



# South African Society of Psychiatrists

Unit 16, Northcliff Office Park, 203 Beyers Naude Drive, Northcliff, 2115  
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PO Box 2127, Cresta, 2118  
Registration No.: 2007/012757/08

## REPORT ON THE INVESTIGATION OF THE CONCERNS ABOUT INSTITUTIONAL AND PATIENT RIGHTS VIOLATIONS AT TOWER HOSPITAL (TH) AS SUBMITTED BY DR KIRAN SUKERI

<b>Initiating Organization</b>	South African Society of Psychiatrists (SASOP)																				
<b>Other supporting organizations present</b>	Treatment Action Campaign (TAC) Members of South African Federation of Mental Health: PE Mental Health Society (MHS) and Rehab EL																				
<b>Liaison with EC Department of Health</b>	Access to institution arranged by EC SASOP Subgroup through the office of Superintendent General for Health, Dr T Mbengashe																				
<b>Authors of report</b>	Zuksiwa Zingela Thupana Seshoka Bernard Janse van Rensburg																				
<b>Reasons for the investigation</b>	Following reports by Dr Sukeri and media reports, the investigation was conducted on behalf of SASOP in its role of advocacy and serving the community																				
<b>Sources of information</b>	1. Dr Kiran Sukeri's list of allegations about the conditions in TH 2. Interviews held on site by the visiting panel with the Tower Hospital team during Session 1, 2 and 3 of the visit (Addendum 1) 3. Documents shown to the visiting panel include the 2 death registers, an unsigned Admission Criteria Guideline, the Tower Discharge Procedure 4. Photos of seclusion rooms and other areas inspected in Hospital, (Addendum 3)																				
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<b>Date of Visit to TH</b>	6 March 2018 (10h00 to 16h00)	
<b>Attendance</b>		
<b>Organization</b>	<b>Attendee</b>	<b>Position</b>
<b>SASOP</b>	Prof Z Zingela (ZZ) Dr T Seshoka (TS) Prof B Janse van Rensburg (BVR)	SASOP EC Chairperson SASOP EC Public Sector Convenor SASOP National President
<b>TAC</b>	Mr Noloyiso Ntamehlo (NN) Ms Siyabulela Mulisi (SM) Ms Thandeka Hlongwane (TH)	TAC Coordinator TAC TAC
<b>MHS</b>	Ms Merle Blunden (MB)	PE Mental Health Society
<b>REHAB EL</b>	Ms Busisiwe Ntloko (BN)	Director
<b>TH Senior Management Team</b>	Mrs Ngcume (CEO) Dr N Snombo (CGM) Mr Baart (NM) Ms JT Ntsaluba (JTN) Mr HC Potgieter (HCP)	CEO Clinical Manager Nursing Manager Quality Assurance Officer Admin Manager



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## 1. Introduction

On the 11th February 2018, Dr Kiran Sukeri, sessional psychiatrists at Tower Hospital, submitted an email to the SASOP President, the Eastern Cape acting Mental Health Director and the National Mental Health Director with concerns about “institutional violations” at Tower Psychiatric Hospital, including patients’ rights, professional misconduct, clinician decisions, patient finances, food and clothing. The SASOP Eastern Cape Subgroup Chair and PUBSEC Convenor were alerted to this this communication and Dr Sukeri was advised by the SASOP Board to consult with Section 27, regarding the verification of information and the submission of his concerns to the Health Ombud, the SA Human Rights Commission and to the National Minister of Health. Submissions to these institutions were made by him on the 21st February 2018.

## 2. Background

- In January 2018, media reports of statistics of deaths of patients in psychiatric hospitals over the past 5 years (2013 to 2017), were published, following a discussion in the Eastern Cape provincial legislature in December 2017. The state of psychiatric services in the Eastern Cape was also profiled in a series of media reports from the 27th of February 2018 over a period of a week prior to the investigative visit. These include a report in The Herald of the 27th Feb 2018 (*Flag raised over addict suicide*), a retraction in The Herald of the 02 of March, 2018 about some aspects of the initial report, an article in The City Press (*Eastern Cape’s ticking psychiatric time bomb*) on the 3rd of March 2018 and front-page news in the Rapport of published on the 4th of March 2018 (*“Hospitaal van gruwels”/“Hospital of Horrors”*).
- The media reports also alluded to bad conditions in Tower Hospital, a psychiatric institution in Fort Beaufort, Eastern Cape, which delivers long-term and rehabilitative care to psychiatric patients.
- On the 2nd March 2018, Dr Sukeri forwarded a notification of his resignation from his part time position at the hospital. Prior to this he had been in a Head of Clinical Unit post at Tower Hospital from December 2015 until May 2017.

## 3. Methodology

### 3.1 Steps taken at SASOP EC level

- The concerns raised by Dr Sukeri were discussed with SASOP president and EC Public Sector (Pubsec) Convenor as soon as they were received, and a way forward was agreed. This consisted of the SASOP EC chairperson contacting ECDoH through the Superintendent General’s office to request access to the institution for a visit.



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- The visit was deemed necessary to give SASOP an opportunity to determine whether the raised concerns were as reported and to further engage with the hospital team on these concerns.
- The indication from ECDoH was that the Chief Director for Quality Assurance had already been issued an instruction to do a preliminary visit to determine if there was indeed a crisis as implied by the concerns raised and whether there was need for a more formal fact-finding team to visit the hospital.
- The SG gave feedback in a period of days to indicate that he was granting access to SASOP to visit the institution and in addition, SASOP could involve any other organization/s that were considered partners in advocating for patients.

## 3.2 Advocacy Partners

Liaison with SASOP National and other concerned organizations like Treatment Action Campaign, Mental Health Society, South African Federation of Mental Health, South African Depression and Anxiety Group, etc. then occurred with agreement reached on a joint visit to be conducted on the 6<sup>th</sup> of March 2018.

## 3.3 Interviews (Refer to Addendum 1)

Interviews were held on-site, with the Tower Hospital Team reflected in the table of attendees listed on page 1. The interviews occurred in the form of 2 sit-down sessions from 10h30 am to 15h30, followed by a session consisting of a tour of specified areas of the hospital and an informal interview of staff members from 16h00 to 17h30. Information shared was mostly verbal but additional sources of information were provided to the visiting panel by the Tower Hospital senior management team. Visit proceedings and minutes are as detailed in Addendum 1, and followed the procedure below:

*Session 1.* Introduction - Chair: Tower Hospital CEO - Ms Ngcume

*Session 2.* Discussion of concerns - Chair: SASOP EC Chair – Prof Zingela

- A. Leave of absence and interference with clinical decisions
- B. Human rights
  - Patient clothing
  - Food
  - Physical health
  - Deaths register, procedures and statistics
  - Seclusion
  - Patients' private fund account
- C. CEO's residence

*Session 3.* Tour of hospital



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- A. Sick ward
- B. Laundry
- C. Kitchen
- D. Seclusion rooms

## 4. Findings

The findings detailed below are based on information obtained during the interview sessions, the tour of the hospital and the supporting documents shown or provided to the visiting panel.

### 4.1 Multi-Disciplinary Team (MDT), Dr Sukeri and Hospital Management (HM) relations

- There appears to have been differences between the MDT and the rest of the HM team about clinical decisions taken by Dr Sukeri regarding admission, leave-of-absence (LOA) and discharge of patients.
- Although guidelines were drafted by Dr Sukeri in 2016 on the admission of patients to Tower Hospital, implementation of the guideline was not endorsed by the ECDoH Head Office management.
- There were also problems between HM and Dr Sukeri regarding the application of an existing Tower Hospital discharge procedure or protocol.
- It appears as if inadequate conflict resolution mechanisms existed, while internal reporting mechanisms for clinicians to register problems seems to have been unsuccessful.

### 4.2 Deaths, death records and record keeping

- Accurate record-keeping and proper documentation is a significant challenge in the institution. Significant discrepancies and inaccuracies exist about the hospital's available information on the number and nature of deaths of inpatients that have occurred over the last 5-8 years.
- This has led to important records not being recorded or stored properly and reported instances where recording of information relating to deaths or patient care has been done retrospectively instead of at the point of occurrence. It is unclear whether this was done as an attempt to give an impression of lower death rates or better care. What is clearer is the fact that the system of record keeping and storing of important records has not been done effectively over many years and has left the care of patients at risk. The institution and health professionals who work there are now also vulnerable to litigation.

### 4.3 Food and Clothing



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- HM at Tower Hospital denied that any problems in this regard existed and pointed out that there was an adequate amount available in the hospital's current budget (2017/18) for proper food and clothing for patients.
- The tour of the kitchen showed enough food in the storage areas of the kitchen. The visiting panel was however not presented with any evidence to show that there were no problems with food and clothing availability prior to Dr Sukeri's report being made public.

## 4.4 Seclusion room

- The current seclusion rooms at Tower Hospital should be regarded as very high-risk areas and should not be used.
- There is inadequate implementation of existing policies and procedures to ensure the safe and legal seclusion of any mental health care user.
- The positioning of the seclusion rooms makes them **very high-risk areas**; being positioned in the court yard, far from the nursing station or any other point of observation by staff.
- They also do not have basic amenities for any person to be cared for while in there for any length of time. For example, there are no toilets, there is no source of water for hydration etc. Should a patient be nursed in seclusion room, the ability to nurse and monitor effectively is severely hampered by these limitations. Patients, once on seclusion room, cannot be observed directly for any escalation or deterioration on presentation. Should they therefore undertake any act of self-harm or suicide while in seclusion, the position is so far that the act may be completed by the time staff become aware there is anything amiss.
- Concern was raised during the walk-about with the accompanying ward staff and there was a case reported to the visiting panel, of a patient who was a habitual self-harmer, who was nursed in the seclusion room and set himself on fire, sustaining significant burn injuries to both legs. The panel had concerns about this case not being reported openly during the visit and interview with the management team. This incident was then confirmed with the management team and it turns out it had occurred around mid-February 2018. The panel was concerned enough about this issue that the chairperson contacted the SG telephonically to express the concerns about the high risk posed by the ongoing use of the seclusion rooms. The recommendation made telephonically was to advise that they should no longer be used, and action should be taken to address the risks.

## 4.5 Patients' physical health

- By admission from the HM, significant improvements can be made in terms of procedures, protocols and physical capacity to ensure that the physical health of patients are properly monitored and maintained.



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- What limits the capacity to address patient's physical health further currently is the significant shortage in medical staff, with only 2 Medical Officers on the floor, inclusive of the CGM.

## 4.6 Hospital Senior Management Team

- Significant governance and leadership challenges seem to be facing the HM at Tower Hospital. Challenges include application of the following skills: problem analysis, problem solving, conflict resolution and change management.
- All members of the senior management team identified that there were difficulties in the smooth running of the institution from early on. No effective strategies were employed to address and solve these challenges, however.
- On at least two occasions (specifically relating to application of the admission criteria and discharge procedure), such problems required the intervention of the ECDoH Head Office.
- Factors which seem to have contributed to the situation reaching tipping point are unclear.

## 5. Analysis

- Tower Hospital, a 400-bed long term psychiatric hospital in the central part of Eastern Cape, has been utilized for many years as a non-voluntary, inpatient facility for patients with serious mental conditions requiring long-term care from across the province. To date, there has been no development in the province that could have facilitated the implementation of the appropriate deinstitutionalization of patients to be treated in a least restrictive community-based environment close to their homes.
- There is little doubt that significant problems existed for some time, in terms of the running of the hospital, such as patient and death records, death notification, as well as the manner and capacity of secluding patient at this facility. This can be said despite some questions that were raised about Dr Sukeri's reasons for and manner of reporting his concerns about problems threatening users' human rights at Tower Hospital.
- Although hospital personnel of all categories, including senior management, largely seems to have good will towards patients and patient-care, there seems to be a limited understanding (especially at senior management level), of how long-standing systemic failures and inadequacy of actions taken to address these failures, have exacerbated the situation and affected patient rights. Such systemic failures seem to have aligned with individual factors within the senior management team of the hospital (communication challenges, flouting of standing protocol and procedure with minimal consequences, poor conflict resolution, lack of proactive management etc.) to create a perfect storm. This seems to have resulted in the crisis that has manifested in Tower Hospital currently.



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- The limited insight by the leaders of the institution regarding issues that affect patient rights and hospital staff, allowed the situation to fester into dissatisfaction of senior staff members and open conflict, with breakdown in the relationship between Dr Sukeri and the rest of the senior management team. While it might not have been due to malicious intention on the senior management team's part to cause these effects, there was a lack of application of appropriate managerial skills, which affected their ability to carry out their responsibilities effectively.

## 6. Contributing Systemic Factors

In addition to challenges already mentioned, the following factors are thought to have contributed to the crisis at Tower Hospital:

- Staff shortages
- Poor infrastructure with archaic seclusion rooms
- Outdated system of record keeping with limited shortage of admin staff
- Limited support for the institution to perform province wide functions from Head Office (i.e. institution needs to be supported with staff needs - filling of vacant posts, additional social workers, ensuring enough occupational therapists to undertake rehabilitative work, ensuring there are enough psychiatrists and medical officers to service the hospital, encourage staff development to increase job satisfaction and decrease staff attrition rates, infrastructure needs, transport, etc.).
- There is evidence that there was support from Head Office regarding the conflict resolution, but this seems to have taken too long to address. It is not clear whether this was because Head Office was alerted too late by the institution's senior management to the issues or whether there was delay from ECDoH's side to act.

## 7. Recommendations

- 7.1 Seclusion. Infrastructure challenges related to the single seclusion rooms must be addressed urgently, current rooms must not be used.
- 7.2 Death registration and notification. Reconciliation of the death register of the hospital with the actual number of deaths is urgently required. Discrepancies and irregularities must be appropriately investigated, and any misconduct must be accounted for.
- 7.3 Information and administration. The hospital's entire information management must be investigated, and more evidence should be considered about possible misconduct
- 7.4 Mental Health Review Board. Evidence must be considered about the effectiveness of the responsible MHRB and the hospital's compliance with the requirements of the Mental Health Care Act.
- 7.5 Food and clothing. More evidence must be obtained and considered about pre-existing problems with food and clothing of patients. Irregularities must be investigated, and misconduct accounted for, while old and broken equipment in the laundry and elsewhere must be attended to.



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- 7.6 Physical health. Measures and procedures are required to ensure that the physical health of patients is properly maintained and monitored, while comorbid medical conditions should be adequately managed.
- 7.7 Policy and procedures. Appropriate policies and procedures must be implemented in terms of clinical governance, psycho-social rehabilitation and sexual relations between users. All new staff need a proper induction with clear explanations of the rationale behind the protocols. The processes to follow when the protocols and guidelines are to be reviewed should be outlined clearly to staff with a proper consultation process followed before such reviews are implemented.
- 7.8 Staffing. The severe shortage of medical, psychiatric and other personnel needs to be addressed urgently.
- 7.9 MDT and HM relations. Roles and responsibilities of HM and the senior clinical team need to be defined and communicated, e.g. through a HR and labour relations workshop or engagement.
- 7.10 Advocacy. Lines of communication need to be well-defined for clinicians to empower them to report problems appropriately through internal and external mechanisms.
- 7.11 Human rights. MHCA training and retraining for all clinical staff to ensure there is adequate knowledge regarding patient rights and how clinicians should be advocating for patients and their rights.
- 7.12 Hospital Management. The leadership, management and governance capacity of the current HM must be further investigated in terms of the reported concerns raised and individuals responsible for poor or harmful decisions must be made to account. More evidence must be considered about any mismanagement of resources or funds, or the inappropriate use of power.
- 7.13 Tower Hospital and community-based psychiatric service. A review of the hospital's mandate, appropriate admission guidelines and discharge protocols must be undertaken in the context of the policy of appropriate deinstitutionalization.
- 7.14 Tower Hospital in the context of Eastern Cape Province. The problems at this hospital must be considered within the context of the whole system of mental health and psychiatric care services and facilities in the Eastern Cape. (Refer to Addendum 2. SASOP actions about conditions in the Eastern Cape since July 2017.)
- 7.15 Hospital family committee. It is finally recommended that advocacy organizations facilitate the constitution of a committee of family members of users at Tower Hospital.

## 8. Limitations

Limitations to this investigation included the following:

- It consisted of a 1-day visit to the hospital, and not all the panel members could take part in the tour of the hospital.
- Only evidence volunteered by the hospital health management, and statements made by them about the concerns raised, was available and considered. Due to limited time, no interviews with other members of staff were possible. There was some limited engagement with nursing staff and other personnel during the hospital tour.
- Due to time limitations, there was also no interview conducted by the panel with Dr Sukeri as the complainant. The panel did nevertheless use the list of allegations and concerns already





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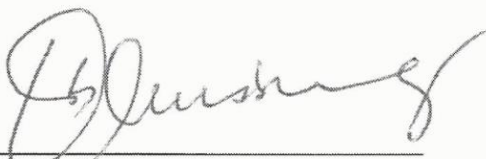
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submitted by Dr Sukeri to guide the questions asked during the interview and walk-about sessions.

## 9. Conclusion

Whatever the intentions of the Tower Hospital team were, this inspection visit highlighted instances of abuse of patient rights and failure to execute duty of care as expected within the guiding framework of the South African Constitution (seclusion of patients without a doctor's prescription or instructions, inhumane and high risk conditions of the seclusion rooms), the Mental Health Care Act and the National Mental Health Policy Framework and Strategic Plan of 2013-2020 (admission and discharge practices of patients in a long-term psychiatric facility). Actions of questionable record keeping regarding patient deaths further imply a need for a more in-depth investigation and thorough exploration of the conditions and psychiatric services delivered at Tower Hospital. In view of previously expressed concerns from the SASOP EC subgroup and SASOP Board, regarding mental health services across the Eastern Cape, such an in-depth investigation would not be complete unless it also considers the conditions and delivery of mental health services across the entire province.

## 10. Signatories

 _____ <b>Prof Z Zingela</b> <b>SASOP Eastern Cape Subgroup Chair</b> Date: 17/3/18	 _____ <b>Dr T Seshoka</b> <b>SASOP EC PUBSEC Representative</b> Date: 18/03/2018
 _____ <b>Prof B-Janse van Rensburg</b> <b>SASOP President (2016-2018)</b> Date: 18/3/18	



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## **ADDENDUM 1. PROCEEDINGS AND MINUTES OF THE SASOP, TAC AND SAMHF MEMBERS' VISIT TO TOWER HOSPITAL ON TUESDAY, 6<sup>TH</sup> MARCH 2018**

*Attendees indicated on page 1.*

### **Session 1. Introduction**

### **Session 2. Discussion of concerns**

1. Patients not given leave of absence from the hospital and interference with clinical decisions
2. Patients not wearing their own clothes, but old, tattered clothes
3. Food provided for patients is not enough
4. Deaths register: numbers do not tally, reporting of death and death certificates
5. Patients' physical health
6. Improper use of seclusion rooms
7. Patients' private fund
8. CEO lives on premises since 2014

### **Session 3. Hospital tour**

1. Sick ward
2. Laundry
3. Kitchen
4. Seclusion rooms in acute male ward

### **Session 1**

#### **Chair: Ms Ngcume – CEO of Tower**

- a. CEO welcomed all the attendees to the meeting
- b. A round of introductions including organizational representation, was conducted to acknowledge all organizations.
- c. An agenda was proposed and agreed upon by all attendees

### **Session 2**

#### **Chair: Z Zingela – SASOP EC Chairperson**

- a. Purpose of the visit outlined by chairperson to all attendees:  
The main aim is to ensure that patient care is addressed and to examine the concerns raised through identifying any challenges or obstacles to care that may have led to such concerns. Visiting team is also keen to explore any factors the hospital team can identify as contributing to the challenges and



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what resources they may need to address those challenges. A walk-about would also be conducted to areas within the hospital to be announced at the point of the walk-about when the sit-down sessions were done.

- b. Mr Baart, Nursing Manager, thanked the group for emphasizing the focus on patient care and wellness
- c. Prof Janse Van Rensburg highlighted the importance of the role of advocacy for all the groups attending and represented at the meeting.
- d. Ms Blunden from Mental Health Society supported the focus on patient care
- e. CEO also expressed that she was glad that the focus of the visit would be on solutions to challenges.
- f. As a way forward, the suggestion was to approach the challenges through following the list of concerns raised by Dr Sukeri and to respond by identifying challenges which may have contributed to the concerns arising in the first place
- g. Excerpts from Dr Sukeri's list of concerns are inserted in blocks:

## **Dr Sukeri**

There is, in my opinion, a cabala at Tower Hospital, consisting of the CEO, nursing services manager and the clinical manager, involved in the daily operations of the institution to the exclusion of all other staff, specifically the MDT.

In late 2017 Mr Nzima (Acting Director of Specialised Services), Dr Matiwane and Dr Qangule facilitated a meeting between the Hospital Management and Dr Snombo (Clinical Manager) and I. The aim of the meeting was to address issues between management and clinicians regarding clinical decisions amongst others. This was, in my opinion, an unsuccessful venture, as management continued to argue their 'expertise' in clinical decision making.

I am aware on a daily basis that my 'days are numbered' and that the CEO of Tower Hospital has every intention of getting rid of me. This is not a delusion. I work to protect my patients' rights but at the same time I am constantly looking over my shoulders!

I am also aware of my obligations to report violations of patient care.

There has to be constructive change initiated by Bhisho to improve the conditions at Tower Hospital and every other public mental health hospital in this province. Our Constitution, National Health Act, Mental Health Care Act provides for the care of our patients, however as in previous years we as clinicians in the Eastern Cape have received no support from provincial authorities in improving public sector mental health care.



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## INTERVIEW AS GUIDED BY DR SUKERI'S ALLEGATIONS

1. Patients not given leave of absence from the hospital and
2. interference with clinical decisions

### **Dr Sukeri.**

I am not allowed to discharge or give Leave Of Absence (LOA) to patients who request it. These are mentally stable patients who are able to live independently and therefore have the capacity to make informed decisions. This is a violation of their right to autonomy.

Recently the CEO instructed a Social Worker to drive to Port Elizabeth to pick up a patient who was granted LOA because his mother refused to accept him but the patient has other family members that could take care of him.

The Hospital Board, Social Worker and other individuals drove to Lady Frere to engage with a family to take a patient home. This was done for one patient, there are 399 others! Recently a patient embarked on a hunger strike because his discharge was refused by management.

There is constant interference by the CEO, Nursing Services Manager and Quality Assurance in clinical decisions. Their argument is that they are also clinical. These involve decisions in the clinical management and discharge planning of patients. The CEO stated that as the HOHE she will not sign any discharge summaries written by myself prior to investigation (by whom I don't know). The CEO has accused me of making unilateral decisions regarding patient care, whereas we work as a Multi-Disciplinary Team (MDT).

In 2016 the MDT devised admission guidelines which were streamlined after consultation with my colleagues from FEH and EDH, however the CEO has shelved it. This would have streamlined referrals to the institution and allowed it to meet its vision and mission as a psychosocial rehabilitation centre.

Adult Basic Education Programme (AET). This programme goes up until Grade 8 and has a basic computer course. When I assessed the patients attending I found many of them unsuitable due to their mental illness, having Grade 12 and beyond qualifications or their selling of tobacco and/or other 'products' on the premises. I was 'scolded' for removing patients from this programme as it is the 'flagship' programme of the institution. Patients on this programme are not allowed LOA or to be discharged. This is an infringement of their rights to keep this programme going. I think it is a valuable programme but it needs to be handled carefully.



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CEO response – “This is not true”. Patients need to be assessed for suitability and prepared. This includes a social worker’s report that is required to ensure patients have somewhere to go to when they leave Tower Hospital.

Challenge stated by hospital management team – The HCU was saying patients can be discharged to anywhere. CEO needs to know patient is stable and has somewhere to go which is safe. Some patients were discharged without any preparation and this resulted in several complaints from relatives because of this. Issues of risks were raised by the relatives because of patients being discharged without ensuring that there will be safe support in the community where they are being discharged to. CEO gave examples of cases where the discharge of patients exposed them or relatives at risk e.g. patient who had burnt down the house, another patient who was discharged and got lost. In both cases, relatives contacted CEO to complain. One complained to NDoH. Dr Sukeri was quoted as saying: *“If a patient was admitted from under a bridge, I will discharge him back to under a bridge.”* (This quote was repeated by CGM and Nursing Manager as having been stated by Dr Sukeri on more than one occasion)

Nursing manager’s response - We are supposed to work as a team. We need to make sure the patient is well prepared for discharge. Examples are patients discharged without adequate preparation. This results in patients coming back soon after discharge having smoked cannabis or relapsed due to not taking their meds. Also, there is an educational program that was set up to enhance patient skills and learning. Patients enrolled in the program are then given leave during school holidays to enable them to write exams. The program has 5 teachers which have been allocated by Dept of Education. Lack of coordination in granting of leave resulted in several patients being unable to sit for their exams and some of them were expected to do well enough to earn distinctions in their exams.

CEO: Admission guidelines were drawn up by the psychiatrist and these were implemented in early 2016. It was found that they were severely limiting access to care in the institution. This had a province wide effect with PE experiencing worsening in overcrowding and a bed crisis while Tower’s Bed Utilization Rate. Went down from in the 80%’s to in the 60%’s. This meant that there were empty beds which could be utilized for admission in Tower, but the admission guidelines were restricting access. A meeting was then convened by Head Office in 2016 and EC psychiatrists were invited to the meeting, including the Tower. After long discussions and debates in the meeting, it was identified that the guidelines should not be used because they were limiting access to care.

Mr Baart: 7 patients who were supposed to write exams, they could not in the end because they were discharged during exam time. Three were expected to do very well with distinctions.

**Dr Seshoka – are there MDT meetings held where decisions re patient care are taken? Concerns have been raised by Dr Sukeri that MDT decisions taken are vetoed by Management.**

Dr Snombo - Yes there are MDT meetings. Patients are admitted to Tower Hospital but do not have proper detention orders. Some patients are mentally stable but immediate relatives are unwilling to



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accept while other relatives might be willing to accept the patient. Logic was that the doctor would then make the calls himself and discharge patients based on relatives confirming willingness of these other relatives to accept discharges. But Dr Sukeri's point was that *if the patient came from under the bridge and he is again stable then he can discharge him back to under the bridge*. If he is stable, we cannot hold him in the hospital if he wants to go.

## **Prof JVR: What is the profile of the hospital?**

Info from CEO and Dr Snombo: 400 beds capacity of usable beds. Currently 323

Currently: BUR – 80 – 85%, AVL – ranges from 900 to over 2000. Some of the patients are previous forensic patients who are now on unconditional discharge.

**Ms Blunden – Re some of the challenges that relate to Tower Social Workers having travel all the way from here to places like EL and PE to do Social work assessments, Mental Health Society could play a supporting and collaborative role there by facilitating some of those visits.**

Further discussions took place re points of clarification around the issue of admission guidelines and discharges. Based on the discussions, these two issues seem to have been a major source of conflict between Dr Sukeri and the other members of the Hospital Senior Management team.

## **Summary of understanding of complaint and responses from hospital team:**

There seems to have been a clash in the ethical principles applied by some members of the clinical team and management with regards to patient care: Clinicians concerned with Autonomy and Justice and this was pitted against Management's concerns with beneficence and non-maleficence. This was compounded by communication problems between the management team, clinicians, social workers and nursing team.

- The main challenge identified by the hospital team with regards to these two issues of admissions and discharges is that the institution is expected to meet province-wide needs while it has limited capacity to meet those needs. An example cited is that of Social Workers who must conduct home visits as far as East London of Port Elizabeth

## **Additional Questions from panel**

**JVR – What were the guidelines for admission? (a copy requested and submitted). The question arises because they are said to have been too restrictive.**

**Chair (ZZ)- What were the discharge guidelines? A copy requested and submitted.**

The HM team reported that both sets of guidelines seem to have contributed largely to the conflict that has yielded allegations and concerns about management interfering with clinical decisions. In both instances, a team from Head Office had to engage the Tower team to attempt to resolve these issues so service delivery could continue. The one meeting took place through the Directorate on the 21<sup>st</sup> of April 2016 to discuss the bed crisis that had been exacerbated, especially in PE, because of the stricter



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admission criteria and higher discharges. The second one was on the 6<sup>th</sup> of Dec 2017 due to the discharge procedure not being followed and the CEO raising concerns to Head Office about the inability to settle the disagreements and conflict with Dr Sukeri surrounding this issue.

## **Dr Sukeri**

Since 2016 several professional staff have left due to, in my opinion, the Management's dictatorial style. These include a clinical psychologist, occupational therapist, 3 medical officers and several nurses. I should think Bhisho would have received the list of resignations, however I won't be surprised if this list has been altered to indicate these resignations as 'transfers' and/or 'retirement'.

Currently there is 1 medical officer for 400 beds. I understand that there are plans to increase this number to four.

There are currently 4 social workers, 2 occupational therapists and 2 occupational therapist community service.

The Clinical Psychologist employed in November 2017 has handed her resignation this month.

The Management insists on continuing with their plan of an OPD and an acute unit. This according to them and the Department of Psychiatry at WSU is when Registrars will be allocated to Tower Hospital. This plan is impossible considering the lack of infrastructural and human resource support.

There is NO staff retention plan! When staff start asking questions they are quickly silenced, this is from my own personal experience. I have been shut out of the handover meetings, watched like a hawk if I access patient files for clinical case studies and told by Sr Ntsaluba that I am not permitted (by the CEO) to access any patient related documentation.

Staff morale at this institution is very low, a probable cause for the high rates of absenteeism and presenteeism at this institution.

## **What is your organogram? Are the challenges with filling posts or getting support from Head Office to fill posts?**

CEO - there was an initial challenge with getting bodies into vacant posts before. There are applicants more recently again who prepared to come to Tower to work.

## **3. Patients not wearing their own clothes, wearing tattered clothes.**

### **Dr Sukeri.**

Patients in the open wards are not allowed to wear their own clothes.

Patient's current clothing is unacceptable. The Nursing Services Manager released a communique on the 08/02/18 stating that it is unacceptable for patients to wear torn and dirty clothes, however in most cases the clothes do not fit the patients and therefore they wear these old clothes.



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CEO – Due to patients absconding now and then, hospital clothes are easier to identify when the patients is in “uniform”. Other challenges: Patients also sell their clothes when they want to buy smokes. Clothes are also stolen by other patients even though there are lockers. When patients are admitted, they are issued with pyjamas and patient clothing, tracksuits, jeans etc. There is a variety of different clothing. The usual colour is blue although there are now other colours added e.g. red golf- shirts or green dresses for females. Clothing is clean and in good condition.

## **Additional questions from visiting panel:**

### **Does the hospital management think the budget is adequate to cover clothing?**

CEO - This is adequate, and the hospital has been able to buy what is needed for patients.

Mr Baart - Patients have 3-4 sets of items each and underwear change is available daily. The ideal would be to have enough for a daily change of all items of clothing.

### **Any challenges with laundry services which affect availability of clean clothing for patients?**

CEO & Mr Baart - Dryer outdated and difficult to find parts and iron not working. There is a maintenance contract through Head Office. The machines are old, they need to be replaced. Head Office is aware

## **4. Food being provided for patients is not enough.**

### **Dr Sukeri**

I have requested on several occasions for a dietitian to be appointed at the institution. I have gone to the extent of requesting assistance from Fort England Hospital regarding this matter and provided this information to the CEO (Ms N Ngcume). I have also provided the institution with a copy of the National Food Services Unit Policy.

Patients are fed on a staple of samp and beans or white samp on most occasions.

At night they are given a soupy mix 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).

I have evidence of patients buying their own food from the local Spar.

Patients do not receive fruit on a daily basis.





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There are no special diets for patients with diabetes or other medical conditions. A soft diet consists of mashed up samp and beans. As you are aware psychiatric medication may result in the metabolic syndrome and these patients not only require exercise but a proper balanced diet.

I have collated evidence of the menu for November 2017 and January 2018. On the 17/01/18 the Food Services Unit requested 2500grams of mince, 2 bags of macaroni, 2 bags of potatoes and 1 bag of carrots for supper, this was for 308 patients. The lunch menu on the same day consisted of 3 boxes of meatballs, 3 bags of samp and 50 kg of butternut.

CEO: R4 829 62mil last year allocated for food budget, hospital has already spent R3 944 124 of this budget. No challenges experienced here.

## Additional questions:

- **Do patients get enough food based on what is provided?**
- **Dr Seshoka** – Are patients getting the food? In some instances, it could be that patients may not be receiving the food.

CEO and Mr Baart: Nurses report on availability daily so that Management can get an idea of availability of food. There also climate meetings and patient surveys conducted where there is an opportunity to get feedback on such issues. No patients have complained about not getting enough food.

- **No dietician** – Food Service Manager only. Only access to a dietician is through Victoria Hospital but this is not formalized.
  - a. Recommendation from panel feedback to team at time of discussion – This could be a provincial strategy which guides the availability of a dietician or access to one where there isn't one available on the hospital organigram. There is a post for physiotherapist but not filled. There is access to the local general hospital for dietetics and physiotherapy patient needs.

## 5. Death register: Numbers do not tally, issue of death being reported as natural, alteration of patient records

### Dr Sukeri

Recently the CEO, Mr Baart (Nursing Services Manager), the Head of Quality Assurance (Sr Ntsaluba) and two Matrons (Srs Nkanjeni and Mathanga) called in Dr TK Nodliwa post the death of a patient and 'forced' her to fabricate notes for a patient that died. I have copies of those notes.



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Patient records are altered to suit the CEO and other members of Management.

Death records are not correctly entered. Of the 4 deaths that have occurred in January 2018, only 2 were certified by a Medical Practitioner. The notes are altered to indicate that the death was certified before removal by a funeral parlour. A death audit will reveal the constant alterations of records, in one case from unnatural to natural.

CEO's response: MEC of Health requested info on deaths from Jan 2013 to Dec 2017 – Number of deaths reported by hospital is 25. Death register “disappeared”. Report of 25 deaths was based on nurses' reports held in the wards due to the death register being lost. There was a “new” death register started from the matron's office in March 2017 (1<sup>st</sup> two pages cover Sept 2016 to Jan 2018) after it was discovered that the old one could not be found. Dr Seshoka assisted the visiting panel in taking a closer look at the Death Registers: These are 2 hand-filled long notebooks.

On perusal of the new Death Register **Dr Seshoka noted the following:**

- Page 5 to 8 is missing in new death Register,
- on page 9 there is nothing,
- page 10 goes back to March 2012 up to January 2018 on page 17.
- Page 13 to 14 are missing.
- The request for the numbers of death info then came in February 2018 from MEC. The old death register started from 02/12/ 1976 to 6<sup>th</sup> November 2015 and the new one from Sept 2016. The request for the numbers of deaths (from 2013 to 2017) was received in February 2018 when the old register would in any rate not have been sufficient to derive the numbers from, as it covers the period 2nd December 1976 to 6th November 2015. There is also a period unaccounted for in the new death register i.e. the period from December 2015 until August 2016. This period was missing when Dr Seshoka checked the new death register. None of the members of the Tower Hospital team in attendance could provide an explanation regarding this missing info.

## **What is the process followed when a patient dies?**

Upon death of a patient, nurses report to Matron's office where this is captured in a handwritten death register, then a physician fills in a notification of death to Home affairs Dept. and a death certificate is then issued.

## **The complaint referred to deaths during the period 2010 to Jan 2018 – 90 deaths occurred during this period according to the complaint.**

There is overlap of the periods in 2012 for example in the old and new Death Registers, and yet the details of the patient names are not the same.



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## **What steps were taken by Management to try and address this shortcoming or incongruity in death registers info?**

- CEO sent people to home affairs and they said this was difficult. CEO will verify who was sent (Data Capturer).
- Hospital started a computerized system from mid-2017. It covered records of 2012 onwards.
- The old register turned up “miraculously” as described by hospital management on the 26<sup>th</sup> of February 2018. When this was found again, the management went back to the old register and re-counted. The numbers of deaths from Jan 2013 to Dec 2017 was found to be **63 and not 25** as initially reported to the MEC’s office.

### **Additional comments**

JVR: This period where info is missing could be verified through admission, discharge and abscond data.

## **M Blunden – are review boards informed of deaths of patients in the hospital? Is the MHRB functional in this area?**

### **Additional Comments from visiting panel:**

Maintenance of accurate records and proper safe keeping or storage for the hospital and for patients seems to be a major challenge which requires serious attention. Reconciliation of death records essential to give a true reflection of the deaths in Tower. This is the only way one can confirm that there are no attempts to conceal any information on death of patients. Anything less will feed into the concerns and allegations about possible death concealment. The records are a mess. There needs to be an urgent reconciliation process so that the death notifications issued, the death certificates issued, and the deaths recorded tally.

CEO – The initial figures given to MEC for that period requested were wrong (25). We re-checked again; they were 63. The 90 was too much even when going back to 2010. It was too high. There are also some patients who died at home on LOA or in other medical hospitals. They also get recorded in our register for as long as they were not on discharge from the institution.

The case of Mr M who died in Nov 2017 and alteration of medical records by a junior doctor, Dr Nodliwa, was not delved into in detail during the session with the management team. It is added here because it was later relayed by a staff member during the walk-about. It was described that the doctor had been instructed to add notes after an audit of files. She was then perturbed by this and reported it to her supervisor within an MDT meeting setting i.e. she did not conceal this. This information was later confirmed by Clinical Governance Manager.



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## 6. Patient's poor physical health

### How is the physical health of patients taken care of when they arise?

Dr Snombo – There is a gap, especially when it comes to patients admitted to the “sick ward” i.e. ward where patients with physical problems are admitted. There used to be 2 sessional GPs who were sharing a full-time post and do overtime. When a full-time doctor was employed, the sessional continued as a sessional doctor. GP left in late 2015. This is the time when the Head of Clinical Unit was appointed.

### Are there any challenges with doctors performing physical examinations and managing patients' medical problems?

Dr Snombo - there is no issue with skills of performing physical examinations on patients admitted to Tower. Doctors do physical examinations when patients are admitted. (Allegation is that patient's health is not well taken care of.)

CEO: All patients are examined monthly by nurses. If they see a change then this is reported to the doctor to be transferred to the “sick ward”. There the patients get closer observation and care until they are better. They are then transferred back to the ward.

Dr Snombo: From Dec 2015 to May 2016, physical problems that required a doctor were attended to by one doctor. From May 2016 until Nov 2016 it was then 2 doctors who looked after patient's physical issues. When the doctors are more then patients are seen more often.

CEO & Mr Baart - Nursing staff had an issue with the stance that “a specialist psychiatrist is not supposed to do physical health related work” for patients because it was “dirty work” which needed to be done by medical officers (this was reportedly said by Dr Sukeri to nurses when physical problems of patients were reported to him). If Dr Snombo was away, then the nurse would contact the HCU to arrange for transfer to the local general hospital.

#### **Dr Sukeri**

The clinical manager is paid for after hour clinical calls at Tower Hospital in addition to her managerial duties for afterhour's availability. In 2016/2017 when four medical officers were employed, the clinical manager insisted to remain on the roster. She is never available on weekends. This sets a precedent for other medical officers. Perhaps the benefits afforded to this clinical manager need investigation?

Appointment of a full time psychiatrist. This is to be welcomed. It will increase the number of full time equivalents to 1.5. However the current situation should be resolved prior to the psychiatrist's appointment to prevent further staff attrition.



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## Additional questions or comments from the panel:

Are there records of patients' referrals to general hospital and how their medical illness was handled, available?

Also, info on availability of doctor on the floor to address these issues should be provided e.g. Duty rosters etc. Adverse events registers also need to be kept and made available as additional evidence.

Issues of patient rights and conjugal or close partner relations between patients were raised by the panel. Other issues raised were safe sex practices, policies and guidelines for the hospital; on how such issues are handled etc. Is there such a policy for the hospital since this is a long-term facility?

## 7. Seclusion Room - abuse was also raised as a concern

Dr Snombo: There is a seclusion room policy and doctors write how long the patient is supposed to stay in there. There is a seclusions register kept. When patients are in the seclusion rooms they are monitored. The door is locked for safety. The patient still has a choice of walking out of the seclusion room.

Challenge of safety in terms of staff being able to conduct continuous direct observation of patients in seclusion. seclusion room, ability to nurse patients in the seclusion room while minimising risk is difficult. There was a patient who was secluded at the orders of a medical doctor. Patient was supposed to be in there for two hours. Patient was secluded for much longer. There is a note in the patient files that indicates that patient was "secluded for 7 days. Nursing process did not indicate this. Verbal report indicated patient was indeed sleeping in the seclusion room at night. **More info and supporting evidence sought by visiting panel from hospital team on this case.**

## 8. Patient's private fund.

### Dr Sukeri

Patients and their families are requested to deposit money into the Hospital Bank Account. Patients are only allowed to draw ZAR100/week. Patients are charged ZAR5 per ZAR100 they withdraw. So for example if 20 patients/week draw money the hospital makes ZAR 100. This is a new procedure, in the past there was a spread sheet of exorbitant charges for amounts drawn.

An audit of this account will show that money was drawn to purchase materials to fix a doctors residence, unless the evidence has been erased!

The highest balance kept in this account is around R80 000. Even DG money goes in there. There is a spread sheet available to track whose money is deposited etc. This is administered by the Finance Manager.



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Family members deposit money in the fund. R100 or less is drawn by the patient. This is a check account which incurs bank charges. The amount of R5 is used to cover bank charges. Initially a sliding scale was used to apply bank charges. There was excess money discovered in the account of up to R10 000. Some patients died while still having money in the account and the rest accumulated when the hospital; was still charging R12 per transaction. This allowed the hospital to drop the bank charges from around R11.00 to R5.00. There are 3 signatories, and 2 needed to sign. Finance Manager is responsible for administration of the account, monies in and monies out in terms of making sure there are checks and balances. The hospital dropped the charges in 2016 to R5 per transaction.

## 9. CEO lives on premises since 2014.

### **Dr Sukeri**

The CEO lives on the hospital premises while she rents her private home to hospital employees. This is definitely a corrupt situation. She is unapproachable and dictatorial in her management style, often alienating staff.

CEO's response: In 2013 there was staff member who was alleged to have 14 stolen grass cutting machines. A charge was laid with the police but no further consequences. Another 2 machines were stolen, and security guards were able to spot the staff member who was stealing the machines on CCTV. The security company was notified, and the staff member happened to be the CEO's next-door neighbour. A charge was laid again with the police, but the CEO feared for her life due to threats because of this issue. CEO is currently renting. The employee brought back the machines, but the police initially continued with the charge. The employee absconded. The CEO submitted a request for hospital accommodation through the district manager which was granted based on her safety reasons and concerns. Mr Baart corroborated this information by indicating that it had indeed occurred as related by the CEO.

### **Additional panel questions: Allegations were in the media. Community may be concerned. Is there a team in place to address the community's concerns?**

CEO's response on Communication strategy – a report was submitted to the reporters on Friday with additional questions submitted on Saturday. Responses within the report submitted to the journalist were again provided but these were not included in the final story that was published.

Mr Baart – MEC went on the radio to address the community regards to the safety after she, her team, MHRB and members of the Health Portfolio Committee made an unannounced visit to Tower on Monday the 5<sup>th</sup> of March 2018. Hospital Board and the MHRB were also here and recommended that local communities should also be informed. Mr Kupelo has written a statement to the newspapers.

**Ms Blunden – More effective partnering to assist integration back into community for patients being discharged.**



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**TAC – apologies for not supporting the hospital in terms of ensuring they have resources they need. We are going to be talking to community to get more case studies of peoples’ experience in psychiatric hospitals.**

## Session 3

### 1. Walk-about/ Inspection

Prof Janse van Rensburg and Ms Blunden had to excuse themselves due to travel arrangements and the walk-about/inspection was conducted by the remaining SASOP and TAC team representatives. The panel requested to visit the areas outlined below with the CEO and Nurse Manager accompanying. Photographs were also taken.

**1.1 Sick ward** – 20 beds for non-life-threatening conditions, limited ability to nurse in isolation where needed (one female and one male side). Equipped with emergency trolley that is checked daily with reports submitted.

**1.2 Laundry** – Staff on floor busy sorting and ironing clothes. Soccer T-shirts in maroon and white, tracksuit tops, pyjamas, shelves with clean clothes of different sizes. Patients seen on hospital grounds wearing clothes in good condition (navy blue, red or blue tops on males). Group of patients escorted by staff seen walking past. Another group of patients in courtyard seated around tables, playing games. Also wearing crocs on feet. Patient clothes and linen seemed adequate with no cause for concern.

**1.3 Kitchen:** Staff available and busy at time of visit. Food manager escorted panel around the kitchen. Separate cold storage rooms for red meat chicken and vegetables and fruit. Separate room for dry grains and beans, bags of sugar etc. Photos taken. Good supply of quantities and variety.

**1.4 Seclusion rooms:** about 4 open ones at one end of the courtyard in one of the male. Metal doors which can be bolted from outside, with viewing panel in the door. Situated far from nursing station. No proper direct line of vision. No CCTV. **Risks to staff and patients due to a few reasons outlined under challenges and gaps**

**Visiting Panel Assessment of seclusion rooms** - A staff member indicated that during the seclusion of the patient who had been put in seclusion room a week or so before the visit, he had set himself alight and sustained injuries to his lower extremities. This turn out to be the patient who was in seclusion without doctor’s orders. These are very high-risk arrears with inhumane conditions due to lack of ablution and access to a water source. The door is bolted from outside once the patient has been put inside the seclusion room and he/she has to rely on others to exit when requiring access to a toilet or a drinking water source. They should not be used due to the level of risk to patients and staff associated with their use. ECDoH needs to attend to this issue urgently.



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## ADDENDUM 2. SASOP ACTIONS ABOUT CONDITIONS IN THE EASTERN CAPE SINCE JULY 2017

SASOP has taken the following actions about conditions in the EC, since July 2017:

- SASOP's letter to the MEC in July 2017 requesting a meeting, based on the report from Subgroups at the 2017 Dr Reddys PubSec strategic meeting in June 2017
- Meeting of SASOP Board representatives eventually with the EC MEC for Health on 7<sup>th</sup> November 2017
- Submissions in November 2017 to the SA Human Rights Commission by both SASOP and the EC Department of Health (Dr Matiwane and Mr Nzima), with another by Dr Lesley Robertson (National PubSec convenor), as part of the Commission's national hearing on Mental Health
- Email submission of concerns about Forensic Psychiatry on 8<sup>th</sup> December 2017 by SASOP EC Subgroup members to Dr Mulutsi (National Director for Forensic Mental Health) and the Sub-committee on Observation Procedure, with a reply back from the National Director of Mental Health (Mr Phakathi)
- Developments in December 2017 at the Port Elizabeth (PE) training site of the Chief Director deciding to close down the site abruptly. This would have otherwise forced 7 registrars to move to other areas, despite having families and homes established in PE, and specialist services to close to 3000 serviced annually at the site, close to half of them children. The decision was only reversed through urgent interventions from the SG and university vice-chancellor.
- Responding to media question in January 2018 following discussion in the provincial executive committee in December 2017 about deaths of patients over the past 5 years in EC psychiatric facilities
- Current reports in February 2018 by Dr Sukeri about Tower Hospital, and assisting him to prepare submissions to the National Minister of Health, the Human Rights Commission of SA, the Health Ombud and Section 27, it added more to a series of messages and experiences to/from the EC structures since July 2017
- Visit on 6 March 2018 by SASOP President to Tower Hospital with SASOP EC Subgroup Chair and PubSec Representative, and with representatives of TAC and the SA Federation of Mental Health to meet with the hospital management about the concerns raised by Dr Sukeri about conditions at the hospital. We are currently drafting our independent report on the findings.
- A review of all actions taken, and its results will be reviewed again by the SASOP Board at their next meeting on the 24<sup>th</sup> March 2018





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## Problems raised with the EC MEC of Health at the meeting with SASOP and senior officials of the EC DOH on the 7<sup>th</sup> November 2017

### 1. Common problems in all SASOP's Subgroup regions

While for each region different problems were highlighted the reported common challenges in all our Subgroups and Provinces included:

- (1) shortage of psychiatrists;
- (2) no or poorly resourced community psychiatric services and poor inpatient facilities in general hospitals with little transfer options to longer-care facilities;
- (3) dysfunctional or absent mental health directorates;
- (4) poor or no communication between existing directorates and professionals;
- (5) dysfunctional or absent Mental Health Review Boards (MHRB);
- (6) no or poorly resourced child and adolescent services and/or no acute beds;
- (7) no or poorly resourced rehabilitation units for substances; and
- (8) inadequate forensic beds and services, resulting in long waiting lists across the country.

### 2. Specific problems in the Eastern Cape

#### 2.1 Overall statistics

- SASOP Full and Associate Members - 44: state psychiatrists - 13; private psychiatrists - 16; lifelong (retired) – 3; registrars (associate members) – 12
- State sector psychiatrists - 13 Psychiatrists for 6 880 966 population in EC. (Stats SA, 2015):
  - Psychiatric hospitals: Fort England Hospital (FEH) – 5; Elizabeth Donkin Hospital (EDH) – 2; Komani Hospital (KH) – 1; Tower Hospital (TH) - 1
  - General hospitals: Cecilia Makiwane Hospital – 1; Dora Nginza Hospital – 0; Uitenhage Provincial Hospital - 0; Mthatha Hospital - 2
- Total beds
  - in 4 designated state psychiatric hospitals = 1364
  - in 6 Mental healthcare units in general state hospitals = 155 operational ones, with 10 of them in a unit that is not designated.

#### 2.2 Psychiatric hospitals

BEDS TYPE	FEH (Grahamstown)	KH (Queenstown)	EDH (Port Elizabeth)	TOWER (Fort Beaufort)
Acute	60	130	84	45
Open ward	15	20	15	0
Frail Care	10	20	25	0
Med-Long stay & Rehab	0	85	0	355



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Forensic Observations	25	10	0	0
State Patients	225	135	0	0
Substance Rehab	20	0	0	0
Adolescents	0	20 (Intellectual Disabilities mainly)	0	0
Geriatric	0	20	0	0
<b>TOTAL</b>	<b>355</b>	<b>440</b>	<b>169</b>	<b>400</b>

## 2.3 Mental Health Care Units

UNIT NAME	Dora Nginza (PE)	Uitenhage Provincial	Cecilia Makiwane (East London)	Mthatha MHU	St. Barnabas (Libode)	Holy Cross (Flagstaff)
No. OF ACUTE BEDS	35	10 (not designated)	50 (only 30 operational due to staff shortage)	60	33 (under construction)	20 (in planning stage)
<b>TOTAL</b>	<b>155</b>					

## 2.4 Meetings with the Eastern Cape Department of Health (ECDoH) – from more recent to previous

A meeting was held between the EC (SASOP) psychiatrists and ECDoH on 15/02/2017 to discuss the challenges in Mental Health Services in EC:

- Shortage of all categories of beds
- Shortage of psychiatrists and inability to fill the vacated posts, e.g.: CMH and EDH (DNH has been added to this list since December 2017)
- Absence of 72 hr observation facilities, especially in East London and Mthatha
- Shortage of medications and “stock outs”
- Dysfunctional Mental Health Review Boards
- Absence of community based mental health services
- District hospitals without mental health beds
- No child & adolescence mental health services
- Inadequate forensic beds within the province



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## **Agreements from the meeting included:**

- PE provincial hospital to have 40 beds for 72 hr assessments, building identified already.
- To establish substance rehab units in PE/EL/Mthatha.
- To implement out-patient services in EDH.
- To open acute unit at TH in about 3-6 months.
- To add 30 bedded unit at KH for male acute patients (achieved, opened on 18/04/2017).
- To organize workshops/training of medical officers in general hospitals on how to manage 72 hr observations.
- Some district hospitals have been identified to be renovated and add mental health beds.
- To have a follow up meeting with the Director of specialised services on 27/02/2017.
- Agreed to establish the district mental health teams to assist with the management of patients at the district levels.
- To increase the number of acute beds in the general hospitals as most of the beds are not optimally utilized.
- To promote integrated mental health services, esp., in general hospitals.
- To have a representative (psychiatrist) in the provincial PTC to address the shortage of medication and with EDL list at all levels.

Of note though, is that the current director has left at the time and a new director has started from July 2017.

## **Previous communication with decision-makers include:**

- Letters were written or copied to the MEC of Health in EC in 2012 and 2016 as well as emails to this effect. The Director under whom Mental Health Services fall, the Chief Director, the DDG, the HoD and MEC have been informed on many occasions over the last decade of the severe conditions about mental health facilities, lack of resources and failing service.
- Numerous meetings were held over this period with the Director, the Chief Director, the DDG and the HoD to try and resolve these issues. An explanation of the lack of money to address these issues has usually been provided.
- On other occasions, the HoD has committed himself to address some of the issues and has e.g. issued orders of steps that need to be taken by his Chief Director responsible for such, only for these to be ignored. This emphasizes the importance of the support and agreement of the hierarchical structure within the department. Officials in the chain of command are also required to support policy decisions taken on higher levels.
- These major challenges may force clinicians to find routes of communication outside of “normal” channels, e.g. sometimes requiring the intervention of other bodies.
- For example, more recently (June 2017), after a serious incident in the MHU in EL during which several patients and staff were assaulted by other patients, no action was taken by hospital or provincial health officials on major shortfalls in security and staff. This was raised



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through the normal channels by the Head of Clinical Unit there. Even after this incident, nothing to date has been done to address the shortfalls there.

## 2.5 Communication with the National Department of Health (NDoH)

In addition to communication with the EC DOH, the NHoD was engaged during 2016 in communication regarding:

- Long waiting lists of both observations and state patients.
- Shortage of forensic beds
- Shortage of psychiatrists and psychologists to conduct mental observations.

Agreements from this meeting include:

- KH and EDH to assist with single panellist observations for minor charges that don't need full panel.
- To discuss the issue of beds with ECDoH.
- To recruit private psychiatrists and psychologists to assist with the observation cases, and to be paid per number of cases observed or hours spent in the observations.
  - Shortage of all categories of staff (mainly acute beds)
  - Shortage of psychiatrists and inability to fill vacant posts (CMH, EDH, UPH)
  - Dysfunctionality MHRBs
  - No Child and adolescent mental health services
  - No community-based health care services
  - Shortage and "stock-out" of medication
  - No facilities for 72-hour observations, (EL, NMM, Mthatha)
  - Several meetings held with ECDoH, but no movement/direction from the department towards addressing the challenges

A follow-up letter was forwarded to the National Director of Mental Health, in particular about the unresolved situation regarding the CEO at Fort England Hospital in December 2016, but no action followed to date. The situation currently remains unresolved, e.g. it is still not clear who is the acting CEO, as the last acting CEO lapsed at the end June. There seems to be no official communication on this issue. This scenario of apparent bureaucratic lethargy may also soon lead to a supply chain problem, where the hospital may run out of basic foodstuffs for patients within a matter of days to weeks.



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## ADDENDUM 3: PHOTOGRAPHS TAKEN DURING TOWER HOSPITAL TOUR

**Photo 1: Seclusion Rooms In Court Yard Of Male Ward**



**Photo 2: Tower Kitchen Food Stores**

