A LEGACY OF NEGLECT: THREE YEARS OF INACTION AT MOHLOMI MENTAL HOSPITAL

OMBUDSMAN'S SPECIAL FOLLOW-UP REPORT ON RE-INSPECTION OF THE MOHLOMI MENTAL HOSPITAL

INSPECTION NO 2 OF 2025/2026

28TH MARCH 2026

FOREWORD

It is now three years since the Ombudsman published her Special Report on the 'Inspection of the Mohlomi Mental Hospital', a document that laid bare the deplorable conditions under which patients at this facility subsist. That report, issued in March 2023, catalogued systemic failures spanning psychiatric staffing, infrastructure, hygiene, nutrition, and the fundamental denial of human dignity to some of the most vulnerable members of our society.

The findings of that inspection were not merely administrative observations; they were a judicial pronouncement on the state's failure to meet its constitutional and international obligations. Section 8 of the Constitution of Lesotho 1993 prohibits torture or inhumane or degrading treatment. Section 27 enjoins the state to adopt policies ensuring the highest attainable standard of physical and mental health for citizens. The Human Rights Act No 24 of 1983 guarantees persons deprived of their liberty the right to humane treatment and respect for their inherent dignity.

Internationally, Lesotho is a state party to the Universal Declaration of Human Rights, which in Article 25 recognises the right of everyone to an adequate standard of living for health and well-being, including medical care. The Convention on the Rights of Persons with Disabilities (CRPD), to which Lesotho is signatory, imposes specific obligations regarding the treatment of persons with mental disabilities.

Section 10 of the Ombudsman Act No 9 of 1996 empowers this Office to:

'enter and inspect police, military or prison cells, government hospitals, asylums, or any other places or centers where any person is detained or kept whether for safe custody or in terms of any law.'

The 2023 report made 97 specific recommendations across fifteen (15) thematic areas, with implementation deadlines ranging from one (1) month to twelve (12) months. It was my expectation, and that of the nation, that the Ministry of Health (MOH) would treat these recommendations with the urgency they demanded. It was my hope that the MOH, the Principal Secretary, and the Director General of Health Services would move with alacrity to address the human rights violations documented in that report. That hope has not been realised.

This follow-up report is therefore issued with a heavy heart but an unwavering resolve. It documents not progress, but regression. It records not reform, but resistance. It chronicles a three-year period during which the MOH has, with few exceptions, failed to implement the recommendations of this Office, resulting in the continued suffering of patients at Mohlomi Mental Hospital.

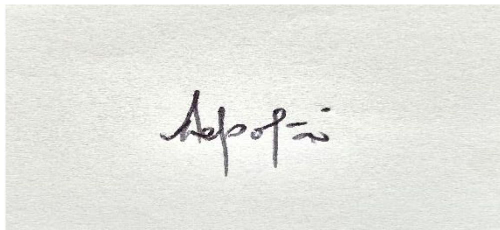
In the intervening period since the 2023 report, this Office has received correspondence from the MOH, made inquiries through our monitoring mechanisms, and awaited the implementation of recommendations. We have not been met with silence as feedback on strides being made has been shared, but not much has changed from the last visit undertaken by the Ombudsman. The Ministry's

own public statements, as reported in the media, have acknowledged the ongoing crisis at Mohlomi, yet meaningful action has been conspicuously absent.

This report is issued not merely to criticise, but to compel. It is issued in the exercise of my constitutional and statutory mandate to protect the rights of all Basotho, particularly those who cannot protect themselves. It is issued in the hope that public exposure of this continuing failure will finally galvanise the executive branch to act.

The structure of this report is as follows: Section 2 provides an executive summary of findings. Section 3 outlines the methodology employed in this follow-up inspection. Section 4 presents a detailed status report on each recommendation from the 2023 report. Section 5 sets out current findings from the re-inspection. Section 6 analyses the systemic failures that have perpetuated this crisis. Section 7 provides updated recommendations with revised timelines. Section 8 concludes.

Signed this 28th day of March 2026



ADV TLOTLISO POLAKI
OMBUDSMAN

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List of Acronyms and Abbreviations

Acronym	Full Form
CBT	Cognitive Behavioural Therapy
CCTV	Closed-Circuit Television
CPEA	Criminal Procedure and Evidence Act
CRPD	Convention on the Rights of Persons with Disabilities
DG	Director General
EEG	Electroencephalography
GOL	Government of Lesotho
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
JTWG	Joint Technical Working Group
LCS	Lesotho Correctional Services
MoH	Ministry of Health
MOU	Memorandum of Understanding
NCD	Non-Communicable Disease
NCDI	Non-Communicable Diseases and Injuries
NDSO	National Drug Service Organisation
NGO	Non-Governmental Organisation

Acronym	**Full Form**
PIH	Partners In Health
PRO	Public Relations Officer
QMMH	Queen 'Mamohato Memorial Hospital
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UN	United Nations
WHO	World Health Organization
PIU	Health Maintenance Project Implementing Unit (PIU)

1.0 EXECUTIVE SUMMARY

This is an inspection report of the Ombudsman issued in terms of section 36 and section 135 of the Constitution of Lesotho 1993 ('the Constitution') and published in terms of section 7(3) and section 7(4) of the Ombudsman Act No 9 of 1996 (the Act'), which enjoins the Ombudsman to *inter alia* inform the specified authorities of her findings and make such recommendations as she may deem fit.

The report communicates the findings and appropriate remedial action that the Ombudsman is recommending in terms of section 135 of the Constitution and section (7)(1)(b) and section 7(5) and 7(6), following the inspection.

Between January and February 2026, the Office of the Ombudsman (OoO) conducted a follow-up inspection of the Mohlomi Mental Hospital to assess the implementation of recommendations made in the March 2023 Special Report. The inspection revealed a picture of systemic neglect that has, in many respects, worsened since the original inspection.

1.1 Key Findings of relapses

The inspection established several key **findings of relapses and deficiencies** at the hospital upon inspection by the Office of the Ombudsman (OoO):

(a) There is a failure to act on Ombudsman's recommendations – the MOH failed to implement previous recommendations to address the inhumane conditions under which patients are being held. Of the 97 recommendations made in 2023, only 12 (12.4%) have been fully implemented. A further 15 (15.5%) have been partially implemented. The remaining 70 recommendations (72.1%) remain unimplemented, with many not even commenced.

(b) With reference to psychiatric staffing, the hospital continues to operate without a permanently appointed psychiatrist. While a foreign Cuban psychiatrist, who can be able to deal with medico-legal issues arrived in early 2025, this single specialist is insufficient to address the needs of both general and forensic patients, and the position remains temporary and non-pensionable. Worse still, he is not vest in either one of the official languages and had to first be inducted on the use of English as a means of communication. As a result, progress made thus far in relation to patients' assessments has been extremely slow, and to date, less than five (5) evaluation reports have been produced.

Under current legislation, this role is essential as the psychiatrist chairs the advisory committee responsible for recommending patient pardons. These resource gaps, compounded by budgetary constraints, remain the primary inhibitors to advancing the program. In the interim, the MOH has indicated that it has solicited financial support from the Dolen Foundation and has proposed an exchange program with specialist including forensic psychiatrists who will assist the hospital in dealing with forensic assessments backlog crisis.

(c) Lack of transport remains an inhibitor as social workers are unable to undertake home visitations for assessment, and this limits comprehensive reporting that assists in determining whether or not the patients can be reintegrated back into their communities. The hospital is still placing reliance on an old ambulance, and most recently an Iveco vehicle which serves as a vehicle undertaking all hospital operations.

The Ministry of Health (MOH) has requested a dedicated vehicle to support social workers in the reintegration of forensic patients.

(d) The Advisory Committee required by law to review patients detained at His Majesty's pleasure has not been reconstituted. The Ministry of Health (MoH) has advised this Office that the reconstitution process is contingent upon the approval and budgeting of seating allowances, which have now been incorporated into the 2026/2027 financial budget.

(e) In terms of overcrowding, the forensic unit, designed for 35 patients, now houses 84 patients, a deterioration from the 77 recorded in 2023. The general wards house 70 patients, bringing the total institutional population to 154 marginally the same from 145 but still exceeding the 110-patient capacity established after 2001 refurbishments. Each of the communal cells currently hosts 10 to 11 patients and there are no longer any vacant observation cells as they are all fully occupied. The hospital no longer classifies patients due to the fact that all single cells have to now be shared between four (4) patients irrespective of circumstances that warrant that a patient be isolated for observation purposes.

(f) Unfilled positions on the establishment list has added to the many challenges of provisioning of mental health services in a manner befitting. The MOH illuminated that a temporary moratorium issued by the Ministry of Public Service (MPS) has paused all recruitment, including pending temporary appointments. This measure, the Ombudsman was informed, will remain in place until the MOH, in consultation with the Ministry of Finance and Development Planning, aligns its staffing requirements with the available budget.

(g) With reference to the infrastructure, the buildings remain in a state of advanced dilapidation. In our previous engagement with the MOH officials, it was acknowledged that the hospital's design is not for a mental institution and that a lot of work has to be undertaken to bring it up to standard. The ceilings are on the brink of collapse, largely due to patients tampering with them and walking in the ceiling space. Furthermore, the walls are unable to support the hospital's increasing demands. The male ward exhibits significant structural deterioration, characterized by damaged ceilings. While partial remediation has been undertaken using steel materials, this appears designed to prevent damage and unauthorized departures, highlighting concerns regarding the environment of care.

(h) The hospital's drug rehabilitation services remain restricted to existing patients only, with no dedicated facility for the broader population. The senior nursing officer, Mrs 'Mantoa Maholi-Rampeta confirmed that ‘due to lack of human resource and infrastructure they are only able to

offer drug rehabilitation to their clients' alone. Due to rising national drug consumption, the hospital has reopened an outpatient addiction care unit directed by a specialist practitioner. However, this expansion necessitates significant upgrades to occupational therapy and addiction infrastructure, requiring external donor support to secure necessary equipment.

(i) I established that the National Mental Health Policy and Strategic Plan (2023-2027) was ultimately approved at the end of 2024, more than two (2) years after its development with Partners in Health; however, implementation has been slow.

(j) The country continues to operate under the outdated Mental Health Care Act No 7 of 1964, with proposed amendments languishing in Parliament. Stakeholders expressed concern that the draft Mental Health Bill is overly prescriptive, particularly regarding administratively burdensome requirements such as mandated sitting allowances for the advisory committee. In response, the Ministry of Health (MOH) has resumed the amendment process, and the draft Bill is currently at a stage where formal legal instructions are being drafted.

(k) The Occupational Therapy Unit is now functional with the appointment of an occupational therapist following the retirement of the sole therapist who retired in 2021. The position was filled in November 2024; however, noting the volume of work to be undertaken for all 145 patients housed at the facility, there is a need to strengthen capacity with not less than four (4) other therapists, given Mohlomi's establishment list. The inadequate number of therapists continues to deprive patients of essential therapeutic interventions.

(l) Despite the Ministry's late 2023 claim that the lice infestation had been addressed, our inspection reveals the problem persists due to overcrowding and poor hygiene protocols. Patients continue to suffer from scabies and other dermatological conditions. Furthermore, broken washing machines forced laundry to be processed in Berea; during this time, dirty clothing often became mixed with clean items. The situation was further aggravated by the Ministry's procurement of low-quality detergents, which failed to eradicate the lice and instead worsened the infestation. The hospital has indicated that the Health Maintenance Project Implementing Unit (PIU) has introduced Darlington Holdings for disease vector control and grounds and gardens services at Mohlomi Hospital to address lice infestation.

As of the date of this report, the majority of issues raised in 2023 have either not been implemented while some remain in progress. The failure to implement the recommendations of the 2023 report constitutes maladministration of the highest order. It represents a continuing violation of the constitutional rights of patients at Mohlomi Mental Hospital and a breach of Lesotho's international obligations. The time for reports and recommendations has passed; the time for action is now.

The remedial action issued by the Ombudsman is set out under Chapter 7 below.

2.0 METHODOLOGY AND SCOPE

2.1 This follow-up inspection was conducted over five days between 27th and 31st January 2026. The inspection team comprised officers from the OoO and engagements were had with medical officers with expertise in psychiatric care.

2.1 LEGAL FRAMEWORK

The inspection was conducted pursuant to Section 10 of the Ombudsman Act No 9 of 1996 and in accordance with the International Health Facility Guidelines version 4.2 of 2019. Regard was also had to the Constitution of Lesotho 1993, the Human Rights Act No 24 of 1983, the Criminal Procedure and Evidence Act No 9 of 1981, and the Mental Health Care Act No 7 of 1964.

2.2.1 Policy Framework

The National Mental Health Policy and Strategic Plan (2023-2027) was finally endorsed or approved subject to the changes being undertaken.

2.2.2 SCOPE OF THE INSPECTION

The inspection covered:

a) All patient wards, including the men's ward, women's ward, and forensic unit
b) The occupational therapy building
c) The pharmacy and drug storage facilities
d) Ablution facilities and water supply systems
e) Kitchen and dining areas
f) Staff offices
g) External grounds and security perimeters

2.2.3 Interviews and Consultations

The inspection team conducted interviews with:

a) Acting Hospital Director
b) Senior Nursing Officer
c) Nursing staff across all wards
d) Lesotho Correctional Services officers assigned to the forensic unit
e) Patients, including those detained at His Majesty's pleasure
f) Ministry of Health officials at the central level

2.2.4 Document Review

The team reviewed:

a) Mohlomi Hospital Staff Establishment List
b) The National Mental Health Policy and Strategic Plan (2023-2027)
c) Construction of upgraded Mohlomi Hospital concept note
d) MOH Correspondences with various ministries on Mohlomi Hospital
e) Approved Budget for 2025/2026
f) Patient Data Records

2.2.5 Limitations

The inspection was announced, pursuant to section 10 of the Ombudsman Act No 9 of 1996, and the team was afforded full access to all areas of the facility. However, some officers were reluctant to speak openly due to fear of reprisal, a limitation that itself speaks to the prevailing culture at the institution.

2.2.6 Reporting Period

This report covers the period from March 2023 to February 2026, being the period between the original inspection and this follow-up.

3.0 STATUS OF 2023 RECOMMENDATIONS

3.1 This section provides a quantitative and qualitative assessment of the implementation status of recommendations contained in the March 2023 Special Report. Recommendations are grouped thematically, with an implementation rating assigned to each.

3.1.1 Rating Scale

Fully Implemented: Action taken that fully addresses the recommendation

Partially Implemented: Some action taken, but significant gaps remain

Not Implemented: No meaningful action taken

Overtaken by Events: Circumstances have changed rendering the recommendation obsolete

3.1.2 Psychiatric Staffing and Patient Release (8 recommendations)

Recommendation	Deadline	Status	Remarks
Source qualified psychiatrist(s)	6 months	Partially Implemented	One (1) Cuban foreign psychiatrist arrived a year ago, whose contract has now lapsed; position is temporary and covers general and forensic patients
Source qualified Occupational therapists	6 months	Partially Implemented	One (1) Occupational therapist was recruited in 2024
Source qualified clinical psychologists	6 months	Partially Implemented	There are two (2) clinical psychologists recruited but they are supposed to be five (5) in terms of the establishment list
Source psychologists	6 months	Not Implemented	No psychologists while establishment lists indicates that there should be two (2) psychologists
Recruit senior nursing officers	6 months	Not Implemented	Only one (1) senior nursing officer works at the hospital, and she will be proceeding on retirement in March 2026
Recruit psychiatric nurses	6 months	Partially Implemented	District-level psychiatric nurses maintained, but hospital shortages persist
Ensure regional clinical psychologists	6 months	Not Implemented	No regional assessment capacity established
Reconstitute Mental Health Review Tribunal	6 months	Not Implemented	Tribunal not reconstituted; it last sat in 2015

Reconstitute Advisory Committee	6 months	Not Implemented	Committee not reconstituted
Release eligible patients	6 months	Partially Implemented	Six (6) patients released *via* court orders since 2023; no systematic review conducted

* The Ombudsman established that despite the recruitment of a psychiatrist, significant service delivery challenges persist due to language barrier. This has caused substantial delays in issuing assessment reports, which are largely below standard. Given that his contract has expired, it may be necessary the Ministry of Health (MOH) source a replacement.

***Inmates released through court orders**

Patient Names	Date of Admission	Duration Spent	Offence	Released
Liau R	30/11/2012	13 years	Violating a grave	04/04/2025
Ramolelekeng R	20/02/2013	11 years	Stock theft	19/11/2024
Malehlohonolo L	26/02/2020	3 years	CPWA (C/S 202 (2))	03/07/2023
Puso N	18/09/2013	12 years	Penal Code	02/05/2025
Motsamai T	24/11/2021	3 years	Assault GBH	22/02/2024
‘Matlali T	13/04/2023	9 months	CPWA C/S 202 (2)	31/01/2024

*One patient, Souru, died of high blood pressure and complications caused by stroke at the Forensic Unit in March 2025; he was 72 years old and had been in observation for 7 years and had transgressed the Penal Code Act No 6 of 2012.

*There were 3 mortalities in 2025: a 19-year-old male patient who had been admitted for substance induced psychosis committed suicide in the seclusion room.

*A 70-year-old male patient who had been at the hospital for more than 10 years demised in May 2025; he had epilepsy, schizophrenia, renal failure and hypertension.

*A 49-year-old female admitted on 20th November 2025 demised on 22nd November 2025 from an unknown or unidentified cause of death – query cardiopulmonary arrest.

3.1.3 Buildings (5 recommendations)

Recommendation	Deadline	Status	Remarks
Maintain buildings and refurbish	12 months	Not Implemented	Buildings continue to deteriorate; ceilings near collapse
Procure gardening services	12 months	Not Implemented	Grounds overgrown; snake risk persists
Address health and safety risks	12 months	Not Implemented	No comprehensive risk assessment conducted
Procure cleaning detergents	12 months	Partially Implemented	Intermittent supply; no consistent provisioning
Provide LCS officers with office space	12 months	Not Implemented	LCS officers remain without dedicated offices

Figure 1: Dilapidated ceilings within the male ward and forensic unit

The current state of Mohlomi Hospital is unsuitable for modern patient care, with inadequate dormitory-style facilities that hinder privacy, isolation capabilities, and safety. To address this, the Ombudsman established that the MOH has proposed a M367 million phased, specialized facility to replace it. Approved by the PISC, the MOH indicated that the new design will feature specific units for acute psychiatric care, forensics, and rehabilitation. Furthermore, the MOH is actively engaging the African Development Bank and other partners for funding and technical support to build this new facility, ensuring improved patient safety and high-quality care.

Figure 2: Overgrown vegetation showing lack of routine maintenance

Chronic neglect of grounds maintenance at the mental hospital has resulted in overgrown vegetation, creating a significant safety risk due to frequent snake sightings. This environment undermines patient care and poses a severe threat to their physical safety

3.1.4 Drugs Supply (3 recommendations)

Recommendation	Deadline	Status	Remarks
Maintain sufficient drug supplies	Ongoing	Fully Implemented	Supply maintained at three-month buffer stock
Provide for forensic unit medical costs	Ongoing	Not Implemented	Funding responsibility remains unclear
Secure pharmacy door	1 month	Partially Implemented	Door was replaced but remains unsecured; issue outstanding for over seven (7) years

3.1.5 Bedding (3 recommendations)

Recommendation	Deadline	Status	Remarks
Replace damaged beds and procure mattresses	6 months	Partially Implemented	Some mattresses were purchased; however, not all patients sleep on mattresses; some still sleep on the floor and on concrete beds without mattresses
Provide consistent toilet paper	6 months	Partially Implemented	Intermittent supply: patients continue to use alternatives
Fix heating system in inbuilt beds	6 months	Not Implemented	Heating system remains dysfunctional

Figure 3 and figure 4: Mattresses and broken beds in forensic and male ward

The facility is currently experiencing a critical shortage of functional beds, compounded by a failure to replace damaged bedding. This situation has severely compromised patient dignity and basic hygiene standards. While a donation of 80 mattresses from private partners is anticipated to address some immediate capacity pressures, current bedding supplies remain sufficient, though in poor condition.

3.1.6 Clothing/Uniforms (4 recommendations)

Recommendation	Deadline	Status	Remarks
Procure beds, mattresses, blankets	6 months	Partially Implemented	Procurement undertaken but not all patients use mattresses
Provide patient uniform clothing	6 months	Not Implemented	Patients continue to wear own clothes; staff donations remain necessary
Procure staff uniforms	12 months	Partially implemented	Some, not all staff uniforms were procured
Repair heating equipment	12 months	Not Implemented	No maintenance undertaken

Under the current legislation, staff members are entitled to two complete sets of uniform items every two years. However, due to ongoing budgetary constraints, the Department has been unable to meet this full entitlement, providing only a single pair to each employee. It is noted, however, that the recent procurement of jackets for all staff represents a positive development, particularly given the multi-year hiatus in uniform provision.

3.1.7 General Cleanliness (4 recommendations)

Recommendation	Deadline	Status	Remarks
Fumigate wards every six months	Ongoing	Partially Implemented	One fumigation conducted in late 2023; none since
Procure bathing soap and toiletries	Ongoing	Not Implemented	Reliance on NGO donations continues
Implement decentralised procurement	12 months	Not Implemented	Centralized bureaucracy persists
Treat patients with rash	6 months	Partially Implemented	Some patients treated; recurrence due to overcrowding

Figure 5 and figure 6: Blocked and unclean bathtubs

The inspection of the shower facilities revealed critical sanitation failures. Several bathtubs were found in an unhygienic state, with clogged drains containing stagnant, contaminated water. The absence of cleaning detergents or apparent daily sanitation schedules poses a significant infection control risk to users

3.1.8 Water and Ablution Services (3 recommendations)

Recommendation	Deadline	Status	Remarks
Maintain water pipes and address leakages	Ongoing	Not Implemented	Leakages continue; blockages frequent
Repair water taps	6 months	Not Implemented	Many wards lack running water
Fix geysers	12 months	Partially Implemented	Geysers were replaced

Figure 7: Showers without doors lacking privacy

Observations revealed that the showers are consistently unclean and present an unhygienic environment. The absence of shower doors eliminates any privacy for patients, compromising their dignity. These conditions create significant barriers to safe, respectful care. It was observed that hygiene standards are not being maintained in the bathing areas. Multiple showers were visibly soiled. There was no evidence of cleaning agents available for use, indicating a failure to adhere to basic cleanliness protocols.

It was established that this is a systemic issue, compounded by a misperception among staff, who treat the facility as a prison rather than a clinical environment. Consequently, staff failed to fulfill their duty of care regarding the cleanliness of the area, treating patients as inmates and denying them a sanitary living environment.

Figure 8 and figure 9: Dirty toilets and broken taps in shower

Site observations revealed consistently poor sanitary conditions across all toilet facilities. The absence of cleaning detergents suggests a lack of proper maintenance protocols, resulting in a persistent, intense, and foul odour that renders the area nearly unusable and poses significant health risks to users.

3.1.9 Heating and Ventilation (5 recommendations)

Recommendation	Deadline	Status	Remarks
Address electricity needs	6 months	Partially Implemented	Some bulbs replaced; system remains inadequate
Provide adequate ventilation	12 months	Not Implemented	Window design prevents adequate airflow
Install solar heating system	12 months	Not Implemented	No installation
Procure solar geysers	12 months	Implemented	Two geysers were replaced and there is hot water in most wards
Procure fan heaters	12 months	Not Implemented	No procurement

The heating system remains non-functional despite a needs assessment conducted by the Project Implementation Unit (PIU). The OoO established that while the PIU previously indicated that

repairs and the installation of Wi-Fi were contingent upon funding, the advanced age and systemic deterioration of the facility render most interim repairs unsustainable. It is increasingly evident that localized fixes are no longer cost-effective or durable; the viable long-term solution is the construction of a new hospital. Although external partners such as Partners in Health (PIH) were consulted for interim renovations, they are currently unable to provide support due to donor funding constraints.

3.1.10 Overcrowding (9 recommendations)

Recommendation	Deadline	Status	Remarks
Appoint psychiatric doctor for evaluations	6 months	Partially Implemented	Foreign Cuban psychiatrist now available for both general and forensic evaluations
Ensure strict legal compliance	Ongoing	Not Implemented	No systemic compliance improvements
Upgrade Mohlomi	12 months	Not Implemented	No upgrades undertaken as yet though plans are underway to ensure new hospital is constructed; no certainty in terms of timing provided
Strengthen absconder management	6 months	Not Implemented	Absconding continues
Consider assisting offenders to stand trial	12 months	Not Implemented	No policy consideration by Ministry of Law and Justice
Consider deinstitutionalization	6 months	Not Implemented	No recommendations made to Minister
Re-establish rehabilitation facilities	12 months	Not Implemented	Blue Cross and similar facilities remain closed
Reopen district observation units	6 months	Not Implemented	District units remain non-functional

3.1.11 Transportation (5 recommendations)

Recommendation	Deadline	Status	Remarks
Procure vehicle for operations	12 months	Not Implemented	No vehicle procured
Procure ambulance	12 months	Not Implemented	Single ambulance or Iveco continues to serve all purposes
Provide transport for social workers	6 months	Not Implemented	Social workers lack transport for home visits and resort to using ambulance once in a week
Ensure vehicle accountability	Ongoing	Not Implemented	No accountability system established
Provide food allowances for outreach	6 months	Not Implemented	No allowances provided

3.1.12 Feeding (3 recommendations)

Recommendation	Deadline	Status	Remarks
Increase funding for food	6 months	Partially Implemented	Minor budget increase; inadequate for needs
Ensure adequate food consistently	Ongoing	Implemented	Adequacy of food and sufficiency improved
Pay suppliers timeously	Ongoing	Implemented	Supplier payment delays have ceased

Figure 10 and figure 11: Improved patients' daily lunch

3.1.13 Furniture and Equipment (6 recommendations)

Recommendation	Deadline	Status	Remarks
Repair furniture and equipment	12 months	Not Implemented	Broken furniture remains unrepaired
Procure computers and laptops	3 months	Not Implemented	Manual record-keeping continues
Procure video conferencing facility	12 months	Not Implemented	No video conferencing capability
Procure EEG machine	12 months	Partially implemented	EEG machine was procured but has been transferred to Makoanyane Hospital for epileptic patients
Procure stationery	3 months	Not Implemented	Stationery shortages persist
Ensure regular maintenance	Ongoing	Not Implemented	No maintenance programme

Figure 11: Broken furniture and equipment in LCS officers' office

Chronic underfunding has resulted in critical infrastructure decay, rendering essential service vehicles, medical equipment, office furniture and equipment non-functional. The failure to maintain essential medical equipment and vehicles has directly impacted the quality of care, placing patients at risk and hindering the hospital's ability to provide basic services

3.1.14 Psychological Services (2 recommendations)

Recommendation	Deadline	Status	Remarks
Provide counselling services	Ongoing	Not Implemented	No counselling services for staff or patients
Recruit clinical psychologists	6 months	Partially Implemented	2 recruited officers

3.1.15 Safety and Security (6 recommendations)

Recommendation	Deadline	Status	Remarks
Train staff adequately	12 months	Not Implemented	No training provided
Ensure acceptable use of force	Ongoing	Not Implemented	No protocols established
Review risk allowance	12 months	Not Implemented	Allowance remains M12.00 per month
Develop compensation policy	12 months	Not Implemented	No policy for staff losses
Replace CCTV equipment	12 months	Not Implemented	CCTV remains non-functional

According to the MOH, the current ward configuration fails to provide a therapeutic or secure environment, escalating the risk of unauthorized patient departures (absconding) and self-harm. Significant security breaches, including compromised entry points and broken doors, have been identified. The facility's layout and lack of adequate supervision have led to inappropriate patient interactions, resulting in documented instances of HIV transmission. These failures jeopardize staff safety and leave high-value medications, such as Antiretrovirals (ARVs), vulnerable to theft or unauthorized access.

Furthermore, the failure to segregate patients based on clinical needs creates a detrimental environment; admitting patients with acute depression or suicidal ideation into high-stimulus areas alongside psychotic patients exacerbates psychological distress. In its current state, the clinical environment is counter-therapeutic and increases the risk of suicidal ideation, transforming a place of healing into one of potential harm.

3.1.16 Recreation (2 recommendations)

Recommendation	Deadline	Status	Remarks
Recruit occupational therapists	6 months	Partially Implemented	One position filled in 2024
Involve patients in recreational activities	Ongoing	Partially Implemented	Football available in male ward; no structured programme

3.1.17 MoU with LCS (4 recommendations)

Recommendation	Deadline	Status	Remarks
Review MoU	1 month	Not Implemented	No review conducted
Determine handover of security	3 months	Not Implemented	No determination made
Reconstitute governance structures	3 months	Not Implemented	JTWG remains defunct
Enhance LCS staff complement	3 months	Not Implemented	Staffing had reduced from 47 to 43 officers; recorded a decline

3.1.18 Staff Welfare (8 recommendations)

Recommendation	Deadline	Status	Remarks
Equip hospital administrator	6 months	Implemented	Only implemented in the last month with a new dedicated resource now available for the hospital's administration
Utilise PIH psychiatrist for forensic assessments	3 months	Partially Implemented	Psychiatrist's contract lapsed and has not been renewed; she was not dealing with medico legal assessments and only dealt with general patients only. New psychiatrist dealing with forensic patients though there is a language barrier
Pay acting allowances	6 months	Not Implemented	Acting staff not compensated
Fill vacant positions	12 months	Not Implemented	Vacancies remain unfilled
Clarify staff roles	6 months	Not Implemented	Role confusion persists
Procure staff uniforms	3 months	Partially Implemented	Uniforms have been procured
Ensure proper procurement channels	6 months	Not implemented	Procurement issues continue
Confirm probationary staff	6 months	Not Implemented	Many staff officers remain on probation since 2018, and it is only now that the HR is working on confirming them

3.1.19 General Recommendations (24 recommendations)

Category	Total	Fully Implemented	Partially Implemented	Not Implemented
Policy and Strategy	5	1	1	4
Judicial and Legal	4	0	0	4
Staff Welfare	3	0	0	3
Budget and Resources	2	0	1	1
Infrastructure	4	0	0	4
Patient Release	2	0	1	1
Accountability	1	0	0	1
Security Systems	1	0	0	1
Ventilation	1	0	0	1
Ablution	1	0	0	1
Total	**24**	**1**	**2**	**21**

3.1.20 Overall Implementation Status

Rating	Number	Percentage	
Fully Implemented	12	12.4%	Fully Implemented
Partially Implemented	15	15.5%	Partially Implemented
Not Implemented	70	72.1%	Not Implemented
Overtaken by Events	0	0%	Overtaken by Events
Total	**97**	**100%**	

3.1.21 The implementation rate of 12.4% over a three-year period represents a fundamental failure of governance. It indicates that the Ministry of Health has not treated the recommendations of this Office with the seriousness they deserve, and that the rights of patients at Mohlomi Mental Hospital continue to be violated with impunity.

4.0 CURRENT FINDINGS

4.1 Psychiatric Staffing and the Advisory Committee

4.1.1 The 2023 report documented that Mohlomi Mental Hospital had operated without a psychiatrist for seven years, since 2016/2017. This Office can now report that, as of January 2025, the hospital had been without a permanently appointed psychiatrist who could deal with medico-legal matters for a total of nine (9) years.

4.1.2 In early 2025, a foreign Cuban psychiatrist arrived in Lesotho and now assists the facility. This development is welcome, but it falls substantially short of what is required. The psychiatrist in question is employed on a temporary, non-pensionable basis, and inasmuch as his scope of work is not limited to general patients alone, the psychiatrist cannot confer in any of the local languages and has had to learn English first to enable him to assess forensic patients requiring evaluation for the Pardons Committee. In the year he has been in service, he has only dealt with less than five (5) patients and issued their reports. Having at least another psychiatrist specialist would be very helpful to address the inadequacy of specialists for purposes of assessing patients.

4.1.3 The Mental Health Review Tribunal and the Advisory Committee, required by law to review the cases of patients detained at His Majesty's pleasure, remain non-functional. These bodies were last reconstituted in 2012, and their mandate expired in 2015. No psychiatrist has been available to serve on these bodies, and no patients have been reviewed through the proper statutory mechanism since that time.

4.1.4 The consequences of this failure are profound. Patients who have recovered from their mental illness remain detained indefinitely because the legal mechanism for their release is inoperative. This Office documented in 2023 that three (3) patients were no longer on medication and were awaiting pardon. Two of the three patients remain at Mohlomi today, three years later, still awaiting review.

4.1.5 One patient, committed on account of sexual offences committed while under the influence of dagga in 1998, has now been detained for 28 years. A second, committed for arson in 2017, has been detained for nine (9) years despite being stabilised.

4.1.6 The absence of a functional review mechanism means that these patients, and dozens like them, are effectively serving indeterminate sentences without judicial oversight. This is not treatment; this is imprisonment without trial, and it violates Section 8 of the Constitution.

4.1.7 The Ministry of Health (MOH) has expressed significant concern regarding the ongoing practice of the judiciary committing forensic patients to Mohlomi Hospital without prior psychological assessments. This lack of vetting places undue strain on the facility’s resources and safety protocols.

Consequently, there is an urgent need for targeted sensitization and engagement initiatives to ensure judicial officers understand the clinical and operational implications of these commitment orders.

4.1.8 The situation is compounded by the absence of clinical psychologists. The 2023 report recommended the recruitment of qualified clinical psychologists for forensic assessment and complex psychotherapy. The MOH has recruited two (2) clinical psychologists who are unable to manage the load of work due to capacity constraints. The hospital continues to operate with two psychologists, none of whom possess the specialized qualifications required for forensic work.

4.1.9 District-level psychiatric services remain critically understaffed. Each of the ten (10) districts has only one psychiatric nurse. The recommendation that clinical psychologists be available for regional assessments has not been implemented, meaning that patients outside Maseru have no access to specialised mental health assessment.

4.1.10 The concerns documented in 2023 remain not merely relevant but urgent.

4.2 Overcrowding in the Forensic Unit

4.2.1 The 2023 report documented that the forensic unit, designed for 35 patients, housed 77 patients at the time of inspection. The current inspection reveals that this situation has deteriorated further. The forensic unit now houses 84 patients (81 male and 3 female), representing an occupancy rate of 240% of design capacity.

4.2.2 The general wards house 70 patients (33 male, 24 females and 13 children), bringing the total institutional population to 154. While this represents a marginal increase from the 145 recorded in 2023, it remains substantially above the 110-patient capacity established after the 2001 refurbishments.

4.2.3 The overcrowding in the forensic unit has predictable and preventable consequences. Patients sleep on mattresses on the floor, with up to eleven patients in rooms designed for four or five. The proximity of patients facilitates the transmission of communicable diseases, including tuberculosis, scabies, HIV AIDS and respiratory infections.

4.2.4 The offence profile of forensic patients remains substantially unchanged from 2023:

Nature of Offence	Number of Patients (2023)	Number of Patients (2026)	Duration Spent
Sexual Offences	27	30	1 – 22 years
Murder	17	19	1 – 30 years
Assault GBH	09	09	2 – 19 years
Assault Common	05	08	2 – 13 years
Malicious damage to property	04	05	2 – 25 years

Stock Theft	03	04	8 – 11 years
House Breaking	04	02	12 - 14 years
Car theft	01	01	11 years
Arson	04	05	3 – 20 years
Contempt of court	02	01	14 years
Violation of a grave	01	0	
TOTAL	**77**	**84**	

4.2.5 The increase of eight (8) patients over three years, while modest, is significant because it has occurred in the absence of any corresponding increase in patient discharges. The forensic unit has become a repository for individuals who, having been found unfit to plead or not criminally responsible, are effectively abandoned by the system.

4.2.6 The closure of impact rehabilitation facilities, such as the Blue Cross Thaba Bosiu Centre, continues to contribute to congestion at Mohlomi. Patients with substance abuse disorders who would previously have been treated at specialised facilities are now accommodated at Mohlomi, which lacks the infrastructure and expertise to provide appropriate care.

4.2.7 The Acting Director: Mental Health Services, Dr Mokhothu and the hospital's Senior Nursing Officer Mrs Maholi, confirmed that drug rehabilitation needs to have its own center or facility opened and they have acknowledged that due to the lack of human resource and infrastructure, they are only able to offer drug rehabilitation to their clients. This means that individuals with substance abuse disorders who are not already patients at Mohlomi have no access to specialised treatment.

4.2.8 Mental observation and treatment units within district hospitals, which were closed or converted during the COVID-19 pandemic, remain non-functional. Patients who should be assessed and treated at district level are instead referred to Mohlomi, contributing to overcrowding at a national facility.

4.2.9 The overcrowding has profound implications for patient welfare and human rights. Patients who have recovered from acute episodes are compelled to cohabit with acutely unwell individuals, leading to relapse. One patient's words from 2023 remain painfully relevant: ‘re folile empa re qetella re boetse re hlanya hape ka lebaka la ho lula le bakuli ba bang’… ‘we have healed but we end up relapsing as a result of living with other patients.’ Sadly, the same patient is still held at the hospital as he awaits assessment and possible pardon.

4.3 Buildings and Infrastructure

4.3.1 The physical infrastructure of Mohlomi Mental Hospital has deteriorated further since 2023. Buildings that were described as dilapidated three years ago are now in a state of critical disrepair. The building itself is deteriorating, with ceilings on the brink of collapse and walls unable to support the hospital's increasing demand'

4.3.2 The hospital's design is not for a mental institution, and a lot of work has to be done to bring it to an acceptable standard. The hospital is different from other institutions in neighbouring countries and does not meet the general standards of a proper mental institution. It is fundamentally unfit for its purpose.

4.3.5 Following a five-year vacancy triggered by the previous therapist's retirement in 2021, the purpose-built occupational therapy facility has officially reopened with the appointment of a new practitioner.

4.3.6 The security fencing that isolates the forensic unit from the rest of the hospital remains in place, but it is no longer sufficient to prevent security breaches. The design of the facility, never intended as a secure forensic unit, continues to pose challenges for the LCS officers tasked with maintaining safety.

4.3.7 The garden and grounds remain overgrown. The 2023 report noted that snakes had been seen in the yard, posing a health risk to patients and staff. This risk persists. No gardening services have been procured, and no maintenance has been undertaken.

4.3.8 The MOH has announced plans to build a new mental health hospital and a dedicated rehabilitation center. Although plans are underway, implementation has been slow, and it remains unclear as to when construction will ensue. No timeline for construction has been provided, and no funding has been appropriated. Three years after this Office's report, there is no evidence of meaningful progress.

4.3.9 The contrast with other health infrastructure developments is striking. The Starlight Oasis of Hope Cancer Centre, Lesotho's first palliative care facility, has been constructed, and the Ministry has launched a National Multi-sectoral NCDIs Coordinating Mechanism with WHO support. Mental health, despite accounting for approximately 431,000 Basotho suffering from some form of mental illness, remains a low priority.

There is a notable absence of age-appropriate specialized units. The facility currently fails to provide dedicated spaces for vulnerable cohorts, specifically children, adolescents, and the elderly. Immediate modernization and structural reorganization are required. The facility must transition toward a patient-centered model that ensures clinical safety, supports mental health recovery, and protects the dignity of all individuals in its care.

4.4 Drugs Supply and Pharmacy Security

4.4.1 The 2023 report noted that drug supplies, which had previously been maintained at a three-month buffer, had reduced to a one-month supply. This situation has now been remedied and the hospital now operate with a three-month stock buffer for essential psychiatric medications which caters for any stock interruptions at the NDSO and will ensure that patients are not left without essential medication for elongated periods of time.

4.4.2 The security of the pharmacy remains a critical concern. The 2023 report noted that the door to the pharmacy was insecure and that this issue had been reported for over six years. That report recommended that an appropriate door be procured within one month. While the door has been changed, it is not secure enough to protect the stock held at the pharmacy; more needs to be done to guarantee the safety and security of this area. The MOH has to take action to protect valuable medications stored in the pharmacy and ensure that controlled substances are appropriately secured.

4.4.3 The financial responsibility for forensic unit patients' medical care remains unresolved. The 2010 Memorandum of Understanding (MOU) between the Ministry of Health and the Lesotho Correctional Services contemplated that medical costs would transition to the MOH. This transition has not been fully effected, and patients requiring medical attention at other hospitals face delays and disputes over funding responsibility.

4.4.4 The MOH's budget allocation to Mohlomi remains inadequate. Mohlomi Mental Hospital only receives 1.8 percent of the national health budget. The hospital's operational capacity has been severely constrained by chronic underfunding, with an annual allocation ranging between M8 million and M9 million. This budget, exemplified by last year's M8 million, is inadequate to meet the needs of the facility. Consequently, the majority of funds are consumed by security services and patient meals due to increased admissions, leaving minimal resources for operational needs. This financial negligence has contributed to chronic neglect and gross violations of human rights for both patients and healthcare workers.

4.4.5 This allocation of 1.8% of the health budget to the nation's only psychiatric hospital, serving a population in which an estimated 431,000 people suffer from mental illness, reflects a profound misallocation of resources. It is a policy choice that prioritises other health expenditures over mental health, and it has direct consequences for patient welfare.

4.5 Bedding, Clothing, and Hygiene

4.5.1 The 2023 report documented that patients slept on mattresses on the floor, on beds without mattresses (on springs or coils), and in isolation rooms on hard, in-built concrete beds with wooden boards but no mattresses. This Office can report that these conditions persist unchanged.

4.5.2 The recommendation that at least 100 beds, 100 mattresses, and 100 blankets be procured within six months has not been fully implemented. Procurement of some mattresses was undertaken. Patients continue to sleep on the floor, on broken beds, and on concrete slabs.

3.5.3 The lack of basic consumables, cosmetics and particularly toilet paper, continues to cause significant problems. Patients, lacking toilet paper, use alternatives including mattress sponge and blanket fabric. This damages bedding and leads to toilet blockages, compounding the hygiene challenges faced by the facility.

4.5.4 The 2023 report noted that patients ripped up their mattresses and blankets as a result of shortages in basic consumables. This practice continues. The hospital's assets are being destroyed because the MOH will not provide M20 rolls of toilet paper consistently.

5.5.5 Patients in the forensic unit are not supplied with clothing by the hospital. They continue to wear their own private clothes, when available, or rely on donations from staff and non-governmental organizations'. One cannot distinguish patients from visitors, which has implications for security and patient dignity.

4.5.6 The lice infestation documented in 2023, while temporarily addressed through treatment in late 2023, has recurred. The Ministry claimed in October 2023 that the issue of lice infestation was dealt with, and patients were taken for treatment. However, because the underlying causes overcrowding, inadequate hygiene supplies, and insufficient cleaning, have not been addressed, reinfestation was inevitable.

4.5.7 The inspection team observed patients with scabies and other dermatological conditions. The cyclical pattern of treatment and reinfestation will continue until the systemic issues are addressed.

4.5.8 Cleaning materials remain in short supply. Staff reported that they have not received adequate cleaning detergents for the past year. Communal areas are cleaned with water only, without detergents. Patients are expected to clean their own wards, but many lack the capacity to do so effectively due to their mental condition.

4.5.9 The 2023 report recommended decentralised procurement to limit bureaucracies and delays. This recommendation has not been implemented. The centralised procurement system continues to cause delays in the delivery of essential supplies, and the quality of goods procured remains compromised.

4.6 Water and Ablution Services

4.6.1 The state of ablution facilities at Mohlomi Mental Hospital remains deplorable. Toilets that were renovated 'some time ago' are mostly non-functional. Blockages occur daily, and staff must pour acid into pipes to clear them. This is not maintenance; it is crisis management.

4.6.2 The 2023 report noted that patients damage ablution facilities and that the Ministry had not provided means to ensure repairs. This situation persists. There is no proactive maintenance programme, and repairs are undertaken only in response to complete failure.

4.6.3 Some wards have no running water. Patients must carry water from other wards to bathe. This is unacceptable in a healthcare facility in 2026.

4.6.4 Water leakages continue to run on a 24-hour basis. The wastage of water resources is matched only by the wastage of financial resources that could have been saved through timely repairs.

4.6.5 Geysers remain broken, although two geysers were procured. Patients bathe with cold water. The 2023 recommendation that geysers be fixed has been partially implemented. The more ambitious recommendation that solar geysers be procured has also not been implemented.

4.6.6 The lack of hot water has implications beyond comfort. Patients cannot properly cleanse themselves, contributing to the hygiene and infestation problems documented elsewhere in this report. Cold water discourages regular bathing, particularly during winter, compounding health risks.

4.6.7 Privacy in ablution facilities remains non-existent. Showers lack doors, and patients are forced to bathe in full view of others. This is degrading treatment that violates Section 8 of the Constitution and the Human Rights Act 1983.

4.7 Heating and Ventilation

4.7.1 The 2023 report documented that electricity lights were not working and had not been replaced for a long time due to lack of funding. This situation has marginally improved, with some bulbs replaced, but the overall electrical system remains inadequate.

4.7.2 Ventilation remains a critical concern. Windows are small and positioned high on walls, preventing adequate airflow. The design, which may have been intended to prevent escapes, has the effect of creating stuffy, malodorous environments that are detrimental to mental and physical health.

4.7.3 Isolation rooms, where acutely unwell patients are confined, lack any form of mechanical ventilation. The air in these rooms is heavy with foul odours. Staff and patients alike are subjected to conditions that are degrading and, in some cases, nauseating.

4.7.4 Dormitories remain cold during winter months. The heating system within the inbuilt concrete beds, noted in the 2023 report, remains dysfunctional. No alternative heating has been provided.

4.7.5 The 2023 recommendation that a cost-effective heating system, such as solar energy, be installed has not been implemented. The recommendation that heavy-duty electric fan heaters be procured has also not been implemented.

4.7.6 The maintenance officer at the hospital, where such a position exists, lacks the consumables and authority to undertake repairs. The centralised system requires approval for even minor expenditures, leading to delays measured in months and years.

4.8 Feeding and Nutrition

4.8.1 The nutritional status of patients at Mohlomi Mental Hospital, which was a source of grave concern, has improved with the change made with a new catering company. Patients continue to receive a diet consisting primarily of pap and beans, with limited variety and nutritional value.

4.8.2 The 2023 report noted that patients were served breakfast of tea without bread. This practice has ceased, and patients are now fed bread and tea, which at least allows for them to take medication that increases metabolic demands.

4.8.3 The hospital has continued to ration food supplies in response to overcrowding but is reasonably far better than it was in 2023. Patients receive adequate quantities of food and, by their own account, don’t cry foul that they become hungry between meals.

4.8.4 The Ministry's failure to pay suppliers timeously, noted in 2023, has been remedied to some extend and has resulted in the food quality and quantity of food being improved. Suppliers, unpaid for extended periods, reduce the quality of provisions or delay deliveries. Patients bear the consequences of this administrative failure.

4.8.5 The 2023 report recommended increased funding for patients' food and general wellbeing. While the Ministry's budget allocation to Mohlomi has increased marginally from M8 million to M8.5 million over three years, this increase has been consumed by inflation and does not represent a real increase in resources available for patient nutrition.

4.8.6 The relationship between nutrition and mental health is well established. Malnutrition exacerbates mental illness, impairs recovery, and reduces the effectiveness of psychiatric medications. By failing to provide adequate nutrition, the Ministry of Health is actively undermining the treatment it purports to provide.

4.8.7 The deprivation of adequate food and a balanced meal is a violation of patients' fundamental human rights. It is also counter-therapeutic, increasing the likelihood of relapse and extending the duration of hospitalisation.

4.9 Furniture and Equipment

4.9.1 The furniture and equipment at Mohlomi Mental Hospital remain in a state of advanced disrepair. Chairs are broken, tables are unstable, and storage units are damaged. The environment is untidy and, in some areas, hazardous.

4.9.2 The 2023 report noted that broken furniture was never repaired or replaced. This observation remains accurate. There is no programme for furniture maintenance or replacement, and items that break are simply left in place or discarded.

4.9.3 The hospital continues to operate with equipment donated from other ministries, much of it obsolete before it arrived. There is no capital budget for equipment replacement.

4.9.4 n 2023, an EEG machine intended for epilepsy care was procured but was subsequently moved from its original location to Maseru District Hospital, and later to Makoanyane Hospital, following a policy decision to manage neurological conditions at the general hospital level. Consequently, many patients remain without access to critical diagnostic equipment, increasing the risks of misdiagnosis and ineffective treatment.

4.9.5 The hospital's administrative functions are hampered by a lack of basic stationery. Patient records are maintained manually, and the absence of computers means that data cannot be easily analysed or retrieved. The recommendation that computers and laptops be procured within three months has not been implemented.

4.9.6 The recommendation that a video conferencing facility be procured for online training and case discussions has also not been implemented. Opportunities for professional development and tele-medicine support remain unrealised.

5.9.7 The lack of equipment extends to the most basic level. Staff reported that they lack the tools necessary to perform their duties effectively. This includes everything from cleaning equipment to clinical instruments.

4.10 Psychological Services

4.10.1 The 2023 report noted the absence of psychosocial support for staff and patients. This situation remains unchanged. No counselling services are provided to either group.

4.10.2 Staff work under conditions of extreme stress, managing violent and aggressive patients with inadequate support and resources. The psychological toll of this work is significant, yet no support is available.

4.10.3 Patients, many of whom have experienced trauma, require psychological interventions as part of their treatment. These are not provided. The hospital's two psychologists are insufficient to meet the needs of 155 inpatients, and they lack the specialised training required for forensic work.

4.10.4 The 2023 report documented an allegation that a female patient was subjected to sexual harassment by an LCS officer. While the officer was removed, the patient was not provided with psychological support. The OoO could not confirm if the patient did receive counselling services she required, as she was released at the instance of a court order.

4.10.5 The absence of psychological services represents a fundamental failure of treatment. Mental health care requires more than medication; it requires therapeutic engagement. Mohlomi provides medication; it does not provide therapy.

4.11 Safety and Security

4.11.1 The safety and security of patients and staff at Mohlomi Mental Hospital remain compromised. The risks documented in 2023 persist, and in some cases have intensified.

4.11.2 Staff continue to manage highly violent and aggressive patients without adequate training or support. Physical injuries, anxiety, and stress remain occupational hazards. The risk allowance of M12.00 per month, noted in 2023 as 'a mockery,' remains unchanged. Three years of inflation have rendered this allowance even more meaningless.

4.11.3 The case of a minor female patient who murdered and facially deskinned another patient, documented in 2023, remains a stark reminder of the consequences of inadequate security protocols. No systemic changes have been implemented to prevent similar incidents.

4.11.4 The CCTV system, non-functional in 2023, remains non-functional. The hospital relies on a private security company whose performance staff describe as inadequate. Despite the payment of 'large amounts of monies,' patients continue to abscond, and security breaches continue to occur.

4.11.5 The alarm system is also non-functional. In the event of a serious incident, staff have no means of summoning immediate assistance.

4.11.6 The forensic unit continues to be understaffed by 43 LCS officers, with five officers per shift. The 2023 recommendation that staffing be enhanced by at least four officers per shift has not been implemented. Officers are overstretched and unable to provide adequate supervision, particularly when patients require escorts.

4.11.7 The protection of patients from sexual abuse and exploitation remains inadequate. The 2023 case of sexual harassment was investigated, and the officer was removed, but no systemic measures have been implemented to prevent recurrence.

4.11.8 Staff who suffer losses as a result of patient violence, such as the nurse whose spectacles were broken, receive no compensation. The 2023 recommendation that a clear policy on compensation be developed has not been implemented.

4.12 Recreation and Occupational Therapy

4.12.1 The occupational therapy building, purpose-built for patient rehabilitation, is now in use as the position was filled. However, one occupational therapist is inadequate to assist all hospital patients. It therefore means that patients continue to lack structured activities that can improve their physical, mental, and emotional wellbeing. They spend their days in idleness, sitting in the sun or wandering the grounds.

4.12.2 The male general ward continues to have access to football, with balls sourced from donations. This is the only recreational activity available to any patients. The female ward and forensic unit have no recreational provisions whatsoever.

4.12.3 The 2023 report noted that recreation can have a healing effect, improving coping skills, concentration, and stress management. The Ministry's failure to provide recreational and adequate occupational therapy is not merely an omission; it is a failure to provide adequate treatment.

4.13 MoU Between the MoH and the LCS

4.13.1 The 2010 Memorandum of Understanding (MoU) between the Ministry of Health and the Lesotho Correctional Services remains in effect but is not being implemented as intended. The governance structures established by the MoU are non-functional.

4.13.2 The Joint Technical Working Group (JTWG), responsible for making final decisions on performance and compliance, has not met in years. The quarterly inspections of the forensic unit, required by the MoU, do not occur. The half-yearly progress meetings do not occur.

4.13.3 The Visiting Committee, another governance structure established by the MoU, is also non-functional. There is no oversight of the implementation of the agreement.

4.13.4 The LCS continues to provide security services at the forensic unit, despite the MoU's contemplation that this arrangement would subsist only until the MOH could afford its own security services. Sixteen years after the MoU was signed, the Ministry remains unable to provide security, and no progress has been made toward transitioning this function.

4.13.5 Role confusion between LCS officers and nursing staff persists. The 2023 report noted that nurses sometimes neglect their duties, leaving LCS officers to clean patients and assist with feeding. This confusion has not been resolved, and staff continue to operate without clear delineation of responsibilities.

4.13.6 The LCS officers remain without adequate office space, as noted in 2023. They operate from makeshift arrangements that are not conducive to proper oversight of the unit.

4.14 Staff Welfare and Benefits

4.14.1 Staff morale at Mohlomi Mental Hospital remains critically low, directly linked to challenging, high-risk, and inadequate working conditions, coupled with a perceived lack of employer support. In response, the Director of Mental Health Services reported that they have initiated team-building exercises, with plans to introduce management leadership sessions as part of a broader turnaround strategy.

4.14.2 Vacant positions remain unfilled. The two senior nursing officer positions and the hospital nursing services manager position, noted as vacant in 2023, remain vacant. Staff acting in these positions continue to serve without acting allowances.

4.14.3 Nurses hired on probationary terms since 2018 remain on probation eight years later. They cannot access benefits such as study leave, and their future remains uncertain. This uncertainty affects their performance and commitment.

4.14.4 The investigation found that the hospital administrator position lacks the necessary resources and delegated authority to address critical facility challenges. Despite a 2023 recommendation to equip the administrator with required skills and qualified support staff, this action remains unimplemented. While the Ministry of Health (MOH) has assigned a new, dedicated administrator, sustained improvement depends on the implementation of the previously ignored, and now overdue, recommendations.

4.14.5 The risk allowance of M12.00 per month, noted in 2023 as requiring review, remains unchanged. This amount, which would purchase approximately one loaf of bread, is an insult to staff who risk physical injury daily.

4.14.6 Staff who suffer losses due to patient violence receive no compensation. The 2023 recommendation that a compensation policy be developed has not been implemented.

4.14.7 The Ministry of Health is restructuring hospital administration, appointing a new HRO to resolve bottlenecks in staff recruitment and confirmation. While the HRO is addressing specialized shortages including a submitted request for ten (10) psychologists, progress is stalled by a Ministry of Finance hiring freeze aimed at managing the national wage bill. Positive developments include the appointment of an occupational therapist to manage patient care, with equipment procurement in progress. However, staffing shortages persist, with two critical doctor vacancies remaining despite the recent hiring of two new doctors.

4.15 Transportation

4.15.1 The hospital continues to operate with a single quantum as the ambulance that used to serve all purposes broke down: operational duties, administrative tasks, and patient transport to Queen 'Mamohato Memorial Hospital for medical attention.

4.15.2 The 2023 recommendation that at least one vehicle be procured for hospital operations has not been implemented. The 2023 recommendation that an ambulance be procured has also not been implemented.

4.15.3 Social workers, who require transport for home visits and investigations, remain without vehicles. Their ability to assess patients' home circumstances and plan for discharge is severely constrained.

4.15.4 Staff undertaking outreach work receive no food allowances. They must either fund their own meals or go without.

4.15.5 On occasion, when the ambulance is unavailable or petrol has run out, patients must be transported to other hospitals using public transport. This is inappropriate for mental health patients and poses risks to patients and the public alike.

5.0 ANALYSIS OF SYSTEMIC FAILURES

5.1 The failure to implement the recommendations of the 2023 report is not attributable to a single cause. It is the product of multiple, interconnected systemic failures that have persisted across changes in political leadership and administrative personnel.

5.2 The most fundamental failure is at the policy level. Mental health has been systematically under-prioritised by successive governments. This is evidenced by:

a) The allocation of only 1.8% of the health budget to the nation's only psychiatric hospital
b) The three-year delay in approving the National Mental Health Policy and Strategic Plan
c) The continued operation under the Mental Health Care Act No 7 of 1964, a law enacted 62 years ago
d) The failure to reconstitute statutory bodies required by law.

5.3 The Ministry of Health's administrative systems are characterized by inertia rather than action. This manifests in:

(a) The nine-year delay in securing a pharmacy door

(b) The five-year vacancy in the occupational therapist position

(c) The eight-year probationary status of nurses hired in 2018

(d) The failure to respond to repeated requests from hospital management.

5.4 The financial resources allocated to mental health are manifestly inadequate, but even these inadequate resources are not deployed effectively. The centralised procurement system creates delays and compromises quality. Funds appropriated for maintenance are not spent. Budgets for consumables are exhausted early in the financial year.

5.5 The shortage of mental health professionals in Lesotho is acute, but the Ministry's response has been inadequate. The failure to offer competitive remuneration and conditions of service has resulted in the emigration of the few specialists the country has trained. The reliance on a single, temporary foreign psychiatrist is not a solution.

5.6 The governance structures established by law and by agreement are non-functional. The Mental Health Review Tribunal has not sat since 2015. The Advisory Committee has not sat since 2015. The Joint Technical Working Group established by the MoU does not meet. There is no oversight, no accountability, and no mechanism for resolving the challenges that arise.

5.7 The 2023 report recommended that the Ministry's chief accounting officer and Director General be called to account to Parliament. There have been no consequences for the failure to implement recommendations. Without accountability, there is no incentive for action.

5.8 The systemic failures documented in this report have a human cost. Patients remain detained indefinitely without review. They sleep on floors and concrete slabs. They go hungry. They suffer from preventable diseases. They relapse because their environment undermines their recovery. Staff work under impossible conditions, risking injury and burnout, for wages that do not reflect their contribution.

5.9 Lesotho's failure to address the conditions at Mohlomi Mental Hospital places it in breach of multiple international obligations, including:

(a) Article 25 of the Universal Declaration of Human Rights

(b) Article 12 of the International Covenant on Economic, Social and Cultural Rights

(c) The Convention on the Rights of Persons with Disabilities

(d) The African Charter on Human and Peoples' Rights

5.10 The situation at Mohlomi invites comparison with the Life Esidimeni tragedy in South Africa, in which 144 psychiatric patients died from starvation and neglect after being transferred to unlicensed facilities. That tragedy was described as ‘the greatest cause of human rights violation’ in democratic South Africa. Lesotho is not there yet. But the trajectory is concerning, and the underlying conditions neglect, under-resourcing, lack of oversight are similar.

6.0 UPDATED RECOMMENDATIONS

6.1 This section updates the recommendations from the 2023 report, taking into account the passage of time and the continuing failures documented herein. Recommendations are grouped thematically, with revised deadlines. The Ministry of Health is directed to implement these recommendations within the stated timeframes.

6.2 Immediate Actions (Within 3 Months)

No.	Recommendation	Responsible Authority
6.2.1	Secure the pharmacy door with an appropriate security door to protect medications	MoH
6.2.2	Procure and distribute basic toiletries, including toilet paper, soap, and sanitary towels	MoH
6.2.3	Pay acting allowances to staff serving in vacant positions	MoH
6.2.4	Confirm probationary staff hired since 2018 in their positions	MoH
6.2.5	Procure stationery for administrative functions	MoH
6.2.6	Convene the Joint Technical Working Group under the MoH-LCS MoU	MoH, LCS
6.2.7	Approve and publish the revised National Mental Health Policy and Strategic Plan implementation framework	MoH

6.3 Short-Term Actions (Within 6 Months)

6.2 Immediate Actions (Within 3 Months)

No.	Recommendation	Responsible Authority
6.3.1	Source and appoint additional qualified psychiatrists on permanent and pensionable terms	MoH
6.3.2	Source and appoint qualified clinical psychologists for forensic assessment	MoH
6.3.3	Recruit senior nursing officers and psychiatric nurses to fill vacant positions	MoH
6.3.4	Reconstitute the Mental Health Review Tribunal and Advisory Committee	MoH, Ministry of Law and Justice
6.3.5	Conduct medical assessments of all patients detained at His Majesty's pleasure	MoH
6.3.6	Release patients deemed eligible for His Majesty's pardon based on assessments	MoH, Ministry of Law and Justice
6.3.7	Procure 100 beds, 100 mattresses, and 100 blankets	MoH
6.3.8	Procure patient clothing/uniforms	MoH
6.3.9	Procure staff uniforms	MoH
6.3.10	Fumigate all wards and address lice infestation	MoH
6.3.11	Repair water taps and address leakages	MoH
6.3.12	Fix geysers to provide hot water	MoH
6.3.13	Increase the food budget and ensure adequate, nutritious meals	MoH
6.3.14	Pay food suppliers timeously	MoH
6.3.15	Procure computers and laptops for administrative functions	MoH
6.3.16	Recruit additional occupational therapists	MoH
6.3.17	Enhance LCS staff complement by at least four officers per shift	LCS
6.3.18	Review the risk allowance from M12.00 to M300-500 per month	MoH, Ministry of Public Service
6.3.19	Procure two vehicles for hospital operations	MoH
6.3.20	Reopen mental observation and treatment units at district level	MoH

6.4 Medium-Term Actions (Within 12 Months)

No.	Recommendation	Responsible Authority
6.4.1	Undertake comprehensive building maintenance, including paintwork and repairs	MoH
6.4.2	Procure gardening services and maintain grounds	MoH
6.4.3	Repair or replace broken furniture and equipment	MoH
6.4.4	Replace non-functional CCTV and alarm systems	MoH
6.4.5	Procure a video conferencing facility for training and case discussions	MoH
6.4.6	Install solar heating system and solar geysers	MoH
6.4.7	Procure an additional ambulance	MoH
6.4.8	Procure heavy-duty electric fan heaters for wards	MoH
6.4.9	Procure vehicle dedicated for social workers services	MoH
6.4.10	Develop and implement a policy on compensation for staff losses	MoH
6.4.11	Conduct training for staff on patient support and use of force	MoH
6.4.12	Implement decentralised procurement system	MoH
6.4.13	Establish measures to protect patients from sexual abuse	MoH, LCS
6.4.14	Review and revise the MoH-LCS MoU	MoH, LCS
6.4.15	Determine and implement handover of forensic unit security to MoH	MoH, LCS

6.5 Long-Term Actions (Within 24 Months)

No.	Recommendation	Responsible Authority
6.5.1	Develop and commence construction of a new, fit-for-purpose mental health facility	MoH, Ministry of Finance
6.5.2	Develop and commence construction of a dedicated drug rehabilitation center	MoH, Ministry of Finance
6.5.3	Overhaul the Mental Health Care Act No 7 of 1964	MoH, Parliament
6.5.4	Integrate mental health program with HIV/AIDS and TB programs	MoH
6.5.5	Establish regional clinical psychologist capacity for all districts	MoH
6.5.6	Re-establish impact rehabilitation facilities for substance abuse	MoH
6.5.7	Increase mental health budget allocation to at least 5% of health budget	MoH, Ministry of Finance

6.6 Accountability Recommendations

No.	Recommendation	Responsible Authority	Deadline
6.6.1	The Principal Secretary and Director General: Health Services should appear before Parliament to account for the failure to implement the 2023 recommendations	MoH	3 months
6.6.2	The Ministry should provide this Office with quarterly progress reports on implementation of these recommendations	MoH	3 months
6.6.3	The Ministry should establish an internal monitoring mechanism to track implementation	MoH	3 months

7.0 CONCLUSION

7.1 This is a difficult report to write. It is difficult because it documents not progress but regression. It is difficult because it records delays in the implementation of Ombudsman's recommendations over elongated period of time. It is difficult as it records not reform but resistance. It is difficult because it describes the continuing suffering of vulnerable Basotho at the hands of a state that has forgotten its duty to care for them.

7.2 The conditions at Mohlomi Mental Hospital are not inevitable. They are the product of choices: choices about budget allocation, choices about prioritisation, choices about accountability. The MOH has chosen, year after year, to underfund mental health. It has chosen to leave vacant positions unfilled. It has chosen to ignore recommendations. It has chosen to leave patients sleeping on concrete floors.

7.3 These choices have consequences. Patients who could be living with their families remain detained. Patients who could be contributing to society remain institutionalised. Patients who could be recovering remain ill. And staff who could be providing care remain demoralised and unsupported.

7.4 The Life Esidimeni tragedy in South Africa should serve as a warning. That tragedy, in which 144 psychiatric patients died, did not happen overnight. It was the culmination of years of neglect, of warnings ignored, of patients forgotten. Lesotho is on a similar path. The conditions at Mohlomi are a warning sign. The question is whether the government will heed that warning before lives are lost.

7.5 This Office has done what it can. We have inspected, we have reported, we have recommended. We have given the Ministry every opportunity to act. They have not acted. The responsibility now lies with others: with Parliament, which must hold the executive to account; with the courts, which must enforce constitutional rights; with civil society, which must advocate for the forgotten; and with the public, which must demand better.

7.6 The 2023 report ended with an expression of hope that the Ministry would use the report to inform intervention measures. That hope has not been realised. This report ends with a demand: act now or explain to the nation why you have chosen not to.

7.7 The patients of Mohlomi Mental Hospital have waited long enough.