REPORT OF THE PUBLIC PROTECTOR IN TERMS OF SECTION 182(1) OF THE
CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996 AND SECTION 8(1)
of the Public Protector Act, 1994

PUBLIC PROTECTOR
SOUTH AFRICA

Report No 20 of 2017/18

"Allegations of undue delay by the North West Provincial Department of Health"

REPORT ON AN INVESTIGATION INTO AN ALLEGATION OF UNDUE DELAY BY
THE NORTH WEST PROVINCIAL DEPARTMENT OF HEALTH TO RESPOND TO A
COMPLAINT LODGED BY MR GODFREY MASENG REGARDING THE DEATH OF
HIS LATE MOTHER, MS ZIPHORA MASENG, WHO DIED AT THE MAFIKENG
PROVINCIAL HOSPITAL ON 03 JUNE 2003
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Executive Summary

(i) This is a report of the Public Protector issued in terms of section 182(1)(b) of the Constitution of the Republic of South Africa, 1996 (the Constitution) and section 8(1) of the Public Protector Act, 1994 (the Public Protector Act).

(ii) The report relates to an investigation into the alleged undue delay by the North West Provincial Department of Health (the Department) to respond to a complaint lodged by Mr Godfrey Maseng, regarding the death of his late mother Ms Ziphora Maseng who died at the Mahikeng Provincial Hospital (the Hospital) on 03 June 2003.

(iii) The complaint was lodged on 27 January 2015 by Mr Godfrey Maseng (the Complainant).

(iv) In the main, the complaint was that the Department unduly delayed to respond to his complaint regarding the death of his late mother Ms Ziphora Maseng (the Deceased) who died at the Mahikeng Provincial Hospital on 03 June 2003.

(v) On analysis of the complaint, the following issues were identified and investigated:

(a) Whether the Department failed to exercise due diligence to the Deceased by failing to give her proper and urgent medical attention during her admission at the Hospital on 29 May 2003; and

(b) Whether the Department failed to respond to a complaint lodged by the Complainant regarding the passing on of the Deceased at the Hospital on 03 June 2003.

(vi) The investigation process was conducted through interviews and meetings with the Complainant; correspondence with the Department; analysis of all relevant
documentation; and consideration of and application of all relevant laws, policies and related prescripts.

(vii) Key laws and policies taken into account to determine if there had been maladministration by the Department were principally those imposing administrative standards that should have been complied with by the Department and include:

(a) Section 195(1)(a) and (f) of the Constitution, which requires that the public administration must be governed by the democratic values and principles enshrined in the Constitution which include, inter alia, the promotion and maintenance of a high standard of professional ethics and an accountable public administration. These principles enjoin the Department to exercise a high level of professionalism and ethics including accountability in the performance of their duties. The Department should also strive to be above reproach;

(viii) Having considered the evidence uncovered during the investigation against the relevant regulatory framework, the Public Protector makes the following findings:

(a) Regarding whether the Department failed to exercise due diligence to the Deceased by failing to give her proper and urgent medical attention during her admission at the Hospital on 29 May 2003:

(aa) The allegation that the Hospital failed to provide the Deceased with appropriate and urgent medical attention during her admission at the Hospital on 29 May 2003 is substantiated.

(bb) The Departmental Clinical Investigation Report No.CIC95/2003 confirmed that the Hospital failed to provide the Deceased with appropriate and urgent medical attention during her admission.
(cc) The Departmental Clinical Investigation Report further made a finding and the Hospital admitted failure to provide the Deceased with urgent and proper medical care during her time of admission at the Hospital on 29 May 2003. Such conduct constitutes improper conduct as envisaged in section 182(1) of the Constitution and maladministration as envisaged in section 6(4)(a)(i) of the Public Protector Act.

(b) Regarding whether the Department failed to respond to a complaint lodged by the Complainant regarding the passing on of the Deceased at the Hospital on 03 June 2003:

(aa) The allegations that the Department failed to respond to a complaint lodged by the Complainant regarding the passing on of the Deceased during her admission at the Hospital on 29 May 2003 is substantiated.

(bb) The Department conceded during an Alternative Dispute Resolution session on 12 June 2015 that it failed to respond to a complaint lodged by the Complainant on 22 April 2004.


(dd) Such conduct constitutes improper conduct as envisaged in section 182(1) of the Constitution and maladministration as envisaged in section 6(4)(a)(1) of the Public Protector Act.

(ix) In the light of the above findings the Public Protector takes the following remedial action as contemplated in section 182(1)(c) of the Constitution:
(a) The Head of the Department must pay to the Complainant an *ex gratia* amount of R50 000.00 (fifty thousand rand only) in full and final settlement of the matter. The Head of Department must further liaise with the Complainant to obtain his bank particulars and effect payment within 21 working days from the date of receipt of the said bank particulars.

(b) An action plan will be requested indicating how remedial action will be implemented within 30 days of the issuing of the final report.

(c) The Head of the Department must provide the Public Protector with monthly progress until the implementation of the remedial action has been fully effected.

(d) The Member of the Executive Council for Health (MEC) must ensure that his/her office is responsive to complaints or requests for intervention by members of the public.
REPORT ON AN INVESTIGATION INTO AN ALLEGATION OF UNDUE DELAY BY THE NORTH WEST PROVINCIAL DEPARTMENT OF HEALTH TO RESPOND TO A COMPLAINT LODGED BY MR GODFREY MASENG REGARDING THE DEATH OF HIS LATE MOTHER, MS ZIPHORA MASENG, WHO DIED AT THE MAFIKENG PROVINCIAL HOSPITAL ON 03 JUNE 2003

1. INTRODUCTION

1.1 This is a report of the Public Protector issued in terms of section 182(1)(b) of the Constitution of the Republic of South Africa, 1996 (the Constitution) and section 8(1) of the Public Protector Act, 1994 (the Public Protector Act).

1.2 The report is submitted in terms of section 8(3) of the Public Protector Act to the following people to note the outcome of the investigation:

1.2.1 The North West Premier: Honourable SOR Mahumapelo;

1.2.2 The North West Director General: Dr L Sebego;

1.2.3 The MEC for Health: Dr Magome Masike; and

1.2.4 The Head of the North West Provincial Department of Health: Dr Andrew Lekalakala.

1.3 A copy of the report is also provided to Mr Godfrey Maseng, the Complainant, to inform him of the outcome of the investigation.

1.4 The report relates to an investigation into an allegation of undue delay by the North West Provincial Department of Health (the Department) to respond to a complaint lodged by Mr Godfrey Maseng regarding the death of his late mother.
Ms Ziphora Maseng (the Deceased) who died at the Mafikeng Provincial Hospital (the Hospital) on 03 June 2003.

2. THE COMPLAINT

2.1 The complaint was lodged on 27 January 2015 by Mr Godfrey Maseng (the Complainant).

2.2 The Complainant in essence alleged that:

2.2.1 The Deceased was admitted at the Hospital on 29 May 2003 due to bleeding from the mouth;

2.2.2 During her admission at the Hospital, she was conscious and responding well, but her medical condition warranted an Intensive Care Unit (ICU) admission;

2.2.3 The Deceased was made to wait for a long time at the Out-Patient department before she was taken to ward 3 (three) of the Hospital, and was not given proper medical attention. She was told that the doctor on call was at Zeerust Hospital and no one could assist her with medical care;

2.2.4 The Deceased had to wait for the doctor on call who was at Zeerust Hospital, which is 70 km away from the Hospital. On the doctor's arrival she was taken to ward 3 (three) without any medical attention being provided to her;

2.2.5 When the Complainant visited the Deceased at the Hospital on 03 June 2003, she was still in ward 03 (three). He realised that the Deceased seemed confused and her face was swollen;

2.2.6 Upon enquiry regarding her state of health, an intern doctor informed him that she fell from the Hospital's open bed and further that since her fall, there were no
doctors to provide proper medical care to her except intern doctors and nursing staff;

2.2.7 The Deceased was only taken to the ICU on 30 May 2003 after his visit and upon his enquiry regarding her state of health. The Deceased died in the ICU on 03 June 2003 due to Hospital negligence. The Hospital should have immediately admitted her to the ICU on her arrival at the Hospital on 29 May 2003;

2.2.8 Had the Hospital taken her to the ICU immediately on admission, she would have received proper medical care and her falling from an open bed could have been avoided as there were cot beds available. Medical doctors at the ICU could have attended to her immediately;

2.2.9 After the Deceased had passed on the Complainant reported his concerns to the then Chief Executive Officer of the Hospital, Dr Lekalakala, and an investigation was launched;

2.2.10 An outcome of the investigation confirmed that the Hospital failed to exercise proper medical care and further made an incorrect medical diagnosis of the Deceased which led to her passing away; and

2.2.11 The Complainant lodged a complaint with the Department and his complaint was not responded to.

3. **POWERS AND JURISDICTION OF THE PUBLIC PROTECTOR**

3.1 The Public Protector is an independent constitutional body established under section 181(1)(a) of the Constitution to strengthen constitutional democracy through investigating and redressing improper conduct in state affairs.

3.2 Section 182(1) of the Constitution provides that:
"The Public Protector has the power, as regulated by legislation,

(a) to investigate any conduct in state affairs, or in the public administration in any sphere of government, that is alleged or suspected to be improper or to result in any impropriety or prejudice;

(b) to report on that conduct; and

(c) to take appropriate remedial action."

3.3 The Public Protector has additional powers and functions prescribed by national legislation as per the provisions of section 182(2).

3.4 The Public Protector is further mandated by the Public Protector Act to investigate and redress maladministration and related improprieties in the conduct of state affairs. The Public Protector has additional power to resolve disputes involving conduct in state affairs through conciliation, mediation, negotiation or any other mechanism he or she deems appropriate.

3.5 The Department is an organ of state and its conduct and the conduct of its officials constitute conduct in state affairs, as a result this matter falls within the ambit of the Public Protector’s mandate.

3.6 The powers and jurisdiction of the Public Protector to investigate and take appropriate remedial action were not disputed by any of the parties.

3.7 In the Economic Freedom Fighters v Speaker of the National Assembly and Others: Democratic Alliance v Speaker of the National Assembly and Others the Constitutional Court per Mogoeng CJ held that the remedial action taken by the Public Protector has a binding effect. The Constitutional Court further held that:

“When remedial action is binding, compliance is not optional, whatever reservations the affected party might have about its fairness, appropriateness or
lawfulness. For this reason, the remedial action taken against those under investigation cannot be ignored without any legal consequences."

4. THE INVESTIGATION

4.1 Methodology

4.1.1 The investigation was conducted in terms of section 182 of the Constitution and sections 6 and 7 of the Public Protector Act.

4.2 Approach to the investigation

4.2.1 Like every Public Protector investigation, the investigation was approached using an enquiry process that seeks to find out:

4.2.1.1 What happened?
4.2.1.2 What should have happened?
4.2.1.3 Is there a discrepancy between what happened and what should have happened and does that deviation amount to maladministration?

4.2.2 In the event of maladministration what would it take to remedy the wrong or to place the Complainant as close as possible to where they would have been but for the maladministration or improper conduct?

4.2.3 The question regarding what happened is resolved through a factual enquiry relying on the evidence provided by the parties and independently sourced during the investigation.

4.2.4 The enquiry regarding what should have happened, focuses on the law or rules that regulate the standards that should have been met by the Department to prevent improper conduct and/or maladministration as well as prejudice.

4.2.5 The enquiry regarding the remedy or remedial action seeks to explore options for redressing the consequences of maladministration. Where a Complainant has suffered prejudice the idea is to place him or her as close as possible to where
they would have been had the state institution complied with the regulatory framework setting the applicable standards for good administration.

4.3 On analysis of the complaint, the following were issues considered and investigated:

4.3.1 Whether the Department failed to exercise due diligence to the Deceased by failing to give her proper and urgent medical attention during her admission at the Hospital on 29 May 2003; and

4.3.2 Whether the Department failed to respond to a complaint lodged by the Complainant regarding the passing on of the Deceased at the Hospital on 03 June 2003.

4.4 Key Sources of information

4.4.1 Documents
4.4.1.1 Copies of all supporting documents in the matter between the Complainant and Department received from the Complainant and the Department;
4.4.1.2 A copy of a letter of complaint dated 05 December 2014 which was addressed to the MEC; and
4.4.1.3 A copy of the Clinical Investigation report CIC95/2003 from the Department.

4.4.2 Interviews conducted
4.4.2.1 Meeting with the Complainant;
4.4.2.2 Meetings with officials of the Department on 15 June 2016.

4.4.3 Correspondence sent and received
4.4.3.1 A copy of a letter of enquiry dated 10 February 2015 to the Head of Department;
4.4.3.2 A copy of a letter with the requested supporting documents from the Public Protector to the Director: Legal Services, Mr Thelvin Mmako;
4.4.3.3 Copy of a letter from the Public Protector to the Head of the Department, Dr Lekalakala, (the HOD) requesting a response regarding this matter;

4.4.3.4 Copy of a letter dated 22 August from the Public Protector to the MEC requesting his intervention after failure by the HOD to cooperate in this regard;

4.4.3.5 Copy of a letter dated 16 September 2016 from the Complainant to the Public Protector requesting for compensation from the Department;

4.4.3.6 A copy of a section 7(4) Notice in terms of Public Protector Act to the HOD;

4.4.3.7 Copy of a letter dated 29 February 2017 from the HOD apologising to the Complainant and his family for the death of his mother a few days after admission at the Hospital on 29 June 2003;

4.4.3.8 A copy of a letter dated 02 March 2017 from the HOD offering an ex gratia payment in the amount of R50 000.00 to the Complainant and his family;

4.4.3.9 A copy of a letter dated 02 March 2017 from the Complainant refusing to accept an ex gratia payment offered by the HOD;

4.4.3.10 A copy of a letter of response to the Public Protector's section 7(9) notice from the Department dated 07 June 2017;

4.4.4 Legislation and other prescripts

4.4.4.1 The Constitution of the Republic of South Africa, 1996

4.4.4.2 Public Protector Act, 23 of 1994

4.4.4.3 The White Paper on Transforming Public Service Delivery, Government Gazette No.18340 of 1997 (Batho Pele Principles)

4.4.4.4 Promotion of Administrative Justice Act, 2000 (PAJA)

4.4.4.5 The National Health Act, 61 of 2003

4.5 The investigation process

4.5.1 The investigation process commenced with a preliminary investigation which included interviews and meetings with the Complainant, the HOD and other Departmental officials, Alternative Dispute Resolution (ADR) processes;
correspondence with the Department; analysis of the relevant documentation; conducted research; and the consideration and application of the relevant laws, regulatory framework and jurisprudence.

4.5.2 The complaint was initially classified as an Early Resolution matter capable of resolution by way of a conciliation or mediation process in line with section 6(4)(b) of the Public Protector Act to help the parties reach a settlement. However, after several attempts to conciliate the matter, the process did not yield the required settlement which compelled the Public Protector to proceed with a formal investigation with a view to making a determination of maladministration, prejudice and impropriety in terms of powers conferred on the Public Protector by the Public Protector Act and the Constitution.

5. THE DETERMINATION OF THE ISSUES IN RELATION TO THE EVIDENCE OBTAINED AND CONCLUSIONS MADE WITH REGARD TO THE APPLICABLE LAW AND PRESCRIPTS

5.1 Regarding whether the Department failed to exercise due diligence to the Deceased by failing to give her proper and urgent medical attention during her admission at the Hospital on 29 May 2003:

Common cause issues

5.1.1 It is a common cause that on 29 May 2003 the Deceased was admitted at the Hospital due to bleeding from the mouth and further that during admission, the Deceased was conscious but needed urgent medical attention.

5.1.2 The Complainant provided a copy of the Clinic Investigation Committee Report CIC95/2003 dated 22 June 2004 from the Department confirming that the Deceased was admitted at the Hospital on the 29 May 2003 with a history of hypertension and bleeding from her mouth.
5.1.3 It is common cause that when the Deceased arrived at the Hospital she needed urgent medical attention due to her medical condition, and that due to the unavailability of medical doctors at the Hospital she was kept for a long time at the Out-patient department and had to wait for Dr Gonzales, a doctor on call from Zeerust Hospital, to provide urgent medical attention to her as there were no doctors, nursing staff also failed to attend to her.

5.1.4 The Clinical Investigation Committee Report CIC95/2003 dated 22 June 2004 from the Department confirmed that during her admission at the Hospital the Deceased's medical condition warranted intensive care admission as her urea and electrolytes results of 140mm/1 were indicative of acute tubular necrosis and kidney failure. The above mentioned report further indicated that the attending doctor should have classified the Deceased accordingly i.e. the Deceased or patient was supposed to be nursed in an intensive care unit.

5.1.5 The Report further confirmed that a post mortem report confirmed that the Deceased was a high risk patient with bleeding esophageal varices and that she needed intensive monitoring.

5.1.6 It is common cause that the doctor made an incorrect diagnosis on the Deceased, indicating that she had peptic bleeding ulcers instead of esophageal varices. The report indicated further that the doctor should have administered a drip to the Deceased, but failed to do so.

5.1.7 It is common cause that on the same night of admission (29 May 2003), the Deceased fell from an open bed and sustained head injuries and that she was only taken to the ICU after the Complainant's enquiry on the state of her health on 30 May 2003, and that she died on 03 June 2003. After her death, the Complainant appointed Dr James Gunanayam Gunaseluvam to conduct a post mortem on the Deceased to determine the cause of death, and he issued a post mortem report dated 11 June 2003. His post mortem report which was provided
to the Hospital confirmed that the cause of death was fatal brain injuries sustained as a result of falling from the Hospital bed.

5.1.8 The Clinical Investigation and post mortem reports confirmed that the falling of the Deceased from the bed created fatal brain injuries and thus caused her death.

5.1.9 It is a common cause that on 26 May 2004, upon receipt of the Clinical Investigative Report, the Complainant lodged a complaint with the then Chief Executive Officer, Dr Lekalakala; Member of the North West Executive Council (MEC), Hon Kasiencyane Rebecca, and his complaint was not attended to. The Complainant provided the Public Protector with a copy of a letter dated 24 November 2004 wherein he complained about the manner in which the Hospital treated the Deceased during her admission.

5.1.10 The Departmental Quality Assurance Unit Clinical Investigation report dated 22 June 2004 made the following observations and conclusions:-

"CASE SUMMARY: Mrs. Ziphora Maseng, 61 years old admitted at Mafikeng Provincial Hospital on the 29 May 2003 with history of hypertension and bleeding gastric ulcers. She underwent a surgical operation of the left eye i.e. Nucleation (extract of the eye) in March. She fell from the bed the same night of admission (29 May 2003) and sustained head injuries. Post mortem Conducted by Dr. James on 11 June 2003 indicated deep skull bruising, brain contusion, herniation and swelling with evidence of raised intracranial pressure. The Committee identified the following regarding patient handling at the hospital: The admitting doctor is a sessional doctor at the hospital, not a staff member.

1. Urea and electrolytes analysis results of 140mm01/1 were indicative of acute tubular necrosis, kidney failure, which warrants intensive care admission."
2. The attending Doctor could have classified the patient accordingly i.e. the patient was supposed to be nursed in an intensive care unit.

3. A cot bed was not made available for a high risk patient. According to the reports the patient was admitted being conscious and communicating well. Nothing alarmed the nurses that she needed the cot bed. However, being an elderly patient with one eye should have been an indication for cot bed.

4. There was proof that a nurse informed the Doctor who was on call to assist with patient after a fall and the Doctor did not respond.

The nurse received a warning and the Doctor refused to write an incident report on the case.

CIC Conclusion

The Doctor missed to make right diagnosis, he said bleeding peptic ulcers instead of esophageal varices. The nurse should have called for assistance to insert the drip.

The Clinical Investigative Committee is awaiting a report from the Hospital on measures he took with the admitting Doctor to prevent the recurrence of these practices.

The nurse received a written warning. The Doctor involved was not sanctioned. The case was referred to the Hospital CEO."

5.1.11 The contents of the Clinical Investigation Report from the Hospital confirmed that the Hospital failed to exercise due diligence by not giving the Deceased urgent and appropriate medical care or attention during her admission at the Hospital on 29 May 2003.

5.1.12 The report further confirmed that the Deceased should have been taken to the ICU immediately on her admission as her medical condition warranted ICU
admission. The Hospital instead kept her at ward 3 (three) and she was not given medical care until she fell from the Hospital bed unattended to by the medical staff;

5.1.13 The Hospital failed to provide the Deceased with a cot bed, although it was clear that she was a 61 year old semi blind patient, and nurses failed to consider the possibility of her falling from the Hospital bed.

5.1.14 An ADR process took place on 12 June 2016 with the Public Protector being represented by the Provincial Representative, Mr Sechele Keebine, and the Department by Dr CAN April, Dr HH Kabambe, Dr Anderson Robinson and the Departmental Director: Legal Services, Mr Thelvi Mmako. The Complainant was also present.

5.1.15 Dr Kabambe disclosed that during her admission, the health condition of the Deceased warranted admission to the ICU. He further admitted that the Deceased should have been assisted immediately upon arrival at the patient ward.

5.1.16 Dr Kabambe further confirmed that the Deceased should have been assisted with a drip immediately upon arrival at the patient ward. He further advised that the doctor who was supposed to be on call on the date of admission should have attended to her immediately after she fell from the bed. He further advised that the intern doctor was always supposed to work under close supervision of a professional senior doctor.

5.1.17 Dr Robinson also confirmed that the Hospital should have treated the Deceased appropriately according to the Departmental health standards. The contents of the Clinical Investigation Report No.CIC95/2003 (CIC) from the Hospital confirmed that the Hospital failed to exercise due diligence by not giving the Deceased urgent and appropriate medical care or attention during her admission at the Hospital on 29 May 2003.
5.1.18 The report further confirmed that the Complainant was supposed to be taken to the ICU immediately on her admission as her medical condition warranted ICU admission. The Hospital instead kept her at ward 3 (three) and she was not given medical care until she fell from a bed unattended to by the medical staff.

5.1.19 Dr Robinson also confirmed that the Hospital should have treated the Deceased appropriately according to the Departmental health standards.

Matters disputed

5.1.20 The Department did not dispute any of the allegations raised by the Complainant. The Department further accepted negligence that occurred during the admission of the Deceased at the Hospital on 29 May 2003 and promised to write a letter of apology to the Complainant and the Maseng family within seven 07 (seven) days from the date 12 June 2016.

Conclusion

5.1.21 Based on the evidence in the Public Protector's possession and the admissions from the Department, the Complainant's version is more probable in the circumstances. The Department failed to exercise due diligence to the Deceased by failing to give her proper and urgent medical attention during her admission at the Hospital on 29 May 2003. Although the Clinical Investigation Report No.CIC95/2003) indicates that the Doctor on call was not sanctioned, the nurse involved was given a written warning.
5.2 Regarding whether the Department failed to respond to a complaint lodged by the Complainant regarding the passing on of the Deceased at the Hospital on 03 June 2003:

Common cause issues

5.2.1 It is a common cause that the Complainant wrote a formal letter of complaint dated 26 May 2004 to the office of the then MEC, Mr Magome Masike, regarding the passing on of the Deceased during her admission at the Hospital.

5.2.2 It is a common cause that the Complainant wrote another letter dated 15 September 2009 to the then MEC, Mrs Kasiyanye Rebecca, requesting an intervention regarding his complaint and he did not receive a response.

5.2.3 During an ADR process on 12 June 2015, the Department’s officials made admissions that they failed to respond to the Complainant’s enquiries regarding the Deceased during her admission at the Hospital on 29 May 2003. They further profusely apologised for failure to respond to enquiries that the family made over a period of 10 years. They further accepted that negligence and maladministration had occurred and promised to write a letter of apology to the Complainant and his family.

5.2.4 The HOD conceded in his letter dated 29 February 2016 to the Public Protector the Department’s failure to respond to the Complainant’s enquiries regarding the passing on of the Deceased and apologised.

Matters in dispute

5.2.5 The issue under discussion was not disputed by the Department. As indicated above the HOD conceded in his letter dated 29 February 2016 to the Public
Protector the Department's failure to respond to the Complainant's enquiries regarding the death of the Deceased and apologised.

Application of the relevant law

The Constitution

5.2.6 Section 27(1) provides that "everyone has the right to have access to:

(a) Health care services, including reproductive health care;

(1) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

(2) No one may be refused emergency medical treatment".

5.2.7 The Department had an obligation to comply with section 27 of the Constitution, by providing the Deceased with emergency medical treatment or urgent medical treatment during her admission at the Hospital on 23 May 2003, as her medical condition warranted ICU admission.

5.2.8 Failure by the Hospital to provide the Deceased with emergency medical treatment during her admission is a violation of section 27(3) of the Constitution.

5.2.9 Further, section 195 (1) of the Constitution provides that "Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:

(a) A high standard of professional ethics must be promoted and maintained."
(b) .......

(c) ..........

(d) ................

(e) ................

(f) Public administration must be accountable.

(g) Transparency must be fostered by providing the public with timely, accessible and accurate information.

(h)...........

(2) The above principles apply to —

(a) Administration in every sphere of government;

(b) Organs of state; and

(c) ...........

5.2.10 During admission of the Deceased on 29 May 2003, the Hospital had a duty to exercise a high standard of ethics and to maintain same by immediately classifying her as a patient who had to be nursed in an intensive care unit and to provide her with proper medical care, that is to administer a drip, and to put her on a cot bed. The doctor on call also had a duty to respond immediately when the nurses informed him that the Deceased had fallen from a bed as the deceased had head injuries.
5.2.11 The Constitution further obliges the Hospital to respond to a complaint lodged by the Complainant. When the Complainant wrote a letter to the Department complaining about the services the Deceased received during her admission and how she died due to negligence by the Hospital, the Department had a duty to attend to the complaint.

5.2.12 The Department had a duty to respond to the Complainant’s letter of enquiries dated 29 May 2003 regarding the death of the Deceased during her admission at the Hospital on 03 June 2003.

5.3 **National Health Act, 61 of 2003**

5.3.1 Section 5 of the National Health Act, 61 of 2003 provides that “5. A health care provider, health worker or health establishment may not refuse a person emergency medical treatment”.

5.3.2 The Hospital should have immediately on admission of the Deceased admitted her at the ICU, as her medical condition warranted intensive care unit in order for her to be given emergency medical treatment.

5.3.3 After taking her to ward 3 (three) of the Hospital, the nurses failed to administer a drip to her and also failed put her in a cot bed although it was very clear that she was a 61 year old semi blind patient. As a semi-blind patient, the nurses should have foreseen the possibility of her falling from an open hospital bed and should have put her on a cot bed, but failed to do so. Failure by the Hospital to administer a drip to the Deceased and to provide her with emergency medication and to provide a cot bed on 29 May 2003, was in violation of the National Health Act, 2003.
Conclusion

Based on the evidence in the Public Protector's possession and the admissions from the Department, the Complainant's version is more probable in the circumstances.

5.4 Promotion of Administrative Justice Act, 3 of 2000 (PAJA)

5.4.1 Section 3 of PAJA provides as follows:

(1) Administrative action which materially and adversely affects the rights or legitimate expectations of any person must be procedurally fair.

(2) (a) A fair administrative procedure depends on the circumstances of each case.

(b) In order to give effect to the right to procedurally fair administrative action, an administrator, subject to subsection (4), must give a person referred to in subsection (1)-

(a) adequate notice of the nature and purpose of the proposed administrative action:

(b) a reasonable opportunity to make representations:

(c) A clear statement of the administrative action:

(d) Adequate notice of any right of review or internal appeal, where applicable: and

(e) Adequate notice of the right to request reasons in terms of Section 5.

5.4.2 Section 3(1) of PAJA provides that administrative action which materially and adversely affects the rights or legitimate expectations of any person must be procedurally fair.
5.4.3 This section obliges the Department to provide reasons for its failure to provide the Deceased with proper medical attention during her admission. The Department should have come up with an appropriate way or manner of redress.

5.5 The White Paper on Transforming Public Service Delivery, Government Gazette No. 18340 of 1997 (Batho Pele Principles)

5.5.1 The Batho Pele Principles ensure that all the departments develop their service standards for the services they provide to members of the public. In terms of principle 7, where citizens are not satisfied with services received from the department they should raise their concerns with the department and the department should find ways to correct the service provided.

5.5.2 The above principle affords the Complainant an opportunity to raise his complaint regarding his dissatisfaction about the service standard received by the Deceased during her admission at the Hospital. The Hospital should have responded to the complaint lodged by the Complainant timeously.

5.5.3 During an ADR session dated 12 June 2015, the Department made an admission that it failed to respond to formal enquiries made by the Complainant regarding the passing on of the Deceased during admission at the Hospital.

The Department's response to the section 7(9) notice

5.5.4 A section 7(9) notice was submitted to the Department on 12 May 2017 and it responded as follows:

"At outset we apologise for not responding to the notice on 29 May 2017 as indicated in the notice. The MEC and I still had to consult internally in order to respond to the notice and due to unavailability of some the officials that had to be
consulted we were not able to respond on the due date. I was under the impression that my office had requested an extension until it transpired that same has not been done.

We do not intend to respond to each and every aspect to the notice albeit some of the factual averments are not accurate, and that some of the aspects have been left out. The reasons we deem it unnecessary to deal with every aspect of the notice is because since the meeting that took place at your Mafikeng Office between your officials, myself and Mr Mmako we were resolute that this is a matter which we were and still are prepared to settle. Your Mafikeng officials will recall that in a meeting referred to herein, we indicated that we were prepared to pay ex gratia amount to complainant, further that your office would advise us on what reasonable amount would be in the circumstances. We note that to date that advice never came due to the fact that your officials could not reach common ground with the complainant.

Regardless of all these, my office transmitted a letter dated 2 March 2017 to your Mafikeng Office in which we undertook to pay complainant an ex gratia amount of R50 000.00 (fifty thousand). The said letter is acknowledged in paragraph 7.2.26 of the notice. We never received an acceptance of the offer we made in terms of the said letter. This is the only reason we have not taken this matter further. Had we received the banking details of the complainant upon your receipt of the offer we would have paid the money by now. It is unfortunate that notwithstanding our bona fides in trying to resolve this matter we are now accused of causing delays in resolving it. In our view there was nothing further we could do when we did not receive an acceptance of offer with banking details into which the money should be paid.

The Department issued a written apology letter a while ago and submitted same to your Mafikeng office for onward transmission to the complainant. However the notice still requires us to issue an apology. It is not clear whether the apology we
issued was or was not accepted. Notwithstanding this, in accordance with your directive, issue another letter of apology to the complainant within the stipulated period. It is not clear which remedial action is referred in paragraph 10.3 of the notice. Once we receive clarity we will then be in a position to comment. We accept the recommendation in paragraphs 10.5 and 10.6.

In the light of the above, we kindly request your office to furnish us with the complainants banking details so that we can pay ex gratia amount we offered. Note be taken that we will not be able to pay within 21 days as direct in the notice. It will take us a minimum of 30 days to effect payment provided all the required documents or information are received and the complainant is registered on the system as once off vendor.

Unless there are other issues you would like our office to address, we are of the view that once we pay the money and have complied with the other recommendation relating to resolution of complaints this matter will be put to rest.

The contents of this letter represents the view as of the department in its entirety thus the office of the MEC need not compile a separate response*.

5.5.5 Flowing from the above response, it is clear that Department intends to pay an ex gratia amount of R50 000.00 to the Complainant.

6. FINDINGS

Having considered the evidence uncovered during the investigation against the relevant regulatory framework, the Public Protector makes the following adverse findings:
6.1. Regarding whether the Department failed to exercise due diligence to the Deceased by failing to give her proper and urgent medical attention during her admission at the Hospital on 29 May 2003:

6.1.1 The allegation that the Hospital failed to provide the Deceased with appropriate and urgent medical attention during her admission at the Hospital on 29 May 2003 is substantiated;

6.1.2 The Departmental Clinical Investigation Report No.CIC95/2003 confirmed that the Hospital failed to provide the Deceased with appropriate and urgent medical attention during her admission.

6.1.3 The Report made a finding and the Hospital admitted its failure to provide the Deceased with urgent and proper medical care during her time of admission. Such conduct constitutes improper conduct as envisaged in section 182(1) of the Constitution and maladministration as envisaged in section 6(4)(a)(i) of the Public Protector Act.

6.2 Regarding whether the Department failed to respond to a complaint lodged by the Complainant regarding the passing on of the Deceased at the Hospital on 03 June 2003

6.2.1 The allegation that the Department failed to respond to a complaint lodged by Complainant regarding the passing on of the Deceased during her admission at the Hospital on 29 May 2003 is substantiated.

6.2.2 The Department conceded during an ADR process on 12 June 2015 that it failed to respond to a complaint lodged by the Complainant on 22 April 2004.

6.2.3 The Department's failure to provide the Deceased with appropriate and urgent medical attention during her admission contravened sections 27 of the Constitution and 5 of the National Health Act, 2003. Such conduct constitutes improper conduct as envisaged in section 6(4)(a)(i) of the Public Protector Act.
6.2.4 The HOD responded to the section 7(9) notice dated 12 May 2017 by confirming that the Department intends to resolve this matter by offering an ex gratia amount of R50 000.00 to the Complainant and his family.

7. REMEDIAL ACTION

In the light of the above findings the Public Protector takes the following remedial action, as contemplated in section 182(1)(c) of the Constitution:

7.1 The HOD must pay to the Complainant and his family an ex gratia amount of R50 000.00 (Fifty thousand Rand only) in full and final settlement of the matter. Such payment must be effected within 45 days from the date of the final report;

7.2 The HOD must further liaise with the Complainant to obtain bank particulars and effect payment within 21 working days from the date of receipt of his bank particulars; and

7.3 An action plan is requested indicating how the remedial action will be implemented within 15 days of the receipt of the final report.
3. MONITORING

3.1 The HOD to keep the Public Protector apprised regarding the remedial action in 7.1 within 60 days.

3.2 The HOD to keep the Public Protector apprised of the remedial action in 7.2 within 30 days.

ADV SUSISIWE MKHWEBANE
PUBLIC PROTECTOR OF THE
REPUBLIC OF SOUTH AFRICA

DATE: 29/09/2017

Assisted by:

Mr Sechaba Kebina: Provincial Representative
Ms Pachala Moseki: Investigator