ALLEGATION OF INCORRECT ADMINISTRATION OF MEDICATION LEADING TO A BABY'S DEATH AT NETCARE FEMINA HOSPITAL NEONATAL INTENSIVE CARE UNIT

Case Reference: 44645

REPORT OF THE HEALTH OMBUD IN TERMS OF SECTION 81A (11) OF THE NATIONAL HEALTH AMENDMENT ACT, 2013 (ACT NO. 12 OF 2013)

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LIST OF ACRONYMS AND ABBREVIATIONS

BP	Blood Pressure
CIU	Complaints Investigation Unit
CEO	Chief Executive Officer
CPR	Cardiopulmonary Resuscitation
CVP	Central Venous Pressure
EN	Enrolled Nurse
HR	Heart Rate
HPCSA	Health Professions Council of South Africa
NFH	Netcare Femina Hospital
NICU	Neonatal Intensive Care Unit
NHA	National Health Act 61 of 2003
NHAA	National Health Amendment Act 12 of 2013
OHO	Office of the Health Ombud
OPM	Operations Manager
PN	Professional Nurse
QIP	Quality Improvement Plan
SANC	South African Nursing Council
SMT	Senior Management Team
SOP	Standard Operating Procedure
PAIA	Promotion of Access to Information Act

EXECUTIVE SUMMARY

a) This is the Final Investigation Report of the Health Ombud (the Ombud) issued in terms of Section 81A (11) of the National Health Amendment Act (NHAA) 12 of 2013 to inform the Complainant and the health establishment of the findings and recommendations.

b) On 22 December 2023, Ms Maria Lala Masoka (Ms ML Masoka) complained to the Ombud that her newborn baby was given incorrect medication and subsequently died hours after the administration of the medication at Netcare Femina Hospital (NFH).

c) The complaint was risk-rated **high** and allocated Reference No: 44645. Following the initial screening, the complaint was referred to the Complaint Investigation Unit (CIU) on 27 February 2024.

1. The Complaint

a) Ms ML Masoka delivered her baby through caesarean section on 2 March 2023, at Netcare Femina Hospital (NFH). Baby Moatlegi Masoka's birth weight was 3235g, and she was born with a bilateral cleft Lip and Palate. Ms ML Masoka said the doctor advised that the baby should be admitted until his body weight reached 6kg, to enable the surgical team to perform the corrective procedure for the cleft lip and palate.

b) Ms ML Masoka said on 29 May 2023, Baby Moatlegi Masoka was given an incorrect medication that led to his death. Ms ML Masoka further alleged that after the death of Baby Moatlegi Masoka, no one advised the family about a postmortem.

c) Furthermore, Ms ML Masoka alleged that although she complained to NFH, the hospital management did not address her complaint.

d) In the main, Ms L M Masoka alleged the following:

i. NFH administered an incorrect medication to her baby on 29 May 2023.

ii. NFH did not provide post-mortem services to determine the cause of her baby's death.

iii. NFH failed to address her complaint. **(Annexure A)**

e) The Ombud requested Ms Madithapo Masemola (Ms M Masemola) to assist with the investigation of the complaint under section 81(3)(c) of the NHAA.

2. Methodology and Approach.

a) The investigation was conducted in terms of section 81A (1) of the NHAA, which gives the Ombud powers to consider, investigate, and dispose of the complaint relating to breaches of the norms and standards in a fair, economical and expeditious manner, and in terms of Regulation 42 of the Procedural Regulations Pertaining to the Functioning of the Office of the Health Standards Compliance and Handling of Complaints by the Ombud, 2016 (Procedural Regulations).

b) The investigation was conducted through analysis and triangulation of information and evidentiary documents received from the health establishment, application of the applicable legislation, and peer-reviewed articles to enable the Ombud to reach an informed resolution of the complaint.

c) Dr Noor Mahomed Parker (Dr NM Parker) was requested to give an expert opinion regarding the case. Dr NM Parker's qualifications are MBChB, DCH(SA), FCP(Paed), Cert Crit Care (Paed). At the time, he was a Consultant Paediatric Intensivist at Tygerberg Hospital and a Senior Lecturer in the Department of Paediatrics at Stellenbosch University. Baby Moatlegi Masoka's clinical records were shared with Dr NM Parker to enable him to form an opinion on the case.

d) During the on-site investigation, interviews were conducted with the hospital personnel involved and the Complainant. An Inspection of the Neonatal Intensive Care Unit (NICU) was undertaken, and a meeting was held with the electronic *CareOn* system administrator to understand how the system operates.

The *CareOn* is an electronic medical record system that allows all health practitioners in NFH to work paperless. Health practitioners record all interventions, orders, prescriptions, and patient progress in the system. Health practitioners are trained, and upon completion of the *CareOn* System training, each employee is assigned a unique password to log in to the system.

e) Eleven (11) face-to-face interviews were conducted at NFH, and the interviewees' names, designations, and contact details were recorded.

3. The Ombud's investigations established the following:

Allegation 1: Whether Baby Moatlegi Masoka was administered an incorrect medication that led to his death on 29 May 2023.

a) The investigation found that while Dr Elelwani Maemu Mathivha (Dr EM Mathivha) wrote the Adrenaline route as IVI on the script, it was administered as a nebuliser from 24 May 2023, as she wrote in the journal that it should be given as a nebuliser.

During the on-site investigation, the investigator observed that nurses consulted the script when administering medication. The journal is used to document patients' daily clinical progress.

Furthermore, the investigation found that an instruction box was provided underneath each script line item for doctors to write specific instructions.

b) While Dr EM Mathivha explained that she wrote in the journal that Adrenaline should be administered as a nebuliser and instructed Professional Nurse (PN) T Potgieter, the shift leader, on that day, Dr EM Mathivha and PN T Potgieter failed to correct the script to ensure compliance and to avoid clinical risks.

c) The investigation found that although Dr EM Mathivha claimed that there was no provision on the *CareOn* system for adrenaline as a nebuliser, she failed to indicate that in the instruction box provided.

d) Furthermore, Dr EM Mathivha omitted to report the shortfall on the system to the *CareOn* system administrator based within the NFH premises at the time, especially as Dr EM Mathivha stated that she previously reported challenges experienced with the *CareOn* system.

Ms Addel Ferreira (Ms A Ferreira), the nursing manager at NFH, clarified that it was common practice at NFH to report any challenges with the *CareOn* system, as it was a new system being piloted at NFH; hence, the *CareOn* administrator was on-site 24 hours a day.

e) The investigation learned that when the new shift of nurses reported on duty on 29 May 2023, the nurse allocated to care for Baby Moatlegi Masoka was not told that the adrenaline medication was to be administered as a nebuliser, and EN EM Ngoato administered the adrenaline intravenously as stated on the script. This led to complications and the death of Baby Moatlegi Masoka on 29 May 2023.

f) While the investigation could not **substantiate** the allegation that **incorrect medication was given, it established that the intravenous route of administration of the medication written on the script was an error and led to a fatal outcome**. The investigation found that the lack of staff awareness of potential risks and the failure of the treating doctor and the shift leader in the NICU to act promptly to ensure the correct route of the adrenaline medication resulted in a clinical error.

g) The Health Ombud does not determine professional guilt or impose sanctions on healthcare practitioners. However, where a practitioner's conduct is intrinsically linked to the breach of norms and standards within the health establishment, the Health Ombud is empowered to make factual findings and, where appropriate, refer such conduct to the relevant professional council for consideration.

h) NFH acted inconsistently with Regulation 7(2)(b) of the Norms and Standard Regulations Applicable to Different Categories of Health Establishments, 2018 (Norms and Standard Regulations), which state, *"A health establishment must establish and maintain systems, structures and programmes to manage clinical risks."*

<u>Allegation 2:</u> Whether NFH failed to provide post-mortem services to Ms ML Masoka after the death of Baby Moatlegi Masoka.

a) Ms ML Masoka stated that Dr EM Mathivha never advised her on conducting a post-mortem after the death of Baby Moatlegi Masoka.

b) Dr EM Mathivha stated during the interview that she did not recommend a post-mortem as she believed the baby died of natural causes. Dr EM Mathivha said Baby Moatlegi Masoka had

bilateral cleft lip and cleft palate, which led to the baby having aspiration and infection, and it made it difficult for the baby to swallow. Likewise, it resulted in difficult endotracheal intubation.

c) The investigation established that Baby Moatlegi Masoka's condition changed immediately after administration of the adrenaline medication. EN EM Ngoato stated that after administration of adrenaline intravenously, Baby Moatlegi Masoka's skin colour became blue, and he started having difficulty breathing. The *Births and Deaths Registration Act* (Act 51 of 1992) requires that a medical practitioner issue a notification of death (form BI 1663) stating the cause of death. The investigation found that Baby Moatlegi Masoka died after a reaction to the adrenaline medication, and his death could thus not be classified as natural; therefore, a forensic post-mortem was needed to establish the cause of death.

d) The Health Ombud did not determine the medico-legal cause of death. The finding that the death followed a medication-related adverse event was made solely to assess whether NFH complied with applicable norms and standards requiring referral for a forensic post-mortem in cases of sudden or treatment-related deaths.

e) NFH was inconsistent with Regulation 7 (1) of the Norms and Standards Regulation, which states *"The health establishment must establish and maintain clinical management systems, structures and programmes that give effect to national policies and guidelines".*

f) **The allegation that NFH failed to provide post-mortem services was substantiated.**

<u>Allegation 3:</u> Whether NFH failed to address the complaint of Ms ML Masoka.

a) The investigation established that Ms ML Masoka and her husband were redressed by Dr EM Mathivha and PN M Themba, the acting unit manager of NICU (date not provided). Dr EM Mathivha explained that the death of Baby Moatlegi Masoka was due to excessive bleeding from the lungs, which Ms ML Masoka disagreed with.

b) Ms ML Masoka confirmed that a second redress meeting occurred (date not provided). Ms ML Masoka, her husband, Mr TNE Kgomongwe, the NHF Hospital Manager and Ms A Ferreira, the Nursing Manager, were in attendance. The meeting took place following the Health Ombud for NFH's intervention to address Ms ML Masoka's complaint. Ms ML Masoka and her husband were not happy with the answers provided by NFH management, as he indicated that NFH could not confirm the cause of death, as a post-mortem was not conducted.

c) The investigation found that Ms ML Masoka's family were redressed; the fact that they were unhappy with the outcome did not mean that NFH did not address their complaint.

d) **The allegation that NFH did not address Ms ML Masoka's complaint was unsubstantiated.**

4. Additional Findings

(i) Medication Administration Protocols

a) The investigation found that the policy/SOPs guiding the administration of medication had passed their review date. The Medication Management policy, the Standard Operating Procedures (SOPs) for Medication Administration, and Medication Administration Routes had passed their review dates in 2021.

b) The NFH Medication Administration Routes SOP only stated the oral, intramuscular, subcutaneous, intravenous, and bolus routes. The investigation observed that rectal and inhalation administration routes were not included in the SOP. The investigation found this to be of concern, since a number of medications in neonatal wards are often administered via the above-cited routes.

c) While the investigation learned that all SOPs in Netcare Hospitals are drafted nationally, the investigation found that **unit managers and shift leaders in the NICU failed to advocate for the inclusion of other routes and thus updates of SOPs.**

d) **NFH was inconsistent with Regulation 7(1) of the Norms and Standards Regulation, which states, *"The health establishment must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines."***

(ii) Handing over reports between shifts.

a) The investigation found that the methodology of handing over reports in the NICU was a problem, as important information known to the shift leaders was not adequately cascaded down to nurses dealing with patients.

b) The investigation found that if shift leaders were routinely part of the nurses during the handing over of reports between shifts in the NICU, the incident on 29 May 2023 may have been averted.

c) **NFH was inconsistent with Regulation 7 (2) (b) of the Norms and Standards Regulations, which states *"The health establishment must establish systems, structures, and programmes to maintain clinical risks"*.**

(iii) Access to the *CareOn* System.

a) The investigation found irregularities in accessing the *CareOn* system. The investigation found that when new staff did not have a password, they were permitted to use their colleagues' passwords to access the system.

b) While Ms A Ferreira explained that NFH policy forbids staff from utilising other staff's passwords, she conceded that nursing staff hired through the nursing agency sometimes do not have passwords, and it is a challenge for those nurses to access the system.

c) The investigation found that the practice defeated the primary objective of effectively monitoring and accurately tracking who performed specific actions and when.

5. Comments from Ms ML Masoka, NFH, and Dr EM Mathivha

a) The Provisional Investigation Report was sent to Ms ML Masoka, NFH, and Dr Mathivha on 15 December 2025, to allow them to comment on the Health Ombud findings and furnish evidence to vary or disprove the findings, as provided by Section 81A (5) of the NHAA.

b) Ms ML Masoka submitted her comments on 25 December 2025. Dr EM Mathivha requested an extension to consult her legal team. The Ombud granted an extension, and, through her lawyers Norton Rose Fulbright, she submitted her comments on 8 January 2026. Furthermore, NFH requested an extension to submit their comments as most of their managers were on leave. The Health Ombud granted the extension, and their comments were submitted on 16 January 2026.

c) All the comments and the Health Ombud response are found in section 8 of the report.

6. Conclusions

a) This tragic incident highlights systemic failures within the clinical care pathways and the importance of good leadership and stewardship, continuous mentoring and in-service training to keep abreast with developments and innovations within the NICU.

b) This incident highlights the importance of stringent medication safety protocols. Where adherence to protocols is lax, the risk of unintended outcomes is heightened.

c) Clear communication and involvement of shift leaders during report handover between shifts remains critical to avoid risks. This allows junior nurses to ask questions for clarity when needed.

7. Recommendations

7.1 The Netcare group should appoint a Task Team to monitor the Implementation of the recommendations as outlined in this report within one (1) month after the release of this report.

7.1.1 To ensure effective implementation, the Task Team should include the affected health establishment's Chief Executive Officer (CEO) and Nursing Manager, and a representative of the unit implicated in this report.

7.1.2 The Task Team should submit a quarterly summary of progress made on each recommendation to the CEO of Netcare group, the CEO of the Office of Health Standard Compliance (OHSC) and the Health Ombud.

7.1.3 Clear and complete protocols on:

a) The *CareOn* System.

b) Medication and routes of administration.

c) Handover report between shifts.

d) Referral of procedural death for forensic post-mortem

7.1.4 The induction and continuous in-service training of all professional staff, especially doctors and nurses.

7.1.5 Supervision of new and junior staff on the administration of medication.

7.1.6 Regular audits and review of cases in the NICU.

7.1.7 Senior managers in the Netcare Group should investigate and correct/enhance practices within the group.

7.2 **Medication that was administered to Baby Moatlegi Masoka.**

7.2.1 The Health Ombud will refer the following health professionals to the Health Professions Council of South Africa (HPCSA) or the South African Nursing Council (SANC), as appropriate, for further probing.

7.2.1.1 **Dr EM Mathivha (Paediatrician)**

a) Prescription of an incorrect route of medication.

b) Failure to correct the route of adrenaline in the script.

c) Failure to report the *CareOn* system to the administrator located within the hospital to avert medication errors with unintended outcomes.

d) Failure to call for extra medical help during the difficult resuscitation of Baby Moatlegi Masoka, many attempted intubation failures, which may has led to hypoxia and complications therefrom.

e) Failure to refer the body of Baby Moatlegi Masoka for a forensic post-mortem after the baby died of excessive adrenaline intravenously, as required by the Inquest Act 58 of 1959.

7.2.1.2 **PN T Potgieter (Shift leader NICU)**

a) Failure as a shift leader to advocate that the route prescribed by Dr EM Mathivha in the script be corrected.

b) PN T Potgieter allowed the adrenaline medication to be administered as a nebuliser between 24 and 28 May 2023. She failed to ensure the route was corrected on the script after it was ordered intravenously on 24 May 2023. PN T Potgieter accepted, without protest, verbal orders that were contrary to the written script, thus opening the way for subsequent errors.

7.2.1.3 **M Themba (Acting Unit Manager NICU)**

a) As the acting unit manager, PN M Themba failed to provide leadership and ensure that policies/protocols were adhered to in the NICU. As the acting unit manager in the NICU, she was responsible and accountable for all activities in the NICU.

7.2.2 A Unit Manager must ensure that all doctors' prescriptions comply with the provisions of the *CareOn* system, and that all relevant personnel are aware of updates to the treatment plan.

7.2.3 NFH should implement dual verification systems in the NICU to ensure both the route and dosage of medication are cross-checked before administration.

7.2.4 NFH should enable the *CareOn* system to detect erroneous or outlier prescriptions, such as dosages and routes, and create an alert.

7.2.5 This will ensure that NFH complies with Regulation 7(2)(b) of the Norms and Standards Regulations.

7.3 Post-Mortem Services

7.3.1 The NFH Hospital Manager must advise all doctors that a forensic post-mortem is mandatory in all cases where medication errors have contributed to death. This should be implemented within one (1) month of the release of this report.

7.3.2 The NFH Hospital Manager and Nursing Managers must ensure that the hospital policies are aligned with legal requirements for reporting unnatural deaths to the relevant authorities. The protocol to guide medical professionals should be drafted within three (3) months after the release of this report. This should be cascaded within the rest of the Netcare Group.

7.3.3 This will ensure that NFH complies with the Inquest Act 58 of 1959 and Regulations 7(1) of the Norms and Standards Regulations.

7.4 Medication Administration Protocols

7.4.1 The Hospital Manager and Nursing Manager of NFH must ensure that the medication administration protocols governing hospital practice are reviewed and updated within one (1) month after the release of this report.

7.4.2 The Nursing Manager and Unit Manager of the NICU should ensure that all medication administration routes are catered for in the Medication Administration Protocol.

7.4.3 The Nursing Manager of NFH should conduct quarterly medication administration audits in the high-risk units, such as the NICU, to ensure that the staff follow correct procedures.

7.4.4 This will ensure that NFH complies with Regulation 7(1) of the Norms and Standards Regulations.

7.5 Handing over reports between shifts

7.5.1 The NFH Nursing Manager and NICU Unit Manager must ensure that shift leaders are part of each patient report handover in the NICU immediately after the release of this report. This will ensure that any misinformation is dealt with before it can lead to adverse events.

7.5.2 The NICU Unit Manager must ensure that the handover process/procedure between shifts is formalised within one (1) month after the release of this report, to ensure critical patient information, including recent medication changes, is effectively communicated to incoming staff.

7.5.3 The NFH Nursing Manager and Unit Manager of the NICU should ensure that multidisciplinary team meetings are held to review ongoing complex patients in the NICU. This will ensure that all staff are aligned with the treatment plan.

7.5.4 This will ensure that NFH complies with Regulation 7 (2) (b) of the Norms and Standards Regulations.

7.6 The *CareOn* System

7.6.1 The Netcare Group should develop a system that will instantly notify all users of the *CareOn* system about new add-ons on the system within six (6) months of the release of this report. The mode of notification should be immediately accessible to staff, circulars should be published, and in-service training should be provided on the changes.

7.6.2 The Hospital Manager of NFH should ensure that unique passwords are allocated to all agency nurses to access the *CareOn* system to prevent staff from sharing passwords in order to access the *CareOn*. This will enable NFH to conduct proper monitoring. Each nurse must be formally inducted into the *CareOn* system. This is to be done within six (6) months after the release of this report

7.6.3 This will prevent the sharing of passwords and enable proper monitoring and control.

7.7 **Mediation Process**

7.7.1 The NFH Management must initiate and engage in mediation with Ms ML Masoka's family to constructively resolve the issues in dispute. Furthermore, the Complainant is advised of the option to appoint and be represented by a legal practitioner during the mediation process. This mediation process should commence within four (4) months of receipt of the final investigation report.

SUMMARY OF FINDINGS

Findings	Breaches of Norms, standards/guidelines/and protocols
1. Baby Moatlegi Masoka was administered medication via an incorrect route, leading to his death on 29 May 2023.	1.1. Regulation 7(1) of the Norms and Standards Regulations states, *"The health establishment must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines."* 1.2. Regulation 7(2)(b) of the Norms and Standards Regulations, which states, *"A health establishment must establish and maintain systems, structures and programmes to manage clinical risks."*
1. NFH failed to provide post-mortem services to Ms ML Masoka.	1.1. Regulation 4(1) of the Norms and Standards Regulations states, *"Health establishments must ensure that users are provided with adequate information about the health care services available at the health establishment and information about accessing those services."* 1.2. Regulation 7(1) of the Norms and Standards Regulations, which states, *"The health establishment must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines."*
2. Medication Administration Protocols	2.1. Regulation 7(1) of the Norms and Standards Regulation, which states, *"The health establishment must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines."*

1. INTRODUCTION AND BACKGROUND

1.1. This is the Final Investigation Report of the Health Ombud (the Ombud) issued in terms of Section 81A (11) of the National Health Amendment Act (NHAA) 12 of 2013 to inform the Complainant and the health establishment of the findings and recommendations.

1.2. The incident occurred on 29 May 2023, when Baby Moatlegi Masoka, who was admitted to the NICU, was allegedly administered the wrong medication that led to his condition changing for the worse and death after failed resuscitation.

1.3. Ms ML Masoka lodged the complaint with the Ombud on 22 December 2023 and was risk-rated **HIGH** and allocated reference number 44645.

1.4. On 19 January 2024, the Ombud sent a notice of complaint to Dr Richard Friedland (Dr R Friedland), the Group Chief Executive Officer of Netcare Health Care Group, to notify them about the complaint lodged against NFH and to request Baby Moatlegi Masoka's clinical records and any relevant documentation about the investigation. **(Annexure B)**

1.5. On 21 June 2024, a notification of investigation was sent to Dr R Friedland and Mr Tau Naledi Effort Kgomongwe (Mr TNE Kgomongwe), the Chief Executive Officer (CEO) of NFH, to inform them of the Ombud's intention to conduct an on-site investigation from 24 June 2024 until the investigation was completed. **(Annexure C)**

1.6. Upon arrival at NFH on 24 June 2024, the investigator, Ms M Masemola, reported to the CEO's office. Ms M Masemola held a briefing session with members of the Senior Management Team (SMT).

1.7. Face-to-face interviews with nursing staff were conducted from 25 June 2024 to 17 July 2024. All interviews were conducted at NFH.

1.8. Between 24 June 2024 and 17 July 2024, eleven (11) interviews were conducted. **(Annexure D)**

2. SUMMARY OF THE COMPLAINT

2.1 Ms Maria Lala Masoka (Ms ML Masoka) lodged a complaint with the Ombud on 22 December 2023 that NFH administered an incorrect medication to Baby Moatlegi Masoka on 29 May 2023.

2.2 Ms ML Masoka gave birth on 02 March 2023 through caesarean section at 38 weeks of gestation. The baby's birth weight was 3235g. Baby Moatlegi Masoka was born with a Bilateral Cleft Lip and Cleft Palate, club foot with extra phalanges, and Scoliosis. Dr EM Mathivha admitted Baby Moatlegi Masoka to the NICU, as babies with cleft palate have difficulty feeding. Ms ML Masoka indicated that Baby Moatlegi Masoka was admitted to facilitate that his body weight reaches 6kg, to enable corrective surgery.

2.3 Ms ML Masoka alleged that on 29 May 2023, Baby Moatlegi Masoka was administered the wrong medication intravenously, and immediately changed condition, started bleeding through the mouth and nose, and ultimately died after failed resuscitation.

Ms ML Masoka further alleged that NFH did not provide post-mortem services after the death of Baby Moatlegi Masoka, and that NFH did not address her complaint when she wanted to understand what happened on 29 May 2023, as her baby's condition was alright before the adrenaline injection was administered.

2.4 In the main, Ms ML Masoka alleged that:

a) The medication given to Baby Moatlegi Masoka on 29 May 2023 was incorrect.

b) NFH did not provide post-mortem services to determine the cause of her baby's death.

c) NFH failed to address her complaint.

3. POWERS AND JURISDICTION OF THE HEALTH OMBUD TO INVESTIGATE

3.1 The Health Ombud draws his powers in terms of Section 81A (1) of the National Health Amendment Act (NHAA), 12 of 2013. Section 81A (1) of the NHAA stipulates that *"the Ombud may, on receipt of a written or verbal complaint relating to norms and standards, or on his or her initiative, consider, investigate and dispose of the complaint in a fair, economical and expeditious manner."*

3.2 Section 81B (2) of the NHAA provides that: *"When dealing with any complaint in terms of this Act, the Ombud, including any person rendering assistance and support to the Ombud (a) is independent and impartial; and (b) must perform his or her functions in good faith and without fear, favour, bias, or prejudice."*

The expert opinion was sought from Dr Noor Mohamed Parker (Dr NM Parker).

3.3 In conducting this investigation, the Ombud was assisted by Ms Madithapo Masemola (investigator), who has been designated and seconded by the Office of Health Standards Compliance with the concurrence of the Ombud per Section 81(3)(c) of the NHAA.

3.4 NFH is a private health establishment, and its investigation falls under the scope of the Health Ombud mandate, as the Ombud has jurisdiction to investigate all private and public health establishments in South Africa.

4. THE ISSUES IDENTIFIED FOR INVESTIGATION

4.1 Whether the medication given to Baby Moatlegi Masoka was incorrect on 29 May 2023.

4.2 Whether NFH failed to provide post-mortem services.

4.3 Whether NFH failed to address the complaint of Ms ML Masoka

5. INVESTIGATION

5.1 Scope of Investigation

5.1.1 The investigation confined itself to the admission of Baby Moatlegi Masoka in the NICU from the time he developed a stridor on 24 May 2023, and 29 May 2023, when Baby Moatlegi Masoka's condition changed immediately after administration of adrenaline intravenously, and died after failed resuscitation.

5.2 Methodology

5.2.1 During the on-site visit, a briefing session meeting was held where the NFH senior management was informed of the purpose of the investigation and sensitised about the provision of Section 81A (5) of the National Health Act.

5.2.2 Onsite investigations took place from 25 June 2024 to 17 July 2024, where face-to-face interviews were conducted, and an inspection of the NICU was undertaken to observe the day-to-day activities in the NICU.

5.2.3 The particulars of all interviewees' full names, official designations, and the venue where the interviews occurred were documented. All interviews were recorded and later transcribed.

5.3 Evidentiary Material Analysis

5.3.1 The investigator analysed all the evidentiary material impacting the investigation. Supporting documents were requested from NFH during the investigation.

5.3.2 The patient's clinical records indicated that Baby Moatlegi Masoka was delivered on 02 March 2023 through caesarean section. Baby Moatlegi Masoka was born with multiple congenital abnormalities, bilateral cleft lip and cleft palate, scoliosis, and clubfoot. From the onset, a decision was taken to admit the baby to the NICU to attain a weight of 6kg before surgical intervention to correct the bilateral cleft lip and cleft palate could be undertaken.

5.3.3 From 23 May 2023, Baby Moatlegi Masoka started having episodes of coughing and noisy breathing after feeds, although there was no obvious respiratory compromise. Baby Moatlegi Masoka was diagnosed with stridor on 24 May 2023. Adrenaline and Solucortef were prescribed intravenously on 24 May 2023, but according to the clinical records, the adrenaline was given as a nebuliser. Vancomycin and Meropenem antibiotics were also prescribed. Baby Moatlegi Masoka's respiratory symptoms persisted, necessitating oxygen via nasal cannulae.

5.3.4 The Ombud sought the services of a paediatric intensivist expert, as the investigation dealt with a baby who had been admitted to the NICU with bilateral cleft lip and cleft palate, who died after administration of adrenaline intravenously. Dr Noor Mahomed Parker, a

Paediatric Intensivist at the Paediatric Intensive Care, Tygerberg Children's Hospital, and a senior lecturer in the Department of Paediatrics, Stellenbosch University, was requested to analyse Baby Moatlegi Masoka's clinical records and offer an expert opinion to strengthen the Ombud findings.

5.3.5 Dr NM Parker's opinion highlighted clinical management problems relating to medical errors, communication failures, delays in recognising the error by the staff, and failure to manage the airway, and failure to seek when help was needed.

Furthermore, there were systemic issues and possible medical negligence. Regarding medication administration protocols, there was inconsistent documentation, lack of staff awareness and failure to act promptly to avert complications once the erroneous dosing had occurred.

6. DETERMINATION OF ISSUES INVESTIGATED IN RELATION TO THE EVIDENCE OBTAINED

6.1 Baby Moatlegi Masoka was delivered on 2 March 2023 at NFH through Caesarean Section. Baby Moatlegi Masoka was born with multiple congenital disabilities and was transferred to the NICU. Baby Moatlegi Masoka needed to attain a weight of 6kg before corrective surgery could be performed.

6.2 On 24 May 2024 at 12:12, PN T Potgieter informed Dr EM Mathivha that Baby Moatlegi Masoka had developed a stridor. At 12h19, Dr EM Mathivha prescribed Adrenaline 0.5ml intravenously daily, indicating that the Adrenaline 0.5ml should be diluted with 4.5ml normal saline. While the prescription indicated an intravenous route, the investigation established that Dr EM Mathivha then wrote in the patient progress journal that the adrenaline should be given as a nebuliser, as she claimed the *CareOn* system did not have a provision for the nebuliser route for adrenaline.

6.3 The investigation learned that after the stridor was diagnosed on 24 May 2024, Baby Moatlegi Masoka had difficulty retaining feeds; he was distressed, coughing, and he was vomiting. The investigation learned that the medications to be given orally were omitted as the baby was vomiting after feeds. (No indication that another route was prescribed to administer such medication)

6.4 On 25 May 2023, at 12h01, Dr EM Mathivha changed the dose of Adrenaline 0.50ml from daily to 8 hourly intravenously.

6.5 The investigation observed that while the Adrenaline was ordered intravenously on 24 May 2023 and reviewed again on 25 May 2023, it was administered as a nebuliser, as Dr EM Mathivha wrote a directive in the journal and spoke to PN T Potgieter, who was a shift leader. This directive was contrary to her formal prescription, which stated that Adrenaline had to be given intravenously.

6.6 During inspection of the NICU, the investigator observed that the prescription sheet on the *CareOn* system had an instruction box where doctors are to write key instructions. The investigation found that Dr EM Mathivha wrote instructions for diluting Adrenaline with Normal Saline but did not indicate that it should be given via nebuliser. The investigation further established that the instruction box was always accessible to the person administering medication, as it is in the same window, unlike the journal in which patients' daily progress is recorded.

6.7 During the interviews, Dr EM Mathivha indicated that she explained to PN T Potgieter that Adrenaline should be administered as a nebuliser. Dr EM Mathivha explained that there was no provision on the system for the Adrenaline nebuliser route at the time. This was disputed by Ms Adell Ferreira (Ms A Ferreira), the Nursing Manager at NFH. Ms A Ferreira said that at the time of the incident, the *CareOn* system provided a dropdown box for the doctors to choose the desired route when prescribing. Ms A Ferreira said the issue that Dr EM Mathivha ordered Adrenaline intravenously rather than via nebuliser was not a system's problem but a user error. She confirmed the dropdown menu was already available when Dr EM Mathivha underwent the *CareOn* system training in 2021.

6.8 Dr EM Mathivha was asked whether she reported the matter to the system administrator and the reason why she didn't write in the prescription instruction box provided, that Adrenaline should be given as a nebuliser. Dr EM Mathivha said she did not report on this specific challenge but indicated she had reported on other matters related to challenges with the *CareOn* system in the past.

6.9 The investigation learned that on 29 May 2023, a new shift of nurses came on duty. On the day, Baby Moatlegi Masoka was allocated to EN EM Ngoato, an Enrolled Nurse who had been working in the NICU since 2013.

6.10 EN EM Ngoato said that on the morning of 29 May 2023, she carried on with her routine as usual, feeding Baby Moatlegi Masoka, changing the baby's nappy, and giving medication at 08h00 (Erythromycin 50mg orally and Fluconazole 30mg Intravenously only) since the night shift nurses had already administered other morning medications.

6.11 EN EM Ngoato said Ms ML Masoka was in the ward at 14h00, and she told her that she would administer medication to Baby Moatlegi Masoka. EN EM Ngoato then prepared the Adrenaline 0.5mg IVI as prescribed and confirmed with PN Boitumelo Gwendoline Motlogelwa (PN BG Motlogelwa), her supervisor, that day. After confirming the drug and route with PN BG Motlogelwa, EN EM Ngoato gave the Adrenaline medication to Baby Moatlegi Masoka through the CVP line. EN EM Ngoato signed for the administration, and PN BG Motlogelwa countersigned.

6.12 PN BG Motlogelwa confirmed that she verified the prescribed route with EN EM Ngoato but told her that she was not sure about the Adrenaline being given IVI, as she is used to IVI Adrenaline being administered during the resuscitation of patients. PN BG Motlogelwa said she asked EN EM Ngoato to consult the senior nurses on duty on the matter, then continued with her own work.

6.13 The investigation established that although PN BG Motlogelwa queried the route ordered, she co-signed for administration before EN EM Ngoato could ascertain the route. PN BG Motlogelwa said she did not follow up with EN EM Ngoato regarding what the senior nurse said, as she believed she would go and enquire as advised. PN BG Motlogelwa was asked why she co-signed the medication sheet with EN EM Ngoato if she was unsure of the route. She said, ***"I signed before the medication was given."*** She further said, ***"I think it is a mistake I made and that I learned because sometimes I don't know, we tend to do that. I should let her go and check with another RN, and they would have countersigned her, not the way I did."***

6.14 EN EM Ngoato said immediately after the Adrenaline administration, Baby Moatlegi Masoka started to have difficulty breathing and was turning cyanotic. EN EM Ngoato immediately called for help. PN M Themba and PN T Potgieter came and inquired what was wrong, and she indicated that Baby Moatlegi Masoka was not well. EN EM Ngoato said she realised that Baby Moatlegi Masoka's condition was further worsening and she rang the bell again for help. PN M Themba and PN T Potgieter again arrived, and they started resuscitating the baby. They called Dr EM Mathivha.

6.15 Dr NM Parker, the Consultant Paediatric Intensivist at Tygerberg Hospital, explained that the dose Baby Moatlegi Masoka was given was 10 times the Cardio-Pulmonary Resuscitation (CPR) dose (0.01–0.03 mg/kg), causing severe systemic overstimulation. Dr MN Parker said while Adrenaline is typically used to support cardiovascular function, in the case of Baby Moatlegi Masoka, the high dose had a toxic effect.

6.16 This was confirmed by PN T Potgieter, who said the condition of Baby Moatlegi Masoka was critical. Baby Moatlegi Masoka was said to be pale. The saturation was 97%, and the pulse was 157 beats per minute. At 14h30, pulse rate was 123b/m, saturation 48%. PN M Themba called Dr EM Mathivha, who arrived at 14h32 prescribed KONAKION MM PAED 4mg stat intravenously as the baby was bleeding through the nose and mouth. For stomach washout Adrenaline 1mg + 9 mL of 0.9% saline was administered. The vital data observation readings were as follows: Blood Pressure (BP): 87/37; Heart Rate (HR): 180.

6.17 At 14h34, Dr EM Mathivha attempted to intubate but failed. At 14h56, a second attempt at intubation and at 15h05 a third and both failed. A nasogastric tube was inserted. Dr EM Mathivha then performed a stomach washout using Adrenaline diluted in normal saline (Strengths not stipulated). Baby Moatlegi Masoka was suctioned intermittently as he was bleeding profusely through the nose and mouth.

6.18 The nasogastric tube was removed at 14h59. The vital data observations registered HR 179, BP 86/34 and saturation of 90%.

6.19 Ms L Van Zyl confirmed that she was one of the RN's who assisted with Baby Moatlegi Masoka's resuscitation. She confirmed that Dr EM Mathivha struggled to intubate as Baby Moatlegi Masoka had a difficult airway and was bleeding with a lot of secretions.

6.20 Dr EM Mathivha missed an opportunity to seek help, although she knew that the bilateral cleft lip and palate and stridor made the intubation process difficult.

6.21 From 15h10 to 15h15, thick bloody mucus secretions were suctioned from Baby Moatlegi Masoka through the orogastric route . Ms L Van Zyl stated that Dr EM Mathivha said she could not visualise the throat of Baby Masoka. Dr EM Mathivha stopped the attempt to intubate and Nepuffed Baby Masoka on 100% oxygen. Baby Masoka's oxygen saturation was 37% and increased to 63% with Neopuff breaths given.

6.22 Dr NM Parker indicated that the repeated failure to intubate due to difficulty in visualising the vocal cords and bloody secretions during multiple intubation attempts delayed effective ventilation and worsened the baby's condition as it exposed him to prolonged hypoxia. Dr NM Parker further indicated that multiple intubation attempts can also lead to local trauma, contributing to bleeding in the airway.

6.23 At 15h 11, Dr EM Mathivha successfully intubated Baby Masoka after Dormicum was given. Thick, bloody secretions were coming out from the ET tube. Although Baby Masoka was breathing spontaneously, his oxygen saturation dropped from 63% to 24%.

6.24 At 15h17, Dr EM Mathivha removed the ET tube while Baby Masoka's oxygen saturation was dropping. At 15h19, the oxygen saturation dropped to 9%, the HR was 44b/m, and his BP did not register on the monitor. Neopuff was connected, and tracheal suctioning was done. The tongue fell back blocking the airway. The I-GEL Supraglottic Airway was put in place.

61.25 At 15h26, the I-GEL Supraglottic Airway was removed, and Dr EM Mathivha attempted intubation again but without success as she could not visualise the vocal cords.

6.26 At 15h32, the I-GEL Supraglottic Airway was placed in the airway to avoid compression. HR increased to 159b/m, and saturation to 55%.

6.27 At 15h34, a tongue depressor was used to hold the tongue down while Dr EM Mathivha tried to intubate Baby Masoka again but failed.

6.28 At 15h38, the HR dropped to 65 and saturation to11%. Dr EM Mathivha attempted to intubate again at 15h45 but was not successful. The saturation went up to 65% and HR to 127 b/m.

6.29 From 16h03 to 16h11, resuscitation of Baby Masoka continued with suctioning of thick bloody secretions, and at around 16h10 no vital data observations were registering on the monitor.

6.30 At 16h13, chest and abdominal X-rays were done. Dr EM Mathivha declared Baby Moatlegi Masoka dead at 16h20.

6.31 Dr EM Mathivha was asked during interviews why she did not seek an anaesthetists' help, since they are experienced with difficult intubations. Dr EM Mathivha responded that the doctor would

have done the same thing she did! However, Dr NM Parker confirmed that calling an anaesthetist or another colleague to assist with the intubation might have improved the chances of survival.

6.32 Ms A Ferreira explained that during her one-on-one discussion with Dr EM Mathivha after the incident, she asked why Adrenaline was ordered intravenously if it was to be given as a nebuliser. Dr EM Mathivha responded that ***"She didn't know that the note she wrote on the script did not indicate that the Adrenaline was a nebuliser."***

6.33 Ms A Ferreira said that after she showed Dr EM Mathivha the script, Dr EM Mathivha said she was unaware that she had prescribed Adrenaline intravenously, she was under the impression that she had ordered the Adrenaline as a nebuliser.

6.34 Ms ML Masoka indicated that after she was told her baby had died, NFH asked if she needed a post-mortem to be done. Ms ML Masoka said that because she was traumatised, she could not offer an answer. She alleged that Dr EM Mathivha then told her to concentrate on the burial of the baby.

6.35 Ms ML Masoka said a month after Baby Masoka's funeral, she was invited to a meeting with Dr EM Mathivha and PN M Themba. Ms ML Masoka was accompanied by her sister-in-law (name not provided) and her husband. Ms ML Masoka indicated that during the meeting, it was clear that no investigation had been conducted, as Dr EM Mathivha could not answer their questions. Ms ML Masoka alleged that Dr EM Mathivha said she did not know what happened, but assured the family that Adrenaline was prescribed as a nebuliser.

6.36 Ms ML Masoka said that as a family, they decided to complain to the management of NFH after the meeting with Dr EM Mathivha. In October 2023, they complained to the Health Ombudsman as they had not received any response from NFH management. She said the Health Ombudsman referred the complaint to NFH for investigation.

6.37 Ms ML Masoka said NFH did not revert to her within the stipulated 25-day period, so she called NFH and was invited to a second meeting in November 2023. She said during this meeting which was attended by Mr Tau Naledi Effort Kgomongwe (Mr TNE Kgomongwe) and Ms A Ferreira, it was explained that the baby was given Adrenaline intravenously instead of nebulisation as prescribed. The NFH management could not confirm the cause of death as a post-mortem was not performed. She said the family was given the NFH Investigation Report to take home.

6.38 The Health Ombud investigation established that the investigation report submitted by NFH to the Health Ombud cited challenges with the script. The report indicated that the script was wrongly written, indicating Adrenaline to be administered intravenously.

6.39 To strengthen the report, the Health Ombud requested Dr NM Parker to give an expert opinion on the case as a Paediatric Intensivist. Dr NM Parker analysed records provided by the Health Ombud for scrutiny and gave an expert opinion.

7. FINDINGS

7.1 Allegation 1: Whether Baby Moatlegi Masoka was administered an incorrect medication leading to his death on 29 May 2023.

7.1.1 The investigation confirmed through the clinical records that on 24 May 2023, Dr EM Mathivha prescribed Adrenaline 0.5ml intravenously daily. Dr EM Mathivha's remarks on the script were: *"Add 0.5 mL to 4.5 mL of 0.9% saline."*

7.1.2 Further, the investigation found that Dr EM Mathivha wrote in the journal that Adrenaline ordered intravenously on the script should be given as a nebuliser. These were two contrasting routes of administration. Dr EM Mathivha was asked why the nebuliser order was not written in the instruction block provided on the prescription sheet. Dr EM Mathivha's response was, *"I think it was an oversight; it was not an intentional thing".*

7.1.3. During the interview, Dr EM Mathivha explained that the *CareOn* system did not provide a nebuliser route on the script. Although PN M. Themba confirmed that no route for Adrenaline nebuliser was provided at the time of the incident, as the *CareOn* system was updated later, Ms A. Ferreira disputed the statements made by both Dr EM Mathivha and PN M. Themba. Ms A. Ferreira said the Dropbox for Adrenaline providing all routes was available since 2021 when the *CareOn* system was commissioned. This was confirmed by the resident electronic *CareOn* system administrator prescribed Adrenaline on 24 May 2023. Dr EM Mathivha indicated that when she prescribed Adrenaline on 24 May 2023, she had discussed with PN T Potgieter that the medication was to be given as a nebuliser. PN T Potgieter confirmed that Dr EM Mathivha verbally instructed her to administer Adrenaline as a nebuliser but did not query or request that the prescription be corrected, despite knowing that a new shift of nurses would be working on 29 May 2023.

7.1.5 While Ms ML Masoka alleged that incorrect medication was given to Baby Moatlegi Masoka, the investigation found that the medication was not incorrect; the prescribed route was incorrect, as Dr EM Mathivha intended it to be given via nebuliser. From 24th to 29th May 2023, Dr EM Mathivha failed to correct the script and to report the alleged limitations of the *CareOn* system to the system administrator located within the hospital, thus failed to obviate possible clinical risk.

7.1.6 The investigation learned from Dr NM Parker's opinion that the sudden change in Baby Masoka's clinical condition after the administration of Adrenaline intravenously was due to the overdose of Adrenaline, which caused systemic overstimulation. Dr NM Parker stated that Adrenaline overdose led to hypertension and pulmonary oedema resulting in pulmonary haemorrhage observed during resuscitation.

7.1.7 Dr EM Mathivha was asked during interviews why she did not seek medical help during the resuscitation of Baby Masoka. Dr EM Mathivha's response was "No, I didn't call anyone, the child was bleeding, so when you have a situation like that, you know why you cannot visualize the anatomy most of the time, you do a quick risk assessment, whether it's an anaesthetist or me, they need to clear that airway to see what's happening". The investigation found that the failure of Dr EM Mathivha to intubate Baby Masoka initially, and the failure to seek help during resuscitation exacerbated Baby Masoka's condition. Dr NM Parker stated, *"The combination of the congenital anomalies affecting the mouth, nose and upper airway, including possible swelling of laryngeal tissue due to reflux, makes securing a stable airway difficult especially during emergency intubations"*.

7.1.8 Furthermore, the investigation found that PN T Potgieter failed in her duty to advocate for Baby Masoka, as she perpetuated the problem by allowing the administration of Adrenaline via nebuliser without ensuring the script was corrected for 6 days.

7.1.9 The investigation found that Dr EM Mathivha, PN T Potgieter, and PN M Themba, the acting Unit Manager, had time to address the *CareOn* system shortcomings, if any at all, as the *CareOn* administrator was stationed within the premises daily.

7.1.10 Dr NM Parker advised that, although the correct route of administration (nebuliser) was written in the journal, the script was written for intravenous administration. This discrepancy between the notes and the official script suggests a failure to ensure consistency and accuracy in medical records, contributing to the error.

7.1.11 While the investigation could **not substantiate** the allegation that an incorrect medication was given; it was established that the medication route written on the prescription sheet was incorrect. The investigation found that the lack of staff awareness and the failure of the treating doctor and the shift leader in the NICU to act promptly to ensure the correct route of the Adrenaline medication was addressed on the script led to the clinical error.

7.1.12 The Health Ombud does not determine professional guilt or impose sanctions on healthcare practitioners. However, where a practitioner's conduct is intrinsically linked to the breach of norms and standards within the health establishment, the Health Ombud is empowered to make factual findings and, where appropriate, refer such conduct to the relevant professional council for consideration.

7.1.13 NFH acted inconsistently with Regulation 7(2)(b) of the Norms and Standard Regulations, which state, *"A health establishment must establish and maintain systems, structures and programmes to manage clinical risks."*

7.2 Allegation 2: Whether NFH failed to provide post-mortem services to Ms ML Masoka.

7.2.1 Ms ML Masoka explained that after the death of her baby, Dr EM Mathivha spoke to her to explain what happened to the baby. Ms ML Masoka said that although Baby Moatlegi Masoka changed condition after the administration of Adrenaline intravenously, Dr EM Mathivha told her that the baby died from bleeding in the lungs.

7.2.2 Ms ML Masoka said that Dr EM Mathivha encouraged the family to concentrate on Baby Masoka's burial and promised to discuss other matters later. Ms ML Masoka said while she believed what Dr EM Mathivha was saying at the time, as she is a good doctor, in hindsight, she thinks Dr EM Mathivha was hiding something.

7.2.3 While Ms ML Masoka initially stated that Dr EM Mathivha never advised the family about a postmortem, during the interview, she conceded that Dr EM Mathivha asked her if she needed a postmortem after the death of Baby Moatlegi Masoka, and Ms ML Masoka said she did not offer a response as she was traumatised.

7.2.4 The investigation further probed why Dr EM Mathivha did not recommend the postmortem, as Baby Masoka died immediately after the performance of a medication procedure. Dr EM Mathivha stated that she did not recommend a postmortem as she believed the baby died of natural causes.

7.2.5 While Ms ML Masoka may not have responded when asked about whether she needed a postmortem or not, Dr EM Mathivha should have required a postmortem to determine the cause of death. The investigation established that Baby Masoka died after a medication procedure. Dr NM Parker concurred with the Health Ombud that a definitive cause of death was needed to confirm the role of Adrenaline overdose in subsequent pulmonary haemorrhage and the death of Baby Masoka. The *Births and Deaths Registration Act* (Act 51 of 1992) requires that a medical practitioner issue a notification of death (form BI *1663*) stating the cause of death.

7.2.6 Baby Masoka's condition changed after the medication was administered, leading to pallor, difficulty in breathing and bleeding. The National Health Act 61 of 2003 defines *"Any death due to a physical or chemical influence, direct or indirect, and/or related complications (this would by definition include procedure and anaesthetic-related deaths, as by nature they involve physical and chemical influences)"*. The Inquest Act 58 of 1959 states that *"The doctor (or any person, for example, appointed relations officers in their specific institution) must report any suspected unnatural death to a policeman as soon as possible."*

7.2.7 The Health Ombud did not determine the medico-legal cause of death. The finding that the death followed a medication-related adverse event was made solely to assess whether NFH complied with applicable norms and standards requiring referral for a forensic postmortem in cases of sudden or treatment-related deaths.

7.2.8 The NFH action was inconsistent with Regulation 7(1) of the Norms and Standards Regulations in this regard, which states, *"The health establishment must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines."*

7.2.9 The allegation that NFH failed to provide postmortem services was substantiated.

7.3 Allegation 3: Whether NFH failed to address the complaint of Ms ML Masoka

7.3.1 Ms ML Masoka indicated during interviews that NFH did not address her complaint. However, during the on-site investigation, it was established that Ms ML Masoka, accompanied by her husband, met with Dr EM Mathivha and PN M Themba, for a redress meeting. During the meeting, Ms ML Masoka confirmed that Dr EM Mathivha explained that Baby Masoka died due to bleeding from the lungs, an assertion that Ms ML Masoka said she disagreed with, as *"the baby was okay until Adrenaline medication was administered intravenously, leading to the deterioration of Baby Masoka's condition and death."* Ms ML Masoka indicated she was unhappy with the reasons provided.

7.3.2 The investigation learned that a second meeting was held with Ms ML Masoka, Mr TNE Kgomongwe, the NFH hospital manager and Ms A Ferreira, the Nursing Manager. Ms ML Masoka stated that the hospital manager said they could not state the cause of Baby Masoka's death, as a postmortem was not conducted.

7.3.3 While Ms ML Masoka alleged that NFH did not address their complaint, the investigation found that two redress meetings were held. The fact that Ms ML Masoka was not happy with the outcome of the meeting does not mean the complaint was not addressed.

7.3.4 The allegation that NFH did not address Ms ML Masoka's complaint was unsubstantiated.

Additional Findings

7.4 Medication Administration Protocols

7.4.1 The investigation found that the policy/SOPs guiding the administration of medication had passed their review date. The Medication Management policy, the Standard Operating Procedures SOP for Medication Administration, and Medication Administration Routes had passed their review dates in 2021.

7.4.2 The NFH Medication Administration Routes SOP only stated the oral, intramuscular, subcutaneous, intravenous, and bolus routes. The investigation found that the SOP did not include some routes of administration, such as drops, rectal and inhalation. The investigation found this to be of great concern, as many medications in neonatal wards are administered per oral drops, per rectum or by nebulisation.

7.4.3 While the investigation learned that all SOPs in Netcare Hospitals are drafted nationally, the investigation found that unit managers and shift leaders in the NICU failed to advocate for the inclusion of other routes and ensure the review of SOPs.

7.4.4 The investigation found that NFH was inconsistent with Regulation 7(1) of the Norms and Standards Regulations, which states, *"The health establishment must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines."*

7.5 Handing over reports between shifts

7.5.1 The investigation found that the methodology of handing over reports between shifts in the NICU had shortcomings, as important information given to the takeover shift leaders was not adequately cascaded down to nurses dealing directly with patients.

7.5.2 PN M Themba, the acting unit manager at the time of the incident, stated that in the NICU, shift leaders take reports from each other, and the nurse allocated to a particular patient gives a handover report to the oncoming nurse. PN M Themba said the shift leaders do not go around to each patient to give a report.

7.5.3 The investigation found that if shift leaders were routinely part of nurses' handing over of the report process between shifts in the NICU, the incident on 29 May 2023 could have been averted.

7.5.4 NFH was inconsistent with Regulation 7 (2) (b) of the Norms and Standards Regulations, which states *"The health establishment must establish systems, structures, and programmes to manage clinical risks".*

7.6 Access to CareOn System.

7.6.1 The investigation found irregularities in accessing the *CareOn* system. The investigation found that when new staff lacked a unique password, they would use their colleagues' passwords to access the system.

7.6.2 The investigation established, through the attendance register, that EN EM Ngoato was not on duty on 28 May 2023, but entries were made in the system at 08h04, 08h06, and 08h07 using her password.

7.6.3 While Ms A Ferreira explained that NFH policy forbids staff from utilising other staff's passwords, she indicated that sometimes NFH encounter challenges as nursing staff hired through the nursing agency do not have unique passwords.

7.6.4 The investigation found that the practice defeated the primary objective of effective monitoring and accurate tracking of who performed specific actions and procedures at a particular time.

8. COMMENTS FROM MS ML MASOKA, NFH, AND DR EM MATHIVHA

8.1 The Provisional Investigation Report was sent to the Complainant, NFH, and Dr EM Mathivha on 15 December 2025, as provided for by section 81A (5) of the NHAA to afford persons implicated the opportunity to comment and provide evidence, if any, to vary/disprove what the Health Ombud has found before issuing the final investigation report.

8.2 The Health Ombud received comments from the Complainant, NFH, and Dr EM Mathivha through her lawyers. The Health Ombud studied their comments carefully and incorporated those that had a substantial impact on the report.

9. CONCLUSIONS

9.1. This tragic incident highlights systemic failures within the clinical care pathways and the importance of good leadership and stewardship, continuous mentoring and in-service training to keep abreast with developments and innovations within the NICU.

9.2. The incident highlights the importance of stringent medication safety protocols. Where adherence to protocols is lax, the risk of unintended outcomes is heightened.

9.3. Clear communication and involvement of shift leaders during report handover between shifts remains critical to avoid risks. This allows junior nurses to ask questions for clarity when needed.

10. RECOMMENDATIONS

10.1. The Netcare group should appoint a Task Team to monitor the Implementation of the recommendations as outlined in this report within one (1) month after the release of this report.

10.1.1 To ensure effective implementation, the Task Team should include the affected health establishment's Chief Executive Officer (CEO), the Nursing Manager, the implicated operational manager in this report and a senior Netcare Group quality assurance manager.

10.1.2 The Task Team should submit a quarterly summary of progress made on each recommendation to the CEO of Netcare group, the CEO of the Office of Health Standard Compliance (OHSC) and the Health Ombud.

10.1.3 Netcare should prepare and provide clear and comprehensive protocols on:

a) The *CareOn* System.
b) Medications and routes of administration.
c) Nursing handover report between shifts.
d) Referral of death from procedures and medications for forensic postmortem.

10.1.4 The induction and continuous in-service training of all professional staff, especially doctors and nurses, on different policies and SOPs, including the electronic patient management system.

10.1.5 Supervision of new and junior staff on the administration of medication.

10.1.6 Regular audits and clinical review of cases in the NICU.

10.1.7 Senior managers in the Netcare Group should investigate within the group and correct practices similar to those uncovered by the Health Ombud's investigation.

10.2 The medication that was administered to Baby Moatlegi Masoka.

10.2.2 The Health Ombud will refer the following persons to the Health Professions Council of South Africa or the South African Nursing Council, as appropriate, for further probing.

10.2.2.1 Dr EM Mathivha

a) Prescription of an incorrect route and/or of medication.

b) Failure to correct the route of Adrenaline in the script.

c) Failure to report apparent *CareOn* system defects to the administrator located within the hospital to avert medication errors with unintended outcomes.

d) Failure to call for extra medical help during the difficult resuscitation of Baby Moatlegi Masoka, as many failed attempts at intubation may have led to trauma and resulted in extended hypoxia with complications.

e) Failure to refer the body of Baby Moatlegi Masoka for forensic postmortem examination after the baby died following administration of excessive Adrenaline intravenously, as provided by the Inquest Act 58 of 1959.

10.2.2.2 PN T Potgieter (Shift leader NICU)

a) As a shift leader, she failed to advocate that the route prescribed by Dr EM Mathivha in the script be corrected.

b) PN T Potgieter facilitated that Adrenaline medication be administered as nebulization between 24 and 28 May 2023, but failed to ensure that the route was corrected on the script, which was written for intravenous on 24 May 2023. PN T Potgieter accepted, without protest, verbal orders that were contrary to the written script, thus opening the way for subsequent errors.

10.2.2.3 PN M Themba (Acting Unit Manager)

As the acting unit manager, PN M Themba failed to provide leadership and ensure that policies and protocols were adhered to in the NICU. She was responsible and accountable for all activities in the NICU.

10.2.3 The NICU Unit Manager must ensure that all doctors' prescriptions comply with the provisions of the *CareOn* system, and that all relevant personnel are aware of updates to the treatment plan.

10.2.4 NFH should implement dual verification systems in the NICU to ensure both the The route and dosage of medication are cross-checked before administration within one (1) month after the release of this report.

10.2.5 NFH should enable the *CareOn* system to detect erroneous or outlier prescriptions, such as doses and routes, and the system to give an alert.

10.2.6 This will ensure that NFH complies with Regulation 7(2)(b) of the Norms and Standards Regulation.

10.3 Post-mortem Services

10.3.1 The NFH Hospital Manager must advise all doctors and post a notice at an appropriate place that a forensic postmortem is mandatory in all cases where medication errors have contributed to death. This should be implemented within one (1) month of the release of this report.

10.3.2 The NFH Hospital Manager and Nursing Managers must ensure that the hospital policies are aligned with legal requirements for reporting unnatural deaths to the relevant authorities. The protocol to guide medical professionals should be drafted within three (3) months after the release of this report. **This should be cascaded with the rest of the Netcare Group**.

10.3.3 This will ensure that NFH complies with the Inquest Act 58 of 1959, and Regulations 4(1) and 7(1) of the Norms and Standards Regulations.

10.4 Medication Administration Protocols

10.4.1 Medication Administration Protocols guiding practice in the hospital are reviewed and signed off within one (1) month of the release of this report.

10.4.2 The Hospital Manager and Nursing Manager of the NICU should ensure that all medication administration routes are covered in the Medication Administration Protocol.

10.4.3 The Nursing Manager of NFH should conduct quarterly medication administration audits in the high-risk units, such as the NICU, to ensure that the staff follow correct procedures.

10.4.4 This will ensure that NFH complies with Regulation 7(1) of the Norms and Standards Regulation.

10.5 Handing over reports between shifts.

10.5.1 The NFH Nursing Manager and NICU Unit Manager must ensure that shift leaders are part of each patient report handover in the NICU immediately after the release of this report. This will ensure that any misinformation is dealt with before it can lead to adverse events.

10.5.2 The NICU Unit Manager must ensure, within one (1) month after the release of this report, that the handover process/procedure between shifts is formalised to ensure that critical patient information, including recent medication changes, is effectively communicated to incoming staff.

10.5.3 The NFH Nursing Manager and Unit Manager of the NICU should ensure that regular multidisciplinary team meetings are held to review complex patient cases in the NICU. This will ensure that all staff are aligned with the treatment plan.

10.5.4 This will ensure that NFH complies with Regulation 7 (2) (b) of the Norms and Standards Regulations.

10.6 The *CareOn* System

10.6.1 The Netcare Group should develop a system that will instantly notify all users of the *CareOn* system about new add-ons on the system within six (6) months of the release of this report. The mode of notification should be immediately accessible to staff, circulars should be published, and in-service training should be provided on the changes.

10.6.2 The Hospital Manager of NFH should ensure that unique passwords are allocated to all agency nurses to access the *CareOn* system to prevent staff from sharing passwords to access the CareOn. This will enable NFH to conduct proper monitoring. Each nurse must be formally inducted into the *CareOn* system. This is to be done within six (6) months after the release of this report

10.6.3 This will prevent the sharing of passwords and enable proper monitoring and control.

10.7 Mediation process.

10.7.1 The NFH Management must initiate and engage in mediation with Ms ML Masoka's family to resolve the issues in dispute constructively. Furthermore, the complainant is advised of the option to appoint and be represented by a legal practitioner during the mediation process. This mediation process should commence within four (4) months of receipt of the final investigation report.

11 LIST OF REFERENCES

11.1 National Department of Health. (2016). Procedural Regulation Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, published.

11.2 National Department of Health. (2018). Regulations Regarding the Rendering of Forensic Pathology Services

11.3 National Department of Health. (2018). The Norms and Standards Regulations Applicable to Different Categories of Health Establishments

11.4 Patient's Rights Charter.

11.5 Parker, N.M. (2024). Report on the death of Baby Moatlegi Masoka (DOB 2 March 2023) (Male)-Focusing on medical history, treatment complications, systemic issues, and recommendations. Tygerberg Hospital

11.6 Republic of South Africa (2003). National Health Act No. 61 of 2003. (Act 61 of 2003). Government Printers. Pretoria.

11.7 Republic of South Africa (2013). National Health Amendment Act No.12 of 2013. (Act 12 of 2013). Government Printers. Pretoria.

11.8 Republic of South Africa. (1992) The *Births and Deaths Registration Act* 52 of 1992. (Act 51 of 1992). Government Printers. Pretoria.

11.9 Republic of South Africa (1959). The Inquest Act 58 of 1959. (Act 58 of 1959). Government Printers. Pretoria.

11.10 The Constitution of the Republic of South Africa, 1996.

11.11 The Nurses' Pledge of Service.

11 LIST OF ANNEXURES

Annexure A Ms ML Masoka's letter of complaint

Annexure B Notice of Complaint

Annexure C Notice of Investigation.

Annexure D List of interviewees.

Annexure E Ms ML Masoka's comments

Annexure F NFH comments

Annexure G Dr EM Mathivha's comments

13. ADDENDUMS

13.1 Dr EM Mathivha, through her lawyers, requested a copy of the medical expert opinion on 29 December 2025.

13.2 The Health Ombud response:

13.2.1 The Health Ombud is reluctant to share the medical expert opinion report or any other evidentiary material before the finalisation and publication of his investigation report, lest this could sully the integrity of the investigation process and result.

13.2.2 The request for the medical expert opinion has since been referred, under the Promotion of Access to Information Act (PAIA), to the CEO of OHSC, Dr Siphiwe Mndaweni, as the Information Officer, for consideration. The response was provided to Dr EM Mathivha's lawyers.

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