



SAFEGUARDING QUALITY HEALTHCARE

ANNUAL REPORT 2025/26



INTEGRITY

We act with honesty
and transparency.



COMPASSION

We care about people
and treat them
with respect.



ACCOUNTABILITY

We take responsibility
and deliver on
our commitments.



TABLE OF CONTENTS

CONTENTS	PAGE
TABLE OF CONTENTS	2
ABBREVIATION/ACRONYMS	5
LIST OF TABLES	6
LIST OF FIGURES	7
1. FOREWORD BY THE HEALTH OMBUD	8
2. MANDATE OF THE HEALTH OMBUD	10
2.1. Legislative Mandate	10
2.2. Vision, Mission, and Values	10
3. SUMMARY	11
4. OHO COMPLAINTS MANAGEMENT PROCESS	13
4.1.Complaints Call Centre	13
4.2. Complaints Assessment Unit	13
4.3.Clinical Complaints Investigation Unit	14
4.4. Legal Complaints Handling & NPM Unit	14
5. ANNUAL PROGRAMME PERFORMANCE	15
5.1.Call Centre Unit	15
5.2.Complaints Assessment Unit	19
5.3.Complaints Investigation Unit	23
5.3.1. Appeals Cases	28
6. OHO INVOLVEMENT IN NATIONAL PREVENTIVE MECHANISM (NPM)	30
6.1. Background of the NPM	30
6.2. NPM Mandate	30
6.3. NPM Unannounced Visits	30
6.4. NPM Responsible Team	31
7. HUMAN RESOURCES AND FUNDING	32
7.1. Human Resources	32
7.2. Linking Performance with Budget	32
8. OFFICE ACCOMMODATION	34
8.1.Background	34

CONTENTS	PAGE
8.2. Challenges	34
8.3. Proposal	34
9. ENGAGEMENT WITH EXTERNAL STAKEHOLDERS (FY 2025/26)	35
9.1. Presentation at the AOMA/AORC Webinar	35
9.2. Joint Investigation Planning with Public Service Commission	35
9.3. Inaugural Biennial Health Ombud Conference 2025	35
9.4. Engagement with South African Private Practitioners Forum CEO	38
9.5. Presentation at the AOMA/AORC Webinar	38
9.6. Public Protector 30th Anniversary International Conference	38
9.7. Consultative Forum with Health & Welfare SETA	39
9.8. Farewell Assembly in Honour of Justice Edwin Cameron	39
9.9. Consultation Meeting with the Department of Higher Education & Training	39
9.10. Participation in the AOMA/AORC Webinar	39
9.11. Meeting with the Interim Ombudsman for Higher Education & Training	39
9.12. Strategic Partnership with Stakeholders	40
10. STRATEGIC PLANNING	41
10.1. Discussions	41
11. HEALTH OMBUD BILL	43
11.1. Background	43
11.2. Challenges	43
11.3. Status Quo	43
11.4. The Current Status	43
11.5. The Next Step	43
11.6. The Amendment of the Current NHA	43
12. MEDIA ENGAGEMENTS	44
12.1. Introduction	44
12.2. Building Public Awareness Through Media Engagements	44
12.3. Strengthening Trust Through Community Engagements	44
12.4. Expanding Digital and Social Media Presence	45
12.5. Enhancement of Health Ombuds Website	45

CONTENTS	PAGE
12.6. Outcomes and Impact	45
12.7. Challenges Encountered	45
12.8. Lessons Learned	46
12.9. Published Health Ombud Reports	46
12.9.1. Medical Care and Death Investigation: Wits Donald Gordon Medical Centre	46
12.9.2. Clinical Care Evaluation: Pietersburg Provincial Tertiary Hospital	47
12.9.3. Neonatal Clinical Route Investigation: Netcare Femina Hospital	48
12.9.4. Psychiatric Care Systemic Assessment: Northern Cape Mental Hospital & RMSH	49
12.9.5. Care and Seclusion Evaluation: Dr George Mukhari Academic Hospital	50
12.9.6. Conclusion and Way Forward	50
13. FUTURE PLANS	51
13.1. Resolution of Legacy Backlog Complaints	51
13.2. Institutionalised Participation in the NPM	51
13.3. Data-Driven Staff Development	51
13.4. Peer Inter-Institutional Engagements	51
13.5. Enterprise Application of Artificial Intelligence	51

ABBREVIATIONS/ ACRONYMS

CAU	Complaints Assessment Unit
IPID	Independent Police Investigative Directorate
JICS	Judicial Inspectorate for Correctional Services
NDoH	National Department of Health
NHAA	National Health Amendment Act 12 of 2013
NHI	National Health Insurance
NPM	National Preventative Mechanism
OHO	Office of Health Ombud
OHSC	Office of Health Standards Compliance
OPCAT	Optional Protocol to the Convention against Torture
SAHRC	South African Human Rights Commission
SLA	Service Level Agreement

LIST OF TABLES

Table 1	Complaints received, escalated and closed in the Call Centre for 2025/26
Table 2	Risk rating of Complaints received at CCC during FY 2023/24-2025/26
Table 3	Complaints resolved within 60 working days during the 2025/26 financial year.
Table 4	Cases received for investigation by CIU per the classification of Health Establishment
Table 5	Cases Received for Investigation in 2025/26 Financial Year, Classified by Province and Discipline
Table 6	Complaints Investigations Unit Annual Performance for the 2025/26 Financial Year
Table 7	Number of NPM Unannounced Inspections during 2025/26 FY
Table 8	Human resources capacity in the Office of the Health Ombud

LIST OF FIGURES

Figure 1	Comparison of low-risk complaints received and closed per quarter by FYs 2023/24- 2025/26
Figure 2	Comparison of annual performances during 2023/24 – 2025/26 FYs
Figure 3	Comparison of total complaints received and closed by the CCC from 2023/24 until 2025/26 FYs, per province
Figure 4	Satisfaction Survey responses for the 2025/26 financial year
Figure 5	Mechanism of complaint lodging for FYs 2023/24-2025/26
Figure 6	Complaints received by the Complaints Assessment Unit per province for the 2025/26 Financial year
Figure 7	Complaints received and resolved within 60 working days per province for FY 2025/26
Figure 8	Comparison of Complaints Assessment Unit annual performance during FY 2023/24-2025/26
Figure 9	Comparison of the number of complaints received at the CAU during FYs 2023/24-2025/26
Figure 10	Complaints Investigation Unit cases received/resolved during 2023/24 to 2025/26, disaggregated by resolution timeframes
Figure 11	Distribution of CIU cases received by facility type during 2023/24–2025/26 financial year
Figure 12	Distribution of CIU cases received by health facility type during 2023/24–2025/26 financial years
Figure 13	Risk Profile of Complaints Resolved through Investigation by CIU, during 2023/24 - 2025/26 Financial Years

1. FOREWORD BY THE HEALTH OMBUD



Professor Taale Mokoena
Health Ombud

It is my greatest pleasure and honour to present my third annual financial report for the year 2025/26 as the Health Ombudsman. We have realigned the working processes within the Office of the Health Ombud to achieve the Health Ombud's mandate and the National Preventive Mechanism.

It has been a financially trying year with the National Treasury exercising stringent austerity measures. This implies that without funding, we could not tackle the legacy backlog cases. Through the recommendation from the Parliamentary Portfolio Committee on Health (PPCOH), we have approached the Health and Welfare Sector Education and Training Authority (HWSETA) for resources to undertake the "Letsema Project" to address these backlog cases.

The financial year under review showed a steady and sustained rise in complaints and a growing complexity and acuity of these complaints. Despite this, the staff has turned out admirable results. Although the OHO failed to meet its annual performance targets in percentage terms, overall throughput in absolute terms was higher, accompanied by a continued high level of accuracy, as evidenced by fewer appeals against the Health Ombudsman's findings and recommendations. The increasing number of complaints lodged partly reflects growing community awareness of the Health Ombuds' work through ongoing publicity engagements.

The move to the new Office of Health Standards Compliance (OHSC) was welcomed. However, OHO staff are still working in open-plan offices, which remain disruptive and lack privacy during consultations with complainants and other affected parties.

Funding constraints limited the OHO's engagement with several institutions, both locally and abroad, to benchmark best practices. This is not a "nice" to-do activity but a prerequisite if we are going to improve how we work. Working in silos is inimical to progress and high-standard service to our people.

Lastly, one needs to acknowledge and thank the Ministry and the National Department of Health, the Parliamentary Portfolio Committee on Health and above all, the OHSC for their continued support even under austerity measures.

The inaugural Biennial Health Ombud Symposium brought together stakeholders and academics to address the pressing issue of access to safe, high-quality health care without the burden or exclusion imposed by limited individual financial resources. It was, by all accounts, a very successful conference, but there is still room for improvement. We hope the next symposium in 2027 will be an even more resounding success.

A handwritten signature in blue ink, appearing to read 'Taale Mokoena', written in a cursive style.

Professor Taale Mokoena
Health Ombud
South Africa

2. MANDATE OF THE HEALTH OMBUD

2.1 Legislative Mandate

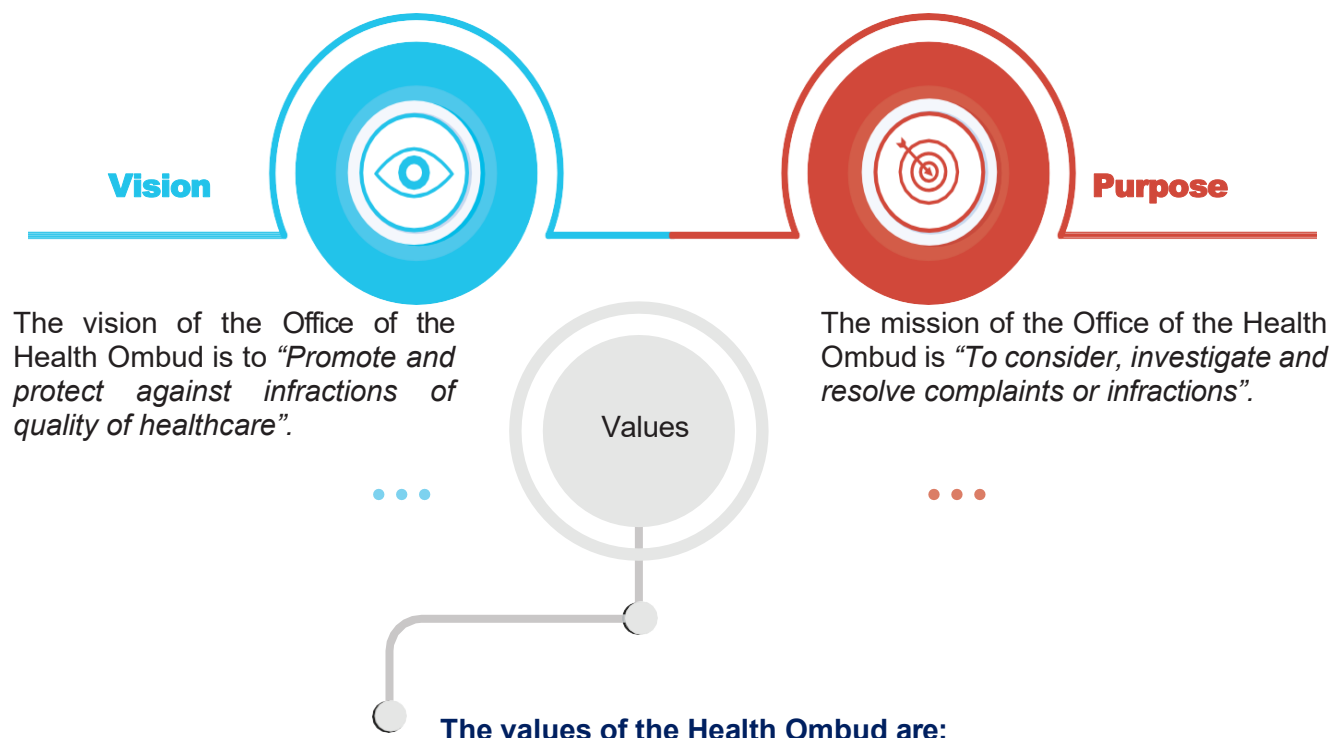


The Health Ombud is appointed by the Minister of Health in terms of Section 81 of the NHAA and is supported by staff designated and seconded by the OHSC, with the concurrence of the Ombud.

The functions of the Ombud are set out in Section 81A, wherein the Ombud may, on receipt of a written or verbal complaint relating to norms and standards, or on his or her own initiative, consider, investigate and dispose of the complaint in a fair, economical and expeditious manner.

These statutory provisions enable the Health Ombud to investigate complaints, request documents or any evidentiary material, whilst maintaining his independence and impartiality.

2.2 Vision, Mission and Values



1. Accountability
2. Independence
3. Honesty
4. Advocacy
5. Effectiveness
6. Professionalism
7. Confidentiality
8. Results-driven

3. SUMMARY

This summary provides an overview of the activities and performance of the Office of the Health Ombud (OHO) for the 2025/26 financial year, which broadly reflects a significant and persistent growth in demand for its services and growing operational pressures across its subunits.

The reporting period recorded a significant rise in complaints, with a total of 4,297 new complaints received through the Complaints Call Centre (CCC), a 9% increase from the 3,938 cases received in the 2024/25 financial year. This builds on the sharp 63% increase observed between the 2023/24 and 2024/25 financial years, clearly signalling an upward trend in complaints lodged with the OHO. Low-risk complaints accounted for the majority (94%) of complaints received; however, an important and growing proportion of medium-, high-, and extreme-risk-rated complaints remain.

It is worth noting that, for high- and extreme-risk-rated complaints, most cases in the reporting period (130; 81%) originated from public facilities. This builds on the backdrop of the Complaints Investigations Unit's case volumes increasing by 189% from 19 cases in 2023/24 to 55 in 2024/25, and by a further 58% to 87 cases in 2025/26. However, while contributing a comparatively smaller proportion of total cases, private health facilities also show steady growth across the three previous financial years, with high- and extreme-risk-rated cases rising by 400% from 3 cases in 2023/24 to 15 in 2024/25 and 13 in 2025/26.

As with previous years, Gauteng Province continues to account for the highest proportion of complaints received by the CCC, with 2096 cases (48.78%), followed closely by the Western Cape with 590 cases (13.73%) and KwaZulu-Natal with 432 cases (10.05%). This could signal higher complaint reporting among these provinces and/or higher health service utilisation and therefore a growing strain on health system capacity in more urbanised provinces. According to Stats SA's 2025 mid-year population estimates, these provinces had the highest population densities at 16.1M, 7.6M, and 12.2M, respectively, which therefore account for case-per-population rates of 13.02, 7.76, and 3.54 cases per 100,000 people, respectively. Even when expressed per population, Gauteng and KwaZulu-Natal far surpass the rest combined. This probably reflects both the less satisfactory resolution of complaints at the originating Health Establishments and the poor quality of healthcare delivery in Gauteng.

Complaints Call Centre:

Despite a historically strong performance, the Complaints Call Centre experienced a decline in performance during the reporting period. While the overall annual complaints closure rate remained relatively high at 89.7%, the unit did not meet its annual performance target of resolving 90% of low-risk complaints within 25 working days, achieving approximately 79%. This decline resulted in a "backlog" of 418 unresolved cases, largely due to increased complaint volumes and ongoing human resource constraints, with no commensurate increase in staffing.

Complaints Assessment Unit

The Complaints Assessment Unit (CAU) also faced increased work pressure, with its caseload rising significantly due to more referrals from the Call Centre. The unit managed 158 cases during the reporting period, of which 126 were new, and the remaining 32 were carried over from the previous financial year (2024/25). This caseload represents a significant increase of 43.6% from 110 cases in the 2024/25 financial year. The overall performance also declined compared with the 2024/25 financial year. Of the 48 cases that received the required information from the health establishments and/or the complainants, 21 were resolved within the prescribed 60 working days, resulting in an output of 43.75%, representing a 6.25% deviation from the annual target of 50%. The contributing factors included staffing constraints, case complexity, delays in information receipt, and operational disruptions.

Complaints Investigation Unit

As with all subunits within the OHO, the Complaints Investigation Unit (CIU) reported a marked

increase in case intake: the unit received 87 new high- and extreme-risk-rated cases. This marked a 58.2% increase from the previous financial year (2024/25) when 55 cases were received. During the 2025/26 financial year, a total of 38 cases (22 high-risk and 16 extreme-risk-rated cases) were closed across the 9 provinces. Of these, 10 were resolved within 6 months, 18 within 24 months and 10 beyond 24 months. The highest number of resolved cases recorded was in Gauteng (16; 42.1%), followed by KwaZulu-Natal (8; 21.1%) and the Western Cape (4; 10.5%). Limpopo Province and the Northern Cape each accounted for 3 resolved complaints (7.9% each), while the Eastern Cape recorded 2 cases (5.3%). The North West and Free State provinces reported the fewest cases, with 1 each (2.6% each).

National Preventive Mechanism (NPM) Engagement

The Office of the Health Ombud (OHO) continued to fulfil its role within the National Preventive Mechanism (NPM) during the 2025/26 financial year. Under the reconfigured structure, in which the South African Human Rights Commission (SAHRC) comprises the NPM, the Health Ombud served as the health expert and executing agent for the SAHRC. The monitoring of places of deprivation of liberty was undertaken in line with South Africa's obligations under the United Nations' Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), to which the country has been a signatory since 2019.

A key development since its inception was the reconfiguration of the NPM in December 2024, designating the South African Human Rights Commission (SAHRC) as the NPM, supported by four (4) other independent oversight institutions providing technical support within their respective expert mandates, including the Health Ombud, Judicial Inspectorate for Correctional Services (JICS), the Office of the Military Ombud (OMO) and the Independent Police Investigative Directorate (IPID). Some of the findings observed during NPM inspections of the various facilities include overcrowding in some Correctional Service Centres, a shortage of staff and provisions such as bed sponges and sanitary towels in some SAPS holding cells and Correctional Centres, limited staff uniforms in some Correctional Service Centres, poor or deteriorating infrastructure and non-compliance with the Occupational Health and Safety Act. Of note are the two (2) reports on Tower Psychiatric Hospital and Boitumelo Regional Hospital Psychiatric Unit, with several deficiency findings and respective recommendations largely centred on infrastructure, staffing, and outdated standard operating procedures.

Overall, there is a persistent and significant increase in complaint volumes across all subunits, coupled with increased low case complexity and limited capacity (human and financial). These factors have placed considerable pressure on OHO's operational capacity. Consequently, the OHO was unable to meet its performance targets as per the annual performance plan and, as a result, has an increasing number of cases carried over across quarters and financial years. This observation highlights the need to strengthen human and financial resources and implement mechanisms to improve efficiency, such as leveraging digital technologies, including Artificial Intelligence (AI).

Inaugural Health Ombuds Symposium

The Health Ombud hosted a successful inaugural biennial symposium in September 2025 with the theme "Health and health care as human rights". The symposium brought together a range of stakeholders in the healthcare space, both public and private. Delegates from both within the country and internationally deliberated on models of access to universal quality health care. It was made clear that there's no single model that fits all. The role of the private sector in all aspects of health care was explored. The consensus was that there needs to be dialogue among all stakeholders. Litigation before the courts should not derail the quest for universal access to safe, good-quality healthcare.

Interactions and engagements with several institutions

It is important that the Health Ombud interacts with and engages sister organisations at home and abroad to share best practices. The Health Ombud Symposium was just one such engagement.

4. ORGANISATION OF THE OFFICE OF THE HEALTH OMBUD (OHO) COMPLAINTS MANAGEMENT PROCESS

The mandate of the Health Ombud derives from Section 81A (1) of the National Health Amendment Act, 2013 (Act No. 12 of 2013) and it is to consider, investigate and dispose of complaints relating to breaches of prescribed norms and standards in a fair, economic and expeditious manner; and the Ombud may initiate investigations on his/her own accord.

The OHO Complaints Management Unit comprises four (4) distinct but interrelated subunits, namely the Complaints Call Centre, the Complaints Assessment Unit, the Clinical Complaints Investigation Unit, and the Legal Complaints Handling and National Preventative Mechanism (NPM) Unit.

4.1 Complaints Call Centre Unit

Purpose: to receive complaints from the public through telephone calls, walk-in submissions, emails, written letters, and mobile SMS. The staff at the call centre register, record, and screen all complaints received, and refer them to the next level as appropriate. All “*low risk*” complaints are addressed and resolved at the call centre level. Complaints which receive “*medium*” and “*high*” risk ratings are referred to the Complaints Assessment Unit.

Complaints which receive an “*extremely high*” risk rating may be referred directly to the Clinical Complaints Investigation Unit, while those with legal merit or from lawyers and other statutory bodies are referred to the Legal Complaints Unit.

Definition of risk ratings:

Low risk is when the complaint involves no harm to patients, staff, or visitors, no loss of service, and minimal financial loss. There is minor damage to customer service relationships.

Medium risk is where the complaint involves limited patient complications from treatment but requires no further treatment. A staff member was injured and required treatment, resulting in loss of work time or restricted functionality, reduced or disrupted services, significant financial loss, or some loss of services.

High risk involves serious permanent complications or death of a patient from treatment otherwise not expected from usual patient management; permanent injury to staff members or visitors; loss of service capacity, major financial loss and breakdown of customer service relationships.

Extreme risk involves death of the patient from treatment otherwise not expected from usual patient management; death of a staff member or visitor; complete loss of service capacity; major financial loss; and serious threat to customer service relationships.

4.2 Complaints Assessment Unit

Purpose: to screen and assess the *medium*, *high* and *extreme* risk-rated complaints. The Complaints Assessment Unit disposes of medium risk-rated complaints through desktop investigations and refers the *high* and *extreme* risk-rated complaints, after further screening, to the Complaints Investigation Units (clinical or legal) for onsite investigation following the receipt of information from the Health Establishment and/or Complainant.

4.3 Clinical Complaints Investigation Unit

Purpose: to investigate high and extreme-risk-rated complaints involving allegations of clinical mismanagement or perceived negligence across public and private health establishments in all nine

provinces. The unit conducts comprehensive on-site investigations by gathering evidence through inspections of health facilities within the health establishment, witness interviews, issuing subpoenas when necessary, and requesting and analysing evidentiary materials to ensure a comprehensive case review.

The Ombud has statutory powers to access all relevant records and conduct *in loco* inspections of areas pertinent to the investigation. The Ombud may refer findings indicative of gross professional misconduct to appropriate statutory professional regulatory bodies for further investigation. Where there is apparent criminality, the Ombud refers such cases to the law enforcement authorities.

4.4 Legal Complaints Handling and National Preventative Mechanism Unit

Purpose: to investigate high and extreme risk-rated complaints referred from the Complaints Call Centre or the Complaints Assessment Unit, and to investigate some extremely high risk-rated complaints.

Additionally, to investigate complaints with legal merit or from lawyers and other statutory bodies. The Unit also provides legal advice and expertise to the Health Ombud, liaises with legal units in the Office of Health Standards Compliance (OHSC) and the National Department of Health, and coordinates the Health Ombud's input and participation in the National Preventative Mechanism (NPM).



5. ANNUAL PROGRAMME PERFORMANCE

5.1 Call Centre

During the 2025/26 financial year, the Office of the Health Ombud (OHO) received 4297 new complaints through its Complaints Call Centre (CCC). Of these, 3355 were from public health establishments, while the remaining 942 were from private health establishments. Table 1 reflects the complaints received, escalated or closed (finalised) in the CCC for the 2025/26 financial year. This is in addition to the 101 complaints carried over from the previous financial year, 2024/25. As illustrated, low-risk complaints account for the majority (94%) of new cases received at the CCC, with the remainder categorised as medium (3%), high (1%), and extreme (2%) risk.

Table 1: Complaints received, escalated and closed in the Call Centre for 2025/26

Complaints Call Centre Financial Year 2025-2026				
Total new complaints received	4297 (+ 101 carried over from 2024/25)			
• Low risk	4042			
• Medium risk	111			
• High risk	50			
• Extreme risk	94			
Closed at the Call Centre	Low	Medium	High	Extreme
	3624	49	25	28
New cases assigned for Assessment	126			
New cases assigned to the Director	16			

The main reasons for closure of medium, high and extreme cases (n=102) by the CCC included the following:

- Complainant **failure** to respond to requests for the submission of required documentation necessary to facilitate further analysis of the matter (52 cases: 51%).
- Complaint lodging duplication due to concurrent submission of complaints to both the Office of Health Ombud (OHO) and the involved health establishment (17 cases: 16.7%).
- Complaint being dealt with by another entity (9 cases: 8.8%)
- Voluntary **withdrawal** of complaints by complainants due to various reasons (2 cases: 2%).
- Lodging of complaints by individuals who are **unable to obtain** the required **consent** from the next of kin to act on behalf of the patient (3 cases: 2.9%).



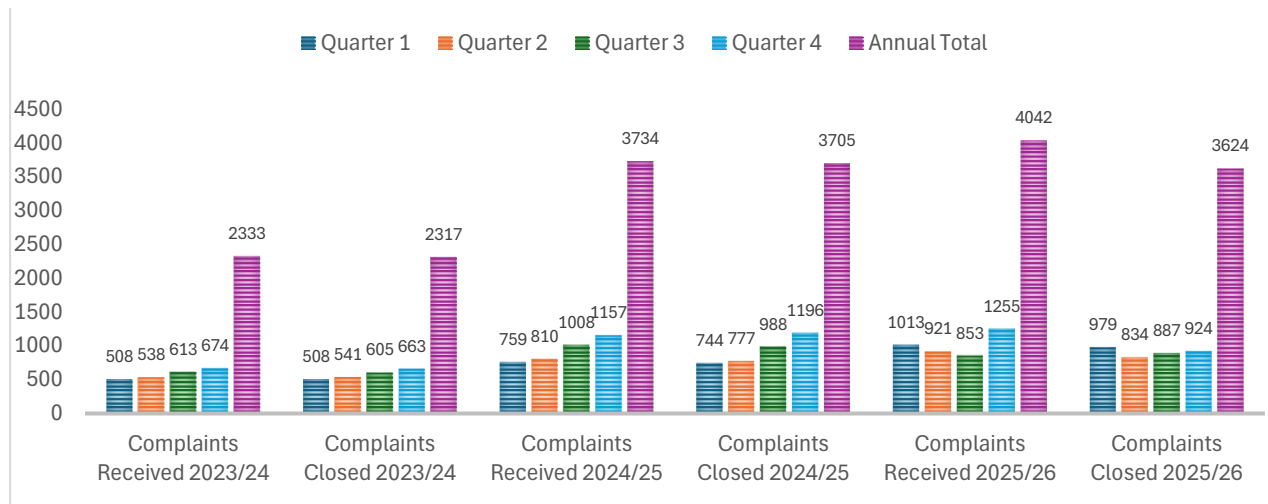


Figure 1: Comparison of low-risk complaints received and closed per quarter by FYs 2023/24- 2025/26

Figure 1 shows a consistent upward trend in the number of low-risk-rated complaints received over each FY. Additionally, low-risk complaint volumes increased significantly over the three financial years, rising by 60% from 2,333 cases in 2023/24 to 3,734 cases in 2024/25, and by a further 8% in 2025/26 to 4,042 cases, reflecting persistent growth in demand for complaint investigation. In terms of closure rates, these remained high at around 99% in both 2023/24 and 2024/25. However, performance declined slightly in the 2025/26 FY to approximately 90%, resulting in a “backlog” of 418 cases compared to 16 and 29 cases in 2023/24 and 2024/25, respectively.

The quarterly analysis shows consistent general performance in the two preceding years, and a notable drop in closures during Quarter 4 of 2025/26, which contributed most to the reported “backlog” buildup. Overall, these data suggest that although the organisation had historically managed complaints effectively, the recent increase in volumes is placing strain on capacity, resulting in reduced performance against APP and an increase in unresolved cases. However, the absolute number of finalised cases was 3726, comparable to 3892 in the previous financial year.

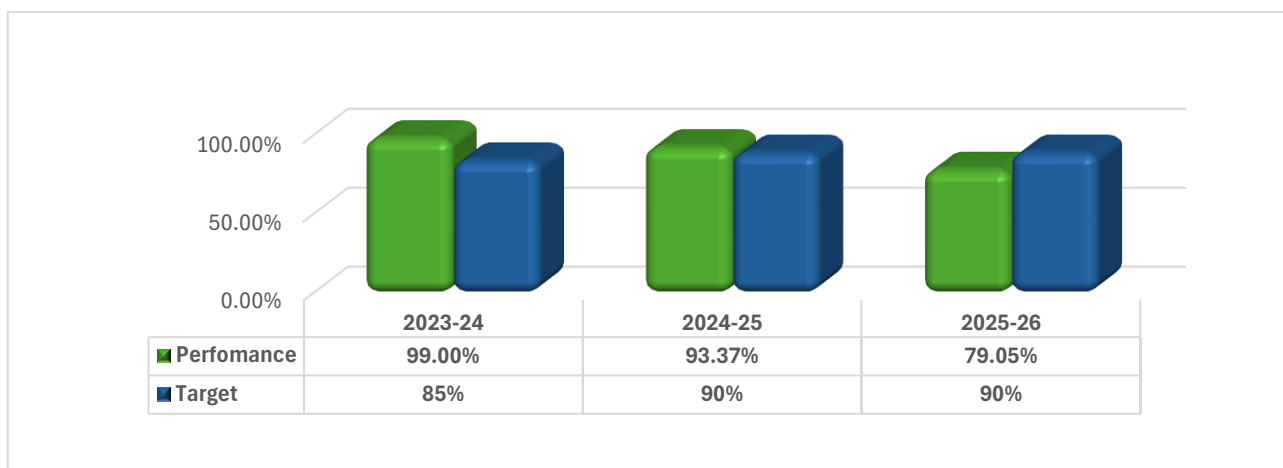


Figure 2: Comparison of annual performances during 2023/24 – 2025/26 FYs

Figure 2 shows that, in contrast to the past two financial years (2023/24 and 2024/25), the unit did not meet its performance measure of closing 90% of low-risk complaints within 25 working days of lodgement in the CCC. There was a total of 3,624 cases closed, 3,288 within the SLA and 336 outside the SLA.

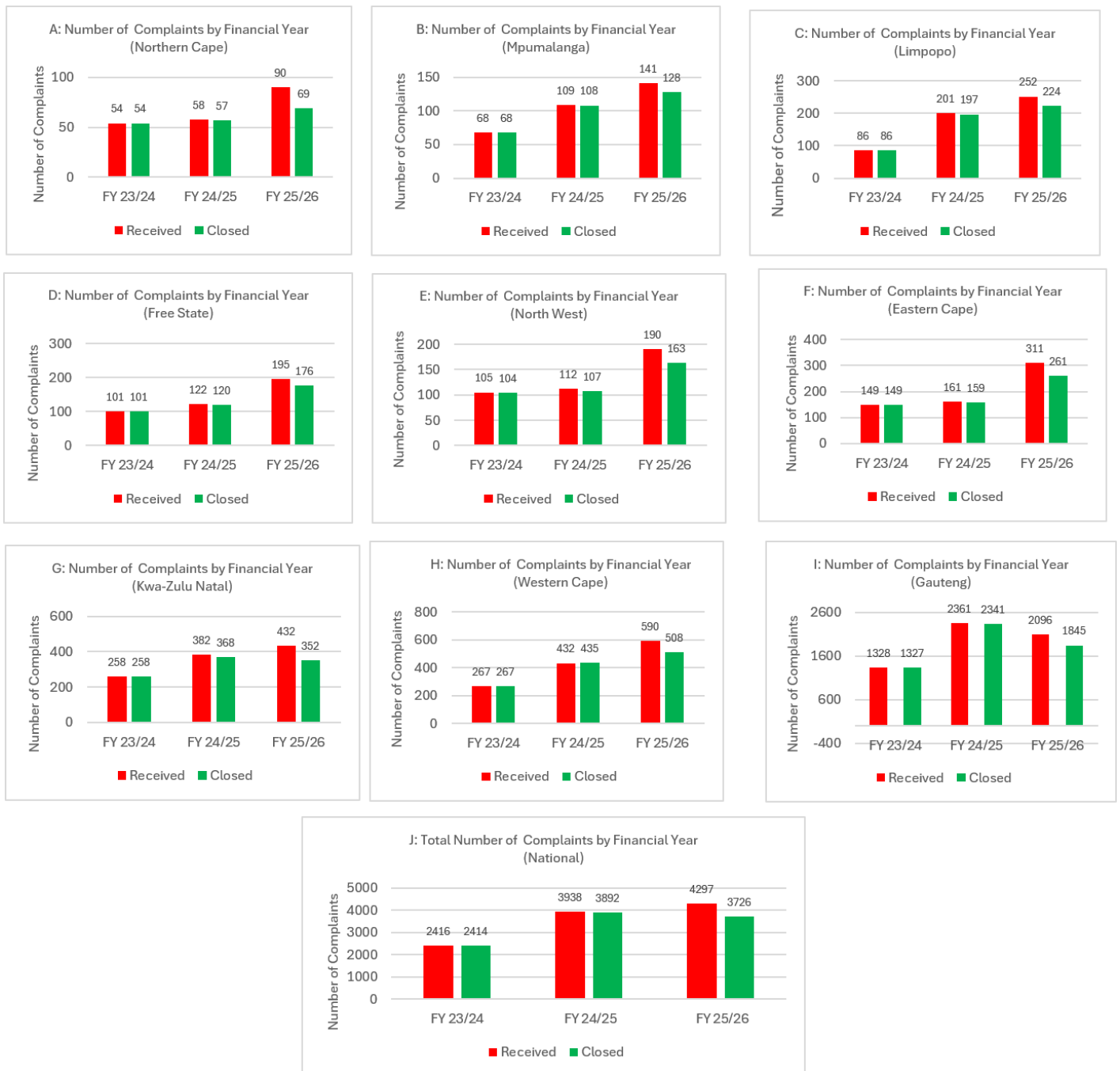


Figure 3: Comparison of total complaints received and closed by the CCC from 2023/24 until 2025/26 FYs, per province. NB the scales are not the same for all provinces

As shown in Figure 3, the highest number of complaints continues to come from the Gauteng Province, followed by the Western Cape and KwaZulu-Natal.

The total number of complaints received by the CCC in Figure 3 includes medium-, high-, and extreme-risk cases across the three financial years. Some of these were closed within the CCC, while others were escalated for assessment and investigation. However, the latter may not have been resolved within each respective individual financial year.

Overall, the total number of complaints received significantly increased from 2,416 in 2023/24 to 3,938 in 2024/25 (a 63% increase) and further to 4,297 in 2025/26 (a 9% increase), indicating a clear upward trend, particularly between 2023/24 and 2024/25. In contrast, although the number of complaints closed rose by 62% from 2,414 in 2023/24 to 3,892 in 2024/25, it declined slightly by 4.3% to 3,726 in 2025/26, despite a higher number of complaints received.

The decline in performance, and therefore an increase in the “backlog” of cases, can be attributed to several key factors: first, complaint volumes have increased progressively over the financial years, placing additional pressure on the unit; secondly, human resource shortage in the face of increasing volume of complaints; thirdly, increasing complexity of cases (Table 2).

Satisfaction survey 2025/26

A satisfaction survey is conducted to assess complainants' satisfaction with the CCC's complaint-handling process. It also provides the unit with an opportunity to identify service gaps and implement improvements where necessary.

As part of the complaint closure process, complaints officers contact complainants by phone to provide an update on the case's progress. During this interaction, complainants are requested to rate their experience of the complaint-handling process, and the response is recorded.

Upon closure of the complaint, a follow-up email with a survey is sent to the complainant, requesting that they rate the service received.

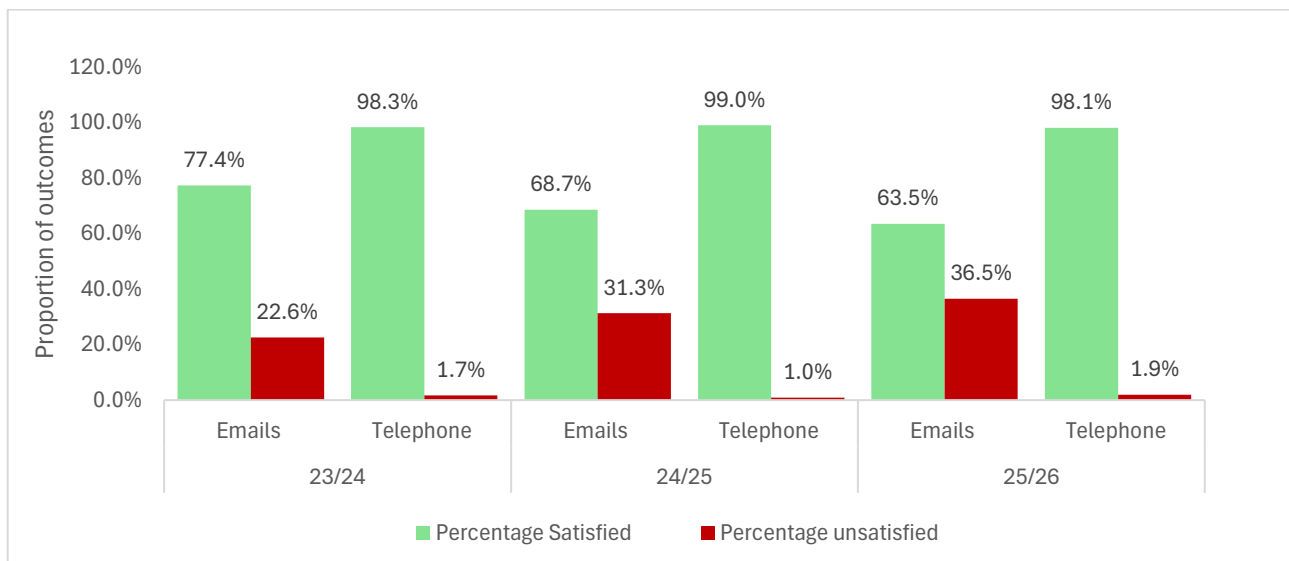


Figure 4: Satisfaction Survey responses for 2025/26 financial year

Note: Figure 3 excludes non-responsive complainants for whom satisfaction outcomes were sought via both email and telephone. For FY 2023/24, this comprised 2171 non-responsive complainants via email and 1149 via telephone; for FY 2024/25, it included 3442 via email and 2210 via telephone; and for FY 2025/26, it included 3326 via email and 2245 via telephone.

The satisfaction survey results across the three financial years (2023/24 to 2025/26) show a clear and consistent difference in performance between the telephonic and email survey methods used for case closure. The key outcomes measured among responding complainants are satisfaction versus dissatisfaction. Telephonic surveys consistently have higher satisfaction rates than email surveys, ranging from 98.1% to 99% satisfaction over the 3 financial years. Email satisfaction rates are comparatively lower, ranging between 63.5% to 77.4%, indicating a generally positive response to “personal” contact.

It is worth noting that, across all 3 financial years, satisfaction rates consistently exceeded dissatisfaction rates in each satisfaction survey method. The overall high satisfaction recorded suggests that complainants generally regard resolved cases as satisfactory.

Risk Rating	2023-24		2024-25		2025-26	
Extreme	03	1.49%	35	3.43%	94	3.35%
High	33		100		50	
Medium	48	1.99%	69	1.75%	111	2.58%
Low	2333	96.52%	3734	94.82%	4042	94.07%
TOTAL	2416	100%	3938	100.00%	4297	100.00%

Table 2: Risk rating of Complaints received at CCC during FY 2023/24-2025/26

Broadly, the complaints call centre (CCC) experienced a substantial increase in complaint volumes over the three-year period. The number of complaints received by the CCC increased from **2,416** in **FY 2023/24** to **3,938** in **FY 2024/25**, and further to **4,297** in **FY 2025/26**. This represents an overall increase of approximately **78%** over the three-year period. While low-risk complaints continued to dominate, their proportion declined slightly, and the proportions of medium- and extreme-risk complaints increased significantly over the reporting period.

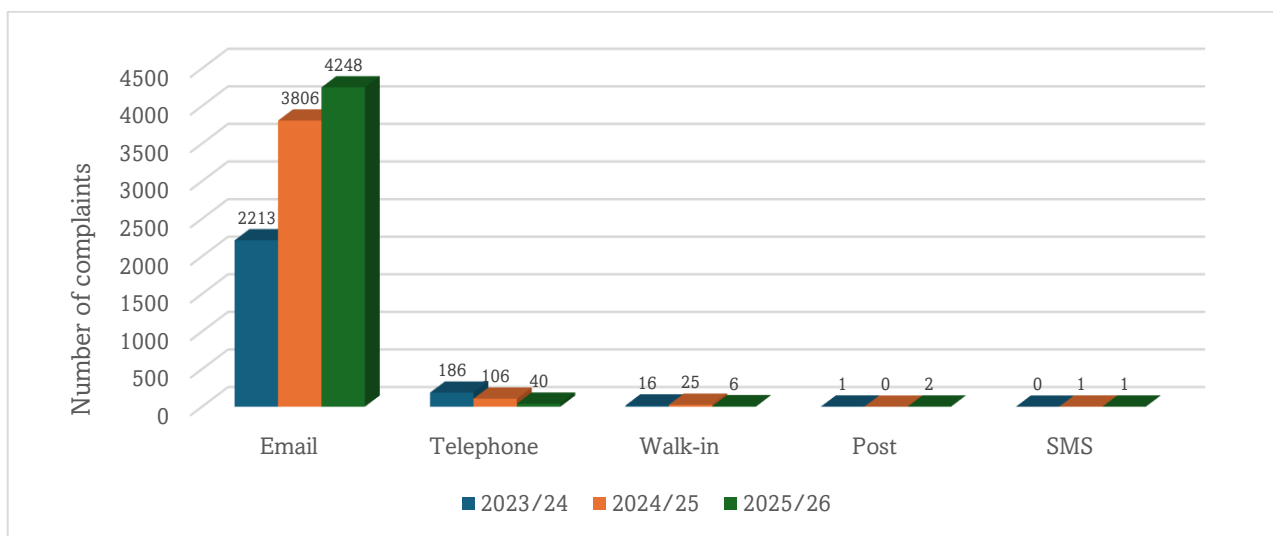


Figure 5: Mechanism of complaint lodging for FYs 2023/24-2025/26

Figure 5 shows that emails have consistently been the most common channel for lodging complaints, followed by telephonic complaints. In contrast, there were minimal complainants presenting themselves at the OHO office or lodging complaints by post or SMS.

5.2 Complaints Assessment Unit

The CAU received 126 new cases from the Complaints Call Centre during FY 2025/26. This was in addition to 32 cases carried over from the previous financial year (2024/25), bringing the total CAU caseload to 158, a 43.6% increase from 110 cases in FY 2024/25, as shown in Table 3. Forty-eight (48) of these 158 cases received information from the health establishment and/or the complainant, and 22 of these were resolved by the end of the financial year (2025/26). Of these, 21 were resolved within 60 working days of receipt of information, and 1 was resolved after 60 working days, which falls outside the SLA.

By the end of the reporting period (2025/26), the 26 remaining complaints that received information were still awaiting further resolution by the CAU. Consequently, the CAU achieved a performance of 43.75% (21/48), against the annual target of 50%, with a deviation of – 6.25%. Of the remaining 110 cases received, 65 were referred to the Complaints Investigation Unit for further management and 45 were i) awaiting submission of information from the health establishment and/or the complainant, and ii) those that were yet to be notified.

Financial Quarters	Complaints resolved through assessment		Complaints which received the information		Cum Target	Achievement	Deviation
	Absolute	Cumulative	Absolute	Cumulative			
Quarter 1	5	-	14	-	35%	35.7%	+0.7
Quarter 2	7	12	19	33	40%	36.4%	-3.6
Quarter 3	3	15	7	40	45%	37.5%	-7.5
Quarter 4	6	21	8	48	50%	43.75%	-6.25%
TOTAL	21	21	48	48	50%	43.75%	-6.25%

Table 3: Complaints resolved within 60 working days during the 2025/26 financial year

As shown by Table 3, CAU resolved five (5) Complaints within 60 working days in Quarter 1 during FY 2025/26, in Quarter 2, seven (7) complaints were resolved in SLA, three (3) complaints in Quarter 3, and six (6) were resolved in Quarter 4. A total of 21 complaints were resolved cumulatively within 60 working days. Only one complaint was resolved after 60 working days.

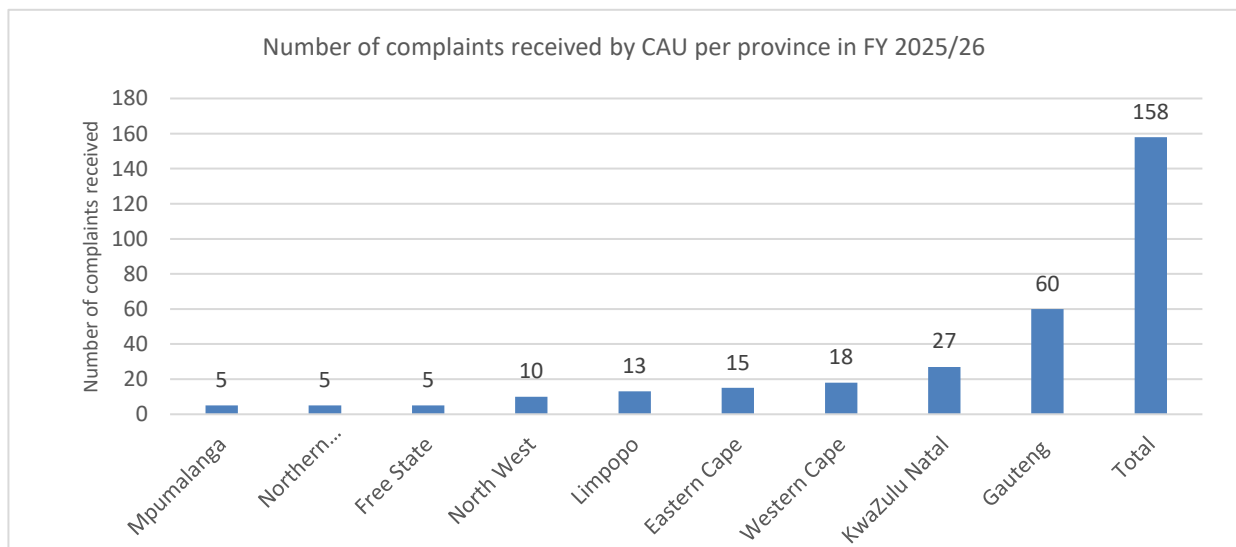


Figure 6: Complaints received by Complaints Assessment Unit per province for the 2025/26 Financial year

Figure 6 illustrates that, of the 158 complaints managed by the CAU in FY 2025/26, the bulk were from Gauteng Province, 60 cases (38%), followed by KwaZulu-Natal Province, 27 cases (17%), and Western Cape Province, 18 cases (11.4%).

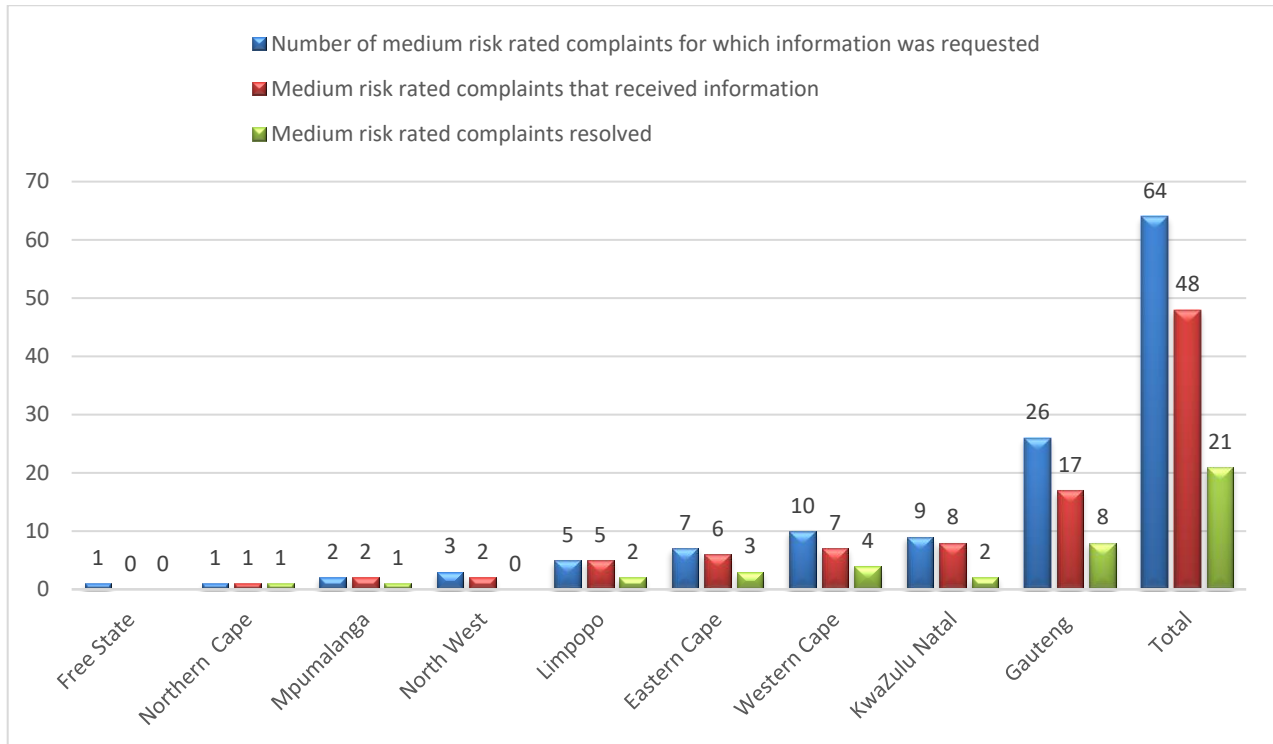


Figure 7: Complaints received the information and resolved within 60 working days per province for FY 2025/26

Figure 7 shows that GP had the highest burden of complaints, with seventeen (17) complaints, of which eight were resolved within the SLA. This was followed by KwaZulu-Natal Province, which had eight (8) complaints, of which two (2) were resolved, resulting in a low-resolution rate of 25% (2/8).

The Western Cape had seven (7) complaints, and four (4) were resolved, a high-resolution rate of 57% (4/7). Free State Province is the only province in which there was neither submission of information nor resolution of complaints, despite 5 cases being lodged in the province, as shown in Figure 6.

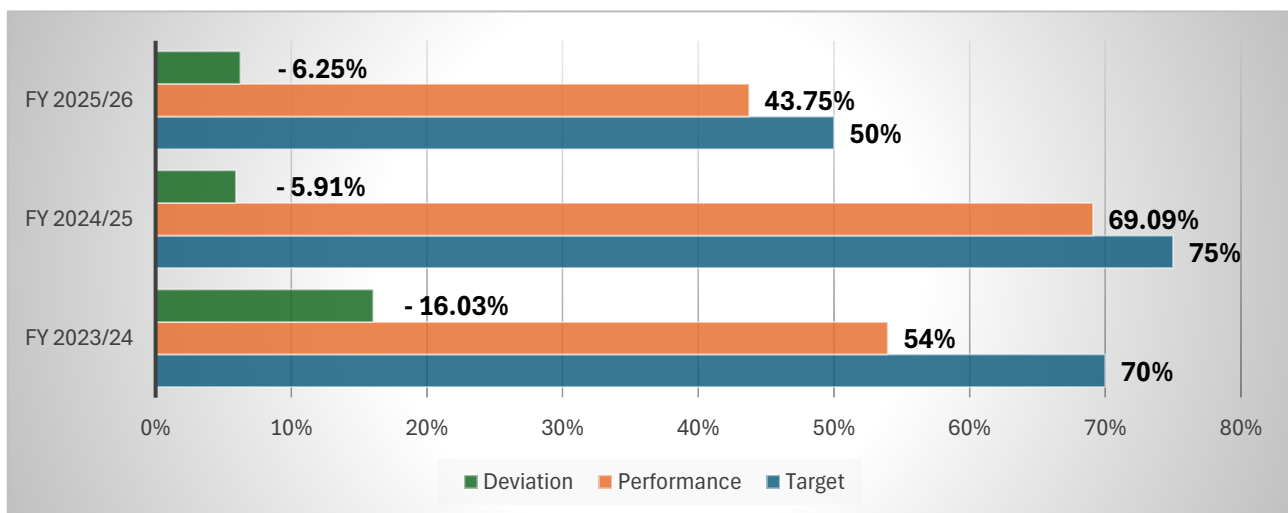


Figure 8: Comparison of Complaints Assessment Unit annual performance during FY 2023/24-2025/26

Note: The performance indicator changed in FY 2025/26 and measured the percentage of medium-risk complaints resolved within 60 working days (SLA) of receipt of information from the health establishment. Figure 4 indicates a decline in performance in FY 2025/26 (43.75%) compared to previous FY 2023/24 (54%) and FY 2024/25 (69.1%). It is worth noting that the CAU's performance

indicator and its measurement methodology changed between FY 2024/25 and FY 2025/26. In FY 2024/25, the indicator measured complaints resolved through assessment within 30 working days and included all complaints assigned for assessment, regardless of risk rating (medium, high, or extreme). In contrast, during FY 2025/26, the timeframe increased to 60 working days, with the numerator and denominator limited to medium-risk-rated complaints for which the requested information had been received from the complainant and/or health establishment. Consequently, the FY 2025/26 results are not directly comparable with those of FY 2024/25 or other previous reporting periods. The changed parameters should not make much difference; what matters is the performance under each regimen.

The following reasons contributed to the Complaints Assessment Unit's failure to meet the Service Level Agreement (SLA)

- Surge of new complaints from Complaints Call Centre- In 2024/25, the unit was managing 110 complaints versus 158 complaints in 2025/26 (43.6% increase)
- Staff constraints: The unit was and is operating with only six assessors who were required to manage 158 complaints and resolve them within 60 working days. Complexity of cases, which includes sourcing information (which may be delayed) from more than one health establishment, with each Assessor only being able to assess one complaint at a time.
- Analysis before referral of high and extreme-risk-rated complaints
- Disruption of work efficiency by the Office relocation process.
- Time constraints and reduced operational efficiency because of limited staff working times due to transportation challenges secondary to the OHSC office move.

Three-Year Overview of the Complaints Assessment Unit

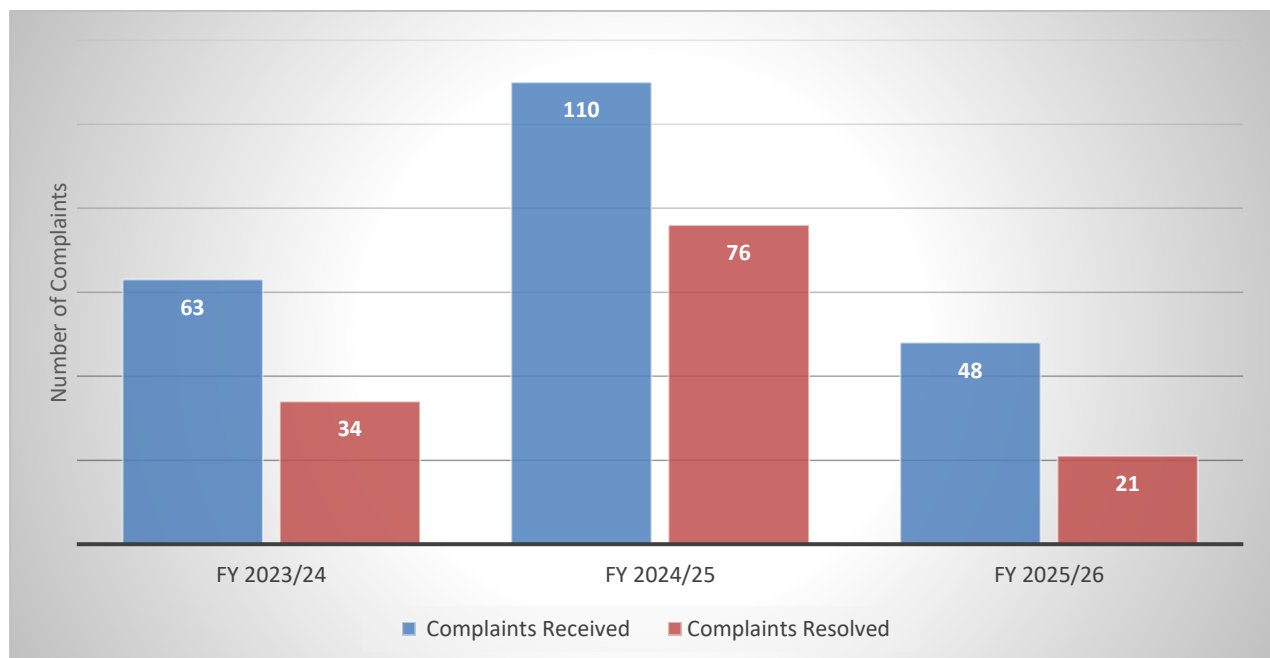


Figure 9: Comparison of Number of complaints received at the CAU during FYs 2023/24-2025/26

The complaints assessment unit received an increasing number of complaints, 74.6% between 2023/24-2024/25 and 14.5% between 204/25-2025/26 (Figure 4). This caseload growth contributed to the increase in cases carried over between financial years.

5.3 Complaints Investigation Unit

During the reporting period (FY 2025/26), the Complaints Investigation Unit (CIU) received 87 new high- and extreme-risk-rated complaints. As shown in Figure 10, the Complaints Investigation Unit experienced a steady increase in the volume of cases received from 2023/24 to 2025/26, alongside a gradual improvement in resolution efficiency, particularly in reducing the number of older, long-pending matters.

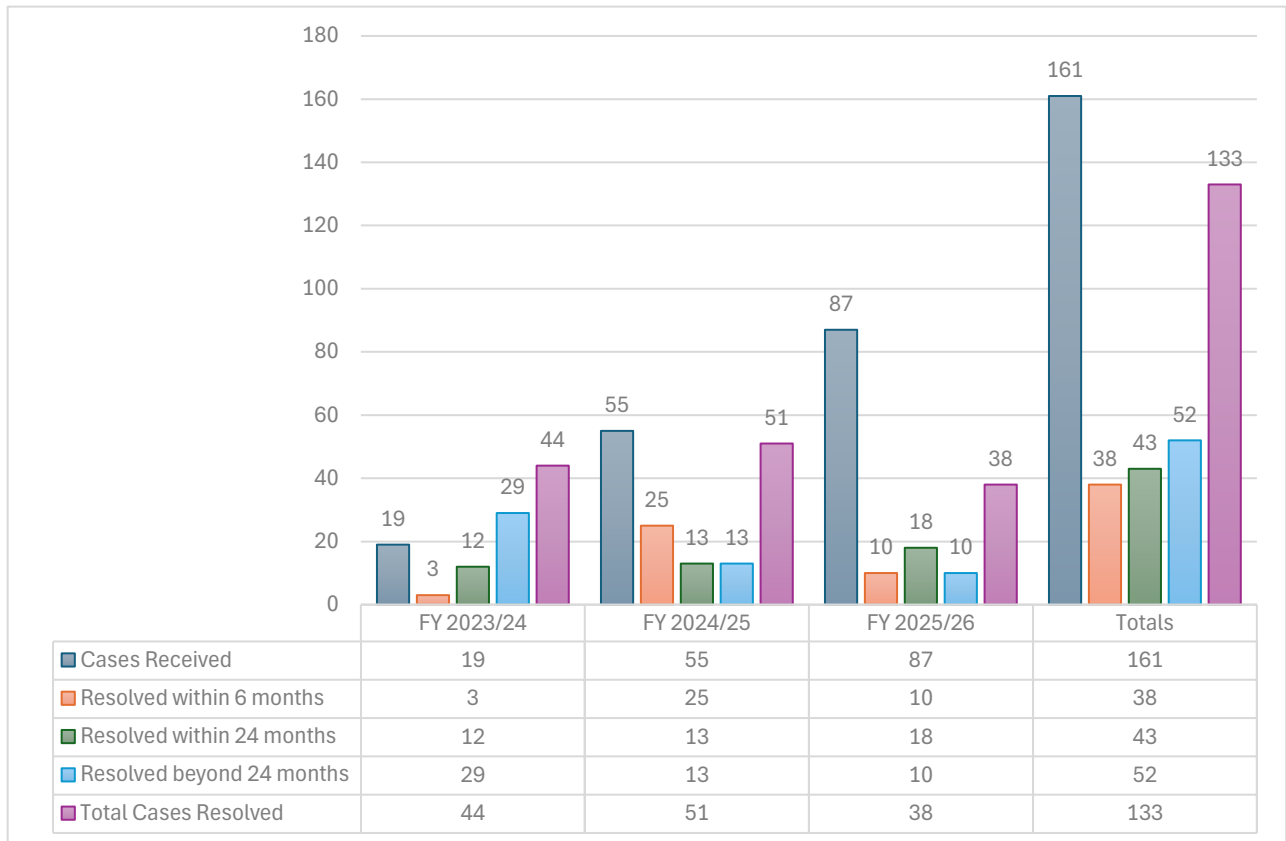


Figure 10: Complaints Investigation Unit cases received and resolved during the 2023/24 to 2025/26 financial years, disaggregated by resolution timeframes: 6, 24, and beyond 24 months

One hundred and sixty-one (161) cases were received over the three-year period. The annual intake increased significantly, from 19 cases in 2023/24 to 55 in 2024/25 (189% increase), and then to 87 in 2025/26 (58% increase). This reflects a sustained upward trend in complaints referred for investigation, with the current (2025/26) financial year accounting for more than half of the total cases received (54%) over the three years. Overall, the Office of the Health Ombud experienced an absolute increase in the number of cases received across all subunits.

This probably reflects the increased awareness of the work done by the OHO. In terms of case resolutions, 133 cases were resolved over the three-year period. Of these, 38 cases (28.6%) were resolved within 6 months, 43 cases (32.3%) within 24 months, and 52 cases (39.1%) beyond 24 months. Broadly, this indicates that while the CIU has made steady progress in improving medium-term resolution (within 24 months), a significant proportion of historical backlog cases remain outstanding.

A more focused analysis of case resolutions by timeframe over the 2023/24-2025/26 financial years shows the following:

- During 2023/24, 44 cases were resolved. Of these, 3 cases (approximately 7%) were resolved within 6 months, 12 cases (27%) within 24 months, and 29 cases (66%) were resolved beyond

24 months. This indicates a consistent focus on resolving older, long-standing cases during this period.

- During 2024/25, the resolution performance improved both in volume and timeliness with 51 cases resolved versus 44 in FY 2023/24, a case resolution improvement of 15.9%. Most cases (25; 49%) were concluded within 6 months, with 13 cases (25.5%) closed in each of the remaining timeframes (within 24 months and beyond 24 months). Overall, this reflects a notable reduction in the resolution of aged cases compared to the previous year (2023/24).
- During 2025/26, a lower number of cases were resolved (38) in comparison to the two previous financial years. Of these, 10 cases (26%) were resolved within 6 months, 18 cases (47%) within 24 months, and 10 cases (26%) beyond 24 months. While overall case resolution numbers declined compared to previous years, the distribution shows a more balanced resolution pattern, with a continued focus on reducing older cases.

Overall, the data above reflects two key trends. Firstly, there is a consistent year-on-year increase in case inflow, placing increasing demand on the Complaints Investigation Unit. Secondly, there is a gradual shift towards improved timeliness and resolution, particularly in 2024/25 and 2025/26, when a larger proportion of cases were resolved within 24 months than in 2023/24. However, the persistence of cases resolved more than 24 months ago across all years highlights the ongoing legacy backlog. This category shows a declining trend from 29 cases in 2023/24 to 10 in 2025/26, due to refocusing work on new cases to avoid them ageing into backlog cases (>24 months).

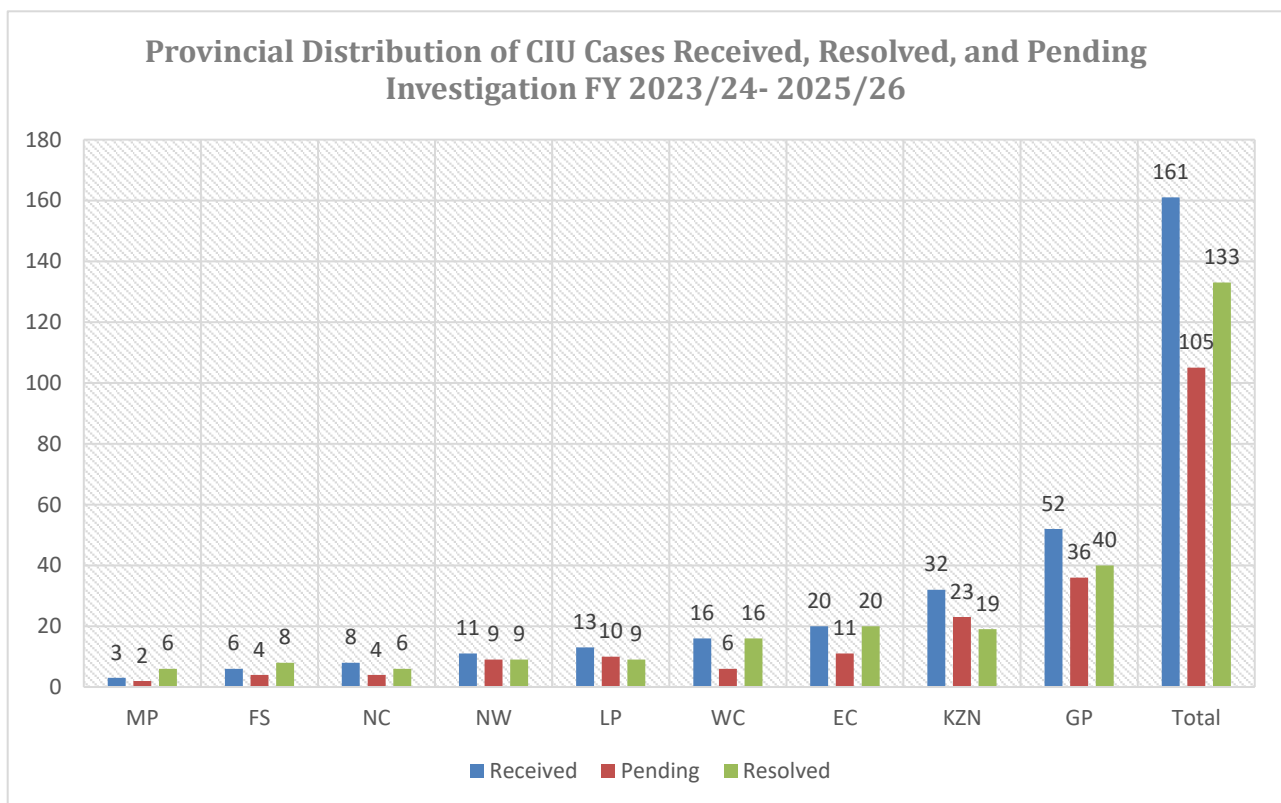


Figure 11: Provincial Distribution of Cases Received, Pending Resolved by CIU, and Pending Investigation across Nine Provinces for the FY 2023/24–2025/26

Figure 11 illustrates the provincial distribution of the 161 complaints received from the nine provinces over the three financial years (2023/24–2025/26). It is noted that Gauteng recorded the highest number of complaints, with 52 cases (32.3%), followed by KwaZulu-Natal with 32 (19.9%), and Mpumalanga with the fewest (1.9%). This distribution partly reflects variation in the distribution of regional healthcare facilities, with urbanised provinces carrying higher patient caseloads, which may

reflect their higher population density and concentration of health establishments.

By the end of the 2025/26 financial year, 105 cases remained open, with Gauteng again accounting for the largest share of pending cases (34.3%), followed by KZN (23; 21.9%). The persistence of pending cases across all provinces indicates systemic constraints in case processing and limited investigative capacity, warranting targeted intervention. It is worth noting that the buildup of legacy backlog cases stems from the OHO being opened without any investigative personnel, and thus, cases could not be investigated.

Regarding provincial case resolutions, 133 complaints were resolved during the reporting period. Gauteng recorded the highest number of resolved cases, at 40 (30.1%), followed by Eastern Cape with 20 (15%) and KwaZulu-Natal with 19 (14.3%).

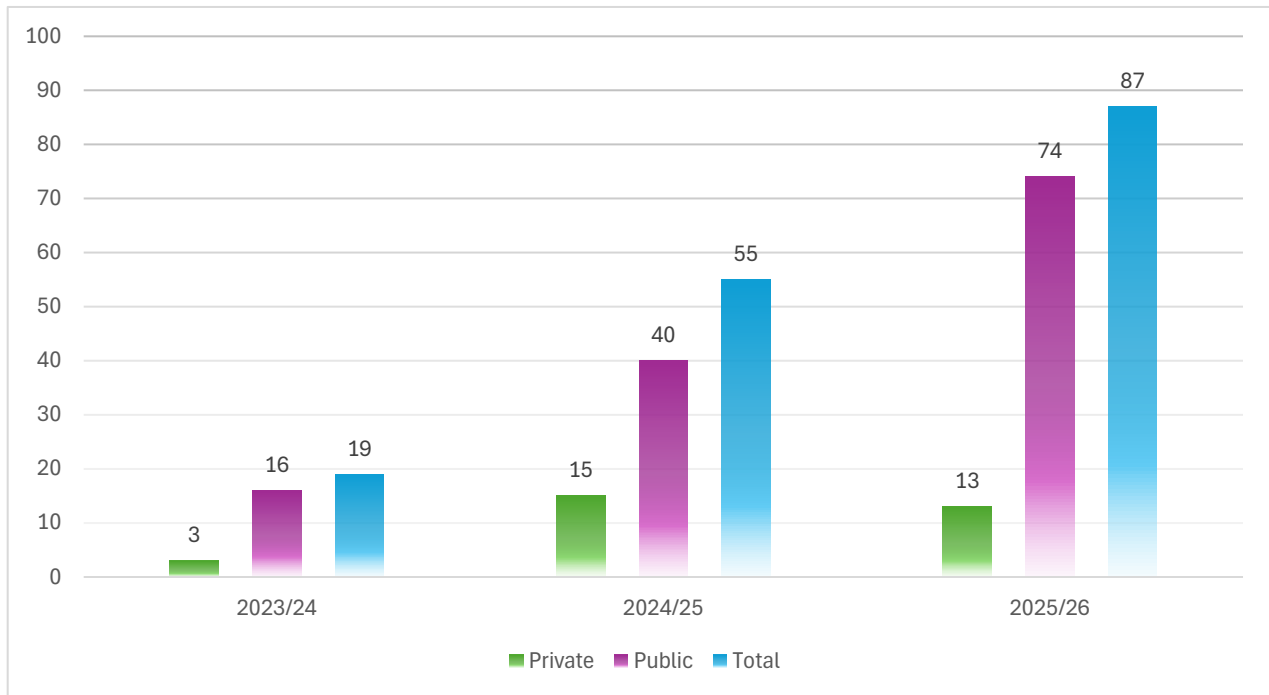


Figure 12: Distribution of CIU cases received by health facility type during 2023/24–2025/26 financial years

The distribution of cases received by health facility type shows a consistent upward trend across the reporting periods, as shown in Figure 12. Public facilities account for most cases, increasing significantly from 16 in 2023/24 to 40 (a 150% increase) in 2024/25, and then by 85% to 74 in 2025/26. This sharp rise suggests either an improved reporting rate, increased utilisation of healthcare services and facilities, or a growing burden within the public healthcare sector. While the private health sector accounts for a comparatively smaller proportion of total cases, it also shows steady growth during the reporting periods, mirroring the overall trend of increasing cases across the board. Overall, the distribution of complaints by health facility type indicates that most matters investigated by the CIU originate from the public healthcare sector. However, the global increase in case intake warrants further investigation into underlying causes.

TOTAL CASES RECEIVED FOR INVESTIGATION				
Health establishment classification	2023/24	2024/25	2025/26	Total
Regional Hospital	06	07	29	42
Private Hospital	03	13	14	30
District Hospital	03	14	17	34
National Central Hospital	01	05	09	15
Provincial Tertiary Hospital	04	05	08	17

TOTAL CASES RECEIVED FOR INVESTIGATION				
Health establishment classification	2023/24	2024/25	2025/26	Total
Clinic	00	03	04	07
Community Health Centre	00	00	03	03
Emergency Medical Services (EMS)	02	00	03	05
Maternity Services	00	01	00	01
Specialised Hospitals	00	02	00	02
Miscellaneous	00	05	00	05
Total	19	55	87	161

Table 4: Cases received for investigation by CIU per the classification of Health Establishment

Table 4 illustrates the distribution of the 161 cases received for investigation across the various categories of health establishments over the three financial years (2023/24 to 2025/26). There is a clear case predilection for hospital-level services, particularly among regional (42; 26.1%), district (34; 21.1%), and private hospitals (30; 18.6%), with a marked increase in the overall caseload in the latter two financial years (55 and 87 cases). No complaints were recorded from laboratory services and rehabilitation centres during the three-year period. Overall, the distribution of complaints indicates that hospitals remain the primary source of cases investigated by the Unit. The significant increase in complaints in 2024/25 and 2025/26, particularly from referral hospitals, suggests increased pressure on higher-level referral facilities and on complicated cases at that level.

Discipline	Gauteng	KwaZulu-Natal	Western Cape	Eastern Cape	Northern Cape	Free State	Northwest	Mpumalanga	Limpopo	Total
Surgical	10	7	5	1	0	0	2	1	2	28
Maternal and Child Health	6	1	0	3	0	3	2	1	2	18
Medical	6	9	1	3	3	1	1	0	4	28
Critical Care	1	1	0	0	0	0	0	0	0	02
Psychiatry	0	1	0	0	0	0	0	0	0	01
A&E	3	3	2	0	0	0	0	0	1	09
Dentistry	1	0	0	0	0	0	0	0	0	01
Total	27	22	08	07	03	04	05	02	09	87

Table 5: Cases Received for Investigation in 2025/26 Financial Year, Classified by Province and Discipline

Table 5 reflects the varying patterns of clinical risk and service pressure within the health system. For the financial year 2025/26, Gauteng and Kwa-Zulu Natal recorded the highest number of cases- 27 (31%) and 22 (25%) respectively, while the Surgical, Maternal & Child Health and Medical disciplines represent the most prominent areas of concern across the system accounting for 28 (32.2%), 18 (20.7%) and 28 (32.2%) cases respectively. The lowest cases reported occurred among the Psychiatric and dental disciplines- 1 case (1.15%) each.

Output indicator	Method of Calculation	Annual Target	Actual Performance	Variance
Percentage of complaints resolved within 6 months through investigation	Investigation Cases resolved within 6 months, plus cases resolved in the previous reporting period/ Investigations assigned for investigation within 6 months	50%	21.73% (10/46)	-28.26%

Output indicator	Method of Calculation	Annual Target	Actual Performance	Variance
	plus cases resolved in the previous reporting period *100			
Percentage of complaints resolved within 24 months through investigation	Investigation Cases resolved within 24 months, plus cases resolved in the previous reporting period/ Investigations assigned for investigation within 24 months plus cases resolved in the previous reporting period * 100	20%	23.68% (18/76)	+3.68%
Percentage of complaints resolved beyond 24 months through investigation	Number of legacy cases resolved/ Total number of legacy cases during the current reporting period * 100	12%	7.69% (10/130)	-4.30%

Table 6: Complaints Investigations Unit Annual Performance for the 2025/26 Financial Year

Table 6 illustrates that the unit failed to meet two of its annual performance targets: 50% for case resolutions within 6 months and 12% for those beyond 24 months. However, the unit made positive progress in case resolution within 24 months, achieving +6.47% against its 20% annual target.

The unit's underperformance can be attributed to various challenges as outlined below:

- **Resource Constraints, case volume increases and resultant backlogs:**

Limited human and operational resources have materially contributed to the backlog. The legal subunit operated without one investigator, who had been placed on precautionary suspension pending the outcome of a 10-month disciplinary process. Rising case volumes compound these resource challenges, as the unit received a high number (87) of high- and extreme-risk-rated complaints, which put pressure on its limited investigative capacity. These come on the background of existing backlog cases, which adversely affect the unit's ability to meet its Annual Performance Plan targets.

- **Performance Measurement Limitations**

The current performance indicators are calculated over 6-month, 24-month, and beyond-24-month intervals, including the total number of pending cases as the denominator. This methodology offsets the resolution rate.

- **Case complexity and external factors**

High- and extreme-risk-rated cases, including those involving multiple health establishments, are inherently complex and labour-intensive, thereby extending investigation timelines. Delays are also driven by difficulties in securing witness participation, particularly where individuals are no longer accessible due to staff rotation, relocation, resignation, or retirement. Some cases also require external expert opinion, which is associated with prolonged turnaround times, significantly delaying case finalisation.

Furthermore, the relocation of the office from Pretoria Central to Centurion was disruptive, with extended building works to configure the new premises. The added problem is reduced working hours due to the need to transport staff between the Pretoria CBD and the new offices.

The growing complexity of cases renders the 6-month target difficult to achieve!

- **Dual responsibilities**

The Unit is balancing investigative functions with NPM duties, including report writing on investigation and inspection findings. Some of the mitigating strategies/remedial actions undertaken/planned include:

- Strategic prioritisation of high-impact, actionable complaints, particularly those of significant public interest or involving serious breaches of norms and standards, or those that reinforce accountability and elevate national awareness and visibility to impact behavioural change.
- Augmenting investigative capacity through the appointment of additional investigators and/or the strategic use of temporary or contract resources to stabilise caseload pressures.
- Review and recalibrate performance indicators to clearly differentiate between newly assigned cases pending evidence review and those already assessed, ensuring a more accurate reflection of operational performance.
- Backlog Reduction Strategy, i.e. implement a targeted backlog-reduction plan that includes strategic use of temporary or contract resources to eliminate historic legacy cases.

5.3.1 Appeals Cases

Section 88A (1) of the NHAA gives any person aggrieved by the decision of the Ombud the right to lodge an appeal with the Minister in writing, within 30 days of them gaining knowledge of the decision. The Minister is enjoined to appoint an independent ad hoc tribunal to adjudicate on the appeals.

Only one (1) appeal, case Ref. 50343, was lodged with the Minister during the 2025/26 financial year and is pending adjudication by the independent ad hoc Tribunal.

One (1) appeal, case Ref. 36234, was adjudicated against the Ombud during the year under review based on an error in law and therefore set aside. As a result, the Ombud was ordered to investigate the allegations against the doctors and the hospital's management was implicated.

Three (3) appeals lodged in previous years are still pending the Minister's appointment of the ad hoc Tribunal.



Three-Year Overview of the Complaints Investigations Unit

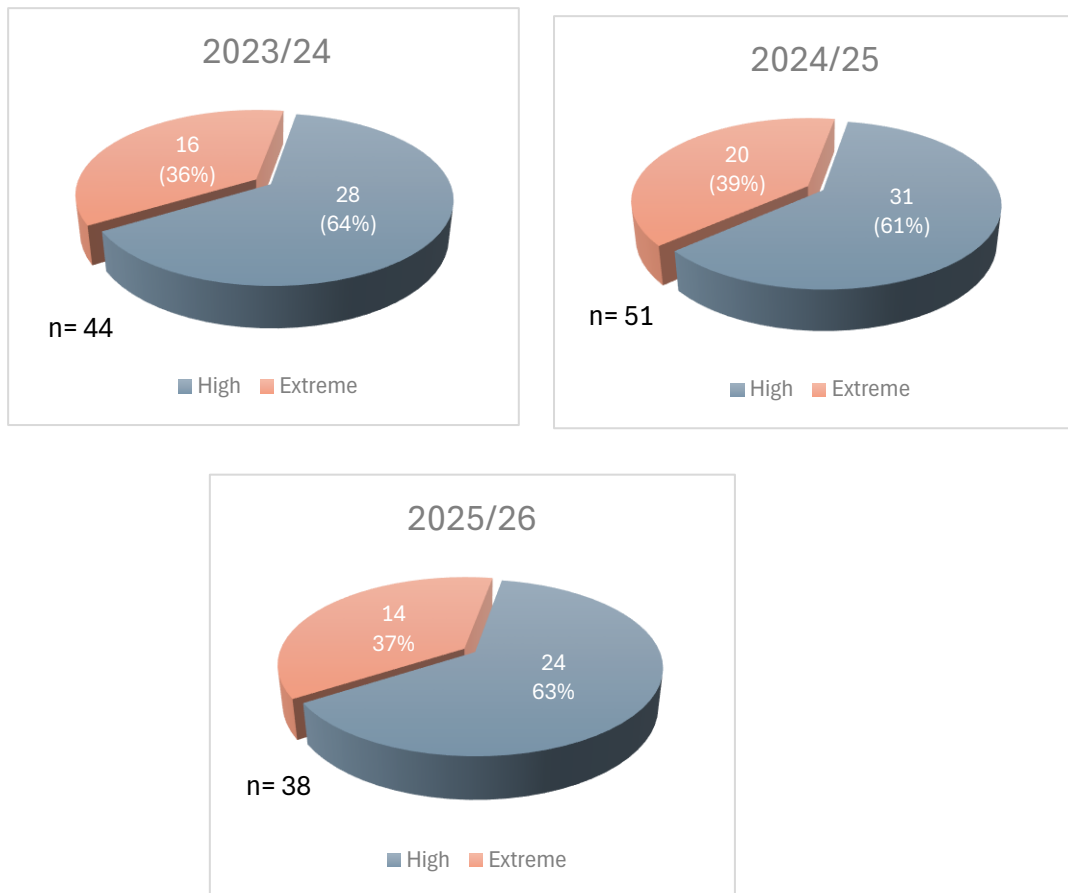


Figure 13 Risk Profile of Complaints Resolved through Investigation by CIU, during 2023/24 - 2025/26 Financial Years

It is noted that the risk rating of cases investigated for the past three years is predominantly extreme risk (average 63%).



6. INVOLVEMENT OF THE OFFICE OF HEALTH OMBUD IN NATIONAL PREVENTATIVE MECHANISM (NPM)

6.1 Background of the NPM

The National Preventive Mechanism (NPM) was established in South Africa after the ratification of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). It was ratified by the Parliament of the Republic of South Africa in March 2019. Article 3 of the OPCAT enjoins States or Parties to designate, maintain, or establish an NPM to strengthen the protection of persons who are or may be deprived of their liberty.

The South African Cabinet appointed the South African Human Rights Commission (SAHRC) as a single designated NPM organisation, supported by four (4) other independent oversight institutions, viz. the Judicial Inspectorate for Correctional Services (JICS); the Office of the Military Ombud (OMO) and the Independent Police Investigative Directorate (IPID), and the Office of the Health Ombud (OHO) in December 2024.

6.2 NPM Mandate

The mandate of the NPM is to strengthen the protection of persons who are or may be deprived of their liberty in places of detention. This mandate is realised through proactive and preventive monitoring of places of deprivation of liberty and by examining the treatment of persons deprived of their liberty during regular unannounced visits to such places.

Although the previous Health Ombud did not participate in the NPM due to a lack of funding, the current Health Ombud started participation and continues, in collaboration with other NPM members, to conduct joint unannounced visits in all nine (9) Provinces, with the OHO particularly focusing on psychiatric institutions, while still awaiting specific funding that has been requested through the National Department of Health. To date, 17 unannounced NPM visits have been conducted.

6.3 NPM Unannounced Visits

The NPM visiting delegation conducted the following oversight visits over the reporting period:

PROVINCE	DATES	SAPS	OLD AGE HOMES	PSYCHIATRIC FACILITIES	CORRECTIONAL CENTRES	SECURE CARE CENTRES	TOTAL
KZN	Sept 2025	0	0	0	1	0	1
EC	Sept 2025	5	0	1 (Tower Psychiatric Hospital)	1	0	7
NW	March 2026	4	0	0	1	0	5
FS	March/ April 2026	0	0	1 (Boitumelo Regional Hospital Psychiatric Unit)	3	0	4
Total		9	0	2	6	0	17

Table 7: Number of NPM Unannounced Inspections during 2025/26 FY

Findings by the NPM

The NPM visiting team found the following challenges, amongst others:

- Overcrowding in most Correctional Service Centres.
- Shortage of sleeping beds (sponge) and sanitary towels at several SAPS holding cells and Correctional Centres.
- Shortage of uniforms in some Correctional Service Centres.
- Poor or deteriorating Infrastructure.
- Shortage of resources, including human capital.
- Non-compliance with the Occupational Health and Safety Act, e.g. fire extinguishers and hydrants were out of service.

Two (2) reports with findings and recommendations have been produced specifically for Tower Psychiatric Hospital and the Boitumelo Regional Hospital Psychiatric Unit.

6.4 NPM Responsible Team

The Health Ombud has assembled a special team within the Legal Complaints Investigation Unit, including himself, to attend to NPM matters, such as workshops, training, strategic planning meetings, and inspections.



7. HUMAN RESOURCES AND FUNDING

7.1 Human Resources

During the 2025/26 financial year, the OHO Complaints Management Programme had 34 staff members. One investigator's and one complaints officer's position, which were vacant during the current reporting period, are expected to be filled in the first quarter of 2026/27. The Executive Manager post became vacant during the third quarter of the reporting period and will be filled during the 1st quarter of 2026/27. During this reporting period, the OHO had 32 permanent staff members, 1 contract staff member, and 1 intern.

STAFF CATEGORY	# PERMANENT	# CONTRACT	TOTAL
HEALTH OMBUD	0	1	01
EXECUTIVE ASSISTANT	1	0	01
EXECUTIVE MANAGER	1	0	01
PERSONAL ASSISTANT	1	0	01
DIRECTOR / SENIOR INVESTIGATORS	3	0	03
DEPUTY DIRECTORS / INVESTIGATORS	10	0	10
ASSISTANT DIRECTORS	7	0	07
COMPLAINTS OFFICERS	6	0	06
ADMINISTRATION OFFICER	1	0	01
ADMINISTRATION CLERKS	2	0	02
INTERNS	0	1	01
TOTAL		02	34

Table 8: Human resources capacity in the Office of the Health Ombud

7.2 Linking Performance with Budgets

Programme	2025/26			2024/25		
	Budget	Actual Expenditure	(Over)/ Under Expenditure	Budget	Actual Expenditure	Over/Under Expenditure
Complaints Management and Office of the Ombud	32,319,573	33,589,946	(1,270,375)	34,480,304	32,941,059	1,539,245

The National Treasury approves the budget in the OHO. The main expenditure drivers for the reporting period were:

- Employee compensation (R30 316 193: 90%).
- Support for the complaints call centre (R320 969: 1%).
- Travel expenditure for investigations (R930 681: 3%)
- Venues and facilities, including the Health Ombud conference costs (R989 508: 3%)
- Legal services for the NDoH tribunal cost incurred (R675 515: 2%)

Additional funding is being sought from the SETA for Health and Welfare, on the advice of the Parliamentary Portfolio Committee on Health, specifically to support the resolution of legacy backlog cases.



8. OFFICE ACCOMMODATION

8.1 Background

The OHSC, which houses the Health Ombud, entered into a lease agreement for an office space with Mergence Africa Property Investment Trust, a Dipula Properties subsidiary, at Eco-glades Office Park-1, Block B, 70 Ribbon Grass Street, Highveld, Centurion, commencing September 2025.

8.2 Challenges

The Health Ombud and the Executive Manager have been allocated approximately suitable office space.

The current office space has the following limitations that negatively affect the ability to be fully effective when interviewing clients. The number of offices allocated to the OHO staff is insufficient to accommodate all Investigators and Assessors. Some of them share offices, which negatively impacts privacy when analysing confidential voice evidence, interviewing clients, or liaising over the phone with complainants and other relevant parties.

- 8.2.1 The Call Centre operates in an open space that is prone to noise disruptions. There is no confidentiality while interviewing clients or other stakeholders.
- 8.2.2 Many Complaints Assessors and Investigators also work in an open space and experience distractions.
- 8.2.3 Some of the offices have poor ventilation, with no windows, therefore limiting access to fresh ventilation. This does not comply with the space-planning norms and standards for office buildings as gazetted. The Occupational Health and Safety Act, 1993 (Act 85 of 1993) sets out norms and standards and how offices occupied by a specific number of people should be constructed.
- 8.2.4 With relocation of the office from Pretoria Central to Centurion, a bus was procured to collect staff members at a hired parking lot in Pretoria Central and to ferry them to and from the new offices. This arrangement has resulted in staff arriving around 9:00 am and departing at 15:30. As a result, their office working hours have been effectively reduced, straining the OHO's already constrained operational capacity.

8.3 Proposal

A review of the current office allocation plan indicates that more offices need to be assigned to OHO staff members, in line with the original proposal.



9. ENGAGEMENT WITH EXTERNAL STAKEHOLDERS DURING THE 2025/26 FINANCIAL YEAR

9.1 Presentation at the AOMA/AORC Webinar

The Health Ombud delivered a presentation at the African Ombudsman and Mediators Association (AOMA) Webinar and the African Ombudsman Research Centre (AORC) on “An Argument for a Specialist Health Ombudsman” On 13 March 2025. The presentation highlighted the importance of specialised oversight mechanisms in addressing complex healthcare complaints and strengthening accountability within the health sector.

9.2 Pre-planning Session for a Joint Investigation with the Public Service Commission

The OHO, led by the Health Ombud, and the Public Service Commission (PSC), led by the KwaZulu-Natal Commissioner, Ms Yasmin E. Bacus, held a pre-planning session on 30 May 2030 to facilitate a joint investigation into the spate of deaths of young doctors and other health professionals in KwaZulu-Natal Public Hospitals. The engagement focused on strengthening inter-institutional collaboration and aligning the scope, approach, and coordinated oversight in addressing systemic issues within the health sector.

9.3 Inaugural Biennial Health Ombud Conference 2025

The Office of the Health Ombud hosted a two-day Inaugural Biennial Health Ombud Conference on 11–12 September 2025 under the theme “*Health and Healthcare as a Human Right.*” The conference brought together key stakeholders from the health sector, oversight bodies, regulatory institutions, academia, and Ombudsman institutions from across Africa.

The Minister of Health, Dr Aaron Motsoaledi, delivered an opening address, emphasising the OHO's contribution to a gradual but meaningful transformation in how our health system responds to complaints and upholds the dignity of those it serves.

The conference provided a platform to deliberate on health and health care as a human right enshrined in the Constitution of the Republic and espoused by the World Health Organisation's (WHO) Sustainable Development Goals 2030. The conference emphasised access to universal quality healthcare. Different models for achieving universal access to healthcare and quality, adopted by different countries, were discussed and counterpoised against the South African National Health Insurance.

The conference emphasised the need for public-private collaboration in delivering universal access to healthcare with defined, designated benefits or coverage. Despite ongoing litigation over NHI, delegates affirmed that the country needs dialogue to craft a workable, collaborative public-private approach to universal healthcare that leverages all available resources. It was suggested that the Health Ombuds should continue to rally key role players in the health sector for the contemplated dialogue.

The conference also emphasised the importance of collaboration between the Health Ombud, other oversight institutions, regulators locally and internationally, and other key stakeholders to compare and adopt best practices and seek advice and assistance. Leveraging digital solutions to improve efficiency, data management, and reporting processes is crucial.

The outcomes of the conference reaffirmed the critical role of the Office of the Health Ombud in promoting accountability and improving the quality of healthcare services in the Republic.



The Health Ombud hosted a gala dinner during the Inaugural Biennial Symposium. From left to right are: Dr S Dhlomo- Chairperson of Parliamentary Portfolio Committee on Health, Adv. S Tiroyakgosi - Botswana Ombudsman, Dr J Phaahla - Deputy Minister of Health, Prof T Mokoena - the Health Ombud, Adv. Ms T Polaki- the Lesotho Ombudsman, Lt Gen (Ret) V Masondo - Military Ombud, Dr E Kenoshi – Chairperson of Office of Health Standards Compliance



The Health Ombud, Prof. Taole Mokoena, is addressing delegates at the Inaugural Health Ombud Conference.



Audience at the Inaugural Biennial Health Ombud Symposium



From left to right: The Botswana Ombudsman, Adv. Stephen Tiroyakgosi, the Lesotho Ombudsman, Adv. Tlotliso Angelina Polaki, the Public Protector of South Africa, Adv. Kholeka Gcaleka, and the Health Ombud, Prof. Taole Mokoena, at the Inaugural Health Ombud Biennial Symposium.

9.4 Meeting with the South African Private Practitioners Forum CEO

The Health Ombud held a meeting with Dr Simon Strachan, CEO of the South African Private Practitioners Forum (SAPPF), on 23 September 2025. The meeting sought to explore opportunities for collaboration, focusing on strengthening cooperation between the Office of the Health Ombud and the private healthcare sector to address complaints and promote accountability.

9.5 Presentation at the AOMA/AORC Webinar

The Health Ombud presented at the AOMA and the AORC Webinar on 07 October 2026 on the topic “Maximising Impact and Reach: Strengthening Ombudsman Recommendations.” The presentation focused on enhancing the effectiveness, implementation, and oversight of the Ombudsman recommendations to strengthen governance and accountability.

9.6 Public Protector 30th Anniversary International Conference

The Health Ombud attended the 30th Anniversary International Conference of the Public Protector of the Republic of South Africa, held from 13 to 16 October 2025. This significant milestone highlighted the institution’s continued commitment to upholding justice, promoting accountability, and protecting citizens’ rights.



From left to right: Lt Gen (Ret) Vusumuzi Masondo, Military Ombud; Adv. Kholeka Gcaleka, Public Protector of South Africa; Judge Selby Baqwa, Former Inaugural Public Protector of South Africa; Adv. Tlotliso Angelina Polaki, Lesotho Ombudsman; Prof. Taole Mokoena, Health Ombud; and Adv. Stephen Tiroyakgosi, Botswana Ombudsman.

9.7 Meeting with Health and Welfare Sector Education and Training Authority

The Health Ombud met with the Acting CEO of the Health and Welfare Sector Education and Training Authority (HWSETA), Ms Zandile Mafata, on 24 November 2025. The purpose of the meeting was to explore a partnership with HWSETA to support capacity development initiatives that will significantly improve turnaround times, especially for resolving legacy backlog cases, and strengthen the overall human resource capacity of the Office of the Health Ombud.

9.8 Farewell Dinner in Honour of Justice Edwin Cameron

The Health Ombud attended the farewell dinner in honour of Justice Edwin Cameron, Outgoing Inspector-General of the Judicial Inspectorate for Correctional Services (JICS) on 03 December 2025. The engagement with the introduction to the Incoming Inspector General, Justice Leonard (Lee) Bozalek, recognised the ongoing collaborative relationship between the OHO and JICS in strengthening oversight, accountability, and the protection of human rights within institutional settings.



From left to right: Adv. K Mabyalane, Ms N Sebe, Justice E Cameron, Prof. T Mokoena-Health Ombud, Dr P Groenewald-Minister of Correctional Services and Mr S Sibanyoni.

9.9 Consultation Meeting with the Department of Higher Education and Training

The Health Ombud met with the Deputy Director-General for the University Education of the Department of Higher Education and Training, Dr Marcia Socikwa, on 11 December 2025. The engagement focused on the operations of the Office of the Health Ombud and its evolution in fulfilling its mandate, as a possible template for establishing a Statutory Higher Education Ombudsman.

9.10 Participation in the AOMA/AORC Webinar

The Health Ombud attended the AOMA and the AORC Webinar, “Implementing ISO 9001: Strengthening Quality Management and Accountability in African Ombudsman Institutions,” on 20 January 2026. The webinar focused on strengthening quality management systems and enhancing accountability within ombudsman institutions across Africa.

9.11 Meeting with the Interim Ombudsman for Higher Education and Training

The Health Ombud met with the Interim Ombudsman for Higher Education and Training, Dr Marcia Socikwa, on 27 February 2026. The engagement served as a follow-up to the initial consultation and aimed to provide insight into the administrative processes and informal protocols that underpin the

office's functioning.

9.12 Partnerships with Stakeholders

The Health Ombud, together with OHSC, continued to strengthen partnerships with patient advocacy groups, community health workers, and local leadership structures through targeted stakeholder engagements. These collaborative platforms expanded the reach of public awareness initiatives and enhanced the credibility and visibility of the Ombud's work.

Stakeholder engagement further strengthens working relationships with provincial health departments and healthcare facilities, fostering a more cooperative environment for implementing recommendations and advancing quality healthcare outcomes.

These engagements took place across provinces, including Gauteng, KwaZulu-Natal, Mpumalanga, the Northern Cape, the North West, the Western Cape, and the Free State, ensuring comprehensive geographic coverage and inclusive stakeholder involvement. Additionally, the Health Ombud participated in health conferences, professional platforms, and webinars as noted above, facilitating connections with key professional and institutional stakeholders. These events also included engagements organised by groups such as the South African Medico-Legal Association (SAML), the Board of Healthcare Funders (BHF), and the Hospital Association of South Africa (HASA), as well as participation in industry exhibitions.

Collectively, these engagements heightened the visibility of the entity's initiatives, strengthened relationships with key stakeholders, clarified complaint-resolution processes, and reinforced the regulatory mandates of both OHSC and the Health Ombud. The Health Ombud delivered the keynote oration at the Colleges of Medicine of South Africa (CMSA) Admission Ceremony held in Johannesburg on 26 June 2025. The address focused on the ethical challenges posed by the innovations in healthcare, with emphasis on surgical care, including the use of artificial intelligence (AI) in medicine. The Health Ombud highlighted the need to balance technological innovation with ethical principles, patient safety, accountability, confidentiality, and equity in healthcare delivery.



Health Ombud delivering an Oration at the CMSA Graduation Ceremony on 26 June 2025.

10. STRATEGIC PLANNING

10.1 Discussions

The Office of the Health Ombud held its 2025 Work Plan Review and 2026 Planning Workshop on 5 December 2025. The purpose of the session was to review the Office's current performance, assess operational challenges, and define strategic priorities and interventions for the upcoming planning cycle.

The workshop provided an opportunity to reflect on key achievements and areas for improvement, with a focus on strengthening operational efficiency and aligning organisational objectives with the Office's mandate.

A guest presentation by Dr Frank Magwegwe, a resilience and well-being expert, focused on strengthening staff resilience, reinforcing organisational values, and fostering a culture of appreciation, purpose, and collective responsibility, particularly within the context of ongoing systemic and resource-related challenges.

The identified key strategic focus areas were as follows:

- Strengthening Complaints Management and Investigations
- Enhancing turnaround times for complaint resolution
- Utilisation of additional methods for lodging complaints, including WhatsApp, SMS, chatbots, and AI-enabled solutions. Improving coordination between the Assessment, Clinical, and Legal Investigation units.
- Exploring digitalisation of complaints management processes to improve efficiency and tracking.

Legislative and Policy Development

- Progress on the draft Health Ombud Bill to strengthen the mandate and independence of the Office was noted, including its submission to the Parliamentary Portfolio Committee on Health as per their request.
- It was proposed that mediation be incorporated prior to appeals through amendments to the National Health Act Amendment Act (NHAA), 2013 and/or relevant Regulations.

Institutional Capacity and Resourcing

- Team building initiatives were discussed; however, implementation remains constrained by limited funding.
- The appointment of a scientific language writer remains pending due to funding constraints.
- A funding gap affecting the Human Resources unit was noted. Potential funding partnerships were identified, including Health and Welfare Sector Education and Training Authority (HWSETA) and the Clinton Health Access Initiative (CHAI).
- Rebranding of the Office was confirmed as completed.
- Office accommodation was secured; however, the open-plan configuration remains a challenge.

Governance, Oversight and Reporting

- Improving the quality and timeliness of reports to the OHSC Board
- Enhancing monitoring of the implementation of Ombud recommendations.
- Strengthening internal accountability mechanisms.

Stakeholder Engagement and Visibility

- Strengthening relationships with key stakeholders, including the Department of Health and oversight bodies.
- Enhancing public awareness of the OHO mandate and services, including the need to strengthen marketing and outreach, particularly to rural and underserved communities.

Key Challenges Identified:

- Funding constraints impacting human resources, research, technology adoption, and outreach activities.
- Legislative amendments still pending, affecting appeals, enforcement, and mediation processes.
- Delays in expert opinions and limitations in accessibility for persons with disabilities.



Staff photo during the Strategic Planning Workshop.



11. HEALTH OMBUD BILL

11.1 Background

The creation of the Health Ombud post is provided for in section 81 of the NHAA. Section 81(3)(b) stipulates that the Ombud is located within the OHSC. Section 81(3)(c) provides that the Ombud is assisted by persons designated and seconded by the OHSC with the concurrence of the Ombud –this effectively means that the Health Ombud has no staff. The staff who are seconded to the OHO remain employees of the OHSC.

11.2 Challenges

These restrictive provisions have created various challenges for the efficient functioning of the Office of the Health Ombud, as the Ombud is unable, amongst other things, to recruit and select employees and to procure goods or services from service providers without the involvement of the OHSC.

To circumvent this and ensure an effective and independent office of the Health Ombud, a Health Ombud Bill was drafted with the intention of defining the functions of the Health Ombud, and to provide for the appointment, remuneration, powers and functions of the Health Ombud, which would extend to the staff of the OHO.

11.3 Status Quo

The Bill was served at the Social Protection, Community and Human Development (SPCHD) Cluster in January 2023, and the National Treasury raised concerns about the increasing number of statutory bodies being created. The Cluster requested that the National Department of Health consult with the National Treasury, which then rejected the Bill for lack of funding.

Work undertaken to date

- The draft Bill has been amended and internally refined to address identified gaps in the existing legislative framework.
- Key provisions have been aligned with the operational mandate and strategic objectives of the Office of the Health Ombud.
- Preliminary consultations and internal reviews have been conducted to ensure legal and policy coherence.
- Inputs specific to the Office of the Health Ombud are currently being consolidated as part of the SEIAS process.

11.4 The Current Status

The draft Bill has reached the Socio-Economic Impact Assessment System (SEIAS) stage. At this stage, the Bill is being assessed to evaluate its potential socio-economic implications, regulatory impact, and alignment with government priorities.

11.5 The Next Step

The SEIAS report, inclusive of the Health Ombud's inputs, will be submitted to the Presidency for consideration of SEIAS recommendations and incorporation of any required revisions to the draft Bill. Thereafter, the Bill will be advanced through the Cabinet approval processes. Ultimately, the Bill will be introduced to Parliament for legislative consideration.

11.6 Amendment of the Current NHA

Should the Health Ombud Bill not proceed, an alternative solution would be to amend the current National Health Amendment Act to establish the Office of the Health Ombud as an autonomous entity. Such amendments could provide for ringfenced funding to enable the OHO to independently appoint its own human resources and undertake its own procurement of goods and services. Importantly, this approach would also allow liability to vest in the institutional entity of the "Office of the Health Ombud" rather than in the person of the Health Ombud.

12. MEDIA ENGAGEMENTS

12.1 Introduction

During the 2025–2026 reporting period, the Health Ombud significantly advanced its commitment to transparency, public accountability, and community partnership through a strategically expanded programme of media and community engagement. Recognising communication as a critical enabler of a safe, responsive, and learning-oriented health system, these initiatives were designed not only to increase visibility of the complaints mechanism but also to strengthen public trust and promote a culture of continuous improvement.

12.2 Building Public Awareness Through Media Engagement

Media engagement remained one of the most effective channels for reaching large and diverse audiences across South Africa. The refined integrated marketing strategy prioritised improving public understanding of the Health Ombud's mandate, how to lodge a complaint, the importance of reporting unsafe or poor-quality care, and the findings and recommendations arising from major investigations. Throughout the year, the Ombud participated in more than 40 media engagements, including television and radio interviews, print media engagements, and online news platforms. These engagements often followed the release of investigation reports and addressed systemic issues related to breaches of norms and standards regulations.

Central to this approach was the deliberate use of communication platforms to empower patients and communities with knowledge of their rights, improve access to reporting mechanisms, and reinforce the importance of speaking about unsafe or poor-quality care. The Health Ombud positioned communication as a tool for early identification of systemic risks and for fostering shared accountability across the health system.

Key investigations featured in the overall media included:

- Investigation into allegations of medical negligence resulting in the death of a patient at Pietersburg Provincial Tertiary Hospital
- Alleged incorrect administration of medication leading to a baby's death at Netcare Femina Hospital Neonatal Intensive Care Unit
- Investigation into the care and death of a mental health care user at Dr George Mukhari Academic Hospital
- Investigation into the treatment, complications, and deaths of psychiatric patients at Northern Cape Mental Hospital and Robert Mangaliso Sobukwe Hospital
- Investigation into allegations of a medico-legal hazard resulting in disability and death at Wits Donald Gordon Medical Centre.
- Media coverage served as a critical bridge between the public and the health system by translating complex investigative findings into accessible information, addressing misconceptions, and reinforcing accountability.
- Notably, increased media exposure correlated with a rise in both the volume and complexity of complaints received, reflecting improved public understanding of the complaints process. Through this, proactive media engagement has also helped foster a health system culture that is attentive to risk and committed to learning from failures.

12.3 Strengthening Trust Through Community Engagement

While national media ensured broad reach, community engagement provided depth, trust, and direct connection. During the reporting period, approximately 24 community engagement activities were

conducted to bring Ombud's services closer to communities, particularly in underserved and rural areas. These activities included visits to health facilities, participation in stakeholder forums, and engagement at local gatherings. Such platforms enabled direct interaction with patients, caregivers, community leaders, and frontline health workers. Community outreach created valuable opportunities to educate the public about their health rights, explain the complaints process in clear and accessible language, listen to lived experiences, and encourage early reporting and local resolution of concerns. In areas where awareness of the Ombud's services had previously been limited, face-to-face engagement proved especially impactful. Communities expressed appreciation for the Ombud's office's direct presence and for the opportunity to share concerns in a supportive environment.

12.4 Expanding Digital and Social Media Presence

Digital platforms played an increasingly important role in communication during the reporting period. Social media channels, including Facebook, X, LinkedIn, YouTube, and Instagram, as well as regular updates to the OHO website, were used to disseminate press statements, investigation outcomes, educational materials, and guidance on submitting complaints. More than 40 digital communications resulted in increased online engagement and enquiries, increased website traffic following media releases, growth in electronic complaint submissions, and wider dissemination of patient rights information. These platforms were particularly effective in reaching younger audiences and urban communities, complementing traditional media and in-person outreach.

12.5 Enhancement of Ombud Website Launch

During the reporting period, a significant milestone was the enhancement and relaunch of the Health Ombud website. The redesigned platform aims to improve accessibility, user experience, and public interaction, focusing on clarity, responsiveness, and inclusivity. Key enhancements include a more intuitive interface, simplified navigation, improved multilingual content, and user-friendly guidance for lodging complaints. Additionally, the website features better feedback mechanisms, allowing users to track enquiries, access information more efficiently, and engage more meaningfully with the Ombud's office. This digital transformation marks a deliberate shift toward more accessible, patient-centred communication channels that facilitate timely reporting and learning within the system.

Central to this broader communication strategy is the intentional use of multiple platforms to empower patients and communities with knowledge of their rights, enhance access to reporting mechanisms, and emphasise the importance of speaking out about unsafe or poor-quality care. The Health Ombud utilised communication and digital innovation to promote the early identification of systemic risks and encourage shared accountability across the health system.

12.6 Outcomes and Impact

The combined media and community engagement programme yielded several notable outcomes, including increased awareness of the Health Ombud's role and services, increased complaints from previously under-represented regions, improved complaint quality, strengthened public trust and stakeholder relationships, and enhanced responsiveness from health authorities following public reporting. Collectively, these outcomes contribute to a health system that is more transparent, responsive, and focused on continuous improvement.

12.7 Challenges Encountered

Despite significant progress, several challenges were encountered during the reporting period. Limited financial and human resources constrained the frequency and reach of outreach activities. Persistent public misunderstanding of the Ombud's mandate necessitated ongoing education efforts. Language and accessibility barriers necessitated multilingual communication in certain provinces, while the rapid spread of misinformation on social media underscored the need for proactive, timely responses. These challenges underscored the importance of sustained investment in communication

and outreach capacity.

12.8 Lessons Learned

Key lessons from the reporting period include the recognition that transparency builds public trust and encourages reporting; that community participation significantly enhances access and awareness; that partnerships with other oversight and regulatory institutions amplify reach and credibility; and that communication must be continuous, proactive and responsive. These lessons reaffirm the central role of communication in supporting a safe, accountable and patient-centred healthcare system.

12.9 Published Health Ombud Reports

During the 2025/26 financial year, the Health Ombud released five investigation reports via media briefings and subsequently published them on the Health Ombud's website to ensure public access and promote transparency. These reports related to Pietersburg Provincial Tertiary Hospital (Limpopo), Northern Cape Mental Health Hospital and Robert Mangaliso Sobukwe Hospital (Northern Cape), Wits Donald Gordon Medical Centre (Gauteng), Dr George Mukhari Academic Hospital (Gauteng), and Netcare Femina Hospital (Gauteng).

12.9.1 The Investigation into the Medical Care and Death of a Patient at Wits Donald Gordon Medical Centre (WDGMC)

The report was publicly disseminated through media channels on 03 December 2025. Broadly, the investigation established that although the patient's emergency care was prioritised, key clinical management and documentation standards were not met. Specifically, the investigation revealed that:

- I. 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.
- II. WDGMC 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. This was designed to save patient costs.
- III. 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 has recommended that WDGMC

- i. Develop and implement a formal, documented protocol for the removal of port needles in Oncology Outpatients.
- ii. Establish proper medical records and files for each patient.
- iii. Engage in a mediation process with the patient's wife to facilitate the resolution of outstanding matters.
- iv. The Health Ombud concluded that the incident reflects an unwitting breach of documentation

and clinical risk management obligations, which, although an act of goodwill aimed at saving patients from hospital charges, constitutes an infraction against prescribed norms and standards of care.

- v. 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.

12.9.2 The Investigation into the Death of a Patient at the Pietersburg Provincial Tertiary Hospital

The report was publicly disseminated through media channels on 03 December 2025. The investigation against Pietersburg Provincial Tertiary Hospital (PPTH) relating to the patient's death was initiated after a complaint from a family member was lodged in March 2025, alleging medical negligence.

The investigation conducted at PPTH established systemic failures in clinical care, staffing, governance, and leadership that directly contributed to a preventable patient death, highlighting a breakdown in basic patient safety, warranting disciplinary action. Specifically, the investigation revealed that the care provided at PPTH was grossly substandard and marked by systemic failures, which directly contributed to a preventable patient death.

Key Findings

- i. The patient was not prioritised appropriately, thus compromising urgent care. The patient spent 21 hours without a doctor's review after admission.
- ii. The doctors did not attend to patients before leaving duty, breaching the duty of care, lack of clinical supervision, including interns making decisions without oversight.
- iii. Surgical intervention was delayed despite clear clinical indications. The Ombud further uncovered serious documentation failures and a falsification of medical records to conceal negligence.
- iv. There were administrative delays of nearly four hours (3 hours and 55 minutes) before a patient file was opened at Rethabile Community Health Centre (RCHC), violating the Norms and Standards Regulations.
- v. There was a failure to triage the patient, and inadequately skilled staff were assigned to critical areas unsupervised, and essential triage equipment was missing. RCHC acted inconsistently with the Norms and Standards Regulations.
- vi. Failure to provide timely medical attention to the patient was substantiated.
- vii. The family was not provided with postmortem services to determine the exact cause of death of the patient.

Additional Findings

- i. Falsification of medical records at RCHC to conceal procedural failings.
- ii. Poor supervision of medical interns and registrars at PPTH with junior staff taking independent clinical decisions without supervision.

- iii. Systemic leadership failures, including prolonged acting appointments without compensation, leading to low morale and weak accountability.
- iv. Infrastructure and resource gaps, such as missing equipment, inadequate waiting areas, and medication stockouts, compromise patient safety.
- v. The Ombud further noted that both health establishments acted inconsistently with several provisions of the Prescribed Norms and Standards Regulations (2018), thus compromising the constitutional right to access safe, good-quality healthcare as guaranteed under Section 27(1)(a) of the Constitution.

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

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 appointment waiting times, poor leadership, and lack of supervision compromised service quality and accountability, placing patients at risk.

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

12.9.3 The Investigation Regarding Neonatal Death at Netcare Femina Hospital

The report was publicly disseminated through media channels on 23 March 2026. The Ombud's investigation into the death of a baby at the Netcare Femina Hospital following a complaint lodged by the child's mother alleging that incorrect medication contributed to her baby's death.

Key Findings

- i. The investigation found that while the prescribed medication was correct, a clinical error occurred when adrenaline was administered intravenously instead of by nebulisation due to an incorrect route prescription.
- ii. Communication failures resulted in the unnatural infant's death. The report also substantiated that NFH failed to refer the death for a forensic post-mortem.
- iii. Additional findings identified outdated medication protocols, inadequate Neonatal Intensive Care Unit (NICU) shift handovers, and irregular electronic medical record access controls.

The Health Ombud recommendations:

- iv. The Health Ombud directed NFH and the Netcare Group to establish a task team to oversee remediation measures and report progress quarterly; strengthen medication safety with dual-verification systems; update clinical protocols and shift handover procedures; improve electronic medical record controls and staff access; and engage in further mediation with the mother.
- v. Some of the healthcare professionals involved will also be referred to their respective regulatory bodies for further inquiry.

12.9.4 The Investigation into the Treatment, Complications, and Subsequent Deaths of Two Psychiatric Patients at Northern Cape Mental Health Hospital (NCMHH) and Robert Mangaliso Sobukwe Hospital (RMSH).

The report was publicly disseminated through media channels on 30 July 2025.

Findings at NCMHH and RMSH:

- i. The investigation revealed gross mismanagement surrounding patient Mr CM's care, which ultimately led to his death at RMSH. His deteriorating clinical status was never attended to by either the nursing personnel or the doctors.
- ii. Mr TM was discovered unresponsive in his bed at NCMHH on 3 August 2024. The resuscitation process was delayed due to the unavailability, malfunction, or lack of preparedness of resuscitation equipment. There was also a lack of monitoring of the patient's vital signs by medical or nursing personnel before and during resuscitation. The patient did not survive the resuscitation attempt. The post-mortem report indicated that he died due to "exposure to the elements" at NCMHH.
- iii. The investigation into the circumstances surrounding the care and admission of patient, JL, to RMSH revealed that he had an acute subdural haemorrhage. An emergency craniotomy and craniectomy were successfully performed on 07 July 2024 and 23 July 2024, respectively, and he was discharged back to NCMHH on 28 October 2024. Mr JL remains bedridden.
- iv. Mr DB was transferred from NCMHH to the Emergency Centre at RMSH on 30 July 2024 after collapsing and being unresponsive in Ward M2 at NCMHH. He was stabilised and later admitted to the RMSH Medical Recovery Unit for hypoglycaemia. The medical care and investigations conducted in the Emergency Centre were appropriate. However, the nursing personnel's monitoring was found to be inadequate.
- v. Infrastructure: NCMHH was built in 2005 and has not received substantial upgrades since its commissioning in 2019.
- vi. Staff shortage: NCMHH has 153 operational beds and is currently experiencing significant shortages in key positions, which negatively impact service delivery and operational efficiency.
- vii. Governance: The four incidents resulted from serious systemic deficiencies in leadership, communication, sound financial stewardship, accountability, and poor supply chain and procurement processes. These had an impact on substandard care at NCMHH and on the adverse working conditions under which healthcare personnel perform their duties.

Recommendations

- i. NCMHH and RMSH 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.
- ii. 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.
- iii. Emergency response teams should be assembled, and staff should be trained in emergency procedures.

- iv. NCMHH and RMSH, working with the Provincial SCM Department, should prioritise the procurement of medical equipment such as stretchers, beds, otoscope sets (ENT Diagnostic Set), resuscitation drugs, and emergency equipment to ensure adequate emergency preparedness according to each health facility's needs. Healthcare providers should be trained in Basic Life Support (BLS) and Advanced Life Support (ALS) to enable them to respond effectively to medical emergencies and to ensure compliance with the Norms and Standards Regulations Applicable to Different Categories of Health Establishments "Access to care".

12.9.5 The Investigation into the Circumstances Surrounding the Care and Death of a Mental Health User at Dr George Mukhari Academic Hospital (DGMH).

The report was publicly disseminated through media channels on 23 March 2026.

Key Findings

- i. A procedural irregularity in the admission process of the patient.
- ii. The patient's condition was not properly evaluated before admission.
- iii. The use of mechanical restraints was not justified, and there was a disregard of statutory and policy prescripts, thus undermining patient safety and lawful, ethical care.
- iv. The negligence and breach of legal and ethical obligations on the part of the healthcare workers who failed to investigate the patient's sexual assault allegations.
- v. The patient was physically assaulted and left/kept naked during seclusion, and the seclusion was not authorised. She was denied food and prescribed medication during seclusion.
- vi. The infrastructure and systems at DGMAH failed to meet minimum mental health care standards.

Recommendations

- i. The internal disciplinary action for two doctors for misuse of mechanical restraints on patient Ms LM and violating Regulation 9(2) of the MHCA, and mandatory training for re-education.
- ii. Referral of doctors to the HPCSA for professional misconduct.
- iii. Referral of nurses to the SANC for formal disciplinary inquiry under nursing regulations and policies to address the falsification of drug registers, for gross negligence, breach of professional duty and an offence under the Medicines and Related Substances Act.
- iv. Internal disciplinary inquiry against some of the staff members in line with the disciplinary code for public servants and the Labour Relations Act.
- v. The renovation of DGMAH's MHC Unit to create a safe and recovery-oriented environment aligned with modern mental health facility design principles.

12.9.6 Conclusion and Way Forward

Looking ahead, the Health Ombud will continue to expand and strengthen its communication and outreach efforts. Key priorities include enhancing engagement with multilingual media, increasing coverage of community outreach activities, and further developing digital education initiatives. The 2025/2026 reporting period marked a significant advancement in improving the visibility and accessibility of the Health Ombud through sustained media engagement and meaningful community outreach. The Ombud advanced its mandate to protect patients, promote accountability, and support ongoing improvements in the quality and safety of healthcare services in South Africa.

13. FUTURE PLANS

13.1 Resolution of Legacy Backlog Complaints

As per the recommendation of the Parliamentary Portfolio Committee on Health, a funding request was submitted to the Health and Welfare Sector Education and Training Authority (HWSETA) to address the challenge of legacy backlog cases through a specialised project, viz. the Letsema Project.

Engagements are ongoing with the relevant HWSETA manager. There have been challenges with the support request, namely that operational costs and salary funding fall outside HWSETA's mandate. The proposed solutions include referring the matter to the Department of Higher Education and Training (DHET) or to HWSETA to provide interns (nursing and LLB graduates) to support the project.

13.2 Participation in the National Preventive Mechanism

South Africa became a signatory to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2019. The United Nations Organisation requires States to establish an NPM which will monitor the OPCAT programme. South Africa opted for a multi-institution model for NPM, which includes the SAHRC (the designated co-ordinator), JICS, IPID, the Military Ombud, and the Health Ombud. The government has not voted in special funding for the NPM process, but individual member institutions are expected to fund their own participation.

Previously, the Health Ombud did not participate in NPM due to insufficient funding. However, the current Health Ombud does not consider non-participation a viable option because expertise in the inspection and monitoring of psychiatric hospitals resides only with the OHO among the NPM member institutions. Therefore, the Health Ombud started active participation in the NPM process. A funding request was submitted and is awaiting approval from the National Treasury.

The Health Ombud will lobby the NDoH, National Treasury and the Parliamentary Health Portfolio Committee to realise this.

13.3 Staff Development

To achieve the Health Ombud's objective of monitoring and improving quality and safety in the healthcare delivery system, there is a need to analyse complaints and media reports of poor service provision. This requires research and data analysis skills. Consequently, the Health Ombud continues to seek funding to build staff capacity in data analytics.

13.4 Strengthen and Nurture Institutions

We owe it to the Public we serve to strive to deliver the best of breed. In this regard, engagement with sister organisations to learn best practices is essential. Working in silos engenders complacency, which, without being critiqued by and critiquing their peers' work, they simply become outdated and inappropriate in the face of a rapidly growing body of knowledge and clinical care worldwide.

13.5 Application/Adoption of Artificial Intelligence

Artificial intelligence and digital care are becoming more readily used as tools in clinical care and complaints management. It is the express intention of the Health Ombud to deploy these tools in our work schedule.





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