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Health Ombud

MEDIA STATEMENT

For Immediate Release
3 December 2025

To All Editors and Health Journalists

THE HEALTH OMBUD RELEASED INVESTIGATION FINDINGS ON THE MEDICAL CARE AND THE DEATH OF MR MABUBULA, AT WITS DONALD GORDON MEDICAL CENTRE, AS WELL AS THE DEATH OF MR RAMPHELE AT PIETERSBURG PROVINCIAL TERTIARY HOSPITAL

Pretoria. The Health Ombud, Professor Taole Mokoena, has published the findings of two investigation reports regarding the medical care and death of Mr Edward Mabubula at Wits Donald Gordon Medical Centre (WDGMC) in Gauteng Province and the death of Mr Pitsi Eliphuz Ramphele at Pietersburg Provincial Tertiary Hospital (PPTH) in Limpopo Province.

INVESTIGATION FINDINGS INTO THE MEDICAL CARE AND DEATH OF MR MABUBULA, AT WITS DONALD GORDON MEDICAL CENTRE

A complaint about the death of Mr Mabubula was lodged on 20 May 2021 by Mrs Irene Tebogo Mabubula, following the medical treatment received by her late husband at the WDGMC. Mrs Mabubula alleged that Mr Mabubula suffered a cerebral air embolism and a subsequent stroke after a chemoport flushing procedure conducted in the Oncology Ward at WDGMC on 27 March 2021.

The key investigation question was whether Mr Mabubula died directly as a result of actions by WDGMC.

The investigation, conducted under Section 81A of the National Health Amendment Act (Act No. 12 of 2013), established that while the patient's emergency care was prioritised, key clinical management and documentation standards were not adhered to. Specifically, the investigation revealed that WDGMC:

- Failed to document baseline clinical examination findings and create a formal patient record for the outpatient procedure as required by the National Health Act and applicable Norms and Standards Regulations.
- Was undertaking "courtesy" practice within the Oncology Department for approximately 15 years without documenting patient clinical details and processes, which deviated from Norms and Standards Regulations.

The Health Ombud commissioned independent experts to provide an objective opinion on this complex and unusual incident. Independent expert opinions confirmed a causal link between the chemoport flushing procedure and the cerebral air embolism, which, while rare, is a documented complication which can lead to the adverse event experienced by the patient.

The Health Ombud concluded that the incident reflects an unwitting breach of documentation and clinical risk management protocols, which, although an act of goodwill aimed at saving patients from hospital charges, constitutes an infraction against prescribed norms and standards of care. The Health Ombud did not attribute malice and direct culpability for the patient's death, which was certified as due to natural causes related to his advanced metastatic cancer and subsequent complications.

The Health Ombud has recommended that WDGMC:

1. Develop and implement a formal, documented protocol for the removal of port needles in Oncology Outpatients.

2. Establish proper medical records and files for each patient.

3. Engage in a mediation process with Mrs Mabubula within four (4) months to facilitate the resolution of outstanding matters.

The complaint is now regarded as finalised in line with Regulation 41(1)(a)(iv) of the Procedural Regulations pertaining to the functions of the Office of Health Standards Compliance and Handling of Complaints by the Ombud.

INVESTIGATION FINDINGS INTO THE DEATH OF MR PITSI ELIPHUZ RAMPHELE AT THE PIETERSBURG PROVINCIAL TERTIARY HOSPITAL

Mr Pitsi Eliphuz Ramphele's case was investigated following a complaint lodged by Dr Mamphela Ramphele on 27 March 2025, alleging medical negligence that led to her nephew's death at Pietersburg Provincial Tertiary Hospital.

Mr Ramphele first sought treatment at Rethabile Community Health Centre (RCHC) on 26 November 2024. He experienced prolonged administrative delays. He was not prioritised according to the urgency of his medical condition and was ultimately not seen by a doctor before being referred to the Pietersburg Provincial Tertiary Hospital. He was later admitted with Acute Small Bowel Obstruction (ASBO), and he died on 28 November 2024, while waiting for proper surgical management.

The Health Ombud's mandate, derived from Section 81A (1) of the NHAA, empowers the Ombud to investigate and dispose of complaints relating to non-compliance with prescribed health norms and standards in a fair, impartial manner without fear or favour.

Key Allegations and Findings

Upon analysing the complaint and allegations, the investigation team identified seven allegations that formed the basis of the investigation. The investigators found multiple instances of substandard care, poor supervision and systemic management failures at both RCHC and PPTH.

Allegation 1: Whether there was a delay in opening a file at RCHC

Finding: There were administrative delays of nearly four hours (3 hours and 55 minutes) before a patient file was opened at RCHC, violating Regulation 22 of the Norms and Standards Regulations.

Allegation 2: Whether Mr Ramphele was triaged at the RCHC Outpatient Department

Finding: There was a failure to properly triage Mr Ramphele as unqualified staff were assigned to critical areas, and essential triage equipment was missing. RCHC acted inconsistently with Regulations 13(1) of the Norms and Standards Regulations, which states, "*The Health establishments must ensure that medical equipment is available and functional in compliance with the law", and* Regulation 5(2)(a) of the Norms and Standards Regulations, which states, "*A health establishment must implement a system of triage*."

Allegation 3: Whether a doctor did not see Mr Ramphele at RCHC

Finding: Failure to provide timely medical attention to Mr Ramphele was substantiated, as doctors at RCHC left before all patients were attended to, including Mr Ramphele. RCHC acted inconsistently with Regulation 5(1) of the Norms and Standards Regulations, which states, "The health establishment must ensure that users are attended to in a manner that is consistent with the nature and severity of their health condition."

Allegation 4: Whether Mr Ramphele was triaged on arrival at PPTH

Finding: The assertion that Mr Ramphele was triaged upon arrival at PPTH was unsubstantiated. The investigation, based on the clinical records, established that Mr Ramphele's vital data observations were taken on 26 November 2024 at 23:25. However, a triage score and colour code were not assigned according to the South African Triage Scale (SATS) clinical guidelines. The triage room at PPTH is operated by Enrolled Nursing Auxiliaries (ENAs) who lack the necessary skills to assess patients and assign scores. Furthermore, ENAs were working without the supervision of a Professional Nurse (PN) while in the triage room, which violates their Scope of Practice as outlined in Regulation R2598 of SANC. This regulation clearly stipulates that "*ENAs must operate under the direct supervision of a Registered Nurse*".

PPTH acted inconsistently with Regulation 7 (1) of the Norms and Standards Regulations, which states, "*The health establishment must establish and maintain clinical systems, structures and procedures that give effect to national policies and guidelines.*" Additionally, PPTH further acted inconsistently with Regulation 5(2)(a) of the Norms and Standards Regulations, which states, "*A health establishment must implement a system of triage*."

Allegation 5: Whether Mr Ramphele was not monitored while placed on non-operative/conservative management for ASBO

Finding: That there was negligent patient monitoring at PPTH was confirmed, as Mr Ramphele spent over 21 hours without a medical review despite clear signs of his clinical deterioration. This failure is inconsistent with Regulation 5(1) of the Norms and Standards Regulations, which states, "The health establishment must ensure that users are attended to in a manner that is consistent with the nature and severity of their health condition."

Allegation 6: Whether Mr Ramphele's surgical intervention was delayed/overlooked

Finding: PPTH failed to afford Mr Ramphele surgical intervention. The Health Ombud concluded that timely surgical intervention could have prevented Mr Ramphele's death. PPTH acted inconsistently with Regulation 5(1) of the Prescribed Norms and Standards Regulations Applicable to Different Categories of Health Establishments, 2018, which provides that "*The health establishment must ensure that users are attended to in a manner that is consistent with the nature and severity of their health condition.*"

Allegation 7: Whether the family was not provided with postmortem services to determine the cause of death

Finding: The Ramphele family was not provided with postmortem services to determine the cause of death of Mr PE Ramphele. PPTH acted inconsistently with Regulation 7(2)(a) of the Norms and Standards Regulations, which states, "*A health establishment must ensure that clinical policies and guidelines for priority health conditions issued by the national department are available and communicated to health care personnel.*"

Additional Findings:

- Falsification of medical records at RCHC in an attempt to conceal procedural failings.
- Poor supervision of medical interns and registrars at PPTH, with junior staff taking independent clinical decisions without supervision.
- Systemic leadership failures, including prolonged acting appointments without compensation, leading to low morale and weak accountability.
- Infrastructure and resource gaps, such as missing equipment, inadequate waiting areas, and medication stockouts, are compromising patient safety.

The Ombud further noted that both health establishments acted inconsistently with several provisions of the Prescribed Norms and Standards Regulations (2018), compromising the constitutional right to access healthcare as guaranteed under Section 27(1)(a) of the Constitution.

The Ombud concluded that human resource misallocation, failure to adhere to triage protocols, and inadequate supervision of medical interns and nurses were key contributors to systemic dysfunction at both RCHC and PPTH. Additionally, prolonged acting appointments, poor leadership and supervision eroded service quality and accountability, placing patients at risk.

The investigation reaffirmed that patients' rights to safe, quality, and dignified care must be upheld at all levels of the healthcare system, in line with the OHSC's mandate to promote compliance with national health standards.

Recommendations

The Health Ombud made several binding recommendations, including:

1. Appointment of a Task Team within one (1) month of this report to monitor implementation of all recommendations, with quarterly progress reports to the Head of Department (HoD) of Health, the Chief Executive Officer (CEO) of the OHSC, and the Health Ombud.
2. Recruitment of additional administrative staff and procurement of equipment at RCHC to reduce waiting times and improve patient registration within six (6) months of this report.
3. Mandatory retraining of nursing staff on triage protocols using the South African Triage Scale (SATS) and ensuring that qualified nurses supervise triage duties within one (1) month of the report.

4. Introduction of biometric logging systems for all staff doctors to ensure accountability and adherence to working hours within three (3) months of this report.

5. Referral of implicated healthcare professionals — doctors and nurses involved in falsifying records or professional negligence — to the Health Professions Council of South Africa (HPCSA) and the South African Nursing Council (SANC) for disciplinary action.

6. To ensure that RCHC and PPTH comply with Regulation 7 (2) of the Norms and Standards Regulation, the CEO of PPTH and the HoD of Surgery should induct all doctors regarding post-mortem services available in the province within two (2) months after the release of this report.

Recommendations on Additional Findings

- Infrastructure improvements, including the construction of sheltered waiting areas at RCHC and the restoration of monitoring equipment and medication stock management systems at PPTH, should be instituted within four (4) months of this report.

- Audit and permanent filling of acting positions should be effected within six (6) months to restore leadership stability and accountability.

- Enhanced supervision of medical interns and registrars in accordance with HPCSA training guidelines must be adhered to immediately.

Restoring Accountability and Public Confidence

The Health Ombud emphasised that these findings demonstrate the urgent need for stronger oversight, ethical leadership, and compliance with health norms and standards across all health facilities.

"This case underscores the critical importance of timely, competent, and compassionate care in serving communities and saving lives," said the Health Ombud, Prof Mokoena. "Leadership accountability, staff supervision, and adherence to clinical protocols are non-negotiable elements of quality healthcare. The recommendations must be implemented fully to restore public confidence and prevent recurrence of similar tragedies."

The complete detailed reports are available for public access on the Health Ombud website at www.healthombud.org.za.

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Issued by the Health Ombud.

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