

# OFFICE OF THE HEALTH OMBUD

## Report of Investigation into Allegations against Rahima Moosa Mother and Child Hospital Gauteng

By Professor Malegapuru W. Makgoba  
The Health Ombud

MR ChB (Natal), DPhil. (Oxon), FRCP (Lond), FRS (SA), OMS

14 March 2023



Ihhovisi Lokulandela Amaqophelo Ezempilo  
Office of the Health Ombud  
Kantoro ya Mosekaseki wa Maphelo



**“An Unsafe Hospital”;** detailed report compiled by Prof. A Coovadia and Prof. H Lombaard: 21 February 2017. No evidence to indicate that the recommendations were considered or implemented.

- ‘Dirty, Filthy, Unsafe’ – these were the most common words used to describe the hospital in 2022 – a far cry from the hospital that received a Khanyisa award for the best regional hospital in 2016. (<https://midrandreporter.co.za/171354/health-workers-honored-at-khanyisa-health-awards/>).
- During the investigation into allegations against RMMCH, the most striking thing has been the fact that the hospital has been neglected to such an extent, in almost all respects, for several years.
- Within RMMCH, senior managers, including Dr FG Benson, were found to exhibit a significant lack of discipline and manipulative behaviours.
- The callousness and apparent disregard for human safety is chilling, evident in the dire lack of resources for a hospital providing critical tertiary level specialist services in the 21st century.
- Two individuals – Dr T De Maayer and Mr A Sauls – were found to have made a significant contribution in their respective roles towards advocacy for patient safety and the provision of quality health services.

- I found incontrovertible proof that confirms and substantiates the three (3) allegations raised in the complaint lodged by Hon. H Ismail. In addition to the initial issues raised, a further fourteen (14) findings were identified by the investigation. Key recommendations have been tabled for implementation by the Gauteng MEC and HoD for Health and RMMCH CEO.
- Overall, the GDoH is **in a mess**, and this has been going on for some time, at least seven years. The criteria used by GDoH to select Hospital CEOs is far below the required standard for such senior positions.
- The monitoring and evaluation systems are weak, and the CEO appointment systems are weak to non-existent. My findings are informed by the experiences of investigating i) the Life Esidimeni tragedy in Gauteng in 2016, ii) the Tembisa Provincial Tertiary Hospital COVID-19 death in 2021, and iii) the current RMMCH complaint, including various suspensions and impending resignations in the province.
- It is important that the Health MEC and Premier prioritise the quality of health services within the province. As the economic hub of the republic, a quality health system and a healthy citizenry is an absolute necessity. The success of the NHI is dependent on a quality health system and the GDoH should lead by example. (Prof. Makgoba, 2017 and 2021)

The complaint was lodged by a Member of Parliament's Health Portfolio Committee, Hon. Haseenabanu Ismail on 06 April 2022 and risk-rated **high**.

Complaint issues:

1. Expectant mothers at RMMCH were sleeping on the hospital floor.
2. The Hospital's Chief Executive Officer (CEO), Dr. Nozuko Precious Mkabayi (Dr. NP Mkabayi), was not working full-time to ensure everything ran smoothly. Since the CEO was appointed on 01 January 2021, she had only spent 182 days at the hospital.
3. Patients' health and dignity, and the well-being of healthcare workers was severely affected.

- Onsite visits, in-person interviews, audio recording and transcription, literature review, and analysis of documentary and photographic evidence.
- In total, interviews were conducted with 34 individuals between 04 August 2022 – 29 November 2022. Two witnesses were interviewed twice.
- A provisional Report was issued on 21 December 2022 in terms of Section 81A (5) of the National Health Amendment Act (NHAA), 12 of 2013, to the following persons: Hon. H Ismail; Dr. A Manning; Dr. NE Mokgethi; Dr. N Nolutshungu; Dr. NP Mkabayi; Ms. LB Baloyi, and Ms. T Goduka.
- The objective was to afford any implicated person the opportunity to be heard and provide evidence to vary/disprove the Ombud's findings and recommendations.
- Feedback to the Provisional report from all seven individuals indicated that the Ombud's findings were not only confirmed but strengthened by almost all the responses that were received.

1. The allegation that expectant mothers at RMMCH slept on the hospital floor was substantiated and confirmed.
2. The allegation that the CEO of RMMCH was not full-time at the hospital to ensure that everything ran smoothly was substantiated and confirmed.
  - 2021: a shortfall of 27 days was unaccounted for
  - 2022: a shortfall of 71 days were unaccounted for
3. The allegation that the health and dignity of patients, and the well-being of healthcare workers is severely compromised was substantiated and confirmed.

4. **Human Resources:** There were several lapses in the pre-employment processes followed by the Gauteng Department of Health when filling the position of CEO at RMMCH in 2020.
5. **Infrastructure:** RMMCH was built in 1943 and has never received any substantial upgrades. The aging infrastructure and sewage reticulation system are failing, leading to pipe spillages and toilet blockages. There does not appear to be ongoing maintenance of the hospital infrastructure, despite the allocation of budget, personnel, and the apparent need.
6. **Blood Bank (SANBS) and Laboratory (NHLS) Services:** The hospital's laboratory and blood services do not operate 24 hours a day. This is highlighted as a major gap as RMMCH provides high-risk specialist obstetrics, gynaecology, neonatology, paediatric and surgical services where these services are obligatory.

7. **Radiology services (CT scan):** There is one CT Scan machine at RMMCH, purchased in 2006, which is problematic.
8. **Hospital Board:** Since April 2019, RMMCH shared Hospital Board with HJH; the functionality was questionable.
9. **Security challenges:** Security at RMMCH is poor, and the security personnel is not adequately equipped with the 'tools of the trade'.
10. **Shortage of Nursing Staff:** Chronic ongoing problem leading to the long-term use of "Nursing Agency" staff
11. **Flouting of Supply Chain Management (SCM) Processes:** A global lack of knowledge of SCM processes was identified at all levels within RMMCH.



- 12. RMMCH catchment population:** Statistics of patients admitted at RMMCH in the past 3 financial years reveal that 43%, 41%, and 41% of all patients admitted to RMMCH in the 2019/2020, 2020/2021, and 2021/2022 financial years, were non-SA citizens, respectively.
- 13. Nosocomial Infections:** Mainly due to staff shortages, overcrowding, and poor hand hygiene.
- 14. Infection Prevention and Control:** 'self-made' concocted solution used to prepare the skin before abdominal surgical procedures in August 2022 contributed to at least 11 'relook' surgeries.
- 15. Lack of an Intensive Care Unit (ICU) for adults at RMMCH:** Any adult patients requiring ICU services are placed into an operating theatre, which is closed until a vacant ICU bed is found.

# Recommendations for GDOH



**Ihhovisi Lokulandela Amaqophelo Ezempilo**  
**Office of the Health Ombud**  
**Kantoro ya Mosekaseki wa Maphelo**

---



- Ensure that a suitable, and permanent CEO for RMMCH is identified and appointed as a matter of priority, within three (3) months.
- The advertisement for the CEO position should be in line with standardised requirements for CEOs of regional and tertiary level hospitals to ensure any potential candidates meet all the relevant criteria and are 'fit for purpose'.
- To ensure success, the GDoH should provide ongoing regular support to the new RMMCH CEO, which should be documented on a monthly basis.

## 12 Transfer of Dr NP Mkabayi to Provincial Office

- The Gauteng MEC for Health should offer professional and psychological support and assistance to Dr. NP Mkabayi in her new position at the GDoH.
- GDoH should not only provide supervision and support but also ensure that Dr NP Mkabayi undertakes training to remediate the gaps identified in her competency assessment and the Ombud's findings.
- Stabilization, support/training and transfer of Dr NP Mkabayi should be undertaken for the remainder of Dr NP Makbayi's contract period with GDoH, coupled with regular assessment and monitoring by GDoH and the HPCSA.

The Premier should ensure that RMMCH is one of the first hospitals to be refurbished, within six (6) months.

Consideration should be given based on the collapsing sewage system, leaking steam pipes, dilapidated buildings, and unkempt surrounding areas within the hospital perimeter.

- GDoH should prioritize and fast-track the gazetting of RMMCH as a Tertiary hospital which would ensure that RMMCH receives a tertiary grant, within eight (8) months.

- The Gauteng MEC of Health must urgently appoint an independent forensic and audit firm within two (2) months to:
  - Conduct a competency, 'fit for purpose' assessment of the leadership and management staff at RMMCH.
  - Assess the need to upskill all RMMCH managers / EXCO members to ensure they are able to perform their functions in line with the expectations of RMMCH service delivery.
  - Review corporate governance at the hospital in line with appropriate and applicable King IV corporate governance principles to promote and improve a culture of good corporate governance.
  - Investigate HR practices pertaining to Dr. NP Mkabayi, with particular focus on her appointment, supervision, leave management and related irregularities, and resolution of complaints.

## Implement Recommendations made in the 2017 report “An Unsafe Hospital” by Prof. A Coovadia and Prof. H Lombaard.

- The MEC and HoD for Health should revisit the 2017 RMMCH report with a view to implementing the recommendations, as a matter of urgency.
- A comprehensive implementation plan is to be submitted to Ombud within six (6) months including detailed realistic strategies, time frames, and names, designations and contact details of persons responsible for implementation.



# 17 Review RMMCH staff establishment

- The GDoH should prioritize the review of the RMMCH staff establishment and appoint staff in line with their skill sets in all departments to ensure compliance with Regulation 19 (2) (a) of the Norms and Standards Regulations.
- A review of the utilization of nurses from Nursing Agencies is also recommended to reduce the strain on the goods and services budget.
- A report detailing progress in this regard should be sent to the Ombud within six (6) months.

- The GDoH is to fast-track the establishment of a fully functional adult ICU at RMMCH within six (6) months.
- The ICU will ensure that patients are treated in a manner consistent with the nature and severity of their health condition as provided for in Regulation 5 (1) of the Norms and Standards Regulations and allow scheduled surgical procedures within the theatres to continue in an uninterrupted manner.

- The Gauteng Department of Health and RMMCH should institute a disciplinary inquiry within one (1) month following prevailing policy and compatible with the Labour Relations Act, 66 of 1995 against the following personnel:
- **Sr. T Goduka** for using an unauthorized self-concocted solution in the maternity operating theatres during August and September 2022.
  - i. By doing so, she put the lives of patients at risk and the reputation of GDoH at stake. Her actions led to several adverse events (post-operative wound sepsis), which necessitated eleven 'relook' surgeries in theatre in August and September 2022.
- **Dr. NP Mkabayi** for her failure to ensure that the RMMCH has functional systems in place by:
  - i. Failing to ensure adequate HR controls were in place to restrict access to and loss of RMMCH personnel information.
  - ii. Flouting standard HR practices by requesting her own HR personnel file, not signing for it, storing it in her office - from where it subsequently went missing - and not reporting the loss to the HR department or the South African Police Service (SAPS).
  - iii. Failure to manage leave as stipulated in her contract with GDoH and in accordance with sections 5.7 - 5.9 of the "Determination on Leave of Absence in the Public Service" document.

# Discussion



**Ihhovisi Lokulandela Amaqophelo Ezempilo**  
**Office of the Health Ombud**  
**Kantoro ya Mosekaseki wa Maphelo**

---



No	Investigation Findings	Related Norms and Standards
1.	<p>RMMCH Human Resource Department (HRD) failed to ensure proper controls to monitor leave processes at the hospital.</p> <p>RMMCH HRD failed to put measures in place to control and monitor HR files of health personnel</p>	<p>Regulation 5 (1) states that “the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition.”</p> <p>Regulation 8 (1) provides that “the health establishment must maintain an environment which minimises the risk of disease outbreaks, the transmission of infection to users, health care personnel and visitors.”</p>
2.	<p>RMMCH Human Resource Department (HRD) failed to ensure proper controls to monitor leave processes at the hospital.</p> <p>RMMCH HRD failed to put measures in place to control and monitor HR files of health personnel</p>	<p>Regulation 19 (1) provides that “the health establishment must ensure that they have systems in place to manage health care personnel in line with relevant legislation, policies and guidelines.”</p>

No	Investigation Findings	Related Norms and Standards
3.	The dignity of patients and the well-being of healthcare workers are severely compromised.	<p>Regulation 5 (1) states that “the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition.”</p> <p>Regulation 19 (1) states that “the health establishment must ensure that they have systems in place to manage health care personnel in line with relevant legislation, policies, and guidelines.”</p>
4.	RMMCH was built in 1943 and has never received any substantial upgrades. The aging infrastructure and sewage reticulation system are failing, leading to pipe spillages and toilet blockages	<p>Regulation 15(1) provides that: “the health establishment must ensure that engineering services are in place”.</p> <p>Sub-regulation (2) provides that, for the purposes of sub-regulation (1), “the health establishment must have 24 hour electrical power, lighting, medical gas, water supply and sewerage disposal system”.</p>

No	Investigation Findings	Related Norms and Standards
5.	<p>RMMCH security is inadequate. There are no access control measures to monitor hospital entry and exit.</p> <p>A case of hijacking within RMMCH premises was reported; most interviewees stated that they felt unsafe within the hospital premises.</p>	<p>Regulation 17(1) states that: <i>“the health establishment must have a system to protect users, health care personnel and property from security threats and risks.”</i></p> <p>Sub-regulation (2) states that <i>“the health establishment must ensure that security staff is capacitated to deal with security incidents, threats, and risks.”</i></p>
6.	<p>Severe chronic shortage of nursing staff for over five years.</p> <p>RMMCH is dependent on Nursing Agencies to provide staff and skilled professional nurses.</p> <p>Procurement of these services is through the goods and services budget, leading to over-spending.</p>	<p>Regulation 19 (1) provides that “the health establishment must ensure that they have systems in place to manage health care personnel in line with relevant legislation, policies and guidelines.”</p> <p>Sub-regulation (2) (a) states that: “for the purpose of sub-regulation (1) the health establishment must, as appropriate to the type and size of the health establishment, have and implement a human resource plan that meets the needs of the health establishment.”</p>

No	Investigation Findings	Related Norms and Standards
7.	<p>Sporadic incidents of nosocomial infections in the neonatal unit.</p> <p>Use of diluted disinfectant (Povidone- Iodine) solution for skin cleansing pre-operatively led to eleven post-operative ‘relook’ surgeries between August – September 2022</p> <p>RMMCH security is inadequate. There are no access control measures to monitor hospital entry and exit.</p> <p>A case of hijacking within RMMCH premises was reported; most interviewees stated that they felt unsafe within the hospital premises.</p>	<p>Regulation 8 (1) provides that “the health establishment must maintain an environment which minimizes the risk of disease outbreaks, the transmission of infection to users, health care personnel and visitors.”</p>
8.	<p>Non-functional RMMCH Hospital Board</p>	<p>Regulation 18 deals with Governance and it provides that: “the health establishment must have a functional governance structure with written Terms of Reference”</p>