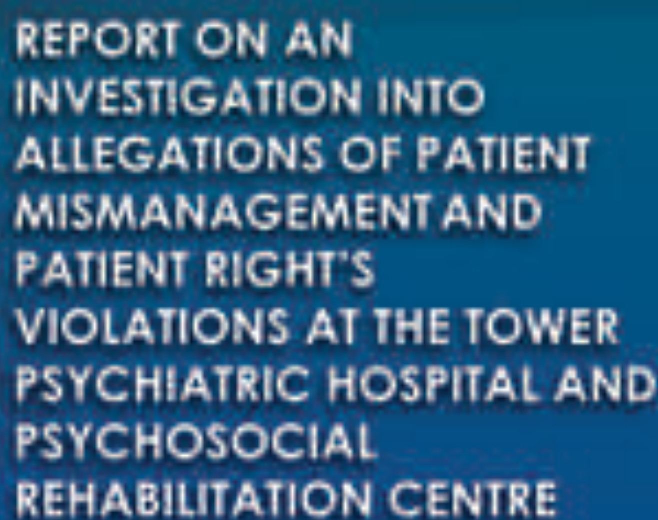

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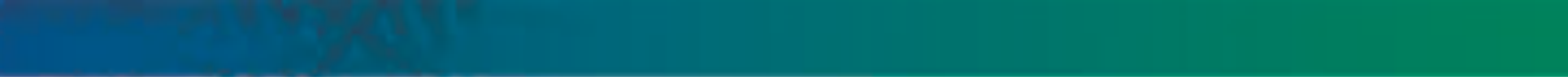

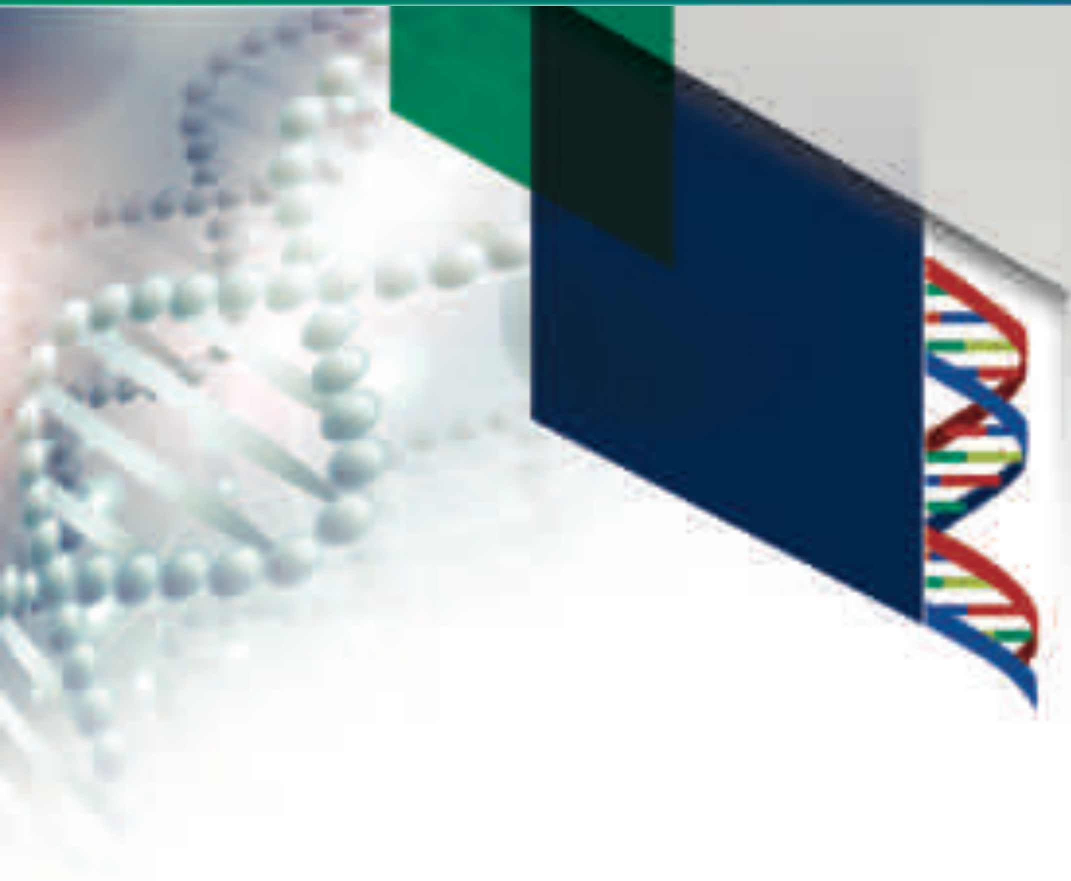

REPORT ON AN INVESTIGATION INTO ALLEGATIONS OF PATIENT MISMANAGEMENT AND PATIENT RIGHTS VIOLATIONS AT THE TOWER PSYCHIATRIC HOSPITAL AND PSYCHOSOCIAL REHABILITATION CENTRE

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Health Ombud: Republic of South Africa

ACKNOWLEDGEMENTS

'There are only two sorts of doctors: those that practice with their brains, and those who practice with their tongues'. Said William Osler. This Report speaks to this famous statement.

This Report is the product of independent teams; the OHSC investigators, the Director of the Complaints Centre and Assesement Unit, the 34 witnesses interviewed, who came to give evidence at Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre (TPHPRC) and at East London. We listened and your voices are captured in this Report.

I received insightful written and oral inputs from the Mental Health Review Board (Central Region) and the Eastern Cape Technical Task Team appointed by Dr. TD Mbengashe, the Superintendent-General, Eastern Cape Department of Health.

I am very grateful to Dr. Kiran Sukeri for finally bringing this unique, complex but important complaint to the Office of the Health Ombud.

I am equally gratefull for all the inputs, comments and verification of statements I received from all concerned after releasing the 'Draft Interim Report'. I found these constructive and important in strengthening the final Report.

The major findings of the Report are found in Chapters 2-4. The Report draws significantly from the meticulous work of the OHSC investigators, Ms HM Phetoane and TJ Monyela who spent almost two weeks on the ground 'sniffing for evidence'. I am indebted to their work.

For all the support I received from Ms. L Jiyane: Executive Personal Assistant (PA) to the Health Ombud, who was responsible for all the logistic and recordings of the investigation and Dr. S Mndaweni, CEO of OHSC for her constant support and encouragement and all the of the OHSC staff, I am truly grateful.

I am indebted to my family for all the sacrifice and support through out this investigation. For all the trouble I have put you through, I shall forever be grateful to you all.

ABBREVIATIONS

AET	: Adult Education and Training
AN	: Auxiliary Nurse
CCC	: Cost Containment Committee
CEO	: Chief Executive Officer
CFO	: Chief Financial Officer
CM	: Clinical Manager
DSS	: Directorate of Specialised Services
DENOSA	: Democratic Nursing Organisation of South Africa
Dr	: Doctor
EC	: Eastern Cape
ECDoH	: Eastern Cape Department of Health
EN	: Enrolled Nurse
TTT	: Technical Task Team
HACCP	: Hazard Analysis Critical Control Point
HE	: Health Establishment
HIS	: Health Information Systems
HIV	: Human Immunodeficiency Virus
HoD	: Head of Department
HPCSA	: Health Professions Council of South Africa
IPC	: Infection Prevention and Control
ITU	: Internal Transformation Unit
MDT	: Multi-Disciplinary Team
MEC	: Member of the Executive Council
MHCA	: Mental Health Care Act
MHCU	: Mental Health Care User
MHCS	: Mental Health Care Services
MHRB	: Mental Health Review Board
MTTR	: Ministerial Task Team Report
MO	: Medical Officer
MOA	: Memorandum of Agreement
MOU	: Memorandum of Understanding
NEHAWU	: National Health Education & Allied Workers Union
NoDH	: National Department of Health
NSM	: Nursing Services Manager
NHA	: National Health Act
NHP	: National Health Policy
OHSC	: Office of Health Standards Compliance
OPD	: Out Patients Department
OT	: Occupational Therapy
PEC	: Patient Experience of Care
PMFA	: Public Finance Management Act
PN	: Professional Nurse
PSA	: Public Servants Association of South Africa
QA	: Quality Assurance
SAHRC	: South African Human Rights Commission
SANC	: South African Nursing Council
SASOP	: South African Society of Psychiatrists
SASSA	: South African Social Security Agency
SCM	: Supply Chain Management
SMS	: Senior Management Service
SG	: Superintendent General
SLA	: Service Level Agreement
SOP	: Standard Operating Procedure
TAC	: Treatment Action Campaign
THETA- SETA	: Tourism, Hospitality and Sports Education Training Authority
TPHPRC	: Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre

LEGISLATION AND OTHER PRESCRIPTS

I. Constitution of the Republic of South Africa,1996
II. National Health Act, 2003, 61(Act No. 61 of 2003)
III. National Health Amendment 2013 (Act No.12 of 2013);
IV. Mental Health Care, 2002 (Act No.17 of 2002)
V. Policy Guidelines on Seclusion and Restraint of Mental Health Care Users; 2016
VI. National Mental Health Policy Framework and Strategic Plan 2013-2020
VII. Eastern Cape Provincial Policy on Accommodation
VIII. South African Food-Based Dietary Guidelines
IX. Policy for Food Service Management in Public Health Establishments
X. Births and Deaths Registration, 1992(Act No. 51of 1992)
XI. Other Documents that were Consulted as part of the investigation

1. Report on the visits conducted in all nine (9) provinces during May 2017 to determine the status of the implementation of the National Mental Health Policy Framework and Strategic Plan 2013-2020.

2. Technical Task Team Report on the enquiry into allegations of Human Rights Violations and the conditions at Tower Hospital, Eastern Cape 7th-29th March 2018.

3. MHRB (Central Region)'s Report.

'if a patient who was admitted to Tower Hospital came from under a bridge, he/she must be discharged back to under the bridge' or 'if an MHCU was admitted from under a bridge, I will discharge him back to under a bridge'. Both ascribed to Dr. Sukeri.

EXECUTIVE SUMMARY

No *prima facie* evidence of institutionalised, systematic or deliberate violations of Human Rights by staff at Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre (TPH-PRC) was found.

As South Africans, *we are not a nation of Human Rights violators*. In a 124-year old, 400-bedded chronic mental health institution and rehabilitation Centre (TPHPRC), at Fort Beaufort, the Health Ombud could only identify and confirm one unquestionable instance of Human Rights violation, following a detailed and systematic evidence-based analysis of Dr. Sukeri's complaint. *This violation was agreed by all stakeholders and all witnesses interviewed*. There was thus no **prima facie** evidence of systematic, deliberate or systemic Human Rights violations found nor was there evidence found of a culture or intent to violate Human Rights by staff at TPHPRC. There were no other 'degrading and inhumane treatments' observed or found as alleged by Dr. Sukeri. This finding was corroborated by evidence from the OHSC investigators, the Mental Health Review Board (MHRB) Central Region, the Eastern Cape Technical Task Team (EC TTT) and evidence from research and the 34 witnesses interviewed by the Ombud.

Dr. Sukeri's coy complaint was primarily about chronic systemic failures and neglect of the ECDoH on Mental Health Care Services (MHCS) with pernicious systemic effects and the power struggles for change. It was not about Human Rights violations primarily as initially alleged and peddled in the media.

Scientific Misconduct Committed

Dr. Sukeri failed to conduct credible studies, research or audits with rigorous verification of the information, data or figures available before making false and damaging pronouncements to the public through the media. This was a grave error. Over an 8-year period, 68 MCHUs had died at TPHPRC and not the falsified and exaggerated total of 90 deaths as reported in the media by Dr. Sukeri's collaboration. These total deaths translated into approximately 8.5 deaths/year or 0.71 deaths/month in a 400-bedded hospital. Therefore, the notion by Dr. Sukeri that *'an alarming number of patient deaths at the hospital in recent years had gone unrecorded' and without proper research and evidence must be regarded as false, untrue and must be eschewed.* For Dr. Sukeri to release such 'shoddy', poorly-researched, falsified and exaggerated patient's vital statistical information into the public *via the media, amounted to 'scientific misconduct or fraud'*, a cardinal sin in science. He was in ***'Violation of Generally Accepted Research Practices*** – that included 'improper reporting of results to present a misleading outcome' and the **'Falsification of Data'** – rather than manipulate the experiments or the data to generate preferred results, this transgression simply fabricates the data entirely (https://www.enago.com/academy/10-types-of-scientific-misconduct/). From this low averaged total death estimate of 0.71 deaths/month and an overall performance of 89% in the National Core Standards assessment, it must be safe to conclude that TPHPRC would rank and compare favourably with the best health establishments of its kind (Weskoppies and Sterkfontein in the country) in the world and must be regarded as such (Khamker N et al 2010 and Walker et al 2013).

The False 'Life Esidimeni' copy-cat phenomenon comparison

It was established and confirmed by all concerned (Dr. Sukeri, the complainant, Ms. HM Phetoane and Ms. JT Monyela, the OHSC investigators, Ms. NE Ngcume, the Chief Executive Officer (CEO), TPHPRC, Prof. Z Zingela, Chair of the EC Technical Task Team and confirmed by the Health Ombud) that a total of 68 patients died at TPHPRC over an 8-year period; this must be compared with a final total of 144 deaths recorded at Life Esidimeni over a period of one year during the 'Marathon Project' Robertson & Makgoba 2018). It was this total death figure of 90 that led to the false comparison. There was thus a **17x fold increase** of deaths at Life Esidimeni compared to deaths at TPHPRC (**12/0.71**); there was no link between the 68 deaths with the alleged Human Rights violations, unlike the 144 deaths in Life Esidimeni; therefore, to compare and label Dr. Sukeri's complaint at TPHPRC as 'another Life Esidimeni' in scale/magnitude or any dimension is both misleading and false. Despite Dr. Sukeri admitting that he was wrong in this comparison and having made the corrections and admission of 'statistical

miscalculations' to the Ombud, followed by an apology to the National Health Minister, Dr. Aaron Motsoaledi and copied to the Health Ombud he has yet to succeed in correcting these in the media and the publics' mind. This incindence at TPHPRC was **no Life Esidimeni.**

Irretrievable breakdown and loss of trust and confidence

Dr. Sukeri has irretrievably lost the trust and confidence of the TPHPRC Board, the Mental Health Review Board (Central Region), Dr. TG Mbengashe, the Superintendent-General, Dr PP Dyantyi the former Health MEC, the Management team at TPHPRC (Ms. NE Ngcume, Dr. Snombo and Mr. Baart) and other colleagues at TPHPRC and other officials within the ECDoH; his complaint has had the effect of dividing the psychiatric professionals in the South African Society of Psychiatrists SASOP National versus the SASOP EC and between members of SASOP within the EC. Ka Sepedi '*Ba re O nyetše sediba*' meaning 'he pooed into his water well' and in Japanese he committed a '*Hara-kiri, Seppuku or Kamikaze*'. He has irretrievably destroyed trust and confidence across a range of stakeholders by the manner in which he went about his complaint. He disregarded all possible and available processes to him.

Dr. Sukeri claimed in some of his media quotes in City Press newspaper 04-03-2018 that *'I know what I'm going to tell you will jeopardise my safety, as well as that of my family, but I don't care. Those patients urgently need to be helped'. 'He was aware that he had not followed due processes'; He did not care anymore as he 'could no longer keep quiet or remain silent' about these 'inhumane conditions'; He showed Rapport* newspaper *copies of the 'lost' register indicating at least 90 patients at the institution since 2010 and four patients died in January alone.''We've been struggling with the same kind of problems in the Eastern Cape for years. I 've been fighting for the rights of psychiatric patients for 12 years', said a tearful Dr. Sukeri to the Rapport* newspaper.

Patient's Confidentiality and Dignity: a Violation of the Cardinal Rule of Medical Practice

'Trust is an essential part of the doctor-patient relationship and confidentiality is central to this. Patients may avoid seeking medical help, or may under-report symptoms, if they think their personal information will be disclosedby doctors without consent, or without the chance to have some control over the timing or amount of information shared.

Doctors are under both ethical and legal duties to protect patients' personal information from improper disclosure. But appropriate information sharing is an essential part of the provision of safe and effective care. Patients may be put at risk if those who are providing their care do not have access to relevant, accurate and up-to-date information about them'(https://www.gmc-uk.org/Confidentiality good practice in handling patient informatio...).

Dr. Sukeri violated his professional codes of practice and ethics and breached his confidentiality contractual obligations with his employer, TPHPRC and the ECDoH. By sharing the death register (with personal patient's information) with the Rapport newspaper and subsequently on public national television (TV) with eNCA's Checkpoint reporters, Dr. Sukeri violated one of the cardinal rules of the Health Profession's practice, which is **confidentiality.** This violation was in breach of the National Health Act.

By violating patient's confidentiality, he violated patient's dignity. Dr. Sukeri acted in the most unprofessional way for a senior health professional, in a 'noble profession' steeped in centuries of values, traditions, ethics and codes of conduct to advance and improve human life, protect and do no harm to humankind; he simply and consciously ignored all these. He has so far showed very little remorse for his actions; and he lied under oath.

Brought Professional and National Disrepute

Dr. Sukeri's complaint whilst important for Mental Health Care Services in the EC, it is equally injurious to the health's professions reputation, integrity and also to the quality of the health system and its professionals. Consequently, Dr. Sukeri has single-handedly brought disrepute to our country, its health system and its health profession and professionals at enormous human and financial costs by the manner of his actions; the processes he chose to articulate his complaint; surely this conduct and consequences thereof calls for something at the highest level to be done *i.e. when a nation or society can no longer or loses trust its 'brain trust', something profoundly faulty has taken place.*

ECDoH: A department with a track record of 'successful' failures

Available evidence gathered and corroborated by several independent research reports, showed that ECDoH:

i) failed to prioritise mental health services over a long period;

ii) has a long history of failures to implement policies as documented in the Treatment Action Campaign (TAC)& Section 27 2013 investigation Report, Dr. Sukeri 2014 (3 articles referenced), The Ministerial Task Team Report (MTTR) following the Life Esidimeni tragedy (May 2017), Dr. Mo Nagdee's email Feb 2018& OHSC investigators 2018 Report);

iii) **the above long history demonstrated the ECDoH was incapable of recovering or correcting by itself and without the assistance of an external tough task master or administrator;**

iv) failed to provide the necessary leadership and governance of mental health services;

v) failed to 'treat specialists with respect and not simply as subordinates/employees' (Dr. Mo Nagdee);

vi) Not only failed to implement its plans on mental health services, but also seemed incapable of action or implementation over long periods;

vii) failed to develop community-based mental health services, the sine qua non of de-institutionalisation;

viii) failed to guide and provide support to TPHPRC;

ix) failed to maintain adequate infrastructure standards at TPHPRC;

x) as a result, infrastructure has degenerated over time;

xi) failed to instill Consequence Management to hold senior staff accountable;

xii) the work ethic has severely deteriorated.

xiii) the leadership and governance are in disarray; and

xiv) there are severe shortages of staff in general and at critical areas;

The TPHPRC outburst was just the needed lightening rod and representative of a broader systemic and prolonged poor-quality service delivery for Mental Health Care Users (MCHUs) in the EC.

The National Health Minister must evoke the appropriate and relevant Sections of the Constitution to appoint an Administrator with respect to Mental Health Services in the ECDoH. This must be done within 90 working days through the appointment of an Administrator.

This Complaint has re-emphasised the urgent need to review the NHA 2003 and MHCA 2002 that took away the powers of the President, the National Minister of Health and Magistrates in addressing issues of Mental Health nationally. Locating Mental Health Services at the Provincial sphere of government in the so called 'concurrent competence' has created difficulties rather than solutions to Mental Health Care Service. This competency must revert back to the National Health Minister (Health Ombud Report page 54-55 item 14).

Dr. Sukeri should be reported to the Health Professions Council of South Africa (HPCSA) as a matter of urgency for serious professional misconduct and violations of 'codes' of health practice identified in the report. The rationale for the recommendation is:

- Dr. Sukeri released unverified, false and damaging death statistical information to the public;
- Dr. Sukeri violated the confidentiality of patients and by so doing their dignity;
- He violated his confidentiality clause signed in his contracts;
- He failed in his duty of care as a professional;
- He violated the MHCA;
- He discharged patients without proper authorisation and without following the MHCA;
- Dr. Sukeri denied Ms. Ngcume, the CEO, the right to exercise her duty fully by discharging MHCUs without her 'knowledge';
- Dr. Sukeri was found to be untruthful, 'evasive' and duplicitous in his evidence;
- He created an irretrievable loss of trust and confidence with colleagues at TPHPRC and ECDoH;
- He was jointly responsible for creating a 'toxic working environment' in which to care for vulnerable MCHUs;
- It is the Ombud's role to protect the integrity of the health system and of users against abuse;
- Dr. Sukeri caused unnecessary reputational damage to the National Health System and its integrity;
- He caused unnecessary pain and reputational damage to innocent staff members, MHCUs and to TPHPRC as an institution and the ECDoH;

- *That some MHCUs discharged have been re-admitted, one has committed a crime and others are not coping well, as so far as found, questioned the quality of assessments undertaken, the clinical judgements/decisions and competence of the practitioner.*

The HPCSA should consider the immediate suspension of Dr. Sukeri from any practice pending a process to assess his 'fitness for office' as proposed out below, to safeguard the wellbeing of patients, protect him and the integrity of the profession. Disciplinary proceedings must be instituted against Dr. Sukeri in compliance with the Disciplinary Code and Procedure applicable to Senior Management Services (SMS) members in the Public Service. This should follow a fair, transparent and due process;

- Dr. Sukeri should be charged for gross misconduct and incompetence on the basis of the findings in this report especially the violation of patients' confidentiality and for committing what amounted to scientific misconduct.
    - o Consideration must be given that he may need assistance with psychological counselling.
    - o Currently and from all the evidence gathered he is like a 'round peg in a square hole' within TPHPRC and the ECDoH.
    - o He has irretrievably broken trust within the TPHPRC and the ECDoH.
- The HPCSA must consider the appointment of a panel of 3 independent members, Chaired, by a senior psychiatrist to speedily resolve and finalise Dr. Sukeri's 'fitness to hold office', for his professional and ethical violations, broken relationships, misconducts and incompetence. Alternatively, the Minister should set up a special ad hoc panel to address the '*fitness to hold office'* of Dr. Sukeri; and
- Dr. Sukeri must, in addition to making an apology to the National Health Minister and copied to the Health Ombud (page 61 dated 12th July 2018) and sending a correction to the Rapport Ombudsman, should make a public and unconditional apology in writing to the nation, to his peers in psychiatry, to the medical profession, to the staff at TPHPRC and the ECDoH and to the many patients and families whose lives he compromised through peddling false and exaggerated information. He must acknowledge the pain inflicted to many persons and the reputational damage caused. This apology must be widely publicised and accorded the same weight by the media as they have done with the complaint. SASOP must as a professional body take appropriate actions with regards Dr. Sukeri.

The Management at TPHPRC was so dysfunctional and riddled with dead-end power struggles, it must be overhauled with 'new blood'. This must be done through the SG's Office and the proposed Administrator.

All the recommended internal disciplinary decisions already identified were upheld and must be completed speedily following due processes and in accordance with fair labour practices.

Chapter 1

CHAPTER 1

1.1. INTRODUCTION AND METHODOLOGY

On the 4th March 2018, Ms. Suzanne Venter 'broke' a story in the Rapport newspaper of a complaint brought by Dr. Kiran Sukeri, a senior Psychiatrist at TPHPRC. The story was a collaboration between Ms. Venter and Dr. Sukeri. Dr. Sukeri's complaint was confirmed and brought into sharper context and perspective by another psychiatrist, Dr. Mo Nagdee in an e-mail exchange with Mr. B Nzima, Acting Director of Specialised Services. Dr. Sukeri's complaint was depicted and portrayed in the media as another 'Life Esidimeni saga', even by Dr. Sukeri as alleged by certain sections of the media such as City Press, and the Rapport newspapers and the eNCA TV programme, Checkpoint. This comparison has continued and has had the effect of creating a national mass hysteria and shame so soon after the harrowing experience suffered through the Life Esidimeni tragedy. The media hype and 'Life Esidimeni copy-cat phenomenon or jumping on the bandwagon' comparison has blown the complaint out of proportion to reality. **This created a 'mountain out of mole hill'.**

Another effect of this misrepresentation was to create an expectation within the local public that this complaint will lead to financial rewards just like what happened in Life Esidimeni, with some even dubbing Dr. Sukeri's complaint as '*Life Esidimeni R1.2m, (**Adv Maxakato**)*. One point two million rands (R1.2m) is in reference to the average award given to each relative/family member of the Life Esidimeni tragedy, by former Deputy Justice Dikgang Moseneke.

To unravel this complex complaint, the Ombud adopted the following complex approach:

- the Ombud dispatched two OHSC investigators to visit TPHPRC to conduct an independent onsite investigation into the complaint to verify some of the allegations in the statement and gather any other relevant information;

- the OHSC investigators developed their own method which is detailed in Chapter 3; importantly, the OHSC investigators used Dr. Sukeri's complaint letter and all documents he forwarded to the OHSC to interrogate Dr. Sukeri in the preparation of their Report .

- the Ombud adopted a different approach of focusing on the complaint in preparing for the interviews as spelt out in Chapter 4;

- the Ombud conducted his own investigation through recorded interviews in the presence of the Director Complaints Centre and Assessment, who has provided his own independent report;

- the Ombud also conducted his investigation in the presence of the OHSC investigators for them to fill in gaps; for them to ask further questions on witnesses they have seen and on new witnesses but also for them to detect areas of agreement, discrepancy and consistency of evidence they have heard on their own;

- the Ombud received and read the EC TTT's Report after preparing his findings and recommendations;

- the Ombud conducted his research on the complaint; did not read nor allow the Investigators to have sight of the EC TTT's Report until their independent reports were completed and written;

- the findings were discussed and debated after the reports were finalised;

- After the completion of the investigation report, the Health Ombud provided the main parties, Dr. Sukeri, Ms. Ngcume, Dr. Mbengashe, Prof. Zingela and Mr. Phakathi and all the OHSC investigators with the Interim Report for their comments and inputs. All responded and their inputs were incorporated into this final Report. *These inputs have strengthened the findings and recommendations of the Ombud;*

- there was great value in this complex type evidence triangulation;

- the team of OHSC investigators – Ms. HM Phetoane and Ms. TJ Monyela conducted onsite visits, documentary evidence reviews, inspections and interviews at the Tower Psychiatric Hospital from the 16th April - 20th April 2018 and again on the 07th- 10th May 2018 to establish the veracity of the complaint;

- the investigators from the OHSC focused on the "MHCU". The MHCU was the objective, either through analysis of clinical records and scrutiny of conditions to which the MHCU are subjected to;

- the complainant was interviewed twice for approximately 5hrs in two occasions;

- all documents provided by the complainant as evidence were considered and formed the basis of the interviews and the report writing;

- a telephonic follow up was made with the complainant and was requested to avail himself on the 17th April 2018 for a fact-finding interview at TPHPRC. A follow-upinterview with the complainant was done on the 10th May 2018.

Between the 5th June and 8th June 2018, the Health Ombud together with the Director of Complaints Centre and Assessment, Mr. Monnatau Tlholoe, the Senior Investigator (Health) Ms. Helen Mamodiehi Phetoane and the Deputy Director of investigations, Ms. Joyce Tinyiko Monyela interviewed 34 staff members in 36 interviews in relation to Dr. Sukeri's complaint. The witnesses included officials of the ECDoH, the TPHPRC staff, the MHRB members, the labour representatives of Democratic Nursing Organiation of South Africa (DENOSA), National Health Education & Allied Workers Union (NEHAWU) and the Public Servants Association of South Africa (PSA), the full list of witnesses is attached as Annexure 2b. In total 25hrs:48min:36secs were spent on these interviews. *1:48:41 was spent interviewing* Dr. Sukeri. All the interviews were recorded. All the witnesses gave evidence under oath. Further documents were requested from Dr. Sukeri and Ms. NE Ngcume and e-mail exchanges follow up took place where necessary to clarify or confirm some issues with all witnesses. *All witnesses cooperated well*. The complaint was investigated in terms of Section 81A (1-11) of the National Health Amendment 2013, Act No. 12 of 2013.

Chapter 2

CHAPTER 2: FINDINGS (1)

A PERSPECTIVE THROUGH THE DIRECTOR OF COMPLAINTS CENTRE AND ASSESMENT'S EYES

The interrogations took place from the 5th - 8th of June 2018. A total of 34 persons were interrogated by the Health Ombud, Prof Makgoba in the presence of Ms. HM Phetoane, Ms. JT Monyela and Mr. M Tlholoe. The interrogations were audio recorded by Ms. L Jiyane.

The following is a summary of the interrogations:

2.1. Navigating the complaint with the complainant

Dr. Sukeri came to TPHPRC as a transfer in 2015 as a Medical Head of Clinical Unit Grade 2 and he reported to the CEO, Ms. Ngcume; a fairly good relationship existed with Dr. Sukeri constantly visiting the CEO without appointment to discuss issues. His level of responsibility and authority included patient care, training and development of policies. Policies are approved by the CEO, Ms. Ngcume. He subsequently resigned to pursue his private practice but the CEO convinced him to rather provide sessional work; a motivation was submitted to ECDoH Head Office. He however had to report to Dr. Snombo, the Clinical Manager.

a. Basic Human Rights

i) Lack of dignity; he stated that patients were sleeping in seclusion/single cells which were old and damp, and had cement blocks, with no toilets. There was general corroboration by witnesses to the state of the single/seclusion rooms. The seclusion/single cells were at times used as seclusion rooms and were situated far away from the nurses' station without constant monitoring. Patients wore torn and dirty clothes.

ii) Patients autonomy to make decisions about their outcome such as discharge was impacted upon. He cited that some patients did complain about some aspects such as sleeping in the seclusion/single rooms, clothes and food.

iii) Food; asked if there were patients losing weight to support his complaint of poor quality of food, he indicated that he did not monitor their weight. He further admitted that no patients lost weight nor fell ill as compared to the general population. There was no evidence to support the allegation. How does a clinician make such serious allegations without testing them through clinical interventions?

a. Users kept in a highly restricted environment longer than clinically accepted. He asserted that there was no agreed upon definition of long term institutionalisation. Patients live in an environment where their individuality becomes mingled with total institutionalisation.

Asked why it took so long for these matters to become a complaint. He stated that all these matters were raised at different levels; Hospital meetings (Handover, Head of Sections and Clinical) with minutes, Directorate Specialised Services, South African Society of Psychiatrists (SASOP) and National Department of Health (NDoH), Mr. Sifiso Phakathi. He submitted that in 2016 he contacted Section 27. None of these are statutory complaints management structures.

He was not aware at the time that there was an Ombud in the Province and neither did he raise it with the SG. He did not receive any acknowledgement nor response from the Department of Specialised Services. However, he received a call from Dr. Nogela wherein he raised concerns about him writing to several agencies about the TPHPRC situation. He was however aware that the Republic has Office of the Public Protector, of the South African Human Rights Commission (SAHRC) and of the Health Ombud.

2.2. Provincial response to the Media complaint

The MEC, Dr. Dyantyi and HoD, Dr. Mbengashe had an unannounced visit on the 5th March 2018 at TPHPRC and most of the issues raised were dispelled but the state of the seclusion/singe rooms was indeed found to be in a bad state. SASOP also conducted an investigation after permission was sought from Dr. Mbengashe. The Central Region Mental Health Review Board also conducted its own investigation and submitted a report to the EC Provincial Office. As part of crisis management, the EC provincial office initiated the renovation of the seclusion/single rooms.

2.3. Management

Failures which necessitate accountability and consequence management have been left unattended. Difficulties associated with the centralised system of decision making was exacerbated by the under-serviced mental health care programme. Health establishment management felt disempowered to take decisions and solve problems they were faced with especially on infrastructure and staff shortages. The complainant felt undervalued as management did not always take his issues, concerns and complaints seriously. It was reported that plans exist to increase acute mental health beds in the province.

2.4. Human Resources

b. Staffing

Understaffing and difficulties retaining existing staff is a key human resource constraint. The high vacancy is claimed to be exacerbated by the centralised process of recruitment and filling of posts. It was reported that an exercise of human resource organisational review was done and key posts of the Head of and Clinical Head Psychiatric have been excluded. It was purported that this was done without consultation and a general feeling was that mental health was a step child of the department. SASOP further highlighted the plight of medical officers employed for psychiatry who in most instances are reshuffled to either casualty or other general wards.

c. Retention Strategies

None existed.

d. Code of conduct

Many opined that Dr. Sukeri's conduct was inappropriate; he took confidential information out of the facility to the media without exhausting internal processes. Dr. Sukeri also conceded that he should not have taken the matter to the media but also argued that he was no longer an employee of the state. This was an error on his part as his employment contracts stipulated otherwise.

Ms. Mali "kept" patient's money without reporting to anyone and failed to submit the money to the Revenue Office for an estimated period of two weeks. Dr. Snombo failed in her role to act against Ms. Mali and the CEO also failed to act on deviation of practice by Dr. Snombo.

Mr. Baart, the Nursing Services Manager, was disciplined for not implementing corrective action for the incident of the patients detained in the seclusion/single rooms without following proper procedures.

This is an inconsistent application of the Disciplinary Code. A junior doctor was coerced to change her medical entry in a patient file and Dr. Sukeri who was his supervisor instead of supporting the doctor related to her concerns about the matter, reported the junior doctor to the HPCSA.

There was a common thread in most witnessed that Dr. Sukeri was not a credible witness; he sang praises to the MHRB but when interviewed by EC TTT he questioned their effectiveness. Likewise, in his presentation to the Health Ombud, he presented his dissatisfaction with the Ombud's investigators that they were 'aggressive in their approach' but changed the position that it was actually SASOP who were 'aggressive'. *Is this a credible witness?*

The presentations showed inconsistency in addressing conduct failures.

e. Employer- Employee Relations

As part of ensuring labour peace in the health establishment; Internal Transformation Unit (ITU) was established but did not have a constitution; it stopped sitting in 2016 due to failure of management to implement resolutions agreed upon in the meetings, especially on staff survey that management failed to undertake.

Unions were not in support of Dr. Sukeri's approach in addressing the complaint. Management could have however taken better decisions. He was part and parcel of committees wherein issues were discussed and was alienated and stopped from participating in the meetings. Management failed to effect discipline for misconducts such as theft, drunk on duty, and late coming. The staff in supply chain management have no training. Service providers are not paid on time. There has been high resignation of staff, especially doctors. It was alleged that that inconsistency and overworked staff were contributory factors. DENOSA further submitted that the lack of general assistants impacts on nurses as they have to participate in cleaning activities. Staff was aware of the grievance procedure. There is nonetheless no compliance to timelines.

The unions unanimously indicated that there was lack of provincial support.

2.5. Information Management

Concessions were made by the complainant, the CEO and Member of the Executive Council (MEC) that incorrect statistics was submitted to various stakeholders (media and legislature). The data was not validated; because the mortality register was missing.

2.6. Infrastructure

There was unanimous presentation that the physical infrastructure, especially seclusion/single rooms were in an unacceptable state. Hospital Management has since 2016 reported the matter at provincial office but had never received attention until the matter was reported to the Ombud and exposed in the media.

At the time of the interviews, the service provider was reported to be on site renovating the seclusion/ single rooms. Clearly, this is poor management decisions and echoes the submission by labour that provincial office was not supportive to their complaints.

Provincial wide plan to increase number of acute mental health beds was in place; 60 of the beds were planned for TPHPRC. This needs to be closely monitored to see its realisation, especially that the ECDoH has a track record of 'successful failures'.

SASOP further presented that the Eastern Region was under pressure for acute beds; MHCUs are kept in casualty for very long periods which compromise their safety and that of others. An incident wherein an open room was converted into a psychiatric unit without consideration of expected building standards for MHCUs; the unit is reported to be not fit for purpose.It was also reported that the plan to build a new psychiatric hospital has not been realised for over 10 years. *An example of failure to implement agreed plans.*

2.7. Security

The CCTV cameras were reported out of service for about 2 months and there was an incident of theft of pigs which could not evaluated from the camera; matter apparently reported to the service provider for repair.

The nursing service manager was reported to be responsible for the management of the CCTV and he admitted that he has no required skills to manage the security system but was doing it because it was delegated.

2.8. Patient-related

f. Mental Health Review Boards

It was a general submission that Mental Health Care Users (MHCUs) were detained without proper documentation. It was submitted that challenges were around incorrect filling of Mental Health Care Forms and lack of training for nurses and doctors.

g. Quality of Mental Health Care

Two adverse incidents occurred in the hospital;
Dr. Sukeri as the Medical Head of Clinical Unit

- a case of a mental healthcare user who burnt himself after being kept in the seclusion/single room without following procedure nor at doctor's prescription, and
- another user was found dead in the hospital ground and carried to the ward by nurses without being examined by the doctor. The clinical manager, Dr. Snombo who was on call when notified did not come on site to examine and certify the patient dead. The cause of death was declared natural.

Dr. Sukeri as the Medical Head of Clinical Unit Grade 2 did not show leadership and guidance in the care of users; he should have employed strategies to address the gaps he identified in the quality of care of users, but instead he took the matter to external stakeholders. He seemed to have not advocated for the users as he claims in his allegations.

No evidence was presented that he reviewed the mortality statistics with a view to improve the quality of care. He could not demonstrate that he championed mortality meetings to improve quality of care at TPHPRC.

He further made allegations of about the quality of food but as a clinician did not instruct nurses to at least weigh patients weekly to prove his allegations. It was reported that Dr. Sukeri tended to discharge patients without following proper procedures and that he was undertaking an illegal de-institutionalisation.

It was confirmed that there was a diarrheal outbreak and one patient died as a result. The cause of death was classified as natural.

h. Quality of food

There was no evidence available to support the opinion that patients were receiving poor quality of food, except complaints of insufficient quantity and lack of variety. An outbreak related to food poisoning was reported which was suspected as due to expired chicken livers. No abnormalities were detected following the laboratory sample testing.

i. Mental Healthcare Users Funds

TPHPRC has a user fund account with one of the recognised banks in South Africa for mental healthcare users and their supporting persons to deposit their monies. An initial bank charge of ±R12, 00 was later reduced to ±R5, 00. The ECDoH was aware of the fund and the health establishment has an existing Standard Operation Procedure (SOP) to manage the fund.

Unclaimed money was noted in the fund and management took a decision in line with the SOP to use R6 000,00 of the money to paint the doctor's house.

It also came to light that Ms. Mali, Social Worker, at the health establishment "assisted" a patient to access his disability grant from South African Social Security Agency (SASSA) and retain the money in her possession for ± two weeks. Only when the complainant complained, did her colleagues and management become aware of the incident. She initially reportedly denied the incident but later conceded with an excuse that she "forgot".

She breached the hospital practice that money should be reported to the Revenue Office for safekeeping.

This unethical behavior was not addressed by hospital management team, especially the direct supervisor, Dr. Snombo. Only a statement was requested and no further action was taken.

2.9. Findings

2.9.1. Management

a. ECDoH was reactive to the challenges that were reported.
b. There was no provincial support to Mental Health Care Facilities.
c. No accountability and consequence management across all levels of the Department.
d. There were difficulties with role clarification within the management team at TPHPRC due to lack of communication and direction leading to lack of understanding.
e. Decentralisation of power rendered hospital management ineffective in discharging their responsibilities.

2.9.2. Mental Health Review Board

a. The Mental Health Review Boards were not provided with the needed resources (administration support and fax facilities to discharge its powers. There was also excessive delay in reimbursement for their subsistence and travel claims.
b. Most patients in the ECDoH were detained without legal documentation due to incomplete forms.

2.9.3. Human Resources

a. TPHPRC has a high vacancy rate.
b. A shortage of competent and qualified staff could have contributed to the inadequate mental healthcare.

2.9.4. Breach of Code of conduct

a. The complainant, Dr. Sukeri approached the media without exhausting all internal avenues in the province. He breached the code of conduct of the employer, his contracts of employment and the code of ethics of the HPCSA.

b. Ms. Mali illegally accessed the patient's SASSA earnings and should be held liable using the Disciplinary Code and Procedure for a criminal prosecution; theft.

c. Dr. Snombo acted against the code of conduct in that she did not hold those reported under her accountable for their omissions and commissions. She also deviated from the professional code of conduct by certifying a patient who was found on the hospital grounds dead over the phone and failed to open a case of inquest for the death. This represented a professional misconduct.

2.9.5. Infrastructure

a. Inadequate and poor infrastructure, especially the absence of compliant seclusion/single rooms, lead to poor protection of MHCUs.

2.9.6. Information Management

a. Weakness in capacity to collect, analyse and utilise as well as retain health data at health establishment and provincial level.

Chapter 3

CHAPTER 3: FINDINGS (2)

3.1. THE OHSC INVESTIGATORS' REPORT ON THE ALLEGATIONS MADE BY DR. SUKERI

Chapter 3 depicts the independent findings of the investigators from the OHSC appointed in accordance with the National Health Act, 2003 (Act No. 61 of 2003) Section 81A subsection (3)(b)(ii)-(iv) namely Ms. HM Phetoane and Ms. JT Monyela. These findings were obtained through interviews, meticulous verification and analysis of documents, photographic evidence and inspections *in loco* in a *non-minacious milieu*. The investigators had extensive engagement with the complainant, hospital Management, staff, and the Mental Health Care Users, to provide the Health Ombud with independent comprehensive findings to assist in preparing the recommendations thereof. By its very comprehensive nature its methodology is spelled out in the text below.

In addition to the investigation by the OHSC investigators at Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre (TPHPRC), the Health Ombud conducted interviews with relevant stakeholders from the 05th – 08th June 2018 in East London, where investigators from the OHSC were also present and participated in the interviews. The witnesses interviewed by the Ombud validated the findings obtained in the investigation done at TPHPRC by the OHSC investigators prior to the Health Ombud's interviews.

3.2. PURPOSE

The purpose was to provide an independent report to the Health Ombud about the outcome of the investigation regarding the allegations cited by the complainant Dr. Kiran Sukeri on the Institutionalised Violations at TPHPRC in Eastern Cape.

3.3. BACKGROUND

3.3.1. On the 21st February 2018 the complaint was lodged with the OHSC and subsequently registered on the complaints management system and was allocated Reference 4756.

3.3.2. In his letter titled: Institutionalised Violations at TPHPRC.

Dr Sukeri's official (Unsigned) Letter to the National Health Minister and the OHSC

20 February 2018

The Honourable Minister of Health
Republic of South Africa
Dr. A Motsoaledi

Sir,
RE: Institutionalised Violations at Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre

As a way of introduction; I am a sessional Psychiatrist employed at the above institution (as of July 2017). I was in full time employ at the same institution from December 2015 to May 2017.

I feel obliged to make you aware of the following institutionalised violations of human rights and other pertinent issues at this institution. There are early signs of some change butI am not convinced that these are adequate.

Basic Human Rights

It is my belief that the Constitutional Rights to dignity and adequate food are being violated. There is no dietitian and meals are not consistent with the National Food Services Unit Policy. My observation is that patients are fed a staple of samp and beans or white samp on most occasions.

At night patients are given a soupy mixture of either chicken livers or tinned pilchards (On the 19/01/18 supper consisted of 24 tins of pilchards, 1 bag of carrots, 2 bags of potatoes, soup and gravy mix for 308 patients). Patients do not receive fruit on a daily basis. There are no calibrated special diets for patients with diabetes and other medical conditions. Patients in Clinic A have been bathing in cold water since the last quarter of 2016.Dignity is compromised by the poor state of hospital clothes, which is often torn and dirty and poorly fitting. Patients in the open ward are not allowed to wear their own clothes.

Violation of autonomy and the Mental Health Care Act no.17 of 2002

It is my opinion that users are kept in a highly restrictive environment longer than is clinically acceptable. My clinical decisions to discharge and/or permit leave of absence to mentally stable patients is constantly questioned, irrespective that these decisions were made with a complete multi-disciplinary team. The management of the patient finance account deserves a thorough investigation. I have reason to believe that notes have been fabricated where patients have died.

Inadequate Rehabilitation of users

The Occupational Therapy Department has not been able to access the necessary equipment to function. The Adult Education Program (grade 10) has inappropriate patients attending. Although this has been brought to the attention of management, no appropriate steps have been taken to address such issues as patients who have undergraduate qualifications, completed Grade 12, mentally unstable or involved in transactional activities from attending.

Human Resources

Since 2016 several staff members have left the institution. These include a Clinical Psychologist, 2 Occupational Therapists, 3 Medical Officers and several professional nurses. The current Clinical Psychologist has handed her resignation this month. A list of staff members who have resigned, retired or transferred should have been submitted to Bhisho but I won't be surprised if this document would have been changed to reflect otherwise.

The Management insists on continuing on their plans for an Out-Patient Department (OPD) and Acute unit despite the staff constraints. Although there are plans to employ four additional medical officers and a full time psychiatrist, this staff complement will not be adequate to meet both acute, chronic and rehabilitative requirements of the institution.

The current Clinical Manager is paid for after hour clinical calls at the institution in addition to her managerial duties. She is never available on weekends, although she is on the call roster. This sets a precedent for other Clinicians. This also impacts on Clinical Governance oversight.

The CEO is dictatorial in her management style, often alienating staff. The CEO lives on site while she rents out her private residence to staff employed at the institution. I suspect that this could possibly be a corrupt situation.

I have attempted to bring some of the above issues to the attention of the Management, Department of Specialised Services (Bhisho) and the SASOP since 2016. The latest engagement was an onsite meeting with Mr. Nzima (Acting Director of Specialised Services – Bhisho) and Dr. Matiwane to address interference with clinical decision making. Unfortunately this meeting was unsuccessful as the Management continued to insist that their clinical training allows them to interfere in clinical decisions.

I am aware that the CEO wants to remove me from the institution. I have been shut out of clinical and other meetings. Irrespective of this hostile environment I continue to work to protect my patient's rights and access to care. I am acutely aware of my obligations to report violations.

There has to be constructive change at Tower Hospital to improve the conditions of care for our patients. I hope this matter receives your due attention.

I thank you for attention

Regards
Dr. K Sukeri MBChB, FCPsych (SA), PhD

Annexure 1

3.3.3. OHSC acknowledged receipt of the complaint on the 21st February 2018 and was logged as Reference 4756.

3.3.4. Considering that Dr. Sukeri was a clinical consultant, a senior employee of the ECDoH, who had lodged a complaint and the extreme risk rating of the complaint as assessed by the Complaints Centre and Assessment Division, the Health Ombud decided to investigate the allegations made against TPHPRC.

3.3.5. Investigators from the OHSC were appointed in accordance with the National Health Act (61 of 2003). Section 81A subsection(3)(a)(b)(ii)- (iv) and commenced the investigation from 16th -20th April 2018 and continued on the 07th -10th May 2018.

3.3.6. In addition, the Health Ombud conducted interviews with relevant stakeholders from the 05th – 08th June 2018 in East London. The outcome of which is captured in part two of the report and fully in the Health Ombud's report in Chapter 4.

3.3.7. A notification letter was forwarded to the Superintendent-General of ECDoH, Dr. TD Mbengashe; and Ms. NE Ngcume; the CEO of TPHPRC was copied, informing them about the Health Ombud's Office's intention to investigate the complaint.

3.3.8. Dr. Sukeri resigned on the 2nd of March 2018 and went public and had his story published in the print media (The Herald, City Press, Rapport newspapers) over the weekend of the 03rd and 04th March 2018 as he could no longer "remain silent" about the treatment of patients at the institution.

3.3.9. Dr. Sukeri had made submissions of his concerns to the SASOP National, SASOP Eastern Cape (none of these have the legal power and authority to investigate complaints) and the Acting Director of Mental Health prior to submitting his complaint to the Health Ombud, the National Minister of Health and the SAHRC.

3.3.10. Dr. TD Mbengashe; the SG responded to the allegations by appointing an independent investigative team prior to the investigation by the Health Ombud. This team, chaired by Professor Zingela became known as the ECTTT. This team had their terms of reference and were to commence with their investigation at the TPHPRC on the 07th March 2018 and submit a report by the 29th of March 2018. SASOP Eastern Cape also investigated the allegations made by Dr. Sukeri with the permission granted by the SG. These reports were not shared with the investigators from the OHSC, the Health Ombud and the TPHPRC management team.

3.3.11. During the interviews in East London, the following incidents came to light:

- Two weeks prior to the interviews in East London, an outbreak of diarrhoea affecting 37 MHCUs in which one MHCU at TPHPRC died. The cause of the diarrhoea was cited as food poisoning. The cause of death of the MCHU was declared as natural following post mortem examination. The chicken livers that were served to the MHCUs were alleged to have been expired and to be the possible cause of the food poisoning, it was established beyond reasonable doubt that the chicken livers had not expired and there was no identifiable microorganism to confirm the alleged food poisoning, and

- The second incident was of Ms. L Mali, a social worker at TPHPRC. Ms. L Mali was alleged to have stolen R1500.00 of a MHCU's money. On the 07th June 2018, Ms. Mali pretended under oath not to understand English and tried very hard to deny the theft of the alleged R1500.00, which she ultimately admitted to. During the investigation, two of Ms. Mali's colleagues (social workers) who were also interviewed under oath confirmed that they were aware of the allegations of social grant mismanagement by Ms. Mali and had confronted her. It was subsequently reported in the media (Rapport newspaper) dated 10th June 2018, following the interview with the Ombud that an alleged amount of R10 000,00 had been illegally withdrawn from the SASSA account of a MHCU admitted at TPHPRC.
  These allegations were of serious nature and required disciplinary action. There was no evidence that these corrective measures were instituted against Ms. Mali.

These allegations are of serious nature and require disciplinary action. There was no evidence that these corrective measures were instituted against Ms. Mali.

3.4. BRIEF BACKGROUND ON TPHPRC

Tower Psychiatric and Psychosocial Rehabilitation Centre is a 400-bed psychiatric hospital located in the Raymond Mhlaba Local Municipality area of Fort Beaufort, Eastern Cape in South Africa. The hospital was established in 1894. The health establishment is over a century old, this is possibly when the seclusion rooms were constructed.

The Institution serves the entire province of the Eastern Cape, with an estimated population of 7.1 million. It is the only institution that provides medium to long-term psychiatric care and psychosocial rehabilitation services. *In June 2016, the institution's overall performance of the National Core Standards was 76 and improved to 89 in June 2017. This performance is stellar*. The institution does not render Acute and Outpatient psychiatric services.

The institution renders 24-hour seven days a week service to the mental health care users. Their units are divided into semi-acute/ closed wards, psychogeriatric, a sick and frail ward for males and females. The Rehabilitation Centre is the flagship of the institution. The Centre provides an onsite adult basic education, computer literacy, piggery, carpentry, leather works, garden projects, car wash, sewing and artwork. The Art Work project jointly runs an annual exhibition with Fort England Psychiatric Hospital at the Grahamstown National Arts Festival.

The CEO is a qualified registered nurse with midwifery and psychiatric nursing and 40 years of work experience. The management team consists of the CEO. Clinical Services Manager, Nursing Services Manager. There is an established multi-disciplinary team consists of Nurses, a Psychiatrist, Clinical Psychologist, Occupational Therapists and Social Workers of which Dr. Sukeri was the head.

The administrative service consists of an onsite Human Resources Department, Finance Office and Supply Chain Office. There is a Hospital Board appointed by the MEC that deals with the day to day governance of the Hospital. There is the Mental Health Review Board (MHRB) in the Central Region appointed by the MEC according to the Act. Their role is that of oversight and advisory at TPHPRC.

At the time of the site visit, there were 315 MHCU admitted at TPHPRC.

3.5. METHODOLOGY

Following the request from the complainant Dr. Kiran Sukeri to investigate the allegations made against the health establishment the following methodology was adopted:

- A preliminary assessment of the complaint was conducted in the Complaints Centre and Assessment Division to determine its relevance to the mandate of the Health Ombud; it was determined the complaint raised issues of right to access of health service as well as other interrelated such as human dignity;
- Appointed a team of OHSC investigators – Ms. HM Phetoane and Ms. JT Monyela to conduct onsite visits, documentary evidence reviews, inspections and interviews at the Tower Psychiatric Hospital from the 16th - 20th April 2018 and again on the 07th - 10th May 2018 to establish the veracity of the complaint;
- The investigators from the OHSC focused on the "MHCU". The MHCU was the objective, either through analysis of clinical records and scrutiny of conditions to which the MHCU are subjected to;
- A telephonic follow up was made with the complainant and was requested to avail himself on the 17th April 2018 for a fact-finding interview at TPHPRC. A follow-up interview with the complainant was done on the 10th May 2018. Dr. Sukeri was interviewed twice for approximately 5hrs during those two occasions;
- All documents provided by the complainant as evidence were considered and formed the basis of the interviews and the report writing;
- The investigation was preceded by a brief discussion with management and staff at TPHPRC to obtain an overview of the situation in respect of the allegations made and to undertake the investigation;
- Listened and conducted interviews. A total of 24 personnel were interviewed including the complainant, the TPHPRC management team and the Hospital Board Members (Annexure 2a);
- A request for clinical records, policies, guidelines and any relevant information was made to the CEO of TPHPRC; and
- The Health Ombud conducted interview sessions in East London from the 05th – 07th June 2018. (Annexure 2b). Investigators from the OHSC were present at these interviews.

3.6. INVESTIGATION FINDINGS

Dr, Sukeri made allegations about Patient food, cold water bathing and hospital clothing Below are the Investigator's findings:

3.6.1 Patients Food

- There was no dietician explicitly appointed for TPHPRC. When dietary advice was sought; the dietician at Victoria Hospital was consulted.
- The hospital relies on the expertise of the food services manager who was appointed in December 2017. The food service manager makes decisions relating to patient food/diet as there was no guidance from a Dietician on site.
- Samp and beans are prepared twice a week. This is a staple and traditional dish in the Eastern Cape, it is commonly known as "Umngqusho" and is nutritious.
- The only complaint that MHCUs cited during interviews was that they get 'little' food or small portions; they did not complain about 'Umngqusho'. This was witnessed by the preparation of 36 tins of Lucky Star pilchards for 315 patients.
- There were adequate amounts of food in storage and the freezers as well as fresh produce.
- At the time of the visit, there were no expired meat products in the freezers; including chicken livers that were found.
- An outbreak of diarrhoea at TPHPRC affected 37 MHCHs in which 1 MHCU died but cannot be ascribed to the quality of the food. It had been alleged in the media that the chicken livers served to the MHCUs had expired. However, it was established that the chicken livers that were served to the MHCUs had not reached their expiry date. There was no identifiable microorganism isolated as the cause of the alleged food poisoning.
- Food was found to be adequate and so was the quality of the food. (Annexure 4).
- **There was no violation of MHCUs' right of dignity as alleged.**

3.6.2 Cold Water Bathing in Clinic A

- There have been ongoing problems with the geyser in Clinic A. The geyser problems were reported to maintenance departments both at district and province as early as June 2017.

- Water was heated in an urn for bathing MHCUs that were bedridden. MHCUs admitted in Clinic A used the bathing facilities in Clinic B. The geyser was recently replaced in April 2018.

- Adequate alternative arrangements for bathing were made for MHCUs. MHCUs admitted in Clinic A used the bathing facilities in Clinic B.

3.6.3 Hospital Clothing: (Annexure 5)

- During the investigator's unannounced visits and walkabout at TPHPRC, no MHCUs were seen with torn or dirty clothing. Most of the patients were seen wearing well-fitting clothes and shoes. The clothes were clean and in a good condition.

- The hospital clothing worn by patients bears the Tower Hospital logo. Patient clothing and bed linen seemed adequate at the time of the visit.

- There was circular issued by the Nursing Service Manager (NSM) dated 08th February 2018 highlighting that it was unacceptable that MHCUs were alleged to be going out of the wards being dirty and wearing torn clothing. During the interview with the NSM, he cited that was in reference to a single incident of a single MHCU and he felt strongly that he should nip this kind of alleged practice in the bud.

- Dr. Sukeri alleged that patients in the open ward were not allowed to wear their own clothes. Upon probing, the investigators discovered that Dr. Sukeri had made a request of used clothing from the Rotary Club Eastern Cape. He indicated that he was a member of the Rotary club in the EC. This donation was intended to be used as a clothing bank for patients attending occupational therapy. This donation was not declared according to the policy and prescripts of the department. Management could not support the idea of patients wearing their own clothes; because it would compromise patient safety and make it difficult to distinguish patients from staff and visitors. If a patient had absconded from the institution, s/he would not be easily identified in the community. This decision also added to the tensions between management and Dr. Sukeri.

- The picture evidence that was provided to the OHSC investigators by Dr. Sukeri on patient clothing, showed an MHCU wearing a white Golf shirt with small holes. These small holes were consistent with the type of tobacco stubbings that the MHCUs at TPHPRC were smoking.

- It is a finding that there was no evidence of MHCUs wearing/being issued with torn clothes. There were adequate quantities of clothing for MHCUs. MHCUs were not allowed to wear their own clothes for safety and security reasons. MHCUs were seen wearing well-fitting and clean clothes.

- **Allegations of compromised dignity by the poor state of hospital clothing which was often 'torn and dirty' could not be substantiated.**

3.6.4 MHCUs' Discharges

- It was Dr. Sukeri's opinion that MHCUs were kept in a highly restrictive environment longer than is clinically acceptable. There was no policy nor credible studies to guide what constituted reasonable stay on this matter. This was just Dr. Sukeri's opinion. The investigators found that:

- Dr. Sukeri had developed admission and discharge guidelines for TPHPRC. These guidelines would not be adequately implemented without properly developed community-based psychiatric services in the ECDoH. Therefore the guidelines were not endorsed following a meeting resolution organised by the ECDoH.

- It was evident that some of the MHCUs were discharged from the hospital without proper documentation, this included the MHCA 03 forms that are a legal requirement to be completed and signed by the head of the health establishment and a social worker's report. It is a finding that this is a violation of the Mental Health Care Act.

- There were no proper mechanisms to ensure that all the discharged MHCU's (MHCA 03 forms) reached the head of the establishment's office prior discharge; this has led to missed opportunities of patients that left the institution without the knowledge of the head of the health establishment and the MHRB.

- Some of the MHCUs were mentally stable, but because families and relatives were reluctant to accept the users back, Dr. Sukeri took it upon himself that he would call the MHCU's families and arrange for discharge. One family has since lodged a complaint with the OHSC against Dr. Sukeri.

- Dr. Sukeri was quoted as saying. *"If an MHCU was admitted from under a bridge, I will discharge him back to under a bridge"*. This quote was repeated by the CEO, Dr. Snombo, the Clinical Services and Mr. Baart, the Nursing Services Manager as having been said by Dr. Sukeri.

- *A total of 142 MHCUs were discharged from December 2015 to December 2017. Of the 142 MHCUs discharged, Dr. Sukeri discharged 51,and only 27 had the legally required MHCA 03 forms. This is a violation of the MHCA.*

- *See the update received from Dr. Mbengashe, the SG on follow up of discharges on Paragraph 4.15.1 pages 49.*

- *It is a finding that the* referring hospitals were referring patients without the correct legal documentation as required by the Mental Health Care Act (MHCA); the ECDoH provincial management made the decision that TPHPRC cannot refuse to admit patients. This resulted in the doctors at TPHPRC participating in the illegal practice of admitting MHCUs without proper detention orders (including Dr. Sukeri).

- The ECDoH failed to provide leadership and appropriate interventions.

3.6.5 Allegations of Interference with Dr. Sukeri's Clinical Decisions

- The TPHPRC Management team consisted of the CEO, Clinical Manager and the Nursing Services Manager. When Dr. Sukeri was permanently employed he was part of the management team at TPHPRC and he reported directly to the CEO, but when he became sessional, he reported to the Clinical Manager, Dr. Snombo.

- Dr. Sukeri's employment contracts stated that his duties were to provide specialist guidance in the management of psychiatric patients, participation in the academic training programme in the hospital and any other duties assigned by the clinical manager. In his contract as a permanent employee and as a sessional doctor, he was aware of the reporting lines that are clearly outlined in his employment contract.

- Referral hospitals were referring patients to TPHPRC who did not fit the referral criteria. These are patients who were often severely mentally retarded and physically ill, and were referred to TPHPRC because the hospital had extra beds. This is one of the decisions that Dr. Sukeri was questioning, that it cannot be right to admit patients with physical illness and severe mental retardation without proper resources allocated (staff) on the basis that they had extra beds.

- The ECDoH provincial management had a different view to Dr. Sukeri's; they made the decision that TPHPRC cannot refuse to admit patients.

- Dr. Sukeri felt that management interfered with his decision of discharging patients that are clinically and psychologically stable. He strongly felt that some of the MHCUs were admitted at the hospital against their will. When questioned he could not provide evidence to support this allegation.

- Dr. Nogela, the Director in the DSS at the ECDoH, called a meeting in April 2016 at the ECDoH's head office to discuss admission guidelines drafted by Dr. Sukeri. These proposed guidelines were creating a bed crisis within the EC hospitals. The three labour unions had also raised concerns about the declining bed occupancy rate because of these 'restrictive' proposed guidelines. All psychiatric hospitals in the province were represented and Professor Z Zingela, Associate Professor and HoD, Walter Sisulu University and Nelson Mandela Academic Hospital, SASOP Eastern Cape chairperson was also present at this meeting. All those in attendence did not endorse these guidelines.

- Communication gaps existed between the health establishments and Dr. Sukeri regarding the existing TPHPRC's discharge protocol.

- There was no evidence of interference with Dr. Sukeri's clinical decisions; there were occasions of disagreement between Dr. Sukeri, TPHPRC management and the ECDoH.

3.6.6 Allegations of Fraud into MHCU's Finance Account

Dr. Sukeri felt that MHCUs were being charged an exorbitant amount of money to deposit and withdraw their own money. This was the normal practice at Standard Bank. Investigators found that:

- MHCU's money was banked in the hospital's Standard Bank Business Cheque Account. This account has been in existence for more than 20 years unregulated by the ECDoH's finance department. There were no guidelines/policies from the ECDoH on the management of patient's finances.

- Initially, MHCUs were charged R12 (twelve rands). This amount was based on what Standard Bank was charging its clients for each withdrawal and deposits at the time. There were no guidelines/policies from the ECDoH district/ province on the management of patient finances. The TPHPRC formulated their own guideline in 2016. The initial R12 was reduced to R5 by management decision/agreement and Dr Sukeri was part of Management and therefore bound by its decisions/agreements. MHCUs are currently charged an amount of five rands (R5) per R100 withdrawal. The maximum that a user can withdraw was R100.00 (per week). The R5.00 fee was used to cover bank charges. The account was quite expensive to maintain monthly.

- There were personnel who have been selected to be signatories for the account. There are three signatories, and two were authorised to sign. There is a spreadsheet to track how much is deposited and withdrawn; this was administered by the finance manager in the revenue department. The MHCU's family can also make deposits into the account.

- The balance in the bank account was R550 00.00 at the time of the investigation. When an MHCU passes on as a pauper, his/her money was kept in the account. The unclaimed funds were said to be used for MHCU-related expenses. Funds raised by the hospital board were banked in the same account.

- Money that was not claimed by MHCU's families who had died as paupers has been used for reasons stated below:

- A service provider contracted for bread delivery failed to deliver bread to patients. An amount of around R 780.00 was used to buy bread at the local supermarket and evidence was provided,

- It would have taken a long time to have the residents prepared for the doctor if the request had been made to province maintenance department if it were not done the hospital would have lost the services of that doctor. The renovation work done included paint and plumbing; and

- No evidence of fraudulent activity was found in the use of the MHCUs' finances. The evidence provided answered adequately to the allegations of money spent to renovate the medical officer's onsite accomodation and purchasing of bread for patients, which does not amount to fraud.

3.6.7 Allegations of Fabricated Medical Records

Dr. Sukeri alleged that during a clinical records audit meeting facilitated by the Quality Assurance Manager, Ms. Ntsaluba, Dr. Nodliwa was forced/ pressurised to retrospectively update the medical records of a MHCU that had passed away. The audit finding was that there was a gap that the MHCU's blood results were not written on the clinical notes, and the doctor also didn't write in the clinical notes that treatment had been reviewed, but it was written in the prescription chart. The MHCU's blood results were normal. The clinical audit team felt that this information should be incorporated into the MHCU's medical records. It is a finding that the notes that the doctor wrote were not a continuation on the patient's file, it was written in a separate page. During the investigation, the separate page that was being alluded to was not found in the file by the investigators. The doctor in question has since resigned from TPHPRC, so she could not be interviewed to verify this allegation. The flow of the notes in the record in question did not reflect any falsification. The staff that was interviewed also affirmed that they have had no pressure from the hospital management to falsify records.

3.6.8 Allegations of inadequate rehabilitation of users

Dr. Sukeri's alleged that Occupational Therapy (OT) department has not been able to access the necessary equipment to function could be substatntiated based on the below:

- Occupational health services were not serving the intended purpose due to lack of support from health establishment, district and the province management. There was no proper/adequate rehabilitation equipment. The OT department was currently run by two Community Service Occupational therapists without any supervision, mentoring and coaching from a fully licensed OT;

- The AET (Adult Education and Training) is a flagship programme for the TPHPRC's rehabilitation programme. The programme starts at grade 8 up to grade 12. It was found that there was no formal screening to assess the numeracy and literacy skills of MHCUs in the AET programme which has led to inappropriate selection MHCU's for the programme. Numbers of patient;

- Some of the MHCUs on the programme were discharged before writing their final examinations with the department of education. The discharge of these MHCUs also added to the tensions that were simmering between the management and Dr. Sukeri because there was a difference in the approach of managing the discharges of MHCUs on the programme between Management and Dr. Sukeri, and

- It was evident that MHCUs were not adequately screened for AET. The MDT including Dr. Sukeri were responsible for ensuring that MHCUs were properly screened prior to enrollment to the AET. There was no SLA or memorandum of understanding between the Eastern Cape Department of Education and the ECDoH.

3.6.9 Human Resources

Dr. Sukeri in his complaint submitted, that since 2016 several staff members have left the institution. This was true; however, no research or scientific studies were conducted to support the allegation of '*high staff turnover*' at TPHPRC. The Investigators requested and obtained a list of staff who had resigned from 2016 January to 2018 April and their exit interviews questionnaires. The staff exit interviews questionnaires analysed did not point to any management inadequacies or a "toxic" environment at TPHPRC but to retirement, personal reasons and career advancement. There were severe staff shortages of all categories at the TPHPRC, this included professional nurses, medical officers, psychologists, physiotherapists, occupational therapists, social workers and general workers. All the recruitment processes were highly centralised at the ECDoH provincial office and led to delays in the appointment of crucial staff. It was a finding that the decision-making and recruitment of personnel were highly centralised and this has contributed to severe staff shortages of all categories.

3.6.10 Allegations of the CEO being Dictatorial in her Management Style

There was no evidence found that the CEO was a micro manager and dictatorial in her leadership role and style. All staff members that were interviewed did not concur with this allegation.

3.6.11 Planned OPD and Acute Unit

There were plans to open a 60-bed Acute and OPD facility within the health establishment. The mandate from the ECDoH when recruiting Dr. Sukeri was for him to head this unit. The provincial directorate of specialised services has approved the project; it is well known by Dr. T Nogela. There would be no new building, but a section of the hospital would be used for this project. Staff for the unit is still to be advertised and appointed. The hospital board was aware and supportive of the project. Evidence of the role of the MHRB in this project was not clear. It is a finding that the ECDoH planned to open a new Acute and OPD unit in this financial year. However, this new unit would exert more pressure on the already overstretched staff that is available. This was because he felt that the plan to open the unit was rushed, and this would add to the challenges that were already facing the health establishment, which was supported by the finding of the investigators.

3.6.12 Allegations of Clinical Services Manager being paid in excess to her managerial duties

The findings revealed that the clinical manager was paid fixed commuted overtime. She was paid 16 hours a week. The hours that she covered far exceeded what she was paid for due to the shortage of doctors. There is no additional remuneration for onsite commuted overtime hours. An arrangement was made with the neighbouring provincial hospital that on weekends if there is no doctor available at TPHPRC, a doctor would come from the provincial hospital and assist but there was formal written agreement. There was no evidence found to suggest that Dr. Snombo was being paid extra for hours worked.

3.6.13 Allegations of CEO is staying onsite while renting out her Private residence

The district manager permitted the CEO to stay on site in line with the criteria set out in the ECDoH cccommodation policy. This was done for her safety as she was receiving threats from the community and one staff member. A lease agreement was signed in 2014 and is signed annually for renewal. The CEO's house was rented out as there was no one staying in it, and her children were staying in East London. Monthly rent is being deducted from the CEO's salary. There was no evidence of a corrupt situation identified as alleged by Dr. Sukeri and nothing sinister was found about this arrangement.

3.6.14 Allegations of enabling factors for Social Workers

Dr. Sukeri alleged that social workers had to travel vast distances to contact families and used their own mobile devices for official purposes. Social services are an essential part in the management of the MHCUs. There was no system to control cell phone usage; this resulted in high telephone bills at the institution. Social workers currently do not have cell phones; they have access to open lines in the administration building. There are only three vehicles that are allocated to TPHPRC. The social

workers can only access a vehicle once a week. There were no vehicles specifically allocated to the Social Workers when they were expected to do site visits and track patient's families. It is a finding that the social workers were not provided with official cellphones and had limited access to pool vehicles. The limited access to vehicles and cellphones has impacted adversely on their core service delivery.

3.6.15 Allegations of certification of deaths and the number of deaths (Annexure 6)

Dr. Sukeri had alleged that a far greater number of deaths had occurred than reported at TPHPRC.

The total number of 90 deaths as reported by the media was inflated and incorrect in collaboration with Dr. Sukeri was incorrect. There was no electronic register; only manual registers were in use. The death register normally contains sacred and confidential patient information that belongs to the patients, and was the propriety of the hospital and the ECDoH management. The death registers commonly included MHCU names, ID numbers, medical and psychiatric diagnosis, date of death and the cause of death.

Information Recorded in the Registers

Most records include:
- name and surname of deceased;
- occupation;
- marital status;
- if married the name of the spouse;
- when and where died;
- sex;
- age;
- name, surname and occupation of father;
- name and maiden surname of mother;
- if parents are deceased;
- cause of death;
- signature, address ;
  (if not where death occurred)
  and relation of informant;
- where and when the death was registered
  and the signature of registrar.

Reference: (www.nrscotland.gov.uk)

The 25 deaths that were reported to the Eastern Cape MEC of Health by the CEO were from the 2012/2013, 2013/14, 2014/15, 2015/16, 2016/17 financial years. That was based on the information provided by the wards as the death register was missing at the time.

The verified figure of the total number of deaths was sixty-eight (68). The investigators conducted a physical count on the 09th May 2018 with the Nursing Service Manager; 68 deaths were verified. Again, on the 10th May 2018, verification was done with the CEO; a total of 68 was obtained. These deaths that occurred from 2010 January to 2018 January would reflect approximately 8.5 MHCUs deaths per year. The hospital has a total bed occupancy of 400, and there were approximately 8.5 deaths per year. Using these approximate figures, this would translate into a death percentage of 2.1, which would compare favourably with the best institutions in the world.

The old death register that was reported missing was mysteriously found. It could not be established whether Dr. Sukeri was the one who had kept the missing death register in his office until it was found. However, it is not contested that Dr. Sukeri showed the death register to the journalist of the Rapport newspaper and showed copies of the Register with eNCA journalists. Dr. Snombo cited in an interview with the investigators and under oath with the Health Ombud, that she recalls seeing the death register in Dr. Sukeri's office. Dr. Snombo made a written statement to this effect. Dr. Sukeri agreed during his interview with the investigators that he miscalculated the total death numbers.

A total of 68 deaths occurred over time, from 2010-2018 January. The total death number was inflated by Dr. Sukeri. He agreed during his interview and through a manual count from the two death registers that he had 'miscalculated the death number. Dr. Sukeri obtained the death register from Mr. Kobese and divulged the contents of the information to external parties without proper consent and permission from patients and their relatives, the head of the health establishment and the ECDoH provincial office. This action was in contravention of his employment contract which reads: 'An employee may not disclose any information relating to his work or any other confidential information of the employer to a third party either during his employment or anytime thereafter without the express written approval of the employer'.The allegation that a 'far number of deaths had occurred than reported at TPHPRC could not be substantiated.

3.6.16 Certification of the Death of a Patient

A male patient Mr. XXX was found dead on the 4th November 2017 outside clinic A. The cause of death was not established. He was admitted on 30th /July/2013 and diagnosed with Bipolar mood disorder, Hypertension, Renal Impairment and was HIV positive. Dr. Snombo declared the cause of death as natural, based on the diseases that the patient had. There was no other doctor on duty to certify the patient as it was a weekend. Dr. Snombo was called and certified the patient dead telephonically. This is a violation of the code of professional ethics by Dr. Snombo. The death was not reported to the South African Police Services (SAPS) and was not recorded as an adverse event in the institution's adverse events management register, which is a breach of the MHCA. This represented a professional misconduct. There was a lockable gate outside Clinic A; the gate was said to be always locked. It was not clear how the patient managed to leave the ward. There was no physical security guard stationed at the Clinic. The CCTV camera was not working on the day of the incident.

3.6.17 Allegations of MHCUs placed in Inhumane Seclusion rooms (Annexure 7)

Ward 6B is a 32-bedded ward, admitting male acute psychiatric patients with diagnoses varying from schizophrenia to bipolar disorder. During the site visit on the 16th May 2018, there were 22 patients in the ward and there are 8 seclusion rooms. The seclusion rooms are located away from the nurse's station in the courtyard. There are no ablution facilities inside the seclusion rooms. The room has one door and one window. The window has burglar proofing. There were no fire detection systems; doors were locked from the outside, there was a small opening on the door to allow staff to view MHCUs in the seclusion rooms. There was peeling paint from the walls; suggesting long-term maintenance neglect.

When investigators arrived at the ward 6B seclusion rooms; it was noted that the rooms were recently cleaned. One room showed signs that it had been recently mopped as there were still wet patches on the floor. The staff that was interviewed did not seem to be sure as to the use of seclusion rooms (if they are still in use or not). One staff member verbalised that two MHCUs were currently using the seclusion rooms. One of the seclusion rooms was used by a white patient who preferred not to mix with black patients. The other was used by a patient who could not sleep in the dormitory with other patients due to him tending to smear faeces on the walls and equipment; his behaviour made the life of other patients uncomfortable in the dormitory, this was the reason for his seclusion. The seclusion of these two patients was not legally prescribed. Some patients preferred and requested to sleep in the seclusion room, but it is not being done anymore. Seclusion of patients is being practised. For some of the patients, the seclusion was prescribed, and there were patients who were secluded without a proper prescription. This was evidenced by a patient who burnt himself while he was secluded without prescription by a medical officer or a psychiatrist. Some patients were kept in seclusion more than the required amount of time. The seclusion rooms were not fit to be used by patients. Patients who were secluded were not being searched for weapons and other hazardous items prior to seclusion.

The National Policy Guidelines on Seclusion and Restraint of MHCUs was available on request. It is evident that health care providers did not adhere to the prescribed policy on seclusion and restraint of MHCUs. The prescriptions, monitoring and reporting on seclusion of patients revealed gaps. Seclusion notes that were available dated back to 2017. Below is a list of patients that were secluded in the first quarter of 2018, the period of seclusion for 5 patients did not meet the National Policy Guidelines on Seclusion and Restraint of MHCUs of 2-4hrs. The ECDoH Provincial management was aware of the seclusion challenges at the health establishment. The TPHPRC management until recently did not submit quarterly reports to the MHRB (Central Region). Dr. Sukeri recognised that seclusion of MHCUs was a Human Rights deviation, but could not change the archaic seclusion by following prescribed guidelines singlehandedly.

3.6.18 List of Patients that were in the first three months of 2018 Secluded:

Date on which seclusion was employed	Mental Health Care User	Number of hours secluded	Prescribing doctor
02/01/2018	MHCU 1	14 hours	Dr A
13/02/2018	MHCU 2	2 hours	Dr A
02/03/2018	MHCU 3	2 hours	Dr A
08/03/2018	MHCU 4	11 hours	Dr B
16/03/2018	MHCU 5	10hours	Dr A
16/03/2018	MHCU 6	10 hours	Dr A
18/03/2018	MHCU 7	2 hours	Dr A
29/03/2018	MHCU 4	10 hours	Dr A

3.6.19 MHCU burnt in Seclusion

The MHCU was admitted to ward 7B. On duty was nursing auxiliary (Kahlana). There were 30 MHCUs in the ward. The ward is 30 bedded. The MHCU has a history of self-harm. There was no Professional Nurse in the ward at the time of the incident. One Professional Nurse was responsible for two wards (7A and 7B). The incident happened in one of the seclusion rooms. The seclusion was not prescribed by a medical officer or psychiatrist; he was put in seclusion by Professional Nurse Mr. X Mtsila. PN Mtsila is the NEHAWU union shop-steward at TPHPRC. The MHCU was not adequately searched before being secluded.

When the Quality Assurance Manager questioned the patient, he said that he had wrapped a blanket around his legs and used a cigarette lighter to set himself on fire. Nurse Kahlana discovered the patient at 03:30 am. Mr. Mtsila was charged and is to appear at a disciplinary hearing. Moreover, the matter has been referred to the South African Nursing Council (SANC). The hearing outcome will be shared with the Office in due time. This incident was not reported to the MHRB. The MHCU was not interviewed as he was admitted at Cecilia Makiwane Hospital and recovering from the burn wounds. This incident depicts gross violations of the MHCA and the Scope of Practice of Professional nurses as well as compounded by the severe shortage of staff.

3.7 OTHER FINDINGS OUTSIDE OF DR. SUKER'S COMPLAINT

3.7.1 Main Kitchen

- Food was prepared in a kitchen of poor quality standards. There are no cleaning checklists; the kitchen was found to be dirty.
- The food handlers have a dual role; they prepare food for patients as well as clean the kitchen. This dual role may affect Infection Prevention and Control (IPC) measures. Currently, there is no programme to address the skills development of food handlers.
- Environmental swabs were taken from the kitchen in January 2018. It was the first time that an environmental swab was done. The swab results revealed Klebsiella Pneumoniae. It was isolated from the kitchen sink, the kitchen drains and as well as on two of the kitchen staff member's hands.
- The CEO was notified of the laboratory Klebsiella Pneumoniae findings. The CEO instructed the IPC nurse to conduct in-service training on hand washing. The hand washing training was only limited to the kitchen staff.
- The Eastern Cape district/provincial IPC office did not regularly provide guidance and support. The laboratory findings were not shared with the IPC officers/coordinators at district/provincial office.
- There were broken window panes; paint were peeling off from the kitchen ceiling and wall, broken and cracked floor tiles. All these problems pose a high risk in the preparation of the food but are also a reflection of the poor maintenance. Thiscan cause injury to staff and could be a possible breeding ground for bacteria and other microorganisms.
- There are issues of pest control in the kitchen. Cockroaches and bird droppings were observed in the kitchen. There was no record in the kitchen to show when last pest control was carried out.
- Kitchen staff do not have appropriate kitchen wear apparel although safety shoes are being worn. There was no hair covering caps for people entering the kitchen as well as for the kitchen staff.
- Steam pots are leaking. Some of the steam pots have not been used for months due to service and maintenance issues, as the parts cannot be purchased locally.
- Fire extinguishing devices have no definite date as to when they were last serviced; this poses a danger to all staff members that work in the kitchen in the event that there is a fire.
- In one of the freezers/cold storerooms, the thermostat was not working correctly. There was ice on the freezer floor; this rendered the cold storage floor to be very slippery thus exposing staff to injury.

3.7.2 Pest Control: (Annexure 8)

- It was noted that the level of cockroach infestation was unacceptably high in the kitchen. Fumigation was done on 2017/11/08 and again on 2018/03/14 by Twenty-Four Seven Pest control services. Previously the pest control was done by Zaapit Pest Control company.
- During the tenure of Zappit's contract; the infestation was brought under control. Due to the use of different service providers, the infestation has recurred.
- The quality assurance manager had requested that it be done monthly, but there are still challenges with the pest control service companies not adhering to contract terms.

3.7.3 The Laundry

- Some of the laundry was washed outside the hospital. An agreement has been reached with other neighbouring hospitals (Waterberg TB Hospital and Fort Beaufort Hospital) to assist with laundering of TPHPRC's MHCUs clothes and bed linen. However, a written agreement between the hospitals was not available. On visiting the laundry no torn clothing was seen.
- Neatly packed maroon and navy-blue tracksuits were seen including pink ladies/ female night dresses. All clothing items are marked with the Tower Hospital logo/name and seemed adequate for MHCUs.
- The laundry was not fully equipped, and some machines were old and redundant awaiting condemning and disposal. Laundering support services were sourced from the neighbouring hospitals. There was no written Service Level Agreement (SLA).

3.7.4 Records Management

- There were no policy/guidelines on record management and archiving. Staff dealing with patient and other essential records are not trained on records management. There are no control measures/systems in place for people accessing essential records this includes death registers. There was no system of record keeping and storage of necessary documents, old records that should be in archives are still kept in the hospital. The institution uses manual records; there was no electronic records management system in place. All of the previously cited factors put TPHPRC at high risk for inaccurate reporting and loss of data integrity.

3.7.5 Supply Chain Management

There were challenges with supply chain management from the facility, district and the provincial level. Currently, the health establishment was not involved in the selection of suppliers. This was evidenced by poor-performance, poor-quality products and services rendered by suppliers. The lengthy turnaround time by the Cost Containment committees (CCC) affects the health establishment negatively; this indicated that the provincial supply chain management underestimated the importance of supplier management for TPHPRC.

3.7.6 Infrastructural Challenges (Annexure 9)

The infrastructural challenges encountered by the TPHPRC raised significant concerns about the ability of the ECDoH to provide the TPHPRC's Management. Infrastructural related needs were not dealt with adequately. Some of the Contractors/service providers that were appointed by the ECDoH were said to have inadequate capacity and were inexperienced. The infrastructural challenges in the kitchen. The broken window panes allowing birds to fly into the kitchen poses a risk of food contamination. The dual function of food handlers can lead to lowering of standards that should be maintained in the kitchen. Infection prevention and control strategies are not vigorously implemented.

The geyser in Clinic A was not functioning well since June 2017. It was recently replaced in April 2018. This talks to the provincial infrastructural department appointing inexperienced service providers and the prolonged turnaround time to attend to infrastructural challenges. Window panes in the kitchen were requested to be fixed in July 2017 but are still not fixed to date. Broken tiles, rising damp and peeling paint in some sections of the hospital. The delay in fixing the infrastructural problems is attributed to the provincial infrastructural department. Evidence provided reflected that numerous communications have been made in this regard but seemingly fell on deaf ears. It was evident that the ECDoH has been aware of the infrastructural challenges faced by the institution. Thiswas seen by the frustration of the Chief Artisan at TPHPRC. The challenges that were witnessed by the investigators and some captured in photographic evidence in (Annexure 9) manifested a history of longstanding leadership and support deficiencies /deficit to the TPHPRC.

3.7.7 Hospital Board

The chairperson resigned in March 2018. Dr. Sukeri did not raise his concerns with the Hospital Board. The board only learnt about his concerns when the CEO called an urgent special board meeting on the 26th February 2018, to inform the board about the correspondence she received from the ECDoH about the email that Dr. Sukeri emailed to several stakeholders e.g. SASOP, National, Provincial Health Department Specialised Services and Human Rights Commission. Dr. Sukeri failed to recognise the officially appointed structure that is entrusted with the role of governance and oversight at TPHPRC.

3.7.8 The Mental Health Review Board (MHRB) Central Region

The MHRB recently visited the institution when appointed to the task team by the Superintendent-General of the ECDoH. They knew and understood their role, their independence and the Act that established them. However, they were not given necessary administrative support by the ECDoH. The review board has had no support visits and no communication with the institution prior to this. There was no evidence to demonstrate that:

- The death of Mr. XXX outside clinic A was reported to the MHRB;
- MHCUs that were dischargedwere reported to the MHRB;
- Dr. Sukeri reported the matter of the burnt MHCU (Mr. YYY) in a seclusion room; and
- Dr. Sukeri reported the number of MHCU who were secluded in a given month.

Dr. Sukeri never reported the perceived increase in deaths at TPHPRC. There is no evidence of support provided by the central MHRB (Central Region) to the health establishment. There was poor administrative support from the ECDoH which limited the MHRB to execute its functions properly.

3.7.9 South African Society of Psychiatrists

The CEO and other staff members that were interviewed said that they were not individually interviewed by the visiting delegation from SASOP Eastern Cape. The visit by SASOP was a one-day visit. The staff that was interviewed felt that the SASOP report was one-sided. Professor Z Zingela and Dr. T Seshoka are cosignatories of the SASOP investigation report into the allegations made against TPHPRC; they were also part of the task team appointed by the Superintendent-General. Dr. Sukeri is a member of SASOP Eastern Cape. When questioned Dr. Sukeri cited that he had no role to play in the SASOP investigation.

3.7.10 Closed Circuit TV Cameras

There have been incidents of significance which should have been captured by the CCTV. The cameras have not been operational for over 4 months. There is no security manager at the health establishment. The Nursing Services Manager (NSM) is responsible for all security concerns in the facility. The NSM has not had any security training. The security cameras are always off when an incident occurs. The footage when a mental health care user died outside his clinic was not readily available. On two occasions piglets were stolen from the piggery outside the Occupational health department, on those two occasions the CCTV cameras were not operational. No evidence was provided to the investigators on action that was taken by the Hospital Management to address these security breaches. This reflected a failure not only of poor reporting of security breaches but also of poor contract management. This pointed to failure to effectively hold a service provider to account in the performance, delivery and the quality service it provided. The unavailability of these CCTV footage appears like a cover up by the hospital management.

3.7.11 The Provincial Eastern Cape Department of Health

The investigation into the allegations made against TPHPRC by Dr. Sukeri revealed some leadership/ management deficiencies. The investigators finding included but were not limited to:

- The ECDoH provincial office has neglected TPHPRC by failing to implement its oversight mechanisms and has done little to raise mental healthcare quality standards at the institution.
- The Chief Financial Officer (CFO) at the ECDoH Mr. S Kaye, stated under oath in an interview with the Health Ombud, that there are massive infrastructural related expenses. Infrastructural budget has been spent and monitored centrally until recently (March 2018). The seclusion rooms at the TPHPRC were recently demolished and renovated following the recommendations that were made by the SASOP investigation. The seclusion renovation project was seen as "an emergency and urgent", a deviation was then made. The funds were reprioritised in April 2018 to respond to the challenge. The CFO was not able to definitively demonstrate how much was being spent on mental health care services.
- Infrastructural challenges including the seclusion rooms and the kitchen at TPHPRC have been known by the ECDoH's provincial infrastructural unit over long periods of time (Annexure 9).
- The ECDoH has a heavy reliance on psychiatric hospitals to provide much needed acute and community- based psychiatric services. There are no existing established community-based psychiatric services, this has led to doctors discharging MHCUs into the community and has created revolving door patterns of care. The unavailability of community-based psychiatric services has hindered the process of deinstitutionalisation and the freeing up much-needed beds for the admission of acute MHCUs.
- There were no policy guidelines from the ECDoH toguide the health establishment regarding how to deal with mental health care user's funds.
- The ECDoH CCC are said to be a system to control expenditure, however the CCC have placed strict cost-cutting measures which have affected the delivery of mental health care services at TPHPRC. The provincial CCC does not adhere to stipulated timelines. The procurement of goods, services, the appointment of staff and the acquisition of vital mental healthcare service delivery components is given approval by the provincial CCC. These committees increase the turnaround time required for requisition of goods and services.
- There was no tangible evidence to show that the EDCoH Quality Assurance office provided regular support to the institution in terms of complaints management, adverse events management and Infection Prevention and Control.

- Old laundry and kitchen equipment were awaiting to be condemned and disposed of, but there was seemingly no commitment and willingness from the ECDoH's asset disposal committee to deal with the old and broken equipment that had been lying around at TPHPRC for years.

- It was evident that the MHRB (Central Region) did not receive the much-needed administrative support from the ECDoH.

- The ECDoH for over long periods of time failed to ensure that data and information generated by the facility is reliable and of quality standards. TPHPRC has been using old data collection methods. The death registers in use were manual. The DHIS does not have data elements that cater for psychiatric care. This challenge makes one wonder, whether all data furnished to the provincial ECDoH DHIS office is a true reflection of what has been taking place at TPHPRC.

3.7.12 The CEO

- The investigation revealed that the CEO failed to make her expectations of Dr. Sukeri clear. This was mainly because the facility needed his services to function as a psychiatric institution. He was highly valued and respected, and the management feared to lose his services, so the CEO did not follow through the letter of the law and treated him with "kid gloves". Dr. Sukeri used to call the CEO "Mama". Dr. Sukeri was called "Bantu".

- The CEO came through as a credible witness. She was highly qualified and experienced professional nurse highly respected by her staff and people in the ECDoH provincial office. There was no evidence found that the CEO was a micromanager and dictatorial in her leadership role and style.

- The lines of authority were blurred. Boundaries were not set, and this led to Dr. Sukeri not recognising the CEO as his manager.

- The CEO failed to escalate Dr. Sukeri's concerns because she did not recognise them as complaints. Most of these concerns were discussed during management meetings or handover meetings, and they ended up in heated debates but were not formal complaints. The CEO was aware of the existence of the Ombud Office in the Eastern Cape, Advocate G Maxakato.

- There were no consequence Management for staff that acted either unprofessionally or violated policy/procedures. There was a dereliction of duty on the CEO's part (it was alleged that there were employees at TPHPRC who stole equipment, came on duty late and some of them drunk).

- The CEO was not proactive enough in dealing with the concerns that Dr. Sukeri raised even if there was no written complaint. Dr. Sukeri alleged that he raised the issues verbally on several occasions.

- The CEO complied with the internal policy of the institution when she gave permission for the patient's fund to be used for renovating the doctor's accommodation and other patient related expenses. The internal policy was not in line with the PMFA.

- Failed to take the responsibility to ensure that Dr. Sukeri was disciplined for discharging mental health care users without the appropriate legal documentation required to be signed off by the head of the health establishment.

- Failed to discipline Dr. Snombo for certifying the death of a MHCU telephonically and not taking disciplinary action against Ms. Mali for the theft of MHCU's SASSA grant.

- There were poor conflict resolution, problem analysis and significant leadership challenges.

3.7.13 Dr. Sukeri and the Hospital Management Relations

- Dr. Sukeri was a former full-time and later a sessional psychiatrist at the TPHPRC. On the 2nd of March 2018, Dr. Sukeri resigned from the hospital citing "degrading and inhumane" treatment of patients. During the time that the investigators were at TPHPRC, they did not observe this *"degrading and inhumane"* treatment as alleged by Dr. Sukeri.

- The relationship between the management and Dr. Sukeri stonewalled because he did not honour his employment contracts, he did not want to follow established procedures and guidelines that were set in his employment contracts. He was not only critical, but also at times very dismissive of the CEO's managerial style.

- He made antagonistic remarks and had a mocking attitude towards the management. Internal conflict resolution was inadequate. Proper mechanisms for clinicians and other staff members to register their concerns and complaints were inadequately used.

- It is a finding that Dr. Sukeri was uncooperative, he displayed a condescending and unprofessional demeanour in the handover meetings and was unwilling to engage members appropriately and professionally, hence he was excluded from the handover meetings.

- He misinformed and exaggerated to the public and the media as to the correct death figures at TPHPRC. He was collaborating with sections of the media in preparing some of the articles that were published and TV interviews that were aired. He had said that 90 MHCUs had died at TPHPRC, the actual number was established to be 68 deaths that happened from 2010-2018. After proper analysis and verification, he admitted that *he had indeed miscalculated the number of total deaths.*

- Dr. Sukeri blamed the CEO specifically for the challenges that were currently encountered by TPHPRC. This is evidenced by his utterances on eNCA's Checkpoint part 2 of the documentary. ***In the documentary Dr. Sukeri shared confidential information of MHCUs from the death register, which reflected the names of the deceased and the diagnosis of MHCUs on public television. This was in violation of his professional code of ethics and medical practice and the confidentiality clauses that he had signed in his employment contracts. This also violated the MHCUs rights to dignity.***

- Dr. Sukeri did not follow agreed admission and discharge guidelines. The ECDoH did not endorse the guidelines developed by Dr. Sukeri and he applied them unilaterally and secretly as previously described.

- Differences existed between a section of the Multi Disiplinary Team (MDT) and the management team regarding clinical decisions taken by Dr. Sukeri concerning admissions and discharges of MHCUs.

- Dr. Sukeri failed to follow the proper complaints management system of both the institution and of the ECDoH.

- By reporting his concerns to the media, Dr Sukeri irretrievably damaged his trust and the TPHPRC management, the hospital board and sections of SASOP.

- Challenges that have been raised over a period of years by different stakeholders remained unresolved by the ECDoH, the problems remained unaddressed and impacted on the staff morale.

- There was no evidence of management interference in clinical decisions; there were, however, occasions of disagreements regarding the way Dr. Sukeri handled MHCUs issues. This may have been a reflection of a power struggle between Dr. Sukeri and the TPHPRC management.

- He did not follow the available internal complaints management processes; he did not comply with the principles of natural justice.

- An analysis of Dr. Sukeri's letter to the Health Minister does not come across as a "complaint" letter but as a way of making the Minister aware of the issues that he is raising. After all the Minister's office did not represent a Complaint Management structure within the National Health System.

- There is a media liaison official/spokesperson for the ECDoH, Mr. S Kupelo. Dr. Sukeri failed to liaise with Mr. S Kupelo before engaging the media.

- The death register that went missing was probably in Dr. Sukeri's possession when it was needed, subsequently the CEO submitted incorrect death statistics to the MEC, which misinformed the legislature.

- It is a finding that Dr. Sukeri's actions have tarnished the ECDoH's reputation but at the same time highlighted the neglect faced by the TPHPRC.

- He was not a reliable witness, during the interviews, and was evasive and could not give direct responses to simple questions asked.

- Dr. Sukeri was insincere and deceitful in his dealings with different stakeholders. For example, he praised the MHRB and said that they were doing a great job, but to the investigators from the OHSC, he said that the MHRB were 'useless and inefficient'.

- He failed to ensure that MHCUs that are referred for AET were fully assessed for their numeracy and literacy skills as he was the Head of Psychiatry at the health establishment. He failed in his primary responsibility to act in the best interest of the MHCUs.

- He was against the establishment and opening of the 60-bed Acute and OPD unit at TPHPRC for which he was recruited. This was because he felt that the plan to open the unit was rushed, and this would add to the challenges that were already facing the health establishment. When interviewed Dr. Sukeri, referred to the establishment of the new Acute unit as the "management's plan" which he had agreed to when taking the appointment. This was after he had been part of the team that went on benchmarking exercise at other psychiatric institutions within the EC in preparation of the planned new unit.

- He felt that he was not being respected as the head of clinical Psychiatry by the management and CEO.

- Other witnesses concededthat Dr. Sukeri's decision to discharge patients drastically reduced the bed occupancy rate at the institution and this led to bed crisis.

- He failed to report to the MHRB (Central Region), the death of the patient outside Clinic A, improper seclusion practices at the institution and report the patient who set himself on fire.

- He failed to report the alleged human right's violations to the statutory bodies until his complaint was already in the public domain; Office of the Health Ombud, South African Human Right's Commission and the Office of the Public Protector.

3.7.15 Dr. Snombo

- The challenges of not having enough doctors at TPHPRC has led to a culture of not responding to calls when a doctor is on call because the doctors often work more hours than expected. Dr. Snombo is not being paid extra for being on call. It becomes her duty to put in place measures to ensure coverage in such situations.

- Dr. Snombo has been prescribing seclusion for patients without following the prescribed guidelines, this was a contravention of the MHCA. This action by Dr. Snombo necessitates that disciplinary measures to be instituted against her.

- She also failed to institute corrective measures against Dr. Sukeri for discharging MHCUs without the correct documentation. She failed to apply workplace policies consistently in dealing with challenges that she faced with Dr. Sukeri.

- As the Clinical manager Dr. Snombo failed to ensure that there is always a medical officer on call when needed, this has led to incidents where nurses had to ensure that MHCUs' health needs were met in the absence of a doctor.

- Dr. Snombo did not physically examine the MHCU to certify the user dead. The circumstances surrounding the death were not observed. Despite the known comorbid conditions of Mr. XXX, the circumstances surrounding the death were not observed.

- Social Worker fall under Dr. Snombo's leadership but when it came to light that Ms. Mali may have misused MHCU's SASSA grant all she did to ask for a statement and no further action was instituted. She was clearly derelict of her duty as manager.

3.7.16 Media Coverage of TPHPRC

An article in the Herald, City Press and Rapport Newspapers appeared on 4th March 2018. These articles presented "shocking" images of an isolation room at TPHPRC. Dr. Sukeri spoke out about the alleged "degrading and inhumane" treatment of patients and "claimed death registers had been altered, and that an alarming number of patient deaths at the hospital in recent years had gone unrecorded". The figure of 90 deaths were reported in these articles. **On the 12th June 2018 and again on the 19th June 2018, eNCA's current affairs show** *Checkpoint* **debuted a collaborative documentary** *by the Grocott's* **Mail and** *Health-e News',* **named "The Writing on the Wall", about what they referred to as the next Life Esidimeni tragedy. Part one of this two-part series highlighted the alleged Human Rights violations and mismanagement at TPHPRC. The documentary featured exclusive interviews with TPHPRC's "whistleblower", Dr. Kiran Sukeri, as well as ex staff members and patient families. Dr. Sukeri is seen in the documentary saying that "I believe that the CEO is behind the crisis at Tower".**

Mr. X Mtsila, the union representative at TPHPRC (who without prescription kept an MHCU in a seclusion room) was quoted by the Grocott's Mail in an article dated 15th March 2018 written by Kathryn Cleary , as saying "the union was worried about the institution's intolerance for whistleblowers. When you speak up about something that is wrong, the management takes you as someone who is trying to have them blacklisted. They will chase you – but at the end of the day, I'm speaking about what has been hidden at Tower." Mr. Mtsila also violated the ECDoH's Communication Policy in participating in the article.

3.8 PART TWO

On analysis of the complaint, the Health Ombud considered investigating the allegations further by involving other relevant stakeholders. The investigation process was conducted through interviews, correspondence with the EC Department of Health, analysis of all relevant documents and reflection of all relevant laws, policies and related prescripts. The investigation process commenced with interviews with the former Health Ombud for the Eastern Cape, the Tower Hospital Management, HoD and other departmental officials, SASOP: EC, The Mental Health Review boards and representatives from organised labour (PSA & NEHAWU)

3.8.1 The complainant

Dr. Kiran Sukeri studied at the University of Transkei in 1991 and completed MBChB degree in 1996, did his internship at Frere Hospital in East London and became a Medical Officer in Psychiatry at Frere Hospital. He joined the Registrar Programme at Walter Sisulu University in 2001 and qualified as a Psychiatrist in 2006, worked as a psychiatrist in East London in 2015 completed his Doctorate with Walter Sisulu University. Currently running a private practice in Grahamstown. He wanted to work at TPHPRC because he had a passion for community psychiatry. In 2015 December, Dr. Sukeri was appointed as the Head of Psychiatry Clinical Unit for the institution. He was clear about his employment contract and the power of his authorities.

When he was a full-time Psychiatrist, he reported to the CEO, and as a sessional Psychiatrist he reported to Dr. Snombo, the Clinical Manager (Copy of contract requested).

3.8.2 Summary from the Ombud's interview of Dr. Sukeri

- Dr. Sukeri did not raise his concerns with the officially appointed Health Ombud in the province, Advocate G Maxakato or the ECDoH Superintendent-General's Office. He added that he had raised the matter with Section 27 and the ECDoH Directorate of Specialised services. The Eastern Cape Health Ombud learnt about the complaint through the media.

- Dr. Sukeri has worked at two psychiatric hospitals since 2006 in the Eastern Cape since qualifying as Psychiatrist, he has raised concerns about the state of mental health care services in institutions within the Eastern Cape. The incident at TPHPRC was the culmination of the frustration that he felt with the management at TPHPRC and the ECDoH provincial management for failing to deal with long-term dilapidation and deterioration of mental health care services in the province.

- Dr. Sukeri notified SASOP of his concerns, but he did not request SASOP to investigate the allegations he had made. SASOP redirected him to lodge his complaint with the Office of the Health Ombud, Human Rights Commission, and the National Health Minister. He lodged the complaint with these statutory bodies on the 21st February 2018. *This explanation was accepted.*

- An article was published in the media on the 04th of March 2018 by Ms. Suzanne Venter. In this article, it was stated by Dr. Sukeri that the Health Ombud received his complaint on the 11th February 2018. Dr. Sukeri confirmed that this was an error, his complaint was lodged with the Office of the Health Ombud only on the 21st February 2018. He promised to correct this wrong date by writing to the Press Ombudsman and to the Editor and journalist of the Rapport newspaper.

- He agreed that there were errors in the way that he calculated the deaths. He confirmed that he exaggerated the comparison of his complaint to the Life Esidimeni saga. He probably used the "missing" death register to verify these numbers for himself and for the media. The number of deaths was reported in the media as 90, he stated that he had given the media a figure of 86. *Dr. Sukeri concurred that the correct number was 68 in the presence of the OHSC investigators over an 8-year period. He admitted that whatever total of 86 or 90 provided to the media, was wrong. He would again ensure that this wrong and exaggerated total was corrected to 68. Dr. Sukeri could therefore not sustain the argument of 'the claimed death registers had been altered, and that an alarming number of patient deaths at the hospital in recent years had gone unrecorded' at TPHPRC' nor explain adequately why he inflated the totals, on the basis of this new corrected figure.*

- He confirmed that there were issues that were unresolved in his relationship with the CEO. Initially, *the relationship was cordialand he was given the leeway to operate as a consultant.*

- He provided no evidence on the poor-quality food. There was no evidence of wasted patients or patients losing weight, illness or deaths related to poor quality of food. There was no scientific proof that the food served had affected the health of patients. He based his allegations on his observations. Given lack of evidence, his allegations on food quality were baseless and unfounded

- Dr. Sukeri indicated that a Complaints Management Committee was established in 2017 at TPHPRC. *It was later corrected and confirmed by the CEO that the Complaints Management Committe was established in 2008 and became more structured when the National Core Standards were introduced in 2013.* Dr. Sukeri was not truthful on this issue. It came out clear that he did not lay any complaint with the Complaints Management Committee that existed at the institution.

- Dr. Sukeri fully understood the Mental Health Review Board's roles and responsibilities. He was of the opinion that the MHRB (Central Region) was "useless" inefficient and dysfunctional.

- He vehemently denied allegations of using the TPHPRC's resources to run his own private psychiatric practice.

- He acknowledged and understood that the Multi-Disciplinary team took decisions on the discharge of patients and the CEO had final authority on the discharge of patients.

- It was a finding that Dr. Sukeri was very frustrated to the extent that he decided to go to the media and in so doing violated his Health Professional Codes of conduct. He should have respected the confidentiality clause that he signed in his employment contracts.

- He acknowledged that he should have allowed the statutory bodies to handle his complaint. His emotions and passion for mental healthcare users got translated into emotional overdrive. In his own words *"He lost his cool"*.

3.8.3 Summary from the Ombud's interview of Ms. Ngcume (CEO)

- The CEO denied and nullified the allegations that she had resigned from her post as the CEO of TPHPRC (Grocott Mail 6th June 2018). What she confirmed was that she had applied for early retirement and her last working day will be the 31st August 2018.

- The TPHPRC had functioned for a number of years without a psychiatrist. Dr. Sukeri was transferred to TPHRPC in view that he would assist with the plans to establish the planned new 60-bed Acute and OPD unit. Dr. Sukeri assumed duty at TPHRPC in December 2017.

- The CEO emphasised that Dr. Sukeri never raised complaints in a formal way. She strongly felt that Dr. Sukeri had an 'agenda' because he did not explore all the available channels of complaints management process. He could have involved the Hospital Board, the Mental Health Review Board, the Province and the Superintendent-General.

- In 2016 the Dr. Sukeri had developed an admission guideline with many limitations that made it very difficult to admit patients. These guidelines were discussed and not endorsed by the ECDoH and other psychiatrists in the province. The Public Servants Association (PSA) and the National Education Health Workers Union (NEHAWU) Trade Unions at the institution also had a concern about the bed utilisation rate that was declining as a result of Dr. Sukeri's guidelines.

- A Meeting regarding Admission Guidelines was held, and Prof. Zingela attended with all Psychiatric institutions in the Eastern Cape. The Meeting resolved that the guidelines should not be used. Dr. Sukeri was present at this meeting.

- Dr. Nogela, the Director from the DSS intervened and called for a meeting between the clinicians and the administrative staff to try and resolve the issues raised in relation to patient care and clinical decision-making. The outcome of the meeting was "poor" according to Dr. Sukeri's version as there was no resolution, regarding how the CEO would separate clinical duties from administrative duties. The CEO was of the opinion that she also had a clinical background with her nursing experience and Healthcare background that enabled her to make clinical decisions. The final meeting's resolution was not in support of Dr. Sukeri's approach.

- A figure of 25 was erroneouly given to the MEC as the total number of deaths at TPHPRC. The MEC was misinformed because the death register was missing. The figure given to the MEC was derived from the numbers given by the staff in the wards to CEO. The CEO admitted that it was incorrect of her to provide erroneous figures to the MEC. She has apologised for this in writing.

- Dr. Sukeri did not want to listen, he argued that 'if a patient does not have relatives and is stable and was admitted from the street, he should be discharged back to the street'. The CEO had noted that Dr. Sukeri discharged some patients without the social worker's report and the MHCA 03. She stated that Dr. Sukeri had said to her that *'after all there are many more patients that were discharged without the CEO's knowledge'*.

- The CEO acknowledged that the seclusion rooms do not meet the required standards. They were built in 1894 and they were in the process of being renovated.

- The CEO clarified that there was no problem with the patient's clothing. The patient clothing was ordered in bulk. *Dr Sukeri's statement was again found wanting.*

- The CEO failed to execute her duty to institute corrective measures to her staff.

- It came out strongly during the interview that the CEO was aware of the Eastern Cape Health Ombud's office. However, the CEO failed to utilise the Eastern Cape Health Ombud's office's expertise in dealing with concerns raised by Dr. Sukeri.

3.8.4 Health Ombud's Interpretation of the working Relationships

- Human Rights violations allegations were 'a smoke screen' to a deeper problem of the relationships of management at the Hospital and Dr. Sukeri.

- Management was not working well together, they have got tensions, and the human right's violations have become a side show. The "issues" were blown out of proportion to their reality. Almost every witness concurred with this interpretation.

- Dr. Sukeri tried to raise a 'complaint' which has not been listened to, and it spilled over in the public domain and assumed a proportion that it was not,

- Dr. Sukeri acknowledged that the situation was not managed well. He did not manage this situation well either. *He was not without blame*. He went to the media because he thought the issues needed to be highlighted.

- Relationship and management failures, which were not managed well at the level of the institution has led to a national and an international issue.

3.8.5 Recommendations made by Dr.Sukeri for consideration by the OHO

- Overhaul of the Mental Health System with a Provincial Mental Health Equity

- Set up the Mental Healthcare system that accommodates long-term care that fit into the South African Mental Healthcare Framework

- Mental Healthcare Policy to be finalised and approved. He has indicated that there was a draft circulated for inputs.

- Role clarity should govern institutions on who makes clinical decisions and administrative issues.

- How to maintain quality healthcare standards regarding patient care and who monitors them.

- Development of Referral Pathways and Development of Standardised admission and discharge guidelines.

3.8.6 Mental Health Review Board

- During the interviews, the current and former members of the Eastern Cape (Central Review Board), conceded that Dr. Sukeri did not raise his concerns with them and they have learnt of his complaint through the media.

- They expressed their dissatisfaction and disappointment in the manner that Dr. Sukeri handled the issue, given the fact that they were available to can intervene.

- They have also affirmed that none of his concerns were submitted through the quarterly reports that were submitted from TPHPRC.

- The reports on the injuries of Mr.YYY, who burnt himself in the seclusion room and the death of Mr. XXX were not submitted to the MHRB (Central Region) for investigation, which contravened the National Policy Guidelines on Seclusion and Restraint of MHCUs.

- The MHRB (Central Region) members indicated during the interviews that the MHCA forms for admission are not user-friendly and not correctly completed by the referring institutions. In light of the above, there were MHCUs that were admitted with incomplete forms that were not legally complaint. This is a contravention of the MHCA.

- The MHRB cited that they have trained Doctors, Nurses and administration staff on the completion of the admission forms to curb the situation of MHCUs that were admitted with incomplete forms. The MHRB must be commended for this effort. It is a finding that the previous MHRB (Central Region) was not legally appointed by the MEC but by the ECDoH Superintendent-General.

- This finding was consistent with the National Health Council's Report that was completed to determine the status of the implementation of the National Mental Health Policy Framework and Strategic Plan 2013-2020 following the Life Esidimeni saga. Below is a summary of the National Health Council Report.

3.8.7 National Health Council (NHC) Report

Following recent developments involving MHCUs in Gauteng, the NHC resolved on 06th April 2017, that the National Department of Health (NDoH) must visit all provinces with the view to undertake a comprehensive assessment of the status and readiness of the provinces to implement the National Mental Health Policy Framework and Strategic Plan 2013-2020.

3.8.8 Summary of NHC Report on the Eastern Cape

- There was no dedicated Mental Health Directorate in the Province.
- The Provincial Mental Health Strategic Plan that was not aligned to the National Mental Health Policy Framework and Strategic Plan 2013-2020. Only a draft document available but was not costed.
- The ECDoH was not able to provide a dedicated MH budget from PHC to general Hospitals.
- There was a 27% vacancy rate for Psychiatrists and 41% for Clinical Pyschologists.
- The MHRBs were appointed by the HoD. There were no dedicated budget and annual operational plans for the MHRBs. There was limited administrative support for the MHRB from the ECDoH.
- Infrastructure at TPHPRC and other specialised psychiatric hospitals in the Province did not comply with standards. Infrastructure had not been prioritised.
- There were no plans for community-based MH infrastructure in the province. There were no designated clinics and community health centres that provide psychological services in the community. There was no policy in the Province on contracted services, but the Life Esidimeni contract in the Eastern Cape had been regularised.
- There were NGOs that were not compliant with the MHCA in the Province. There was no deinstitutionalisation plan at all facilities with long term MHCUs.
- There were no approved guidelines for licensing of community-based mental health facilities in terms of Regulation 43 of the Mental Health Care Act as amended.
- There were no approved guidelines on the referral system for MHCUs between all levels of care.
- There were no district specialist MH teams in the Province.
- There should be a review of the provincial data set for Mental Health Care indicators to include Data Set on substance abuse.

3.8.9 Limitations

The investigators were unable to interview Dr. Nodliwa pertaining to the allegations of falsification of medical records, as she has resigned from the institution. Mr. YYY the MHCU who burnt himself in the seclusion room was not available for interview as he was admitted for treatment of the burns in another health establishment. CCTV footage could not be accessed to verify incidents that occurred in Clinic A and the piggery.

3.8.9 Conclusion

Mental health care users are among the most vulnerable in society, often unable to make critical decisions for their primary day-to-day care. MHCUs in the Eastern Cape are still subjected to “appalling” facilities with limited care due to limited resources. The MHCUs in the Eastern Cape were not prioritised over a long period. The delivery of mental health care services at TPHPRC highlighted the need to better understand how the provincial health department manages resources, both regarding implementation and value for money. Cost-saving measures are being pursued by the ECDoH. However, mental health care services are not being given the attention they deserve. There is an increase by the ECDoH in emphasis on ensuring clean audits at the expense of effective mental health care service delivery. In the context of declining resources in the government’s budget, the ECDoH should invest in accelerated investment in infrastructure. There are severe shortages of staff and infrastructural challenges at TPHPRC. The establishment of the new Acute and OPD unit will no doubt exacerbate the already strained resources at the institution. The TPHPRC management should be commended for ensuring that the death rate remains low over a period of eight years despite the constraints of staff shortages and a deteriorating infrastructure faced by the institution. The death rates achieved at TPHPRC over an period of 8 years, would be the envy of most hospitals CEOs in our country and globally. The staff deserve to be commended for this.

The focus of the ECDoH has been mainly on institutionalised care rather than community-based psychiatric care. The ability for MHCUs to adapt to living in the community after extended hospitalisation is not adequately assessed. There is an urgent need for the admission and discharge processes to be reviewed. MHCUs who were mentally stable could not be discharged as they did not have adequate social support, were often

not wanted back home by some of their relatives and most vital the absence of community-based psychiatric support services. This indicated a badly planned mental health care service. The discharge planning process should be aimed at placing patients closer to their places or their homes where they are accepted and properly cared for. This will enable all the members of the MDT team to thoroughly ensure that every aspect was investigated before the patients were discharged.

At health care professional level, all should be trained on how to manage mental health disorders. At the management level, managers need to be trained in mental health management, care and treatment to ensure that Mental Health is treated as an essential part of health care service delivery. The investigation highlighted that there were few isolated instances where patient rights have been violated: Healthy and safe environment exemplified by the antiquated seclusion rooms and the dilapidating kitchen. The only constant incident of human right's violation, was the continued use of the seclusion rooms at TPHPRC. All witnesses concurred with this view.

The pictures that have been shared with the media were the same pictures that Dr. Sukeri used in his complaint as part of the evidence; it was probable that Dr. Sukeri had the death register while it was missing. Dr. Snombo saw the death register in Dr. Sukeri's office and submitted a written statement to this effect. This statement was cited to the OHSC investigators and later repeated under oath in an interview with the Health Ombud. The death statistics that were given to the MEC were not a coverup of deaths at TPHPRC. Death statistics at the institution were overly exaggerated by Dr. Sukeri in the media. The recent demolition and renovation of the seclusion rooms at TPRPRC may be viewed as a cover-up by the ECDoH or a sudden response to Dr. Sukeri's complaint.

The provincial infrastructural management should ensure that qualified and experienced contractors are appointed to eliminate bottlenecks in the implementation of projects. Significant problems existed for a long time at TPHPRC and in the ECDoH provincial office. Instances, where the Mental Health Care Act and the Policy guidelines on Seclusion have been violated, are a cause for concern.

Dr. Sukeri did not follow appropriate and available internal complaints mechanisms. There was no evidence to confirm the allegations on the i) quality of food, ii) patient's clothing, iii) falsification of medical records, iv) violation of the ECDoH Accommodation policy, v) there was no evidence that the CEO is an autocratic leader, vi) that there was no evidence found of interferences with Dr. Sukeri's clinical decision-making. Disciplinary measures should be instituted against those who have transgressed the ECDoH's policies and guidelines including Dr. Sukeri.

Dr. Sukeri was a Senior and Head of Psychiatry Clinical Unit. As part of his duties he was responsible for training future young doctors and preparing the next generation of psychiatrists. He was supposed to ensure that mental health care training and service meet the highest possible quality assurance standards. He should have applied his critical and reflexive lens to assist the ECDoH to improve the quality of long-term mental health care service and practice in the Eastern Cape. As teacher, trainer, mentor and role model, Dr. Sukeri failed TPHPRC and the ECDoH.

Whatever the intentions by Dr. Sukeri, his complaint has highlighted the challenges faced by MHCUs in the Eastern Cape. In his closing remarks to provide a way forward, it is significant that Dr. Sukeri's proposals were mostly directed at the system rather than at TPHPRC. From the verification of deaths that was conducted with Dr. Sukeri, it is reasonable to conclude that Dr. Sukeri's perception of 'increased deaths and that an alarming number of deaths had gone unregistered (contained in his letter and in the media) at TPHPRC' must be regarded as wrong and untruthful.

The single death incident, the single burn incident and the single so-called manipulation of records were all found to be isolated events that are not commonplace occurrences at TPHPRC. However, these isolated incidents were depicted and portrayed wrongly as if it was the culture at TPHPRC by the media. The management and staff at TPHPRC were cooperative from the commencement of the investigation, despite the busy schedule and the tremendous strain from all the investigations and interviews they were subjected to. The OHSC investigators would like to thank the staff and management team at TPHPRC for their cooperation during the investigation into the allegations levelled against the institution by one they regarded as their own.

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Chapter 4

CHAPTER 4: FINDINGS OF THE OMBUD (3)

4.4. THE CHRONOLOGY AND ANALYSIS OF DR. SUKERI'SCOMPLAINT

4.4.1. On the 4th March 2018, Ms. Suzanne Venter 'broke' a story in the Rapport newspaper of a complaint brought by Dr. Kiran Sukeri, a senior Psychiatrist at TPHPRC. The story was a collaboration between Ms. Venter and Dr. Sukeri. The complaint by Dr. Kiran Sukeri and the report of Ms. Venter in the Rapport and City Press are attached as Annexure 1, 1a, 1b. Dr. Sukeri's complaint was confirmed and brought into sharper context and perspective by another psychiatrist, Dr. Mo Nagdee in an e-mail exchange with Mr. B Nzima, Acting Director of Specialised Services (Annexure 1c). These documents constituted the complaint.

4.4.2. The complaint by Dr. Sukeri in its various versions contained 4 elements: Basic Human Rights; Violation of Autonomy and the Mental Health Care Act no. 17 of 2002; Inadequate Rehabilitation of Users and Human Resources at TPHPRC, Fort Beaufort, Eastern Cape Province. This is also fully described by the OHSC investigators.

4.4.3. Analysing the complaint revealed that each of these elements listed were accompanied by statements and/or opinions of Dr. Sukeri with very little or no substance, no factual, no scientific or no medical evidence to substantiate or to support the complaint. Dr. Sukeri had provided no studies, no audits or no research results of his own or others to support his complaint; this was surprising for a senior medical scientist of his level and calibre; he knew that the power and truth of science lay in the accuracy and rigorous verification of data. The nations'and media'strust and belief in him would rest on his credibility as a medical scientist and the credibility of his evidence.

For example, when former Health MEC, Honourable Qedani Mahlangu made the announcement in the Gauteng Legislature on 13th September 2016 that 36 MCHU's had died in Gauteng, she had uncontestable medical evidence that she later provided with documents that formed the basis of the Ombud's investigation (Makgoba MW 2017). There was no such comparable evidence available in this complaint. Dr. Sukeri conceded at the interview that these were indeed opinion/ statements and he had no scientific or medical evidence for some of his statements/opinions that needed such evidence.

It became essential that Dr. Sukeri be interviewed by the Ombud to elaborate, explain and provide the necessary evidence if any for his alleged complaint.

Following the interview and the written Report of the OHSC investigators, the Ombud went through the same documents provided by Dr. Sukeri and used by the OHSC investigators. These were found to be vague and of poor quality; some were related to the general and routine management of patients, others lacked rigorous checking or verification that is basic to any research or scientist conducting such research; yet others had been addressed and resolved at other platforms by management. The documents used by Dr. Sukeri on the calculation of deaths were riddled with errors, that were clarified and corrected during his 5-hours of interviews with the OHSC investigators. He accepted these clarifications and corrections. It later turned out that the MHRB (Central Region), EC TTT and SASOP had also requested documentary evidence, which he had promised to have, but has so far not provided.

4.5. THE LIFE ESIDIMENI COPY-CAT PHENOMENON

Dr. Sukeri's complaint was depicted and portrayed in the media as another 'Life Esidimeni saga', even by Dr. Sukeri as alleged in certain sections of the media such the Rapport, City Press and the eNCA TV programme, Checkpoint. The reported death of 90 MHCUs became etched in the public's mind, the reported statement by Dr. Sukeri saying 'the government did not seem to have learnt any lessons from Esidimeni' and another documentary flighted as 'The next Life Esidimeni to air on eNCA by Health-e News and Crocott Mail 11th June 2018, all taken together, created this copy-cat phenomenon comparison. Dr. Sukeri would have been fully aware of the final total of 144 deaths recorded at Life Esidimeni over a period of one year during the 'Marathon Project' (Robertson & Makgoba 2018). This Life Esidimeni comparison has had the effect of:

i) creating a national mass hysteria and shame so soon after the harrowing experience suffered through the Life Esidimeni tragedy. The media hype and 'Life Esidimeni copy-cat phenomenon or band wagon' comparison has blown the complaint out of proportion to reality. This media hype created a mountain out of mole hill. However, this comparison has no factual basis (see below).

ii) Another effect of this misrepresentation was to create an expectation in the local public that this complaint will lead to financial rewards just like what happened in Life Esidimeni, with some even dubbing Dr. Sukeri's complaint as 'Life Esidimeni R1.2m, (Adv Maxakato 2018). One point two million rands (R1.2m(was in reference to the average award given to each relative/ family member of the Life Esidimeni tragedy, by former Deputy Justice Dikgang Moseneke (http://www.gauteng.gov.za/government/departments/office-of-the-premier/Pages/Life-Esidimeni.aspx).

This Life Esidimeni comparison was not only factually inaccurate and far from the truth, but also ill-informed, poorly researched, unscientific, false and exaggerated. For example,

- **8** patients/month on average were estimated to have died at Life Esidimeni compared to 68 patients/year over an eight-year period at TPHPRC i.e. **0.71** patients/month average; in the end a total 144 MCHUs died at Life Esidimeni in one year, during the 'Marathon Project i.e. **12** patients/month (Robertson & Makgoba 2018 SAMJ in press, Health Ombud Final Submission to the ADR signed 6th November 2017);

- there was no link between the 68 deaths with the alleged Human Rights violations, unlike the 144 deaths in Life Esidimeni; therefore

- the scale/extend and degree of Human Rights violations at TPHPRC were very few, isolated and secondary and not comparable to the litany of Human Rights violations found and catalogued for Life Esidimeni (supported by medical, forensic and post mortem evidence), which were primary as detailed in the Ombud's Report (Makgoba MW, 2018, *www.ohsc.org.za*), elaborated and aired during the Alternative Dispute Resolution (ADR) testimonies (published in full in Timeslive 20th March 2018) and (http://www.gauteng.gov.za/government/departments/office-of-the-premier/Pages/Life-Esidimeni.aspx);

- the Life Esidimeni tragedy was a once-in-lifetime event with no precedent *recorded in the history of medicine* and has thus become a landmark case study for quality healthcare, health professionals, politicians, lawyers, ethicists, actuaries and Constitutional lawyers and the TPHPRC story is hardly ever likely to reach this status;

- there was no family movement involvement in the TPHPRC complaint compared to the many families in the Life Esidimeni saga who suffered and continue to suffer and be haunted through this trauma; and

- The tragedy generated over 12000 media hits across the world (The Health Ombud Annual Report 2017/18).

Just taking the example of the above Death statistic alone and using the 1-year total deaths comparison, the Life Esidimeni saga was **17x fold** or seventeen-fold greater at a minimum to what occurred and was established at TPHPRC. With the final data now available, Robertson & Makgoba (SAMJ 2018 in press) found an age adjusted death rate of 63/ 1000 amongst the patients transferred from Life Esidimeni to alternative care facilities (NGOs), almost eight times the preliminary crude death rate of 8/1000 for the general population in 2016. This adjusted death rate is not only significant but also very high.

It must be noted that TPHPRC scored 76% in the overall performance of the National Core Standard in June 2016 and this score improved to 89% in June 2017 (OHSC). This was a stellar performance (The National Core Standards Peer Review Assessment Reports 2016 & 2017). Finally, the crude death percentage estimate of 2.1 deaths annually (68 deaths x 100/400 = 2.1%) at TPHPRC plus the overall National Core Standards performance would compare favourably with the best institutions in the world and would be the envy of many health establishments' CEOs in our country. This was despite all the infrastructural, human resources and financial constraints faced by TPHPRC over many years as reported by the OHSC investigators. It was therefore important that this ill-informed, unscientific, exaggerated false 'copy-cat' comparison in the media is put into proper perspective and corrected. As a knowledge society we must reject this form of journalism.

More importantly, it would be advisable in future for the media of our country to seek the advice of the Office of the Statistician-General or other similar or equivalent experts/authorities (just as the Ombud did in the analysis of deaths in Life Esidimeni) before putting out such potentially explosive and injurious vital statistical information into the public space of an unsuspecting public, which later proved to be false and exaggerated. The media should balance its power to critique, inform and educate against its propensity to sensationalise (scoop) and bring *disrepute to society, institutions and persons, which is what happened in this complaint.* There was no comparison of the TPHPRC complaint with Life Esidemini. Dr. Sukeri's complaint is totally different. Dr. Sukeri now understands, has acknowledged and confirmed that this comparison was wrong during the interview. **This incidence was no Life Esidimeni.**

This however, did not detract from nor diminish the importance and uniqueness of Dr. Sukeri's complaint, it is just so different and had to be investigated as such.

4.6. OMBUD'S APPROACH

For this coy complex complaint, the Ombud adopted the following approach:

- the Ombud dispatched two Health Investigators to visit TPHPRC to conduct an independent onsite investigation into the complaint, to verify some of the allegations in the statement and gather any other relevant information;

- the Ombud conducted his own investigation through recorded interviews in the presence of the Director Complaints Centre and Assessment, who has provided his own independent report.

- The Ombud also conducted his investigation in the presence of the OHSC investigators for them to fill in gaps; for them to ask further questions on witnesses they have seen and on new witnesses but also for them to detect areas of agreement, discrepancy and consistency of evidence they have heard on their own;

- The Ombud focused his investigation on the complaint;

- The Ombud received and read the EC TTT Report after preparing his findings and recommendations;

- The Ombud also received and read an NHC-discussed document on a Life Esidimeni follow up initiative by the National Minister of Health to assess the status of Mental Health in the 9 Provinces;

- The Ombud conducted research on the complaint itself through literature analysis; did not read nor allow the Investigators to have sight of the EC TTT Report or the NHC-discussed document until their independent reports were completed and written;

- The key parties were provided with the Interim Report for inputs and comments to which they have all responded. These comments were incorporated and have strengthed the final Report; and

- There was great value in this type of complex interdependent triangulation.

4.7. MS. VENTER'S REPORT

Ms. Venter's report in the Rapport and City Press, 04th March 2018, indicated that 90 deaths had occurred at the TPHPRC establishment over a 10-year period; that the Office of the Health Ombud had been informed on the 11th February 2018; 'claimed death registers had been altered, and that an alarming number of patient deaths at the hospital in recent years had gone unrecorded'. There was no 'alarming number of patient deaths' found.

Each of these statements in Dr. Sukeri's complaint all proved untrue, false and exaggerated.

4.7.1. In the light of 2, 3, 4, 5 & 6 above, it seemed only logical for the Ombud to prepare a set of questions for Dr. Sukeri, covering the evidence that underpinned his complaint, the processes Dr. Sukeri followed both professionally and contractually and the possible consequences. The responses and findings of the answers to these questions formed the bedrock of the Ombud's Report and Recommendations. These findings were corroborated by the independent findings and reports of the OHSC investigators, the Director of Complaints Centre and Assessment and the MHRB (Central Region).

4.7.2. Between the 5th June and 8th June 2018, the Health Ombud together with the Director of Complaints Centre and Assessment, Mr. Monnatau Tlholoe, the Senior Investigator (Health), Ms. Helen Mamodiehi Phetoane and the Deputy Director Investigations, Ms. Joyce Tinyiko Monyela interviewed 34 staff members in 36 interviews in relation to Dr. Sukeri's complaint. The witnesses included officials of the ECDoH, the TPHPRC staff, the MHRB members, the labour representatives of DENOSA, NEHAWU and the PSA, the full list of witnesses is attached as Annexure 2b. In total 25hrs:48min:36secs were spent on these interviews. All the interviews were recorded.

4.7.3. This Report of the Ombud is an analysis, a consolidation and is founded on:

- the investigation conducted and the evidence gathered and analysed by the Ombud;

- corroborated by the evidence gathered by the OHSC investigators;

- corroborated by the evidence from the OHSC's Director of Complaints Centre and Assessment;

- corroborated by the evidence gathered by the MHRB (Central Region); and

- and cross-referenced with the EC TTT Report, which included SASOP representatives from the Eastern Cape.

4.8. THEMES THAT EMERGED

Four themes emerged out the investigation, evidence, analysis and consolidation. These are:

i) The Complaint itself

- The complaint was very *important and unique* for the ECDoH;

- This was the first complaint lodged by a senior health professional consultant psychiatrist against his employer, TPHPRC and ECDoH;

- Dr. Sukeri made the following telling statements:

- He had been 'fighting for **12 years**', this is certainly much longer than his 2-years employment at TPHPRC;

- His recommendations for a solution forwarded during the interview with the Ombud, were directed to the **system and the ECDoH rather than at TPHPRC;**

- He admitted he **'lost his cool'**, went to the media and exaggerated his complaint;

- He was aware he violated his professional and contractual obligations but 'no longer cared';

- Dr. Sukeri's complaint was supported by Dr. Mo Nagdee's email to Mr. B Nzima (attached), which pointed out to deeper, chronic and systemic failures of Mental Health Services within the ECDoH and *widespread 'unhappiness' amongst professional staff within the ECDoH;*

- Dr. Sukeri's complaint was also supported by evidence from Mr. Wilson of PSA and others which points to prolonged failures by the ECDoH to attend to complaints raised by staff since 2007; and

- There was very little evidence of systemic institutionalised human rights violations as compared to 'few isolated incidents of professional misconduct.

ii) The Eastern Cape Health Department

- Almost every witness conceded that Mental Health and its services were not a high priority within the ECDoH.

- The ECDoH was the cause of all the woes with Mental Health Care Services.

- The ECDoH failed to guide and support TPHPRC

- It has a long history of failure to implement or action plans supported by well-researched studies.

iii) TPHPRC and CEO Ms. NE Ngcume;

- The management was in total disarray and engaged in 'power struggles'

iv) The Complainant Dr. Kiran Sukeri

- He violated his professional oaths and his employer's confidentiality contractual clauses;

- No amount of anger or frustration could be an excuse for a senior professional to behave this way and violate his professional and contractual oaths, ethics and codes of practice; and

- Everybody disagreed totally with the manner and ways in which Dr. Sukeri raised the complaint; He irretrievably broke trust and the confidence of his colleagues.

All the witnesses gave evidence under oath. Further documents were requested from witnesses and further telephonic or e-mail exchanges were sought to verify and corroborate evidence with witnesses.

4.8. WHO WAS DR. KIRAN SUKERI THE COMPLAINANT

Dr. Kiran Sukeri was employed as a Full-time Medical Specialist at TPHPRC since 1st December 2015. He reported to the CEO, Ms. NE Ngcume. He later became employed as a part-time Medical Specialist in the same hospital reporting to Dr. Snombo, the Clinical Services Manager at TPHPRC. Dr. Sukeri was the only and most senior psychiatrist at TPHPRC. He was the Head of the Department of Psychiatry and Chaired the MDT. In these positions he was part of Management. He enjoyed enormous respect and some would say he was 'revered'. Both contracts that Dr. Sukeri signed were entered between Dr. Sukeri and the Department of Health Eastern Cape Province-Tower Hospital. The appointments were motivated by Ms. Ngcume, the CEO, were recommended by Dr. Nogela, Director of Specialised Services and approved by the Superintendent-General, Dr. Mbengashe. These were recorded and signed in Dr. Sukeri's contracts and clearly defined his responsibilities, and levels of authority and powers in decision-making. He confirmed during the interview that he understood these contracts well. Dr. Sukeri was the first and most high-ranking clinical consultant to bring a complaint against his employer without following proper established processes and procedures, which he was aware of. *This is one critical uniqueness of this complaint.*

4.8.1. Dr. Kiran Sukeri holds a Fellowship in Psychiatry from the College of Medicine, South Africa and a PhD degree from WSU. He is registered with the Health Profession Council of South Africa and a Member of SASOP. His HPCSA Registration number is: MP0481254. Dr. Sukeri's academic interest and 'passion' lie in the area of the systemic provision of mental health services within the EC. He has written 3 papers on the subject between 2014-2015 that are listed below for ease of reference. However, the translation of this academic work into the policy framework and practice has not taken place and has been a long and arduous road; this has been what may be termed a 'Power Struggle' or his 'crusade'. Below are links to three articles published:

- https://doi.org/10.4102/sajpsychiatry.v20i2.568
- https://www.ajol.info/index.php/sajpsyc/article/viewFile/125054/114587
- http://dx.doi.org/10.7196/sajp.609

4.8.2. This academic interest and passion went for the past 12 years. In the media reports it was alleged that he has been at this *'fight for 12 years'*; in the media reports it was also alleged that Dr. Sukeri understood the consequences of his course of action in taking this melodramatic media approach or *seppuku* sometimes commonly known as *hara-kiri,* but he could no longer *'keep quiet'*; so, his action must be understood to be *considered, conscious and premeditated.* During the interview, he agreed with this interpretation and this was further confirmed by the SASOP representatives, Prof. Zingela and Dr. Seshoka and other witnesses that Dr. Sukeri was *'not blameless in all of this"* and also by the Ms. Ngcume, the CEO, who felt Dr. Sukeri had an 'agenda'. Dr. Sukeri also agreed that he was *'not blameless' but denied he had an 'agenda'.*

4.8.3. The complaint at TPHPRC therefore did not correspond with his 2-years period of employment at TPHPRC; it was longer and broader; further analysis of Dr. Sukeri's complaint and his published works revealed another dimension i.e. its significance and as symptomatic of a broader malaise with pernicious effects on the delivery of quality mental health services in the EC; i.e. *these services were not prioritised in the ECDoH; were not planned for and resourced adequately, community-based psychiatry services were not developed; the leadership and governance of mental health services were poor and dysfunctional and non-existent in critical areas e.g. No Directorate of Mental Health despite National Policy recommendations; the services were severely short of staff and infrastructure was deteriorating over many years; these observations were further supported by research studies done through Tac and Section 27 (Death and Dying in the Eastern Cape) since 2013.*

4.8.4. Dr. Sukeri's 12-year fight period corresponded with the length of complaint on the seclusion rooms in another way as expressed by Mr. Wilson of the PSA Union and others during the interviews.

4.9. DUTY OF CARE

However, as a senior consultant psychiatrist and Head of the Department of Psychiatry and Chair of MDT at TPHPRC, Dr. Sukeri failed in his basic duty of care to:

- Dr. Sukeri released unverified, false and damaging death statistical information to the public;
- report the MCHUs who were secluded to the MHRB;
- report the patient who burnt in the Seclusion room to the MHRB;
- report the 'perceived increases in deaths or unrecorded deaths'to the MHRB or Tower Hospital Board;
- conduct a well-researched death audit before going prematurely to the media with falsified, 'shoddy' and exaggerated deaths statistics;
- approach the appropriate statutory bodies such as the SAHRC, the HPCSA, the Public Protector or the Health Ombud timeously to investigate his complaint, before going to the media;
- ensure that MCHUs were discharged without violating the MHCA, after being properly prepared, into properly assessed environments, into caring families and not the uncaring and inhumane approach Dr. Sukeri was alleged to have adopted;
- use the independence, advocacy and authority of the MHRB effectively; and
- **Dr. Sukeri could not explain why he failed to carry out all these basic duties of care.**

4.10. DR. SUKERI'S CONTRACT

Dr. Sukeri's contract named the CEO as his line manager i.e. he reported and was accountable to the CEO, Ms. NE Ngcume. The CEO was the accounting officer of the establishment and her decisions superseded those of Dr. Sukeri. She was an experienced Professional Nurse who was also specialised in Psychiatric Nursing. She was legally permitted and within her rights to override some of Dr. Sukeri's decisions if she had good reasons to believe the decisions were contrary to good professional practice, good governance, good policies and contrary to the strategic plans at TPHPRC and would impact on the institution's reputation. Dr. Sukeri was aware of and familiar with this management structure. Dr. Matiwane confirmed this role of the CEO in decision-making and in how he intervened during a meeting in December 2017 between Dr. Sukeri and Ms. Ngcume. Dr. Sukeri conceded to this interpretation of his contract in the interview with the Ombud. He was however not comfortable and the Ombud sympathised with him, but that was what he had signed for legally and how the system operated in the current National Health System. However, some of Dr. Sukeri's actions undermined the very contracts he seemed to understand or even undermined the CEO and at times he appeared dismissive of his peers and colleagues at TPHPRC. Many perceived he had no respect for them. *'Dr. Sukeri did not take criticism kindly'*, Dr. Snombo said.

4.10.1. While Dr. Sukeri resigned from TPHPRC as a consultant psychiatrist on 2nd March 2018, he did not resign from being a registered health professional, bound by the oath and the professional and ethical codes of the HPCSA, neither did he realise that his signed 'confidentiality clause' in his Employment contracts still bound and required of him 'to seek expressed permission from his line manager/s to divulge information to a third party'; in his case this would be Ms. NE Ngcume and Dr. Snombo or the EC Provincial spokesperson; Dr. Sukeri did not consult nor obtain such written or verbal permission from the CEO, Ms. NE Ngcume or from Dr. Snombo before divulging *confidential information* (alleged Complaint) to the media, SASOP and the public. He confirmed this at the interview and in writing later through an email.

Finally, Dr. Sukeri could not resign from the responsibility and accountability of patients he treated or looked after. These treatment records or 'finger prints' are the basis of 'doctor-patient' relationship that live with every doctor throughout their lives.

4.10.2. Dr. Sukeri further violated his oath as a Health Professional by revealing patients' confidential information on national TV without following due and available processes and without obtaining written or verbal permission from patients or their relatives. Dr. Sukeri also violated the Provincial Health Policy on 'employees speaking to the media'. Employees spoke to the media through Mr. Sizwe Kupelo, the Provincial Media Spokesperson. Dr. Sukeri did not contact or consult the relevant provincial Health Spokesperson at the time of going to the media, so did Mr. Mtsila in the Groccott's Mail article. *These actions violated his professional oath and his 'confidentiality' clauses signed in his contracts (Medical Records in South Africa 2011).*

4.11. FOOD QUALITY AND DIGNITY

No patient at TPHPRC was found to be malnourished, wasted or to have lost weight; there were no increased incidences of illness that may be related or attributed to poor quality food/ nutrition (e.g. repeated infections or pellagra) and there were no incidences of increased deaths. No staff member or relative ever complained of malnourished or wasted MCHUs. No patient was found to have complained about the quality of the food at TPHPRC. The OHSC investigators interviewed some patients, the ward and kitchen staff and Ms. Ntsaluba, the Quality Assurance Manager and could not find any substance to the alleged 'violation of the patients rights to dignity' with regards food. *This was all very unlike and in complete contrast to the evidence that emerged out of the Life Esidimeni investigation.* This was further confirmed from pictures, direct observations by the many witnesses interviewed and by the OHSC investigators, members of the MHRB, who visited unannounced and investigated independently, the former MEC Health, SG and EC TTT.

Dr. Sukeri could not offer any alternative or contrary evidence for his allegation in the statement and for such an allegation to emanate from a person of his stature and qualifications was truly astounding. The proof of the pudding is in the eating i.e. if food quality was poor, it should reflect and be verifiable in the health conditions of the MCHUs. For example, a diagnosis of iron deficiency anaemia in a patient if correct can only be proven by the administration of iron with consequent specific response and recovery. Iron deficiency cannot be cured by anything other than iron. This allegation in the statement on food and patients' dignity must be regarded as untrue and unscientific.

4.12. TORN OR 'TATTERED' CLOTHES

Those that visited TPHPRC unannounced to hopefully observe the alleged 'torn or tattered clothes' only noticed a few users with 'cigarette burnt clothes', including Dr. Sukeri. The notice released by Mr. Baart during 08th Feb 2018 was based on a single severely 'psychotic' MCHU who was observed tearing his clothes and not a generalised state of affairs at TPHPRC (confirmed in an interview with Ombud). While the notice was found to be misleading it incumbent upon Dr. Sukeri to seek clarityand verification with Mr. Baart as part of Management. This is even more when such a document is going to become a public document and as most medical scientists would do. These visitors included the former MEC Health, the SG, the MHRB (Central Region)members and others who did not notice any 'torn'or 'tattered' clothes and they arrived at TPHPRC on Monday the 5th March 2018 at 9am. The OHSC investigators did not notice any torn clothes either despite arriving at TPHPRC *impromptu* or without warning on a separate date from the MEC, the MHRB members and SG.

By most witnesses and observed credible evidence, including the OHSC investigators, the MHRB (Central Region) and the EC TTT this alleged statement of Dr. Sukeri was also found untrue. Even Dr. Sukeri's pictures did not show any'tattered or torn clothes' but clothes which appear burnt with cigarettes 'stubs'.

4.13. SECLUSION ROOMS

The issue of 'single rooms or seclusion process' was a long standing and well-known complaint of staff and everyone interviewed conceded and was aware this did not comply with policy or modern practice and the Mental Health Care

Act 2002, and therefore should not be used, but the provincial health department was 'dragging its feet' and not acting or paying attention to this chronic complaint and an unquestionable Human Right violation. The OHSC investigators and the EC TTT all accepted this as a violation of the MHCA.

This archaic practice represented an unquestionable Human Rights violation and almost every witness accepted and agreed with this. It should have changed in 2002 when the MHCA was introduced. That it remained and the ECDoH had not attended to this was of grave concern.

4.14. INTERFERENCE WITH CLINICAL DECISIONS

Ms. NE Ngcume and others did not interfere with clinical decisions. There was no evidence found to this allegation. Clinical discussions at hand-overs, ward rounds, grand-rounds, post mortems analysis, clinical or management meetings or audits in the overall management of patients are firstly *confidential* and secondly could not be regarded as complaints. This is how the profession and health system manage patients and regularises its processes. Some of the documents furnished by Dr. Sukeri to the OHSC investigators and later perused by the Ombud fell into this category. These did not constitute a complaint.

4.15. MHCU'S DISCHARGES LINKED TO CLINICAL DECISIONS

Ms. NE Ngcume and others did not agree with certain reckless decisions of poor patients' assessments and poor preparations of patients being discharged back into the community without proper and safe care and without social worker's reports or being refused admission into TPHPRC through the application of unapproved restrictive admission criteria. There were no developed community-based psychiatry services in the EC. Some MHCUs were 'homeless' and with no social or family support structures. To discharge patients in these circumstances would constitute careless and **deinstitutionalisation by stealth or default.** Dr. Sukeri's approach would jeopardise the well-being of patients and violate their Human Rights, the very Rights he accused others of violating. It would simply create the 'revolving door patients' syndrome. He was advised against this approach in at least 3 meetings by Dr. Nogela, Dr. Matiwane and other peers as this approach was also contrary to the EC Mental Health plans in the community.

A meeting was called by head office in April 2016 to discuss new restrictive admission criteria that were causing a bed crisis allegedly drawn by Dr. Sukeri. It was agreed by and a resolution of that meeting that these criteria be not adopted. Dr. Sukeri was part of this meeting. These were not complaints but matters of differences in approach that are often contested and debated sometimes with passion in the medical profession and in the management of patients at such platforms.

There was no policy, guideline or definition of what constituted prolonged restrictive stay in the hospital. As Dr. Sukeri put it, 'It is my opinion that users are kept in a highly restrictive environment longer than is clinically acceptable'. This was again just another opinion with no sound scientific basis, research or explanation for practical implementation within the context of TPHPRC and the ECDoH.

However, evidence emerged that showed that Dr. Sukeri ignored these advices and decisions and continued to discharge MCHUs in violation of the MHCA 2002 and without authorisation and the knowledge of the CEO. In a meeting with Ms. Ngcume, Dr. Snombo and Mr. Baart it was alleged and confirmed by Ms. Ngcume and Dr. Snombo that Dr. Sukeri said *'after all I have discharged patients without you knowing'*. This has proven to be true by the follow up of discharged MHCUs undertaken through the SG's office ***(see item 4.15.1 below).***

4.15.1. In a progress report provided by Dr. Mbengashe, the SG to the Health Ombud on 15 th August 2018, following the EC TTT recommendations showed that Dr. Sukeri had discharged patients without ensuring social circumstances of the users. Follow up of the users that were discharged by Dr. Sukeri revealed the following:

- Out of a total of 142 discharges, Dr. Sukeri had discharged 51 or 35.92%.
- 42 discharges have been traced and found and 9 are outstanding
- The whereabouts of the 9 have been identified and a process is underway to locate them.
- 11 users were not coping well, some with relapses and re-admissions; 1 user was reported missing; 2 users passed away, 1 user committed suicide and 1 user committed murder and was imprisoned.
- The ECDoH was liaising with the communities in follow up to trace all users.

The OHSC investigators had also found MHCUs that were discharged without proper authorisation reported on ***page 25-26 under 'MHCUs Discharges'.***

- *By discharging patients this way, Dr. Sukeri was knowingly defiant and insubordinate of Ms. Ngcume's instructions and the ECDoH policy.*
- *Dr. Sukeri by so doing denied the CEO her right to exercise her duty fully.*

- *That some MHCUs have been re-admitted, one has committed a crime, one has committed suicide and others are not coping well in the community, as so far found, questioned the quality of assessments undertaken, the clinical judgements/decisions and competence of the practitioner.*

- This action represented a gross violation of the MCHA and is a serious Health Professional misconduct. It also confirmed Ms. Ngcume's fears.

Dr. Sukeri conceded to the Ombud, the Director of Complaints Centre and Assessment and the OHSC investigators that he got his **'death figures'** wrong. The total figure of 90 reported in the Rapport and City Press and subsequently reported in other newspapers was not only wrong but also inflated and exaggerated. The figure of 90 deaths got etched into the public's mind and created the comparisons with Life Esidimeni. The correct figure was 68 and Dr. Sukeri has now recalculated and verified this figure. Dr. Sukeri's corrected death figure of 68 was now in total agreement with the figures recalculated by the CEO and verified by the OHSC investigators after the death register was unexpectedly recovered. The ECTTT independently arrived at the same total of 68 during their investigation. These death statistics were verified from the only two death registers available at TPHPRC as *confirmed by Mr. Baart.*

4.16.1. It was therefore finally established by all concerned (Dr. Sukeri, the OHSC investigators, Ms. Ngcume, the CEO, Prof. Zingela, Chair of the EC TTT and confirmed by the Health Ombud) that a total of 68 patients died at TPHPRC and not 90 as reported in the media over an 8-year period; this translated to 68 patients per year in a 400-bed occupancy. Dr. Sukeri was responsible for peddling *this false information of 90 deaths* by collaborating with the media in preparing articles.

4.16.2. What beggars belief was that the most senior psychiatrist at TPHPRC gave the public, the country and the international community not only wrong information but also exaggerated or released alarmist data, without proper research and rigorous verification and without following proper processes, which he now admitted was wrong. This conduct amounted to *'scientific misconduct or fraud'*.

These wrong death figures 'inflamed the situation, created havoc and created the so-called Life Esidimeni copy-cat phenomenon'. It not only shocked staff at TPHPRC but also brought disrepute, 'a feeling of shame' to some hospital and the Provincial Health Department staff. It also broke trust between Dr. Sukeri, his immediate line managers (Ms. Ngcume and Dr. Snombo), the Hospital Management and other hospital staff, the Tower Hospital Board and MHRB (Central Region). His death figure was wrong by 22 *MCHUs or exaggerated by 32.35%.*

He informed the Health Ombud that he has written to the Press Ombudsman to rectify this and he would also correct this with the journalist and Editor of Rapport. The newspaper stood by its story of the 04th March 2018. This was not true.

On the 3rd July 2018, the Ombud received a forwarded e-mail from Dr. Sukeri approaching the Rapport Editor to correct the errors of his publication. This was now 4 months after the original Rapport publication, 2 months after recognising the error following an interview with the OHSC investigators and a month after the interview with Ombud. In all this period he knew ***his information was wrong, had caused reputational damage nationally and internationally and pain to many people and he did nothing to correct the error.*** The reputational damage caused was long done and the public's mind had set in already. He has not written to the Press Ombudsman as promised about the inaccuracies of his figures. In an attempt to explain himself out of this situation, Dr. Sukeri forwarded below an e-mail exchange.

'RE: "Hospitaal van Gruwels" (4/03/18).

Please allow me to respectfully bring the following to your attention, in relation to the above-mentioned article:

Number of deaths:

In that article it is mentioned that 90 deaths occurred at Tower Hospital since 2010, although the original article by Ms S Venter stated 86.

During my interview with the Health Ombudsman, Prof MW Makgoba, I acknowledged that I had made an error in the calculations of the deaths at Tower and I also stated that the figure should have been 68, not 86.

I am prepared to assume responsibility for the incorrect figure, for the following reasons:

In 2016 I wrote down 16 deaths when it should have been 6; I did my calculations based on calendar years, whilst the Department of Health bases their figures in financial years;

Note: that the revised figure of 68, may not be the final figure since there is more than one death register.

Subsequent to my meeting with Prof MW Makgoba, I contacted the journalist and made her aware of the incorrect figure published and the need to rectify the mistake ***in the interests of the public in general as well as the entities involved or mentioned in the article'.***

He then wrote this apology:

12 July 2018

The Honourable Minister of Health
Republic of South Africa
Dr. A Motsoaledi

Sir,
RE: Tower Psychiatric Hospital, Eastern Cape, RSA

I would kindly like to personally place on record to you my apology for the incorrect death statistic that was printed in the Rapport on the 04/03/18.

My error stemmed from the following:
- I used calendar instead of financial years
- I made a writing error for 2016

After correcting for the above the death statistic for the period 2010-2017 would stand at 68. However, this may not be the correct statistic as there is more than one death register.

Corrective measures taken by myself include the following:
- Acknowledgement of my error to the Task Team
- Acknowledgement of my error to the Health Ombudsman and his investigative team
- A written request to the internal press Ombud at Media24 to correct the error. Media24 have subsequently published a correction in both their online and print media.

I want to stress that I am dedicated to assist the Department of Health in improving mental health services in the public sector. This is evident from my academic research and personal dedication to Mental Health in general. In this regard I await your kind counsel.
Yours sincerely,

Dr. Kiran Sukeri
Cc Prof MW Makgoba, Mr. S Phakathi

Dr. Sukeri has thus failed to successfully correct this exaggerated wrong information publicly in the media and one can only presume he did not have such a letter and corrections that he had promised and he was not truthful to the Ombud and his team under Oath during the interview.

Dr. Sukeri did not seem to appreciate or lacked the insight to appreciate the harm, pain and reputational inflicted to so many through his actions.

A response from the Rapport Press Ombudsman was a small blurb correction in the Rapport 08th July 2018 page 2, and without an apology.

This was further confirmation that the newspaper stood by their story of the 04th March 2018 as they did not admit to any wrongdoing on their part. Dr. Sukeri had approved their original draft

4.17. THE OFFICE OF THE HEALTH OMBUD NOTIFICATION

The offices of the Health Ombud, the South African Human Rights Commission and the Minister were only notified by Dr. Sukeri on the 21st February 2018, only 11 days and not 21 days before the story broke in the Rapport and City Press. This created the impression that the statutory bodies were not paying attention to his complaint. Despite agreeing with this interpretation (see below), again Dr. Sukeri failed to correct these wrong dates publicly. The reason/s for this misinformation is not clear. That these statutory offices were not contacted timeously and provided an opportunity to discharge their responsibilities constituted a serious error of judgement on Dr. Sukeri's part.

4.17.1. Again, to explain himself out, Dr. Sukeri wrote the e-mail below.

On the 3rd July 2018 Dr. Sukeri wrote to the Editor of the Rapport as follows:

'Date of complaint to the Office of the Health Ombudsman:

The same article states that I lodged my complaint with the Office of the Health Ombudsman on the 11/02/18; the correct date should be 21/02/18.

I feel that the wrong date could impact on the reputation of the Health Ombudsman's office and give the wrong impression that the Health Ombudsman did not immediately act on the complaint'. ***'Words fail me'***

4.18. COLLABORATION WITH THE MEDIA AND PATIENTS' CONFIDENTIALITY

Dr. Sukeri collaborated with the media, without the knowledge and expressed permission of his line manager and against the well-known provincial media policy to reveal false and inaccurate information. He was aware that the information he was sharing was patients' and was confidential. Patient's confidentiality is basic to any practicing doctor. **He initiated** the call to the Rapport journalist on the 2nd March 2018 and provided an interview, following what he described as a 'humiliating experience' incident earlier at TPHPRC, to 'tell all' and the journalist then called the Ombud later that day seeking certain clarifications. At this point, the Ombud had not heard of the complaint nor knew who Dr. Sukeri was.

*Dr. Sukeri then **'showed Rapport'** copies of the 'lost' register indicating at least 90 patients died at the institution since 2010…' The information in the death register was patients' confidential information and is the property of the patients, TPHPRC and ECDoH. He later shared the same death register, sharing the same personal information of patients and names of colleagues on the public TV programme eNCA's Checkpoint.*

The newspaper journalist provided Dr. Sukeri with her draft story before publication. Dr. Sukeri confirmed receipt of this draft during the interview with the Ombud. It was therefore his duty as a senior health professional and Medical Scientist to check and verify the information in the draft. This is a very rare honour accorded few by journalists. Most journalists write and publish without this approach. What ultimately appeared publicly in the Rapport and City Press on 4th March, Dr. Sukeri had sight of and therefore had his approval and must therefore take full responsibility for.

During the interview with the Ombud Dr. Sukeri confirmed this, but he also acknowledged he gave a figure of 86. From the City Press article, the figure of 90 also came from Dr. Sukeri. What figures he provided was neither here nor there? His figures appeared elastic. Where had he got his figures from? The only place where this information resided in a hospital would be the death register/s copies of which he shared with City Press and eNCA Checkpoint. That he later corrected this total figure from 90 or 86 to 68 using the same death register was mind blowing. Subsequently, Dr. Sukeri collaborated with another journalist, the producers of the eNCA TV programme, Checkpoint to reveal personal patients' information.

Dr. Sukeri claimed that the confusion in his calculation may have arisen because he used the calendar year while TPHPRC used the financial year. Using the financial year, the total death figure was 68, confirmed and agreed by all. In comparison, the total death figure was calculated to be 74 using the calendar year, and **not 86 or 90.** There were only two death registers at TPHPRC. Therefore, Dr. Sukeri's explanation cannot be true. These errors in calculations could only arise out of errors in the data, fabrication of the data or exegeration of the data or a combination of all. As a medical scientist it was his responsibility to ensure that such vital statistical information is accurate.

In his responses provided in these email exchanges above, Dr. Sukeri did not appear to have respect for the truth. It can be concluded from Dr. Sukeri's responses, he remains oblivious to the damage he caused in various platforms (print media and television) to the protection of the privacy of patients and their families as well as breach of his employment contracts. The Health Professions Council of South Africa has listed on its website (http://www.hpcsa.co.za/Public/ConductEthics) unprofessional conduct against which it may take disciplinary steps; this list includes 'Disclosure of information in regard to patient without his/her permission'. To this extend, Dr. Sukeri's conclusions demonstrated "intentional ignorance" of his ethical rules. Confidentiality is usually thought of as an ethical issue, but it is also a legal obligation:

This Improper conduct cannot be condoned at any cost. He seemed to think the breach of confidentiality is less significant and inconsequential.The National Health Act, 2003 permits the disclosure of personal health information with the informed consent of the patient. It cannot be contested that Dr. Sukeri shared private confidential patient's information contained in the death registers with the Rapport newspaper and subsequently with eNCA journalists. If a senior health professional could go public sharing such patient'sprivate and confidential information what would stop 'Jo Soap' out there from doing the same? For a senior health professional to take this approach in the management of patients that rocks the very foundations of medical practice through violating patients' and employer's confidentiality again beggars belief but represented gross misconduct and incompetence on his part.

4.19. COMPLAINTS MANAGEMENT PROCESSES AND SYSTEMS IGNORED

Dr. Sukeri did not follow the available and well-known protocols of the establishment or the province in addressing his complaints. There is no shred of evidence in writing that he addressed his complaint to Ms. NE Ngcume, the CEO, to his line manager Dr. Snombo, or to Dr. Nogela, former Director of Specialised Services, the DDG of Specialised Services, the Dr. Mbengashe, the SG or the MEC or their offices. All these channels were open and available to him as consultant psychiatrist. Below is Dr. Sukeri's response and confirmation to whom he complained, as asked by the Ombud:

- Ms. NE Ngcume: No
- Dr N Snombo: No
- Dr. T Nogela: No (Please note he had resigned prior to my complaint, my complaint was made to Mr Nzima, the Acting Director for Specialised Services). Dr. Sukeri's response on Dr. Nogela is not completely truthful as the complaint existed and dated longer and Dr. Nogela and Dr. Sukeri had known and worked with each other. However, Dr B. Nzima denies ever being complained to directly by Dr. Sukeri. He received Dr. Sukeri's complaint on 11th February copied to him as part of a long email exchange between Dr. Sukeri and his SASOP colleagues. The complaint had become public knowledge within the SASOP discussion group and could not easily be subjected through the complaints processes.
- Dr. S Beja: No
- Dr. TD Mbengashe: No
- Dr. PP Dyantyi: No
- Tower Hospital Board: No
- Mental Health Review Board (Central Region): No

Dr. Sukeri as demonstrated above and admitted during the interview showed he did not follow established complaints management process of which he was fully aware.

4.19.1. More importantly Dr. Sukeri never addressed his complaint to the Hospital Management and the Hospital Board at TPHPRC or the MHRB (Central Region). These are the three most important structures he should have first approached. As a consultant psychiatrist he knew this. He has provided no evidence or explanation to counter this claim but has confirmed he did not consult them. The MHRB (Central Region) made this one of the negative findings against Dr. Sukeri

4.20. DUPLICITOUSNESS IN EVIDENCE

What was is even more troubling was Dr. Sukeri's alleged 'praise' for the MHRB (Central Region) when he met with them but his 'disparaging comments' of the very same Board when he met the Investigators, the EC TTT and the Health Ombud. He described them as 'useless or inefficient or non-functional' depending on who he spoke to. In another newspaper article he also described the OHSC investigators as being 'aggressive' but claiming the opposite when he met them face-to-face but instead it was the EC TTT that was 'aggressive'. In the words of Sir Sydney Ruff Diamond, the British Governor of India and Randy Lal, the Khazi of Khalabar in the famous ***Carry On Up the Khyber*** comedy, 1968, *'he was two-faced'*, aptly described as duplicitous. This duplicitous approach which angered members of the MHRB was also confirmed by the MHRB and EC TTT under Oath and the OHSC investigators.

4.21. THE DEATH REGISTER OBTAINED FALSELY AND PATIENTS' CONFIDENTIALITY

All evidence so far gathered suggest that Dr. Sukeri obtained the death register falsely (this he denied) and did not clear the so-called 'research' he was conducting with the CEO or Dr. Snombo. Further evidence emerged that Dr. Sukeri obtained and photocopied patients' files without due authorisation from the CEO. 'When we were analysing the complaints with the top three managers, Dr. Snombo, Mr. Baart and Mr. Portgieter they complained that he (Dr. Sukeri) has accessed information from their departments without authority and photocopied patients' files to compile information to make the accusations' the CEO said.

Dr. Sukeri obtained the death register from Mr. Kobese falsely (under false pretext) and without proper authorisation. He told Mr. Kobese that there were no 'death registers at TPHPRC' and he had not cleared this with Mr. Baart the official in charge of the death register; he told Dr. Snombo he was doing 'research' and had found a 'goldmine', which he had not cleared with Dr. Snombo or the CEO as is required by his contract. These statements were verified with Mr. Kobese, Mr. Baart, Ms. Ngcume and Dr. Snombo.

He then showed copies of this register to the Rapport and eNCA's Checkpoint journalists on national TV (this he did not deny). There was no reason for such a highly classified document of TPHPRC and the ECDoH to find its way into the hands of the Rapport and Checkpoint journalists.

When the death register was flighted on TV, the names of patients, the ages and the dates of death were exposed and this exposure could lead to litigation. In so doing, Dr. Sukeri compromised the deceased and MHCUs Human Rights to Dignity and Confdentiality.

In plain English he stole the death register and other documents of patients, photocopied these and acted in bad faith. He used a false reason to Mr. Kobese for obtaining the death degister. Dr. Snombo has signed a statement that indicated that she saw the so-called lost death register in Dr. Sukeri's Office and there were some discussions about it and he spoke about having found a 'gold mine and conducting some research'. Dr. Snombo's statement reads: '*I, Dr. N. Snombo hereby testify that at some point last year (2017) between the months of April and August, Dr. Sukeri was in possession of the old death register, which I saw on his desk in his office.*' Dr. Snombo has never seen an old handwritten death register dating back to 1894, she does not believe such a Register existed at TPHPRC, she confirmed this to the Ombud. How else would Dr. Sukeri discuss the minutiae of the death statistics with the media. The register was last seen in his office by Dr. Snombo, his line manager. Mr. Phumzile W Kobese, a professional nurse at TPHPRC also signed another statement alleging Dr. Sukeri came to his office requesting the death register, which *he collected and brought back*'. Mr. Kobese confirmed this statement in the presence of Mr. Baart. Mr. Baart confirmed this death register collection should have been authorised by him but this was not done. Mr. Kobese gave Dr. Sukeri the 2016 death register (the old register). This later statement of Mr. Kobese supported Dr. Snombo's statement. These two statements suggested if proven true that Dr. Sukeri may indeed have had the death register. This would constitute a serious violation of health professional practice *i.e. theft of confidential patients' and hospital records by a senior doctor without proper authorisation.*

4.22. DR. SUKERI AND THE HPCSA

Dr. Sukeri indicated to the Health Ombud that he did not contact the HPCSA with his complaint but reported his complaint to SASOP, a non-statutory body with no legal powers to investigate complaints. It turned out that Dr. Sukeri sent a complaint to the HPCSA regarding the alleged falsification of the record where a junior Dr. Nodliwa was 'allegedly pressurised' by the TPHPRC Quality Assurance and management to alter a patient's record during an Audit. It would appear Dr. Sukeri was aware where and knew how to lodge complaints but was only selective. He would have been certainly aware of the Public Protector's Office, the South African Human Rights Commission, both of which have existed since the dawn of our democracy. He clearly was aware of the existence of the Health Ombud's office since he referred to its Report and the Life Esidimeni tragedy.

4.23. SASOP 'INVESTIGATION'

SASOP as a professional body of Psychiatrists has no legal powers of investigation. By conducting and releasing a so-called 'investigation report' co-signed by its President, SASOP acted *ultra vires*. Only the Public Protector, the SAHRC and the Health Ombud have such legal powers of investigation in such a matter, and not SASOP. The SASOP representatives accepted this interpretation. Even more scary was the notion that anyone or any organisation could enter the premises of a hospital to peruse confidential hospital documents without having legal authority to do so. This was what SASOP did. One can only wonder as to the motive.

By placing the complaint in the media before the established internal processes and the legislated formal structures were exhausted, *Dr. Sukeri showed immature, poor and reckless judgement*. In so doing he undermined the importance and roles of these statutory structures, he undermined the significance of his complaint and the noble profession whose oath he undertook; he undermined all the ECDoH policies on Complaints Management. The disproportionate melodrama that unfolded in the media could have been easily avoided. As a consequence, a professional complaint was handled through the most unprofessional and amateurish way by Dr. Sukeri.

4.23.1. Dr. Sukeri conceded that this whole saga could have been handled differently and less dramatically had he followed protocol. However, he was so deeply frustrated and because of *his passion for patients and his discipline* (psychiatry) he *'lost his cool'*.

4.23.2. All ECDoH and facility staff interviewed agreed this complaint was 'blown out of proportion and could have been easily resolved and with less drama within the available internal structures and processes of the system, had Dr. Sukeri exercised any of these.

4.23.3. The Ombud could not find any witness who agreed with Dr. Sukeri's approach of the manner of handling this complaint. Many felt 'betrayed, mistrusted, that he had broken their trust, he has brought them shame and disrepute, some were shocked while others felt that he was partly responsible or partly to blame as he was most senior psychiatrist at TPHPRC. 'They do not know how to work with such a person any longer.' He is therefore '*not without blame himself in the drama'* as the EC TTT and others confirmed under Oath.

4.23.5. THE POWER STRUGGLE AT TPHPRC

There was however, an admission of a power struggle on the future direction of TPHPRC between the CEO and Dr. Sukeri. However, it was the credible evidence of many that Dr. Sukeri only wanted his way and no other ways. *He wanted to change the admission and discharge criteria and policy even against the considered views of his line manager, his peers and the provincial government's plan.* His view or approach could not carry the day or convince his own peers in discussions and at meetings. The CEO provided Dr. Sukeri with an example of a MHCU who 'murdered a nurse at taxi rank' as a consequence of not prior assessing where patients would go after discharge, but Dr. Sukeri insisted that *'if a patient who was admitted to Tower Hospital came from under a bridge, he/she must be discharged back to under the bridge'. This statement was provided by Ms. Ngcume, Mr. Baart, Dr. Snombo and a member of the Hospital Board. The statement was further discussed in Dr. Matiwane's office during December 2017, in the presence of Dr. Sukeri. 'Dr. Sukeri did not deny', said Dr. Matiwane. The statement was also given to the OHSC investigators, to the EC TTT and Health Ombud. A member of the MHRB also provided an example of how negative a family responded to a young man who was discharged but his family was not properly prepared.* The OHSC has received a complaint from a family member about Dr. Sukeri. This 'callous and insensitive response' just aptly summarises the gulf in patient's management approaches between the two protagonists in this power struggle. Dr. Sukeri's approach was clearly out of kilter with the nuanced cultural environment of the Eastern Cape. His approach might have been suitable for another world and in another era, but certainly not the Eastern Cape at this historic juncture. *This power struggle led to a failure to respect the CEO and the Management team; it led to a breakdown in trust, relationships and confidence; it led to a failure to respect and adhere to established processes, protocols and some policies of the ECDoH. It created a 'toxic' working environment and the management and leadership of TPHPRC suffered as a consequence.*

4.24. SUMMARY ANALYSIS OF THE COMPLAINT FINDINGS

Having systematically gone through each allegation in Dr. Sukeri's complaint, the Ombud found:

- Dr. Sukeri released unverified, false and damaging death statistical information to the public
- one incident of unquestionable and undisputed Human Rights violation, i.e. the use of the seclusion rooms.
- 2 incidents of professional misconduct (mis-classification of a single death as 'natural' and the 1 burnt MHCU in the Seclusion Room). These did not constitute Human Rights violations, but professional misconducts.
- Several areas of incompetence, professional and gross ethical misconduct by Dr. Sukeri and other officials.
- There was no evidence provided nor found of violation of patients' dignity or autonomy by staff at TPHPRC instead it was Dr. Sukeri who violated the MCHA and the NHA.
- There were no Human Rights violations found related to the food quality, clothing, bathing in cold water or patients' finances.
- There was no institutionalsed Human Rights violations or 'degrading or inhumane treatment' found at TPHPRC.
- There was a 'power struggle' at TPHPRC between the Management and Dr. Sukeri..
- Severe staff shortages were identified.
- It was established and agreed by all that 68 patients died at TPHPRC over a period of 8 years.
- There was no set or agreed policy as to how long a MCHU can stay or be institutionalised at TPHPRC. With the prevalent community stigma on Mental Illness, poor research on the subject, no community-based mental health care services provision, inappropriate assessment and preparation it's virtually impossible to make a principled and informed guideline on this issue. Dr. Sukeri accepted this interpretation during his interview with the Ombud.
- The CEO did not interfere with Dr. Sukeri's clinical decisions, but was instead treated with much disrespect by Dr. Sukeri.
- The CEO had many one-on-one meetings with Dr. Sukeri and their relationship was 'cordial'.
- There was no evidence found to support the allegation that the CEO wanted to 'get rid' of Dr. Sukeri, in fact the opposite was true. Dr. Sukeri admitted their relationship was 'cordial' he called her 'Mama' and she called him 'Bantu'. How he would later claim the CEO wanted to get rid of him is difficult to fathom.
- Dr. Sukeri discharged MCHUs without proper authorisation, this was found by the OHSC investigators, the EC TTT and confirmed by ECDoH follow up.

- Dr. Sukeri accessed patient's information, photocopied patients' information and conducted research without proper authorisation (Dr. Snombo. Mr. Baart, Mr. Potgieter and Mr. Kobese).
- TPHPRC had shortages of staff with a deteriorating infrastructure over a long time particularly the kitchen.
- Exit interviews provided and analysed did not find that resignations at TPHPRC were related or directly caused by management 'autocracy, dictatorship or intransigence'.
- Furthermore, the death of a patient during the alleged food poisoning outbreak was proven through post mortem findings to be due to natural causes.
- Many of the statements in Dr. Sukeri's complaint were discussed between Dr. Sukeri and Management. Management was convinced that these issues had been'resolved' with Dr. Sukeri but he clearly held a different view.

The Ombud found Dr. Sukeri as a witness 'economical with the truth', evasive to questions, very unreliable at times and duplicitous and in some areasunable to be truthful. He was a passionate but not a credible witness. This was also the finding of the OHSC investigators who spent over 5-hours interviewing him. Like a weather cock his complaint and evidence were inconsistent and appeared to depend on who he spoke to. For a highly educated and senior medical scientist, this troubled the Ombud a great deal.

The Ombud further found:

- *Dr. Sukeri released unverified, false and damaging death statistical information to the public;*
- *Dr. Sukeri committed scientific misconduct/ fraud.*
- *Dr. Sukeri miscalculated his death figures and has since apologised to the National Health Minister and Health Ombud.*
- *The wrong death figures created havoc withseveral unintended consequences such as 'national disrepute, the Life Esidimeni copy-cat phenomenon, loss of trust, irretrievable breakdown of relationship and false public expectations'.*
- *Dr. Sukeri violated patients' confidentiality and dignity.*
- *Dr. Sukeri breached the ECDoH confidentiality clause he signed and the ECDoH Communications Policy.*
- *Dr. Sukeri defied and was insubordinate to Ms. Ngcume, the CEO and the ECDoH policies. He defied the advices of his colleagues in the ECDoH, Drs. Nogela and Matiwane on policy matters.*
- *He discharged several patients without proper authorisation and without the knowledge of the CEO. This was confirmed by the ECDoH follow up study and was in breach of the MHCA. Some have relapsed creating the much-dreaded 'revolving door' and questioned Dr. Sukeri's clinical decisions and judgements.*
- *Dr. Sukeri did not respect his colleagues and did not 'take criticism kindly'. He only wanted his way/s and would do anything to get his 'will be done'.*
- *Dr. Sukeri violated the MCHA and the NHA.*
- *Dr. Sukeri brought disrepute to the nation, to the National Health System and its integrity.*
- *Dr. Sukeri failed in his basic duty of care.*
- *Dr. Sukeri failed to respect, observe and follow all available statutory and easily accessible process of complaints management. He was fully aware of all of these.*

4.25. THE ECDoH

The ECDoH was represented by Drs. TD Mbengashe, Nogela, Mtiwane, Beja, Dr. Dyantyi, former Health MEC and Mr. Kaye, the CFO.The EC department of Health has many laudable plans on glossy paper. However, there was very little evidence that these plans were implemented. There was a huge mismatch or very poor correlation between what was planned, on glossy paper and what was said with great passion on power point presentations and what was implemented in reality on the ground. We heard lots of this during our interviews. In a nutshell we concluded that the ECDoH has no capacity and lacks determination or 'guts' to implement or put plans into action. For example, we heard of the 'Skiet/Skop and Donder' approach to discipline and Consequent Management of staff, from one senior officials from the Department of Specialised Services, but we were never shown or given a single example or any evidence of this. Instead we were informed that the environment in the ECDoH was not yet conducive or ready for this 'Skiet/Skop and Donder' approach. This mismatch needed urgent correction by the Premier, the MEC, the SG and the Special Services Department. The major stumbling block to effective mental health services delivery can be located from the level of the Chief Director Health Services downwards at ECDoH.

Regrettably this correction cannot be done from and with the current staff.

The National Health Department must focus, review and take this function over to avoid further damage and continued poor quality service delivery. The leadership and governance at EDCoH and at TPHPRC are in total disarray and need urgent overhaul. Following the Life Esidimeni Report, the National Minister of Health:

i) Recommendation 9 by the Health Ombud requested the National Health Minister to request the Human Rights Commission to to 'undertake a systematic and systemic review of human rights compliance and possible violations nationally related to Mental Health'. This recommendation was effected and the outcomes and report of this **recommendation were eagerly awaited.**

ii) Appointed teams of senior specialists to visit the 9 Provinces to determine the status of the implementation of the National Mental Health Policy Framework and Strategic Plan 2013-2020. These teams identified several weaknesses within the Provinces. The report was debated at the NHC and the National Health Department has followed the recommendations of the Report with a series of Workshop and interventions. The findings as pertains the ECDoH painted a not so rosy picture that was consistent with the findings of the OHSC investigators and most of the witnesses who testified.

iii) The National Health Minister also followed up with the findings and recommendations of the EC TTT. A progress report was provided **on Item 4.15.1, page 49.**

However, it was too early to assess the full impact of these interventions.

The ECDoH failed to:

- to provide leadership and guidance to the TPHPRC
- when the allegations became public knowledge in the media, money was suddenly found to demolish and renovate the century old seclusion rooms at TPHPRC. Which begs the question why were the seclusion rooms left to deteriorate over such a long time when funds could be made readily available? This can be interpreted as a default response and damage control by the ECDoH provincial management.
- to ensure that the health establishment's infrastructure is adequately maintained and kept in good condition over a long period. There was no tangible evidence to believe otherwise. The challenges of infrastructure including the seclusion rooms and the kitchen have been common knowledge to the ECDoH Infrastructural department. The TPHPRC infrastructure has been neglected over a longperiod of time.
- to establish community-based psychiatric services. In that failure, they have unduly frustrated the process of de-institutionalisation.
- to guide the health establishment regarding how to deal with MHCU's funds. There were no policies/guidelines to this effect.
- The ECDoH Cost Containment Committees have increased the frustration felt by staff and management at TPHPRC due to the strict cost-cutting measures which have affected the delivery of services. These committees increase the turnaround time required for requisition of goods and services.
- The ECDoH has centralised most of the vital components of service delivery in health care settings. This has led to many challenges in respect of the acquisition of goods and services as well as the recruitment of employees.
- The EDCoH Quality Assurance office failed to provide support to the health establishment in terms of complaints management, Adverse events and Infection Prevention and Control. There was no support from the province. Dr. Beja is the head of Quality Assurance and Infection Prevention and Control in the province. The TPHPRC has been severely neglected by Dr. Beja's office.
- The ECDoH Asset Disposal Committee failed to ensure that the old laundry and kitchen equipment is speedily dealt with to procure new equipment that will enhance service delivery.
- The Directorate of Specialised Services failed to assist and support the CEO in relation to the challenges that were faced by the TPHPRC over a long time period of time.
- There is no evidence to suggest that mental health care users that have been admitted at TPHPRC for more than 8 years will be de-institutionalised to free up much-needed beds for acute psychiatric patients. The unavailability of community based psychiatric services hindered the freeing up of much needed acute psychiatric beds.

- The ECDoH failed to ensure that the health establishment data integrity was maintained. There is no visible support from the DHIS provincial office. There was no mention of a skills development plan to empower the available data capturer and information officer at TPHPRC (Health Metrics Network 2008).

- Some of these above findings from the OHSC investigators and the Ombud are confirmed through findings and recommendations of an NHC-discussed document on 'Report on the visits conducted in all nine (9) provinces during May 2017 to determine the status of the implementation of the National Mental Health Policy Framework and Strategic Plan 2013-2020' and some of the recommendations of the MHRB (Central Region).

4.26. TPHPCR

Tower Hospital was represented by Ms. Ngcume, Mr. Baart, Dr. Snombo, 3 Middle Managers, 3 Social Workers and 3 Labour Union leaders.

Ms. NE Ngcume, the CEO

- Failed to make her expectations of Dr. Sukeri clear. This is mainly because the facility needed his services to function as a psychiatric institution. He was highly valued and respected, and the management feared to lose his services, so the CEO did not follow through the letter of the law and treated him with "kid gloves". Dr. Sukeri used to call the CEO "Mama". Dr. Sukeri was called "Bantu". She was 'blackmailed'.

- The CEO came through as a credible witness. She is a very highly qualified experienced professional highly respected by her staff and people in the ECDoH Provincial Office. There was no evidence found that the CEO was a micro-manager and dictatorial in her managerial style and leadership role.

- Because of the close relationship that the CEO and Dr. Sukeri shared, the lines of authority were blurred. Boundaries were not set, and this led to Dr. Sukeri not recognising the CEO as his manager.

- She failed to escalate Dr. Sukeri's concerns because she did not recognise them as complaints. Most of these concerns were discussed during management meetings or handover meetings, and they ended up in heated debates but were not formal complaints. The CEO was aware of the existence of the Ombud office in the Eastern Cape, *Advocate G Maxakato.*

- There were no consequence management for staff that acted either unprofessionally or violated policy/procedures. There was a dereliction of duty on the CEO's part (it was alleged that there were employees at TPHPRC who stole equipment, came on duty late and some of them drunk).

- The CEO was not proactive enough in dealing with the concerns that Dr. Sukeri had raised even if there was no written complaint. Dr. Sukeri alleged that he raised the issues verbally on several occasions.

- The CEO complied with the internal policy of the institution when she gave permission for the patient's fund to be used for renovating the doctor's accommodation and other patient related expenses. The internal policy was not in line with the PMFA.

- Failed to take the responsibility to ensure that Dr. Sukeri was disciplined for discharging mental health care users without the appropriate legal documentation required to be signed off by the head of the health establishment.

- Failed to discipline Dr. Snombo for certifying the death of a MHCU telephonically.

- There were poor conflict resolution, problem analysis and significant leadership challenges.

4.27. The MHRB (Central Region)

Following their own independent investigation of Dr. Sukeri's complaint the MHRB made following:

- Could not find direct interference with clinical decisions as alleged by Dr. Sukeri;

- Failed to understand why Dr. Sukeri did not follow the correct procedures to deal with these issues;

- Could not find proof that management interfered with clinical records;

- There were no corrupt activities and the hospital complied with the PFMA;

- Could not conclude that patient's rights were violated;

- There was adequate food and clothing;

- Under oath expressed their anger that Dr. Sukeri could speak so despairingly of them to different stakeholders;

- The MHRB (Central Region) was informed by Ms. Cikiswa Ngxesha, the PA to the CEO that *'Dr. Sukeri had many one-on-one consultations with the CEO through her.*

Chapter 5

CHAPTER 5: RECOMMENDATIONS

These recommendations are derived from the distillation of findings of the OHSC investigators, the MHRB (Central Region), the Director of Complaints Centre and Assessment and the consolidated analysis of the findings of the Health Ombud. They are written to improve mental health services provision in the EC; to protect MCHUs, to protect the National Health System and the professionals within the system. They also underscore the importance of tried and tested processes in addressing complaints. The outcome of an idea, a solution or a question is as good as the process/es followed to pursue it.

The recommendations fall into 3 categories: National, Provincial (ECDoH) and Institutional (TPHPRC).

5.1. NATIONAL

5.1.1. The National Health Minister must evoke the appropriate and relevant Sections of the Constitution to appoint an Administrator with respect to Mental Health Services in the ECDoH. This must be done within 90 working days through the appointment of an Administrator.

5.1.2 This complaint has re-emphasised the urgent need to review the NHA 2003 and MHCA 2002 that took away the powers of the President, the National Minister of Health and Magistrates in addressing issues of Mental Health nationally. Locating Mental Health Services at the Provincial sphere of government in the so called 'concurrent competence' has created difficulties rather than solutions to Mental Health Care Service. This competency must revert back to the National Health Minister (Health Ombud Report page 54-55 item 14).

5.1.3. The appointed senior health official/ Administrator in 5.1.1, must specifically address and ensure the following:

- The ECDoH to correct all the systemic failures identified in this report; these include systemic failures in implementation of mental health care policy and delivery of quality mental health care services over long periods at Head Office from Directorate level, through to Chief Director, DDG and SG level; the competencies and the phenomenon of staff 'resting on broken laurels' must be investigated and reviewed as priorities;

- Consequence Management be an inherent part of this new culture i.e. starting with officials who have presided over the current serious inadequacies in mental health care services across EC must be held to account with appropriate sanctions; these many failures have gone on for too long at the cost of untold sufferings of MCHUs;

- A Directorate of Mental Health and Substance Abuse as recommended by the current National Mental Health Policy Framework and Strategic Plan (2012-2020) be established, to be headed by a Director with the necessary skills level to oversee implementation of policy and delivery of mental health care services. This Directorate must work hand in hand with the Department of Social Development to ensure delivery of both mental health services and preventative and treatment interventions for substance abuse.

- ECDoH urgently addresses the current serious mental health care service challenges: Human Resource shortages brought about by e.g. dismantling of existing multidisciplinary teams, sudden decisions to close services in or chronic under-resourcing of mental health services in community psychiatric services, general hospitals and psychiatric hospitals. Recently reviewed ECDoH organograms must be adequately populated with enough specialist psychiatrists, clinical psychologists, social workers and occupational psychiatrists in terms of numbers and academic and clinical skills in order to meet both service delivery and training needs;

- Must engage and address the important issues raised in Dr. Mo Nagdee's email. This recommendation will automatically address the so-called 'Power Struggles' or the 'crusade for change'.

5.1.4. Dr. Sukeri should be reported to the HPCSA as a matter of urgency for serious professional misconduct and violations of 'codes' of health practice identified in the report. The rationale for the recommendation is:

- Dr. Sukeri violated the confidentiality of patients and by so doing their dignity.

- He violated his confidentiality clause signed in his contracts.

- He failed in his duty of care as a professional.

- He violated the MHCA.

- He discharged patients without proper authorisation and without following the MHCA.

- He was found to be untruthful.

- He created an irretrievable loss of trust and confidence.

- He is jointly responsible for creating a toxic working environment in which to care for vulnerable patients.

- It is the Ombud's role to protect the integrity of the health system and of users against abuse.

- The unnecessary reputational damage to the National Health System and its integrity.

- He caused unnecessary reputational damage to innocent staff members, MHCUs and to TPHPRC as an institution and the ECDoH.

The HPCSA should consider the immediate suspension of Dr. Sukeri from any practice pending a process to assess his 'fitness for office' proposed out below, to safeguard the wellbeing of patients, protect him and the integrity of the profession. Disciplinary proceedings must be instituted against Dr. Sukeri in compliance with the Disciplinary Code and Procedure applicable to SMS members in the Public Service. This should follow a fair, transparent and due process.

- Dr. Sukeri should be charged for gross misconduct and incompetence on the basis of the findings in this report especially the violation of patients' confidentiality and for committing what amounted to scientific misconduct.
    - o Consideration must be given that he may need assistance with psychological counselling.

    - o Currently and from all the evidence gathered he is like a 'round peg in a square hole' within TPHPRC and the ECDoH. He has irretrievably broken trust within the TPHPRC and the ECDoH.
- The HPCSA must consider the appointment of a panel of 3 independent members, Chaired, by a senior Psychiatrist to speedily resolve and finalise Dr. Sukeri's 'fitness to hold office', for his professional and ethical violations, broken relationships, misconducts and incompetence. Alternatively, the Minister should *set up a special ad hoc panel to address the 'fitness to hold office' of Dr. Sukeri.*

- Dr. Sukeri must, in addition to making an apology to the National Health Minister and copied to the Health Ombud and sending a correction to the Rapport Ombudsman, should make a public and unconditional apology in writing to the nation, to his peers in psychiatry, to the medical profession, to the staff in TPHPRC and the ECDoH and to the many patients and families whose lives he compromised through peddling false and exaggerated information. He must acknowledge the pain inflicted to many persons and the reputational damage caused. This apology must be widely publicized and accorded the same weight by the media as they have done with the complaint. SASOP must as a professional body take appropriate actions with regards Dr. Sukeri.

5.1.5 The ECDoH, through the offices of the SG and DSS, must go through records, identify and embark on an investigation of all MCHUs discharged by Dr. Sukeri at TPHPRC and make follow up assessment on their wellbeing in order to decide upon the proper future course of action for the discharged MCHUs and for Dr. Sukeri; a preliminary report has been provided which must be completed expeditiously. Dr. Sukeri must bear the full responsibility and consequences of the outcomes of this investigation.

5.1.6. It is suggested that SASOP focuses onto its *raison d'etre* which as a professional body is to serve, guide and develop psychiatrists of the highest order, with high professional *and ethical standards and who respect truth and are truthful.* SASOP has no legal authority to conduct investigations and should resist such temptations to mislead public opinion and the media through the publication of false information on poorly conducted 'investigation' that it had no legal authority to undertake. In similar vein the media should seek expert professionals or equivalent authorities before putting out 'vital statistical information or data' into an unsuspecting public.

5.1.7 While health professionals must 'expose abuse' they should conduct themselves with intgrity, uphold the highest standards of ethics, must be truthful at all times and not violate or perpertrate the very abuses they are trying to expose *i.e. exposure of abuse must not be a cover up or an excuse for professional misconduct or incompetence.*

5.2. PROVINCIAL (ECDoH)

5.2.1. The Department of Specialised Services must:

- develop a provincial mental health policy, through a systematic process of consultation and consensus building with a range of stakeholders.

- develop a provincial mental health information system, integrated with the (DHIS) district health management information system, based on a set of nationally agreed indicators and a minimum data set.

- build community mental health care services that include out patient services (combining general health out patient services in PHC and specialist). These community mental health care services need to be established before downscaling of mental hospitals can proceed.

- conduct and evaluate training programmes for general health staff at PHC level and at all Mental Health Care hospitals in the Eastern Cape.

- develop specialist mental health teams to support PHC staff.

- develop clinical protocols for assessment and interventions at PHC level.

- strengthen the role of the community and family associations in policy development and implementation, as well as the planning and monitoring of services.

The ECDoH Directorate of Specialised Services should develop the above within 12 months

5.2.2. The SG and Health MEC should consider the immediate suspension of **Ms. NE Ngcume,** the CEO from all managerial tasks with immediate effect. Internal disciplinary processes should be instituted against the CEO:

- for neglecting to correct the actions and institute disciplinary measures against Dr. Sukeri Dr. Snombo and Ms. Mali.

- While she has taken some actions, these actions are not commensurate with the violations committed, confirming the failure to address Consequence Management.

- for providing false information and under-reporting the death statistics to the MEC.

- for failing to inculcate the culture of discipline and Consequence Management at TPHPRC.

- failure to safeguard MHCUs death records.

- Ms. NE Ngcume, the CEO must be reported to the Nursing Council for possible disciplinary inquiry.

5.2.3. As almost every witness conceded that there was no Consequence Management within the ECDoH and at TPHPRC facility. Staff could '*steal willy*, staff could and do come late to work and could come drunk to work'. The EC TTT also made this a recommendation that needed to be effected. There was no reason for the Ombud to doubt the sincerity of these compelling evidences. However, it was not tested. No disciplinary processes were instituted, so staff operated with impunity:

- Doctors certify patients on the phone being aware this is a breach of the law and codes of practice (Dr. Snombo).

- Ms. Mali, a Social Worker took a patient's grant money through the patient's SASSA card. This a clear violation and abuse of staff patient relationship and theft.

- Nurses subjected patients to seclusion without Doctors' prescription, this is gross negligence and a violation of the MHCA.

- Closed Circuit TV cameras were not functioning when important violations occurred such as the '*unnatural death of a patient outside his ward and theft of piglets that took place on two occasions*'. *These activities are reminiscent of a pattern of 'inside jobs'*.

- No one has received the 'Skiet/Skop and Donder' disciplinary treatment so enthusiastically spoken upon in relation to Consequence Management by the ECDoH.

- All staff that have been identified to have violated policy and the Mental Health Care Act must be charged immediately and undergo disciplinary inquiry following due processes.

5.2.4. Dr. Snombo

- Internal disciplinary processes should be instituted against Dr. Snombo for failing to correct the actions of a junior doctor (Dr. Nodliwa) and Ms. Mali, the Social Worker.

- her conduct to certify the death telephonically was unethical; she contravened the certification of death policy. The CEO should institute disciplinary measures against Dr. Snombo for contravening the certification of death Policy.

- for contravening the Policy Guideline on Seclusion and Restraint of mental health care users, Dr. Snombo should be reported to the HPCSA.

5.2.5. Mr. V Baart

Internal disciplinary processes should be instituted against Mr. Baart for:

- failure to report to the CEO the risk pertaining to the dysfunctional electronic security system (CCTV).

- failure to enforce compliance to subordinates pertaining to clinical records audit and reporting of deficiencies.

5.2.6. Professional Nurse Mr. Mtsila

Has contravened the scope of professional practice by secluding the MHCU without the prescription of a medical officer, which amounts to gross negligence. Disciplinary measures should be instituted internally. His conduct be reported to the South African Nursing Council. He also violated the ECDoH Communications Policy for which he must be charged.

As a member of NEHAWU facing disciplinary action and breaching the ECDoH Communications Policy, Mr. Mtsila was often conflicted. His evidence should be treated with circumspect.

5.2.7. Social Worker Ms. L Mali

Ms. Mali should be suspended with immediate effect from all duties pending the disciplinary process outcome, in light of the serious nature of the act that she has committed. Her conduct should be reported to her professional body, South African Council for Social Service Profession (SACSSP) and the South African Police Service for possible criminal charges.

INSTITUTIONAL: SPECIFIC TO TOWER HOSPITAL

5.2.8. Seclusion Rooms

- The current seclusion rooms at TPHPRC should not be used until they meet the requirements as specified in the Policy Guidelines on Seclusion and Restraint of Mental Health Care Users.

- All staff members at TPHPRC to be given training on the Policy Guidelines on Seclusion and Restraint of Mental Health Care Users. This training should be facilitated by the Directorate of Specialised services for mental health within 60 working days. This training should be made a compulsory part of induction for all personnel appointed at mental health care institutions.

5.2.9 Patients' Finances

The ECDoH finance directorate must benchmark with other tertiary mental health institutions in the country as to how patient funds are managed. The Provincial Finance Department must provide guidance and support to the TPHPRC management in line with National Treasury Regulations.

5.2.10. Laundry

- Provincial laundry services manager to provide SLA between the hospitals that are assisting TPHPRC with Laundry Services to ensure continuous laundering services within 90 working days.

- The District and Provincial management Asset Management to condemn the current old laundry equipment and expedite the issuing of condemning and destruction certificates. This should be done within the 180 days.

- The ECDoH Human Resources manager must in light of the findings, expedite the appointment of laundry general workers within 180 days.

5.2.11. Food Services

The ECDoH Human Resources manager must create and appoint a registered qualified dietician within 180 working days.

5.2.12. Kitchen

- Fast tracking the appointment of kitchen cleaning staff; minimum of two cleaners within 60 working days. The appointed cleaners should undergo Infection Prevention and Control training within 90 working days of assumption of duty.

- The provincial manager for infrastructure to fast-track the installation of fully equipped handwashing facilities with elbow taps, and must be placed near the food preparation stations within 180 working days.

- Provincial and district Infection Prevention and Control unit must ensure efficient disinfection of the kitchen using appropriate disinfectants; this must be done with immediate effect. Repeat monthly microbiological swabs of the kitchen and food handlers should be done until the results are negative. The results will be shared with the Office of Health Standards Compliance.

- A certificate of acceptability must be displayed in an apparent conspicuous place.

5.2.13. Infrastructure and Maintenance

- The provincial infrastructure manager must visit the health establishment within 30 working days to assess the state of the hospital's infrastructure; this assessment should include the kitchen. The assessment report and plan of action must be made available to the Office of Health Standards Compliance.

- Procurement of a new power supply generator that will supply the main kitchen should be prioritised. This should be procured within 180 working days.

5.2.14. Records Management

- The health establishment management should develop a policy/SOP in line with the National Guideline for Filing, Archiving and Disposal of Patients' Records and related Documents. This guideline should be specific in terms of who and how the information accessed is to be shared with internal and external stakeholders. The current records management staff should be given the appropriate training within 30 days.
- All records that are older than 10 years must be removed from the health establishment and taken for archiving. This should be facilitated by the district and provincial health information officers with immediate effect. National Guideline for Filing, Archiving and Disposal of Patient Records should be adhered to.

5.2.15. New OPD and Acute Unit

The health establishment is not ready to have a new Acute and OPD unit. Challenges that relate to infrastructure, human resources and supply chain management are yet to be dealt with. The project should be put on hold until the ECDoH has dealt adequately with the current situation.

5.2.16. Patients' Discharges

A policy guideline should be developed on how to deal with patients with no relatives that have been admitted for more than ten years and are mentally stable in the absence of community-based mental health services. This policy/guideline should be developed and implemented by the ECDoH within 12 months.

5.2.17. Mental Health Review Board and the Hospital Board

- There should be a collaboration between the hospital board and the newly-appointed MHRB. It is recommended that on a bi-annual basis that the chairpersons of the respective boards meet to discuss hospital issues.
- The hospital board and the MHRB (Central Region) should be involved in the strategic planning process of the institution so that they understand the strategic thrust and focus of the department
- The MHRB (Central Region) should be provided with adequate administrative support.

5.2.18. Adult Education and Training

The ECDoH should undertake to fast tract a memorandum of Agreement/ Service Level Agreement between the ECDoH and the Eastern Cape Department of Education in relation to the AET programme. The agreement should be available within six months.

5.2.19. Social Workers

- The social workers should be provided with mobile phones; this should be done in line with the approved treasury regulations. The procurement of the cellphones should be done within 90 days.
- The limited access to vehicles has impacted adversely on their core service delivery. Two vehicles should be allocated to TPHPRC by the ECDoH Fleet Manager within 90 days. The vehicle must be adequately monitored by the fleet management unit as well as the users of the vehicle.

Chapter 6

CHAPTER 6: CONCLUSIONS

The Health Ombud's investigation into TPHPRC has highlighted significant challenges that were identified beyond the health establishment in the areas of Mental Health Care Service as well as governance issues by ECDoH; there was generally a need for ECDoH to infuse the spirit of accountability in the delivery of mental health care services. There were also glaring shortages of human resource capacity, adequate management, infrastructural challenges, especially inhumane conditions of seclusion rooms.

The centralisation of power, lack of accountability and failure of Consequence Management and many other issues have been put bare.

The allegations made by Dr. Sukeri, could not all be substantiated except for the seclusion rooms. In Setswana, "molaya kgosi wa itaela", this was typically with Dr. Sukeri's 'complaint'. The investigation revealed he was equally culpable and accountable.

The Health Ombud hopes that the recommendations extended will assist the ECDoH to improve the conditions of Mental Health Services at TPHPRC and within the whole province to improve service delivery.

There is a dire need for mental health care services to be overhauled. This must start with the evaluation of leadership and management competencies against the NHA and the National Mental Policy Framework and Strategic Plan 2013-2020. This was sadly found rudimentary at ECDoH. Whatever EcDoH does in future, with regards mental health care services, must comply with the National Policy Framework and Strategic Plan 2013-2020.

Dr. Sukeri's recommendations complemented by Dr. Mo Nagdee's detailed analysis must be taken into consideration as part of the overhaul and revitalization.

Dr. Sukeri's public apology, if done well would go a long way in restoring faith and public confidence in what is undoubtedly a critical institution in the delivery of quality mental health care service in the ECDoH.

Following a detailed analysis and investigation conducted independently by OHSC investigators, MHRB (Central Region), the EC TTT and the Ombud and taking into account Dr. Sukeri's inputs we can safely conclude that there was one unquestionable human rights violation and several isolated incidents of professional misconduct and breaches of laws. *On the basis of the available evidence no Constitutional damages could be sought or justified.*

In future the quality of the complaints must adhere to the highest standards of ethics and professional codes of conduct and that proper internal complaints management process are followed and that statutory bodies are informed timeously. In this way the integrity of the National Health System, its reputation and its staff shall be protected. This will will also safeguard and protect the users.

The Office of the Health Ombud should guard against being used as a battering ram or a licensing office for claims against Health Establishments, the state or health personnel. Ours should be to investigate complaints without fear, favour or prejudice in search of the truth from whomever or wherever it originated.

Advocacy for patients is a well recognised phenomenon within the Health System and is supported fully. However, health professionals must observe and practice the highest ethical standards, must respect the truth and be truthful at all times and advocate with integrity.

There is no place for advocacy through unethical conduct, or through lying or peddling untruths or through disrespect for tried and tested professional complaints processes.

There is no advocacy through bringing disrepute to a profession, to a health system, to a nation and to fellow professionals and other innocent human beings.

REFERENCES

REFERENCES

1. Makgoba, MW., (2017) The Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province. (www.ohsc.org.za).

2. Robertson, L., Makgoba, MW., (2018) Mortality analysis of people with severe mental illness transferred from long-stay hospital to alternative care in the Life Esidimeni tragedy South African Medical Journal. *in press.*

3. Khamker, N., Moola NM., Roos JL., Rheeder P., Profile of mortality patients admitted to Weskoppies Psychiatric Hospital in South Africa over a 5-year period (2001-2005). Afr J Psychiatry (Johannesburg 2010 July: 13 (3): 211-7.

4. Walker ER., Robin EM., Druss BG., (2015) Mortality in Mental Disorders and Global Burden Implications. JAMA Psychiatry 72:334-341.

5. Tac & Section 27. (2013). Death and Dying in the Eastern Cape.

6. Sukeri.K., : https://doi.org/10.4102/sajpsychiatry.v20i2.568.

7. Sukeri.K.,https://www.ajol.info/index.php/sajpsyc/article/viewFile/125054/114587.

8. Sukeri, K., http://dx.doi.org/10.7196/sajp.609.

9. The Alternative Dispute Resolution (ADR) testimonies (published in full in Timeslive 20th March 2018).

10. Report on the visits conducted in all nine (9) provinces during May 2017 to determine the status of the implementation of the National Mental Health Policy Framework and Strategic Plan 2013-2020.

11. The EC TTT Report

12. Medical Records in South Africa: An MPS Guide (2011).

13. Health Metrics Network, Framework and Standards for Country Health Information Systems (2008) World Health Organisation.

Annexures

Tower Psychiatric Hospital and Rehabilitation Centre Annexures

Annexure 1:	Official unsigned letter from Dr. Sukeri to the OHSC
Annexure 1(a):	Ms Venter's Media Article City Press dated 04 March 2018
Annexure 1(b):	Ms Venter's Media Article Rapport dated 04 March 2018
Annexure 1(c):	Dr Mo Nagdee's email
Annexure 2(a):	List of Witnesses interviewed by the OHSC investigators
Annexure 2(b):	List of Witnesses interviewed by the OHO
Annexure 3:	Laboratory Results following allegations of food poisoning
Annexure 4:	Pictures of food and the kitchen
Annexure 5:	Patients Hospital clothing pictures
Annexure 6:	Pictures of the death registers
Annexure 7 :	Seclusion Room Pictures
Annexure 8:	Pest control
Annexure 9:	Infrastructural challenges pictures

Annexure 1: Dr Sukeri's Official (Unsigned) Letter to the National Health Minister and the OHSC

Dr. K Sukeri
20 February 2018

The Honourable Minister of Health
Republic of South Africa
Dr. A Motsoaledi

Sir,
RE: Institutionalised Violations at Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre
As a way of introduction; I am a sessional Psychiatrist employed at the above institution (as of July 2017). I was in full time employ at the same institution from December 2015 to May 2017.

I feel obliged to make you aware of the following institutionalised violations of human rights and other pertinent issues at this institution. There are early signs of some changebutI am not convinced that these are adequate.

1. Basic Human Rights

It is my belief that the Constitutional Rights to dignity and adequate food are being violated. There is no dietitian and meals are not consistent with the National Food Services Unit Policy. My observation is that patients are fed a staple of samp and beans or white samp on most occasions.
At night patients are given a soupy mixture of either chicken livers or tinned pilchards (On the 19/01/18 supper consisted of 24 tins of pilchards, 1 bag of carrots, 2 bags of potatoes, soup and gravy mix for 308 patients). Patients do not receive fruit on a daily basis.
There are no calibrated special diets for patients with diabetes and other medical conditions.
Patients in Clinic A have been bathing in cold water since the last quarter of 2016.
Dignity is compromised by the poor state of hospital clothes, which is often torn and dirty and poorly fitting. Patients in the open ward are not allowed to wear their own clothes.

2. Violation of autonomy and the Mental Health Care Act no.17 of 2002

It is my opinion that users are kept in a highly restrictive environment longer than is clinically acceptable. My clinical decisions to discharge and/or permit leave of absence to mentally stable patients is constantly questioned, irrespective that these decisions were made with a complete multi-disciplinary team. The management of the patient finance account deserves a thorough investigation. I have reason to believe that notes have been fabricated where patients have died.

3. Inadequate Rehabilitation of users

The Occupational Therapy Department has not been able to access the necessary equipment to function. The Adult Education Program (grade 10) has inappropriate patients attending. Although this has been brought to the attention of management, no appropriate steps have been taken to address such issues as patients who have undergraduate qualifications, completed Grade 12, mentally unstable or involved in transactional activities from attending.

4. Human Resources

Since 2016 several staff members have left the institution. These include a Clinical Psychologist, 2 Occupational Therapists, 3 Medical Officers and several professional nurses. The current Clinical Psychologist has handed her resignation this month. A list of staff members who have resigned, retired or transferred should have been submitted to BhishobutIwon't be surprised if this document would have been changed to reflect otherwise.

The Management insists on continuing on their plans for an Out-Patient Department (OPD) and Acute unit despite the staff constraints. Although there are plans to employ four additional medical officers and a full time psychiatrist, this staff complement will not be adequate to meet both acute, chronic and rehabilitative requirements of the institution.

The current Clinical Manager is paid for after hour clinical calls at the institution in addition to her managerial duties. She is never available on weekends, although she is on the call roster. This sets a precedent for other Clinicians. This also impacts on Clinical Governance oversight.

The CEO is dictatorial in her management style, often alienating staff. The CEO lives on site while she rents out her private residence to staff employed at the institution. I suspect that this could possibly be a corrupt situation. I have attempted to bring some of the above issues to the attention of the Management, Department of Specialised Services (Bhisho) and the South African Society of Psychiatrists since 2016. The latest engagement was an onsite meeting with Mr. Nzima (Acting Director of Specialised Services – Bhisho) and Dr.Matiwane to address interference with clinical decision making. Unfortunately this meeting was unsuccessful as the Management continued to insist that their clinical training allows them to interfere in clinical decisions.

I am aware that the CEO wants to remove me from the institution. I have been shut out of clinical and other meetings. Irrespective of this hostile environment I continue to work to protect my patient's rights and access to care. I am acutely aware of my obligations to report violations.

There has to be constructive change at Tower Hospital to improve the conditions of care for our patients. I hope this matter receives your due attention.

I thank you for attention

Regards
Dr. K Sukeri MBChB, FCPsych (SA), PhD

Annexure 1 (a): Ms Venter's Media Article City Press 04 March 2018

The Eastern Cape's ticking psychiatric time bomb
Suzanne Venter 2018-03-04 12:28

The government is facing yet another ticking bomb involving psychiatric patients in an Eastern Cape psychiatric hospital. On Friday a psychiatrist resigned citing the "degrading and inhumane" treatment of patients. Dr Kiran Sukeri, a psychiatrist at the Tower Psychiatric Hospital in Fort Beaufort said he could no longer "remain silent" about the treatment of patients at the institution.

"I know what I'm going to tell you will jeopardise my safety, as well as that of my family, but I don't care. Those patients urgently need to be helped." Sukeri said a far greater number of people have recently died at the hospital than the government is officially admitting. In recent reports in the Eastern Cape daily, The Herald, the Eastern Cape heath department was quoted as saying that 25 patients died at Tower hospital between 2012 and 2017.

Sukeri told City Press' sister newspaper Rapport that the hospital's deaths register recently "disappeared" and was replaced with a new one. He showed Rapport copies of the "lost" register indicating at least 90 patients died at the institution since 2010 and four patients died in January alone. Only two of the four deaths in January were signed off by a medical doctor, he added. Other claims include:

- That some patients are sometimes kept in solitary confinement with just a bucket for a toilet if they become "restless". Psychiatric guidelines stipulate that a patient may never be kept in solitary confinement for more than four hours;
- That a patient who was last month locked up in solitary confinement panicked, wrapped his legs in a sheet and set himself on fire; and
- Medical doctor Theresa Nodliwa was forced to amend the notes she had made on a patient's medical file by hospital CEO Ntombizandile Ngcume and other managerial staff, to make it appear that the patient had been examined twice. Nodliwa has since asked for a transfer and did not want to discuss the matter with Rapport;
- Patients' clothes are tattered, despite a clothing budget of millions of rands;
- Patients have to pay staff a R5 levy per withdrawal from the hospital account, to access the money their families send them; and
- The food patients are served is of poor quality. This includes a sardine stew that is served twice a week. It contains 36 cans of sardines, about one for every 10 patients.

Sukeri said there was no doctor on duty at the hospital on weekends. Last year, he began recommending that patients with serious medical conditions not be sent to Tower because of the lack of specialised medical care. However, Ngcume refused to implement this because the hospital would "get too few patients".

The conditions at Tower Hospital come just 18 months after Rapport wrote about the Life Esidimeni scandal. In his reply to the debate on the state of the nation address last month, President Cyril Ramaphosa apologised for government's handling of the Esidimeni tragedy.

A total of 143 mentally ill patients died after the Gauteng health department sent them to unaccredited non-governmental organizations in an attempt to save money. Sukeri said the government did not seem to have learnt any lessons from Esidemeni. "We've been struggling with the same kind of problems in the Eastern Cape for years. I've been fighting for the rights of psychiatric patients for 12 years," said a tearful Sukeri.

He said more than 20 clinical personnel at Tower Hospital had resigned, asked for transfers or taken early retirement in the past five years. On February 11, Sukeri laid complaints about the hospital's conditions with the health ombudsman, the SA Human Rights Commission and the SA Society of Psychiatrists. As a result, the hospital chief executive told him to vacate his office. Ngcume referred Rapport questions to Sizwe Kupelo, the provincial department of health spokesperson, who said the allegations of a falsified deaths register were untrue and the correct death figure was 63 for the period. Patients died from serious illnesses such as respiratory diseases, heart illnesses, cancer, tuberculosis and HIV.

In respect of the poor quality food, Kupelo said a dietician at the nearby Victoria hospital could help out if the food was not up to standard. Kupelo said the food given to patients every day "is calculated by the food service manager and no complaints were raised on the shortage of food. There are daily reports submitted in a written form indicating whether food was sufficient or not," he said. Kupelo supplied account statements to Rapport showing the purchase of vegetables and other food items.

"The institution followed the provincial menu ... The menu provides for users with special needs e.g. vegetarian and those who eat meat. Patients who buy from supermarkets buy snacks as a form of treats not due to starvation. On a monthly basis users attend occupational therapy, are given opportunities for outings, and do shopping at Spar and other shops. The institution has never had challenge of food fortunately. We utilise food contracts which makes it easy for us to have food available all times."

Kupelo said the clothing budget for 2017/2019 was R2.7 million of which R1.2 million had been spent.
"The institution has a three-year contract for patient clothing and linen. The hospital is facing no challenges relating to patient clothing and linen. We have a clothing and linen bank system to control the flow of clothing between the wards and laundry. It is totally not true that the current status of patients clothing is unacceptable," Kupelo said.

Kupelo said the reason patients paid an R5 levy when withdrawing cash was because deposits into the hospital accounts cost the department R12.95 and withdrawals cost R11.95.

Professor Zukiswa Zingela, president of the South African Society of Psychiatrists in the Eastern Cape, said Sukeri's complaints had been received and would be investigated.

With regards to the death register, Kupelo said: "A new register was developed following the sudden disappearance of the old register. The stolen register was miraculously found in the matron's office on Tuesday 27 February 2018. It is now clear that there are elements within the hospital who are hellbent on causing disruptions within the service. We suspect the same person who reported this information kept the old death register to him/herself is behind the malicious allegations against the institution. The report of 90 deaths during that period is incorrect. There are 63 deaths documented in our register during that period." Kupelo said Dr Sukeri "has a tendency of defying authority and continues to discharge patients outside protocols".

Annexure 1 (b): Ms Venter's Media Article Rapport 04 March 2018

Posted on March 5, 2018 Leave a comment
Hospitaal van gruwels – Tower- psigiatriese hospitaal in Fort Beaufort, Oos-Kaap

Psigiatriese pasiënte is weer op skokkende wyse deur die regering versaak skaars 18 maande nadat Rapport die volle omvang van die Life Esidimeni-ramp geopenbaar het waarin 144 pasiënte dood is.

Die ingang na die Tower- psigiatriese hospitaal word streng bewaak en Rapport is toegang geweier. Die "haglike en onmenslike" manier waarop pasiënte in 'n Oos-Kaapse staatshospitaal behandel word, het Vrydag gelei tot die bedanking van 'n psigiater daar omdat hy "net nie meer kan stilbly" nie. Dr. Kiran Sukeri, 'n psigiater by die Tower- psigiatriese hospitaal in Fort Beaufort, 85 km noord van Grahamstad, sê die Suid-Afrikaanse Psigiatriese Vereniging (Sasop) en die gesondheidsombudsman moet dringend die toestande by dié inrigting, die langtermyntuiste van 323 psigiatriese pasiënte, ondersoek. 'n Baie emosionele Sukeri het die afgelope week, enkele ure voordat hy sy bedanking ingedien het, sy hart teenoor Rapport oopgemaak.

"Ek weet die onthullings wat ek maak gaan die veiligheid van myself en my familie in die gedrang bring, maar ek gee nie om nie. Hierdie pasiënte moet dringend gehelp word," sê hy. Sukeri beweer onder meer dat:

Die sterftesyfer by die hospitaal baie hoër is as wat amptelik gesê word. In die Oos-Kaapse dagblad The Herald het die Oos-Kaapse gesondheidsdepartement te kenne gegee dat 25 pasiënte by die Tower-hospitaal tussen 2012 en 2017 gesterf het. Ek veg al 12 jaar lank vir die regte van pa¬siënte en kan nie langer stilbly nie.

Sukeri beweer egter dat die sterfteregister by die hospitaal onlangs "verdwyn" het en vervang is met 'n nuwe een. Hy het aan Rapport afskrifte van die "verlore" register gewys wat toon dat daar in Januarie alleen vier pasiënte dood is. Luidens dié register is daar sedert 2010 reeds 90 pasiënte dood. Volgens Sukeri is net twee van die vier sterftes in Januarie deur 'n dokter afgeteken. Dat pasiënte meer ure en soms selfs oornag in eensame aanhouding in haglike kamers met slegs 'n toiletemmer opgesluit word as hulle "oproerig" is.

Psigiatriese riglyne bepaal dat pa¬siënte nooit vir langer as vier uur in afsondering toegesluit mag word nie en slegs in 'n kamer waar daar ordentlike toiletgeriewe is; Dat 'n pasiënt wat verlede maand in afsondering opgesluit was paniekerig geraak het, 'n laken om sy bene gedraai en homself aan die brand gesteek het. Hy het ernstige brandwonde aan sy bene opgedoen; Dat dr. Theresa Nodliwa deur die uitvoerende hoof gedwing is om aantekeninge op 'n pasiënt se lêer te wysig om te sê dat sy die betrokke pasiënt twee keer ondersoek het terwyl dit nooit gebeur het nie. Nodliwa het intussen gevra vir 'n oorplasing na Limpopo en wou nie die voorval met Rapport bespreek nie.

Dat daar geen dokter oor naweke aan diens is by die hospitaal nie. Sukeri sê hy het verlede jaar reeds aanbeveel dat pasiënte met ernstige mediese toestande nie na Tower gestuur moet word nie weens die gebrek aan gespesialiseerde mediese sorg, maar die hoof van die hospitaal, Ntombizandile Ngcume, het geweier omdat die hospitaal "te min pasiënte sou kry".

Pasiënte se klere is gehawend en vol gate ondanks 'n klerebegroting wat miljoene beloop;

Dat pasiënte 'n "heffing" van R5 aan personeel moet betaal elke keer as hulle geld wat hul familie vir hulle in 'n hospitaalrekening betaal, wil onttrek. Die kos wat pasiënte kry van skokkende gehalte is.
Dit sluit 'n sardynebredie in wat twee keer per week voorgesit word en waarvan die hoofbestanddeel 36 blikkies sardyne is – sowat een blikkie sardyne vir elke tien pasiënte. Die jongste onthullings kom terwyl die Esidimeni-skandaal steeds woed.

Pres. Cyril Ramaphosa het verlede maand in die repliek op sy staatsrede om verskoning gevra vir die regering se hantering van die skandaal, waartydens 144 pasiënte volgens 'n polisie-ondersoek dood is nadat die Gautengse departement van gesondheid hulle – in 'n poging om geld te bespaar – na ongeregistreerde fasiliteite gestuur het.

Uit Sukeri se onthullings is dit egter duidelik dat die departement niks uit die Esidimeni-skandaal geleer het nie. "Terwyl die hele land aangegryp is deur die Life Esidimeni-ramp in Gauteng sukkel ons al jare met soortgelyke probleme hier in die Oos-Kaap.

"Ek veg al 12 jaar lank vir die regte van psigiatriese pasiënte en kan nie langer stilbly nie," het Sukeri, wat by tye so emosioneel was dat die trane oor sy wange geloop het, die afgelope week aan Rapport gesê.

Hoewel die hospitaal 'n begroting van amper R3 miljoen het om klere vir pasiënte te koop, loop almal in gehawende klere rond. Hy sê meer as 20 kliniese personeel by die Tower-hospitaal het die afgelope vyf jaar bedank, gevra vir verplasings of vroeër afgetree, hoofsaaklik weens die haglike omstandighede waarin hulle moet werk.

Sukeri het al op 11 Februarie 'n dokument met klagtes en besonderhede van die misdrywe by die hospitaal aan die gesondheidsombudsman, die Suid-Afrikaanse Menseregtekommissie en Sasop gestuur. Sukeri sê ná sy klagtes is hy Vrydagoggend ingeroep vir 'n dringende vergadering met Ngcume waar hy uitgetrap is en opdrag gegee is om sy kantoor te ontruim.

Nadat hy haar gevra het of hy nou "onder 'n boom moet werk", het hy bedank.
"Ek kan nie meer nie.
"Al wat ek wil hê is dat die pasiënte beter behandeling moet kry en gehelp moet word.
"Hulle regte word verkrag en dis 'n baie toksiese omgewing. Geen mens kan so werk nie."

Pasiënte word gereeld vir lang tye in die kamers vir afsondering toegesluit. Die kamers het nie toilette nie. Rapport het die hospitaal – omring deur hoë draadheinings en met veiligheidswagte by die hek – Donderdag besoek, maar is toegang geweier.

Ngcume het alle klagtes en navrae verwys na Sizwe Kupelo, die woordvoerder van die Oos-Kaapse departement van gesondheid. Kupelo sê die aantygings oor 'n vervalste sterfregister is onwaar.
Die korrekte syfer is 63. Hy het wel toegegee dat baie pasiënte by Tower sterf aan ernstige toestande soos lugwegsiektes, hartsiektes, kanker, tuberkulose en MIV.

Oor die swak kos sê Kupelo dat daar 'n dieetkundige by die naburige Victoria-hospitaal is wat kan help as die kos nie op peil is nie. Sukeri sê dis vir hom nuus.

Volgens Kupelo is die klerebegroting vir 2017-'19 R2,7 miljoen waarvan meer as R1,2 miljoen reeds bestee is. Hy het nie verduidelik waarom pasiënte se klere so oud en vol gate is met so 'n reusagtige begroting nie.

Kupelo erken dat pasiënte 'n R5-heffing moet betaal op kontantonttrekkings, maar sê dis baie billik omdat die familie se inbetalings in die hospitaal-rekening die departement R12,95 kos en onttrekkings R11,95.

Prof. Zukiswa Zingela, president van Sasop in die Oos-Kaap, sê hulle het Sukeri se "ernstige klagtes" ontvang en gesê dit word ondersoek.
Deur: Rapport

Annexure 1 (c): Dr. Mo Nagdee's email
From: Mo Nagdee

Sent: 09 February 2018 09:07 AM
To: Brian Nzima
Subject: Re: Request Panelist for Tower Hospital

Dear Mr Nzima,

I have little doubt that you are genuine in your quest to improve matters and appreciate this. Nonetheless, the situation at present in my personal opinion, is as follows (there are many evidence-based examples to back this up of course):

1. The vast majority of specialist psychiatrists in the EC have lost confidence in, and frankly respect for, the DSS and the ECDOH Head Office as a result of years of ineptitude, broken promises, inaction, indifference and hostility we have experienced in various settings, hospitals and regions. Most of us have little doubt that matters have deteriorated and that, far from making progress, we have in fact regressed in the ECDOH over the past few years.

2. There cannot be any "regaining of momentum" for as long as the DSS and ECDOH fail to proactively make genuine efforts to win back the trust and respect you have lost.

3. This process can perhaps begin in the first instance by the simplest of professional etiquette on the part of the ECDOH e.g.

   - Treat specialists with respect and not simply as subordinates/employees. Value their expertise and experience and demonstrate that appreciation accordingly.

   - Cease issuing unilateral "invitations" expecting attendance at meetings at short notice without first consulting with specialists re: their availability. We have full time jobs, and our first priority is our patients, rather than yet another talk shop at which little is achieved. A "top down" approach is unlikely to be met with a productive response from specialists.

   - Include all specialists in your correspondence and invitations.

   - Acknowledge receipt of correspondence, and demonstrate addressing of matters, or at least real plans to do so, with realistic timelines. We understand resource constraints and the dysfunctionality of the broader system in which we all operate etc, but that does not mean that requests, emails, letters, motivations, suggestions, etc from senior specialists and clinical staff should simply be ignored. This contributes immensely to a breakdown in trust and respect.

   - Communicate with us in an open, honest and transparent manner. This has not been the case for a long time now.

   - Acknowledge that we are mutually accountable to each other and hold us and yourselves accountable accordingly. In the same light, provide sufficient and necessary support to specialists who require it e.g. in the context of hostile hospital managers.

   - Examine and scrutinize why so many specialists are fed up and have left the EC state sector of late. Formulate a recruitment and retention strategy that addresses these. Any decent mental health service simply cannot be provided without sufficient specialist psychiatrists and MDT personnel.

4. Establishing a Mental Health Advisory Committee would be welcome, but only if you create an atmosphere of genuine mutual trust, respect and accountability. What needs to be done to improve matters and mental health services is actually pretty obvious and clear - we have many documents, plans, policies etc that spell this out already. What we require on the part of the ECDOH is action not more chatter in the form of endless rounds of meetings, workshops, etc. Unless this is the case, I have little doubt that such a Committee will be yet another dead-end exercise.

Whilst I appreciate you may not necessarily agree with these views, I trust they are received in the spirit they are intended.

Regards,
Mo Nagdee
Head: Clinical Department, Fort England Hospital, Grahamstown
Associate Professor: Psychiatry, WSU
Clinical Associate: Psychology, Rhodes

Annexure 2 (a): List of Witnesses interviewed by the OHSC investigators

	Name	Designation	Date Interviewed
1.	Dr Kiran Sukeri	Complainant	2018/04/17 (1st session) 2018/05/10 (2nd session)
2.	Ms N Ngcume	Chief Executive Officer	2018/05/10
3.	Dr N Snombo	Clinical Manager	2018/05/09
4.	Ms J Ntsaluba	Quality Assurance Manager	2018/04/19
5.	Mr V Baart	Nursing Services Manager	2018/05/09
6.	Mr H Potgieter	Middle Manager	2018/04/17
7.	Mr CCS Wilson	Chief Artisan	2018/04/17
8.	Ms NE Tokwe	Infection Prevention Coordinator	2018/04/19
9.	Ms L Chowles	Stores manager	2018/05/08
10.	Ms A Ntshotho	Information Officer	2018/04/17
11.	Ms C Kahlana	Data Capturer	2018/04/17
12.	Ms N Mafani	Human Resources Manager	2018/05/08
13.	Ms M Mahleza	Occupational Health and Safety Officer	2018/04/16
14.	Ms A Kwaza	Food Services Manager	2018/04/16
15.	Ms S Smith	Occupational Therapist	2018/04/17
16.	Ms Liwane	Finance Manager	2018/05/08
17.	Ms R Zono	Hospital Board Member (Deputy Chairperson)	2018/05/07
18.	Mr. M Tshona	Hospital board member	2018/04/17
19.	Ms T Leve	AET Educator	2018/04/17
20.	Ms T Mbiko	AET Educator	2018/04/17
21.	Ms N Magoqwana	AET Educator	2018/04/17
22.	Ms Z Kom	AET Educator	2018/04/17
23.	Ms. S Ndzena	AET Lecturer	2018/04/17

Annexure 2 (b): List of Witnesses interviewed by the OHO

PROGRAMME FOR INTERVIEWS			
DAY 1: TUESDAY, 05 JUNE 2018			
	NAME	DESIGNATION	INSTITUTION
1.	Adv G Maxakato	Former Eastern Cape Ombudsman, and current Senior Manager: Legal Services	ECDOH
2.	Dr Kiran Sukeri	Complainant & Head of Psychiatry	Tower Hospital
3.	Ms N Ngcume	Chief Executive Officer	Tower Hospital
4.	Sr J Ntsaluba	Quality Assurance Manager	Tower Hospital
5.	Mrs N Mafani	Quality Assurance Manager	Tower Hospital
6.	Mr Hendrik Potgieter	Middle Manager	Tower Hospital
7.	Dr N Snombo	HR Manager	Tower Hospital
8.	Mr VL Baart	Infection Prevention Coordinator	Tower Hospital
9.	Mr EK Tom	Middle Manager Admin	Tower Hospital
10.	Dr T Nogela	Information Officer	ECDOH

DAY 2: WEDNESDAY, 06 JUNE 2018			
	NAME	DESIGNATION	INSTITUTION
1.	Dr NP Mafuya	Former Chairperson of the Eastern Region	MHRB
2.	Mr NC Zantsi	Former and Current Member of the Central Review Board	MHRB
3.	Mrs PM Du Preez	Former Chairperson of the Western Review Board	MHRB
4.	Mr Mdledle	Former and Current Member of the Central Review Board	MHRB
5.	Ms S Njezula	Current Chairperson of the Eastern Region	MHRB
6.	Dr TD Mbengashe	Head of Department	ECDOH
7.	Ms SM Smith	Occupational Therapist	Tower Hospital
8.	Ms PMakeleni	Occupational Therapist	Tower Hospital
9.	Prof ZZingela	Eastern Cape Chair	SASOP
10.	Dr T Seshoka	Eastern Cape Public Sector Convenor	SASOP

DAY 3: THURSDAY, 07 JUNE 2018			
	NAME	DESIGNATION	INSTITUTION
1.	Mr CCS Wilson	PSA: Union Representative	Tower Hospital
2.	Mr X Mtsila	Nehawu: Union Representative	Tower Hospital
3.	Ms K Mathanga	Denosa: Union Representative	Tower Hospital
4.	Mrs N Mavuso	Deputy Director General: HR & Corporate Services	ECDOH
5.	Dr P Maduna	Deputy Director General: ClinicalManagement	ECDOH
6.	Mr S Kaye	Chief Financial Officer	ECDOH
7.	Ms MV Petshwa	Social Worker	Tower Hospital
8.	Ms L Mali	Social Worker	Tower Hospital
9.	Dr ML Matiwane	General Manager: Hospital Services	ECDOH
10.	Ms VP Fejela	Social Worker	Tower Hospital
11.	Dr PP Dyantyi	Former MEC for Health	ECDOH
12.	Dr S Beja	Chief Director: Quality Healthcare Assurance Systems	ECDOH

DAY 3: THURSDAY, 07 JUNE 2018			
	NAME	**DESIGNATION**	**INSTITUTION**
1.	Mr MTC Bobotyana	Former Chairperson of the Central Review Board	MHRB
2.	Ms N Ngcume (Re-examination)	Chief Executive Officer	Tower Hospital
3.	Mr VL Baart (Re-examination)	Nursing Service Manager	Tower Hospital
4.	Ms AP Mfefe	Social Worker	Tower Hospital
TOTAL:	**Interviewees: 34** **Re-examination: 2** **Interviews Conducted: 36** **Time Recorded: 25:48:36**		

NATIONAL HEALTH LABORATORY SERVICE

EAST LONDON LABORATORY
Amalinda Drive, East London, EC, 5201
Fax: 043 743 3001

Practice Number 5200296 pg 1 of 1

FULL FINAL LABORATORY REPORT

PATIENT: LAB NUMBER: TD 02542116 REPORT TO:

Tower Hospital COOKED CHICKEN LIVERS

DOB not stated Sex	Sample Ref: F1	NOLUTHANDO MANELI
ADM	Collected: 20/05/2018 ?	No ward
3-33 Phillip Frame Rd	Received: 23/05/2018 12:46	EH Amatola District Municipali
Chiselhurst	1st Print: 31/05/2018 16:35	PO Box 320
Eastern Cape	Reprint: 04/06/2018 15:45	East London
5247		Eastern Cape
		5200

Patient Location: EH Amatola District Municipality

FOR ENQUIRIES AND FOLLOW-UP TESTS, PLEASE QUOTE PATIENT'S MRN NUMBER MRN84190366

MICROBIOLOGY
Tel: 043 701 6001

Tests requested: PCR L monocytogenes #
Test referred to another laboratory

Molecular Microbiology:

PCR for Listeria monocytogenes:
Listeria monocytogenes PCR result Negative

PCR L monocytogenes performed at Charlotte Maxeke Infection Control Laboratory
(Tel 011 489 8579)

Authorised by: D Schnugh (Medical Scientist) PCR L monocytogenes

NATIONAL HEALTH LABORATORY SERVICE

EAST LONDON LABORATORY
Amalinda Drive, East London, EC, 5201
Fax: 043 743 1051

Practice Number 5200296

pg 2 of 3

Tower Hospital COOKED CHICKEN LIVERS
EH Amatole District Municipality

LAB NO: TD 02542116 04/04/2018 11:45

PUBLIC HEALTH
Tel: 043 701 4001

Specimen received: Food
Tests requested: Food Investigation #
Test referred to another laboratory

Food:

Aerobic Bacterial count	190000	cfu per g
Total coliform count	<10	cfu per g
Escherichia coli	Absent in 1g/ml	
Salmonella species	Absent in 25g	
Shigella species	Absent in 25g	
E.coli 0157	Absent in 25g	
Clostridium perfringens	<10 cfu/g	
Presumptive Bacillus cereus	<100 cfu/g	
Coagulase positive Staphylococci	<20 cfu/g	
Campylobacter species	Absent in 25g	
Yersinia enterocolitica	Absent in 25g	
Yeasts	<10 cfu/g	
Moulds	<10 cfu/g	

Method(s) used: [illegible]

The above test result relates only to the item/sample as received

REFERENCE METHOD(S):
Total Viable Colony Count - Petrifilm Method......Petrifilm ISO 4833
Coliform Count - Petrifilm Method.................Petrifilm ISO 4831
E.coli Count - Petrifilm Method...................Petrifilm ISO 16649-2
Salmonella Isolation and Detection Methods......GPL 2826
Clostridium perfringens Enumeration Method........ISO 7937
Bacillus cereus Enumeration Method................ISO 7932
S.aureus Enumeration Method.......................ISO 6888-1

Food investigation performed at Charlotte Maxeke Infection Control Laboratory (Tel 011 489 8579)

Butternut, Apples, Potatoes and Bananas

Fresh produce

Frozen red meat and buttered Hake portions

Lucky Star Pilchards

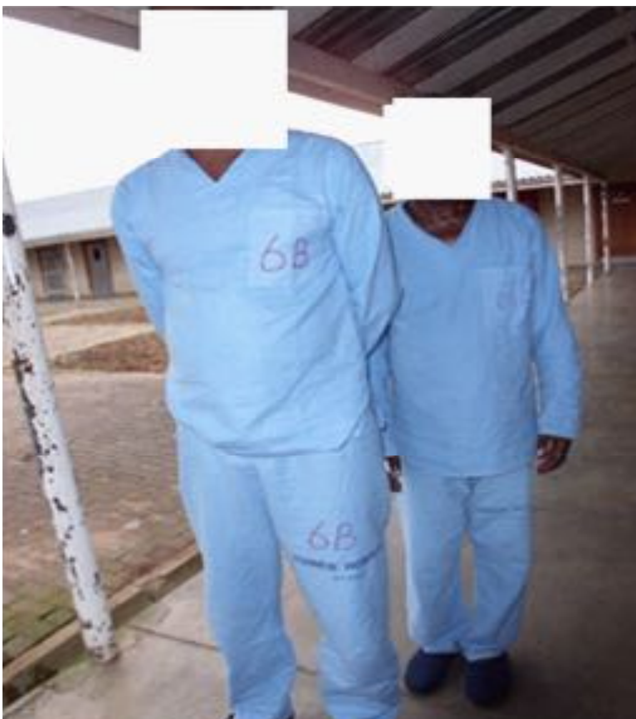
Weet-Bix

Maize Meal

Sample of food served for lunch on the day

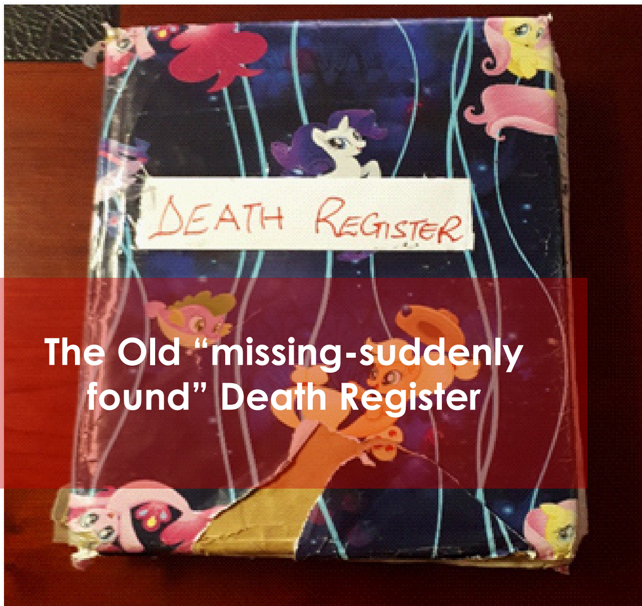
Joko tea bags and Weet-Bix

Annexure 5: Patient Clothing Pictures



Neatly packed tracksuits and pyjamas

Annexure 6: Pictures of the Death Registers

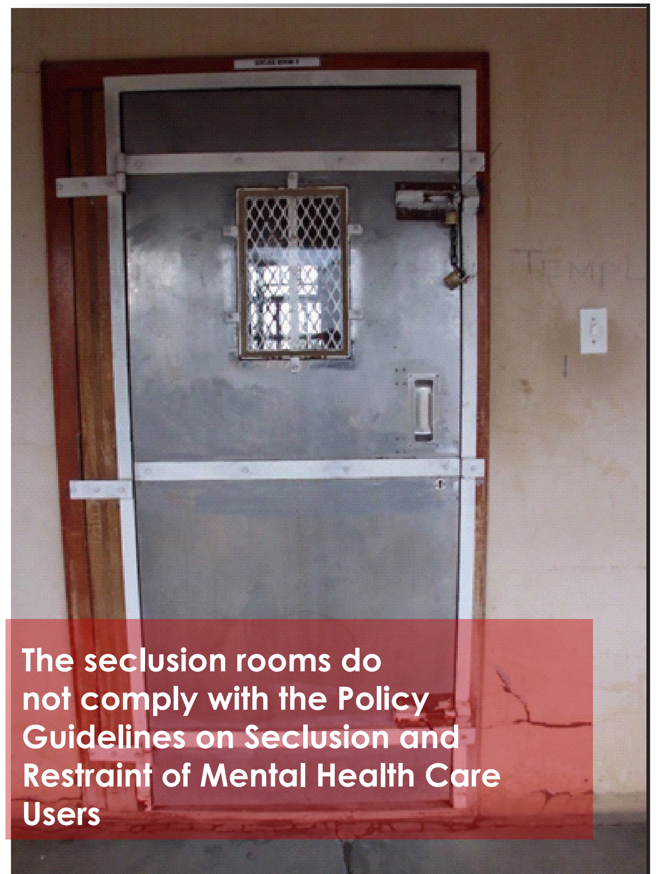


The Old "missing-suddenly found" Death Register

The 2nd Death Register

Annexure 7: Seclusion Pictures

Seclusion rooms far from nurse's station


The seclusion rooms do not comply with the Policy Guidelines on Seclusion and Restraint of Mental Health Care Users

No ablution facilities inside

Annexure 8: Poor Pest Control

Annexure 9: Pictures Reflecting Infrastructural Challenges

Ceiling damaged from leaking roof

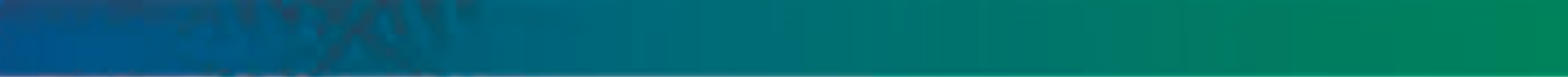
Broken drainage pipes and blocked drain at the main kitchen

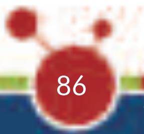
Cracked wall outside OT workshop

Rising damp on walls

Broken tap, blocked drain and tiles peeling from the wall in the OT department

Broken Toilet in OT Department





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25d, 44m, 15.8s; East 28d, 12m, 00.1s