THE INDEPENDENT *AD HOC* TRIBUNAL

In the matter between:

DR LEKOPANE MOGALADI **First Appellant**

DR MAKHOSAZANE NGOBESE **Second Appellant**

And

THE HEALTH OMBUD **Respondent**

CORUM: NKABINDE J, PROF LR MATHIVHA, PROF E VARIAVA

PROFESSORS MATHIVHA, VARIAVA (MAJORITY) PARAS: 1-110
NKABINDE J (MINORITY) PARAS: 111-329

APPEAL DECISION OF THE REPORT LOOKING INTO CIRCUMSTANCES SURROUNDING THE CARE AND DEATH OF MR SHONISANI LETHOLE AT TEMBISA PROVINCIAL TERTIARY HOSPITAL

PROF MATHIVHA AND PROF VARIAVA:

INTRODUCTION

1. Mr Shonisani Lethole ("Mr Lethole") was described by his family as a very responsible young man, a son of the soil.[1] It is clear from interviews with his family and loved ones that he was deeply loved, cherished and respected.[2]

2. The Office of the Health Ombud ("the Ombud") described Mr Lethole as a "*34-year old severely ill, athletic patient and without a history of comorbidities*".[3] He was received at the Tembisa Provincial Tertiary Hospital ("the Hospital") on 23 June 2020 with chest pain, difficulty breathing and generalised body weakness. On 25 June 2020, he stated publicly on Twitter that the Hospital's facilities were "*unbearable*" and uncaring, and that he hadn't eaten for 48-hours. Mr Lethole was diagnosed with COVID-19. He was intubated on 27 June 2020 and passed away on 29 June 2020.

3. Following a complaint to the Ombud by the Minister of Health, the Ombud investigated the circumstances surrounding the care and death of Mr Lethole at the Hospital. He produced a Final Report on 27 January 2021 in which certain findings and recommendations were made.

[1] Transcript Lethole interview 10 July 2020 p 54, 63.

[2] Transcript Lethole interview 10 July 2020.

[3] Final Report p 9 at para 1.

4. Two persons in relation to whom findings and recommendations were made in the Final Report have appealed to this *Ad Hoc* Tribunal:

   4.1 the first appellant, the Hospital's CEO (Dr Lekopane Mogaladi); and

   4.2 the second appellant, the head of the Hospital's COVID-19 unit (Dr Makhosazane Judith Ngobese).

5. We agree with the decision of our fellow tribunal member, retired Justice Nkabinde, in several respects and disagree on a few. We deal with the issues raised in the appeal as follows:

   5.1 First, we set out the two appellants' grounds of appeal.

   5.2 Second, we consider three preliminary issues upfront: whether the Tribunal is dealing with an appeal or a review, whether a valid complaint existed, and whether the Ombud acted within his mandate. We agree with the outcome of Justice Nkabinde's decision on these aspects.

   5.3 Third, we deal in turn with each of the recommendations made by the Ombud in respect of Dr Mogaladi, the CEO. In line with our mandate, we set out why we either confirm, set aside, or vary the recommendations and the factual findings that underpin them in light of Dr Mogaladi's grounds of appeal.

5.4 Fourth, we deal similarly with each of the recommendations made by the Ombud in respect of Dr Ngobese.

6. We differ with Justice Nkabinde in that we consider the question of accountability to be central to the Ombud's report and to this appeal. While we recognise the immense challenges brought by the COVID-19 pandemic, the Norms and Standards Regulations Applicable to Different Categories of Health Establishments (GG No 41419, 2 February 2018) ("the Norms and Standards") remained applicable. Where we find, on a fair consideration of the facts, that these Norms and Standards have not been fulfilled, and where there is a *prima facie* indication that the appellants had some responsibility in relation to their non-fulfilment, we consider it appropriate and important to recommend that an accountability process follows.

GROUNDS OF APPEAL

7. Dr Mogaladi asked that the Ombud's findings insofar as they relate to him should be set aside entirely.[4] He raised six grounds of appeal:

7.1 First, that the Ombud exceeded the bounds of his mandate.[5]

7.2 Second, that the Ombud made irrational findings and recommendations.

[4] Mogaladi grounds of appeal para 167.

[5] Mogaladi grounds of appeal paras 6.1 to 6.6.

7.3 Third, that the Ombud disregarded evidence before him and made findings which are contrary to the evidence.

7.4 Fourth, that the Ombud made unreasonable findings.

7.5 Fifth, that the Ombud did not give him a fair hearing and the opportunity to question witnesses who gave adverse evidence against him.

7.6 Sixth, that the Ombud only relies on a few witnesses whose evidence supports his conclusions.

8. Dr Ngobese asks that the findings and recommendations made against her by the Ombud are set aside. She raises twelve grounds of appeal:

8.1 First, that the Ombud failed to afford Dr Ngobese her rights under section 81A(5) of the National Health Act 61 of 2003 ("the Health Act").[6]

8.2 Second, that the Ombud erred in finding that Dr Ngobese was responsible to ensure that critical care equipment was available and functioning properly.

---

[6] Section 81A(5) of the Health Act provides:

> *"If it appears to the Ombud that any person is being implicated in the matter being investigated, the Ombud must afford such person an opportunity to be heard in connection therewith by way of giving of evidence, and such person is entitled, through the Ombud, to question other witnesses, determined by the Ombud, who have appeared before the Ombud in terms of this section."*

8.3 Third, that the Ombud erred in making findings and recommendations against Dr Ngobese in relation to the signing and / or completion of the morbidity and mortality templates (“MMT”).

8.4 Fourth, that the Ombud erred in making findings and recommendations against Dr Ngobese relating to patient files.

8.5 Fifth, that the Ombud erred in finding that Dr Ngobese provided multiple different versions of when certain photographs were taken.

8.6 Sixth, that the Ombud erred in finding that Dr Ngobese had stated that she provided the listing items but had in fact provided additional information.

8.7 Seventh, that the Ombud erred in finding that Dr Ngobese had assisted Dr Ncha in preparing erroneous reports.

8.8 Eighth, that the Ombud erred in finding that Dr Ngobese was an indirect party to an “administrative bungle” in the records.

8.9 Ninth, that the Ombud erred in finding that Dr Ngobese withheld important information from the MEC and Ombud.

8.10 Tenth, that the Ombud ought not to have relied on information provided by the Ombud’s investigator, Ms Helen Phetoane.

8.11 Eleventh, that the circumstances of the COVID-19 pandemic were not considered properly by the Ombud.

8.12 Twelfth, that the Ombud inappropriately made findings against Dr Ngobese in relation to his own mandate when he was restricted to making findings about Mr Lethole's death and care.

8.13 Thirteenth, that the Ombud had erred in finding that she had "*excluded*" Quality Assurance.[7]

9. We have considered all of the above grounds of appeal in assessing the three preliminary points and, thereafter, whether we confirm, set aside or vary the specific findings and recommendations made against Dr Mogaladi and Dr Ngobese respectively. As follows from our decision, we partially dismiss and partially uphold both of the appeals in confirming and varying some of the findings and recommendations, and setting aside others.

APPEAL OR REVIEW?

10. We agree with Justice Nkabinde that the *Ad Hoc* Tribunal's mandate under section 88A of the Health Act is to determine an appeal.

11. At the hearing of the appeal, counsel for Dr Mogaladi accepted that it was not necessary for the *Ad Hoc* Tribunal to pigeon-hole the nature of its process because ultimately what the CEO sought from the process was justice.

---

[7] Ngobese grounds of appeal para 9 and sub-paras.

12. We are satisfied that regardless of how the process is categorised, the *Ad Hoc* Tribunal's role is to reconsider the merits of the Ombud's decision, to decide whether it was right or wrong or perhaps vitiated by an irregularity to the extent that it caused a failure of justice.[8] The appellants' procedural fairness concerns can be considered in this framework according to the *Ad Hoc* Tribunal's statutory mandate. We are further satisfied that the grounds of appeal are capable of being determined on the basis of the record before us.

A VALID COMPLAINT EXISTS

13. We agree further with Justice Nkabinde that there existed a valid complaint before the Ombud, that being the complaint made by the Minister of Health which included reference to a newspaper article and the late Mr Lethole's tweet. We are satisfied that the Minister's complaint contains adequate information in terms of Regulation 33(4) of the Procedural Regulations Pertaining to the Functioning of the Office of the Health Standards Compliance and Handling of Complaints by the Ombud (GG No 1364, 2 November 2016) ("the Procedural Regulations").[9]

---

[8] Tantoush v Refugee Appeal Board and Others [2007] ZAGPHC 191 para 90.

[9] Regulation 33(4) provides:

> "*(4) The complaint must contain adequate information regarding the complaint including, at least, the contact details of the complainant or his or her representative, and the evidence or basis for the complaint, and such other particulars as the Ombud may require to deal with the complaint."*

THE OMBUD ACTED WITHIN HIS MANDATE

14. We agree with Justice Nkabinde that the Ombud acted within his mandate in conducting the investigation and preparing his Final Report.

15. We understand that the Ombud's mandate is to investigate complaints relating to the Norms and Standards, and that he must dispose of a complaint in a fair, economic and expeditious manner.[10] The issues raised in the Minister's complaint required the Ombud to consider Mr Lethole's treatment, care and death at the hospital in the context of the Norms and Standards.

16. Section 2(a) of the Health Act says that its objects are, amongst others, to establish a healthcare system that provides "*in an equitable manner … with the best possible health services that available resources can afford*". This is in the context of the Constitution's protection of the right to health under section 27(2).[11] In order to realise his mandate in the context of the Act's aims, it is appropriate for the Ombud to make recommendations following any findings he makes on a complaint.

17. The Ombud described his recommendations as follows:

---

[10] Section 81A(1) of the National Health Act.

[11] Section 27(2) of the Constitution provides:

> *"The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."*

"The recommendations made in this final report are meant to encourage and foster a culture of high-quality health care at [the Hospital]. A culture that respects the dignity of patients, a culture that complies with the prescribed Norms and Standards of the National Health System and a culture that is consistent with the ethics and codes of good clinical practice."[12]

18. To make meaningful recommendations, the Ombud appropriately tried to understand not only what happened to Mr Lethole but <u>why</u> this was so. For instance –

    18.1 What were the underlying business systems, processes and conduct that led to any infringements of the Norms and Standards as relevant to Mr Lethole's experiences at the Hospital?

    18.2 And how can this information be used to improve compliance with the Norms and Standards?

19. We are satisfied that the scope of the investigation and Final Report fell within the Ombud's mandate.

20. In the sections that follow, we consider whether the Ombud was right or wrong in making the findings and recommendations he made in respect of Dr Mogaladi and Dr Ngobese in light of their grounds of appeal.

---

[12] Final Report p 196 para 11.

THE RECOMMENDATIONS CONCERNING DR MOGALADI

Recommendation 1: Mr Lethole not being fed

21. We respectfully disagree with Justice Nkabinde that the Ombud's recommendation – that the CEO should face a disciplinary enquiry for "*presiding over a hospital that on two separate occasions could not provide Mr Lethole with food for prolonged periods*"[13] – should be set aside.

22. The Ombud makes the finding in his Final Report that "*Mr Shonisani Lethole was not provided with meals at [the Hospital] on two occasions, first for 43h24 after admission and furthermore, he was not fed for another 57h30 while intubated, sedated and on a mechanical ventilator*."[14]

    22.1 The first occasion is in the period from 23 June 2020 at 12:36 (when the Ombud considers Mr Lethole fell under the Hospital's care) until 25 June 2020 at 08:00, when Mr Lethole's medical records reflect that he received breakfast.[15]

    22.2 The second period relates to the time that Mr Lethole was intubated. Dr Mogaladi does not appear to dispute that Mr Lethole was not fed during this time i.e. that no nasogastric tube had been fitted to feed

[13] Final Report p 191 para 9.

[14] Final Report p 185 para 3.

[15] Final Report p 63.

him while he was intubated. Dr Mogaladi's dispute on the facts rather is that it was not necessary or medically required for Mr Lethole to be fed during this time.

The first period

23. We consider that the evidence supports the Ombud's factual finding with respect to the first period in which Mr Lethole did not receive food.

24. The Ombud considered Mr Lethole's tweet of 25 June 2020 at 20:31 – in which it was alleged that he "*did not eat for 48 hours*" – but the finding is not solely reliant on the tweet. The Ombud's finding is based on a carefully constructed timeline of events as supported by the best available evidence. We agree that the evidence supports the Ombud's timeline.

25. The Ombud correctly considered that Mr Lethole's tweet credibly reflected that he had not received food at the time it was sent,[16] in the context of Mr Lethole's hospital records, and the oral evidence of his family, and Hospital staff. As we read the Ombud's Report, he considered that the circumstantial evidence and probabilities supported what was reflected in Mr Lethole's tweet. We agree with this finding.

[16] Final Report p 52.

26. The Ombud considered evidence given by Mr Lethole's father and girlfriend who were informed by Mr Lethole between 11:00 and 12:00 on 24 June 2020 that he had not eaten since his arrival at the Hospital.[17] These sources are hearsay evidence insofar as the truth of the fact (whether or not Mr Lethole was fed) depends on the statements of Mr Lethole, who is unable to give evidence. However, we agree with the Ombud who considered that these are reliable accounts for the following reasons.

26.1 First, the Ombud says that there is no reason why Mr Lethole, as a "*responsible young man*", would have been dishonest when he tweeted the Minister and made the same statements to his parents and girlfriend that he had not eaten and was hungry.[18]

26.2 Second, the Ombud considered that certain circumstantial evidence supported the likelihood that Mr Lethole was not fed.

26.2.1 For example, the Area Manager for the Emergency Unit, Mr Vijendra Gajraj, confirmed that he had received complaints from patients that they had not been fed supper on 23 June 2020 and breakfast on 24 June 2020.[19] Mr Gajraj said that even if food had been ordered, it was possible that it did not reach the COVID-19 area due to there being only two nurses there at the time.[20] If

[17] Final Report p 49 and 52.

[18] Final Report, p 52 – 53.

[19] Final Report, p 58; Transcript Gajraj interview 6 August 2020.

[20] Transcript Gajraj interview 6 August 2020.

food was ordered it could possibly have ended up being given to patients in the casualty section.[21]

26.2.2 Mr Gajraj said that the Hospital was experiencing staffing challenges. He said that there were insufficient doctors and insufficient nursing staff because nurses were refusing to work in areas of the Hospital dealing with COVID-19 for fear that the working environment was not safe.[22]

26.2.3 Mr Wilfred Mothwane, the Deputy Director of Nursing, corroborated Mr Gajraj's evidence and said that staff were not cooperating between 22 and 24 June 2020 so food could not be served to patients at that time even if it was ordered.[23] Amongst others, he said that he observed food lying at the doors of Casualty as staff without personal protective equipment were refusing to enter the ward to distribute the food for fear of contracting COVID-19. Dr Urmson similarly testified that nurses were refusing to go into the COVID-19 unit.[24]

26.2.4 These circumstances were further corroborated by the fact that Dr Ncha and Dr Mothwane visited the ward with Mr Gajraj and Mr Sono (the A&E Operational Manager) after receiving

[21] Transcript Gajraj interview 6 August 2020.

[22] Transcript Gajraj interview 10 July 2020 p 4 – 5.

[23] Final Report p 59.

[24] Transcript Urmson interview 6 August 2020 p 6.

complaints that nurses were refusing to assist patients out of fear of contracting COVID-19.

26.3 Third, Mr Lethole's medical records reflect that he received breakfast, lunch and supper on 25 July 2020 in Ward 23. Mr Lethole's parents and his girlfriend testified that Mr Lethole had informed them when he was given food on 25 July 2020.

27 One of the Hospital's staff, Nurse Bertha Sokana, claimed that she wrote a note in Mr Lethole's records that he tolerated his lunch. She also claimed to have filled out the forms for ordering food in terms of the Hospital's Standard Operating Procedure ("SOP") for ordering food. The SOP required that food had to be ordered through completing and submitting the TPH48F/Bed diet list to the Food Service Unit and that it was, by all indications, a reliable process.[25] She claimed that Mr Lethole was therefore fed lunch on 24 June 2020.

27.1 The Ombud rejected her evidence as proof that Mr Lethole had been fed, amongst others, because the ordering of food in terms of the SOPs had been abandoned in April 2020.[26] The forms she claimed to have used were also never produced and the scrap pieces of paper that were used instead were not credible evidence to show that the food

[25] Draft Report p 32.

[26] Final Report p 59.

had actually been received by a patient, least of all any particular patient.[27]

27.2 The note in Mr Lethole's records was in any event undated and had no information on it that identified Mr Lethole. It therefore could not support her claim that she fed Mr Lethole at a particular time.

27.3 She, in any event, did not recall who Mr Lethole was.[28]

28 Dr Mogaladi argued in his appeal that the Ombud did not refer to any credible or reliable evidence that dealt with events relating to the period when Mr Lethole was actually admitted at the hospital.[29] He argues that the nurses recorded that Mr Lethole had been given lunch and that these are part of the patient records and that it was irrational for the Ombud to have rejected these notes.[30] He says that the Ombud failed to interview any other patient who was with Mr Lethole in Ward 23 at the time.[31]

28.1 We have set out above why the Ombud correctly rejected Nurse Sokana's evidence.

28.2 Another nurse, Ms Sylvia Tshabalala claimed to have provided Mr Lethole with breakfast on 23 June 2020 at 09:00 and lunch around

[27] Final Report p 55.

[28] Final Report p 55.

[29] Mogaladi grounds of appeal para 43.

[30] Mogaladi grounds of appeal para 86 – 87 and 94.

[31] Mogaladi grounds of appeal para 126.

13:00. However, the Ombud correctly rejected her evidence, amongst others, because Mr Lethole was only registered at the Hospital at 12:28.[32] Nurse Tshabalala's version was therefore demonstrably unreliable.

28.3 The Ombud went so far as to try to obtain the CCTV footage for the Casualty section and Ward 23 to see if it showed food being delivered, but these were unavailable, the system apparently having been out of order since January 2020.

28.4 In line with Dr Mogaladi's insistence, the Ombud did in fact attempt to contact a sample of five patients who were at the Hospital at the same time as Mr Lethole, none of whom responded to the investigator's calls.[33] The Ombud makes the valid point that, in any event, even if other patients were fed, it does not prove that Mr Lethole was fed. After the Ombud's preliminary report, five previously admitted patients did give evidence and none could confirm whether or not food was ordered, none knew Mr Lethole and none could confirm whether or not Mr Lethole was fed.[34] Their evidence simply neither supports nor contradicts any party's version. For example:

[32] Final Report p 58.

[33] Final Report p 62.

[34] Final Report p 63.

28.4.1 Mr Erik Chikwa was a patient at the Hospital from 23 June 2020 for six days. He deposed to an affidavit stating that he was not provided medication for a three-day period and was not provided any food for one day during his stay.[35]

28.4.2 Ms Sarah Nkwana was admitted to the Hospital on 22 June 2022 and states that there was food available even though she was unable to eat at the time.[36]

28.4.3 Ms Dorothy Magagula was a patient at the Hospital and says that she did not receive food that the services were "*very very poor*" because she slept on the floor despite being pregnant.[37]

28.5 Dr Mogaladi also disputes the timeline of events by arguing that the Hospital was only responsible to feed Mr Lethole from the time at which he was formally admitted on 24 June 2020 and therefore became a patient of the Hospital.[38]

28.6 The Ombud correctly considered that Mr Lethole became a patient when he was diagnosed with community-acquired pneumonia by Clinical Associate Tshali on 23 June 2020 at 19:30 and that a "*duty of care by the Hospital to admit Mr Lethole*" arose at this time.[39] This is

[35] Chikwa affidavit 11 November 2020.

[36] Nkwana affidavit 28 October 2020.

[37] Magagula affidavit 28 October 2020.

[38] Mogaladi grounds of appeal para 81.

[39] Final Report p 50 – 51.

because Mr Lethole was an emergent admission (as opposed to an elective admission) and because standard practice is that a person diagnosed with pneumonia is admitted for intravenous antibiotic treatment and further investigations without delay.[40]

28.7 The Ombud further considered as evidence in support of this position that Mr Lethole was receiving oxygen on 23 June 2020 at 22:00 and that the following day on 24 June 2020 at 10:00, he was prescribed medication for the treatment of COVID-19 by Clinical Associate Molekane.[41] For these reasons, the Ombud considers that Mr Lethole was "*totally under the care and totally dependant*" on the Hospital at that stage.[42]

28.8 We agree with these findings.

29 Dr Mogaladi argues that the Ombud's concern with the discontinuation of the SOPs on how food was ordered is misplaced – the bed/diet lists were discontinued in order to minimise the risk of spreading COVID-19.[43] Dr Mogaladi argues that the Ombud, by considering the absence of these medical records, cast a reverse onus on the Hospital to prove that Mr Lethole was fed.[44] He argues that this reverse onus is particularly inappropriate when

[40] Final Report p 51.

[41] Final Report p 51.

[42] Final Report p 52.

[43] Mogaladi grounds of appeal para 101.

[44] Mogaladi grounds of appeal para 22.

the nursing notes provide *prima facie* proof that Mr Lethole had in fact been fed.[45]

29.1 We have set out above why the Ombud appropriately rejected Nurse Sokana's notes as evidence that the food was ordered.

29.2 We also do not consider that the Ombud's commentary on the abandonment of the SOP system was inappropriate.

29.2.1 The Norms and Standards require that a health establishment ensures that health records of patients are kept, protected and managed in terms of the Health Act.[46]

29.2.2 The Ombud's criticism of the Hospital's abandonment of the SOPs for an unreliable "*scrap paper*" system[47] is appropriate because it fails to ensure that patient records (insofar as they relate to the patient's nutritional intake) are kept and managed effectively.

29.3 We also do not think that the Ombud applied a reverse onus.

29.3.1 We set out above the evidence which the Ombud considered which indicated that Mr Lethole was not fed during this first period.

---

[45] Mogaladi grounds of appeal para 92.

[46] The Norms and Standards at 6(1) provides:

> *"The health establishment must ensure that health records of health care users are protected, managed and kept confidential in line with section 14, 15 and 17 of the Act."*

[47] Final Report p 57.

29.3.2 Insofar as there exists a duty in terms of the Norms and Standards and SOP to keep patient records in respect of food, and no such record exists, it is a fair inference for the Ombud to find that the absence of those records generally supports the evidence of Mr Lethole not being fed.

29.3.3 The inference accords with the proven fact that Mr Lethole was not fed and is, in our view, the most readily apparent and acceptable inference to draw.

The second period

30 Dr Mogaladi does not dispute the fact that Mr Lethole was not fed during his intubation. His complaint instead appears to be that it was irrational for the Ombud to hold the Hospital and its management accountable when he considers it was not necessary to feed Mr Lethole at this time.

31 Dr Lourenza Urmson is a medical officer who attended to Mr Lethole on 27 June 2020 and caused for him to be intubated. She testified that she had telephonically ordered that a nasogastric tube be inserted,[48] and that she believed that a tube was in fact inserted[49] even though this was not done.

[48] Transcript Urmson interview 6 August 2020 p 14.

[49] Urmson signed statement 2 July 2020.

32 The doctor treating Mr Lethole considered it clinically necessary for a nasogastric tube to be inserted, thus we accept that it was indeed necessary to feed Mr Lethole while he was intubated.

Whether the recommendation should be confirmed

33 The Norms and Standards require that a health establishment "*must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition*".[50] If a patient, who is under the care of the Hospital, is not fed for an inappropriate length of time, this is a failure to attend to the patient in a manner that is consistent with the nature and severity of their health condition. Adequate nutrition is, after all, critical to a person's health and recovery when ill.

34 Counsel for Dr Mogaladi accepted at the hearing that the CEO (together with other management staff) represented the Hospital and that he was the accounting officer. He said that:

> *"He is overall in charge of the institution. … He must make sure that the infrastructure works. He is in charge of the staff complement, which are many. He must make sure that within the limits of his powers and abilities, he makes the conditions at the Hospital to be workable so that patients can receive care. In brief, he manages the institution."*[51]

[50] Norms and Standards at 5(1).

[51] This is our own transcription from the recording of the hearing.

35 Dr Mogaladi argues that he was far removed from the care of Mr Lethole as he does no clinical work, does not interact with or treat patients and did not in fact have any interaction with Mr Lethole in particular.[52] His argument, more broadly, is that it is unfair to hold him responsible for any failure to feed Mr Lethole. We disagree.

35.1 Providing food to patients is part of the institutional management process which the CEO governs as the head of the Hospital. All those processes start and end with the CEO. He is the captain of the ship.

35.2 Mr Lethole was not fed for the two periods set out above. This occurred under circumstances in which the management system ordinarily in place to facilitate patients being fed (the SOPs) had been withdrawn and where staff were uncooperative.[53]

35.3 We think it is reasonable and fair in this context to require that the CEO account for whether and to what extent he was responsible for the systemic and managerial failures that led to Mr Lethole not being fed. This is in line with his mandate as CEO as described by his counsel. The recommendation that he face a disciplinary enquiry on this ground is therefore appropriate in our view.

---

[52] Mogaladi grounds of appeal para 27.

[53] Several witnesses testified to staff being uncooperative. See for example Transcript Urmson interview 6 August 2020 p 5.

35.4 We appreciate that the context of the COVID-19 pandemic posed unparalleled challenges to the Hospital at the time of the events. We have considered this in our evaluation of the evidence and are satisfied that, on a *prima facie* basis, the CEO should nonetheless account for his role. A disciplinary enquiry would be able to determine finally whether he has any responsibility for the non-compliance with the Norms and Standards, and whether that responsibility (and any sanctions that would follow) is mitigated by the context at the time.

35.5 We stress that the recommendation is not a final finding that the CEO is responsible for Mr Lethole not being fed. It may be that Dr Mogaladi would ultimately be exonerated by the disciplinary process.

36 Dr Mogaladi claims that the Ombud's process was unfair in respect to this finding. We disagree.

37 We consider that the Ombud's process was substantively and procedurally fair and that it would be fair for this *Ad Hoc* Tribunal to confirm the Ombud's recommendation on the basis of the evidence before it.

37.1 During the investigation process, the CEO was interviewed extensively on the issue of whether or not Mr Lethole was fed. The transcripts of the interviews show that Dr Mogaladi defended the Hospital – claiming that Mr Lethole was only the Hospital's responsibility from when he was

an admitted patient on 24 June 2020,[54] and he defended the timelines in his own report which had been prepared by Dr Ncha.[55]

37.2 When the Ombud's investigator took Dr Mogaladi through the inconsistencies between Dr Ncha's report and the documentary evidence in Mr Lethole's medical records, Dr Mogaladi's response was that Casualty is by its nature managed differently to other wards and this reflected in certain of the medical records being incomplete.[56] He drew attention to the difficulties faced by the Hospital with limited infrastructure and high demand of services.[57]

37.3 Ultimately, however, Dr Mogaladi said he, as the CEO, was satisfied that Mr Lethole had in fact been fed because "*as a manager, you put in systems … that actually have to be done*."[58]

37.4 The CEO was also forewarned in the Ombud's Draft Report that the Ombud intended to recommend that the Acting Health MEC should commence a disciplinary enquiry against him.[59] The Draft Report made clear that the Ombud considered Mr Lethole had not been fed for

---

[54] Transcript Mogaladi interview 23 July 2020 p 11.

[55] See, for example, Transcript Mogaladi interview 23 July 2020 p 13 - 14.

[56] Transcript Mogaladi interview 23 July 2020 p 23 – 24.

[57] Transcript Mogaladi interview 23 July 2020 p 29.

[58] Transcript Mogaladi interview 23 July 2020 p 28.

[59] Draft Report p 94 para 7.

certain periods. It further implicated managerial responsibility for this outcome.[60]

37.5 The Hospital, on behalf of Dr Mogaladi, provided written representations on the Draft Report which included "*additional evidence*" which he considered needed to be taken into account.[61]

37.6 In those representations, Dr Mogaladi made submissions on the recommendations that ought to follow the Ombud's findings.

37.6.1 Amongst his recommendations which were not pursued in the Final Report, the Ombud had said in his Draft Report that the National Minister of Health and Gauteng MEC for Health should give serious consideration to the appointment of "*new leadership*" at the Hospital to correct the *laissez-faire* attitude to care demonstrated in the Ombud's findings.[62]

37.6.2 In Dr Mogaladi's submissions on the Draft Report, he said that this recommendation was inappropriate – that the single incident did not warrant the removal of the Hospital's entire leadership.[63] He emphasised, however, that the Hospital had "*an established history of taking disciplinary steps against its officials that are*

[60] See, for example, Draft Report p 95.

[61] Mogaladi written submissions 13 November 2020.

[62] Draft Report p 93 para 4.

[63] Mogaladi written submissions 13 November 2020 p 4.

found wanting in the clinical management of our patients, or contravention of any established rule in the workplace".[64] The submissions further said that "*We are not opposed to any recommendation that seeks to suggest that [a] disciplinary hearing against the concerned officials take place to further test the prima facie case established by the investigation*".[65]

37.7 Dr Mogaladi therefore accepted – correctly so in our view – that if there was *prima facie* evidence of conduct warranting the discipline of one of the Hospital's officers (which includes him) that the correct recommendation was for a disciplinary process to take place to "*further test*" those *prima facie* findings.

37.8 Dr Mogaladi also made submissions on the issue of whether or not Mr Lethole was fed. He provided several affidavits and audio recordings of meetings. Those affidavits and the audio recordings, as described in Dr Mogaladi's submissions, takes his version of events no further, however. The patient and nursing personnel's testimony did not credibly prove or disprove if Mr Lethole in particular was fed at any particular time.

37.9 Dr Mogaladi also criticised the character and trustworthiness of Mr Gajraj and Mr Mothwane. Their evidence is, however, corroborated

---

[64] Mogaladi written submissions 13 November 2020 p 1.

[65] Mogaladi written submissions 13 November 2020 p 1.

by a number of other witnesses on important issues. The criticism of their credibility is not founded in fact.

37.10 Before this *Ad Hoc* Tribunal, Dr Mogaladi argued that he was denied the right to just administrative action by the Ombud because he was not afforded the opportunity to question witnesses who gave adverse evidence against him. He specifically mentions that he was not given an opportunity to question the following people:

37.10.1 Mr Gajraj;

37.10.2 Mr Erik Chikwa, a patient who testified that he did not receive food at the Hospital for one day;

37.10.3 Ms Kwena Dorothy Magagula, a pregnant patient who testified to not receiving food; and

37.10.4 Dr Fareed Abdullah who prepared a report for the Ombud on Mr Lethole's clinical management.

37.11 We accept that Dr Mogaladi is implicated in the Final Report and that this gives him the right to be heard by the Ombud in terms of section 81A(5) of the National Health Act.

37.12 However, because no witness in particular said that Dr Mogaladi was to blame, in other words, Dr Mogaladi was not "*implicated*" by the witnesses, we do not think that he has the right to interview or cross

examine any particular witness. Counsel for Dr Mogaladi in fact accepted in his heads of argument that "*it does not appear that anyone implicated*" him and that it appears to have been the Ombud himself and his investigator (Ms Helen Phetoane) who implicated him[66] on a conspectus of the evidence.

38 Other than the demand to interview the four witnesses, Dr Mogaladi has not sought to lead any further evidence on the issue of whether or not Mr Lethole was fed before this Tribunal.

39 We are satisfied that Dr Mogaladi has had ample opportunity to be heard on this recommendation and the factual findings that underpin it. We are also satisfied that the factual findings and the recommendation should be confirmed.

40 We are also satisfied that there was no application of a reverse onus by the Ombud on Dr Mogaladi or the Hospital management to prove that Mr Lethole had been fed. The evidence as laid out above, paints a clear picture that Mr Lethole had indeed not been fed in the periods set out above.

---

[66] Mogaladi heads of argument para 150.

Recommendation 2: Presiding over a Hospital that provided negligent care

41 We respectfully disagree with Justice Nkabinde who would set aside this recommendation. We would vary the recommendation made by the Ombud that Dr Mogaladi should face a disciplinary enquiry for presiding over a hospital that provided "*negligent care*" to "*presiding over a health establishment that provided substandard care."*

42 The evidence shows that Mr Lethole was provided with substandard care at the Hospital, i.e. care that fell below the Norms and Standards. We consider it fair to require that the CEO of the Hospital answer to a process that would determine whether he has any responsibility for the managerial and leadership failures that, on a *prima facie* basis, appear to have caused that substandard care.

43 Mr Lethole's substandard care is demonstrated in the following, which factual findings were also made by the Ombud in his Draft and Final Reports:

43.1 As set out above, Mr Lethole was not fed for two lengthy periods of time.

43.2 Mr Lethole was nursed in an area where he was in proximity with deceased patients at the COVID-19 Isolation Ward as well at Ward 23, for hours before the bodies could be moved to the Hospital Mortuary.

43.3 Mr Lethole was transferred to a Ward being used exclusively for patients whose COVID-19 status was confirmed despite that his results were not known at the time.

43.4 Diagnostic investigations that were ordered for Mr Lethole, and which were critical to his care, were not followed through.

43.5 Results from tests that were conducted were not seen, reviewed, interpreted, repeated or acted on timeously.

43.6 Neither Mr Lethole, nor his next of kin, nor the staff involved in his care were timeously informed of his COVID-19 test results even though the results were readily retrievable from the National Health Laboratory Service website as of 25 June 2020.

43.7 There were significant delays in Mr Lethole being properly evaluated by a registered medical practitioner.

43.8 There were undue delays in Mr Lethole being intubated.

43.9 He was intubated without an x-ray being used to determine the position of the tube and without a nasogastric tube being inserted.

43.10 Mr Lethole's condition was inadequately monitored while he was intubated.

43.11 Nurses failed to notify doctors on call when Mr Lethole's condition deteriorated.

43.12 The decision not to resuscitate Mr Lethole contravened the Tembisa Hospital Resuscitation Guidelines.

43.13 There were undue delays in certifying Mr Lethole's death.

43.14 Mr Lethole's family were not timeously informed of Mr Lethole's condition or his passing.

44 This treatment of Mr Lethole indicates a failure to comply with the following paragraphs of the Norms and Standards:

44.1 paragraph 5(1), which requires health establishments to ensure that healthcare users are attended to in a manner which is consistent with the nature and severity of their health condition;

44.2 paragraph 7, which requires health establishments, amongst others, to maintain systems, structures and programmes to manage clinical risk; and

44.3 paragraph 8, which requires health establishments to maintain an environment that minimises the risk of transmission of infection to users, healthcare personnel and visitors.

45 In addition to what we set out above relating to Mr Lethole not being fed, there is *prima facie* evidence that managerial, strategic and leadership failures underlay the provision of Mr Lethole's substandard care, which include the

following findings that were similarly made in the Ombud's Draft and Final Reports:

45.1 The Hospital was not adequately resourced or prepared to be a designated COVID-19 hospital. Dr Mogaladi himself recognised this, stating that "*structurally we were completely completely not prepared*".[67] There was no evidence that the risks involved were assessed and the Hospital's capacity was comprehensively reviewed and addressed at a senior level. There was no evidence that the risk was escalated to the District, Provincial and National levels.

45.2 There were severe staff shortages with several staff being newly appointed, inadequately inducted and poorly supervised. There were also problems with staff non-cooperation at the time, apparently linked to fears regarding unsafe working conditions.

45.3 The record-keeping in the Hospital was poor and there was poor collaboration and communication between staff, particularly during handover periods.

45.4 Communications by individuals such as Dr Ngobese to senior management on concerns around staffing, facilities, and processes in COVID-19 management at the Hospital were not appropriately responded to.

[67] Mogaladi interview 6 August 2020 p 19.

46 We are satisfied that it would be appropriate for Dr Mogaladi as the CEO of the Hospital to answer for what responsibility he may have for this *prima facie* evidence of management, strategic and leadership failures through the process of a disciplinary enquiry.

Recommendation 3: Presiding over a health establishment that showed poor record-keeping

47 The Ombud's Final Report and Draft Reports explained why good record-keeping is important:

> *"Medical Records are the cornerstone of health care and clinical practice. Records represent our historical fingerprints as a profession. From these records, health care providers undertake research and develop lessons and policies for the future. Recently, Medical Records play an important role in the evaluation of prescribed norms and standards and in litigation cases. As a profession, we stand or fall by good or poor record-keeping or missing records in the courts. It is therefore essential that all health professionals pay particular care to the way observations and decisions are carried out and recorded in patients' notes."*[68]

48 The Ombud further noted the following in both his Final and Draft Reports:

48.1 "*The Clinical Records at [the Hospital] are not up to standard and befitting of a tertiary level hospital*."[69]

---

[68] Final Report p 190 para 7; Draft Report p 94 para 6.

[69] Final Report p 196 at para (xxi); Draft Report, p 98, para 12.

48.2 There was a culture of poor record-keeping at the Hospital.[70]

48.3 The Quality Assurance audit of Mr Lethole's Clinical Records yielded a score of 19/37 or 51%, "*indicating a very poor score for compliance with clinical record-keeping standards*".[71]

48.4 Poor record-keeping resulted in inadequate monitoring and management of Mr Lethole's condition.[72]

48.5 The confusion around the date of Mr Lethole's death transpired due to poor record-keeping and a lack of proper communication.[73]

48.6 The Hospital and its management "*must take responsibility and accountability for this appalling record-keeping*".[74] The CEO was the "*ultimate accounting officer answerable for record-keeping and record management practices*".[75]

49 Many witnesses confirmed the poor quality of Mr Lethole's clinical records, including Dr Ncha, Dr Ratau-Dintwe, Dr Ngobese, and Dr Ngwata.[76]

---

[70] Final Report p 190 para 6.

[71] Final Report p 17 para 22 and p 123 – 124; Draft Report p 5 and 82.

[72] Final Report p 140; Draft Report, p 86.

[73] Final Report p 12, para 6; Draft Report, p 5.

[74] Final Report p 17 para 22. See also: Draft Report p 73.

[75] Final Report p 121; Draft Report p 73.

[76] Final Report p 169 and 187; Draft Report p 28 – 29.

50 The Ombud recommended, amongst others, that Dr Mogaladi face a disciplinary enquiry for presiding over "*a health establishment that showed poor record-keeping*".[77]

51 The facts show that the record-keeping with respect to Mr Lethole was poor and that this was an outcome of poor practices and culture generally around record-keeping. This infringes the Norms and Standards which require that a hospital ensures that a healthcare user's records are protected, managed, and kept confidential in line with the National Health Act.[78]

52 The CEO has statutory duties in this regard. Section 13 of the National Health Act obliges the person in charge of a health establishment to ensure that health records are properly created and maintained.

53 It is therefore appropriate that Dr Mogaladi account for his role as the CEO in the Hospital's failures in respect of record-keeping.

54 While the recommendation in the Ombud's Final Report was not duplicated in precise terms in his Draft Report, it is clear that in substance, the findings of poor record-keeping were made in the Draft Report, and that these were directly stated to be the responsibility of management and the CEO in

[77] Final Report p 191 para 9.

[78] Norms and Standards at 6(1).

particular as the ultimate accounting officer.[79] As indicated above, Dr Mogaladi also said in his response to the Draft Report that he was not opposed to "*any recommendation that seeks to suggest that disciplinary hearing against the concerned officials take place to further test the prima facie case established by the investigation*".[80] Dr Mogaladi has had extensive opportunity to deal with the finding and recommendations and did not seek to lead any further evidence on this issue before this *Ad Hoc* Tribunal to take the matter any further.

55 For all of these reasons, we confirm the Ombud's recommendation.

Recommendation 4: Signing inaccurate and misleading reports

56 The Ombud found that Dr Mogaladi signed inaccurate and misleading reports to the former MEC for Health, Dr Bandile Masuku, and to the Ombud.[81] These were the reports prepared by Dr Ncha on Mr Lethole's case at Dr Mogaladi's instruction. The Ombud set out several inaccuracies in the reports signed by Dr Mogaladi in his Final Report.[82] The Ombud therefore recommended that Dr Mogaladi face a disciplinary enquiry for signing the reports.

---

[79] Draft Report p 94 para 7.

[80] Mogaladi written submissions 13 November 2020 p 1.

[81] Final Report para 2 p 19.

[82] Final Report p112 – 115.

57 There are indeed several inaccuracies in the reports signed by Dr Mogaladi, as explained by the Ombud. We therefore confirm the factual finding that the reports were inaccurate.

58 There is no evidence, however, that Dr Mogaladi intended to mislead Dr Masuku or the Ombud when signing Dr Ncha's reports. We do not think that signing an inaccurate report is *per se* misconduct or poor performance warranting a disciplinary enquiry. There is therefore no basis to refer Dr Mogaladi to a disciplinary enquiry for signing the reports prepared by Dr Ncha, even if they were inaccurate.

59 We therefore agree with Justice Nkabinde that this recommendation should be set aside.

Recommendation 5: Side-lining Quality Assurance

60 The Ombud found in his Draft and Final Reports that Dr Ncha had been assigned by Dr Mogaladi to take charge of the complaint regarding Mr Lethole "*at the exclusion of the Quality Assurance unit*".[83] Quality Assurance was only engaged after the Ombud's investigator's briefing with Dr Mogaladi.[84]

[83] Final Report p 29. See also Draft Report p 79.

[84] Final Report p 28.

61 The Ombud recommended that Dr Mogaladi face a disciplinary enquiry for "*side-lining Quality Assurance*" in exercising their responsibility in addressing complaints and safeguarding Mr Lethole's medical records.[85]

62 In his grounds of appeal, Dr Mogaladi says that he never side-lined anyone. In his heads of argument, Dr Mogaladi did not deny that it was protocol for Quality Assurance to be engaged once an issue and complaint like Mr Lethole's had been raised. Dr Mogaladi does not deny in his heads of argument that Quality Assurance were not engaged. Dr Mogaladi's case in the heads of argument is that there was no complaint before the Ombud about side-lining Quality Assurance, so he lacked competence to investigate the issue. As we have said above, we consider that the Ombud acted within his mandate and therefore do not consider this complaint to have merit.

63 Dr Mogaladi further raised in his grounds of appeal that the Ombud's finding on this issue was irrational because, as the CEO, he "*does not perform the functions of keeping records of patients*".[86] For the reasons we set out to follow, it is clear that Dr Mogaladi – as the head of the Hospital – did have certain duties in this regard and that it was in terms of his instruction to Dr Ncha that the correct process of engaging Quality Assurance was not followed.

---

[85] Final Report p 19 para 2.

[86] Mogaladi grounds of appeal para 29.

64 Gauteng Province Health Circular Letter 22 of 2016 ("*Confiscation and Safekeeping of Medical Records of Serious Adverse and those with Potential for Litigation*") ("**Circular 22 of 2016**") stipulates the measures that heads of institutions throughout the Gauteng Department of Health are obliged to follow with respect to the safe keeping of priority medical records. Non-compliance with the Circular was raised in both the Ombud's Draft and Final Reports as informing the Ombud's finding and recommendation against Dr Mogaladi.[87]

65 The Circular is contextualised in reference to many institutions in the province reporting medical records to be missing or unavailable during investigations and during litigation processes. In view of these challenges, it requires that certain measures *"must be implemented and adhered to with immediate effect"* by heads of health institutions. These include the following:

> *"1. All medical records of patient's involved in Serious Adverse Events or having potential for future litigation must be confiscated immediately after identification of an incident.*
>
> *2. The medical records must be audited and cross checked against the index checklist to confirm the records that are part of the clinical record at the time of the incident.*
>
> *3. Generate a copy of the medical record for investigation purpose and seal the original for safe keeping under lock and key in an area designated by the Head of Institution.*
>
> *4. The Heads of Institutions are further instructed to create a potential Litigation records schedule of all medical records and*

[87] Draft Report p 85 – 86; Final Report p 129 and 134.

> *reports in their custody before sending a copy to Quality Assurance at the Head Office.*
>
> *5. The Heads of Institutions are requested to bring the contents of this circular minute to the attention of all staff members and managers."*

66 Notably, the Circular stipulates that "*Failure to comply with this circular will constitute misconduct.*"

67 In his interview with the Ombud's investigator, Dr Mogaladi said that he was informed by the MEC for Health about the public outcry around Mr Lethole's tweet and his subsequent passing.[88] He undertook to investigate the issue further.[89] Dr Mogaladi understood that the ordinary procedure in obtaining a patient's file would have been for Quality Assurance to "*immediately"* copy[90] it and to secure the original file.[91] Despite this, he said that he thought Dr Ncha was the first person to obtain the file and that this was done at his request.[92] On Dr Mogaladi's own version, he instructed Dr Ncha to take control of the file, not Quality Assurance, despite knowing that the correct procedure was for Quality Assurance to handle the process. This does not comply with Circular 22 of 2016.

---

[88] Transcript Mogaladi interview 23 July 2022 p 2 – 3.

[89] Transcript Mogaladi interview 23 July 2022 p 3.

[90] Dr Mogaladi said: "*once the file is there immediately is actually has to be recorded. If ever the quality assurance is not there bring it straight to me*".

[91] Transcript Mogaladi interview 23 July 2020 p 3 – 4.

[92] Transcript Mogaladi interview 23 July 2020 p 4.

68 Dr Mogaladi claimed in the appeal that the Circular did not apply because there was no potential for litigation.[93] This ground of appeal does not have merit. The issue as conveyed to Dr Mogaladi by the MEC for Health was certainly one in general terms that had "*potential for future litigation*", involving both allegations of improper care and a person who passed away in the Hospital. It was, in any event, an incident involving a "*serious adverse event*", being Mr Lethole's death. Dr Mogaladi, in any event, considered that the correct process was to engage Quality Assurance on his own version.

69 The failure to follow Circular 22 of 2016 was consequential. It resulted in confusion and uncertainty about the integrity of Mr Lethole's medical records, and it appears that it may have led in turn to the inaccurate report that Dr Ncha compiled.

70 The Norms and Standards require health establishments to ensure that health records are protected, managed and kept confidential in line with sections 14, 15 and 17 of the Act.[94]

71 Section 17 of the Health Act, in turn, requires the *"person in charge of a health establishment*" who is in possession of a patients' health records to "*set up control measures to prevent unauthorised access to those records*". Quality Assurance's role in terms of the Circular is part of the control measures that

[93] Mogaladi grounds of appeal para 164.

[94] Norms and Standards at 6(1).

informs the CEO's duties in this regard, him being the person in charge of the Hospital.

72 We are therefore satisfied that, factually, Dr Mogaladi did not comply with the Circular and that this further infringed the Norms and Standards as read with the Health Act. We are satisfied that Dr Mogaladi has had ample opportunity to be heard on the issue.

73 We therefore vary the recommendation that Dr Mogaladi should face a disciplinary enquiry for the non-compliance with Circular 22 of 2016. We vary the language of the recommendation to remove any ambiguity that might exist in the phrase used by the Ombud of "*side-lining* *Quality Assurance*".

Recommendation 6: Failing to report the missing doctor's notes

74 The Ombud found, and Quality Assurance corroborated, that there were missing doctor's notes from Mr Lethole's file for 23, 24, 25, 28, 29 and 30 June 2020.[95] He said further that the "*missing notes were never reported to the South African Police Service ("SAPS") as is required by law*".[96] The Ombud recommended that Dr Mogaladi face a disciplinary enquiry for failing to report the missing doctors' notes to the SAPS for loss or theft.[97]

[95] Final Report p 17 para 22

[96] Final Report p 18 para 23.

[97] Final Report p 19 para 2.

75 Dr Mogaladi considers the finding and recommendation to be "*preposterous*" because it cannot be expected of a CEO to run to SAPS every time hospital records might be missing and, in any event, he did not consider the records to be missing at all.[98] He says that the finding is irrational because missing notes are not a criminal act requiring a report to be made to the police.[99]

76 We are not aware that there is any specific legal obligation on the CEO of a hospital to report missing clinical notes to SAPS. In the appeal, the Ombud did not take the *Ad Hoc* Tribunal to the legal source of such a duty.

77 There is also no basis in fact to infer that there were missing clinical notes that had been or were suspected of being stolen. We therefore have no basis to find that there was a crime or a suspicion thereof that might otherwise initiate a complaint to SAPS.

78 We therefore agree with Justice Nkabinde to set aside the findings and recommendations on this issue.

Conclusion on Dr Mogaladi's appeal

79 An over-arching concern raised in Dr Mogaladi's appeal is that he is "*not the employer of the many nurses and employees at the Hospital*" and he "*cannot*

[98] Mogaladi grounds of appeal paras 98 to 99.

[99] Mogaladi grounds of appeal para 161.

be held vicariously liable for their conduct".[100] This complaint is without merit for two reasons:

79.1 First, the Ombud did not, and nor do we, impute the conduct or omissions of other Hospital employees on the CEO.

79.2 As we have set out above on each issue, it is Dr Mogaladi's own actions or omissions – as the CEO – which inform the recommendation for a disciplinary enquiry against him.

79.3 The recommendations are grounded in his duties as the head of the Hospital under the Health Act and the Norms and Standards, and in terms of his functions as a CEO (as were also described by his counsel in the hearing). In terms thereof, he is required to put in place and manage systems, processes, facilities and staff in a way that will realise the Norms and Standards and comply with the Health Act. Where there are *prima facie* indications that he has failed in these duties as the CEO, we consider a disciplinary enquiry to be an appropriate recommendation.

79.4 Second, neither the Ombud, nor we, hold Dr Mogaladi liable for anything. We have found non-compliance with the Norms and Standards and have confirmed and varied the Ombud's recommendations as they relate to Dr Mogaladi insofar as there is a

[100] Mogaladi reply to respondent's written submissions para 26.

prima facie indication that he should account for whether he failed in his duties in relation to the non-compliance.

79.5 The recommendations do no more than to call on the CEO to account for his own conduct.

RECOMMENDATIONS CONCERNING DR NGOBESE

Recommendation 1: Failing to ensure the availability and functioning of critical care equipment

80 The Norms and Standards require that the Hospital ensure "*that medical equipment is available and functional in accordance with the law*".[101] The availability and functionality of medical equipment in turn impacts on the duty of the Hospital under the Norms and Standards to ensure that patients are attended to in a manner which is consistent with the nature and severity of their health condition.[102]

81 The Ombud made the recommendation in his Final and Draft Reports that Dr Ngobese – as the head of the COVID-19 unit at the time – should face a disciplinary inquiry for failing "*to ensure that critical care equipment at Ward 23 was available and functioning properly*".[103]

[101] Norms and Standards at 13(1).

[102] Norms and Standards para 5(1).

[103] Final Report p 19 para (vi) and p 194 para (vi). Draft Report p 96 para (v).

82 The Ombud found that there was a delay in intubating Mr Lethole because the sterile equipment for intubation was not available.[104] He found further that the blood gas machine was not functional in the ward where Mr Lethole had been kept.[105] This impacted negatively on Mr Lethole's care. This is evident from the nursing notes on 29 June 2020,[106] in the period after which he had been ventilated which shows that his blood gas levels were not measured on occasion due to the non-availability of the blood gas machine.

83 In her interviews with the Ombud's investigator, Dr Ngobese described her responsibilities as follows.

83.1 She said it was her role to "*assist*" if the COVID-19 unit "*needed a blood gas, an extra bed or another person to assist*".[107]

83.2 She said, "*So if there's no [personal protective equipment] I would try find the persons in charge of [personal protective equipment] so I was a conduit basically between the people that are working and also the hospital itself.*"[108]

---

[104] Final Report p 89; Draft Report p 56.

[105] Final Report p 146; Draft Report p 75.

[106] Final Report p 159 p 161; Draft Report p 60.

[107] Transcript Ngobese interview 10 July 2020 p 4.

[108] Transcript Ngobese interview 6 August 2020 p 9.

83.3 After Mr Lethole died, she did in fact sign off on a list of equipment as head of the unit including beds, blood gas machines, stethoscopes and temperature monitoring equipment.[109]

84 Dr Ngobese, on her own version, therefore had a role to play in ensuring that the critical care equipment in the COVID-19 ward was available and functioning.

85 Despite this, in the appeal she says that the responsibility lies with the Technical and Administrative staff of the Hospital and not medical doctors.[110] Her responsibility, she said, was only to report faulty equipment to management and she says she discharged her responsibility in this regard.[111]

86 We uphold the Ombud's finding and recommendation that:

86.1 Critical care equipment, including sterile equipment for intubation and a blood gas machine, were not available or functioning in Ward 23 which infringed the Norms and Standards and impacted negatively on Mr Lethole's care.

86.2 We are satisfied that – on Dr Ngobese's own version – there is *prima facie* proof that she bore <u>some</u> responsibilities in this regard and that

[109] Transcript Ngobese interview 6 October 2020 p 42 -43.

[110] Ngobese grounds of appeal para 2.2.

[111] Ngobese grounds of appeal para 2.7.

she should, in the result, account for her role through a disciplinary enquiry.

86.3 It may be that other people also had responsibilities in respect of ensuring that critical care equipment was functioning in the Ward. That is not an answer, however, to the fact that Dr Ngobese had responsibilities as she herself described. It is fair that she be asked to account for the extent to which she fulfilled these responsibilities.

86.4 We note that Dr Ngobese took on responsibility for Ward 23 in the most trying of circumstances and that she faced enormous challenges in this role. The contents of the email sent by Dr Ngobese to her superior, Dr Ncha, on 22 June 2020, in which she anxiously set out several serious problems in the COVID-19 unit, demonstrates that she took her role seriously and was indeed operating under immense constraints.

86.5 She indeed attempted to "*do something*" about the inadequate equipment in the Ward when she sent a WhatsApp message to a group that included clinical managers about equipment concerns.[112]

86.6 Whether her conduct with respect to the critical care equipment was sufficient and commensurate with her duties as head of the COVID-19 unit and an employee, and whether the circumstances are ultimately mitigating of the failure to ensure critical care equipment was available

[112] Transcript Ngobese interview 6 October 2020 p 41; Ngobese grounds of appeal para 25.1.

and functioning, are issues that would appropriately be left for a disciplinary enquiry to determine.

Recommendation 2: Failing to complete the MMT form timeously

87 We agree with Justice Nkabinde that the Ombud's recommendation – that Dr Ngobese face a disciplinary enquiry for failing to complete the MMT on time – should be set aside. We give our reasons to the extent that they differ with those of Justice Nkabinde.

88 We are not aware that there exists any requirement to complete the MMT forms within any specific number of days after a patient's passing, nor has any been raised by the Ombud.

89 It appears anyway that Dr Ngobese transferred responsibility as head of the COVID-19 unit within a matter of days of Mr Lethole's passing to her incumbent.

90 The facts also show that Dr Ngobese took appropriate action while she was in charge to ensure the process moved forward timeously – including pressing staff to complete the forms, making copies available in the relevant wards, collecting the information and completing the forms herself when this was not

done, and communicating capacity constraints on this issue to her superiors.[113]

91 Dr Ngobese also noted in her appeal that there simply wasn't time during the height of the COVID-19 pandemic to complete all of the MMTs due to the dramatically high death rate at the time and the focus of staff on coping with the crisis.[114]

92 In the circumstances, we find no evidence of any violation of the Norms and Standards or any *prima facie* indication of sanctionable misconduct or poor performance by Dr Ngobese in regard to the MMT forms. We therefore set this recommendation aside.

Recommendation 3: Providing multiple different versions

93 In his Final Report, the Ombud found that Dr Ngobese had given conflicting versions of when exactly she took photographs on her phone of Mr Lethole's medical files.[115] The Ombud considered that this brought into question the reliability and truthfulness of Dr Ngobese's evidence.[116] The Ombud's Final Report recommends that Dr Ngobese face a disciplinary enquiry for providing

[113] Ngobese grounds of appeal para 3.8.

[114] Ngobese grounds of appeal para 3.7.

[115] Final Report p 125 – 127.

[116] Final Report p 127.

"*multiple different versions of when the first set of pictures of Mr Lethole's medical records were taken on 30 June 2020*".[117]

94 We agree with Justice Nkabinde that these findings and the recommendation should be set aside.

95 From our reading of Dr Ngobese's interviews with the investigator and Ombud, Dr Ngobese doesn't appear to have been dishonest but merely elaborated on issues when requested to do so in answer to the investigator as best she could.

95.1 She initially gave estimations of the time she took certain photos on 29 June 2020 based on her usual schedule.

95.2 When the investigator asked more detailed questions, Dr Ngobese was cooperative and sought to assist.

95.3 By looking at time stamps on messages and photos, the investigator was able to compile a more accurate timeline of when the photos were taken.

95.4 There is no indication – whether *prima facie* or otherwise – that Dr Ngobese was dishonest or sought to mislead or to withhold information from the investigator or Ombud.

[117] Final Report p 194 para (vi).

96 In any event, the findings and recommendation were not included in the Ombud's Draft Report and so Dr Ngobese did not have an opportunity to deal with it. Her account before this *Ad Hoc* Tribunal in her appeal is credible.

Recommendation 4: The line-listing items

97 The Ombud's Report recommends that Dr Ngobese faces a disciplinary enquiry for claiming that she only provided line-listing items[118] to Dr Ncha while she in fact provided additional information including handwritten notes and noticing that doctor's notes were missing.[119]

98 Dr Ngobese explained that her purpose in taking pictures of Mr Lethole's file was to complete the MMTs for which purpose the line-listing items were required.[120] In taking the photos, however, she nonetheless gathered more information than just the line-listing items.[121] Thereafter, she simply used the information from these pictures to draft a handwritten note which she shared with Dr Tshabalala on 30 June 2020,[122] which was later also sent to Dr Ncha.[123]

---

[118] The Ombud describes the line-listing items as the patient's name, age, gender, address, district, region, travel history, facility where diagnosed, date diagnosed/ admitted, admission, diagnosis, facility transferred to, comorbidities, treating doctor, and date of death. (Final Report p 130; Draft report p 76 para (vi)).

[119] Final Report p 194 para (vi) and p 168; Draft Report p 74.

[120] Ngobese grounds of appeal para 6.3.

[121] Ngobese grounds of appeal para 6.4.

[122] Ngobese response to Draft Report p 33 para 29.

[123] Ngobese grounds of appeal para 6.6.

99 We consider Dr Ngobese's explanation to be reasonable and credible. There is no indication that she sought to mislead the Ombud. We find no reason to refer Dr Ngobese for a disciplinary enquiry on this basis.

100 We therefore agree with Justice Nkabinde that this recommendation should be set aside.

Recommendation 5: Assisting Dr Ncha in preparing the inaccurate reports

101 The Ombud's Report recommends that Dr Ngobese face a disciplinary enquiry for assisting Dr Ncha in preparing reports to the former MEC and the Health Ombud that were found to be inaccurate.

102 Dr Ngobese's version is a bit conflicting on this issue – in her 6 August 2020 interview, she said that she did not participate in compiling Dr Ncha's report,[124] but in her 20 October 2020 interview she said that she went and sat in Dr Ncha's office and helped Dr Ncha while she compiled the report.[125]

103 Nonetheless, Dr Ngobese said (and the Ombud does not dispute) that Dr Ngobese never read or signed off on the report compiled by Dr Ncha.[126]

[124] Transcript Ngobese interview 6 August 2020 p 16)

[125] Transcript Ngobese interview 6 October 2020 p 10.

[126] Ngobese grounds of appeal para 22.2.

Dr Ngobese cannot be responsible for the contents of a report she never saw and did not write.

104 We therefore agree with Justice Nkabinde that the recommendation should be set aside.

Recommendation 6: Being an indirect party to the administrative bungle

105 The Ombud's Report recommends that Dr Ngobese face a disciplinary enquiry for being an indirect party to the administrative bungle in regard to Mr Lethole's records. We understand the recommendation to relate to the poor management of Mr Lethole's files, the poor note-taking in those files, and Dr Ncha's inaccurate reporting.[127]

106 We found no evidence that Dr Ngobese was responsible for patient file management *per se*. Despite this, Dr Ngobese was aware of issues of inadequate record keeping in the COVID-19 unit and tried to deal with these issues in her email dated 22 June 2020 which was sent to her superior, Dr Ncha. She drew Dr Ncha's attention to several issues and concerns she had regarding the COVID-19 unit. Amongst others, she said, "*Looking at patient notes it's clear that there is no pride in what we are doing. [J]ust scribbling something so that there is something on the paper. Forgetting that*

[127] Final Report p 169.

this is a medico legal document".[128] Dr Ngobese acted responsibly in raising these concerns.

107 On this basis, and based on the findings we make above in relation to Dr Ngobese's role in photographing Mr Lethole's files and her role in compiling Dr Ncha's report, we find no basis in fact to recommend Dr Ngobese's referral for a disciplinary enquiry for being an indirect party to the "*administrative bungle*". We therefore agree with Justice Nkabinde to set this recommendation, and the findings supporting it, aside.

Conclusion on Dr Ngobese's appeal

108 There remain two grounds of appeal raised by Dr Ngobese that don't fall within either the preliminary issues or the specific recommendations which we have dealt with above.

108.1 The first is Dr Ngobese's complaint regarding the Ombud's reliance on information provided by the Ombud's investigator, Ms Phetoane. Dr Ngobese complained in this regard that she was harassed and aggressively interrogated by the Ombud's investigator[129] and that the investigator's assessment of the evidence was unfair, exhibiting unreasonable bias.[130]

[128] Ngobese response to Draft Report para 8.

[129] Ngobese heads of argument para 4.10.

[130] Ngobese heads of argument para 4.10.9.

108.2 The investigation process was clearly stressful for Dr Ngobese. She indeed was interviewed on four separate occasions and was subjected to rigorous questioning by Ms Phetoane. However, we find no evidence of bias or illegality in the investigator's conduct. The Ombud was entitled to rely on the information obtained by Ms Phetoane.

108.3 The second is Dr Ngobese's ground of appeal that the Ombud erred in finding that Dr Ngobese had "*excluded*" Quality Assurance.[131] On our reading of the Ombud's Final Report, there is no such finding made against Dr Ngobese in particular. For clarity, we nonetheless confirm that there is no factual basis to support a finding that Dr Ngobese was responsible for "*excluding Quality Assurance*".

CONCLUSION

109 In concluding our decision, we wish to express our condolences to Mr Shonisani Lethole's family and to all those who knew and loved him. We hope that his legacy will be to inspire meaningful improvement in healthcare services that respect peoples' rights and dignity.

DECISION

110 On the basis of the reasons and findings that we have set out above, our decision is as follows:

[131] Ngobese grounds of appeal para 9 and sub-paras.

110.1 The first appellant's appeal is upheld in the following respects:

110.1.1 The respondent's recommendation that a disciplinary enquiry should be instituted against the first appellant for signing "*inaccurate and misleading reports to the former MEC and the Health Ombud*" is set aside.

110.1.2 The respondent's recommendation that a disciplinary enquiry should be instituted against the first appellant for failing "*to report missing clinical notes to the SAPS as is required by law*" and failing to "*report the missing doctors' notes of the 23rd, 24th, 25th, 28th, 29th, and 30th June 2020, to the SAPS for 'loss or theft'*" is set aside.

110.2 The first appellant's appeal is dismissed in the following respects:

110.2.1 The respondent's recommendation that a disciplinary enquiry should be instituted against the first appellant for presiding over a hospital "*that on two separate occasions could not provide Mr Lethole food for prolonged periods*" is confirmed.

110.2.2 The respondent's recommendation that a disciplinary enquiry should be instituted against the first appellant for presiding over "*a health establishment that provided negligent care*" is varied to:

"*presiding over a health establishment that provided substandard care*".

110.2.3 The respondent's recommendation that a disciplinary enquiry should be instituted against the first appellant for presiding over "*a health establishment that showed poor record-keeping*" is confirmed.

110.2.4 The respondent's recommendation that a disciplinary enquiry should be instituted against the first appellant for side-lining "*Quality Assurance in exercising their due responsibility in addressing complaints and safeguarding records of Mr Lethole*" is varied to:

"failing to comply with Gauteng Province Health Circular Letter 22 of 2016 ('Confiscation and Safekeeping of Medical Records of Serious Adverse and those with Potential for Litigation')".

110.3 The second appellant's appeal is upheld in the following respects:

110.3.1 The respondent's recommendation that a disciplinary enquiry should be instituted against the second appellant for:

110.3.1.1 "*failure to complete the required Morbidity and Mortality Template form timeously*" is set aside;

110.3.1.2 "*providing multiple different versions of when the first set of pictures were taken on the 30th June 2020*" is set aside;

110.3.1.3 "*telling that she only provided line listing items while she provided additional information including handwritten notes and noticing that doctor's notes were missing*" is set aside;

110.3.1.4 "*assisting Dr Ncha in preparing Reports to the former MEC and the Health Ombud that were found to be inaccurate*" is set aside; and

110.3.1.5 being "*an indirect party to the 'administrative bungle'*" is set aside.

110.4 The second appellant's appeal is dismissed in the following respect:

110.4.1 The respondent's recommendation that a disciplinary enquiry should be instituted against the second appellant for "*failure to ensure that critical care equipment at Ward 23 was available and functioning properly*" is confirmed.

(Electronically Generated)

____

PROF LR MATHIVHA

(Electronically Generated)

____

PROF E VARIAVA

NKABINDE J:

Introduction

111. I have had the benefit of reading the judgment penned by my Tribunal Colleagues, Doctors/Professors R Mathivha and E Variava (majority judgment). At the heart of these appeals are the issues of the rationality and procedural fairness of the adverse findings and recommendations for disciplinary hearings. While I agree with parts of the assessment of certain of the adverse factual findings against the appellants, I disagree with others. I do not agree also with the majority's approach to the issues on appeal and order. I am of the view that the appeals should succeed either on rationality ground or procedural fairness ground, individually or jointly, in respect of each appellant. Therefore, I would have upheld both appeals and set aside the Ombud's decision recommending a disciplinary hearing against the two appellants

112. I recognise, from the start, that life and access to *health care* and sufficient *food* are rights for everyone entrenched in the Constitution of the Republic of South Africa, 1996 (Constitution).[132] To achieve the progressive realisation of

[132] Sections 11 and 27(1) (a) and (b) of the Constitution.

each of the entrenched rights the state is enjoined to take reasonable legislative and other measures.[133]

113. At the heart of these appeals is a challenge on the rationality and fairness of the adverse findings and recommendations against both appellants. The appeals are brought in terms of the National Health Act[134] (Health Act) by the first and second appellants, Doctors Lekopane Mogaladi and Makhosazane Judith Ngobese (first appellant/Dr Mogaladi and second appellant/Dr Ngobese) respectively, against certain findings and recommendations by the Health Ombud, Professor Malegapuru Makgoba (respondent/Ombud). They present a classic example of an alleged deprivation of health care and food. The appeals highlight also, the state and capacity of the health care systems at Tembisa Provincial Tertiary Hospital (Tembisa Hospital), particularly during the COVID -19 pandemic.

114. The Ombud was appointed to investigate and report on the care and death of Mr Shonisani Lethole (Shonisani/the deceased) who died while hospitalised at

---

[133] Section 11 of the Constitution provides that "[e]veryone has the right to life." In relevant parts, section 27 (3) of the Constitution reads:

> *"27. Health care, food . . .*
>
> *1. Everyone has the right to have access to—*
>
> *(a) Health care services . . .*
>
> *(b) Sufficient food and water; and*
>
> *(c) . . .*
>
> *2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.*
>
> *3. …." (Emphasis added.)*

[134] 61 of 2003.

Tembisa Hospital. The investigation followed a complaint by the former Minister of Health, Dr Zwelini Mkhize (the Minister). The complaint was ignited by a tweet, ostensibly posted by the deceased. It is alleged, among other things, that the deceased was not given food for 48 hours while at Tembisa Hospital. The tweet triggered an online *#JusticeforShoni* wherein users, nationally and internationally, demanded answers and justice.

115. Following the investigation, the Ombud produced a preliminary report (Draft Report)[135] and later a Final Report[136] in terms of section 81A of the Health Act and made certain adverse findings of fact and recommendations against several health personnel, including the two appellants.

116. This Independent *Ad Hoc* Appeal Tribunal (Tribunal) was established in terms of section 88A (2) and (3)[137] of the Health Act by the Minister to adjudicate an appeal that had been lodged, first by the first appellant and later the second

---

[135] The Draft Report was published on 19 October 2020.

[136] The Final Report was published on 27 January 2021. It is entitled "The Report of the Health Ombud in terms of section 81A of the National Health Act, Act No 61 of 2003. The Report into the circumstances surrounding the care and the death of Mr Shonisani Lethole at Tembisa Provincial Tertiary Hospital Reference # 19109" (Final Report).

[137] Section 88A (2) and (3) of the Health Act provides:

> *"(2) The Minister must, upon receipt of the appellant's written appeal contemplated in subsection (1)–*
>
> *(a) Appoint an independent ad hoc tribunal in terms of subsection (30; and*
>
> *(b) Submit the appeal to the tribunal for adjudication in the prescribed manner.*
>
> *(3) A tribunal contemplated in subsection (2) must consist of not more than three persons, of whom–*
>
> *(a) one must be a person who is a retired Judge of a High Court or a retired magistrate, who must be the chairperson; and*
>
> (b) *two must be persons appointed on account of their knowledge of health care industry."*

appellant. In the appointment letter[138] the Minister cautioned that although section 88A (2) stipulates that the Tribunal must adjudicate the appeal in the prescribed manner, there are no Regulations that prescribe how the appeal must be adjudicated. He advised that the Tribunal must therefore decide on its own fair procedures. The Minister urged that the appeal of the first appellant (at the time) should be finalised within two months.

117. At the time of the establishment of the Tribunal, it was anticipated that there might be more appeals lodged by some of the people against whom certain adverse findings and recommendations were made by the respondent. As it happened, Dr Ngobese later lodged her notice of appeal. The two appeals were heard and are decided together.

118. As the Minister correctly advised, there are no prescribed rules for the adjudication of appeals under the Health Act. Therefore, with a view to fashion its own procedures the Tribunal held preliminary virtual meetings and later engaged with the parties on its proposed process, for example, the issuance of directions to ripen the hearing of the matter. It was agreed that the parties would meet to discuss and if possible, agree how to curtail the proceedings. Following their meeting the parties filed a document styled agreement between the parties wherein certain issues are identified.

[138] Dated 3 March 2021.

119. As its own regulatory process, with a view to ripen the matter for hearing, different sets of directions were issued by this Tribunal. At the hearing the parties raised an issue regarding the nature of the appeal process. This preliminary issue may be disposed of speedily. In the light of the said directions our approach is to adjudicate the appeals based on the evidence on record – without the need for further evidence on affidavit or adducing oral additional evidence that never served before the Ombud. Accordingly, these matters are dealt with as ordinary appeals and not reviews.

120. It is important to mention, at the outset, what the two appeals are about and what they are not about. I do so taking into consideration the Ombud's submissions that the appellants have shown no compassion for Shonisani or for those he left behind prematurely and that they should take responsibility for what happened under their watch. In his submissions the Ombud implores this Tribunal to ensure that the appellants account for their actions and inaction in the contemplated disciplinary proceedings.[139]

121. Quintessentially, and as will become plain later, these appeal concern issues distilled from the notices of appeal, the parties' written submissions and agreed issues. Although the subject under investigation by the Ombud involved medico-legal questions, the issues in these appeals are principally legal in nature. Their determination requires a proper assessment of facts upon which the impugned adverse findings and recommendations were made. As will

[139] Respondent's written submissions, p 72 at para 150.

become more apparent later, the issues include whether (1) the appellants' right to procedural fairness was violated; (2) the Ombud (a) exceeded his mandate, (b) acted irrationally and unreasonably and (c) selectively disregarded certain relevant evidence. At this stage the issues, properly understood, have nothing to do with who should be held accountable or is culpable[140] and/or with any questions relating to whether the adverse factual findings will bind or not bind whoever presides over any anticipated disciplinary enquiry. This observation should, however, not be understood to suggest that no one should be held accountable: Accountability is one of the basic values and principles governing public administration.[141] It follows that those properly found wanting in a high standard of professional ethics, should account. For our purpose, the preliminary issues on appeal need to be determined first.

122. It needs to be emphasised that the investigative process in terms of the Health Act, with its concomitant findings and recommendations, is distinct from a disciplinary enquiry process. The two processes should thus not be conflated. If this were not so and the respondent's contentions were correct, the appeal mechanism and the Tribunal adjudicative process would have been superfluous. Notably, the Ombud correctly appreciated the importance of the

[140] The respondent has, in any event decided on the culpability of certain individual Medical Doctors and personnel, including the appellants. For example, certain "senior health professionals" are found to have been negligent and are said to have delayed in reviewing a severely ill patient which conduct is said to amount to a denial of care.

[141] Section 195 of the Constitution.

investigation being "guided by the facts"[142] and the report of the expert managing COVID-19 patients in critical care.[143] After all, context is everything.

123. Despite criticism of the seeming flaws emerging from the investigation, the assessment and conclusions evident from the Report, one acknowledges straightaway that the task of the Ombud was, indisputably, demanding and onerous especially for someone who is not trained in the legal enterprise. I borrow from the words of an esteemed former Colleague, Justice Sachs,[144] to underscore the complexity in an adjudication process that, "the Working of a Judicial Mind requires exploring the wider dimension of the issues to understand the context, appreciate the impact of the reasoning on those affected by it and to handle the problems in a manner penetrating into widely shared legal imagining". It is for these reasons that, even if there are certain nuances on approach, assessment and conclusions, the Ombud must be applauded for his estimable work.

Parties

124. The first appellant, who has since resigned, was the Chief Executive Officer (CEO) of the Tembisa Hospital. The first appellant was appointed in terms of section 79 of the Health Act.

---

[142] Record, interview transcript of 6 August 2020 between the First Appellant, Respondent, and an investigator from the Respondent's Office, p 53 at para 20.

[143] Id p 52 at para 20.

[144] *The Strange Alchemy of Life and Law,* Published by the Oxford University Press.

125. The second appellant is a Paediatrician. From her responses[145]to the Final Report, she is also trained in the discipline of infectious diseases which, according to her, might explain why she was requested to assist at the Accident and Emergency Casualty COVID-19 isolation area (isolation area) even though she did not physically manage patients because it was not in the scope of her practice. The physical management of patients, she explains, was the responsibility of the adult internal medicine doctors.

126. The Ombud/respondent was appointed by the Minister in terms of the Health Act.[146] Following the investigation the respondent compiled a Draft Report[147] and later a Final Report (collectively referred to as the Reports). The findings and recommendations in the Final Report, concerning the appellants, are the subject matter of these appeals.

<u>Background</u>

The facts

127. What follows is a comprehensive background that is necessitated by the nature of the issues raised in these appeals. On 21 June 2020 the deceased, aged 34 years, contacted his father – Mr Albert Lethole (Lethole senior) – and reported that he was unwell: He was feeling dizzy and could not drive. He

---

[145] In her letter dated 30 October 2020.

[146] In terms of section 81(1) of the Health Act.

[147] This Draft report was not included in the paginated Record but was referred to during oral submissions and later made available to the members of the Tribunal.

asked his father to fetch him from his apartment. Lethole senior fetched him and drove straight to the surgery to see a doctor, with whom he had made a prior booking. The doctor examined and gave him an injection and pills. He returned home and slept. The deceased seemed to have felt better on 22 June 2020.

128. On 23 June 2020, at approximately 02:00, Shonisani complained of severe chest and back pain and asked to be taken to the hospital as he could not bear the pain. He was driven to Edenvale Hospital. There, he was told to go back home and return later that morning because there were no doctors. Instead of going back home Lethole senior drove Shonisani to Busamed Private Hospital (Busamed) where their request, for him to be admitted and later transferred to a public hospital, was refused. While at Busamed, a nursing sister examined Shonisani's pulse, blood pressure, blood sugar and his general basic health. He was driven home at about 04h00.

129. At approximately 05h00 that morning and before being driven back to Edenvale Hospital the deceased ate soft porridge. Upon arrival at Edenvale Hospital the queues were already long. They waited for roughly 4 hours. Shonisani was later screened and assessed. He was referred to Kempton Park Clinic. At the Clinic, he was diagnosed of having suffered back/chest pain, difficulty in breathing and generalised body weakness for two days. Shonisani had no history of co-morbidities. He was given a referral letter for Tembisa Hospital.

NKABINDE J

130. Following his referral, Shonisani (accompanied by his father) presented himself at Tembisa Hospital COVID-19 screening tent at Gate 3 on 23 June 2020 and was admitted at 12h36 as a Patient Under Investigation (PUI) at the isolation area. This was a designated area for patients awaiting their SARS-CoV-2 (COVID-19) test results.

131. Seemingly, it was common practice at Tembisa Hospital for patients to be kept at the isolation area while waiting for their screening, blood test and other results. The blood test result became available on 25 June 2020 at 24h02[148] when, according to documentary evidence, he had already been moved[149] from the isolation area to Ward 23 (designated for COVID-19 positive male patients). The results showed that Shonisani had COVID-19 pneumonia. While at the isolation area (at about 14h42) Shonisani is said, according to the nurses' notes, to have complained of general body pains. On 24 June 2020 he complained to his parents that he had not been given food. The parents brought him food but could not enter seemingly because of the COVID-19 restrictions. While at Ward 23, Shonisani complained to his family about not being assisted to the bathroom. Documentary evidence later surfaced and proved that he had soiled himself. His parents were asked to fetch his clothes on 27 June and ostensibly passed on 29 June 2020.

The tweet

[148] Report, Record p 81.

[149] On 24 June 2020 at 24h02.

132. Shonisani is said to have posted the following tweet to the Minister while he was at the isolation area:[150]

> *"Mkhize can I respond to your tweet if the problems I have at one of your facilities continues, it is becoming unbearable and they don't seem to care. Didn't eat for 48 hours."* *(Emphasis added.)*

133. The Star Newspaper published an article.[151] The article refers to a tweet that is alleged to have gained prominence after the passing of Shonisani. The tweet triggered an online #JusticeforShoni where twitter users demanded answers and justice for the deceased. In the extract from the email sent to the Minister, MEC and CEO, the following appears:

> *"#JusticeforShoni: fix Tembisa Hospital and save lives*
>
> *We want justice for Shonisani, and we do not want other families and friends to suffer our pain and loss. More people are coming forward to tell their stories. All of us need to listen to them.*
>
> *We recognise that during the peak of the COVID- 19 pandemic in South Africa there is an urgent need for all people in South Africa to trust their healthcare system. That trust is only possible through*

---

[150] The Ombud established that the tweet was from the deceased. He had requested an independent twitter analysis from the OHSC IT Directorate and the Communication and Stakeholder Relations Directorate to ascertain the authenticity of the tweet and that there was no evidence that the Minister ever saw Shonisani while he was alive. It was confirmed that the tweet belonged to him. It is said that this information was corroborated by his girlfriend, Ms Lambani. The Ombud states that the Minister's Office also confirmed the authenticity of Mr Lethole's twitter handle.

[151] Dated 2 July 2020. The article is available at ttps: www.iol.co.za/thestar/news/businessman-fighting-covid-19-dies-after-complaining-of-not-being-fed-for-two-days-502849. Other publications, as per the list provided at pp 200 - 201 of the Record include Eyewitness Online News on 2 and 7 July 2020; News24 on 2, 3 and 8 July 2020; Sunday World on 2 July 2020; Times live on 3 July 2020; Independent Online News on 15 July 2020 and Maverick Citizen on 19 July 2020. Links to News referred at pp 200-201 of the record include http://youtu.beIR9Wn-YtjU; http://youtu.be/be/cRPV7dwEpfA and https://youtu.be/NdmfmpthErk.

transparency and accountability. We see this moment as an essential opportunity to do that. Many more families will leave their loved ones in the care of public hospitals in this time, expecting quality care for COVID-19 and non-COVID-19 patients. Without accurate and properly explained information about their loved ones' conditions, they may worry, or worse – turn their backs on the public healthcare system. This is something we cannot afford. Communities need to trust their hospitals and healthcare managers. It is now in your hands" #JusticeforShoni I #GoodHealthcareForAll I Follow the cairn on Twittter@JusticeforShoni."

134. The Gauteng Department of Health referred the matter to the former MEC of Health, Dr Bandile Masuku, and the first appellant. The matter was subsequently referred to the Minister. A petition, apparently signed by 21 758 individuals[152] nationally and internationally, was later submitted to the respondent. The deceased's family felt aggrieved and short-changed by the Tembisa Hospital and the Department of Health as they only learnt about their son's COVID -19 status on 30 June 2020, after his passing.

The complaint

135. The public outcry and media uproar following the tweet (supposedly posted by the deceased) triggered the Minister's attention who then lodged a complaint

[152] At the time of completion of the investigation the count for the petition signatories had allegedly risen to 25 936 individuals.

with the Ombud. The Minister asked him[153] to probe the allegations surrounding the care and death of the deceased.

136. The complaint, summarised in the reports as —

a) the problem I have at one of your facilities continues, it is becoming unbearable;
b) they don't seem to care; and
c) did not eat for 48 hours,

was refined and further condensed by the Ombud into "Unbearable problems, Care, 48 hours." As the Ombud correctly points out, the complaint was referred to him at the peak of the COVID-19 pandemic. Certain statements in the Reports regarding this aspect are matters of public knowledge and will be dealt with later when the issues regarding the appropriateness of the impugned findings and recommendations are addressed.

137. The evidence of Lethole senior, Shonisani's mother, his girlfriend and family spokesperson, allegedly supplanting the deceased's tweet, was relied upon by the Ombud in the Reports.[154] To avoid prolixity, it is unnecessary to repeat these witnesses' statements here. It suffices to mention that their statements echo certain aspects of the deceased's gripe, for example, that he was not

---

[153] On or about 5 July 2020.

[154] Draft Report at pp 18-30 and Final Report, Record at pp 32-49.

provided with food, not assisted to the bathrooms and that the staff at Tembisa Hospital seemed not to care.

The investigation

138. The Ombud commenced with the investigation on 6 June 2020. He notified the Head of the Gauteng Department of Health – Prof Lukhele, Chief Director of the Ekurhuleni Health District – Mr Terrence Magoro and the first appellant of the complaint and scheduled investigation regarding the circumstances surrounding the care and death of the deceased. Clinical records of the deceased were requested. Tembisa hospital was also made aware of the plan for the onsite investigation on 8 July 2020.

139. A Senior Investigator from the Office of Health Standards Compliance (OHSC), Ms Helen Phetoane, was appointed and authorised by the Ombud, in terms of section 81A(3)(a)(b)(i)-(iv) of the Health Act, to gather the necessary information and peruse any documentation that had a bearing on the case of the deceased while he was at Tembisa Hospital. It appears that a Quality Assurance Team[155] was also allocated by the first appellant to work with the investigator when she arrived at Tembisa Hospital and a predetermined list of staff members to be interviewed was provided to her, but she refused to accept it. The investigator interviewed a total of 72 staff members involved in the care

[155] The Team was led by its Deputy Director Ms Matshediso Mahlare.

and management of the deceased and those “that [were] relevant to provide evidence.”[156] Some of their statements are mentioned later.

140. Jointly with the investigator the respondent interviewed certain staff members[157] who were involved in the care and management of the deceased. These interviews were followed by further rounds of interviews to verify what appeared to the respondent to be “incongruent, divergent or falsified evidence obtained from the same staff members in the same ward”. Timeline mappings was the focal point of the investigation.[158]

141. It is reported that the second appellant and a certain Dr Ncha were each interviewed three times during the investigation. These two Health professionals are said to have been the “masterminds of the critical administrative events”[159] that took place around the care of the deceased, the recording in his file, the preparation of reports to the first appellant, and their proximate work in taking charge of the deceased’s complaint allegedly at the exclusion of the Quality Assurance Unit/Team.

142. Evidently from the record, the first appellant compiled and sent a report on 6 July 2020 to the Ombud. The report included the requested clinical records on the events leading to the intubation of the deceased and report on food

---

[156] Draft Report p 15.

[157] In total 113 recorded interviews were conducted in terms of a document referred to as “Annexure 2” to the Final Report.

[158] Draft Report p 17.

[159] Draft Report p 16 and Final Report p 29. While the Draft Report refers to “masterminds”, the Final Report refers to “central figures”.

distribution. The clinical records were analysed by the investigator, the respondent and Dr Fareed Abdullah – a Clinical Expert on the management of COVID-19 patients at the MRC (Medical Research Centre) and Steve Biko Academic Hospital. As will be explained later the clinical records were found wanting.

143. In his report to the respondent[160] the first appellant deals, among other things, with the background including Shonisani's clinical journey as a referred patient and mentions that when he presented himself at the Kempton Park clinic on 23 June 2020 at 09h30, he had a two-day history of difficulty in breathing and generalised body pains. He explains that Tembisa Hospital had been receiving and managing patients with signs and symptoms suggestive of COVID-19 from the time the pandemic was declared. According to him, a total of 1565 patients comprised those under investigation and confirmed. He reported that the Hospital screened a total of 72 532 of which 186 patients were positive. It also received referrals from the District, Clinics Quarantine Sites and "CHC".

144. According to the first appellant, when Shonisani was admitted, Tembisa Hospital had three areas for patient management: (1) the isolation area where the initial assessment of the patient was done before being sent to the ward; (2) Ward 23, a male COVID -19 area with a capacity of 16 beds and 12 oxygen points; and (3) Ward 20, a female COVID-19 area with a capacity of 32 beds and 32 oxygen points.

[160] Dated 6 July 2020. See Record pp 234 -38.

145. The first appellant reported that on arrival at Tembisa Hospital, on 23 June 2020 in the afternoon, Shonisani was screened, diagnosed to have difficulty breathing, sent to triage and was then wheeled to the isolation area designated for patients with respiratory symptoms. There, he was seen by the COVID-19 Team. After examination the test revealed a differentiated diagnosis of Community Acquired Pneumonia with query COVID-19 infection. Shonisani was swabbed for COVID-19 and the management plan was implemented. He was kept at the isolation area on 23 and 24 June while waiting for the test results which came out on 25 June 2020 showing a positive status. Documentary evidence however reveals (and this was confirmed) that Shonisani was moved to Ward 23 at 24h02 on 24 June 2020.

146. The investigator followed the pathway of the deceased's COVID-19 screening, testing and retrieval of the COVID-19 laboratory test results. She interviewed one hundred and thirteen (113) witnesses and collated documentary evidence which was presented to the respondent. The investigation established that the deceased was not adequately assessed nor evaluated by a registered Medical Practitioner for 69 hours 19 minutes from the time of admission at Isolation until the 26th June 2020 and while at Ward 23 when he was reviewed by Dr Bangala and Dr Shabangu.[161] The latter (Dr Shabangu) is said to have been the Physician Consultant for the deceased whom he saw, for the first time, on 26 June 2020.

---

[161] Id.

147. Dr Shabangu is alleged to have failed to ‘’determine whether the treatment plan made by the junior colleagues was in line with the prescribed guidelines.” This, according to the investigation, was so because medical records were silent on this.[162] The doctors are found to have failed to follow through the basic blood test, the CXR and SARS-CoV-2 test results that were ordered while the deceased was at Casualty on 23 June. It was found that the results, properly interpreted, showed “severe multisystem tissue injury of the lungs, kidney, muscles and liver and a systemic inflammatory response which would certainly have necessitated changes in the treatment plan/pathway’’[163] The respondent found that the medical officers and consultant ostensibly ignored these conditions.[164]

148. The investigation concluded that some, if not all, of the tests would have needed to be repeated but were not followed up by the said two “senior Health Professionals” on 26 June 2020. That, the reporting goes, “was not only a grave error of judgement but also negligent”.[165] According to the investigation

[162] Report, p 82.

[163] Report, p 81 under the assessed evidence of Clinical Associate Molekane whose failures included failure to prescribe pain relief medication for the ‘severely ill patient”. Dr Shabangu, in response to the respondent’s preliminary report confirmed that Clinical Associate Molekane prescribed the broad-spectrum antibiotics for the deceased, and she was satisfied that the prescription was in line with COVID-19 guidelines. However, evidence on the prescription revealed that there was no evidence that a senior medical practitioner countersigned the junior clinician’s prescription as required by the Regulations (see in this regard record p 104 under 10.5.)

[164] Record, p 100 under 10.4.

[165] Id.

the long delay by these doctors in reviewing a “severely ill patient” amounted to denial of care.[166]

149. The investigation also showed that although the results had been available from the laboratory website, the nurses’ entries on 25 June at Ward 23 showed that they were still waiting for the deceased’s COVID-19 results. That, the investigation found, implied that the health care practitioners directly involved with the deceased did not know that he was COVID-19 positive. On 26 June, the entries showed that the deceased’s oxygen saturation level had deteriorated to 78% but the nurses failed to inform the doctor on call about this. According to the register that was provided, Doctors Bangala and Shabangu were on call. It is found that the deceased was therefore admitted into their care because “patients admitted to a hospital are admitted to a consultant.[167]

150. Although the clinical associate – Ms Tshali – had ordered certain critical diagnostic investigations (such as FBC, LFTs, U & e, inflammatory markers and muscle makers, Arterial Blood Gases, ECG, Compulsory Chest radiography (CXR) and COVID-19 test which would be essential to determine the diagnosis, severity and management plan of the deceased’s condition), no follow up was made even though the results were available as early as 25 June 2020. The results indicated severe multiple system organ injury of the kidneys, liver, muscles and systemic inflammation.

---

[166] Id.

[167] Record, p 83.

151. It is reported that Doctors Shabangu and Bangala consulted with the deceased on 26 June 2020 but failed to make urgent intervention on the available results. The investigation established that had the Doctors done so and correctly interpreted the result of severe multiple system tissue injury the deceased's illness would have been better appreciated and the course of his treatment would "no doubt" have changed. [168]

152. Dr Bangala is said to have failed to certify the deceased dead, on 29 June 2020. Instead, the deceased was certified on 30 June by Dr Marole when he was already *in rigor mortis* (loosely translated meaning when his body had already stiffened after death due to chemical change in the myofibrils). The alleged failures by the mentioned doctors and the said delays were found to constitute negligence and an indirect denial of access to treatment. As the Consultant, Dr Shabangu, is said to bear the ultimate responsibility and accountability concerning the care of the deceased.

153. The deceased's condition is found to have been reviewed by Dr Bangala only about 3 hours 55 minutes after the recorded deterioration but still the doctor did not notice the deterioration. The doctor is said to have failed to involve the nurses who were directly involved in the care of the deceased to evaluate the nurses' findings. According to the investigation the poor communication among health care providers became detrimental to the treatment plan for the deceased's low oxygen saturation.

---

[168] Record p 93.

154. The delays and failure to act on the results are said to have been callous and negligent, thus resulting in breach of Regulation 5 (1) of the Norms and Standards Regulations which provides that “[t]he health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition.”

155. The established omissions by Dr Urmson include the failure to perform a ventilator functionality test before intubation thus resulting in the deceased not being adequately ventilated for approximately 9 hours. It is found that had Dr Urmson been assisted or supervised by a critical care specialist this could have been avoided. The deceased’s oxygen saturation remained less (between 85% and 75%) for a prolonged period with the potential attendant systemic tissue injury. This is found to be inconsistent with Regulation 10(2)(b) of the Norms and Standards Regulations, requiring the “health establishment to ensure the availability of medicines and medical supplies for the delivery of services.”

156. The alleged further omission relates to the failure to calculate the deceased’s tidal volume scientifically. Instead, the volumes were calculated on an eyeball gauge that is said to be notoriously inaccurate. It is established that such wrong calculation or the predicted body weight has serious consequence on the determination of the tidal volume as this ultimately determined the pressure exerted on the alveoli in the patient’s lungs.

157. A further alleged critical lapse in the care of the deceased by the Consultant Physician, Dr Shabangu, and his team is said to have arisen from their failure to ensure that the nasogastric tube was inserted. The Consultant Doctor is said to have been responsible for deciding and advising on intubation. Without post-intubation X-Rays, it could not be determined whether the intubation tube was in the correct place or not.

158. The Health Establishment was found wanting regarding oversight and supervision of the Clinical Assistant Tshali. This was found to be inconsistent with Reg 2 of the Regulations that Define the Scope of Practice of Clinical Associates, that "they must perform their duties under continuous supervision of a medical doctor." Dr Marole (newly appointed junior doctor according to the report) was found to have misrepresented information in the Clinical records regarding the certification date of the deceased. This is determined to be another instance of a junior doctor working unsupervised.[169] It was determined that the deceased was mismanaged because he was not resuscitated in accordance with the Standard Operating Procedures (SOP).

159. In keeping with *audi* the health establishment was given an opportunity to respond to the allegation against it.[170] The establishment, according to the reports by the first appellant,[171] was the CEO of the Tembisa Hospital.

---

[169] Record p 96 under 10.1.

[170] Record p 111 under 10.10.

[171] Annexures 9(A) – to the MEC Health GDOH, Mr Bandile Masuku, on the deceased (dated 1 July 2020) record pp 227 – 234; 9(B) – the report entitled "Report on [the deceased]" submitted to the respondent by the first appellant (dated 6 July 2020) in response to the Draft report, pp 234 –

160. Documentary evidence in the form of nurse's note (Nurse Kenneth Mothapo) revealed that some of the deceased's linen – in the morning of 27 June 2020 – was soiled when he changed it. Annexure 10 in the Record contains documentary evidential material relating to the quality assurance.[172] The audit report reveals, among other things, the absence of doctors and nurses' forms regarding the patient's progress, absence of their notes concerning the examination of the deceased (on 24, 25, 28, 29 and 30 June 2020) and of records regarding the monitoring of fluid intake and output (on 26, 28, and 29 June 2020). Additionally, the audit report shows that not all clinical records were legible, lack of urine testing and missing daily instruction of fluids balance chart.

161. Annexure 11[173] reflects the missing Doctor's notes between the originals and the scanned copied filed. Annexure 12[174] consists of the deceased's file scan history, showing, *inter alia,* that the deceased's file was first scanned on 30 June 2020 and rescanned on 10 and 21 July, 4 and 22 September and 8 October 2020.

162. A document entitled "standard operating procedure [SOP] for ordering of patient meals"[175] compiled by the Chief dietitian, Mr Selemela, was signed on

---

238; and 9(C)- the report by the first appellant to the respondent (dated 6 July 2020), entitled "Food Distribution" and signed off on 8 July by the first appellant.

[172] Record pp 245 – 248.

[173] Record pp 249 – 250.

[174] Record pp 251 – 252.

[175] Record p 270.

23 October 2017 and was supported by Dr Socikwa on 24 October 2017. It was approved, seemingly by one M J Mathabathe and the first appellant, on 25 October 2017. The SOP enjoins the ward-siter to complete a TPH48F/bed-diet list form, deliver it to the foodservice[s] unit before 07h30am and to write the normal diets in bulk and details of patients on special diets as directed by the bed list. She/he is obliged to only order meals for patients in the ward for the specific meals. The bed lists would be sent back to the wards at lunch and supper with a food trolley so that the ward-sister must update it for the next meal, and it must be returned with a trolley so that food services unit can update statistic for the next meal.

163. The first appellant was interviewed by the investigator and later the respondent. Part of the investigative evidence regarding the first appellant's narration is summed up in the Report.[176] It emerges that the Quality Assurance Manager was requested to provide the first appellant with the original file of the deceased. Then a copy was submitted to the respondent. The investigator took the first appellant through the discrepancies identified in the original file vis-á-vis the copied one and the first appellant allegedly admitted that there were shortfalls noted in the record keeping. The original file would have been compiled by Dr Ncha as the Coordinator of COVID-19.

164. On the allegations that the deceased did not eat, the first appellant emphasised, as is contended on this appeal, that the nature of the investigation

---

[176] Record pp 274 – 281.

was about food and not the overall patient. He was steadfast that the deceased was admitted on 24 June 2020 hence he did not defend the possibility that he was not fed on 23 June as he was not admitted.

165. The first appellant testified that he focused only on the issue of food and did not have an opportunity to reflect on COVID-19 results and the care provided to the deceased. He relied on the undated, untimed and unnumbered nursing notes. The name of the admitting doctor was also missing from the notes, hence the first appellant's admission that there were a lot of gaps in the record-keeping at the Isolation area. The first appellant attributed this to the fact that the causality area was not a normal ward but – "nevertheless a ward". Additionally, he said, nurses were not used to managing patients who required constant monitoring. The first appellant testified that he had introduced a system of headcounts at casualty. He conceded to and was disappointed by the shortfall of the staff not adhering to prescribed procedure of food ordering and distribution. The first appellant asked that those who were admitted with the deceased be identified and interviewed to solicit the truth.[177] As will become apparent later, those ex-patients made statements which have been included in the record.

166. The first appellant related that the COVID-19 pandemic exacerbated the already existing challenges of shortage of staff and space at the Isolation area. According to him, the establishment of the Isolated area and the COVID-19

---

[177] See summary of his narration at Record p 272.

designated ward was “a rough start” and “not easy at all”. He welcomed the investigation indicating that it scaled up challenges that will enable the hospital to develop a Quality Improvement Plan (QIP) and correct the challenges.

167. Further documentary evidential material consists of a detailed developed quality improvement Plan compiled by the clinical manager, Dr Relebohile Ncha. It was approved by the first appellant. [178] It included a brief quality improvement plan prepared by Dr Ngwata.[179] In this short plan Dr Ngwata identifies the problem items, their levels, root causes and improvement plan by the identified individuals. The problem includes high improper clinical notes attributable to negligence, “high” delayed resuscitation caused by staff shortages and “high” delayed certification of death also caused by staff shortages.[180]

168. The affidavits of previously admitted patients,[181] as was requested by the first appellant,[182] were obtained and included in the Record. Some of the statements seek to prove that food was provided at the isolation area but others not. For example, in his affidavit signed on 11 November 2020,[183] Mr Eric Chikwa stated that he was admitted at Tembisa Hospital from 23 June 2020 and stayed there for six days. For the first three days he was not provided

---

[178] Annexure 13 (A) referred at pp 253 to 257 of the Record.

[179] Record pp 258 – 259.

[180] Annexure 13(B) referred to at pp 258 – 259 of the Record.

[181] Included in the Record as Annexures 14 (A-C) – pp 260 to 266 of the Record).

[182] See para 97 below.

[183] Annexure 14 (A).

with medication and one day no food, until his sister called the Management whereafter he was transferred to another Ward where everything was provided as per normal.

169. Another deponent, Ms Sarah Nkwana, states[184] that she was admitted at Tembisa Hospital on 22 June 2020. She mentions that she was there for chest pains and was taken to COVID-19 Ward and got tested. The following day, 23 June, the results were positive. Regarding the issue of food, she says “It’s true that food was available even though I was in pain and could not eat.”

170. Ms Dorothy Magagula states[185] that she was at Tembisa Hospital on 23 – 24 June 2020 and that she did not get food. She says their service “was very very poor because I slept on the floor, and I was pregnant.” She mentions that she reported to the Matron, but she did not take her seriously. She was coughing blood. She says that she had to walk up and down unassisted.

171. The first appellant was also interviewed by the respondent. He was given an opportunity to give a background regarding the situation at Tembisa Hospital. He was appointed on 1 March 2016. Re-aligning the hospital, he mentioned, was a tough process: the critical issues was the space; there were no systems in place; the staff patient ratio was very low. He asserted that he agitated for

---

[184] In her affidavit (Annexure 14 (B)) signed on 28 October 2020.

[185] In her affidavit (Annexure 14 (C)) supposedly (as the handwriting is eligible) signed on 28 October 2020.

more staff to get more hands-on deck to ensure that processes and patient care were done.

172. The first appellant said that he realised that there was a lot of sub-optimal care particularly at certain areas including the isolation area, Internal Medicine, and Gynaecology with the highest maternal mortalities. One of the critical worries at isolation area was the lack of synergy between the Nursing fraternity and the Doctors fraternity but was working on it. As they were progressing, the entire administration was changed by Life Esidimedi (the MEC and Head of the Department left; there was a 3% budget cut; subsequently 75 nursing post were cut and had to restart the whole process of patient care and the daily/weekly operating reports and skills audit was introduced.) But as those processes were underway, the COVID-19 Pandemic emerged which had to be managed. They experienced a soaring number of patients at the isolation area.

173. Reading from the summarised narration of the first appellant, there was skills shortages with the advent of the COVID-19 Pandemic: no Head of the clinical Care but as part of the intervention one was appointed; leading nurses at the Accident and Emergency/Casualty Isolation lacked skills in emergency care but a system was introduced to ensure that care was ongoing; There were more challenges in the Internal Medicine Unit – the first appellant said “it was very very tough” and they had to dismiss two Heads of the Department and appointed an acting Head and when the situation was not improving they

appointed Dr Ngwata. He said that with the appointment things started to improve.[186]

174. Ostensibly because of the requisites of Regulation 5(2)(b) of the Norms and Standards Regulations, which requires the establishment to "ensure access to emergency medical transport for users requiring urgent transfer to another establishment," the respondent asked the first appellant whether the joint venture with Steve Biko Hospital still existed. The question was asked seemingly because according to the respondent, "the [deceased] came already very ill and would have been a very good candidate for ICU/High Care" and because "[Tembisa Hospital] did not have those facilities." The respondent was of the view that "it would have been smart to move [the deceased] to Steve Biko as it [Steve Biko] would have appropriate facilities. The first appellant explained that the joint venture was continuing "in name only" as Steve Biko had taken the entire Tshwane District Hospital as a COVID centre. They could thus no longer refer the patients there.[187]

175. Regarding the timing of the deceased's death the first appellant replied that the deceased could have died on 28 June 2020 at night and was certified on 29 June 2020 in the morning. He was enlightened about further witnesses' evidence including the evidence of Dr Marole who certified the deceased on 30 and yet recorded that he certified him on 29 June when he was already *in*

[186] Record p 275.

[187] Record p 276.

rigor mortis; of the failure of Dr Urmson to order X-Rays and to insert the GN tube to feed the deceased ; of Dr Molehe for failing to follow up on the ordering of post intubation X-Rays until the deceased's death); and of Dr Shabangu failure to check the X-Rays taken on 23 June 2020. When asked, the first appellant confirmed that no one reported to the deceased's family about his COVID-19 status, and no one reached out to the family.

176. Following the interviews the respondent undertook to share his preliminary findings with the first appellant so that he "should sit with the staff and reflect on the inconsistencies pointed out about the care provided to [the deceased]" and to "reflect honestly on **what is it that they did that could have been done differently."**[188] Furthermore, the respondent assured the first appellant that their role in the investigation was guided by the facts and that the report of the expert managing COVID-19 patients in critical care will be included in the Draft Report to enable him to identify the discrepancies and hone in on the identified issues.

177. In closing the interview, the respondent opined that the management and mismanagement of patients in the Public Hospitals and Tembisa Hospital was strictly exclusive for the deceased. He said that the care rendered was not optimal and that this was confirmed by the first appellant that he has honed into the performance of the entire public health space in terms of patient management (found wanting) but was of the view that there were mitigating

[188] Record p 280.

factors such as space constraints and absence of opportunity to refer patients. Also, the first appellant mentioned that although they were challenged and had put systems in place, "it is the people who did not apply those systems."[189]

Preliminary adverse findings and recommendations – indirectly and directly adverse to the first appellant

178. Evident from the table of contents the respondent addressed, among other things, his powers and jurisdiction, the complaint, the investigative methodology and approach, witnesses' narrations of events, the investigative findings, conclusion, and recommendations. On the issue of non-provision of food, the respondent seems to have relied on the evidence of Dr Gajraj who was the area Manager for the isolation area and Ward 23 COVID-19 designated ward which was said to be "telling".[190] Dr Gajraj told the investigator that he had run into difficulties with "Senior Management" for raising the issue of nurses having forgotten to order supper the evening of the 23 and breakfast on 24 June 2020. It is unclear who the senior management referred to is. The first appellant is said to have asserted that he owned the verbal decision for the ordering of food telephonically, thus making a major operational change to suspend the established Standard Operating Procedure (SOP).

---

[189] Record p 280.

[190] Draft Report p 34.

179. The Hospital management is said to have provided the respondent with nurses' notes on pieces of scrap paper produced as evidence by the staff of the Health Establishment to affirm that food was provided to the patients. The notes, the respondent found, could not be relied upon as they did not reflect Shonisani's registered identifiers as required by the guidelines and SOP[191] and because there was no documented evidence from the Medical Records, that he was provided meals on 23, 24 June 2020.[192]

180. The respondent found that there was no evidence that Shonisani was offered food for "**43hours 24 minutes"**. He explicates that if one added the 8hrs since the last meal at 4am at home on that day, this would total "**approximately 52 hours of involuntary fasting."[193]** It was on these bases that the respondent concluded that the tweet was credible and most probably true. The respondent concluded that the evidence provided by Dr Ncha and signed by the CEO as a "Report on [Shonisani], sent to …the MEC, Health GDOP, the OHSC Complaints Centre and Assessment and to the [respondent] on Food Availability was false, without foundation, deceitful and misleading. . . ."[194]

181. The Health Establishment is found to have failed to provide oversight and supervisory support to staff especially to ClinA Ms Tshali who, on 23 June, had observed Shonisani had mild distress and wheezes but failed to determine the

---

[191] Draft Report p 36.

[192] Id p 37.

[193] Id.

[194] Id p 38.

severity of the oxygen saturation and respiration rate which are “critical vital parameters for any PIU especially for COVID-19 suspect.”[195] This is found to have been in breach of Regulation 2 of the Regulations[196] under the Health Professions Act 1974[197] that defines the scope of practice of clinical associates. The supervising medical practitioner was to be identified by the Service in which the associate was working.[198] The intern, Pawson, who worked at the isolation area was found to have been unsupervised by a Senior Medical Staff. The non-supervision is found to have been in contravention of the guidelines of the Health Professions Council of South Africa (HPCSA) that denote that an intern should not work alone in critical emergency unit/casualty without the assistance by the Senior Medical Staff.

182. The Health Establishment is found to have taken the decision not to resuscitate the deceased contrary to the prescribed SOP developed by the Tembisa Hospital that provides that the decision not to resuscitate the patient should be documented and close to the patient. In terms of the HPCSA, such decision should be made by a senior clinician. The health care providers are found to have failed to adhere to the guidelines.[199]

---

[195] Draft Report p 51. See also p 65 of the Draft Report

[196] In terms of Government Notice No R433, Government Gazette 38816.

[197] Act 56 of 1974.

[198] Draft Report p 59 to the top of p 60.

[199] Id p 61.

183. The first appellant is found to have recused the Quality Assurance Unit, the alleged custodian of the Complaints Management Protocols, from handling the case of the deceased. It is found that this was so because Dr Ncha and second appellant had been assigned to handle the matter.[200] The deviation in approach is found to have resulted in the family not being contacted as required by the Complaints Management Protocols. As a result, the family aired their perception on various media platforms.[201]

184. Additionally, the Health Establishment is found to have contravened Regulation 5(1) (b) which ensures access to emergency medical transport for users requiring urgent transfer to another health establishment.

185. The Health establishment is said to have failed to ensure the availability of medicines and medical suppliers for the delivery of services. This was because there were no correct circuits from the Casualty Isolation. The first appellant and Dr Ncha are said to have provided incomplete records to the respondent and the OHSC.[202] This, according to the preliminary findings, reflected that Tembisa Hospital failed to maintain a system of records of users with appropriate security control measures in the clinical service area in terms of section 13 of the Protection of Personal information Act, 2013[203] and the mentioned Circular 22 of 2016.

---

[200] Id pp 79 and 80.

[201] Id p 80.

[202] Draft Report p 85.

[203] Act 4 of 2013.

186. The respondent found that from the evidence gathered it was clear that the management of Tembisa Hospital was either incompetent or in denial or only keen to obfuscate and mislead the investigation as to what transpired to the deceased and to create an unsustainable fictitious and false reality that unfolded around the care of the deceased. This presented the worst administrative bungles in record handling.[204] The basis of this finding is the evidence of inconsistencies and falsehoods appearing from appalling records with missing and illegible clinical notes; the by-passing of legitimate structures such as the Quality Assurance Unit responsible for auditing and safeguarding records; incomplete records and distortion and falsification of obvious facts in the Clinical Records.[205]

187. Before concluding the respondent made a broad observation of the impact of COVID-19 pandemic on the functioning of Tembisa Hospital. He remarked that his findings demonstrated that Tembisa Hospital was neither fit nor ready for purpose as a designated COViD-19 Centre Hospital.[206] This is based on certain facts including that at the time of Shonisani's hospitalisation —

a) the hospital was inadequately resourced to deal with the surge of the PUIs and admission of the confirmed COVID-19 cases;
b) the hospital had no dedicated COVID-19 ICU to manage the severity of Shonisani's condition and admit mechanically

[204] Draft Report pp 87 – 88.
[205] Id p 87.
[206] Id p 88 at para 20.

ventilated patients, as a result the hospital “improvised” by designating a medical, Ward 23, to admit confirmed COVID-19 patients as well as ventilated patients. The respondent mentioned that during this period there was an agreement with Steve Biko to accommodate patients from Tembisa requiring ICU care, but the first appellant clarified that Steve Biko was inundated and fully booked.

c) the hospital had a shortage of nursing and medical staff in the Isolation area on 23 June: The enrolled nurse on duty reported that she worked alone until around 21:00 as the Professional Nurse allocated to work with her was off sick. Evident from the nurses’ statements obtained during the investigation the nurses were unable to cope because of overcrowding in the isolation area and it was impossible to practice physical distancing. It was reported that two (2) nurses were seeing thirty-four (34) patients most of whom required continuous Oxygen which at some point was unavailable because the oxygen cylinders ran empty;

d) the hospital mainly functioned with contractual employees in the Casualty Isolation. These employees were not conversant with the established systems at that hospital as there was limited time during COVID-19 pandemic to orientate the staff appointed during the pandemic;

e) the isolation area was not conducive as per the Occupational Health and Safety Standard because the overcrowded area could not maintain the regulated physical distancing as other patients were kept in stretchers, resulting in inadequate spacing to comply with physical distance. As a result, the Casualty permanent staff "apparently" refused to work in the isolation area citing safety concerns. A memo was addressed by Dr Gajraj, the Manager of the Unit, to those concerned urging them to work in the isolation area and stating that if they refused reasons had to be provided to enable the managers to attend to their concerns accordingly. Despite the staff being addressed by the Deputy Director, Mr Mothwane, on 22 June 2020, the matter remained unresolved; and

f) the hospital was not ready for the challenges of the COVID-19 pandemic but the risks were not escalated to the District, Provincial and National levels.

188. The preliminary recommendation included—

a) consideration by the National Minister to undertake due diligence before designating any Health establishment for a particular mission to ensure that appropriate and adequate resources are made available for the establishment to discharge such a mission;

b) a consideration by the National Minister to appoint a new leadership at Tembisa Hospital to drive a new culture of health care that respects human dignity, the Bill of Rights and that would support the implementation of the National Health Insurance. The Respondent said the culture and positive attitude of care was sadly missing at Tembisa Hospital and that this was not unique to that establishment.

c) A training and mentoring of young health care professionals in the modern era – a rapidly globalising health care environment to ensure that some of the good values, ethics and codes of practice – were brought up to speed. It is stated that the current culture of "falsifying information, missing clinical records, providing incomplete records . . . and a laissez-faire attitude to caring must be rooted out without fear or favour and without compromise of the National Health Systems. Failure to address this will compromise the values of the Constitution and the NHI";[207]

d) whether resources should be allocated to a designated tertiary Hospital, such as Tembisa, to correct glaring deficiencies and limitations identified in the report: Infrastructure, the quality of staff and governance – to be given priority for corrective action; and

[207] Draft Report p 93.

e) an initiation of a disciplinary enquiry against the first appellant who was an accounting officer of Tembisa Hospital for allegedly (i) allowing himself to be misled about [Shonisani's] care"; (ii) signing false and misleading letters to the former Health MEC Dr Bandile Masuku; (iii) failing to safeguard his Clinical Records in accordance with policy; and (iv) side-lining Quality Assurance Unit from exercising its due responsibility in addressing the complaint.[208]

First appellant's response to the preliminary adverse findings and recommendations

189. In accordance with the undertaking made during the interview by the respondent, the first appellant was given an opportunity to respond to the Draft report.[209] He did so in a detailed letter dated 13 November 2020.[210] Although the Draft report[211] was not included in the bundles presented to this Tribunal, it was referred to during the hearing, it was later made available to the members of the Tribunal after the hearing.

190. In his response the first appellant provided additional evidence that was not sought from the relevant parties and thus not considered during the

[208] These remedial actions, to which the first appellant had a chance to respond, appear at p 94, para 7 of the Draft Report.

[209] From the reading of the letter, dated 19 October 2020.

[210] That was copied to the Premier of Gauteng, Mr David Makhura.

[211] Consisting of approximately 103 pages.

investigation.[212] He made it clear that his response does not seek to conceal clinical negligence and the flouting of food distribution protocols. He mentions that the Tembisa Hospital has an established history of taking disciplinary steps against its officials that are found wanting in the clinical management of patients or in contravention of any established rules.[213] He said he is not opposed to any recommendation that seeks to suggest that disciplinary action be taken against officials concerned to further test the *prima facie* case established by the investigation but said that his response is to assist address versions in the report that are irrational, unjustified and unreasonable.

191. The first appellant dealt with the designation of the hospital as a COVID-19 Centre and mentioned that overcrowding was a matter of public knowledge as was established by public institutions, for example, the Human Rights Commission that conducted an inspection in *loco* on 15 May 2018 regarding overcrowding. These institutions[214] agreed in their findings, among others, that the resources were inadequate, infrastructure was poor, the catchment area was large and that there were no referral hospitals.

192. The first appellant took issues with certain findings on the report stating that the Ombud appears to have been analysing a situation that was normal, as if there was no unprecedented pandemic that was exacerbating known

[212] Record p 387 at para 2 of the letter.

[213] Record p 387 at para 3 of the letter.

[214] The "Thuma Mina" Initiative that visited on 18 May 2018 and the National Council of Provinces' visit on 14 May 2019 as well as the Public Protector's (Adv Busisiwe Mkhwebane) visit on 21 August 2020.

challenges of the [Tembisa] Hospital.[215] He said the recommendation in para 3 of the report[216] was made without affording the Minister or delegatee *audi*, notwithstanding the fact that the designation of the hospital as a COVID-19 Centre is what brought the deceased to the hospital. He suggested that context leading to the making of the decision to designate should have been provided by the Minister.

193. The first appellant mentions that although the investigation is a single incident as reflected in the title of its preliminary report, namely: "Report into circumstances surrounding the care and the death of [the deceased]" the respondent made what he refers to as a "sampling method" of a single incident in an 840-bed facility, to conclude that the organisational culture is reflective of *laisses-fare,*[217] disrespectful of the Bill of Rights and warranting the removal of the entire leadership at the hospital. He says that there is evidence[218] that – "in preparation for its new designation – Tembisa Hospital converted the pre-existing section of the Hospital into units that would accommodate Covid-19 patients".[219] He added that at some point they opened two new wards over a

---

[215] Record p 388 at para 7 of the letter.

[216] That "The National Minister of Health should in future undertake due diligence before designating any Health Establishment for a particular mission to ensure that appropriate and adequate resources are made available to the particular Health Establishment to discharge such mission."

[217] That is to say, a culture of lazy people.

[218] That "in preparation for its new designation, Tembisa Hospital converted the pre-existing section of the Hospital into units that would accommodate Covid-19 patients". He added that at some point they opened two new wards over a period of two weeks to manage the pandemic and says that is not reflective of a culture of lazy people.

[219] Record p 391 at para 19 of the letter.

period of two weeks,[220] established joint committees[221] to deal with a looming pandemic.

194. According to the first appellant, all staff members were receptive to the imminent changes, the new way of work and volunteered to participate in interventions like screening of all incoming patients often reporting for duty at 05:00am instead of 07h00 am and 07:30am. The respondent was referred to an article that allegedly captures the massive sacrifices that most staff members faced during the pandemic by Dr Portia Ngwata, Head of Department of Internal Medicine, where she said, "I'm so busy I forgot to buy food for home".[222] The first appellant wrote:

> *"Moreover, if the situation was as the doctor explained in the article, how "much blame would you place at the doorstep of the clinicians on certain poor performances. This is the balance we call upon the [respondent] to strike when assessing the individual submissions that are possibly implicate in the report."*[223]

195. The findings of a culture of lazy people, the first appellant states in the responding letter, stands as a sharp insult, in the face of great sacrifices that health workers and support staff had to endure at the hospital during the pandemic.[224] And says that is not reflective of a culture of lazy people in the

---

[220] Id.

[221] Id at para 20.

[222] Article in TimeLIVE 2020 https://www.timelive.co.za/news/south-africa/2020-08-14-im-so-busy-i-forgot-to-buy-food-for-home-says-tembisa-hospital-doctor

[223] Record p 391 at para 22 of the letter.

[224] Id at para 21.

preliminary report itself that contradicts the finding of an organisational culture that is reflective of *laissez-fare*. The first appellant urged the respondent to reconsider the recommendation regarding the removal of the entire leadership of the Tembisa Hospital as there are no bases for such recommendation.[225]

196. To the preliminary recommendation that a disciplinary hearing be instituted against him, as the accounting officer of the Tembisa Hospital, because he allowed himself to be misled by Dr Ncha,[226] leading to the signing of the reports, the first appellant mentions that there is no rule in the Code of Conduct for the Public Service as contained in Chapter 2 of the Public Service Regulations, 2016 that speaks to a disciplinary charge of this nature, because there is no evidence implicating him in willingness to be misled. He says that there is no evidence that he instructed or permitted any employee during the enquiry to provide incomplete, inaccurate nor misleading information. The first appellant contends that if Dr Ncha indeed wilfully prepared reports she knew were factual inaccurate and misleading "she would have breached the contractual relationship of trust and it was thus unthinkable that he should be held to account for the subordinate's misconduct if he had not instructed or permitted them to provide factually inaccurate and misleading information.[227]

197. The new evidence (concerning the allegation that Shonisani was denied food) was obtained at the instance of and was brought to the attention of the

[225] Record p 393 at para 28 of the letter.

[226] That they were factually "inaccurate and misleading".

[227] Record p 393 at paras 29 read with para 30 of the letter.

respondent by the first appellant. It includes the information contained in the affidavits of patients who were admitted in the same area as the deceased and shared same the cubicle with him at Ward 23. Seemingly, some of the patients complained of unsatisfactory care during the admissions. Therefore, the first appellant states that his mentioning of the contradictory evidence regarding the aspect of food demonstrates that he has not been selective when obtaining the evidence of the patients.[228] This additional evidence of the said patients is mentioned below.

198. The patients include Mr Adjetey Adjei (Adjei) who is alleged to have said that he was admitted on 23, 24 and 25 June 2020 and was "served with three course meals daily". The first appellant states further that Mr Adjei "is the most appropriate person to attest to the serving of food" to the deceased on 25 June 2020 onwards. He writes that:

> *"In any investigation process, a party submits evidence that it considered relevant and material to the investigation. Our submission of a list of officials, together with* ***our pleas to the investigators to obtain statements from patients like Mr Adjei, was merely [disregarded]****. This disregarding of our list has prejudiced our case severely leading to the making of procedurally and substantively unfair findings and recommendations."* (emphasis added)

199. The first appellant also referred to other affidavits including those of Mr Eric Chikwa, Mr benedict Paul Alfred Malele, Ms Sarah Nkwana and Ms Kwena

[228] Id p 394 at para 32 of the letter.

Dorothy Magagula. He denies that the deceased was refused food and states that the hospital does not have an obligation to serve food to patients that are not admitted.[229]

200. The first appellant referred to audio recording of interviews with Ms Ntakadzeni Netshamudzinga (Netshamudzinga), a nurse at Ward 23, and Mr Nono Pela, the Communications Manager. The former attested to her conversation with the girlfriend of the deceased telling the interviewer that the girlfriend had brought a Nondos' meal to cheer up her boyfriend, the deceased, because he was very fond of a Nandos meal. She said that the girlfriend did not complain about his boyfriend not getting food from the Hospital.

201. In another interview of Mr Kenneth Mothapo (Mothapo), a nurse at Ward 23, he told the interviewer that the tweet of the deceased was fabricated. He said that he personally gave the deceased porridge, and the latter ate two spoons and interacted with other patients. He went back to the deceased and asked him to eat. The deceased told him he was going to eat slowly as he was not a big eater.

202. Much of what Mothapo told the interviewer was corroborated by the version of Mr Sikelela Mavuma (Mavuma), who was also a nurse personnel at Ward 23. He attested to a conversation between himself and the deceased where the

---

[229] Id p 395 at para 33 of the letter.

former encouraged the latter to eat to gain strength as he was to be given medication, but the deceased only took two spoons and stopped.

203. Ms Esther Ramoroka, a nursing personnel at isolation area, attested to having been instructed by Dr Gajraj to order food for the patients. She told the interviewer that at that time food was already served to all patients in that department, including those who have been allocated floor beds. She said some ate but others declined their meals.

204. The first appellant responded that there was misinformation about the strike at isolation area. He said that the information was submitted by a certain Mr Mothwane to support the narrative that food was not served to patients in that Department because of the nurses' refusal to work. To disprove his allegation, the first appellant mentioned that he attached letters from the active trade union in the Tembisa Hospital. This evidence, the first appellant tells, appears not to have been considered by the respondent in the draft report.[230]

205. It is said that Mothwane was the Head of Nursing and that whatever might have gone wrong with the nurses he ought to have been held accountable. The first appellant states that Mothwane's evidence ought to have been treated with caution noting that it was provided to the investigator after his precautionary suspension on 28 August 2020. According to the first appellant, Mothwane had a grudge against some of his Exco colleagues and himself. He

[230] Record p 397 at para 36 of the letter.

had, seemingly, communicated on his social media accounts that he was bound to cause turbulences. The first appellant mentions that Dr Gajraj should also be held responsible as the Assistant Manager for the isolation area if patients were not provided food in his department. His role in the entire debacle, the contention goes, ought to have been scrutinised. Moreover, the first appellant says, none of the said Managers had escalated their experienced challenges to the Exco or himself.[231]

206. Certain concerns are raised about the choice of language used in the report that allegedly casts aspersions on regular process during the investigation: for example, the alleged blemishing of the submission of a list of people that were considered relevant to the case suggesting that the investigation had an ulterior motive. Secondly, that words such as "factions" and "warzone" was dramatization and that their use seemed to, purposefully, paint a grave picture on the Hospital's culture, without allowing the hospital the opportunity to respond to such observations.[232]

207. About the calculations of the hours concerning the complaint, the first appellant states that the respondent was disingenuous because he said the following at para 2 of the Draft Report:

> *"The period is calculated as 43 hours 24 minutes, from the recorded time of admission, however, if one added the 8 hours, 36 minutes since*

[231] Id at paras 36 - 37 of the letter.

[232] Record p 389 at para 39 of the letter.

> *the last meals at 4am at home on June 23rd, this period would total approximately 52 hours of involuntary fasting."*[233]

The first appellant states that no attempts had been made to ascertain from the family and relatives why the deceased had been subjected to involuntary fasting for 8 hours 36 minutes as it was the family that could appropriately respond to that allegation.

208. Further in para 2, so stated the first appellant, the respondent remarked:

> *"Therefore the [deceased's Tweet to the Minister had merit and was found credible. The evidence from the Hospital that meals were provided to [the deceased] was found to be without foundation."* (emphasis added)

209. The first appellant thus stated that on the evidence contained in the recordings of the nursing personnel[234] that worked at the isolation area and who interacted with the deceased, he was satisfied that the information was credible, reliable and consistent to conclude that food was provided to the deceased while at Tembisa Hospital. He urged the respondent to verify this in line with the submitted evidence.

---

[233] Record p 398 at para 40 of the letter read with para 2 of the Draft Report.

[234] Id at paras 41- 42 of the letter.

Preliminary adverse findings and recommendation in respect of the second appellant

210. The adverse factual findings made against the second appellant include the following, that—

100.1 she failed to ensure that critical care equipment at Ward 23 was available and functioning properly;

100.2 she failed to complete the Morbidity and Mortality (M&M) forms timeously;

100.3 she provided multiple different versions of when the first set of pictures was taken;

100.4 she claimed to have provided only line listing items to Dr Ncha for the 3 reports/letters, while she provided more; and

100.5 she assisted Dr Ncha prepare reports that were found to be inaccurate.

211. In relation to the second appellant, the Ombud recommended as follows:

> *"9. The Gauteng Department of Health and [Tembisa Hospital] should institute disciplinary inquiry in accordance with prevailing policy and compatible with the Labour Relations Act, constituted of a senior medical doctor and a senior nurse jointly chaired and with experience in disciplinary enquiries against the following staff members:*
>
> *"(i) . . .*

> *(iv) Dr Ncha: She provided the CEO with distorted and false information by drafting letters that were factually incorrect and misleading …. She was assisted by Dr Ngobeze to create these falsified letters. …*[235]
>
> *v) Dr Ngobese: For failure to ensure that critical care equipment at Ward 23 was available and functioning properly; for failure to complete the required Morbidity and Mortality Template from; for evasive responses; for assisting Dr Ncha preparing falsified Reports to the former MEC and the Health [Ombud]. She was an indirect party to the 'administrative bungle' found in these records."*[236] (emphasis added)

It was recommended further that the staff members including the second appellant be reported to the HPCSA or the nursing Council.[237]

The second appellant's response to the preliminary adverse findings

212. The second appellant was interviewed three times during the investigation. It is alleged that together with the Dr Ncha, they were masterminds of the critical administrative events that took place around Shonisani's case including his file, preparation of reports and worked closely to take charge of him.[238] In the interview with the respondent the second appellant related that she was requested to assist in heading the COVID-19 Unit due to her experience in

[235] Draft Report p 95-6 at para (iv).

[236] Id p 96 at para (v).

[237] Id p 97 at para 10.

[238] Id p 16.

infectious diseases.[239] In her response[240] to the Report she explains that she did not physically manage patients as that was not in her scope of practice. That responsibility, the explanation goes, was left to the adult internal Medicine doctors.

213. Responding to the allegation in para 2 of the Report she states:

> "*It is a well-known fact that due to the overwhelming number of COVID-19 patients*, *hospitals had to adjust and prioritize and accommodate COVID-19 patients. Several hospitals in the public and private sector had to enlist the help of other specialities other than internal Medicine to assist in the caring of the COVID-19 patients."*[241]

214. Regarding the finding that both her and Dr Ncha "were Masterminds" of the critical administrative events she states, among other things, that making such a statement is—

> *"defamatory in character and with absolutely no reason." because it implied that they had spoken before the investigation and decided that they were going to make a conscious decision to be deceitful.*[242]
>
> *. . . personal and vindictive. This statement has no basis whatsoever and those that have made the statement need to issue an apology unless if it can be proven without a shadow of a doubt that I was truly*

[239] Id p 26.

[240] The response (reflected in the Record at pp 401 to 440), seems to have been drafted on 30 October 2020 but electronically signed on 11 November 2020.

[241] Response p 5 at para 5.2.

[242] Response p 5 at para 7.

> *being malicious in my involvement of COVID-19 at [Tembisa Hospital.].”*[243]

215. The second appellant referred to communications via emails between herself and the respondent. The first email referred to in her response is lengthy however much of its contents – quoted below – bear mentioning. She states that she refers to the emails to refute the allegation of them being labelled “masterminds”. The emails, she says, also demonstrated that there was no need to hide the [missing] notes. She mentioned that her email was not intended to hide anything but instead was crafted with the intention to assist the hospital with a medico legal issue. The email was forwarded to the first appellant and other Clinical Managers at Tembisa Hospital. It read:

> *“I am grateful for the opportunity …to head COVID at [Tembisa Hospital]. …*
>
> *Having said that I really feel like I am fighting a losing battle. From the very beginning trying to get people to assist in the hospital has been a huge challenge. The very department to which COVID actually belongs is not taking any responsibility. I have just come from a meeting with Dr Vinasethamby and she says the department of Internal Medicine is struggling to even cover their own unit. But bearing in mind that 99% of the patients in the PUI area [the Casualty Isolation] are presenting with an Internal Medicine related pathology. … I am grateful that they allocated a consultant to do a round every day…. EVERY hospital in the world, COVID is being managed by the department of Internal Medicine.*

[243] Id p 15 at para 8.7

Today we are supposed to have 2 doctors on call for COVID. The one is internal medicine, but she has to see 39 patients by herself excluding the patients that are coming in and it is not yet even midday. She too is going to get burn out by the end of this week if nothing gives.[244]

We have 12 patients in casualty, some have been there since last night. Male and female. There are 13 patients in ward 23 which means we have 3 beds. … And still at midday they have not yet been moved. The reasons being given range from: 'the ward is full' (which it is not), to 'sisters are busy'. …

Every time you hear stats you LITERALLY have to go and triple check yourself because FULL is NEVER full, EVER.

It feels like one is a policeman constantly checking up with people.

There is a patient who demised in casualty in the morning, at 11:00 the patient was still occupying a bed.

… Till to this day we are still struggling with the issue of what is PUI… Looking at patient notes its clear that there is no pride in what we are doing, just scribbling something so that there is something on the paper. Forgetting that his is a medico legal document. We don't talk to our patients. They are discharged with some of them not even knowing what is wrong with them. Let alone when a patient dies …families are sent from pilar to post to find out what happened to their loved ones.

. . . I was told of the email of one of the [casualty Isolation] doctors writing that we are compromising the safety of fellow health care workers … and the person is right. One cannot be walking up and down in PPE that is potentially contaminated. But having said that it is

[244] Id p 6.

a challenge because there are <u>no proper facilities to don and doff properly . . .</u>

I get that I am ID, but I am paeds ID. The challenge are being faced have nothing to do with ID. The very patients I am supposed to care for I cannot because I [am] wanted elsewhere I cannot even say what is happening in paeds regarding COVID, but I call myself paeds ID. Instead, I am being phoned because MO's [Medical Officers] have not filled in Death notices and alive patients are lying in the same room as patients that have died. I am being phoned because there is only one person on call I am being phoned because nursing staff want to be swabbed on weekends after being told that they would be seen on Monday.

The biggest challenge here is that THERE IS NO TEAMWORK. At all. . . . There is no communication between nurses and doctors, nurses and nurses, doctors and doctors. Management and nurses, management and doctors etc, communication is literally a 'unicom.'

<u>When it comes to work, I do not like complaining. I just work. It's in my DNA. I love my work. I do it for my patients. And that is why I did peads. They keep you busy but you can actually see them recover. Also, I am supposed to be preparing for my exams, I cannot even do that properly because by the time I get home I am super exhausted. I am on call for covid daily including the night. And I haven't complained because</u> I really belied that covid unit was my baby. And I wanted to take care of it. But from where I am standing right now, it really feels like I am doing more harm than good.

I really feel that COVID should be run by someone with Internal Medicine background for many reasons but mostly because the patients being seen are adult patients. It sounds like I am giving up, but it really is not that at all. I think that I have contributed what I can. And I genuinely do not mind assisting. …But at this rate I am not gong

[to] make it. I do a lot and I was not even asking for compensation. But it may seem like my good nature has come back to haunt me.'' (emphasis added)

216. According to the second appellant, the contents of the emails represented the situation at Tembisa Hospital "at the time" (as at 22 June 2020 and just a day before Shonisani was admitted). The situation is said to have been dire and the morale of the entire staff was down. According to the second appellant, the last two weeks of June 2020 and the first two weeks of July 2020 proved to be their most trying period as the surge in patients, that had been experienced, was unprecedented. She explained that they however continued working, to try to give the patients the best care. She explained in her response that following the email she was called to the Executive Suites to discuss the email together with Dr Mbeleki (the Clinical Manager of Internal Medicine) and Doctors Vinasethamby and Shabangu who are consultants in the department of internal medicine. She needed to describe exactly what assistance was required from the department of Internal medicine.[245] She mentions that after the meeting she drew up a document of guidelines/list of requirements that she sent to Doctors Ncha, Ninasethamby and Shabangu on 23 June 2020.

217. The document was also sent to Dr Naidoo (Specialist Internal Medicine and Dr Rajan (Specialist Emergency Medicine) to get their opinions. This document,[246] entitled "*ROLE OF TPTH COVID DOCTORS and CLINICAL*

[245] Response p 9 at paras 81- 82.

[246] Correctly dated 23 June 2020 and evidently compiled by the second appellant.

ASSOCIATES" is attached to her response. The second appellant dealt with role of the internal medicine Consultants, Morbidity and Mortality, Ward consultants, duties of the clinical associates, labour Wards or any other wards other than dedicated COVID-19 Wards, duties of the MO/Reg, and extras including documentation.

218. Concerning the files and missing notes, the second appellant states that she had requested the respondent and the investigator to conduct an inspection *in loco* to see how the process of scanning and printing of files took place. She said that she was aware that they had already been at the hospital to see the process, but she made the request to get clarity on how pages of notes could potentially go missing during scanning. She was adamant that she had not misplaced the notes. Her request, she said, was rejected because the respondent and investigator said they had no interest in going to the hospital again. The second appellant then questions the fairness of the investigation, stating:

> *". . . If this investigation had been fair there would have been no hesitancy in seeing the process again. However, their declining to see the process raises a concern why they refused and what is it that they were afraid of finding out? Their refusal suggested to me that they already made up their minds that I was guilty and there was no interest in trying to prove otherwise."*

219. The second appellant mentions that on 21 October 2020, the respondent addressed an email to her and Dr Ncha. In the email mention is made, among other things, that:

"We have now established the following facts with regards to [Shonisani's] investigation:

1. On the morning of the 30th of June 2020, [second appellant] took pictures of [Shonisani's] file in Ward 23;

2. On the 30th of June 2020, Mr Sfundo Mtembu, took [Shonisani's] file from Ward 23 for scanning at lunch time: the file was scanned at 14h34;

3. The scanned file missed Drs Molehe and Shabangu'd notes of the 28th of June 2020, it was identical to the file forwarded to my office;

4. On the Morning of the 1st of July 2020 [second appellant] went to the Mortuary to take a second set of pictures of [Shonisani's] file;

5. Suddenly, this missing page of the 28th of June re-appeared on the pictures taken by [the second appellant] later forwarded to Dr Ratau-Dintwe and [the investigator];

6. So, for approximately 24 hrs, it would seem [Shonisani's] file missed this page;

7. We have also established that Drs [the second appellant] and Ncha, on 1st July 2020 were 'going through' [Shonisani's] file preparing responses on his incidence;

. . ." (emphasis added)

220. Towards the end of the email the respondent posed the following and what he referred to as the simple questions and asked to be provided with explanations:

"1. How did this single page go missing from the file? Who took this page out of [Shonisani's] file on the 30th June 2020?

2. How did it re-appear in the Mortuary file of [Shonisani] on the 1st July 2020?

3. Which File or files were Drs [second appellant] and Ncha 'going through' in preparing their responses?

4. Where had these file/s come from?"[247]

221. In her response to the respondent's email the second appellant mentions that she has repeatedly stated that she took the pictures of the deceased's file. The reason for taking pictures, according to her, was because the files would be needed at the mortuary to complete the information for the bereaved family so that the deceased's body could be released and taking those files especially if there had been more than one death would have proved difficult for the process at the mortuary. She explains that the picture capturing system was developed by herself to avoid keeping possession of the files and to make it possible for the pictured file to be accessible to anyone who needed it, for example, the Ward clerks who needed the file for scanning.[248]

222. The second appellant mentions that she never used the file directly to get the information. She explains that she did not have the file in its original format but used pictures of the file taken on her cell phone devise. Responding to questions 1 and 2 above the second appellant states that she does not know how the notes of 28 June 2020 went missing and how they re-appeared in the second scanned file. She repeats her request to the respondent to personally "come to see the process of the files being scanned and how it cannot be accounted for what could have happened to the file and also for him

[247] Response pp 16 - 17.

[248] Response p 21 at para 9.8.

[respondent] to appreciate the number of people who would have had access to the file."[249] The second appellant maintains that had the inspection been conducted, that would have demonstrated the falsity in the allegations against her that certain notes were misplaced.[250]

223. Further in her response the second appellant deals with the investigative finding (ad page 28, para 2) that "she was not warned of the urgency of Shonisani's report. She states that the statement has multiple areas of concern, that when she handed over the list of names, she did not mention the names of the deceased in the order of importance, but the names were written in an arbitrary fashion and so the fact that it was number 51 did not signal the order of importance. The statement under question, her explanation goes, assumes that the death of Shonisani was more important than the death of other patients. According to her, that would have been "completely unethical."[251]

224. It appears that the respondent replied via another email sent on 23 October 2020 stating "[w]e have been to observe what happens at records and scanning. Unfortunately, hospital records with missing notes no matter where that takes place do not put the establishment and its staff in good light." This is true. However, given that context is everything, the challenges brought up by the pandemic ought to have been properly considered.

[249] Response p 19.

[250] Id para 8.13.

[251] Response pp 23 - 24.

225. The respondent found that this was a violation of health care protocols and standards by the second appellant.[252] The respondent used this evidence to justify the recommendation. The second appellant's explanation for not completing the report was that she did not get the time to look at the file and complete it. At the time of Shonisani's demise, she elaborated, she was "trying to catch up with the increasing number of patients that had demised, subsequently multiple other patients who had demised to COVID-19 forms (54 forms) could not be completed."[253] Her evidence, not refuted, appears not to have been considered when the remedial action was made.

226. Regarding the statement (at p 29 para 3) on "best practices", the second appellant states that this was not factual but rather the opinion of Dr Dintwe. The fact that it was a practice elsewhere, she mentions, does not define what the correct practice is.

227. As to the findings that Shonisani was only seen by an unsupervised Clinical Associate and not by a Team, the second appellant categorically denies the statement stating that the COVID-19 team had comprised of both medical doctors and clinical associates. The roster was prepared by herself before the department of Internal Medicine took over. The said doctors came from different disciplines in the hospital.[254] Patients were seen by either the clinical

[252] Id p 63.

[253] Id p 27.

[254] For example, the Emergency Medicine, Internal Medicine, Family Medicine which was supported by Orthopaedic and Gynaecology (O&A) and Surgery. She mentioned that the last three did not always assist and the challenge was known by management of the hospital including the

associates or the medical officer due to the increased number of patients but the medical officer on the floor would assist the clinical associates if she had any issues. She says it could not be discounted that they were supervised. Again, the explanation ought to have been considered when the remedial action was made. It was not.

228. The second appellant takes issues with the finding that health risks were posed on Shonisani when he was moved to Ward 23. She says Shonisani had showed that he had COVID-19 before being admitted to Ward 23. It cannot therefore be said that the transfer posed health risks on him. Regarding the expression (in the last para of p 45) that “words fail me here” the second appellant explains that COVID-19 cases increased before Tembisa was designated to keep PIUs. Then, the confirmed cases were sent to Steve Biko. In the middle of June 2020 however, and the beginning of July there was an indescribable increase in the number of confirmed cases and Tembisa Hospital was unable to transfer patients to Steve Biko as it was also experiencing an overwhelming number of patients. As a result, Tembisa Hospital was forced to keep the patients together such that the patients did not sleep outside or that they were kept in tents and were not well incubated or well equipped. She points out that nobody denies that the circumstances were not ideal.[255]

---

first appellant. Patients were seen by either the clinical associates or the medical officer due to the increased number of patients but the MO on the floor would assist the clinical associates if she had any issues. She says it could not be discounted that they were supervised.

[255] Response p 27 at para 16.

229. Regarding the finding that Ward 23 was not equipped and ready with intubation equipment, the second appellant contends that the statement is untrue because the patients in Ward 23 were intubated even before Shonisani was admitted at that Ward. Each nursing shift, she explains, had a duty to check the emergency trolleys for the ward to avoid having to fetch equipment from another ward. She says the failure should be attributed to the nursing manager who ought to have ensured the nurses were up to par with the standard which she, as the nursing manager expected.[256] There is no evidence to refute the second appellant's explanation. To that end, the adverse factual finding cannot, in my view, stand and the remedial action should thus be set aside on this aspect alone.

230. As to the finding that "there were no blood gas machines in the Ward" the second appellant says the number of blood gas machines in the hospital was inadequate, never mind just the isolation area. As a result, clinicians had to walk around to get a blood gas machines that were properly functional. According to her, there was a blood gas machine placed in Ward 23 and that there were also challenges previously with machines which had been reported to the clinical engineer and the challenges had been addressed. She explains that to say that there were no physical blood gas machines in the ward is misleading.[257] In my view, the investigation should have obtained evidence to test the response by the second appellant. None was. It follows that in the

[256] Response p 28 at para 17.

[257] Response p 28 at para 18.1.

absence of reliable contradictory evidence in this regard, the adverse factual finding to support the recommended remedial cannot stand.

231. The finding about protocols and standards violation by the second appellant (at para 63) is denied as being false. She repeats her explanation at paras 9.1 to 9,8 of her response. Regarding the failure to report the loss of notes to the CEO, she states that she did not know precisely what to write and she had no such experience hence she enlisted the assistance of Dr Ncha who had already started preparing the report when she showed her the pieces of paper containing information that she (Ngobese) had compiled. She states that she was not aware the first appellant had not been informed about missing notes as she had reported the missing notes on the pieces of paper she had written to her immediate superior, supposedly Dr Ncha, who compiled the report.[258]

232. Regarding the exclusion of the Quality Assurance Unit the second appellant denies having been involved in the said exclusion. She specifically said she was "not aware that the QA was deliberately left out."[259]

The Final Report

The remedial action recommended against the first appellant

[258] Id p 30 at para 22.2.

[259] Response p 15 sub-paras 8.8. and 8.8.1.1

233. The Final Report identifies several issues and the role played by different staff personnel including the appellants. The Ombud made many findings of fact and recommendations. Explicit from the investigative evidential material, factual findings and recommendations mentioned above, the Final Report identifies several problems, including the alleged role played by certain medical officers and nursing personnel at Tembisa Hospital. For this judgment, I focus on the adverse factual findings and recommendations, first, in relation to the first appellant and, later, in relation to the second appellant.

234. The respondent made the following factual findings and recommendations as regards the first appellant that are at variance with the adverse preliminary factual findings and recommendations in the draft report.

124.1 Presiding over "such a state of affairs".

124.2 Presiding over a hospital that on two separate occasions could not provide Shonisani food for prolonged periods as identified in the report.

124.3 Presiding over a health establishment that provided negligent care.

124.4 Presiding over a health establishment that showed poor record keeping.

124.5 to report missing clinical notes to the SAPS as is required by law.

124.6 Failing to report the missing doctors' notes of 23-25 and 28-30 June 2020 to the SAPS for loss or theft.

Adverse factual findings against the second appellant

235. Below, the recommendations and evidence relied upon by the respondent are dealt with, *seriatim*. The second appellant was found to have assisted in the compilation of inaccurate report to the first appellant. It will be recalled that the Report itself repeatedly states that the three reports were prepared and authored by Dr Ncha and signed by the first appellant.[260] The finding is confirmed at p 22 of the Record by the respondent. The respondent seems to have relied on the handwritten notes by the second appellant to conclude that she assisted in compiling the inaccurate reports. This is based on p 120, last paragraph, of the Report. Also see first paragraph of p 120 where the following appears:

> *"Dr Ncha was aware that the hospital's Standard Operation Procedure for ordering patient's meals was terminated in April by Ms Mtwesi and was not adhered to, but she failed to be truthful about this deviation. …"*

236. In relation to the finding concerning the various versions when the first set of pictures was taken on 30 June 2020, the respondent relied on the three interviews he had with Dr Ngobese in arriving at this conclusion. On 6 August

[260] Page 111, last para.

2022 Dr Ngobese was questioned by the Ombud and an investigator about the exact time at which she took the pictures.[261] She responded, according to the Final Report, stating that she could not determine the exact time at which the pictures were taken because the original pictures had been deleted from her cell phone.

237. On 14 October 2020, in response to an email from the Ombud about when the pictures were taken, the second appellant stated that she could not recall when the pictures were taken but that it was in the morning before 11.[262] The respondent found that Dr Ngobese's response to the Draft Report also contained a different response to this question of when the pictures were taken on 30 June 2020. Dr Ngobese had stated that the pictures were taken at 12h04 on 30 June 2020 in her response to the Draft Report. She knew this because she realised later that she had a screenshot of a picture that depicted time at which the original pictures were taken.[263] The respondent states that this new evidence was inconsistent with the earlier evidence given by Dr Ngobese on 10 July 2022 wherein she asserted that the pictures were taken around 09h00.[264]

238. The second appellant is found to have said she provided line listing items when she, in fact, provided more than that to Dr Ncha for the compilation of the

---

[261] Report p 126 at para 3.

[262] Ibid last para.

[263] Ibid p 127 at para 1.

[264] Ibid.

reports that were eventually signed by the first appellant. It is unclear which evidence justified this finding. The respondent found the notes compiled by Dr Ngobese on pieces of paper for Dr Ncha in preparation of the reports to be contradictory. The interview record between the Ombud, investigator and Dr Ngobese shows that on 18 August 2020 the investigator conceded to having seen the piece of paper containing information that was provided for Dr Ncha by the second appellant.

239. Based on her evidence shouldering the responsibility as the Head of the COVID-19 Unit, the second appellant was found to have failed to ensure that critical care equipment was available.[265] The interview record confirms that Dr Ngobese did state that it was her duty to make sure that the Unit had functional equipment.

240. The second appellant, who is said to have been responsible for completing a COVID-19 Morbidity and Mortality Reporting Template, completed the form on 10 August 2020 (and was assisted by Dr Ratau-Dintwe) after it was requested by the respondent on 9 August. Evidence reveals that she shouldered the responsibility for the delay of 41 days in completing the form. The Ombud finds that this was another serious violation of Health care protocols and standards by the second appellant.[266]

[265] Report pp 124-125.

[266] Record p 97 under 10.3.

The Remedial action recommended against the second appellant

241. The following remedial action was recommended against the second appellant:

> *"10. The Gauteng Department of Health and TPTH should institute disciplinary inquiry following prevailing policy and compatible with the Labour Relations Act; constituted of a senior medical doctor and a senior nurse, jointly chaired, supported by a senior legal Counsel with experience in medico-legal matters and with experience in disciplinary enquiries against the following staff members:*
>
> (i) . . .
>
> *(vi) Dr. Ngobese: For failure to ensure that critical care equipment at ward 23 was available and functioning properly; for failure to complete the required Morbidity and Mortality Template form timeously; for providing multiple different versions of when the first set of pictures were taken on the 30th June 2020; for telling that she only provided listing items while she provided additional information including handwritten notes and noticing that doctor's notes were missing; for assisting Dr. Ncha in preparing Reports to the former MEC and the Health Ombud that were found to be inaccurate; She was an indirect party to the administrative bungle found in the records."*

It is against this entire background, including the adverse findings and recommendations, that the issues raised in this appeal will be considered.

Issues for determination in respect of the first appellant

242. Following the Final Report, the first appellant filed a notice of appeal challenging the factual findings and recommendations adverse to him. The preliminary question that arises from the grounds of appeal and the submissions is whether there was a complaint and, if so, whether the respondent—

132.1 exceeded the bounds of his mandate during the investigation;

132.2 made irrational factual findings and recommendations;[267]

132.3 selectively disregarded evidence placed before him and made findings which are contrary to the evidence;

132.4 made unreasonable findings; and

132.5 gave first appellant a fair hearing and the opportunity to question witnesses who gave adverse evidence against him and his colleague.

Determination of the issues raised by the first appellant

(i) Complaint

243. The apparent acquiescence in para 62 of the first appellant's written submissions that "[t]he complaint was that [Shonisani] was not fed for 48-hours",[268] shows that there was a complaint. Although the first appellant

[267] Notice of appeal p 3 at para 6.2.

[268] Written submissions at paras 62 and 65 read with para 15 of the notice of appeal.

suggests that he was not given a copy of the complaint[269] he does not use this as a ground regarding the absence or otherwise of the complaint. Nothing therefore turns on that submission. Plainly, there was a complaint. What then remains to be determined are its parameters, whether the respondent exceeded his powers when carrying out the investigation.

244. Regulation 42 empowers the respondent to investigate a complaint in accordance with the procedure he considers appropriate in the circumstances of the case.[270] He may make such enquiries as he deems fit in line with the applicable legislation. Consistent with his powers, the respondent distilled the complaint into three components: (1) unbearable problem; (2) care and (3) 48 hours.

(ii) Did the respondent exceed his mandate?

245. The first appellant remains steadfast that the complaint was limited to the allegation in Shonisani's tweet – of not having been fed for 48 hours. Interestingly, even during his interview with the respondent, the first appellant

[269] Written submissions at paras 63 - 67.

[270] Procedural Regulations pertaining to the functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, 2 November 2016, Government Gazette No. 40396.

maintained that the nature of the investigation should have been confined to food and not the overall care of the deceased. Reliance for this submission is placed on the tweet itself. It is contended that the respondent thus inquired into issues he was not mandated to inquire and make recommendations on.

246. The Constitutional Court has confirmed that the scope of the investigation is determined by the complaint[271] hence the need to examine it but same need not be scrutinised as if it is a pleading.[272] The respondent seeks to distinguish this case from the present matter suggesting that in respect of the former the Constitution empowers the Public Protector to take appropriate remedial action and that in respect of this matter, the Ombud's powers are limited to making recommendations not binding on anyone. The first appellant is correct that this distinction is artificial because the Ombud must still act in accordance with the law. In any event, the binding effect of the Public Protector's remedial action and the non-binding effect of the Ombud's recommendations are not in issue.

247. It is also important to have regard to the enabling provisions of the Health Act, section 81A(1) read with Regulation 33 of the Procedural Regulations Pertaining to the Functioning of the Office of the Heath Standards Compliance Handling of Complaints by the Ombud.[273] Section 81A(1) only allows an investigation by the Ombud on receipt of a written or verbal complaint relating

[271] *Public Protector and Others v President of the Republic of South Africa and Others* [2021] ZACC 19; 2021 (9) BCLR 929 (CC); 2021 (6) SA 37 (CC) at paras 11 and 101.

[272] *Public Protector v Mail & Guardian Ltd & others* [2011] ZASCA 108 [2011] para 32 read with para 31 (*Mail & Guardian*).

[273] Government Gazette No 40396 (Regulations).

to the norms and standards or on own initiative after which she/he may consider, investigate and dispose of the complaint in a fair, economical and expeditious manner. The powers of the respondent to investigate were therefore appropriately triggered by the Minister's complaint and request for the investigation.

248. The first appellant's submission that the respondent "went beyond the mandate of the investigation that he was asked to conduct" is wrong.[274] This is so because the complaint was from the Minister and not Shonisani. The tweet did not constitute a complaint in terms of the Health Act. It was simply a tweet addressed to the Minister. The Minister's complaint, based on the newspaper article, was about more than just food. In any event, even if the tweet itself constituted a complaint, which it was not, the tweet expressly refers to more than just food deprivation: it states that "problems …at one of your facilities" that "continues"; were "becoming unbearable" as "they don't seem to care" and he, Shonisani, hadn't eaten for "48 hours." So, "problems", "care" and not having "eaten" were mentioned in the tweet.

249. It bears mentioning also that the Ombud is located within the Office of the Health Standard Compliance[275] whose functions, through the Ombud, is to investigate complaints relating to breaches of prescribed norms and standards in terms of section 79(1)(c). The Norms and Standards referred to are

---

[274] First appellant's submissions p 7 at para 13.

[275] Section 81(3)(b) of the Health Act.

applicable to distinct categories of health establishments.[276] These Norms and Standard provide for access to care,[277] keeping of records by a health establishment,[278] clinical management,[279] medical equipment which must be available and functional in compliance with the law,[280] and a functional governance structure and waiting times[281] among others. More importantly, the Norms and Standards seek to promote and protect the health and safety of users and health care personnel.[282]

250. Consequently, based on the complaint, inclusive of the tweet read with the relevant Regulations and provisions of the Health Act, the respondent did not exceed his powers.

(iii) Rationality of the adverse factual findings

251. According to the first appellant, one such irrational finding relates to Shonisani not being fed for 48 hours on 23 and 24 June 2020,[283] because the factual

[276] Government Gazette No. 41419. GN 67 of 2 February 2018.

[277] Regulation 5(1).

[278] Regulation 6.

[279] Regulation 7.

[280] Regulation 13.1.

[281] Regulation 22.

[282] Regulation 3. This is somewhat similar to the object of the Office of the Health Standard Compliance (section 79(a) of the Health Act) of which the Ombud is part.

[283] Notice of appeal p 7 at paras 6 and 21 read with the written submissions p 23 at para 68.

finding is not connected to the information which served before the respondent. This necessitates the assessment of the evidence that served before the respondent when making the finding and recommendations.

252. In determining whether Shonisani was fed on 23 and 24 June 2020 the respondent states that the critical determining factor was to ascertain the time at which he arrived and was admitted. The respondent found that he was triaged by a nurse at 11h18 and thereafter by Dr Pawson at 11h40. The doctor advised that he be admitted. Shonisani was registered in the hospital system at 12h28 and was admitted to a bed in the isolation area at 12h36 as a PUI.

253. The respondent then dealt, among other things, with the complaint by Shonisani that he was not fed. It is stated that "[o]n Wednesday, 24th of June 2020, betweenhood and 12h00 noon, Shonisani reported to his father that 'I am very hungry get me some food' and 'I have not eaten since arriving here.'" The respondent established that Mr Lethole senior took food to the hospital but was not allowed into the Ward, but a hospital cleaner took it and promised to deliver it. According to the respondent the food was never delivered as the cleaner was afraid to enter the isolation area.

254. The respondent rhetorically quizzed:

> *"It beggars belief as to why a* responsible young man such as [Shonisani] would send a tweet to the National Minister of Health, call his parents on the 24th June 2020 around midday that 'I am very hungry and get me some food' and 'I have not eaten since arriving

here' and tell his girlfriend that he has not eaten*! Why would he do this?"* (Emphasis added.)

255. Afterwards, the respondent dealt with the hospital's response to the allegation of not eating for 48 hours and mentioned[284] that the first appellant had conceded during the interview to the shortfall of the staff not adhering to the prescribed procedure for food ordering and distribution. The respondent mentioned the evidence of Dr Ncha (relying on the incomplete nursing notes by Nurse Bertha Sokana who told the investigator that food was ordered on the 24th) that Shonisani was offered lunch on 24 June 2020. Nurse Sokana's evidence was rejected as false because there was no completed and signed Bed/Diet list.

256. The respondent then concluded that "in the absence of evidence to prove that breakfast, lunch and supper were ordered, reached the end user, as well served to [Shonisani] on the 24th June 2020, it had to be accepted that [Shonisani] received no food."[285] This conclusion is repeated elsewhere numerously in the Final Report.[286] As will be demonstrated later, this approach and conclusion are incorrect. Investigations ought to reach conclusions on the presence of evidence and not its "absence". Besides, an investigator must keep an open mind to reach whatever conclusion justified by the facts.[287] If

[284] Final Report, Record p 54 at para (f).

[285] Final Report, Record p 55 at para (m).

[286] id p 60 at first para and p 61 at last para.

[287] *Mail & Guardian*, above n 272 at para 140.

not, an improperly conducted investigation is bound to result in findings not supported by facts.[288]

257. It is well-established that the process leading to a decision and the decision itself must be rational. Rationality thus includes an evaluation of the process followed in arriving at the decision.[289] The respondent's seeming spontaneous approach and/or point of departure, that Shonisani did not eat for 48 hours is wrong because, from the evaluation mentioned above, he seems to have accepted as truth the very complaint he was investigating – without first dealing with all relevant evidence to justify whether the complaint must be accepted as a proven fact.

258. In *Mail and Guardian,*[290] the SCA considered whether the investigation was conducted in a proper manner following a review application to have the subsequent report by the Public Protector set aside. The Court held that "[t]here is no justification for saying to the public that it must simply accept that there has not been conduct of that kind only because evidence has not been advanced that proves the contrary."[291] Corroborative evidence ought to have been proven by the investigation. It was not! The remarks and principles in *Mail & Guardian* apply with equal force to the investigation by the respondent as the respondent, similarly to the Public Protector, sources his powers to

---

[288] Id.

[289] *National Energy Regulator of South Africa and Another v PG Group (Pty) Ltd and Others* 2019 (10) BCLR 1185 (CC) paras 49 and 50.

[290] Above n 272.

[291] Id at para 19.

investigate from legislation. Here, the respondent seeks to suggest that the public should accept that Shonisani was not fed for 48 hours simply because of the absence of proof by the Hospital to the contrary. In essence, this is what the Supreme Court of Appeal cautioned against.

259. The approach to the myriad of evidence in the record regarding the aspect of food and the factual finding – that there was no evidence to prove that breakfast, lunch and supper were ordered, reached the end user and Shonisani – are concerning: Such approach and finding presuppose that the onus or burden of proof rested on the hospital/appellants to present evidence proving that food was served, was neither legally tenable nor fair on the part of the hospital and/or the appellants. This is so because the approach is tantamount to a reversal of onus. In any event, the approach is contrary to what the respondent had undertaken that his role in the investigation will be guided by the facts and the report of the expert managing COVID-19 patients in critical care will be included in the Draft report to enable him to identify the discrepancies and hone in on the identified issues.

260. Besides, even if the hospital or the appellants bore such onus, additional evidence from relevant parties was not sought. The additional evidence in the form of sworn statements obtained at the instance of the first appellant was not considered when making the final adverse findings and remedial action. The first appellant's gripe in this regard, specifically regarding issues mentioned above, is that the respondent selectively considered the evidence thereby disregarding relevant one. He mentions that the uncovered evidence

was to assist in demonstrating the irrationality, unreasonableness and unfairness of the adverse factual findings and recommendations. The first appellant raised concerns regarding the fairness of the process when he responded to the Draft Report, mentioning that their "submission of a list of officials, together with our pleas to the investigators to obtain statements from patients like Mr Adjei, was merely [disregarded]. This disregarding of our list has prejudiced our case severely leading to the making of procedurally and substantively unfair findings and recommendations." Already at that stage, according to my observation, the statement was red flagging unfairness or a perception of bias.

261. In fairness to the respondent, I hasten to mentioned that the uncovered evidence was not part of the investigative material when the Draft Report was finalised because the investigator allegedly refused to consider the list of the persons she was requested to interview. As a result, the evidence of certain witnesses, for example, Adjei-who shared a cubicle at the Isolation area with Shonisani, Mr Mothapo and Ms Ramoroka, was not considered. Self-evidently, that casts doubt on the correctness and rationality of the factual finding and conclusion that Shonisani was not fed for 48 hours. Moreover, it is unclear from when precisely the said period of 48 hours (on 23 and 24 June) is said to have commenced.

262. The evidence considered by the respondent when dealing with the "[Tembisa Hospital's] response to the allegation of not eating for 48 hours,"[292] apart from the evidence of Mr Lethole senior and his girlfriend, i.e. what they were told by Shonisani, was that of the enrolled nurse, Ms Bertha Sokana. According to the respondent she testified and maintained that Shonisani ate at 14h00, which according to the respondent gave "credence to the nurse's progress notes". The respondent nonetheless rejected Ms Sokana's evidence as being unreliable because the Bed/Diet list form she had relied upon was incomplete and because lunch was not served at 14h00.

263. In the executive summary the respondent made additional factual finding that Shonisani was not fed for 48 hours from 23 and 24 June 2020 (while at Isolation area for the first 43 hours 24 minutes (until 25 June 2020 at 08h00 when at Ward 23) and that the total period for involuntary fasting allegedly spanned 52 hours.[293] There is simply no evidence on the Record to support this proposition. The respondent also found that, since 27 June 2020, the deceased had "never received feeding after he was sedated and intubated at 13h00 until the day of his demise on 29 June 2020 [at] 22h30".[294] There is no evidence to support this suggestion.

264. Much of the evidence procured by the first appellant, including that of Netshamudzinga, Mothapo and Mavuma remained. In any event, the

---

[292] Report, Record p 53, heading at para 2.

[293] Executive summary p 9 at para 1.

[294] Executive summary p 10 at para 2.

respondent had made it clear that the issues of not being provided with food relates only to 23 and 24 June 2020 when Shonisani was in the isolation area. It follows that the factual findings that (i) Shonisani was not given food until 25 June 2020 at 08h00 (when at Ward 23); (ii) the total period for involuntary fasting allegedly spanned 52 hours; and (iii) that since 27 June 2020, the deceased had "never received feeding after he was sedated and intubated at 13h00 until the day of his demise on 29 June 2020 [at] 22h30" are baseless and irrelevant. The unproven factual findings mentioned above are therefore irrational.

265. My Tribunal colleagues arrive at a different conclusion on this issue. They seem to uphold the appeal against the first appellant – for him to face disciplinary action for presiding over a hospital that, among other things, failed **to feed** the deceased on two separate occasions for prolonged periods as recommended by the respondent.[295] The difficulty I have with the majority judgment in this regard is that it reaches this conclusion without referring to any tangible evidence that served before the respondent justifying the conclusion reached by him. In fact, on its own reasoning, the respondent "considered that the circumstantial evidence and probabilities supported"[296] the allegation that the deceased was not fed. Moreover, the majority finds that the respondent "considered that certain circumstantial evidence supported the

---

[295] Majority judgment para 21.

[296] Id para 25.

[likelihood] that Shonisani was not fed."[297] The majority holds that the absence of SOP records recording that Shonisani ate supports "a fair inference for the Ombud to make that"[298] Shonisani was not fed.

266. The majority concludes that the "inference [drawn by the Ombud from the absence of SOP records] accords with the proven fact that Shonisani was not fed and is, in our view, the most readily apparent and acceptable inference to draw."[299] The majority concede, correctly so in my view, that the respondent relied on inferential reasoning to arrive at the conclusion that Shonisani was not fed. This is not how investigations should work. The majority, like the respondent, do not point to any witness or proof as evidence that Shonisani was not fed for prolonged periods. Had such proof been present, the respondent and the majority would be relying on it to justify their conclusion, not the inferences they are relying on. The majority, indeed, recognise that no witness implicated the first appellant therefore the first appellant's section 81A(5) rights to question witnesses implicating him do not arise. If this be so, this recommendation cannot stand because no one implicated the first appellant.

267. While the majority concedes that no witness in particular "*implicated*" Dr Mogaladi[300] they, inexplicably, conclude that the adverse findings are

---

[297] Id para 26.2.

[298] Id para 29.3.2.

[299] Id para 29.3.3.

[300] Id para 37.12.

rational and procedurally fair. They arrive at this conclusion on the basis, inter alia, that the first appellant was "extensively" interviewed on whether the deceased was fed and forewarned through the Draft Report that disciplinary action will be recommended against him. With respect, this approach misses the important fact that the Draft Report did not recommend that the first appellant be disciplined for presiding over a hospital that failed to feed the deceased on two separate occasions. In any event, the information that had been requested during the investigation included "a report on food distribution".[301] Therefore, to say that the first appellant was forewarned, and that the investigation procedure was procedurally fair, is incorrect. The recommendation that the first appellant be disciplined because the deceased was not fed cannot stand, also on this basis alone.

268. I note that the majority also uphold the recommendation that the first appellant face a disciplinary hearing for presiding over a hospital that provided negligent care to Shonisani.[302] However, they "vary" the finding to read that the first appellant must face a disciplinary hearing for presiding over a hospital that provided "substandard care".[303] In any case, there is evidence in the record by

[301] See above para 142.

[302] Majority judgment para 41.

[303] Id.

Nkwana,[304] Adjei,[305] Mothapo,[306] Mavuma,[307] and Ramoroka[308] – that was disregarded – suggestive of the fact that food was distributed at the isolation area and Ward 23.

269. Section 88A (4) (a) of the Act grants this Tribunal power to vary recommendations of the respondent. However, the majority's exercise of this power presents difficulties. The first is that no party made submissions on the varying of the respondent's recommendations and, if so, what the variation should be and to what extent. This is understandable because both appellants only asked for the setting aside of the recommendations.[309] This is the case the respondent defended. The second difficulty is that the variation of the recommendation in this manner means that the first appellant will be hauled to a disciplinary hearing on a charge he has not been afforded *audi* on. Neither the two reports by the respondent nor this appeal afforded the first appellant an opportunity to respond to the allegation or finding of presiding over a hospital that provided "substandard care". Same applies to the majority's variation of the adverse factual finding (for side-lining Quality Assurance) upon which the recommendation to be disciplined was based.

---

[304] Above para 169.

[305] Above para 198.

[306] Above para 201 – 202.

[307] Above para 202.

[308] Above para 203.

[309] First appellant's heads para 234 and his notice of appeal para 4), (second appellant's notice of appeal para 15 and heads para 15).

270. In any event, in my view, the failure by the respondent to include this recommendation on the Draft Report against the first appellant is, on its own, dispositive of this appeal by the first appellant. Even though the Health Act does give the Tribunal powers to vary a recommendation by the respondent, the proposed variation cannot be triggered under these circumstances.

(iv) Procedural fairness (audi)

271. An assertion by an aggrieved party to any dispute that her right to a fair hearing has been infringed raises a fundamental constitutional right that requires procedures which, in any situation or set of circumstances, are right, just and fair.[310] The Constitutional Court, in *De Lange,*[311] has held that at heart, fair procedure is designed to prevent arbitrariness in the outcome of the decision. In an illuminating decision on this aspect, it elaborated:

> *"[t]he time-honoured principle that no-one shall be the judge in his or her own matter and that the other side should be heard [audi alteram partem] aim towards eliminating the proscribed arbitrariness in a way that gives content to the rule of law. They reach deep down into the adjudicating process, attempting to remove bias and ignorance from it. . . .Everyone has the right to state his or her own case, not because his or her version is right, and must be accepted, but because, in evaluating the cogency of any argument, the arbiter, still a fallible human being, must be informed about the point of view of both parties*

---

[310] *Van Huyssteen and Others NNO v Minister of Environmental Affairs and Tourism and Others* 1996 (1) SA 283(CPD) at 304G-H (*Van Huyssteen).*

[311] *De Lange v Smuts NO and Others* [1998] ZACC 6; 1998 (3) SA 785 (CC) at para 131.

> *in order to stand any real chance of coming up with an objectively justifiable conclusion that is anything more than chance… absent these central and core notions, any procedure that touches in an enduring and far-reaching manner on a vital human interest . . . points in the direction of a violation."*[312]

272. The first appellant contends that the investigation was procedurally unfair[313] because he was not afforded *audi* to question witnesses, such as Dr Gajraj, whose evidence implicated him.[314] Section 81A(5) of the Health Act enjoins the respondent to afford any person an opportunity to be heard in connection therewith by way of giving evidence. Such a person is entitled, through the Ombud, to question witnesses who have appeared before the latter.[315] The affected person should be afforded an opportunity to make representation on the adverse factual findings and contemplated final remedial action.

273. The issue of what procedural fairness means in instances where an investigation has led to a preliminary report and later a Final Report with

---

[312] Id.

[313] Notice of appeal p 3 at para 6.5 read with the written submissions at p 42 at para 149.

[314] Written submissions p 30 at para 95.

[315] For completeness and ease of reference section 81A(5) reads:

> "If it appears to the OMBUD that any person is being implicated in the matter being investigated, the OMBUS **must** afford such person an opportunity to be heard in connection therewith by way of giving evidence, and such person is entitled, through the OMBUD, to question other witnesses, determined by the OMBUD, who have appeared before the OMBUD in terms if this section." (Emphasis added.)

Section 7(9) of the Public Protector Act 23 of 1994 imposes the same obligation on the Public Protector when conducting investigations as section 81A (5) does to the Ombud, albeit the wording is slightly different. When addressing the duty of the Public Protector under this section the Constitutional Court emphasized that the affected/implicated person would be afforded an opportunity to make representations on the relevant evidence. Implicit in the language of section 7(9) the Court held, is that the Public Protector should afford the affected person an opportunity to make representations on the contemplated remedial action.

differing recommendations was addressed in the case of the *South African Reserve Bank v Public Protector and Others.*[316] There, similarly with this matter, the Public Protector allowed the parties a right of reply to the preliminary report but failed to do so in respect of the Final Report that contained different adverse remedial action against the affected parties.[317]

274. The High Court held that given the far-reaching nature of the impugned remedial action and the reasonably foreseeable material impact it would have on the Reserve Bank (the affected party) and the stability of the financial sector, it was incumbent upon the Public Protector to have given notice to the affected party of the intended action and to have called for comment on it.[318] In that matter the procedural fairness argument was based on Promotion of Administrative Justice Act[319] (PAJA). Here it is not, but that is of no moment because *audi* applies irrespective of whether we are concerned with administrative action or not. On appeal to the Constitutional Court, albeit the appeal being confined to the award of costs, the Court remarked that the investigative model was "flawed" partly because the Public Protector "failed to engage with the parties directly affected by her new remedial action before she published her final report."

---

[316] [2017] 4 All SA 269 (GP) para 29 *et seq* especially at para 58.

[317] Id at para 35.

[318] Id at para 58.

[319] 3 of 2000.

275. The adverse factual findings and remedial action recommended in the Final Report, as regards the first appellant, are at variance with the adverse preliminary factual findings and remedial action, in respect of which he was somewhat afforded an opportunity to respond to in the Draft Report. I say somewhat because the email from the respondent forwarding the Draft Report to the first appellant did not even inform him that he is implicated and that his response on the implicating findings and evidence was sought.

276. To recap in respect of the Final Report, the respondent found that the first appellant should be disciplined for(1) presiding over (i) such a state of affairs, (ii) a hospital that could not provide Shonisani food for prolonged periods as identified in the report; (iii) a health establishment that provided negligent care; and (2) failing to report missing (i) clinical notes to the SAPS as is required by law; and (ii) doctors' notes of 23-25 and 28-30 June 2020 to the SAPS for loss or theft. These adverse factual findings were not included in the Draft Report. Nonetheless, the first appellant could not have challenged the evidence of Dr Gajraj without being afforded *audi* because the recommendations in the Draft Report against him were not based on Dr Gajraj's evidence. The latter testified about patients complaining about not receiving some meals on 23 and 24 June 2020. The recommendation in the Draft Report says nothing about the first appellant needing to be disciplined for food related issues.

277. Here, the first appellant was afforded an opportunity to respond to the preliminary findings and contemplated remedial action. As mentioned earlier, there is a stark difference between what the first appellant was afforded *audi*

on and the adverse factual findings and recommendation in the Final Report on which the respondent failed to give notice to the first appellant for his comment. The adverse findings should be set aside on this basis alone.

278. What's more, the respondent and the investigator interviewed the first appellant on 23 July and 6 August 2020. The transcript does not reveal that the first appellant was afforded a chance to reply to Dr Gajraj's damning evidence and yet it was relied upon to make adverse findings against the former. It may be argued that Dr Gajraj's evidence does not *per se* implicate the first appellant. While this may be true, it does not take away that this evidence was central to the respondent's conclusion about Shonisani not being fed for 48 hours and then making an adverse finding on that aspect (namely: of the first appellant presiding over a hospital that on two separate occasions could not provide Shonisani food for a prolonged periods as identified in the Final Report).

279. According to the findings in the Final Report "[t]here was no evidence advanced that demonstrated that the loss of these notes was reported to the [first appellant. . . ."[320] However, the respondent finds that the first appellant ought to have reported missing notes to the SAPS when he was not even made aware that notes were missing. The first appellant ought to have been heard before the Final Report was concluded. He was not. On this basis alone the adverse factual findings must be set aside.

[320] Report p 120, last para.

280. Regarding the finding that the first appellant signed inaccurate and misleading reports, it is common knowledge that Dr Ncha prepared and compiled the reports that were eventually submitted to the former MEC, the respondent and the first appellant. There is no evidence in the record showing that the first appellant knew about the misleading nature of the report or that he was a party to attempts to mislead the respondent and others. Absent evidence corroborating that he knew that the reports were untrue, a recommendation that he be disciplined for signing such reports is unjustified and should be set aside too for that reason alone. This recommendation is not justified by the evidence that served before the respondent.

281. The first appellant is said to have side-lined the Quality Assurance Unit in breach of the Gauteng Provincial Circular 22 of 2016. He responded to this factual finding stating that the complaint was dealt with in terms of clause 6.3.2 of the National Guidelines of 2017. While it is unclear which of the two policies should have been applied in the circumstances or which takes precedence, the respondent does not address the first appellant's response. He should have and evidence ought to have been presented on the correct policy. To the extent I could ascertain from the reading of the record, no such evidence was presented. This indicates the weakness in the investigation. The impugned adverse factual finding should thus be set aside too.

282. While the first appellant admitted the shortfall regarding record keeping, he mentioned that there were challenges in the internal medicine department. He said that systems were put in place, but the problem was that "the people did

not apply them." Also, these aspects ought to have been considered when the remedial action was recommended.

283. In the view I take of the matter, it is not necessary to decide the further issues including the question regarding the finding that the first appellant presided over a health establishment that provided negligent care and showed poor record keeping.

284. Accordingly, there is no merit in the respondent's submission that essentially, the adverse factual findings are not binding on the disciplinary enquiry that may ensue. The first appellant is not complaining about what may potentially happen at the recommended disciplinary proceedings. His gripe, given the context, is about being denied a right to a fair hearing as guaranteed not only in the empowering legislation (the Health Act) but also in the Constitution.[321]

285. On this appeal ground of procedural fairness alone, the adverse factual findings and remedial action against the first appellant should not stand. In the result, the impugned recommendation against the first appellant should be set aside. However, this does not suggest that the Department may not, of its own accord, take disciplinary action against the first appellant if it deems it fit.[322] The first appellant has made it clear that nothing prevents the Department from doing so as it has done before, and the statement is not gainsaid. As it

[321] Section 34 of the Constitution.

[322] This is confirmed by the statement of the first appellant in his letter responding to the Draft Report.

happens, the Department does not need the endorsement of this Tribunal to take any such disciplinary action against those it considers having been remiss in their duties, including the first appellant, if it deems it fit under all the circumstances.

Determination of the issues raised by the second appellant

286. There are similarities between the grounds of appeal of the appellants such as whether there was a complaint laid with the Ombud and whether the Ombud exceeded his mandate in how he investigated the complaint. What has been said concerning these two issues above applies with equal force here and, for brevity, need not be repeated.

287. The further issues raised relate to whether the second appellant was denied her right to procedural fairness (*audi*) in terms of section 81A(5) of the Health Act, whether it was violated and whether the adverse factual findings against her are justified by the evidence (rationality). I deal with these issues below when addressing the factual findings in the Final Report.

Was the second appellant's right to a fair hearing violated (audi)?

288. In the main, the second appellant's contentions relate broadly to procedural fairness. She submitted that although the Ombud afforded her an opportunity

to make written representations (which she did)[323] on the preliminary report**,** she was denied an opportunity, among other things, to question witnesses whose adverse evidence was relied upon, contrary to section 81A(5). Supposedly, this related to the adverse findings on various issues including the non-availability and proper functioning of critical care equipment at Ward 23; the timeous completion of morbidity and mortality templates; the second appellant's alleged indirect contribution to an administrative "bungle" found in the records; the alleged multiple different versions of when the first set of pictures were taken on 30 June 2020; the Ombud's alleged acceptance of the investigator's summary of evidence and accusation levelled against the second appellant; and the findings regarding the safeguarding of the patient's files and their contents.

289. The second appellant submits that she was implicated in the reports of Drs Ngwata and Abdullah and that such reports are relied upon by the respondent. She contends further that the Ombud failed to make available to her for comment a report of the Head of Internal Medicine at Tembisa Hospital, Dr Portia Ngwata, that was relied upon in relation to the "*nuanced independent analysis and review of [the deceased's] Clinical Records following the provision of the Health OMBUD's preliminary report*). A similar contention concerns a report compiled by Dr Fareed Abdullah upon which adverse

[323] The preliminary report was shared with the first appellant, for him to share with all those mentioned in it. The second appellant's written representations are dated 30 July 2021.

findings and recommendations were made against her.[324] She submits that her right to lead evidence and question the said doctors was thus infringed. It is doubtful, and the respondent may be correct, that the second appellant was entitled to cross-examine Drs Ncha and Abdullah as the findings and recommendation were not founded on their reports. The second appellant however seems to be concerned about findings and recommendations following the *analysis and review of [the deceased's] Clinical Records*.

290. The second appellant's further submission relates to the refusal by the respondent to conduct an inspection *in loco* for her to demonstrate difficulties relating to the alleged missing notes, record keeping and management during the COVID-19 pandemic. Responding to the Draft Report, as mentioned earlier concerning the files and missing notes, the second appellant states that she had requested the inspection so that the respondent and the investigator could see how the process of scanning and printing of files took place and to get clarity on how pages of notes could, potentially, have gone missing.

291. The second appellant was adamant that she had not misplaced the notes. Her request, she said, was rejected because the respondent and investigator said they had no interest in going to the hospital again. The second appellant then questioned the fairness of the investigation, stating:

> *". . . If this investigation had been fair there would have been no hesitancy in seeing the process again. However, their declining to see*

[324] Written submissions para 4.13.

the process raises a concern why they refused and what is it that they were afraid of finding out? Their refusal suggested to me that they already made up their minds that I was guilty and there was no interest in trying to prove otherwise."

292. The statement and rhetorical question above are telling. Although they cast some doubt on the fairness of the investigative process and of the adverse factual findings on this aspect, one should be fair to the Ombud: he had initially gone to the hospital to see how the scanning works. In the response the second appellant addressed the question raised regarding the suddenly missing notes of the 28th of June 2020 "for approximately 24 hrs." She maintains that had the inspection been conducted, that would have demonstrated the falsity in the allegations against her that certain notes were misplaced. The second appellant contends that the non-compliance with peremptory provisions of the Health Act must be visited with a nullity.

293. The respondent is correct that the second appellant was afforded a chance to respond to the Draft Report that contained implicating evidence. He considered her response when finalising the report and made many adverse factual findings in the Final Report against the second appellant especially, as briefly mentioned above, in relation to her having been "an indirect party to the administrative bungle" supposedly concerning record keeping.[325] The respondent found that clinical records at Tembisa Hospital were not up to

[325] Final Report p 194 at para (vi).

standard and befitting of a tertiary level hospital.[326] At pages 167 to169 of the Final Report the respondent deals with this aspect: He mentions inaccurate reports wherein in the second appellant is said to have assisted Dr Ncha. According to the respondent, “all the inaccuracies were identified, listed, grouped and analysed concerning the provided Clinical Records and the total evidence provided”. The respondent said that “these many inaccuracies could not be trivialised based on pressures of time as no such pressure existed or were exerted.”[327] The Final Report further reflects that the reports, prepared by senior officials in the presence of available Clinical Records in their possession is extraordinary, misrepresented the facts, were misleading and could not represent the truth.[328] The second appellant is said to have provided varying versions regarding the taking of pictures she took of the file. Her version could “not be true and reliable”.[329]

294. The alleged missing note of the 28th are reflected at page 35 of the second appellant’s response to the Draft Report. It is contended that it is objectively impossible for the alleged page to have gone missing. The second appellant questions the admissibility of the evidence of Mr Baloyi that it was impossible to miss a page in scanning. His evidence, the submission goes, ought not to have been accepted.

---

[326] Final Report p 196 at para (xxi)

[327] Final Report p 167 under para (b).

[328] Id at p 168.

[329] Id.

295. The respondent accepts that the second part of section 81A(5) entitles a person implicated to question other witnesses through him. He points out that this indicates that such implicated person may invoke the right by making a request to him. The respondent is correct. However, that does not detract from the fact that the second appellant repeated her request for inspection to uncover the truth about missing notes but same was rejected. One rhetorically asks how then the identified inaccuracies were to be rectified in the face of the rejection! There is no evidence to suggest that what was requested was not going to assist in establishing the truth as contended for by the second appellant. Therefore, in the absence of the point of view of the second appellant or clarity regarding the impugned finding on the incomplete record and/or missing notes, it cannot be said that the adverse factual findings and remedial action were objectionably justified. To uncover the truth regarding the alleged missing notes of the 28th the respondent should have acceded to the request for inspection in loco. Erringly, he didn't. This was important because the second appellant is said to have been an unreliable and an indirect party to the administrative bungle – regarding for example, missing notes and the taking of pictures to provide line listing.[330]

296. Manifest from the remark by the Constitutional Court in *De Lange*, if the arbiter is not informed about the point of view of both parties (not because her or his version is right and must be accepted) and the conclusion is not based on

[330] Final Report p 168.

objectively justified facts, then any procedure that touches on an enduring and far-reaching manner on a vital human-interest, points to a direction of a violation. The impugned adverse factual finding(s) and concomitant remedial action against the second appellant should, on this appeal ground alone, be set aside.

297. The remarks above do not undercut and should not be understood to undermine what the respondent said regarding the importance of medical records, specifically that they are the cornerstone of health care and clinical practice and therefore that the way they are reviewed, monitored, captured and safeguarded is equally important. The respondent further elaborates that—

> *"[r]ecords represent our historical fingerprints as a profession. From these records, healthcare providers undertake research and develop lessons and policies for the future. Recently, Medical Records play[ed] an important role in the evaluation of prescribed norms and standards and in litigation cases. As a profession, we stand or fall by good or poor record keeping or missing records in courts. It is therefore essential that all health professionals pay particular care to the way observations and decisions are carried out and recorded in patients 'notes.*[331]

298. The second appellant also relied on certain provisions of PAJA and sections 33 and 35 of the Constitution to support her contentions regarding procedural

---

[331] Para 7 of the Recommendations p 190.

fairness. In the view I take of the matter it is not necessary to pronounce on the submissions under PAJA and the Constitution.

Rationality – in relation to the second appellant

299. The legal principles relating to rationality of investigations and factual findings have been discussed above. At the risk of repetition, it suffices to restate that rationality also covers the process by which the decision is made. So, both the process by which the findings were made and the findings themselves must be rational.[332]

300. The second appellant asserts that the pandemic conditions were "not properly considered and applied" by the Ombud. The Ombud, on the other hand, submits that the fact that the Final Report is replete with references to the impact of the pandemic on healthcare workers at the hospital is proof that the issue was considered.

301. The Ombud's response misses the point. The second appellant's issue is the Ombud's failure to have "considered and applied" the impact of Covid in his findings and recommendations. This speaks to mitigation. While the Ombud considered this impact, he did not apply it when crafting his recommendations. A straightforward example of this is how the Ombud expected the morbidity

---

[332] *Zuma v Democratic Alliance and Others; Acting National Director of Public Prosecutions and Another v Democratic Alliance and Another* [2017] ZASCA 146; [2017] 4 All SA 726 (SCA); 2018 (1) SA 200 (SCA); 2018 (1) SACR 123 (SCA) at para 82.

and mortality form to be completed "soon" in line with "standard practice".[333] This ignores the fact that the forms cannot be filled in "soon" when patients are dying on a daily basis because of the pandemic. Ordinarily, the forms can be filled in very soon because the deaths are not as high. Another example is how long it will take the hospital staff to remove bodies of the deceased from the hospital wards to the mortuary.

302. The Ombud's finding and recommendations regarding the filling of the morbidity and mortality form cannot stand: All relevant material should have been considered when the recommendation was made.[334] Similarly, the Ombud's finding that the second appellant was untruthful about having provided only line listing items to Dr Ncha cannot stand. It is not supported by a holistic view of the evidence that served before the Ombud. During the interview of the second appellant by the Ombud and the investigator, the second appellant confirmed with the investigator if she (Dr Ngobese) had shown the "piece of paper" with the notes to the investigator. The investigator confirms that she has seen the piece of paper. Dr Ngobese then confirms that "it was that information" that she provided to Dr Ncha, whose initial and sole purpose was to assist Dr Tshabalala with the compilation of statistics of the deceased for such statistics to be sent to the provincial department of health.[335]

---

[333] Final Report p 97, last para.

[334] *Zuma* above, para 82.

[335] Interview record of 18 August 2020 p 64, paras 5 – 15.

303. One wonders on what basis then does the respondent finds that the second appellant was "untruthful" regarding the information she provided to Dr Ncha. There is no evidence on record to support the adverse finding. The second appellant confined her role in the compilation of the reports to providing the hand-written notes. She knew that the investigator had seen the piece of paper with the hand-written notes. That she admitted to providing the piece of paper and everything therein is also corroborated by other interviews between the Ombud and the first appellant.[336]

304. This takes me to another of the respondent's finding and recommendation, that the second appellant failed to make sure that critical care equipment was functioning at ward 23. The respondent found that the second appellant "was aware that the blood gas machine was not functional as it was posted on the WhatsApp" in the Draft Report.[337] The second appellant responded to the Draft Report stating that the WhatsApp group referred to by the respondent was created by her (second appellant) to allow for communication with all people involved in Covid-19 matters. Further, that the WhatsApp group consisted of "top tier management". The Ombud does not respond to this averment by the second appellant. Therefore, that there was some dysfunctional equipment at Ward 23 did reach the second appellant's seniors, through means created by the second appellant herself.

---

[336] Record of the interview of 6 August 2020 p 19 at para 25 continuing into p 20; interview record of 6 October 2020 p 7, line 5. Also see the Second Appellant's response to the Draft Report p 29 at para 22.1.

[337] P 75, second to last para.

305. To make matters worse for the respondent, the Draft Report found that the nurses at Ward 23 did not report the challenges they were facing, such as there being no blood gas machine, to the manager.[338] This finding is repeated in the Final Report.[339] The respondent's findings against the second appellant in this regard is surprising in the light of the finding that the nurses did not report their challenges to her.

306. Lastly, this finding is more surprising considering the email sent by second appellant to her superior, Dr Ncha, on 22 June 2020, complaining of the array of problems faced by the Covid Unit at the hospital. To find that the second appellant failed to make sure functional critical care equipment was available at Ward 23 is irrational. The respondent failed to consider relevant evidence in arriving at his findings and recommendations.

307. The second appellant contends that the respondent ought to have found that she was not responsible for keeping patients' files as this was an administrative issue within the sphere of administrative staff and not the second appellant as a medical doctor. She submits that she had no responsibility of care of patients and thus the respondent ought not to have made findings against her on the issues. Also, regarding the failure to consider that it was established that the notes of the 28th of June 2020 had not gone missing but were written on the

[338] P 60, last para.

[339] P 94, last para.

back of the notes of the 27th of June 2020 and were probably missed in scanning or taking of pictures of the notes by simply not turning the page.

308. It is submitted that the respondent erred in finding that the second appellant had assisted Dr Ncha in preparing inaccurate, falsified reports to the former MEC and the Ombud himself, thereby failing to consider the second appellant's role. Regarding the finding that the second appellant withheld important information from the MEC and the Ombud the second appellant submits that there is no evidence to support this finding in any way. This is correct. The adverse finding in that regard is thus irrational.

309. On the rationality ground alone, the adverse finding and recommendation against the second appellant should be set aside.

Did the respondent consider the impact of COVID–19 when making the remedial action?

310. The second appellant argues that the COVID-19 pandemic was (and remains) a unique and tragic disaster that doctors, and nurses had to deal with under very stressful conditions. It is contended that this aspect was not adequately appreciated by the respondent.

311. There can be no doubt that the emergence of the Covid-19 pandemic happened at a spur of the moment and, indeed, took all and sundry including our government, by surprise. We endured and were left with insufferable

shattering experiences of sickness, hospitalisation and bereavements, especially of loved ones. It is an undeniable fact that nobody, including the state, was ready to tackle the Covid–19 pandemic and this was demonstrated by the happenings at Tembisa Hospital which was in the public eye following the events concerning Shonisani while admitted at that health establishment. In the Report the respondent made it clear that Tembisa Hospital was designated for COVID-19 and yet it was not ready because it was not resourced adequately for the task, not fit for purpose (because of infrastructural defects), was understaffed and lacked highly skilled staff.

312. As the respondent correctly points out, the circumstances under which health care providers were working were therefore difficult.[340] Indeed, the evidence in the record, including the reports[341] and responses of the appellants[342] in this regard, as mentioned in this judgment, confirms this. For brevity, it is not necessary to repeat what has been said in this text. It suffices to mention what is a matter of public notice that many health workers including medical practitioners and nurses as well as administrative personnel in many health establishments, including Tembisa Hospital, sacrificed their lives to give health assistance and care in the best way they could to save life, albeit in trying circumstance.

---

[340] Respondent's written submissions at para 14.1.

[341] Final Report p 23, fourth para and p 74, second and third paras. Draft Report p 9 at para 18, p 12, third para.

[342] Second appellant's response to Draft Report p 4 at para 4.1, p 5 at para 5.2 and p 6 at para 8.2.

313. It is contended by the second appellant that the respondent failed to consider (a) the evidence relating to the huge increase in deaths during COVID-19 and the impact this had on the completion of morbidity and mortality templates; (b) the huge increase in workload during the pandemic which had a dramatic effect on the second appellant's capacity to attend to the said templates, (c) the skills' shortage (specifically that no special training was provided to the second appellant who volunteered to assist in the internal medicine which was not her speciality during the unprecedent and tragic pandemic); (d) the insufficiency of staff to cope with the COVID-19 crisis and (e) to have regard to the evidence of the meeting, which includes that the template forms were placed in strategic places and information placed in WhatsApp groups to ensure that (i) the templates in question were completed by the treating physicians; (ii) where forms were not completed the second appellant would try to complete the forms the following day but that this was an extremely challenging task when COVID-19 related deaths swamped the wards and (iii) that since the second appellant was not the Consultant physician she found it extremely time-consuming and difficult to trace the deaths and collate all the correct information. In my view, it is against this background that an appropriate remedial action ought to have been considered.

314. From the reading of the two Reports, it is apparent that the respondent did realise the importance of the expert opinion on the impact of COVID-19 hence his undertaking that the investigation would be guided by the facts and the report of the expert managing COVID-19 patients in critical care. That

approach was correct. However, the respondent did not, in my view, adequately consider the broad impact of COVID-19 and its mitigative effect when imposing a remedial action against the appellants. What he said on this aspect when dealing with the remedial action was that the Report is replete with references to the impact of the pandemic on health care workers at Tembisa Hospital. This, it is submitted, indicates that the issue was indeed given proper attention by the respondent. Examples are provided to bolster the submission.[343]

315. It is correct that the Final Report is replete with references to the impact of the pandemic. The remarks, in the examples given, were plainly made as part of the evidential material but not as part of the assessment in determining the appropriate remedial action. Despite that the record is replete with references of such impact, the only remark regarding this aspect appears below the rubric "**RECOMMENDATION**" at p189 of the Report and Record, under para 4. In relevant part, the remarks read:

> *"4. The investigation established that [Tembisa Hospital] does not meet the criteria of a tertiary hospital, let alone the mission of a designated hospital for the management of COVID-19 patients. The hospital had inadequate staff, lacked high skilled professional to manage critical and highly intensive requiring patients and had the poor infrastructure for the mission it was designated to undertake. …"*

[343] Respondent's submissions p 64 at para 130.

316. It is unclear how these remarks have been weighed in relation to the remedial action against the appellants. In my view, the respondent merely paid lip service to the evidence of the appellants in this regard and the direct impact of COVID-19 on all the systems of the Tembisa Hospital, all health care workers including the appellants when assessing the appropriate remedial action against them. Erringly, he did not. On this aspect alone too, the recommendations should be set aside.

Conclusion

317. Based on the rationality and procedural fairness grounds of appeal, individually or jointly, the appeals should succeed. This conclusion should however not be understood to suggest that no one should be held accountable when a proper case for such accountability is made. It is difficult to accept a loss of life of anyone through negligence or otherwise, particularly for the bereaved family with profound grief hence anger that often follows in its wake. Even so, what this judgment seeks to convey in the light of the conclusions reached following the determination of the issues on appeal, is that the adverse factual findings and remedial action recommended should be rational and should be right, just and fair. All relevant factors including mitigatory factors should be considered when determining the appropriate remedy.

318. The question regarding who should be held accountable and the extent of such accountability should, in my view, be left for another day. Similarly, this

judgment does not prohibit the Department of Health from taking steps to fix the systemic issues at Tembisa Hospital raised in the Final Report. It neither bars the Department from taking steps to discipline those properly found wanting in upholding a high standard of professionalism.

Order

319. In the event, I would have upheld both appeals and set aside the mentioned adverse factual findings and recommendations against the appellants to the extent that they have been found to be irrational and procedurally unfair.

(Electronically Generated)

____

Nkabinde J

Counsel for the First Appellant: Adv JF Nalane SC	Instructed by Matela Sibanyoni Inc
Counsel for the Second Appellant: Adv AR Duminy	Instructed by McLeod & Associates
Counsel for the Respondent: Adv J Berger	