

## **Acknowledgements**

The commission extends sincere gratitude to the Minister of Health and to the Member of the Executive Council for Health for their speedy constitution of the commission. We would also like to extend our thanks to all the people who came forward to give evidence to the commission.

The commission acknowledges the good work of the media especially The Witness for bringing to the attention of the public issues of human rights abuses at Townhill hospital.

## **GLOSSARY AND ACRONYMS**

AA	Alcoholics Anonymous
BATHO PELE	People First. Eleven Principles for improved customer care in the Public Services
CPN	Chief Professional Nurse
CCTV	Closed Circuit Television
COHSASA Africa	Council of Health Services Accreditation of South Africa
CURATOR AD LITEM	Legally appointed administrator of patient's property whilst they are certified mentally incompetent
DENOSA	Democratic Nurses Organisation of South Africa
EAP	Employee Assistance Programme
ECT	Electro Convulsive Therapy
FNH	Fort Napier Hospital
HOSPESA	Health and Other Service Personnel Trade Union of South Africa
KZN	KwaZulu Natal
LOA	Leave of Absence
NEHAWU	National Education Health and Allied Workers Union
NUPSAW	National Union of Public Services and Allied Workers
OPD	Out Patients Department
PADCA	Pietermaritzburg and District Council for the Care of the Aged
PSA	Public Servants Association
PRO	Public Relations Officer

SAPS

South African Police Services

SPD

State Patients

## **EXECUTIVE SUMMARY**

### **1. INTRODUCTION**

The National Minister of Health- Dr Manto Tshabalala-Msimang and KwaZulu-Natal MEC for Health, Mrs Peggy Nkonyeni, visited Townhill hospital on Monday 7<sup>th</sup> February 2005. The visit was in response to allegations of human rights abuse at the hospital reported in The Witness of Saturday 5 February 2005. A Commission of Enquiry was established to investigate the allegations.

### **2. COMMISSION OF ENQUIRY**

Eight members including experts in mental health care services, Legal services, Public service oversight, hospital board and a representative of the community formed the commission. A committed secretarial service with the responsibility of audio recording of the proceedings was assigned to the commission.

### **3. OBJECTIVES**

The terms of reference of the Commission of Enquiry were to investigate allegations of human rights abuses of psychiatric patients at Townhill hospital and report their findings to the Minister in line with the media reports.

### **4. METHODOLOGY**

The public was invited through notices in the print and electronic media to make submissions relating to the allegations. Interviews and site inspections were conducted. Written submissions were received. Legislative and regulatory frameworks were studied. Reports of previous commissions as well as hospital records were analysed.

### **5. KEY FINDINGS AND RECOMMENDATIONS**

The findings of the commission confirm media allegations of human rights abuses at Townhill hospital. In addition the commission identified the following systemic defects:

- ❖ Weak management over a long period of time.
- ❖ Absence of a hospital board.

- ❖ Inadequacies in the physical layout and quality of facilities.
- ❖ Abuse of staff by patients.
- ❖ Staff reporting on duty under the influence of alcohol.
- ❖ High rate of absenteeism.
- ❖ Shortage of staff.
- ❖ Lack of discipline.
- ❖ Evidence of racism, nepotism and favouritism.
- ❖ Strained relations between the management and unions.

The commission recommends that remedial and preventative measures be undertaken as a matter of urgency to combat human rights abuses and address deficiencies in the system.

## **1. BACKGROUND INFORMATION**

Following the allegations of human rights abuses at Townhill hospital that appeared in *The Witness* on Saturday 5<sup>th</sup> February 2005, the National Minister of Health- Dr Manto Tshabalala-Msimang and KwaZulu-Natal MEC for Health, Mrs Peggy Nkonyeni, visited Townhill hospital on Monday 7<sup>th</sup> February 2005.

After meeting the hospital Management and conducting an *in loco* inspection, the Minister addressed the hospital community. She had been shocked by the newspaper report and had viewed the allegations seriously more especially as the new Mental Health Care Act was being implemented. She expressed that there should be expeditious intervention.

## **2. COMMISSION OF ENQUIRY**

The Minister established a Commission of Enquiry to investigate the allegations and report to her in three weeks' time. After the expiry of three weeks, the chairman of the commission gave an interim report and requested an extension of the time frame. It had come to light that there were issues that required intensive investigation.

## **3. MEMBERS OF THE COMMISSION**

**Prof DL Mkize**- Head of Department of Psychiatry, Nelson Mandela School of Medicine & Head of Mental Health Services KwaZulu Natal – Chairman.

**Ms P Tengeni** – Resident Commissioner KwaZulu Natal, Public Service Commission- Deputy Chairperson.

**Mr JC Dreyer**- Member of Townhill Hospital Interim Board.

**Miss PB Dlamini**- Secretary to the Commission.

**Ms NG Mhlaluka** – Programme Manager Mental Health & Substance Abuse, KwaZulu Natal.

**Prof EMQ Mokhuane**- Head of Department of Psychology, University of Limpopo (Medunsa Campus).

**Dr T Rangaka**- Specialist Psychiatrist in Private Practice, President Elect of Society of Psychiatrists of South Africa (SASOP).

**Mrs AN Zondi**- Chief General Manager, Legal Services in KwaZulu Natal.

#### **4. TERMS OF REFERENCE**

The mandate of the Commission of Enquiry was to investigate allegations of human rights abuses of psychiatric patients at Townhill hospital. In line with the media reports, the following issues were investigated:

- 4.1 Neglect of patients
- 4.2 Allegations of sexual abuse amongst patients and staff turning a blind eye.
- 4.3 Physical abuse of patients by staff members.
- 4.4 Theft of patients' food.
- 4.5 Theft of patients' belongings.
- 4.6 Patients sleeping on the floor.
- 4.7 Female patients not allowed access to underwear.
- 4.8 Physical abuse of staff members by patients.
- 4.9 Staff reporting on duty under the influence of alcohol.
- 4.10 High rate of staff absenteeism.
- 4.11 Any other matters the Commission deems necessary.

#### **5. METHODOLOGY**

A public notice of the enquiry was posted in The Witness, Isolezwe and Mercury inviting interested or affected parties to participate as members of the commission. The notice in the print media was complemented with advertisements on radio stations Ukhozi and Lotus FM. The notices extended an invitation to anyone who had information related to the matter of human rights abuses at Townhill hospital to make submissions to the commission.

The following documents were studied:

- ❖ Media reports
- ❖ Constitution of the Republic of South Africa No. 108/1996
- ❖ National Health Act 2004
- ❖ Mental Health Care Act No. 17/2002
- ❖ Norms Manual for Severe Psychiatric Conditions
- ❖ Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu Natal 2003
- ❖ Patients' Rights Charter
- ❖ Public Service Act
- ❖ Health is a Human Right, Health MEC Budget Speech 2005

The following reports of previous commissions were reviewed:

- ❖ Retief Commission 1996/1997
- ❖ Manzi / Cassimjee Commission 2002
- ❖ Human Rights Commission 2005

The commission of enquiry undertook a study of media reports. Over a period of six weeks from 01 March 2005 the commission met at least once a week to listen to oral submissions, conduct interviews and analyse written submissions. Members of the public, union representatives, patients and hospital staff, were interviewed. A professional stenographer recorded all interviews and made hard copy transcripts of the material.

The approach adopted by the commission also included *in loco* inspection of Townhill hospital wards and precinct. Further interviews were conducted on site with a random selection of patients and staff.

The methodology further included scrutiny of hospital records with special emphasis on patients' files, incidents reports, human resources records and off duty register to test the reported allegations.

## **5 FINDINGS**

The findings will follow the order of the terms of reference.

### **5.1 Neglect of patients**

There is overwhelming evidence of neglect of patients by staff.

### **5.2 Sexual Abuse**

There is evidence of sexual abuse of patients by staff.

### **5.3 Physical Abuse**

The commission of enquiry received information to substantiate the allegations of physical abuse of patients by staff. .

### **5.4 Theft of patients' food and belongings**

There is ample evidence of staff stealing patient's food and belongings.

### **5.5 Patients sleeping on the floor**

On the commission's *in loco* inspection of Townhill hospital evidence was found of floor beds and patients sleeping on them.

### **5.6 Female patients not allowed access to underwear**

The allegations were confirmed and the nurses agreed that female patients sometimes do not wear panties because of the shortage and because of their psychotic state.

### **5.7 Abuse of staff members by patients.**

The commission found evidence of verbal, physical and emotional abuse of staff members by patients. Patients abuse staff members because of the nature

of their illness. There are no trauma counselling services and no satisfactory Employee Assistance Programme.

#### **5.8 Staff reporting on duty under the influence of alcohol.**

There is phenomenal evidence from hospital records and interviews supporting allegations of staff coming to work under the influence of alcohol.

#### **5.9 High rate of staff absenteeism.**

The commission found evidence of a high rate of absenteeism. A disturbing pattern being the escalation of absenteeism after the 15<sup>th</sup> & 30<sup>th</sup> of each month, these being paydays.

#### **5.10 Any other matters.**

##### **5.10.1 Poor patient management.**

During the *in loco* inspection the commission found evidence of poor patient management by the doctors in that some patients are prematurely transferred to the pre-discharge ward while they are still psychotic and others are not discharged when they are ready for discharge. Evidence was further confirmed in the interviews.

##### **5.10.2. Inadequate recreational facilities**

Patients spend most of their time in the wards with little or no exercise and recreation; there is no reading material to stimulate those who are recovering. What is usually provided is television. The undulating gardens of Townhill hospital were not used in the therapy of the patients.

##### **5.10.3. Racism, Nepotism and Favouritism**

There is overwhelming evidence of racism, nepotism and favouritism at the hospital by the middle management and by doctors in the employment, work allocation and clinical management. Ward accommodation reflects a racial bias.

##### **5.10.4. Staff shortage and poor working conditions**

These are major problems in the hospital and were highlighted in almost all the interviews and confirmed during the inspection. The ratio of nursing staff to patients leaves much to be desired. There are three nurses to 26 patients, of these three nurses –one of them is a nursing sister, two are either a staff nurse or a nursing assistant. While with the psychiatrists there are two psychiatrists to 250 patients. This is ridiculous as psychiatric patients particularly in the acute phase need constant attention, they are mostly restless and running around and some maybe aggressive.

Staff shortage at all levels is a major problem. Townhill hospital has on paper, a staff complement of 336. However, at the most, existing staff is 230 due to factors such as budgetary constraints, unavailability of registered psychiatric nurses particularly males as the majority of them go to the prison department or go overseas. The current staff patient ratio is four nurses to 30 patients. When the nurses and doctors compare themselves to their overseas counterparts there is a marked

difference in staff patients ratios. For example in Australia there is usually six psychiatrists to 26 patients and one psychiatric nurse to two patients.

This kind of patient load causes frustration and demoralization of the highly motivated staff. Generally, staff is of the opinion that they are doing a thankless job. The unions also complained about Townhill being short staffed with volunteers coming in to assist with no certainty that they may be employed in the near future. This also contributes to low morale and lack of effectiveness of staff.

Due to staff shortage staff is not always available to give adequate supervision to patients. The commission heard of an incident where a young girl pushed her head through a broken window. Her head was trapped and she died.

#### **5.10.5. Lack of discipline**

The commission found that there was inconsistency in the way the hospital management addressed cases of misconduct as well as grievances.

#### **5.10.6. Strained relations between management and unions**

There is evidence of perceptions that unions are a stumbling block in the handling of misconduct. On the other hand unions maintain that it is their duty to represent their members.

#### **5.10.7 Media reports**

The commission is aware that in order to sell newspapers spectacular and startling headlines are used because they create interest and discussion.

We feel that the most publicised stories are about the times when things go wrong and completely ignore the stories when things go right. These reports can be very damaging institution and the government as they all serve to create inaccurate and misleading images in the public's mind.

People can be led to fear the institution and lose faith in the government's provision of health services. They also lead to low staff morale.

## **6 RECOMMENDATIONS**

The commission is of the opinion that most of the above adverse findings are a result of poor management over a number of years and the absence of an effective hospital board. Furthermore there was no Provincial Director of Mental Health and Substance Abuse to support the hospital management. Lamentably, the National Department of Health also did not have a National Director of Mental Health and Substance Abuse to ensure a quality mental health care service at Townhill hospital. Therefore we strongly recommend that the management should be strengthened by advertising and filling all the vacant management posts and that the hospital board be put in place without delay.

In the medium to long term a specialised psychiatric hospital must be built.

Further recommendations follow the order of the findings.

## **6.1 Neglect of patients**

- 6.1.1** The Patients' Rights Charter should be supported, implemented and monitored. Every morning these principles must be read and internalised by the staff on duty. Further the Patients' Rights Charter must be communicated regularly to patients as part of ward routine. The Patients' Rights Charter must be included as part of the Performance Agreement.
- 6.1.2** Service standards must be clearly defined and prominently displayed at service delivery points. This will make it easy for the public to recognize what is the acceptable professional behaviour.
- 6.1.3** The responsibilities of patients, including expectations of the institution from patients must be clearly defined and prominently displayed at service delivery points and communicated to patients.
- 6.1.4** Identification tags of staff on their uniform/ clothing is essential to improve professionalism and security at the work place.
- 6.1.5** Implementation of proper identification of patients including name tags and contact telephone numbers of the institution to be contacted.
- 6.1.6** Accurate records of patient's movement's possessions and medication must be kept.
- 6.1.7** Communication & liaison with the SAPS and neighbouring institutions must be improved for speedy return of absconding patients.
- 6.1.8** The security company must make mandatory regular patrols of the hospital perimeter and grounds for improved security.
- 6.1.9** Close circuit television cameras should be installed at strategic points and must have 24hours monitoring by the security.

## **6.2 Sexual Abuse**

- 6.2.1** Rape is a criminal offence, the staff member who was dismissed for raping a patient must be charged accordingly and the employer must refer this matter to the SAPS and relevant statutory council.
- 6.2.2** All cases of alleged sexual and physical abuse must be handled according to the protocol, which ensures that the patient will be examined by at least two independent medical practitioners. The complainant must be accommodated in a transparent process of investigation.
- 6.2.3** All suspected or reported cases of sexual abuse must be handed over to the SAPS and relevant statutory council.
- 6.2.4** There must be separate wards for children and adolescents to avoid sexual abuse of this group of patients.
- 6.2.5** Talks on healthy life style should be given to patients.

## **6.3 Physical Abuse**

- 6.3.1** Staff should be trained on how to handle violent and aggressive patients.
- 6.3.2** Protocols on how to handle acutely disturbed patients should be made available to staff members.
- 6.3.3** The commission strongly recommends that all cases of physical abuse must be reported to the SAPS and relevant statutory council.

#### **6.4 Theft of patients food and belongings**

- 6.4.1** The commission finds it difficult to recommend on theft of patients food: but can recommend on patients' belongings. A full inventory must be kept and updated as patients move from ward to ward.

#### **6.5 Patients sleeping on the floor**

- 6.5.1** This practice is more prevalent in the seclusion rooms therefore we recommend that beds should be fixed to the floor.

#### **6.6 Female patients not allowed access to underwear**

- 6.6.1** The commission recommends that disposable underwear be purchased for psychotic patients.

#### **6.7 Abuse of staff members by patients.**

- 6.7.1** Staff must be aware that, because of the nature of their illness, these patients tend to be abusive. Therefore the patients must be treated with tact, tolerance and compassion.
- 6.7.2** Protocols must be followed in handling aggressive patients.
- 6.7.3** As recognition of dangerousness of the work environment the incentive of a danger allowance should be reinstated.

#### **6.8 Staff reporting on duty under the influence of alcohol.**

- 6.8.1** Breathalyser tests must be kept at the matron's office and any suspected intoxication should be reported immediately and the breathalyser test be administered.
- 6.8.2** All suspected cases of intoxication must be examined by doctors on call.
- 6.8.3** An Employee Assistance Programme should be instituted.
- 6.8.4** Due processes should be implemented including disciplinary action and dismissal.

#### **6.9 High rate of absenteeism**

The high rate of absenteeism is directly related to abuse of alcohol, poor working conditions, annual leave conditions for nurses and poorly functioning leave committee.

- 6.9.1** Abuse of alcohol **see 6.8 above**
- 6.9.2** Employee Assistance Programme and wellness clinic for staff.
- 6.9.3** Poor working conditions-Infrastructure upgrade, danger allowance, all vacant post be advertised and filled, proper supervision, clear career pathing, improved relationship with unions.
- 6.9.4** The institution must plan for the even distribution of leave for nurses throughout the year.
  
- 6.9.5** The present leave committee must be disbanded and all matters related to leave must be dealt with by Human Resources.

**6.9.6** All sick certificates must be scrutinised by Human Resources and irregular certificates should be reported to the Health Professions Council of South Africa.

## **6.10 Any other matters**

### **6.10.1 Poor patient management**

- 6.10.1.1** Guidelines should be developed to assist practitioners to maintain a balance between carrying out their duty of care and getting enmeshed in the affairs of health care users thereby running the risk of violating human rights.
- 6.10.1.2** Patients who are wrongfully detained at Townhill hospital must be referred to the review board.
- 6.10.1.3** The decision taken by the hospital not to discharge Mrs X must be referred to the Review Board and the Health Professions Council of South Africa as a violation of human rights.
- 6.10.1.4** A coordinated interdepartmental collaboration between the Department of Health and Social development in the provision of Mental health services must be fostered. The department of Social Development must be involved in the humane placement of geriatric patients who are being kept illegally at Townhill hospital.
- 6.10.1.5** The hospital should institute sustained mental health care campaigns incorporating a human rights culture and a positive image of the hospital.
- 6.10.1.6** Mr X must have access to his hospital records in accordance with the Access to Information Act.

### **6.10.2 Inadequate recreational facilities**

- 6.10.2.1** Reading material to patients who are ready for discharge should be provided.
- 6.10.2.2** More sporting activities should be developed to cater for various needs of patients e.g. football team for patients and staff.
- 6.10.2.3** Optimal use should be made of the beautiful landscape of Townhill. A walking trail should be developed and used for exercise and milieu therapy.
- 6.10.2.4** Occupational therapists must be involved in the care of patients.
- 6.10.2.5** Families and community support network of the patient must be involved as early as possible in the treatment and rehabilitation of the patient. This will promote the reintegration of the patient into his/her community.

### **6.10.3 Racism, Nepotism and Favouritism**

A designated transformation committee must be formed as a matter of urgency to deal with these anomalies and to educate and train people about transformation. Further the Department of Health should investigate the management style of the Assistant Director and take appropriate action.

### **6.10.4 Staff Shortage**

**6.10.4.1** Strict adherence to the **Norms Manual for Severe Psychiatric Conditions** issued by the department of health, Republic of South Africa must be enforced.

**6.10.4.2** To advertise and fill all vacant posts.

**6.10.4.3** To employ orderlies.

**6.10.4.4** The Department of Health, the Department of Psychiatry and the Department of Nursing should meet as soon as possible with a view to develop a curriculum to train mid level mental health workers.

**6.10.4.5** A psychiatric elective should be added in the training of staff nurses.

**6.10.4.6** There must be a conscious plan to recruit male nurses in the field of psychiatry.

**6.10.4.7** The retention strategy to prevent exodus of nurses must include plans for nurses to go overseas for a certain period to gain experience and be reabsorbed on return.

**6.10.4.8** Facilities for relatives to stay at the hospital with patients should be provided so that they get involved in the treatment and management of patients while they are still in hospital.

#### **6.10.5 Lack of discipline**

The ICN code of ethics for nurses must be put in place and practised and any lack of discipline should be reported to the South African Nursing Council.

#### **6.10.6 Strained relations between management and unions**

There must be a clear recognition agreement between unions and management to regulate their relationship.

### **7. LIMITATIONS**

The commission was unable to interview Dr JW Walker, a main player in the previous poor management as mentioned above.

Social Workers and Psychologist were also not interviewed. It is lamentable that they did not voluntarily come forward to make presentations.

The renovations at Townhill hospital were already underway when the commission conducted an *in loco* inspection. As a result in some instances media reports cannot be verified.

The commission took longer than expected to finish its work as mandated due to the fact that members of the commission are fully employed elsewhere.

### **8. CONCLUSION**

The mark of a great defender of the poor, marginalized and underprivileged is a commitment to consistently and unflinchingly do what is right, just and fair at all times. The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), qualifies without peer. There are laws, regulations, principles and ethical codes promoting respect for human rights and quality patient care.

The tragedy is lack of implementation, compliance, enforcement and oversight bodies to ensure that these benefit mental health care users.

Although mental health impacts on all aspects of life in the country, mental health care is trivialised in a way that sabotages the good intentions of the laws.

A study of departmental strategic plans and budgets reveals such trivialisation, which contributes to a denial of patients' access to quality mental health care.

Townhill hospital is an old institution, which is now structurally not suitable as a health care facility.

It requires drastic transformation of the facility itself, management and the service culture amongst the staff. The institution predisposes the patients to human rights abuses. It contributes to staff demoralisation, burnout and the vicious circle of staff turnover.

Resolving the problems identified at Townhill hospital requires an intersectoral, inter departmental and multi disciplinary approach. The Department of Health must work in collaboration with the Social Welfare Department, Department of Education and the Department of Works in their respective roles to produce a sustainable and innovative solution in the interest of quality patient care.

The hospital board must monitor and evaluate implementation of the recommendations of this commission. At a higher level the Provincial and National Heads of Health care must demonstrate commitment to a sustained support of the laws and regulations that are in place to improve quality health care.