed to the serious inefficiencies in the nursing leadership, communication, and reporting systems within the A&E and nursing departments, as Mr Mohoto had died in July 2024.

9.13.3.7 Ms Fanampe conceded that proper communication and protocols could have prevented the patient's death.

9.13.4 Poor Record Keeping

9.13.4.1 The investigation found that **healthcare providers at RMSH** did not comply with guidelines on principles of good record keeping. Doctors did not consider the HPCSA Guidelines on keeping the Patient Health Records Booklet 9; clauses 3 and 4, stipulating all the information that must be maintained after consulting a patient. The nurses also failed to comply with the SANC Acts or Omissions, R767 of 2014, Regulation 5, which states that *"failure to maintain the health status of the healthcare user under his/her care through – (a) assessing the health status of a healthcare user and the response of the body... (g) monitoring vital parameters, including vital signs of the healthcare user, and (h) keeping clear and accurate records of all actions performed on the healthcare user", is an omission.*

9.13.4.2 The following non-compliance was identified: Clinical notes pages were not identified with the patients' names or hospital numbers. Page numbering was non-existent. The times of consultations were not consistently recorded. Clinical notes were ambiguous, and some of the symbols used were not internationally recognised. Handwriting and signatures were illegible, and the culture of writing the full name and surname before attaching a signature was not practised. Full names and surnames were not recorded by healthcare providers.

9.13.4.3 Nurses' clinical notes were largely written at the change of shifts by enrolled nursing auxiliaries and enrolled nurses, and there were shifts where clinical notes were not recorded at all. The reports did not show evidence of clinical condition and monitoring data. There were no nurses' notes when users were seen by doctors during rounds, and units did not keep a doctors' round book. The investigation found that poor record-keeping negatively affected the continuity of care and the safety of patients.

9.13.5 Clinical Records Audit

9.13.5.1 The Quality Assurance Manager, Ms J. Pasha, was questioned about conducting clinical records audits. She informed the Investigators that clinical record audits were not performed due to a staff shortage. She acknowledged that the failure to conduct the audits hampers the provision of quality care as gaps in record keeping and the care itself will not be identified and, therefore, would not be corrected.

9.13.5.2 The gaps were evident in Mr Mohoto's medical record; urgent action is needed to correct them. RMSH was non-compliant with the Guideline for Clinical Audit in Public Health Facilities October 2016. The guideline states, "Clinical audit should be an integral part of clinical practice and preferably a multi-professional activity. It informs health care providers whether they are providing care that will (i) yield improved outcomes for patients, (ii) bring about efficiency gains, and (iii) raise patient satisfaction to higher levels."

9.13.5.3 The RMSH CEO, management, and quality assurance manager failed to fulfil the roles expressed in the guidelines. In essence, quality improvement processes were not in place at RMSH, and it was not surprising that substandard care and poor record keeping were prevalent in all the analysed medical records. The investigation, therefore, found that RMSH lacked the capacity and commitment to ensure safe and quality care.

9.13.6 Overcrowding and Infrastructure

9.13.6.1 The investigators established that A&E sees approximately 102 patients in 24 hours. During the two on-site investigation visits conducted in March 2025, Investigators witnessed overcrowding in the A&E Department. A patient who was intubated and mechanically ventilated could not be taken to the ICU because the ICU was full.

9.13.6.2 Investigators observed two patients in A&E who required management in the High Care Unit. The issue of overcrowding is aggravated by the absence of a district or regional hospital, while RMSH functions as the only tertiary referral hospital for the whole Northern Cape Province.

9.13.6.3 During a visit to the EC by the Investigators on 24 March 2025, Dr Grove, the acting head of Internal Medicine, said that the EC was experiencing significant overcrowding, with patients lying on the floor (ANNEXURE FF) and some having waited since 22 March 2025, sitting on chairs for three days (ANNEXURE GG). He stated that a patient with Pulmonary Tuberculosis had been sitting in the general Casualty area for 30 days, posing an infection control risk.

9.13.6.4 EC has a challenge with mental healthcare users who may also be accommodated for days before a bed becomes available in the 72-hour ward at the NCMHH. Their presence in EC poses a safety risk to other patients, staff, and the relatives accompanying patients.

9.13.6.5 Furthermore, the investigators observed that the gateway unit in A&E accommodated patients on oxygen therapy and intravenous infusion for over 24 hours, contrary to its establishment to handle moderately stable patients triaged green and yellow.

10 LIMITATIONS

The investigation encountered the following limitations:

- (a) Unavailable healthcare providers for interviews due to relocation.
- (b) Some of the medical records or documents with information relevant to the issues being investigated were unavailable from either NCMHH or RMSH.
- (c) The interviewed healthcare providers were unable to recall some information and thus were unable to provide some critical information on the matters being investigated.

11. COMMENTS FROM NCDOH, NCMHH AND RMSH ON THE PROVISIONAL REPORT

- 11.1 The Health Ombud shared the Preliminary Report with findings and recommendations with Mr Mlatha, the Northern Cape Province HoD for Health, the Northern Cape Mental Health Hospital, and the Robert Mangaliso Sobukwe Hospitals CEOs on 27 June 2025 to afford them the opportunity to comment on the report, in terms of Section 81A. (5) of the NHAA.
- 11.2 The Health Ombud received a response from the HoD acknowledging the receipt of the report on 03 July 2025. However, no substantive comments were submitted except to aver that the summoning of senior personnel from the two hospitals was not to toe a line.
- 11.3 The complaint is considered for closure as the matter has been appropriately investigated and finalised.

12. CONCLUSION

- 12.1 The following conclusions were based on the information obtained during the investigation by the Ombud and the Investigators.
- 12.2 When the incidents occurred in July and August 2024, NCMHH had been experiencing power supply challenges since October 2022 due to the vandalism of the power substation supplying it with electricity. During this period, NCMHH relied on a generator for power supply, which was inadequate for the hospital's needs. However, NCMHH implemented power distribution rationing for certain hours daily to prevent the generator from overloading.

- 12.3 The electricity blackouts experienced in NCMHH significantly exposed the four patients and others to extremely cold winter conditions. Patients were cared for in the dark, and nurses used their cell phone torches as a light source. The situation was not conducive to and was dangerous for the safety of patients and personnel, and healthcare personnel's provision of safe and quality care was severely compromised.
- 12.3.1 Lack of electricity meant that the electromagnetic door locking system did not work, thus resulting in doors left open by heavy objects. This was a security risk for patient containment.
- 12.3.2 Lack of electricity also resulted in the telephone system not working. The hospital did not provide staff with alternative means of communication, leading to staff using personal mobile phones.
- 12.3.3 Lack of electricity also adversely affected pharmacy operations.
- 12.4 Patients were washing/bathing with cold water; the blankets used were thin, of poor quality, and insufficient for the number of patients. Patients also did not have shoes, proper clothing, or pyjamas to keep warm. The wards were extremely cold even during the day, and patients would sit out in the sun to stay warm. The exposure to extreme cold resulted in deaths from hypothermia or lobar pneumonia in some patients.
- 12.5 Dr Kirimi's complaint letter dated 19 July 2024, addressed to the Acting HoD, Mr Mlatha, detailed the adverse circumstances under which patients in NCMHH were subjected to, which negatively impacted their health, and this is a human rights violation. The post-mortem report on Mr Mdimbaza corroborated Dr Kirimi's statement that Mr T. Mdimbaza died due to **"exposure to elements."** Mr Mohoto's diagnosis of **"lobar pneumonia"** most probably resulted from exposure to cold as well.
- 12.6 There was a dire shortage of nurses at NCMHH and RMSH, especially professional nurses, which strained the personnel available and contributed to errors in executing their professional duties. At the NCMHH, wards with 27 patients operated with one professional nurse, one enrolled nurse, an enrolled nursing assistant, or one professional nurse with two enrolled nursing auxiliaries during the day. During the night, it would be one professional nurse, either an enrolled nurse or an enrolled nursing assistant, who was grossly inadequate.
- 12.7 According to the World Health Organisation (WHO), the recommended ratio is 1:4 to 1:6 in acute units and 1:8 to 1:10 in long-term or chronic care units. Therefore, the above staffing ratio of 1:27 per professional nurse is grossly inadequate and unsafe for nurses and patients.
- 12.8 The high-acuity A&E subunit, the Surgical Recovery Unit at RMSH, where Mr Mohoto died on 16 July 2024, was operating shifts without professional nurses. On the day of admission, Mr Mohoto was received by an enrolled nursing assistant, who was supervised by an enrolled nurse. NCMHH and RMSH lacked effective professional clinical leadership and management.

- 12.9 NCMHH and RMSH lacked emergency equipment, which resulted in their failure to intubate Mr De Bruin, Mr Mdimbaza, and Mr Mohoto. Had Mr Mohoto and Mr Mdimbaza's respiratory conditions been appropriately managed, their deaths could have been avoided.
- 12.10 The general nursing and medical care at NCMHH and RMSH was substandard, unsafe, and of poor quality, threatening the well-being of the patients in their care.
- 12.11 Record-keeping was non-compliant with the principles of good record-keeping. It was very poor at both NCMHH and RMSH, hampering the continuity of care. Some handwriting and signatures were illegible, making the information difficult to read. Clinical and nursing notes were incomplete and in shorthand, which lacked meaning and risked misinterpretation.
- 12.12 Both nurses and doctors from NCMHH and RMSH repeatedly cited the inability to recall crucial information due to the lack of comprehensive recording.
- 12.13 The NCMHH and RMSH quality assurance departments were understaffed, ineffective, and inefficient in managing quality assurance issues related to safe and quality healthcare. NCMHH did not comply with the National Guidelines for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa Version 2 – 2022 (National Guideline for PSI Version 2 – 2022). Patients' incidents were not investigated. Clinical record audits were not conducted in either of the two health establishments, as required by the Guideline for Clinical Audit in Public Health Facilities October 2016, which states, "*Clinical audit should be an integral part of clinical practice and preferably a multi-professional activity. It informs health care providers whether they are providing care that will (i) yield improved outcomes for patients, (ii) bring about efficiency gains, and (iii) raise patient satisfaction to higher levels.*"
- 12.14 The care provided to all patients at NCMHH, to Mr Mohoto, and Mr De Bruin at RMSH was substandard and dangerous. However, the care provided to Mr Louw at RMSH was of a satisfactory standard. The Northern Cape Province Department of Health, NCMHH, and RMSH Management should be held accountable for the deaths of Mr Mdimbaza and Mr Mohoto due to the serious systemic preventable challenges that impacted their healthcare provision.
- 12.15 The leadership instability in the Provincial Health Office is not assisting the NCMHH and RMSH; it affects service delivery and the provision of safe and quality health care.

13. RECOMMENDATIONS

- 13.1 These recommendations aim to address the serious problems observed at the NCMHH and RMSH and improve overall safety and quality of patient care. The investigation established that both health establishments faced similar challenges in governance, daily operations, and critical staff shortages. Therefore, recommendations will be addressed jointly.

- 13.2 The Head of Department (HoD) must immediately appoint a Task Team to monitor the implementation of the recommendations as outlined in this report, and inform the Health Ombud and the CEO of the OHSC of the implementation.
- 13.3 To ensure effective implementation, the Task Team should consist of the health establishments' Chief Executive Officers (CEO) as the chairperson and other representatives from relevant departments and units implicated in this report.
- 13.4 The Task Team will be responsible for tracking progress on implementing the recommendations by providing a quarterly summary of progress made on each recommendation to the HoD, the Health Ombud and the CEO of the OHSC.
- 13.5 The Northern Cape MEC of Health, for the time being, Mr M. Lekwene, and the HOD, for the time being, Mr Mlatha, should:
- i) Urgently prioritise recruiting and retaining healthcare providers for NCMHH and RMSH.
 - ii) Identify skills shortages and skills gaps and develop a plan to address them.
 - iii) Secure funding and prioritise the employment of healthcare personnel to mitigate risks and improve overall healthcare outcomes.
 - iv) Appoint non-South Africans to fill in vacancies where no South African applicants are available, e.g. for pharmacy.
 - v) The Ombud should be provided with a plan including strategies and timelines within nine months of receipt of the final report.
- 13.6 RMSH should institute disciplinary measures against **Mr Van Wyk** for unilaterally making a management decision to stop the matron's report that adversely impacted communication, nursing care, and continuity of care. Mr Van Wyk should be capacitated with the Nursing Management skills to assist him in making safe and proper decisions, within three months of receiving the final report.
- 13.7 Appropriate action should be taken against the provincial office's Supply Chain Manager for failing to ensure quality procurement and holding the service provider "**Tropical Enterprise**" accountable before processing and finalising payments. The Supply Chain Manager failed to exercise good financial stewardship, which resulted in fruitless expenditure amid the department's financial constraints.

A forensic investigation should be conducted as soon as possible into the procurement and appointment process involving the service providers, including Tropical Enterprise.

Evidence of implementation should be provided to the Health Ombud within six months of receiving the final report.

- 13.7.1 A forensic investigation should be initiated by the National Department of Health on the procurement processes for the NCMHH relating to buying linen, blankets and pyjamas, buying golf carts, specialised beds and furniture. The delay in securing service providers for the repair of damage to the electricity infrastructure.
- 13.8 The HoD must take disciplinary action against the NCMHH CEO for failing to advocate for patients and hold Tropical Enterprise accountable for the poor workmanship of the procured pyjamas within three months of receiving the final report.
- 13.9 All NCMHH and RMSH Operational, Area and Night Nursing Managers should be provided with leadership and management workshops to assist them with teamwork, communication, decision-making and critical planning skills, within six months of the receipt of the final report.
- 13.10 NCMHH and RMSH should **immediately** cease the practice of allocating only ENs and ENAs to manage units and wards without professional nurses. This risks the safety of patients and exposes nurses to contravention of SANC regulations. The CEO and the Nursing Service Managers should ensure that a professional nurse heads every shift daily without fail.
- A full report on actions taken to address the allocation of nursing personnel with evidence should be provided to the Ombud within six months of receiving the final report.
- 13.11 NCMHH and RMSH should develop comprehensive Standard Operating Procedures (SOPs)/ Protocols/Guidelines to guide healthcare personnel in providing healthcare services, communicate them, and ensure easy access. In-service training should be conducted for all healthcare personnel to support and capacitate them to provide safe and quality care. The Ombud should be provided with the evidence within six months of receiving the final report.
- 13.12 NCMHH and RMSH should develop and implement clear protocols for night supervision, including criteria for selecting staff and ensuring adequate training and support for their night supervisory role. Consideration should be made to allocate night supervisors at NCMHH. Managers should conduct patient rounds and provide oversight and support to the staff.
- Evidence should be provided to the Health Ombud within six months of receiving the final report.
- 13.13 NCMHH and RMSH should prioritise the development/reinstatement and implementation of an effective and efficient reporting system for continuity of care and effective communication.
- Evidence should be provided to the Ombud within six months of receiving the final report.

- 13.14 NCMHH should prioritise appointing a suitably trained, qualified permanent Quality Assurance Manager.
- Evidence of the steps taken to appoint the Quality Assurance Manager should be provided to the Ombud within six months of receiving the final report.
- 13.15 NCMHH and RMSH should conduct regular clinical record audits in line with the National Guidelines to identify gaps in record keeping and clinical care provision, and to ensure that patient care meets required standards. This will assist in strengthening and improving patient care and outcomes.
- Evidence of regularly conducted clinical record audits should be submitted to the Ombud within six months of obtaining the final report.
- 13.16 NCMHH and RMSH should provide training and guidance on clinical care documentation in line with relevant regulations guiding their practice, to ensure that all categories of nursing personnel and doctors understand the importance of accurate and timely contemporaneous documentation in the patient's records.
- Evidence of the training provided should be made available to the Ombud within six months of receiving the final report.
- 13.17 To create a safe clinical practice environment, NCMHH and RMSH should conduct in-service training for all categories of nurses on the SANC Acts or Omissions Regulations, R767 of 2014, and the Scope of Practice. They should also re-establish a documented communication system for handing over reports between shifts for managers and doctors.
- Evidence of the training provided should be made available to the Ombud within six months of receiving the final report.
- 13.18 NCMHH Management Teams, working with the Provincial Infrastructure Department, should urgently address infrastructure repair and maintenance issues. Prioritise repairs and maintenance of the hospital's infrastructure, including broken windows, exposed electric wires, and plumbing issues.
- The Ombud should be provided with evidence of the process initiated to address the matter within six months of receiving the final report.
- 13.19 NCMHH and RMSH, working with the Provincial SCM Department, should prioritise the procurement of medical equipment such as stretchers, appropriate beds, otoscope sets (ENT Diagnostic Set), resuscitation drugs, and emergency equipment to ensure adequate emergency preparedness, according to each health facility's needs.

- 13.19.1 Healthcare providers should be trained in basic life support (BLS) and Advanced Life Support (ALS) to enable them to respond effectively to medical emergencies, to ensure compliance with the Norms and Standards Regulations Applicable to Different Categories of Health Establishments "Access to care", which states that, "5 (1) 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, (2) a health establishment must ... (c) adhere to clinical guidelines on stabilising users presenting in an emergency."

The Ombud should be provided with evidence of the process put in motion for procurement within six months of receiving the final report.

- 13.19.2 The Provincial Office should develop and establish a local supply chain management system at both NCMHH and RMSH and appoint suitably qualified permanent personnel to manage the SCM system, within six months of receiving the final report.

The Ombud should be provided with evidence that this is being implemented within six months of the report.

- 13.20 Emergency response teams should be assembled, and staff should be trained in emergency procedures.

The Health Ombud should receive evidence of the progress made in such training within six months of receiving the final report.

- 13.21 NCMHH, together with the procurement and supply chain Provincial Office, should manage excess furniture and equipment, and distribute it to other facilities, to ensure that the resources are being used efficiently. NCMHH should conduct a thorough inventory of all furniture and equipment to identify surplus items and ensure accurate tracking. Ensure that future procurements are solely for the items necessary for service delivery.

NCMHH, through the Provincial Procurement Office, should provide the Ombud with the plan and implementation addressing the excess furniture within nine months of receiving the final report.

- 13.22 RMSH, through the Office of the HoD, for the time being, Mr Mlatha, should address the shortage of space to accommodate patients in all the A&E units. Evidence of the implementation process should be provided to the Ombud within six months of receiving the final report.

- 13.23 NCMHH should provide adequate office space and accommodation for managers and staff: Ensure that all staff, including managers, have adequate office space and accommodation conducive to performing their duties effectively. Consider renovating office areas to provide a comfortable and productive work environment. Evidence of the process initiated should be provided to the Ombud within six months of receiving the final report.

13.26 Pharmaceuticals

- 13.26.1 Procurement of Essential Emergency Drugs: Ensure the availability of essential emergency drugs in the hospital's pharmacy.
- 13.26.2 Development of a Pharmacy Management Plan: Establish a plan to manage pharmaceutical supplies, including regular stocktaking, ordering essential medications, and managing imminent expiry dates of stock items.
- 13.26.3 Appoint suitably qualified pharmacy staff within six months of receiving the final report.

13.27 Laundry Services

- 13.27.1 Implementation of Quality Control Process: Establish a quality control process for checking blankets and linen to ensure patient comfort and hygiene. Must keep an up-to-date inventory and track linen movement in and out of the hospital for washing.
- 13.27.2 Training of Laundry Staff: Train laundry staff on the importance of quality control and the procedures for checking and maintaining clean linen, within three months of receiving the final report.

13.28 Human Resources

- 13.28.1 Staff Training and Development: Provide ongoing training and development opportunities for staff to ensure that they have the necessary skills and knowledge to provide high-quality care.

The Health Ombud should be provided with a training and development plan, and evidence of training conducted within nine months of receiving the final report.

- 13.28.2 Recruitment and Retention Strategies: Develop and implement strategies to recruit and retain qualified staff, including competitive salaries, benefits, and a positive work environment. "Rural allowance" should be considered as an incentive to attract applications.

Provide evidence of implementation to the Ombud within six to nine months of receiving the final report.

13.29 Quality Improvement

- 13.29.1 NCMHH and RMSH should handle Patient Safety Incidents in accordance with the relevant national guidelines, using such incidents to learn and prevent recurrence.
- 13.29.2 Regular Audits and Reviews: The hospital must conduct regular audits and reviews to ensure that it meets quality and safety standards.
- 13.29.3 During the period under review, staff at the Northern Cape Mental Health Hospital and Robert Mangaliso Sobukwe Hospital operated under severe systemic limitations, including but not limited to:
- (a) Intermittent power outages disrupted the functioning of essential electrically powered medical equipment, environmental heating systems, and lighting, particularly during night shifts and in the winter months. Limited generator capacity, which, although deployed during outages, is inadequate to maintain a consistent power supply even across high-dependency areas of the hospital. The hospitals must ensure adequate power generation capacity to cover all essential areas during power outages.
 - (b) Resource shortages, including insufficient access to clean blankets, warm clothing, and other personal care items necessary to preserve patient dignity, hygiene, and comfort must be addressed.
- 13.29.4 High staff-to-patient ratios made it difficult for nurses to provide comprehensive individualised patient care, implement patient-specific care plans, and document clinical observations in real time.
- 13.29.5 The allocation of lower-category nurses with minimal training in high-acuity units resulted in clinical mismanagement and substandard care.
- 13.29.6 Infrastructure challenges and insufficient accommodation, where existing systems (e.g., laundry services, heating, hot water) failed to support the seasonal demand, compounded challenges in delivering effective care.
- 13.29.7 It is strongly advised that management acknowledge these systemic constraints, undertake periodic internal reviews and advocate for urgent infrastructural upgrades and workforce support mechanisms such as debriefing sessions and wellness services to enable clinical staff to deliver safe, consistent, and dignified care to all patients, regardless of season or external conditions.

13.29.8 Though not excusing individual accountability, the operational deficiencies highlight the need for systemic reform and resource allocation. The cumulative effect of environmental limitations, equipment inadequacy, and staffing pressures significantly hampered the ability of even the well-intentioned and experienced personnel to fully execute their professional roles to expected standards.

13.30 Dr Melakeco

13.30.1 Dr Melakeco acted contrary to HPCSA Booklet 1, General Ethical Guidelines for the Healthcare Professions, Regulation 4, "**DUTY TO CARE**". She failed to conduct an adequate diagnostic workup on 02 August 2024, on Mr Mdimbaza, and made an inappropriate clinical decision to attend to him the following day, delaying the care and referral. The following is therefore recommended:

- (a) An internal disciplinary action should be taken against Dr Melakeco.
- (b) Mandatory attendance of a Continuing Professional Development program focusing on managing complex chronic patients and interdisciplinary clinical communication.
- (c) Referral to the institutional Clinical Governance Committee for review of clinical decision-making practices, with potential supervised clinical audits over six months.
- (d) Submission of a reflective report detailing the lessons learned and corrective actions taken to prevent future occurrences.
- (e) **Dr Mwenze, Dr Anjum, Dr Nieuwoudt, Dr Abrahams, Dr Mathunda, Dr Conradie, and Dr Oss** acted contrary to HPCSA Booklet 1 General Ethical Guidelines for the Healthcare Professions, Regulation 4, "**DUTY TO CARE**". NCMHH and RMSH Management should conduct disciplinary action for failing to care for Mr Mohoto. They also contravened HPCSA, Booklet 3 on the National Patients' Rights Charter. Regulation 2 states, "*2.11 No one shall be abandoned by a healthcare professional who or a health facility which initially took responsibility for one's health without appropriate referral or handover.*" Internal disciplinary actions should be taken by the respective health establishment against the respective doctors.
- (f) NCMHH and RMSH should institute appropriate corrective measures internally against Dr Abrahams, Dr Mathunda, Dr Conradie, and Dr Oss within three (3) months of receiving the final report regarding the gravity of their role in Mr Mohoto's death.
- (g) Mandatory attendance at a Continuing Professional Development (CPD) program focusing on conducting comprehensive assessments, managing patients, and interdisciplinary clinical communication.
Evidence of attendance should be made available to the Health Ombud within 12 months of receiving the final report.

- (h) The Health Ombud will refer Dr Anjum, Dr Nieuwoudt, and Dr Mwenze to HPCSA for further probing.
 - (i) Censure of Dr Bhyat for not providing supervision to junior doctors, not taking clinical ward rounds in the Surgical Recovery Unit once or twice daily, including weekends.
 - (j) Referral of all the doctors to the institutional Clinical Governance Committee for review of clinical decision-making practices, with potential supervised clinical audits over six months.
 - (k) Submission of a reflective report by each doctor on the lessons learned and corrective actions taken to prevent future occurrences.
- 13.30.2 RMSH should support and guide Dr Conradie and ensure that her work is supervised in accordance with the HPCSA Handbook on Internship Training Guidelines for Interns, Accredited Facilities and Health Authorities, 2024.
- 13.30.3 NCMHH and RMSH to empower all medical professionals in Basic and Advanced Life Support training by an accredited body.
Evidence of the process to procure the service should be provided to the Health Ombud within six (6) to nine (9) months of receiving the final report.
- 13.30.4 The respective senior consultants for Psychiatry, Internal Medicine, and General Surgery should establish and enforce effective, clear hierarchical supervision of juniors. Specifically, juniors should not be left alone to make decisions on critical patients.
- 13.30.5 NCMHH and RMSH nursing personnel were all found to have acted contrary to SANC Acts or Omissions, R767 of 2014, which provides that, 4 *“failure to carry out such acts in respect of assessment, diagnosis, treatment, care, collaboration, and advocacy as the scope permits”, and 5 “failure to maintain the health status of the healthcare user under his/her care through – (a) assessing the health status of a healthcare user and the response of the body, ... (c) preventing accidents, injury or trauma, ... (f) providing specific care and treatment of the ill and the vulnerable and high-risk healthcare user, (g) monitoring vital parameters, including vital signs of the healthcare user, and (h) keeping clear and accurate records of all actions performed on the healthcare user”, is an omission.*

The Health Establishments must undertake in-service training for their nursing staff on these SANC guidelines.

The Ombud must be provided with evidence of the implementation of in-service training within nine months of this report.

- 13.30.6 Senior nurses to establish and enforce clear, effective hierarchical supervision of juniors. Specifically, juniors should not be left to undertake clinical nursing tasks that are outside their scope or skill.
- 13.30.7 PN Moima and PN Mahlati failed to execute their nursing duties in line with the SANC Scope of Practice, R.2127. Regulation 2 (1) states that *“The professional nurse takes responsibility and accountability for the following: ... (b) providing safe and quality comprehensive nursing care in a scientific, integrated and evidence based approach, in all healthcare settings,... (d) facilitating the attainment of optimum health for the individual, the family, groups and the community,...(f) assessing and interpreting the health information needs of individuals and groups to plan and respond accordingly, (g) diagnosing and prioritising individual health and nursing care needs based on a comprehensive analysis and the interpretation of data,...(l) providing emergency care, ...(p) creating and maintaining a concise complete and accurate nursing record for individual healthcare users, and (q) referring a healthcare user timeously and appropriately to other members of the multidisciplinary team.”*
- 13.30.8 The following omissions by the NCMHH and RMSH nursing personnel were identified:
- (a) Failure to monitor patients’ vital signs.
 - (b) Inadequate documentation of the care plan and patient condition.
 - (c) Improper handover procedures.
 - (d) Delayed reporting of adverse events and conflicting incident narratives.
 - (e) Failure to assess and document the patient’s deterioration.
 - (f) Inadequate advocacy for referral despite obvious clinical deterioration.
 - (g) Neglect in fulfilling daily documentation responsibilities.
 - (h) Inadequate situational awareness due to a lack of briefing or care plan.

The HE must establish regular nursing in-service training courses to ensure compliance with professional nursing requirements and practices.

- 13.30.9 NCMHH should institute befitting corrective measures internally against PN Tabi, PN White, PN Rhodes, ENA Ranwedzi, and ENA Pieterse regarding the seriousness of their omissions and failure to fulfil their duties in line with their scope of practice, while taking into consideration. Adverse systemic conditions beyond their control, such as the absence of electricity and severe staff shortages under which personnel had to perform their clinical duties.

- 13.30.10 NCMHH should develop an in-service programme and mandatory attendance for professional nurses focusing on conducting comprehensive assessments, monitoring vital signs, advocating for patients, and the SANC Regulations, i.e. Acts and Omissions R.767 and the Scope of Practice R.2127.
- 13.30.11 RMSH should take disciplinary action against PN Moima and PN Mahlathi for their failure to advocate for Mr Mohoto and activate code blue for him to receive emergency care, proportionate to adverse systemic conditions which were prevailing at the time of the incident. The HE must initiate corrective action within six months of issuing this report.
- 13.30.12 RMSH should institute befitting corrective measures internally against EN Ramokgobedi, ENA Marney and ENA Moloi regarding the gravity of their omissions and failure to fulfil their duties in line with their scope of practice. Systemic issues that were prevailing at the time of Mr Mohoto's incident, such as a high acuity unit managed by junior nurses, a severe shortage of professional nurses, and failure by doctors to manage him, should be considered.
- 13.30.13 RMSH should develop an in-service programme and mandatory attendance for professional nurses focusing on conducting comprehensive assessments, monitoring of vital signs, advocacy for patients, and SANC Regulations. i.e. Acts and Omissions R767,2014, and the Scope of Practice, R2598, and R 2127 as amended.
- 13.30.14 **The following corrective actions are recommended for both NCMHH and RMSH Management as appropriate to each health establishment:**
- (a) Performance feedback session focusing on environmental hygiene and maintaining patient dignity.
 - (b) Counselling and mentorship on managing resource constraints while maintaining minimum standards of care.
 - (c) Compulsory retraining of all categories of nursing personnel in full risk assessment, care planning, and early warning score systems.
 - (d) Upskilling, including enrolment in an accredited Advanced Psychiatric Nursing course, to ensure competency in managing high-risk psychiatric patients.
 - (e) Participation in a refresher workshop on basic patient assessment, communication, and role clarity for nursing assistants.
 - (f) Compulsory in-service training on nursing documentation, ethical conduct, and handover practices.

- (g) Supervised mentorship under a senior nurse for three months to ensure adherence to care planning and reporting protocols.
- (h) Performance review to be conducted at three and six months with documented improvement indicators.
- (i) Provide professional nurses with Basic Life Support training by an accredited body.
- (j) Provide in-service training on patient safety incidents and report writing.

14. REFERENCE LIST

- 14.1 Constitution of the Republic of South Africa, 1996
- 14.2 Guideline for Clinical Audit in Public Health Facilities (Draft), October 2016. Hleşcu AA, Grigoraş A, Ianole V, Amalinei C. Advanced Diagnostic Tools in Hypothermia-Related Fatalities: A Pathological Perspective.
- 14.3 Diagnostics (Basel). 2024 Mar 30;14(7):739. doi: 10.3390/diagnostics14070739. PMID: 38611652; PMCID: PMC11011698.
- 14.4 HPCSA Handbook on Internship Training Guidelines for Interns, Accredited Facilities and Health Authorities, 2021
- 14.5 National Guidelines for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa Version 2 – 2022
- 14.6 National Health Act, 2003 (Act No.61 of 2003)
- 14.7 National Health Amendment Act, 2013 (Act No. 12 of 2013).
- 14.8 Public Finance Management Act, No. 1 of 1999 (PFMA Act).
- 14.9 South African Nursing Council Acts or Omissions, R767 of 2014
- 14.10 South African Nursing Council Regulations Regarding the Scope of Practice For Nurses and Midwives, R.2127 of 2022
- 14.11 South African Standard Treatment Guidelines (SASTG) and the Essential Medicines List for South Africa, 2012

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RP302/2025

ISBN: 978-1-83491-179-3

Title of Publications: Investigation of Treatment, Complications and Deaths of Psychiatric Patients at Northern Cape Mental Hospital and Robert Mangaliso Sobukwe Hospital