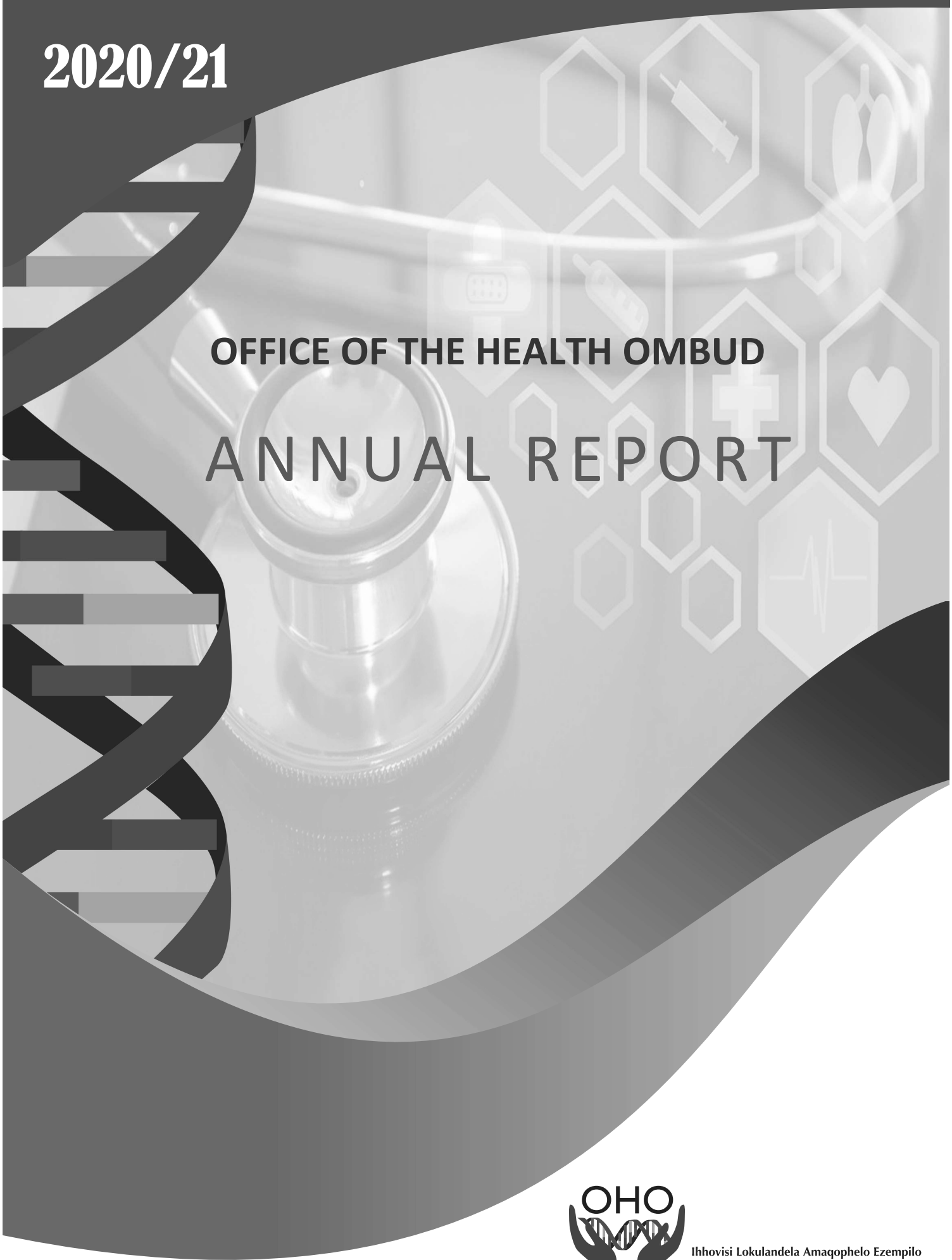
2020/21

OFFICE OF THE HEALTH OMBUD

ANNUAL REPORT



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

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1 FOREWORD BY THE HEALTH OMBUD

This annual report highlights the achievements of the Office of the Health Ombud (OHO) during a period that was marked by the emergence and global spread of COVID-19 pandemic. This momentous development framed the work of the OHO during the relevant reporting period.

One of the most important interventions in 2020/21 was a study that analysed the impact of recommendations made in OHO investigation reports on the national health system. This analysis was conducted independently with the main objectives of providing feedback on how well OHO recommendations are implemented and how they are experienced by the public and health professions. More importantly, the study explored how OHO recommendations provide role-players in the national health system with a better understanding of where improvements are needed and what these entail. This information is invaluable for the improvement of the national health system – and the OHO itself. The assessment of the impact of OHO recommendations was the first undertaken in the country.

The Tembisa Provincial Tertiary Hospital investigation provided a case study centred on a young COVID-19 patient without co-morbidities who was poorly managed in one of our major "tertiary" hospitals. This was a landmark investigation: the wide-ranging findings have downstream ramifications for the hospital, its staff and the national health system in terms of managing and caring for patients suffering from COVID-19 infection.

The twinning agreement signed between the OHO and the United Kingdom's Parliamentary Health Services Ombudsman (PHSO) seeks to promote capacity development, benchmarking, and best practice. Through this agreement staff and procedures will be exchanged.

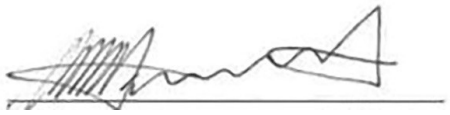
Serving among a panel of experts constituted as the Data Safety Monitoring Board (DSMB) for clinical trials supported by the US Operation Warp Speed afforded me the "kitchen experience" of historic research that produced safe, effective COVID-19 vaccines for global use. This insider perspective is invaluable and assists the OHO in providing advice to our policy-making structures whenever needed. The invitation to serve also emphasises the high regard the office enjoys internationally.

Finally, slow as the bureaucracy of government is, progress is being made with regard the OHO Bill and OHO budget – which will afford the Health Ombud structural independence. Steady improvements are also taking place in the Complaints Centre, Assessment and Investigation units, as shown by the results in the report.

It has been another busy but productive year, despite the COVID-19 pandemic.

The OHO appreciates the continued support of the Chief Executive Officer of the Office of Health Standards Compliance, Dr Siphiwe Mndaweni, and her staff, as well as the Board of the OHSC.

We are grateful for the support received during 2020/21 from Health Minister Dr Zweli Mkhize, Director-General of Health Dr Sandile Buthelezi and the Portfolio Committee on Health. Without all your assistance and encouragement the burden of our task would be heavy. I am particularly grateful to Ms Linda Jiyane for taking care of my office, my staff and me. She has selflessly given us all the support we need.



Professor Malegapuru W Makgoba
MB, ChB (Natal), DPhil (Oxon), FRCP (Lond), FRS (SA), Foreign Associate Members of the National Academy of Medicine (USA), and OMS.
Health Ombud: Republic of South Africa

Date: 06/08/2021

2 GENERAL INFORMATION

Registered name	Office of the Health Ombud
Physical address	79 Steve Biko Road Prinshof Pretoria 0084
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Website address	www.oho.org.za
External auditor	Auditor-General of South Africa (AGSA)
Banker	Standard Bank

3 LIST OF ABBREVIATIONS/ACRONYMS

BHPSA	Better Health Programme South Africa
CEO	Chief Executive Officer
CPR	Cardiopulmonary Resuscitation
DSMB	Data Safety Monitoring Board
FCDO	Foreign, Commonwealth and Development Office
IT	Information Technology
NDoH	National Department of Health
NIAID	National Institute of Allergy and Infectious Diseases
NGO	Non-Governmental Organisation
NPA	National Prosecuting Authority
OHO	Office of Health Ombud
OHSC	Office of Health Standards Compliance
OPCAT	Optional Protocol to the Convention against Torture
PUI	Patient Under Investigation
PPE	Personal Protective Equipment
PHSO	Parliamentary Health Services Ombudsman
TPTH	Tembisa Provincial Tertiary Hospital
TPHPRC	Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre
PPE	Personal Protective Equipment
SAHRC	South African Human Rights Commission
UK	United Kingdom
USA	United States of America

4 ANNUAL REPORT OF THE OFFICE OF THE HEALTH OMBUD

4.1 Introduction

This report reflects the activities of the Office of the Health Ombud (OHO) for the period 1 April 2020 to 31 March 2021 and should be read in conjunction with the Annual Report of the Office of Health Standards Compliance (OHSC) for 2020/21, in which the OHO's activities are summarised under Programme 3: Complaints Management and Office of the Ombud.

The current report highlights the following areas:

- The study undertaken by Better Health Programme South Africa (BHPSA) on the impact on the health system of two investigation reports released by the Health Ombud.
- The conduct of the Tembisa Provincial Tertiary Hospital investigation.
- The signing of a twinning agreement between the United Kingdom's Parliamentary Health Services Ombudsman (PHSO) and OHO.
- The Ombud's appointment to the Data Safety Monitoring Board (DSMB) for five clinical trials on COVID-19 vaccines that were funded by the US Government.
- Activities of the Complaints Centre and Assessment Unit.
- Activities of the Investigation Unit.
- Progress in relation to the OHO Bill, which will separate the Health Ombud from OHSC and establish the former as an independent entity.

4.2 Study on impact of key investigations

The UK government's Better Health Programme (BHP) is a global programme for health system strengthening led by its Foreign, Commonwealth and Development Office and delivered in South Africa by Mott MacDonald. During 2020, the Better Health Programme South Africa (BHPSA) concluded a study to track the impact of OHO reports on two important investigations:

- Report into the circumstances surrounding the deaths of mentally ill patients: Gauteng Province, released on 1 February 2017.
- Report on an investigation into allegations of patient mismanagement and patient rights' violations at the Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre, released on 23 August 2018.

The study sought to determine the changes brought about by these reports in the areas of policy and practice. The ultimate aim was to identify factors that may facilitate or impede implementation of OHO recommendations and indicate ways to strengthen the impact of the Health Ombud's reports.

The emphasis was on determining the impact of the main findings and recommendations in both reports. A secondary activity was an internet search and analysis of media reporting following the release of the reports.

Background

The Life Esidimeni and Tower Hospital investigations both centred on the care of mental health patients in the public sector and contributed significantly to highlighting the state of mental healthcare services.

Limitations

The main data collection method was a desktop review, relying primarily on information in the public domain. This was complemented by responses to a self-administered questionnaire completed by selected respondents. The COVID-19 lockdown imposed serious limitations as face-to-face interviews and site visits to Tower Hospital were not possible.

Study findings

Life Esidimeni

According to a national Department of Health (NDoH) report for 2017/2018, all 18 recommendations in the OHO's Life Esidimeni Report were implemented. However, media research showed that full implementation of some recommendations was delayed due to the slow workings of the criminal justice system.

Significant results following the release of the OHO report included:

- The immediate closure of the Life Esidimeni deinstitutionalisation project and relocation of patients to safe establishments.
- Investigation of all 27 NGOs involved and institution of legal action, where appropriate.
- Publication of new guidelines for licensing of NGOs for the provision of residential or day care for mental health patients.
- Creation of an alternative dispute resolution process for families of the affected service users and the government. This took the form of an arbitration process that made financial awards to families.
- A far-reaching review by the South African Human Rights Commission (SAHRC) on the state of mental healthcare in South Africa with key findings on weaknesses in the services. The report included specific recommendations and time-bound actions for the NDoH, provincial departments of health and related structures.
- The revitalisation of the Mental Health Review Board for Gauteng.
- Initiation of disciplinary procedures for implicated senior officials in the Gauteng Department of Health (GDoH), resulting in the resignation and/or suspension of several officials.
- An investigation by the National Prosecuting Authority (NPA), which resulted in a decision to conduct a formal inquest to determine the responsibility of various role players for the deaths of patients.

Tower Hospital

Tracking the implementation of recommendations made in relation to Tower Hospital was difficult as some could not be verified without a site visit, which was not possible under COVID-related restrictions. Media and online reports revealed the following recommendations were implemented:

- Disciplinary measures were taken against named staff at Tower Hospital. These included the suspension of the whistle-blower who had inadvertently infringed patient rights in the process of raising the alarm.
- An administrator was appointed to review systemic failures in implementing the National Mental Health Policy Framework and Strategic Plan (2013 - 2020), oversee mental healthcare in the Eastern Cape and establish a new directorate within the provincial health department. However, the administrator was unable to achieve any of his mandates due to a lack of support and cooperation from officials in the Eastern Cape Department of Health. He recommended that the relevant officials be held accountable by the province.

Wider impacts

The two reports achieved an impact beyond the systems that had been directly investigated and these wider impacts included:

- Contributing to the development of a culture of accountability in the country.
- Adding impetus to the implementation of many recommendations of the SAHRC review with regard to the strengthening mental health services.
- The NDoH commissioning a study on current spending on mental health services in the public sector and subsequently commissioning an investment case to provide empirical evidence on the costs and benefits of investing in mental health.
- The institution of NDoH action on systemic weaknesses in mental healthcare, including the establishment of mental health review boards in all provinces, the formation of multisectoral and advisory committees on mental health, better integration of mental health into primary healthcare, and strategies to strengthen community-based health services.

Media response to Ombud reports

The Ombud reports on Life Esidimeni and Tower Hospital were widely covered in the mass media and specialised health media. The Esidimeni report received more coverage over a much longer period than the Tower Hospital report, as it had long-term consequences. The Life Esidimeni report was more widely welcomed than the Tower Hospital report which received mixed responses.

Recommendations

The recommendations based on the study are aimed at strengthening the functioning of the OHO and increasing its impact on policy and practice.

Recommendation 1: Extend the legal mandate of the OHO to ensure that the recommendations of the OHO are binding in law. This would avoid the passage of long periods without any action on recommendations. The recommendation would entail legislative change and the establishment of the OHO as a separate statutory entity, with adequate and appropriate human resources.

Recommendation 2: Develop OHO mechanisms and processes to monitor implementation of recommendations effectively. This would require additional resourcing

Recommendation 3: Review the utilisation of administrators. The failure of the administrator to fulfil his terms of reference in the Eastern Cape suggests the appointment of a single person may not be an appropriate remedy in a hostile environment. Perhaps a task team, with suitable competencies, would be more effective.

Recommendation 4: Strengthen the whistle-blower system to ensure potential whistle-blowers are encouraged to report alleged offences and enabled to do so in compliance with the legislative framework and without the risk of negative consequences. Whistle-blowers should maintain ethical professional practice – for example, by preserving patient confidentiality. Awareness activities could be undertaken to familiarise potential whistle-blowers with legally acceptable processes and the protection afforded to them in law. Consideration should be given to the development of a digital "whistle blower app".

4.3 Investigation into the care and death of Mr Shonisani Lethole at Tembisa Hospital

The Health Ombud and Senior Investigator Ms Helen M Phetoane investigated a complex complaint concerning the care of Mr Shonisani Lethole, a patient with COVID-19, who died in Tembisa Provincial Tertiary Hospital (TPTH) in Gauteng in June 2020.The investigation took six months and had wider significance for a health system challenged by the management and care of COVID-19 patients. It was the first investigation undertaken by the OHO since the declaration of a state of national disaster in response to the COVID-19 pandemic. The release of the investigation report generated prominent media coverage and widespread public interest. It prompted the Parliamentary Portfolio Committee on Health to conduct a fact-finding visit to Tembisa Hospital.

Findings of the investigation

A brief summary of the report is presented below. The full document, entitled: The report into the circumstances surrounding the care and the death of Mr Shonisani Lethole at Tembisa Provincial Tertiary Hospital, is accessible on the Health Ombud's website, as are reports on other investigations by the OHO.

Minister of Health Dr Zwelini Mkhize lodged the relevant complaint and requested the Health Ombud to investigate the care and circumstances of death of Mr Lethole. The Ombud commenced the investigation on 6 July 2020, produced a preliminary report, invited those implicated to comment on this document, assessed these responses and prepared a final report which was published in February 2021.

The process was triggered by a tweet from Mr Lethole on 25 June, using the Twitter handle @Shonilethole: @DrZweliMkhize Mkhize can I respond to your tweets if the problems I have at one of your facilities continues it is becoming unbearable, and they don't seem to care. Didn't eat for 48 hours.

The tweet went viral and sparked an online campaign #JusticeforShoni. But by the time the Minister became aware of it (his Twitter account was managed by a third party), Mr Lethole was no longer alive.

The Health Ombud's investigation established that:

- Mr Lethole, a 34-year-old without a history of co-morbidities, was admitted to the Casualty COVID-19 Isolation area of Tembisa Hospital, where patients remained while awaiting their COVID-19 test results. It was confirmed that Mr Lethole had SARS-CoV-2 pneumonia. He was then transferred to a ward that accommodated COVID-infected patients along with other patients.
- For 100 hours and 54 minutes of his total hospital stay of 153 hours and 54 minutes Mr Shonisani Lethole received no meals. There was no evidence that he was served food while in Casualty COVID-19 Isolation and no indication that a nasogastric tube had been inserted to feed him after intubation. His family brought food to the hospital but cleaners did not deliver it to him because they were afraid to enter the isolation area without adequate personal protective equipment.

    - On the failure to feed Mr Lethole in Casualty COVID-19, the report commented: "Whether Mr Lethole was 'officially or unofficially admitted' he depended entirely on the hospital for his needs, wellbeing, and care. He was weak, he was on oxygen, he was already being treated for COVID-19, he had spent the night at the hospital without supper and breakfast. The hospital had a duty of care for Mr Lethole. He was pleading with his parents to bring him food for lunch or supper."

    - On the later failure to insert a nasogastric tube, the reported stated: "This took place when he was most vulnerable and sedated. The health care professional team of doctors and nurses conceded to the investigation this negligent, callous, and uncaring omission. This uncaring attitude represented gross medical negligence."

- A rigorous verification process was required to establish the time and date of Mr Lethole's death "due to incongruities and inexplicable conflicting evidence obtained from the two clinical teams, caring for the same patient, in the same ward and the same hospital . . . There was a clinical team that swore under oath that he died on 28 June 2020, and the other clinical team equally declared that he died on 29 June 2020." These contradictory claims were due to poor record-keeping and a lack of proper communication. The record of telephone calls between the hospital and Mr Lethole's father together with the evidence of the manager of the ward enabled the OHO to establish that Mr Lethole had died at 22h30 on 29 June. His death was only certified by a doctor 10 hours and 15 minutes after he died, and his body remained on his hospital bed until then.

- There was no attempt to perform cardiopulmonary resuscitation (CPR) on Mr Lethole despite the fact that he was young and without co-morbidities. Also, the decision regarding CPR was not documented and not discussed with the patient or his family, according to the Morbidity and Mortality form from TPTH. The report observed: "The decision made not to resuscitate Mr. Lethole was ill-conceived and in contravention of the Tembisa Hospital Resuscitation Guidelines."

- X-rays and blood tests performed on admission showed that Mr Lethole was "severely ill with multiple systemic tissue injuries of the kidneys, liver, lungs, and skeletal muscles and with a systemic inflammatory response, all consistent with SARS-CoV-2 infection". However, these critical results were not reviewed, interpreted and acted upon by the senior

doctors caring for him. The investigation concluded: “Had these grossly dysfunctional test results been properly reviewed and acted upon timeously and followed up, Mr Lethole’s management pathway would have been significantly altered. This failure of tests results, and review analysis constituted a serious error of clinical decision-making in the care of a severely ill patient.”

- The management of Mr Lethole put other patients at risk of COVID-19. From Casualty COVID Isolation he was moved to a ward where the COVID-status of other patients was mixed. The delay in moving his body (and those of others who succumbed to COVID-19) increased the risk of infection to COVID-negative patients. However, family members and others who had visited his home were later traced by health workers to established their COVID-status. Family members had already taken the initiative to test for the virus.

- Independent experts appointed by the OHO established that Mr Lethole’s medical care was characterised by inordinate delays in respect of consultations, follow-up on clinical decisions and interventions. Furthermore, clinical record-keeping was “appalling”.
  - About 69 hours and 19 minutes elapsed between Mr Lethole’s arrival at the hospital and his assessment by two medical practitioners (who failed to appreciate the severity of his condition because they did not review X-rays and test results). The delay in professional care was deemed negligent by the experts who form part of the investigation.
  - Mr Lethole was not regularly monitored and evaluated as would be the norm for someone as ill as he was. He was left for prolonged periods with low oxygen saturation “which would no doubt have resulted in further systemic tissue injuries, contributing to his deteriorating health condition”.
  - When Mr Lethole’s condition deteriorated, necessitating intubation and mechanical ventilation, intubation was delayed by 1 hour and 55 minutes. The standard practice of a postintubation chest X-ray to confirm correct placement of the endotracheal tube was not followed. “The delay in intubation, the failure to do a postintubation X-ray, and the failure to insert a nasogastric feeding tube are all serious clinical failures with consequence,” the investigators concluded.
  - Mr Lethole’s condition was inadequately monitored by the clinicians despite the fluctuation in his oxygen saturation levels while ventilated. The last documented doctor’s review, before he was certified dead on 30 June, was at 17h00 on 28 June 2020. “This for a patient sedated, intubated and not being fed, who needed intensive monitoring, evaluation and interventions, was grossly negligent,” the report observed.

- Interviews with staff, information contained in clinical records, and the findings of independent experts who visited the hospital all led to the conclusion that Mr Lethole’s care contravened several basic prescribed norms and standards, and rules and regulations of health care. “There was a complete mismatch between the severity of his medical condition and the level and environment of his care. The care was provided by well-meaning, but inexperienced and inadequately supervised healthcare practitioners in an unsuitable and not fit for purpose environment,” the investigation found.

- The report further states: “While both the Health Ombud and investigator reported several findings of systems-related nature, these were not sufficient to explain the degree of substandard and negligent care provided to Mr Lethole. The health professionals involved had to shoulder direct and collective responsibility for this sub-standard and neg-

ligent care. They failed Mr Lethole, they failed Mr. Lethole's family, they failed each other through total lack of leadership, a lack of management plan, a lack of collaboration and communication, a lack of teamwork and team spirit, and a failure to observe basic good clinical practice."

- Among the systemic weaknesses and failures noted were: absence of a system of collaboration among health practitioners; lack of proper monitoring and shift change-over procedures; poor record-keeping and poor communication among staff; absence of a clearly articulated (case) management strategy, and – very importantly – "a severe shortage of staff with requisite experience and competencies to the detriment of patient safety". In terms of record keeping, there were no clinical notes on Mr Lethole for two days. "One possibility was that these notes were never recorded . . . or that these notes were lost. In either scenario, to have missing patient's notes in a health establishment represented gross negligence in Mr Lethole's care. TPTH and its management must take responsibility and accountability for this appalling record-keeping," the investigation observed.

Recommendations

The Health Ombud made the following recommendations:

- The Gauteng MEC for Health, Dr Nomathemba Mokgethi, must urgently appoint an independent forensic and audit firm to:
  - Conduct a competency, "fit for purpose" assessment of the leadership and management at TPTH.
  - Review and revise the hospital's admission policy and processes to bring these in line with universally acceptable practice.
  - Review corporate governance at the hospital in line with appropriate King IV corporate governance principles.
  - Conduct an appropriate climate survey among staff and patients to assess attitudes to patient care.

The outcomes of this audit were intended as a foundation for Tembisa Hospital to rebuild and improve its quality of care.

- The Health MEC should also institute a disciplinary inquiry into the actions of Dr Lekopane Mogaladi, the CEO and Accounting Officer of TPTH, for presiding over state of affairs uncovered by the investigation. In particular, the report noted Dr Mogaladi's signing of inaccurate and misleading reports to the former MEC of Health and his failure to report to the police various missing clinical notes.

- The Gauteng Department of Health and TPTH should institute a disciplinary inquiry by a panel comprising a senior medical doctor and a senior nurse, supported by senior legal counsel with experience in medico-legal and disciplinary matters. This inquiry should investigate the actions of nine doctors, four nurses, a clinical associate and various support workers, including food services personnel. Four of the doctors should be investigated for failing in their duty of care. Other practices to be investigated included providing misleading information about the readiness of the facility for COVID-related care, failure to ensure the availability of functioning critical care equipment, poor record keeping, unauthorised use of professional credentials and misuse of authority, and providing inaccurate

and/or misleading information to the investigation.

Legislation provides for affected parties to lodge an appeal with the Minister against any finding of the Health Ombud. Currently, two appellants have registered appeals and an appeal tribunal, as required by law, has been appointed to adjudicate the matter.

A positive response to the report has been its use by some health establishments to review their practices for the benefit of patients and staff.

4.4 Twinning agreement between PHSO and OHO

In March 2021 a twinning agreement between the OHO and the PHSO in the UK was signed by their respective heads, Professor Malegapuru Makgoba and Mr Rob Behrens. The possibility of the two offices concluding a memorandum of understanding had first been discussed during the OHO's benchmarking visit to London two years earlier.

The aim of the twinning agreement is to foster cooperation and the exchange of knowledge, experience and skills in investigating and managing health-sector complaints which cannot be resolved by other government departments or related institutions.

The twinning agreement was facilitated by BHPSA, which will support the OHO to enable its full participation in the twinning agreement and ensure maximum impact.

4.5 Monitoring of US COVID-19 vaccine trials

In June 2020 Professor Makgoba was invited to serve on the data safety monitoring board (DSMB) of the US government's Operation Warp Speed, which was created to expedite the development of an effective COVID-19 vaccine. The programme provided support to five clinical trials designed to investigate the safety, immunogenicity and efficacy of various candidate vaccines.

To preserve the objectivity of clinical trial, the trial researchers remain unaware of the emerging trial data until the field work is complete. However, this data must be monitored to ensure that the test vaccine is not harming people receiving it and, if the vaccine shows clear results early on, that the study is not unnecessarily prolonged. The DSMB fulfils this role by periodically reviewing the data during the course of the trial and evaluating participant safety, study progress and signs of product efficacy (or futility).

The Warp Speed DSMB made regular recommendations to the US National Institute of Allergy and Infectious Diseases (NIAID) concerning the continuation, modification or termination of the trials.

During the current reporting period, three of the five candidate vaccines were recommended for application to the US Food and Drug Administration for emergency use approval. This was a breakthrough in an extraordinary scientific effort to provide protection against a virus that was completely unknown about a year earlier and had massive implications for global health.

Prof Makgoba was co-author of an article articulating the workings and challenges of the DSMB which was published in May 2021 in the Journal of Infectious Diseases.

4.6 Complaints Centre and Assessment Unit

Human capital

During 2020/21, as in the previous year, the unit operated at 76% of its intended human resource complement – that is, with 19 of 25 posts filled. Six of these posts were funded on a contract basis and they made a significant contribution to reducing the backlog in cases assessed.

Complaints Centre and Assessment Unit

The Complaints Centre and Assessment Unit receives and registers complaints from the public regarding breaches of norms and standards by health establishments and speedily resolves low-risk complaints.

The number of people utilising the Complaints Centre and Assessment Unit has grown steadily over the past five years. In 2020/21, the Complaints Centre and Assesment Unit saw a 16.6% year-on-year increase in complaints received and registered – that is, 2 429 complaints, compared to 2 083 in 2019/20. Although this growth is not as great as that recorded two or three years previously, it is gratifying in light of the difficulties posed by the COVID-19 pandemic and related restrictions. Measures for remote working appear to have been effective in ensuring continuity. They included diverting calls to the phones of Call Centre staff and enabling remote access to the online complaints management system

It appears the growing utilisation of the Call Centre is due to complainants' preferring to appeal to the Office of the Ombud rather than seek resolution at health establishment level.

1 Steven Joffe MD, MPH, Abdel Babiker PhD, Susan S Ellenberg PhD, Alan Fix MD, MS, Marie R Griffin MD, MPH, Sally Hunsberger PhD, Jorge Kalil MD, PhD, Myron M Levine MD, DTPH, Malegapuru W Makgoba, MB, DPhil, Reneé H Moore et al. Data and safety monitoring of covid-19 vaccine clinical trials. Journal of Infectious Diseases, jiab263, https://doi.org/10.1093/infdis/jiab263

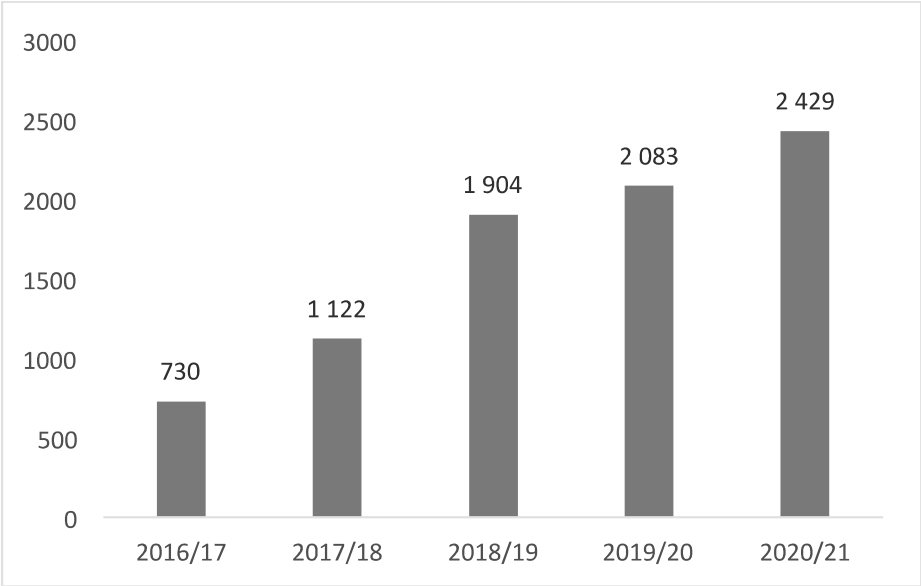


Figure 1: Increase in complaints received by Complaints Centre and Assesment

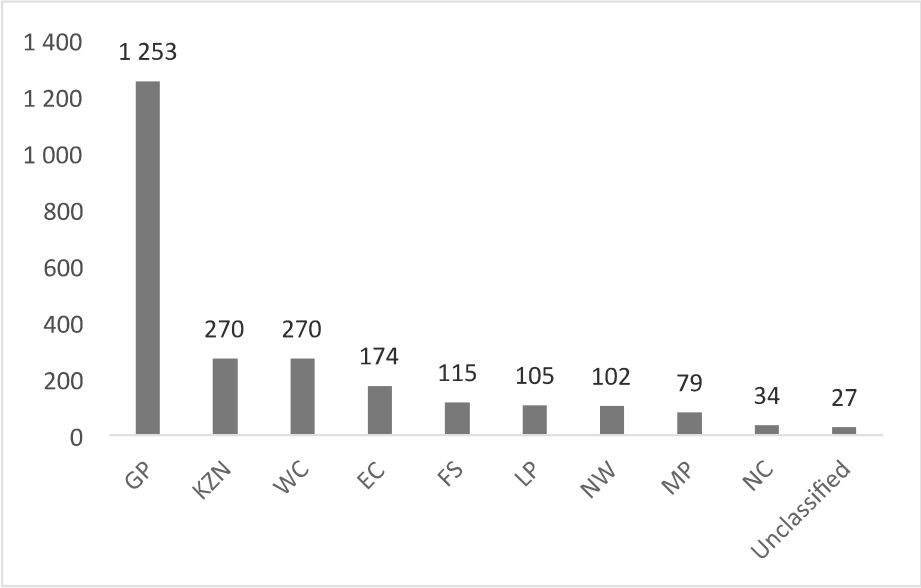


Figure 2: Complaints received in 2020/21 by province

By far the greatest number of complaints – nearly 52% of the total – were received from Gauteng, with the Western Cape and KwaZulu-Natal recording the next most complaints. The figures indicate that the OHO has a footprint in all provinces. The proximity of Gauteng to OHO and confidence of residents in using reporting systems may be a contributory factor to the significantly higher share of complaints received from this province.

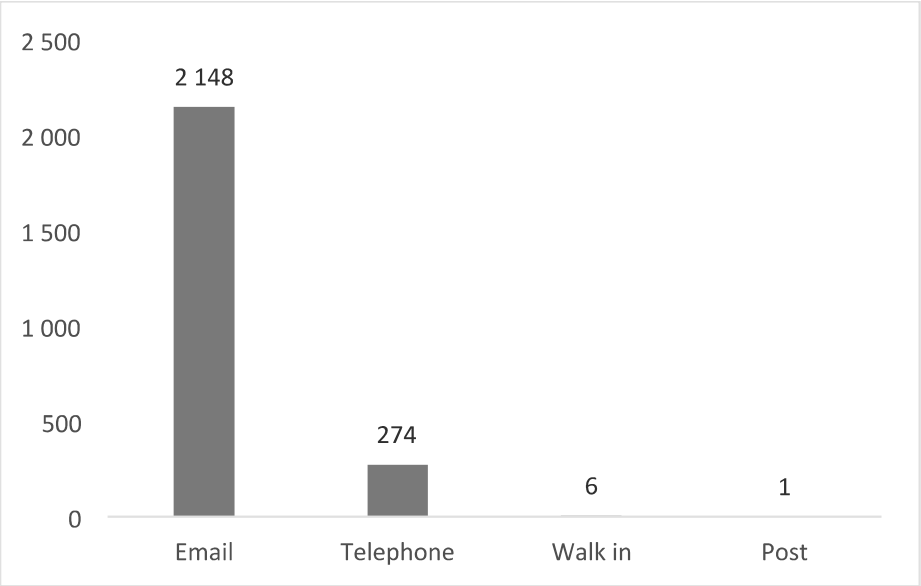


Figure 3: How complaints were received

In 2020/21 about 88% of complaints were received through email, suggesting that they are from a section of the population that is literate and has access to technology. Virtually all other complaints were phoned in to the Call Centre. In 2019/20 a lower proportion of complaints was received by email (77%) than in this reporting year and 22% were registered by phone. It is possible the conditions prevailing due to COVID-19 affected complainants' choices.

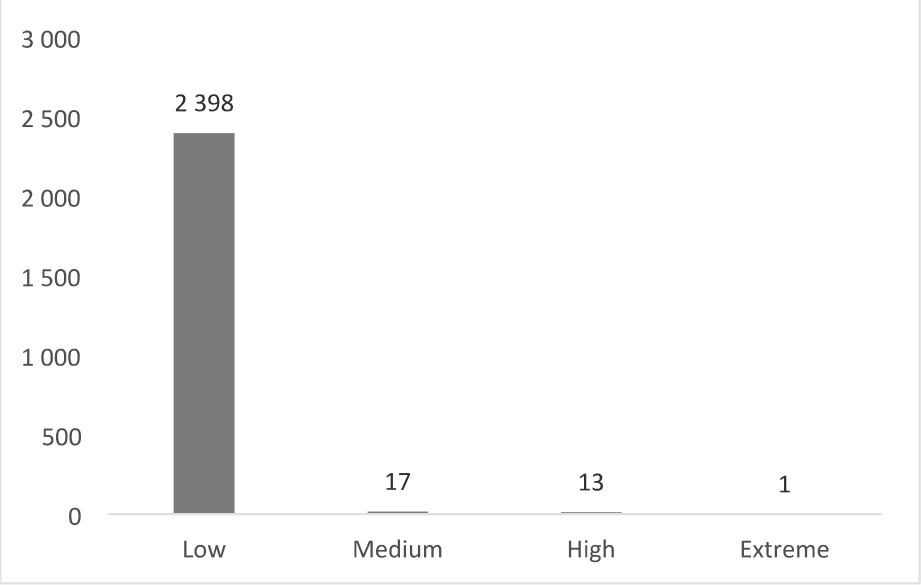


Figure 4: Complaints received by risk classification

Nearly 99% of complaints received were classified as low-risk and many should have been resolved by health establishments. Call Centre complaints officers facilitated the resolution of such complaints by contacting the relevant health establishments and mediating between them and the complainant to ensure a satisfactory outcome.

All medium-, high- and extreme-risk cases – which involve serious breaches of promulgated norms and standards – were assigned for assessment.

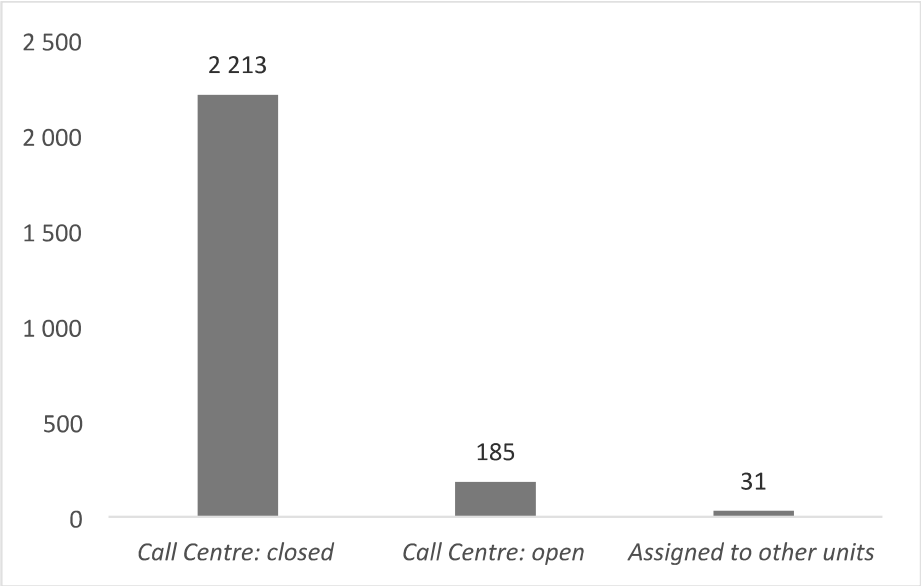


Figure 5: Status of complaints received 2020/21

The overwhelming majority of complaints logged were closed by the Call Centre, and 91.8% were closed within 25 days which was well within the target of 65%.

Complaints Centre and Assessment Unit

The purpose of the Assessment Unit is to assess complaints and either propose ways to resolve them or refer them to the Investigation Unit for investigation. In some instances, complaints are referred to other entities which have jurisdiction over the particular type of complaint.

The Assessment Unit has been under-resourced and has carried a substantial number of open cases from one year into the next. In 2020/21 it had a total of 285 open complaints and managed to resolve 174 of these. This meant the unit closed the financial year with 111 open complaints, compared to 265 at the end of 2019/2020.

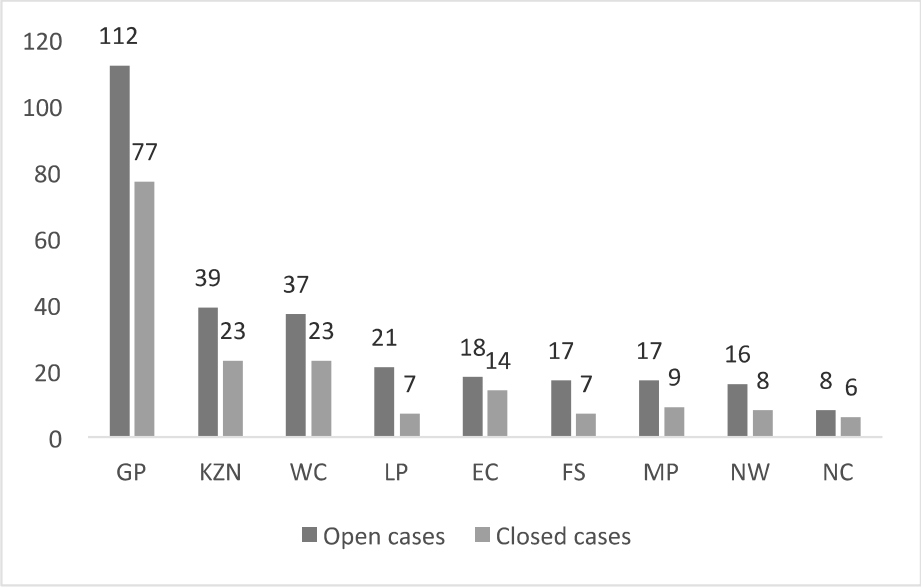


Figure 6: Cases under assessment in 2020/21 by province

Gauteng had the greatest number of open cases at the start of the year and closing 69% of cases in this province made a great contribution to reducing the backlog. In other provinces the proportion of cases closed ranged from a low of 33% in Limpopo and 41% in Free State, to a high of 78% in the Eastern Cape and 75% in the Northern Cape.

The Assessment Unit referred eight cases for investigation during this period. To reduce pressure on the Investigation Unit, 63 cases meeting criteria for investigation were retained and 32 of these were closed through assessment.

The Assessment Unit had aimed to close 45% of all cases, including the backlog of unresolved cases that had accumulated in previous years due to past human resource constraints. Due to the size of the backlog, the unit closed only 2.5% of the global number of outstanding complaints.

Other Assessment Unit achievements

Two abstracts by Mr Monnatau Tlholoe were accepted as poster presentations at the 2020 ISQua Conference:

- Life Esidimeni investigation: lessons and implications for the health sector.
- Reflections on compliance with complaints management in the public health sector of South Africa: OHSC inspection findings.

The unit was represented at a collaborative meeting with the United Nations Subcommittee on Prevention of Torture (SPT) in November 2020. This was coordinated by the Human Rights Commission to discuss progress made in South Africa's implementation of the Optional Protocol to the Convention against Torture (OPCAT). A written response to questions posed by UN subcommittee was submitted, focusing on the Health Ombud and plans to integrate the OPCAT preventive mandate into the OHO.

4.7 Complaints Investigation Unit

The Complaints Investigation Unit was the component of the OHO most affected by the national lockdown introduced by President Cyril Ramaphosa to curb the spread of the COVID-19.

The conduct of onsite investigations was significantly restricted. However, the circumstances prompted the unit to reflect on adapting its processes to suit the new normal. Some investigations were performed via desktop inquiry, showing that not all require an onsite visit. Virtual interviews were conducted with witnesses who consented to this method.

A total of 85 cases that were scheduled for investigation could not be investigated under the regulations applicable to COVID-19 lockdown levels 5, 4 and 3.

In cases where the two-year deadline for completion of the investigation was applicable, an effort was made to determine the COVID risk in areas where the health establishments were located and adopt special precautions when conducting onsite inspections.

Table 1: Investigations prevented by COVID-19 restrictions

Province	Number of investigations
Western Cape	7
Northern Cape	2
Free State	12
Gauteng	33
KwaZulu-Natal	7
Mpumalanga	6
North West	5
Limpopo	5
Eastern Cape	8
Total	**85**

The Complaints Investigation Unit assisted the Health Ombud to investigate the care and circumstances of the death of Mr Lethole at Tembisa Hospital, featured earlier in this report.

The OHSC Board approved the secondment of staff members to the Call Centre and Assessment and Investigation units and a project plan for implementing this was shared with affected staff.

Complaints received and investigated

A total of seven cases lodged in 2020/21 were referred for investigation.

- Two of the seven cases were eligible for investigation within six months. The Health Ombud investigated and resolved one case within six months, while the other was investigated in November 2020 and the preliminary report was undergoing review at year end.
- Five cases were only received for investigation in quarter 4 of 2020/21 and were scheduled for completion in the following financial year.

Investigators handled 10 backlog cases. At year end, closure was pending in four of these cases (awaiting comments from the complainants and the health establishments), and preliminary reports were undergoing review in the other six cases.

Table 2: Progress recorded in respect of current backlog cases

Year of referral for investigation	Cases for investigation, including backlog	Cases resolved during 2020/21	Cases at stage of preliminary report review	Open cases (current)
2015/16	1	0	0	1
2016/17	23	1	0	22
2017/18	83	2	3	78
2018/19	38	0	5	33
2019/20	5	0	0	2
2020/21	2	0	0	2
Total	152	3	10	139

Challenges

The number of backlog cases poses a reputational risk to the OHO and the OHSC. There are complainants who lodged complaints as far back as 2016 still awaiting an outcome.

The majority of matters referred for investigations are rated extreme- and high-risk. Investigators are required to deal with voluminous documentary evidence which has to be gathered and carefully analysed.

The fundamental and persistent constraint on case resolution is the limited investigative capacity of the OHO. This was compounded in 2020/21 by restrictions on travel and other activities due to the pandemic.

4.8. Independence of the OHO

In accordance with a recommendation of the Presidential Health Summit of 2018, the NDoH legal team has prepared the draft OHO Bill to provide for the establishment of the OHO as a separate entity from the OHSC. The Bill will soon be available for consultation and inputs.

The OHSC Board has effected an administrative transfer of the Complaints Centre and Assessment Unit and the Complaints Investigation Units to the OHO.

The OHSC is in the process of re-organising the OHO Budget accordingly.

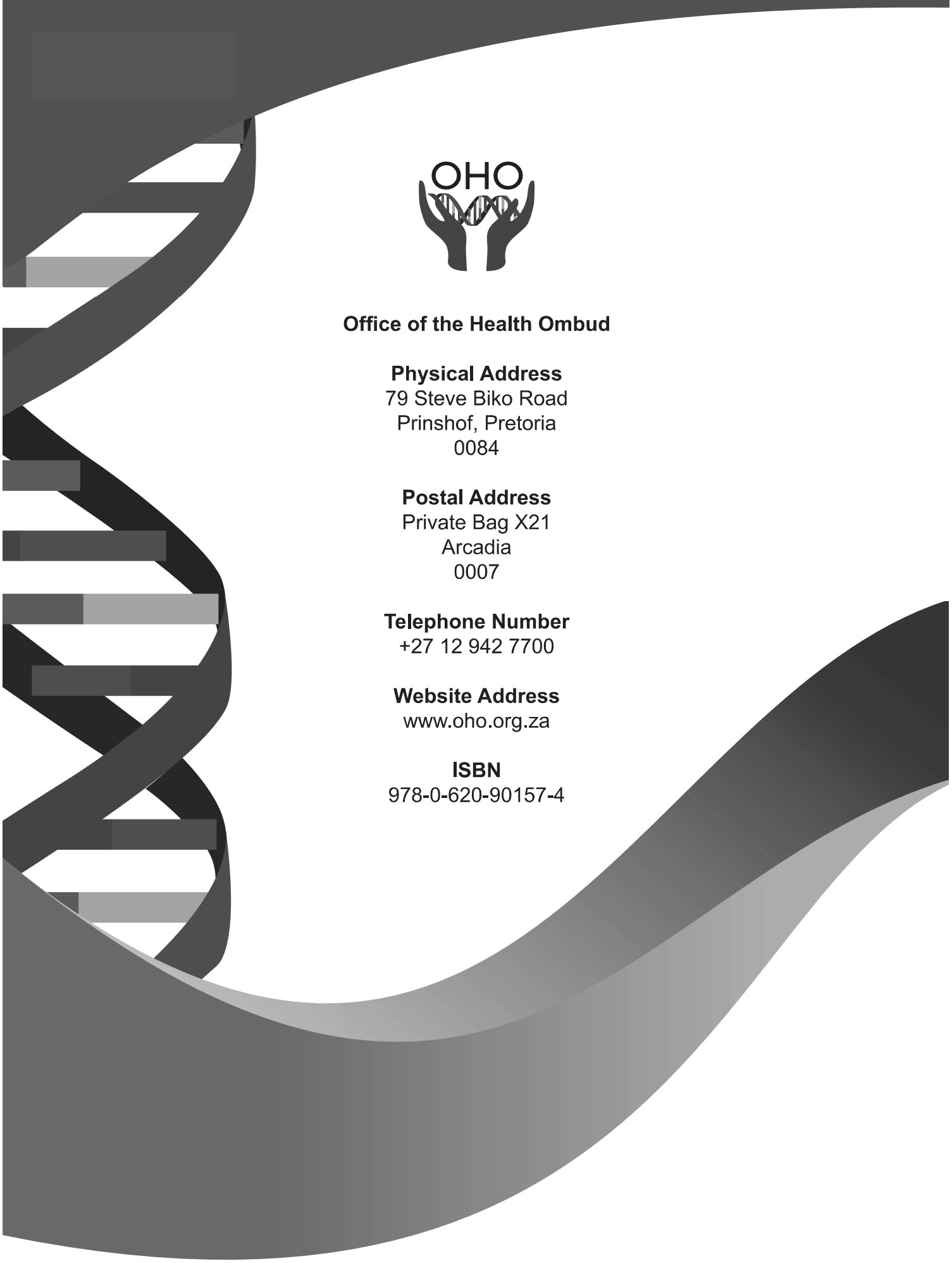
4.9. Conclusion

In the past year, key actions of the OHO have consolidated its position as an entity trusted by the public to discharge its mandate without fear, prejudice or favour. The Tembisa Hospital investigation was the outstanding instance of this.

The study on the impact of previous investigations underscores the importance of the quality of the work we do and its contribution to building a national health system that offers quality care.

Our office continues to enjoy international recognition, as illustrated by the BHPSA-sponsored twinning agreement with the PHSO (UK) and the appointment of the Ombud to the Operation Warp Speed DSMB.

The efficiencies of the Call Centre, the Assessment Unit and the Investigation Unit continue to improve, despite significant resource constraints



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