REPORT OF THE PUBLIC PROTECTOR IN TERMS OF SECTION 182(1)(b)
OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996
AND SECTION 8(1) OF THE PUBLIC PROTECTOR ACT, 1994

PUBLIC PROTECTOR
SOUTH AFRICA

Allegations of maladministration by NECSA

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"ALLEGATIONS OF MALADMINISTRATION IN THE MATTER BETWEEN MR. MA
SEPEPE AND OTHERS AND THE SOUTH AFRICAN NUCLEAR ENERGY
CORPORATION"
## INDEX

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>3</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>11</td>
</tr>
<tr>
<td>2. THE COMPLAINT</td>
<td>11</td>
</tr>
<tr>
<td>3. POWERS AND JURISDICTION OF THE PUBLIC PROTECTOR</td>
<td>13</td>
</tr>
<tr>
<td>4. THE INVESTIGATION</td>
<td>15</td>
</tr>
<tr>
<td>5. THE DETERMINATION OF ISSUES IN RELATION TO THE EVIDENCE OBTAINED AND CONCLUSIONS MADE WITH REGARD TO THE APPLICABLE LAW AND PRESCRIPTS</td>
<td>21</td>
</tr>
<tr>
<td>6. FINDINGS</td>
<td>54</td>
</tr>
<tr>
<td>7. REMEDIAL ACTION</td>
<td>58</td>
</tr>
<tr>
<td>8. MONITORING</td>
<td>59</td>
</tr>
</tbody>
</table>
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, and section 8(1) of the Public Protector Act, 23 of 1994 (Public Protector Act).

(ii) The report relates to an investigation into alleged maladministration by the South African Nuclear Energy Corporation (NECSA) in failing to resolve and address issues raised by Mr. Manyanyata Alfred Sepepe and others (the Complainants). Most of the Complainants were ex-employees of NECSA, while some were sub-contractors previously contracted at NECSA. The Complainants had worked at NECSA from the 1990s until the early 2000s.

(iii) The Complainants alleged that:

(a) They were suffering from medical conditions as a result of working at the NECSA Pelindaba site. Whilst they were employed there, they were not informed about the possible risk of radiation contamination; they were neither given any safety training nor protective clothing, and in some cases they were not legally authorised to work in radiation areas, but were instructed to deal with so-called “clean ups”;

(b) The Complainants were exposed to radiation and hazardous chemicals whilst working at NECSA.

(c) The Complainants initially raised their complaints with NECSA in 2004, but the issues remained unresolved. In a memorandum dated 24 January 2007 to the former CEO of NECSA, Dr Rob Adams, they demanded compensation for the affected employees and for those who had died as a result of occupational related diseases. They also requested access to the NECSA medical facilities for proper medical tests, in the presence of an independent medical officer, and the release of medical files of the affected employees.
(d) The Complainants approached the Earth Life Africa (ELA) in 2007 for assistance regarding their complaint. However, ELA discontinued its assistance to the Complainants due to limited funds.

(e) From 2007 until 2010 the complaints remained unresolved and on 25 May 2010, ELA lodged a formal complaint on behalf of the Complainants with the Public Protector.

(iv) In essence the complaint was that the Complainants suffered adverse medical conditions as a result of their employment with NECSA and this caused them to suffer improper prejudice. Furthermore, the Complainants were allegedly not compensated for the occupational related diseases which they suffered.

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

(a) Whether the Complainants suffered adverse medical conditions as a result of their employment with NECSA and did this cause them to suffer improper prejudice?

(b) Whether due processes were followed by NECSA in the way the Compensation Fund (CF) claims were dealt with and does this constitute maladministration?

(c) Whether due processes were followed by the CF in dealing with the claims lodged and does this constitute maladministration?

(d) Whether the CF properly adjudicated on the fatal claim of the late Mr. Victor Motha (Mr Motha) and did his family suffer improper prejudice; and

(e) Whether there was a failure by NECSA to conduct a proper investigation into the death of Mr Motha?
The investigation process commenced with a formal investigation, conducted through meetings and interviews with the Complainants, medical doctors involved, relevant officials from the National Nuclear Regulator (the NNR), relevant officials of NECSA and the CF as well as an inspection of all relevant documents, an analysis and application of all relevant laws, policies and related prescripts followed. An inspection in loco of the NECSA Pelindaba site was carried out. Consultations were also held with an expert witness in the field of nuclear science.

Key laws and policies taken into account to determine if there had been maladministration by NECSA and CF were Compensation for Occupational Injuries and Diseases Act, 130 of 1993 (COIDA); the Occupational Health & Safety Amendment Act, 85 of 1993 (OHSA); The National Nuclear Regulatory Act, 47 of 1999 (NNRA) and all Safety, Health & Environment policies and Standards (SHE) of NECSA.

Upon completion of the investigation, a notice in terms of section 7(9)(a) of the Public Protector Act, 1994 dated 23 October 2017 was issued to NECSA affording it an opportunity to comment on the Public Protector’s intended findings and remedial action. NECSA responded to the notice in a letter from the Group CEO, Mr P Tshelane, dated 10 November 2017.

A notice in terms of section 7(9)(a) of the Public Protector Act dated 06 March 2018 was also issued to the National Nuclear Regulator (NNR) affording it an opportunity to comment on the Public Protector’s intended findings and remedial action. NNR responded to the notice in a letter from the Chief Executive Officer, Dr M Tyobeka dated 19 March 2018.

Having considered the evidence uncovered during the investigation against the relevant regulatory framework, the Public Protector makes the following findings:
(a) **Issue One: Whether the Complainants suffered adverse medical conditions as a result of their employment with NECSA and did this cause them to suffer improper prejudice:**

(aa) The Public Protector could not make any findings regarding whether the Complainants suffered adverse medical conditions as a result of their employment with NECSA, or that it caused them to suffer improper prejudice;

(bb) The majority of Complainants were never tasked to deal with hazardous materials and furthermore none of the Complainants had any security clearance to access high risk areas. The available information shows that they were not exposed to hazardous chemicals;

(cc) Quite a substantial period of time had passed between the period that the Complainants left NECSA’s employment and the time when they started complaining about this issue;

(dd) Pre 2000 NECSA had no policies or regulations regulating pre-employment and exit-medical examinations for NECSA employees. Currently however, pre- and exit-medical interviews are conducted on all employees of NECSA;

(ee) Inadequate medical records of employees were kept by NECSA prior 2005;

(ff) There was no conclusive evidence presented to the Public Protector indicating that there were any employees who had died because of radiation exposure. The evidence in the form of death certificates only revealed that the deaths were as a result of natural causes; and

(gg) The Public Protector is accordingly unable to conclude whether the conduct of the NECSA constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in term of section 182(1) of the Constitution.
(b) Issue Two: Regarding whether due processes were followed by NECSA in the way the CF claims were dealt with and does this constitute maladministration:

(aa) The allegations that NECSA failed to follow due process when dealing with the CF claims is substantiated;

(bb) There were a few CF claims which had been reported to the CF over the years, but the bulk of complaints relating to the Complainants were reported to the CF in 2007 after the investigation by Dr Joubert. However, the reporting of these claims to the CF were not done in compliance with sections 39(1) and 68(2) of COIDA in that NECSA did not report the accident or occupational disease within seven (7) and fourteen (14) days of having received notice of the accident; and

(cc) Therefore, the Public Protector accordingly finds that the conduct of the NECSA constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in terms of section 182(1) of the Constitution.

(c) Issue Three: Whether due processes were followed by the Compensation Fund in dealing with the claims lodged and does this constitute maladministration?

(aa) The allegation that the CF failed to follow due process when dealing with the Complainants’ claims could not be substantiated.

(bb) The CF processed all claims received from NECSA in accordance with section 40(1) of COIDA; and

(cc) Therefore, the Public Protector is unable to find that the conduct of the CF constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in terms of section 182(1) of the Constitution.
(d) Issue Four: Whether the CF properly adjudicated on the fatal claim of the late Mr. Motha and did his family suffer improper prejudice?

(aa) The allegation that the CF improperly adjudicated on the fatal claim of the late Mr. Motha could not be substantiated;

(bb) The Public Protector established that liability for the payment of compensation as well as reasonable medical expenses, were accepted by the CF. Compensation to the amount of R 7829.53 was paid by the CF on 12 July 2006 in favour of Mr Motha’s father, Mr Jabulani Motha, and an amount of R6 490.00 towards burial expenses was paid on 22 February 2005;

(cc) The calculation of the compensation received by the deceased’s father, was in accordance with section 54(1)(e) and section 54(2) of COIDA; and

(dd) Therefore, the Public Protector is unable to find that the conduct of the CF constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in terms of section 182(1) of the Constitution.

(e) Issue Five: Whether there was a failure by NECSA to conduct a proper investigation into the death of Mr Victor Motha and did his family suffer prejudice?

(aa) The allegation that NECSA failed to conduct a proper investigation into the death of Mr. Motha is substantiated.

(bb) NECSA failed to ensure that the Mogwera commission undertakes the investigation it was commissioned to conduct and the subsequent investigation by Dr Joubert did not carry through all the terms of reference which were given to the Mogwera commission;
(cc) The van der Bijl investigation was not specific on the use of Reflective Protective Equipment (RPE) and the role of the supervisor for the full duration of the task; and

(dd) Therefore, the Public Protector finds that the conduct of NECSA constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in terms of section 182(1) of the Constitution.

(xi) The appropriate remedial action that the Public Protector is taking in pursuit of section 182(1)(c), having taken into account NECSA’s commitment to implement the remedial action in its reply to the section 7(9) notice, are the following:

(a) The NNR and NECSA must within 60 days of this report subject the employees identified in Mzansi Energy Solutions and Innovations (Pty) LTD (MZESI) report for further evaluation as recommended by MZESI. NECSA has indicated its commitment to this remedial action, subject to the availability and cooperation of the identified Complainants. NECSA also committed to pay for all specialist medical costs to investigate the occupational disease claimed by the Complainants. NNR also accepted the proposed remedial action.

(b) NECSA must provide all employees with a copy of the exit medical certificate and the exit certificates should also be placed in their files.

(c) In terms of the Personal Protective Equipment (PPE) issued and training on the use thereof, there should be strict compliance with the register that is kept by managers. This should be audited annually.

(d) All Sub-contractors must be subjected to on-going training on all risk factors within the scope of their employment. NECSA has already indicated that it will ensure that all sub-contractors are trained on risk factors associated with work at NECSA. NECSA also committed to continue to ensure enforcement of the safety requirements as per the Act due to the vicarious liability of NECSA to
acts and omissions that can put the health of the sub-contractor employees at risk section (8) and (9) of the OHS Act.)

(e) NECSA should within 30 days of this report submit to the CF all outstanding information and documents at their disposal relating to the Complainants' claims.

(f) NECSA should issue a written apology to Mr Victor Motha's family for failure to conduct a proper investigation into the death of Mr. Victor Motha:

(g) NECSA must within three (3) months from the date of this report, consider paying to the Motha family an ex gratia payment amount as determined as reasonable consolatory payment for the frustration and distress they have suffered as a result of failure by NECSA to conduct a proper investigation into the death of Mr. Victor Motha.
A REPORT ON AN INVESTIGATION INTO ALLEGATIONS OF MALADMINISTRATION BY THE NUCLEAR ENERGY CORPORATION OF SOUTH AFRICA (NECSA) BY EXPOSING FORMER EMPLOYEES TO RADIATION AND HAZARDOUS CHEMICALS WHILST WORKING AT NECSA

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:

1.3. Mr Phumzile Tshelane : Group Chief Executive Officer: NECSA;

1.4. Dr MB Tyobeka: Chief Executive Officer: National Nuclear Regulator;

1.5. Mr Vuyo Mafata: The Compensation Commissioner; and

1.6. Mr Thobile Lamati: The Director General: Department of Labour;

1.7. A copy of the report is also provided to the Complainants to inform them about the outcome of the investigation.

1.8. The report relates to an investigation into alleged maladministration by NECSA.

2. THE COMPLAINT

2.1. The Complainant is Mr. Manyanyata Alfred Sepepe, representing approximately 406 ex-employees and ex-sub-contractors of NECSA (the Complainants). The Complainants initially raised their complaint with NECSA in 2004, but the issues remain unresolved. The Complainants alleged that:
2.2.1. They were suffering from medical conditions as a result of working at the NECSA Pelindaba site. Whilst they were employed there, they were never informed about the risk of radiation contamination; they were neither given any safety training nor protective clothing, and in some cases they were not legally authorised to work in radiation areas, but were instructed to deal with so-called “clean ups”.

2.2.2. They were exposed to radiation and hazardous chemicals whilst working at NECSA.

2.2.3. They initially raised their complaint with NECSA in 2004, but the issues remained unresolved. In a memorandum dated 24 January 2007, to the former CEO of NECSA, Dr Rob Adams, they demanded compensation for the affected employees and for those who had died as a result of occupational related diseases. They also requested access to the NECSA medical facilities for proper medical tests, in the presence of an independent medical officer, and requested the release of the medical files of the affected employees.

2.3. The Complainants approached Earth Life Africa (ELA) in 2007 for assistance regarding their complaint. The Complainants stated in their complaint to ELA that there was a concern regarding the past health and safety standards at NECSA, and that they had contracted illnesses whilst working at the NECSA Pelindaba site. Furthermore, they stated that they were exposed to radiation and hazardous chemicals whilst working at NECSA and that they were retrenched as a result thereof. However, ELA had to discontinue its assistance to the Complainants due to limited funds. From 2007 until 2010 the complaints remained unresolved and on 25 May 2010, ELA lodged a formal complaint on behalf of the Complainants with the Public Protector.

2.4. During the process of the investigation it was uncovered that compensation claims were lodged on behalf of some of the Complainants with the Compensation Fund (CF), but were never finalised.

2.5. Further to the investigation, it was uncovered that there was a fatal incident at the NECSA Pelindaba site where one of the employees (Mr. Victor Motha) died.
2.6. The Public Protector investigation was initially referred to an external forensic company to investigate on behalf of the Public Protector. Due to unforeseen circumstances, the matter was transferred back to the Public Protector and investigations had to start afresh in August 2014.

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 a power as regulated by national 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 Section 182(2) directs that the Public Protector has additional powers and functions prescribed by legislation.

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 is also given power to resolve disputes through conciliation, mediation, negotiation or any other appropriate alternative dispute resolution mechanism.

3.5 In the Constitutional court, (in the matter of *Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker*
of the National Assembly and Others (CCT 143/15; CCT 171/15) [2016] ZACC 11; 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC) (31 March 2016), Chief Justice Mogoeng stated the following, when confirming the powers the Public Protector:

3.5.1 Complaints are lodged with the Public Protector to **cure incidents of impropriety, prejudice, unlawful enrichment or corruption in government circles** (para 65);

3.5.2 **An appropriate remedy must mean an effective remedy, for without effective remedies for breach, the values underlying and the rights entrenched in the Constitution cannot properly be upheld or enhanced.** (para 67);

3.5.3 Taking appropriate remedial action is much more significant than making a mere endeavor to address complaints as the most the Public Protector could do in terms of the Interim Constitution. However sensitive, embarrassing and far-reaching the implications of her report and findings, **she is constitutionally empowered to take action that has that effect, if it is the best attempt at curing the root cause of the complaint** (para 68);

3.5.4 The legal effect of these remedial measures may simply be that those to whom they are directed are to consider them properly, with due regard to their **nature, context and language**, to determine what course to follow. (para 69);

3.5.5 Every complaint requires a **practical or effective remedy** that is in sync with its own peculiarities and merits. It is the nature of the issue under investigation, the findings made and the particular kind of remedial action taken, based on the demands of the time, that would determine the legal effect it has on the person, body or institution it is addressed to. (para 70);

3.5.6 The Public Protector’s power to take appropriate remedial action is **wide** but certainly not unfettered. What remedial action to take in a particular case, will be informed by the **subject-matter of investigation and the type of findings made**. (para 71);

3.5.7 Implicit in the words “take action” is that the Public Protector is herself empowered to decide on and determine the appropriate remedial measure. And “action”
presupposes, obviously where appropriate, concrete or meaningful steps. Nothing in these words suggests that she necessarily has to leave the exercise of the power to take remedial action to other institutions or that it is power that is by its nature of no consequence; (para 71(a));

3.5.8 **She has the power to determine the appropriate remedy and prescribe the manner of its implementation** (para 71(d));

3.5.9 "Appropriate" means nothing less than effective, suitable, proper or **fitting to redress or undo the prejudice, impropriety, unlawful enrichment** or corruption, in a particular case (para 71(e));

3.6 The Constitutional Court further held that the remedial action taken by the Public Protector has a binding effect, "When remedial action is binding, compliance is not optional, and 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."

3.7 NECSA is an organ of state and its conduct amounts to conduct in state affairs, as a result the matter falls within the ambit of the Public Protector’s mandate.

3.8 The Public Protector’s power and jurisdiction to investigate and take appropriate remedial action was not disputed by any of the parties.

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.

4.1.2 The Public Protector Act confers on the Public Protector the sole discretion to determine how to resolve a dispute of alleged improper conduct or maladministration.
4.2. **Approach to the investigation**

4.2.1. Like every Public Protector investigation, the investigation was approached using an enquiry process which seeks to establish:

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?

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

4.2.2. 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. In this particular case, the factual enquiry principally focused on whether or not NECSA acted improperly in safeguarding the working conditions of the Complainants during their employment at NECSA and whether this failure caused prejudice to the Complainants.

4.2.3. The enquiry regarding what should have happened, focused on the law or rules which regulate the standard that should have been met by NECSA to prevent maladministration and prejudice.

4.2.4. The enquiry regarding the remedy or remedial action, seeks to explore options for redressing the consequences of maladministration. Where the Complainants have suffered prejudice, the idea is to place them as close as possible to where they would have been had the Department or organ of state 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 Complainants suffered adverse medical conditions as a result of their employment with NECSA and did this cause them to suffer improper prejudice?

4.3.2. Whether due processes were followed by NECSA in the way the CF matters were dealt with and does this constitute maladministration;

4.3.3. Whether due processes were followed by the Compensation Fund in dealing with the claims lodged and does this constitute maladministration;

4.3.4. Whether the CF properly adjudicated the fatal claim of the late Mr. Victor Motha and did his family suffer improper prejudice? and

4.3.5. Whether there was a failure by NECSA to conduct a proper investigation into the death of Mr Victor Motha.

4.4. The Key Sources of information

4.4.1. Documents

4.4.1.1. Letter dated 17 November 2001 from the Honourable Minister Phumzile Mlambo Ngcuka to the Motha family;

4.4.1.2. Memorandum dated 24 January 2007 from the Complainants to Dr Rob Adam: CEO NECSA;

4.4.1.3. Letter dated 25 January 2007 from NECSA to the Complainants;

4.4.1.4. Letter complied by Dr Servaas Hofmeyr Rossouw with death register number 2266/2001;

4.4.1.5. Letter dated 2 July 2012 from NECSA by L J Shayi: Group Executive; Nuclear Compliance and Services to the National Nuclear Regulator;
4.4.1.6. Letter dated 5 September 2014 from Public Protector to NECSA;

4.4.1.7. Letter dated 6 November 2014 from NECSA to the Public Protector;

4.4.1.8. Letter from NECSA dated 10 November 2014 addressed to the Public Protector;

4.4.1.9. Letter dated 21 November 2014 from the Public Protector to NECSA; Letter by Mr. Phumzile Tshelane: CEO of NECSA to the Public Protector dated 03 December 2014, responding to a letter from the Public Protector dated 21 November 2014;

4.4.1.10. Letter dated 21 January 2015 from Public Protector to NECSA;

4.4.1.11. Letter dated 22 January 2015 from Public Protector to National Nuclear Regulator (hereinafter referred to as NNR);

4.4.1.12. Letter dated 28 January from Dr. M B Tyobeka: CEO of NNR, responding to a letter from the Public Protector dated 22 January 2014;

4.4.1.13. Letter dated 6 February 2015 from NECSA to the Public Protector;


4.4.1.15. Notice in terms of section 7(9) of the Public Protector to NECSA dated 23 October 2017;

4.4.1.16. Response to the section 7(9) notice from NECSA dated 10 November 2017;

4.4.1.17. Notice in terms of section 7(9) of the Public Protector to NNR dated October 2018;

4.4.1.18. Response to the section 7(9) notice from NNR dated 19 March 2018.
4.4.2. Interviews conducted

4.4.2.1. Meeting held on 10 September 2014 with Complainants and the Public Protector team.

4.4.2.2. On 18 September and 30 September 2014 meetings were conducted with Dr WM Coombs and the Public Protector team;

4.4.2.3. From 29 September 2014 to 2 October 2014 interviews were conducted with +/- 120 Complainants at the Atteridgeville Community Hall;

4.4.2.4. On 5 November 2014 interview conducted with Dr Martjie Joubert and Ms Dorothea Voges;

4.4.2.5. On 6 November 2014 the Public Protector team proceeded to Atteridgeville to conduct further interviews.

4.4.2.6. On 20 January 2015, a meeting was held between the Public Protector Team and officials from NECSA. The following were present from NECSA, Mr. Phumzile Tshelane: CEO, Mr. Vusi Malebane: Legal Advisor, Mr. Ahree Visagie: Specialist, Mr. Dorothea Voges: Attorney, Mr. Xolisa Mabhongo: Group Executive Cooperate, Mr Joseph Shay: Group Executive, Mr. F A Masla, Mr. Hannes Breedt: Medical Doctor, Ms. Santie van Niekerk: Radiation Protective Specialist and the team from the Public Protector, Adv. Singh, Mrs. van Wyk and Ms. Sombhani.

4.4.2.7. On 10 February 2015 a presentation on radiation to the Public Protector team was conducted by an expert in the field of Nuclear Radiation, Professor Mario Iturralde.

4.4.2.8. On 25 February 2015, a meeting was held with Dr Ramatsemela Masango of Mzansi Energy Solutions and Innovations and the team from the Public Protector.

4.4.2.9. A meeting was held on 3 March 2015 with the NNR and the team from the Public Protector. The following were present Mr Thiagan Pather: NNR Manager; Mr Sello Mosoeunyane: NNR: Chief Inspector; Mrs Tlohis Polaki: NNR: Legal Manager; Mr
Ditebogo Kgomo: NNR: Senior Manager; Mr Bismark Tyobeka: NNR: CEO; and from the Public Protector, Adv de Waal, Adv. Singh, Mrs. van Wyk and Ms. Sombhani.

4.4.3. **Correspondence sent and received**

4.4.3.1. Correspondence received from the Complainant to Public Protector;

4.4.3.2. Correspondence received from NECSA;

4.4.3.3. Correspondence received from NNR; and

4.4.3.4. Correspondence from CF.

4.4.4. **Inspection in loco conducted**

4.4.4.1. An inspection in loco was carried out on 30 April 2015 at the NECSA Pelindaba site by the Public Protector Investigation team. The following sites were visited: NECSA visitor centre; Medical Services; Archives; Emergency Services and the SAFARI-1 research reactor. A presentation was also conducted by NECSA on the said date.

4.4.5. **Legislation and other prescripts**

4.4.5.1. NECSA Health Safety Environment Policy (HSE) Orientation programme (HSE – TRM – 5304);


4.4.5.3. SHEQ-INS 5300: Written Safe Work Procedure, Instructions, Orientation and task training (hereinafter referred to as the SHEQ INS 5300) last review date 6 May 2011;

4.4.5.4. SHEQ-INS-2490 Issue and Control over Personal Protective Equipment last review date 22 August 2012;
4.4.5.5. The Compensation for Occupational Injuries and Diseases Act, Act 130 of 1993 (COIDA);
4.4.5.6. The Occupational Health & Safety Amendment Act, 85 of 1993 (OHSA); and

4.4.5.7. The National Nuclear Regulatory Act, 47 of 1999 (NNRA).

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

5.1 Regarding whether the Complainants suffered adverse medical conditions as a result of their employment with NECSA and did this cause them to suffer improper prejudice?

Common cause issues

5.1.1 ELA represented by Mr Mashile Phalane (Mr Phalane) and Mr Victor Munnik approached Dr Murray Coombs (Dr Coombs) from Health Gap Network (HGN), to assist with the complaint of the ex-employees of NECSA, who may have contracted occupation related diseases due to radiation and other exposure during their employment at NECSA. Mr Phalane provided the files of the twenty three (23) ex-employees who were to be reviewed by Dr Coombs. ELA had obtained the medical information with the assistance of the South African Historical Archives (SAHA). At the start of the review process, two (2) of the twenty three (23) ex-workers were known to have already died. This report was presented to NECSA by Dr Coombs in February 2005.

5.1.2 NECSA appointed Dr MS Joubert (Dr Joubert), as an Independent Occupational Medical Practitioner to investigate allegations by the Complainants and Dr Joubert issued a report dated 17 May 2007.
Issues in dispute

5.1.3 It should be noted that the only issue that is common cause between the parties is the existence of the two medical reports, the contents and outcome of both reports remain in dispute between the parties. For ease of reference, the chronology of events and outcome of the medical reports are discussed hereunder.

5.1.4 Dr Coombs reviewed the files and categorised the ex-employees. On examining the medical records, Dr. Coombs noted there were major gaps in the data. The lack of data placed limitations on the review of the files.

5.1.5 Dr. Coombs indicated that despite the lack of information, the information available at that time suggested that there was sufficient evidence to show that some of the employees had been exposed to radiation with the potential of causing occupational disease and/or injury. Prior to the setting up of the medical examinations, Dr Coombs learnt that two (2) more ex-employees had passed away. This brought the total of the deaths to four (4) in the group of 23.

5.1.6 On 20 January 2005, thirteen (13) of the nineteen (19) ex-employees reported for medical examinations with Dr Coombs. The medical examinations revealed that there were general health problems in some of the ex-employees. However, occupation related symptoms were found. Further tests were not carried out due to a lack of funding. Their records were examined and evaluated and formed part of the review as follows:

5.1.6.1 The medical evaluations indicated that ten (10) of the ex-employees were exposed in the course of their employment to a hazardous substance which could cause adverse health effects.

5.1.6.2 Eight (8) of these ex-employees had illnesses and required further medical investigations and/or medical treatment for their conditions.
5.1.6.3 Four (4) of these eight employees' illnesses were likely to be occupationally related.

5.1.6.4 The remaining four (4) had illnesses which were not related to occupational exposure. However they too required follow up medical investigation and treatment.

5.1.7 In a letter dated 25 January 2007 from NECSA in response to the Complainants' memorandum dated 24 January 2007, NECSA stated that the Complainants were requested to avail themselves (by arranging appointments with NECSA medical station) for COIDA prescribed processes. Access to the medical facility was granted to all Complainants. However, NECSA declined the presence of an independent medical practitioner, stating that the option was granted to the Complainants previously. ELA decided not to take up the NECSA offer.

5.1.8 NECSA then decided to appoint Dr Joubert, as an Independent Occupational Medical Practitioner, to investigate all allegations made by the Complainants and ELA. Dr Joubert's report dated 17 May 2007, stated that she reviewed two hundred and seven (207) medical files, of which two hundred and one (201) were ex-employees and four (4) were still employed by NECSA, one (1) was a subcontractor and that one (1) person was invited to join the study.

5.1.9 A total of fifty one (51) ex-employees approached Dr. Joubert for the purpose of being examined. Forty nine (49) were examined, one (1) refused to be examined and one other refused both the interview and examination. Out of these fifty one (51) individuals, fifty (50) were permanent ex-employees and one (1) was a subcontractor. Most of these individuals fell in the job category of General Labourers.

5.1.10 During Dr. Joubert's investigation, she relied on the medical files handed to her by NECSA and in some cases insufficient information was available for a direct conclusion. Hence she concluded as follows:
"Although not all screening tests were performed according to today's standards, regarding accuracy and repeatability, trends could be followed and correlated well with retrospective risk exposure evaluation".

5.1.11 Dr Joubert also found that most of the respiratory related illnesses might be linked to hazardous chemical substances exposure. Some of the employees were identified to have possible lung diseases, but most of them had underlying chronic non-work related lung diseases and had history of smoking cigarettes. Only one case was identified to be suffering from a lung disease that was aggravated by Chemical Substances exposure. As a result this claim was reported to the CF for consideration for compensation.

5.1.12 Dr. Joubert had identified a number of noise induced hearing loss cases. The noise induced hearing losses were investigated in relation to the exposure levels in the area and in the job. The pre and post NECSA employment exposures, ear, nose and throat related illnesses were also investigated. The employees were also referred to an audiologist for further assessment, however not all ex-employees availed themselves for this evaluation. As a result twelve (12) cases of Noise Induced Hearing Loss were submitted to the CF for consideration for compensation.

5.1.13 According to Dr Joubert a few cases were identified as previously exposed to chemicals and investigations were conducted on those specific cases. The investigations were complicated due to the fact that most of these individuals are smokers and were still performing the same type of work, but now are at other employers. All the ex-employees were evaluated against the main risks of radiation, noise, chemical exposure, laser as well as any possible occupation related illness.

5.1.14 Dr Joubert’s findings based on the files reviewed:
Employees not exposed to any of the below four (4) risks | 30 out of 207
Employees exposed to radiation | 118 out of 207
Employees exposed to noise | 163 out of 207
Employees exposed to Hazardous Chemical Substances (HCS) | 74 out of 207
Employees exposed to laser | 3 out of 207

5.1.15 Further, according to Dr Joubert most of the individuals examined were complaining about primary health related cases, such as Hypertension, general poor health and hearing loss caused by noise exposure. Ninety two (92) individuals diagnosed with these illnesses were referred to their preferred medical service provider for evaluation, diagnosing and treatment for their condition of which fourteen (14) individuals were diagnosed with work related conditions. Three (3) cases relating to skin cancers were confirmed as follows: two (2) cases were confirmed to be breast cancers and one (1) pancreatic cancer. None of the cancer cases were confirmed to be occupation related. Some of the ex-employees were not exposed at all to radiation and those exposed had very low levels of exposure.

5.1.16 Table showing cases of occupational diseases referred to the CF with special reference to NECSA:

<table>
<thead>
<tr>
<th>NOISE</th>
<th>LUNG DISEASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases identified</td>
<td>21</td>
</tr>
<tr>
<td>Deceased</td>
<td>2</td>
</tr>
<tr>
<td>Accepted by CF</td>
<td>4</td>
</tr>
<tr>
<td>Rejected</td>
<td>1</td>
</tr>
<tr>
<td>Reported under NECSA</td>
<td>10</td>
</tr>
<tr>
<td>Reported under other employer</td>
<td>3</td>
</tr>
<tr>
<td>Outstanding</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total cases under NECSA</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

5.1.17 Dr Joubert further concluded as follows:
a) A total of thirty two (32) ex-employees of the two hundred and seven (207) are deceased, five (5) employees died during their service period, of which one (1) case was exposed to chemicals and the case was reported and dealt with in accordance with legislation. Only twenty (20) cases had death certificates stating the cause of death. Fifteen (15) of the individuals died of natural causes, one (1) unnatural causes, one (1) work related, two (2) cases were still under investigation and one (1) of the death certificates were illegible;

b) No positive case of chronic effects on the health condition due to exposure to radiation could be confirmed as all exposures were far below 1mSv;

c) Most of the ex-employees whose files were reviewed or physically examined were retrenched. This had an emotional impact on them as they blame the retrenchment as the reason for their financial position. This impact is not compensable under the COIDA.

5.1.18 The final conclusion by Dr Joubert was that “there is no conclusive evidence to indicate an abnormal prevalence of reportable occupational illnesses emanating from exposure to the mentioned risk”.

5.1.19 NECSA informed the Public Protector that a decision was taken to implement the following measures for all current employees:

a) Compulsory exit medical examination to be conducted on all employees whose employment is terminated.

b) It is compulsory for all employees to be examined by an Occupational Physician at least once in 2 years.

c) All employees are provided with their pre-placement and exit audiogram and provided with an option to get all their medical records for their period of employment at NECSA.
5.1.20 On the allegation that "employees retrenched by NECSA due to their medical condition", NECSA stated that it does not retrench people who are sick. However, employees who were off sick for a period longer than 14 days were required to visit the NECSA Medical Services for an evaluation before resuming their duties. Employees with partial temporary disability caused by illness or injury would be placed on light duty or alternative positions on their return to work. Employees with permanent partial disability will be, where possible, accommodated elsewhere in the organisation based on individual requirements. Employees with permanent disability will be covered by the Insurer (Sanlam). The first two (2) years following the successful submission for medical disability is seen as temporary disability. Permanent disability only came in effect after two (2) years. The disability application is reviewed by an internal panel before submission to Sanlam. Claims were/are being submitted for compensation to the CF for employees with partial or total disability caused by occupational disease or injury.

5.1.21 NECSA further stated that at some stage, there was a general retrenchment of employees due to the closure of a number of NECSA facilities and programmes and as a result, a number of employees had to be retrenched. Moreover, due to prolonged financial constraints, some of the general services such as garden- and cleaning services were outsourced.

5.1.22 The evidence revealed that on 2 July 2012 Mr L J Shayi, the Group Executive: Nuclear Compliance and Services of NECSA wrote to the National Nuclear Regulator (NNR). The letter was a response to NNR confirming that the fifty nine (59) individuals who complained to NNR were NECSA’s ex-employees. The NNR also requested copies of the exit medical records conducted on the fifty nine (59) individuals. A total of twelve (12) individuals were registered as workers exposed to radiation. Only three (3) of the twelve (12) individuals registered as workers exposed to radiation had exit medical records and 9 individual’s exit medical examinations were not conducted.

5.1.23 On 21 January 2015 the Public Protector sent a letter to the NNR requesting more information on the matter. In a letter dated 28 January 2015, from Dr M B Tyobeka
the CEO of NNR, the NNR confirmed that they were aware of the allegations by the Complainants against NECSA. The NNR further confirmed receipt of the complaints from seven (7) Complainants. Upon engaging with the Complainants, the NNR identified that the number of Complainants had increased from seven (7) to fifty nine (59). The NNR was also in the process of engaging the services of an Occupational Medical Practitioner in order to review the NECSA’s records and reports to the allegations of exposure to radiation by former employees of NECSA. In May 2005, following allegations by ELA that former employees of NECSA had contracted diseases linked to radiation exposure, the NNR directed NECSA to review the adequacy of the then current medical surveillance programme and associated record keeping system.

5.1.24 The NNR also directed the NECSA to submit a report on the identified remedial actions to be undertaken. NECSA’s response to the directive by the NNR was as follows:

a) NECSA established a task team to compile medical data for present and past employees.

b) NECSA’s medical record system (DOME) was modified to identify record items available and not available.

c) NECSA also appointed as Occupational Medical Practitioner, Dr Joubert to review the compiled medical records for the persons whose records were requested by ELA.

d) A total of 207 medical files were evaluated and 49 individuals were clinically examined by Dr Joubert. Dr Joubert found that "... there is no conclusive evidence to indicate an abnormal prevalence of reportable occupational illnesses emanating from exposure to the mentioned risks".

Independent Evidence
The Public Protector during the weeks of 29 September 2014 to 2 October 2014 interviewed one hundred and eleven (111) additional Complainants. A questionnaire was compiled and each individual was requested to respond thereto. From the interviews conducted the following could be noted:

a) Thirty three (33) were relatives of deceased ex-employees of NECSA. The majority worked at NECSA between the 1980’s to 1990’s. Only half of this number had proof of employment such as employment numbers. The majority of the deceased were general workers. The relatives who provided the information to the Public Protector, were not sure if the deceased were ever exposed to radiation or not.

b) Regarding the issue of Personal Protective Equipment (PPE) and training on PPE; exposure, and information on policies; visits to NECSA medical center and reporting problems to the manager, these were all unknown as the relatives could not supply any information. Allegations were however made that they were not issued with PPE or given any training.

c) The majority of the deceased died during the period 2001 and 2014. None of the ex-employees who died were during their life time interviewed by Dr Coombs or Dr Joubert. Most of the deceased were above the age of 55 when they passed away.

d) The majority of the deceased’s relatives had no Compensation Fund reference numbers.

e) There was a significant period between the time when the majority retired or stopped working until the time they passed on.

f) Out of one hundred and eleven (111) Complainants interviewed by the Public Protector team, twenty one (21) were ex-subcontract workers of NECSA. The majority of them worked between the years 1991 and 1995 and had proof of employment via employment numbers. Most were cleaners
and alleged that they were exposed to chemicals and they said exposure occurred while they were on duty.

g) Most of these 21 ex-subcontract workers stated that they are suffering from the following illnesses: high blood pressure; chest pains; coughing; diabetes; impaired eyesight; asthma and body pains. Since they left NECSA's service in 1995, the possibility existed that they could have worked at other institutions where their health could have been at risk. Further, none of them had evidence that they could have been exposed to radiation, or could site any such incident.

h) Fifty seven (57) out of one hundred and eleven (111) Complainants who were interviewed were full time ex-employees at NECSA at some stage. Their period of employment was from 1975 to 2000, and the majority had proof of employment as per employment numbers. The majority were general workers and they alleged that they were exposed to radiation during their period of employment.

i) The majority of this group confirmed that they were given PPE's and provided with training on how to use it. The majority were trained on issues relating to exposure, but still alleged that they were not trained on safety policies. The majority of them had visited the NECSA Medical Centre at some point during their employment. The majority suspected that they were suffering from radiation poisoning.

j) These Complainants stated that they were not examined either by Dr. Coombs or Dr Joubert. Most of them indicated that they reported their illnesses and/or injuries to management while they were employed at NECSA.

5.1.26 On 10 February 2015, the Public Protector consulted and interviewed an expert in the field of nuclear science and medicine, Professor Mario Iturralde, who is an academic and internationally recognised expert with at least fifty seven (57) years' experience in the nuclear science field. Professor Iturralde was consulted
as the Public Protector required advice and clarity on the subject of radiation, possible causes and effects and other scientific issues related thereto.

5.1.27 None of the evidence obtained from the Complainants through Dr Coombs’ report or from NECSA through Dr Joubert’s report could conclusively confirm that any of the Complainants were exposed to radiation during their term of employment at NECSA. The only evidence was the oral allegations received from the Complainants and due to the lapse of time since they left the service of NECSA, and the possibility that they may have been exposed to work-related illnesses elsewhere, the Public Protector could not find any evidence in the form of records or clear medical evidence to substantiate the allegations.

5.1.28 On 24 March 2016, a meeting was held between the Public Protector, NECSA and NNR with a view to find an amicable solution on evidence that could conclusively confirm whether or not the Complainants are currently suffering from medical conditions that could be caused or related to radiation exposure. This meeting was initiated by the Public Protector as a way to resolving this old dispute that has been referred to various institutions and still remain unresolved.

5.1.29 It was agreed at this meeting that the only solution that could conclusively confirm the Complainant’s allegation was formal medical testing. Due to the cost of these medical tests (that was estimated at about one hundred and fifty thousand rand (R150 000.00) per person), a decision was taken that the NNR - as the regulatory body that has the mandate to investigate allegations of radiation exposure against NECSA - would arrange specialist medical examinations for a sample of seven (7) Complainants to establish whether or not they were suffering from any illness relating to radiation exposure. It was agreed during this meeting that should any of the seven (7) ex-employees test positive, NECSA will undertake more extensive tests.

5.1.30 On 07 April 2016, electronic communication was sent to the representative of the Complainants (Mr. MA Sepepe), informing him of the outcome of the meeting held on 24 March 2016. He was requested to submit a list of seven (7) ex-employees who consented to under-go the specialist medical assessments. On
31 May 2016, a list of six (6) names with supporting documentation was hand delivered to the Public Protector. The representative of the Complainants (Mr. MA Sepepe), was the seventh (7th) individual on the list and he submitted his documents at a later stage.

5.1.31 The NNR appointed Mzansi Energy Solutions and Innovations (Pty) Ltd (MZESI) to conduct the specialist medical examinations and tests on its behalf. The tests were conducted during September 2016 and finally concluded in November 2016 at various private hospitals in Gauteng. The process was monitored by the Public Protector Investigation team and the Complainants were accompanied by the Public Protector team to the medical examinations and tests.

5.1.32 A report of the medical assessments was submitted to the Public Protector during November 2016. The report is summarised as follows:
<table>
<thead>
<tr>
<th>NAME OF COMPLAINANT OR PATIENT</th>
<th>DERMATOLOGY REPORT</th>
<th>MEDICAL &amp; SURGICAL HISTORY</th>
<th>CONCLUSION</th>
<th>IS FURTHER EXAMINATION NECESSARY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee A</td>
<td>N/A</td>
<td>Hypertension&lt;br&gt;Diabetes&lt;br&gt;No Surgical history&lt;br&gt;Stopped smoking a year ago</td>
<td>A causal relationship between the Complainant's symptoms and radiation overexposure could not firmly be established.</td>
<td>Yes, &lt;br&gt;Recommended that Complainant undergoes cardiac and gastrointestinal evaluation.</td>
</tr>
<tr>
<td>Employee B</td>
<td>No evident skin manifestation of nuclear radiation on clinical examination.</td>
<td>Hypertension&lt;br&gt;Type II Diabetes Mellitus&lt;br&gt;Hypercholesterolemia&lt;br&gt;Osteoarthritis&lt;br&gt;Previous surgery on his right leg after an injury at work&lt;br&gt;Previous smoker, but stopped 30 years ago.&lt;br&gt;Consumes alcohol occasionally</td>
<td>In the absence of progressive symptoms and clinical signs, radiation overexposure as a cause of the Complainant's rash is highly unlikely.</td>
<td>Yes, &lt;br&gt;A chromosomal analysis may be considered.</td>
</tr>
<tr>
<td>Employee C</td>
<td>A diagnosis of chronic stasis dermatitis, lipodermatosclerosis with secondary infection was made</td>
<td>Hypertension&lt;br&gt;Type II Diabetes Mellitus</td>
<td>A conclusion of overexposure to radiation as a cause of his clinical findings cannot be reached.</td>
<td>No</td>
</tr>
<tr>
<td>NAME OF COMPLAINANT OR PATIENT</td>
<td>DERMATOLOGY REPORT</td>
<td>MEDICAL &amp; SURGICAL HISTORY</td>
<td>CONCLUSION</td>
<td>IS FURTHER EXAMINATION NECESSARY?</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------</td>
<td>-----------------------------</td>
<td>------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Employee D</td>
<td>N/A</td>
<td>Hypertension</td>
<td>A causal effect from overexposure to radiation cannot be excluded.</td>
<td>Yes, Further testing of the Peripheral Neuropathy is recommended. Chromosomal analysis is recommended.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>History of a possible CVA (stroke)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No previous surgical history</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-smoker. Significant alcohol history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee E</td>
<td>No skin manifestations of nuclear radiation.</td>
<td>Hypertension</td>
<td>A causal link between her symptoms and overexposure to nuclear radiation cannot be established.</td>
<td>No However, Medical records from Kalafong need to be obtained to establish possible causal link, should be sourced.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous laparotomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-smoker and does not consume alcohol.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family history of Hypertension and Diabetes Mellitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee F</td>
<td>N/A</td>
<td>Hypertension</td>
<td>A causal link of his penile symptomatology and overexposure to radiation cannot be established.</td>
<td>Yes, A urological evaluation of his penile lesions and possibly a histological assessment is recommended.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No previous surgical history</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-smoker and does not consume alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee G</td>
<td>N/A</td>
<td>No significant medical history</td>
<td>A causal link between clinical findings cannot be established.</td>
<td>Yes, A chromosomal analysis is recommended. Further evaluation of the neuropathy symptoms is recommended. Pathology results and oncology report should be sourced.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous left orchidectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-smoker. Consumes alcohol occasionally</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Application of the relevant law

5.1.33 In terms of section 8(1) of the Occupational Health and Safety Act, 85 of 1993 the employer shall provide and maintain as far as is reasonably practicable a working environment that is safe and without risk to the health and safety of his employees.

5.1.34 Chapter 7: Hazardous Chemical Substances Control (HCS) Part 11 NECSA HSE Systems HSE – INS – 0105 puts in place measures to control hazardous chemical substances present on site. These control measures include the requirements for the zoning of and access to chemical facilities, activities with HCS, workplace and medical surveillance and personnel monitoring systems, removal of contaminated items from the chemical facility, training of personnel to work with HCS and the requirements of PPE Chapter.

Not all employees at NECSA are monitored by dosimeters, only employees who are occupationally exposed are monitored.

5.1.35 Chapter 8: Radiation Protection Programme prescribes the HSE measures to control radiological hazards in areas where radioactive materials are present. It also deals with the emergency plan, in case of radiological emergency. The Radiation Protection Programme is licensed by the National Nuclear Regulator.

Conclusion

5.1.36 The Public Protector noted that there were policies in place at NECSA dating back to 1997, regarding access control which were implemented at all workplaces where hazardous materials occurred in potentially hazardous quantities. Admission to such working areas required workers to be registered as occupationally exposed person. This also included medical surveillance and training to be done.

5.1.37 The Public Protector also noted that NECSA has workers who are registered according to different areas, hazards and workplaces. Workers are monitored to
assess the exposure to the hazards as well as the efficiency of implemented conformed measures.

5.1.38 Formal systems and procedures were not fully in place in the past and the Public Protector noted the improvements as time went on. The Public Protector further noted that it was NECSA's policy from the beginning to perform medical surveillance, as well as training of employees in hazardous areas and to register occupationally exposed workers for all occupationally exposed illnesses.

5.1.39 A difficulty that the Public Protector experienced during the investigation was the significant time period that had lapsed since the Complainants were employed at NECSA. This made it difficult to determine if the ex-employees had indeed been exposed to any radiation or any other work-related illnesses while they were in NECSA's employ. Most of the Complainants worked for NECSA between 1995 and 2000. Furthermore, the majority of the Complainants were employed as general workers and had no access to restricted or dangerous areas.

5.1.40 It was also difficult to establish if training was provided at the time or whether PPE's were issued at that stage. The Public Protector noted that currently there are clear policies on training, PPE's and record keeping in place at NECSA.

5.1.41 The Public Protector also noted that exit medical interviews, which was regarded as the most important interview due to the fact that it reflects the medical status of the individual at the time when an employee left the company, was not done for the majority of the Complainants. This made the investigation difficult, as any existing medical conditions could have been identified at that stage. For example, if any of the Complainants had suffered exposure to radiation this would have been uncovered at that stage. Now however, there is no record or evidence of such exposure. The Public Protector also noted further that there were no clear policies at that stage governing the enforcement of exit medical interviews.
The Public Protector further noted that Dr. Coombs found that 10 ex-employees were exposed to hazardous substances. From Dr. Joubert's report however, the Public Protector noted the difficulty she encountered in that the Complainants did not explain to her which symptoms they were suffering from. This led to the approach that all Complainants had to be evaluated against the main risks of radiation, noise, chemical exposure, laser, as well as any other possible risk.

The Public Protector noted that Dr. Joubert relied on the evidence in the files and that in most cases insufficient information was available for a direct conclusion.

Dr. Coombs could conclude that there was evidence of radiation exposure after reviewing some of the Complainant's files. Dr Joubert could not reach the same conclusion. Instead, Dr. Joubert could only conclude that some of the Complainants were exposed to hazardous substances. The latest (2016) specialist medical assessment conducted by MZESI could not conclusively exclude the possibility that the Complainants were exposed to radiation.

In the absence of conclusive medical evidence, the Public Protector is not a position to conclude that the Complainants suffered adverse medical conditions as a result of their employment with NECSA as alleged.

Regarding whether due process was followed by NECSA in the way the CF matters were dealt with and does this constitute maladministration?

Notwithstanding the fact that the Complainants did not make specific allegations regarding the process that NECSA have followed when submitting their compensation claims to the CF, the Public Protector sought to understand whether NECSA had discharged its obligations in terms of COIDA.
Issues in dispute

5.2.2 The Public Protector sought, on own initiative, to determine whether NECSA complied with the provisions of COIDA. In terms of section 39(1) of COIDA, NECSA is obliged to report an injury on duty to the CF within seven (7) days upon receipt of notice of an accident or having becoming aware of the incident.

5.2.3 In terms of section 68(2) of COIDA, NECSA is obliged to report to the CF within fourteen (14) days upon receipt of the notice from the employee or having becoming aware of the occupational disease.

5.2.4 Dr. Coombs from HGN was instructed by ELA to review the medical files of NECSA ex-employees and he found that a significant number of the ex-employees had signs of occupational related diseases. In his letter dated 4 May 2005 to NECSA, Dr. Coombs indicated that he completed WCL22 forms in respect of seven ex-employees and sent them to the CF.

5.2.5 It would appear that NECSA became aware that some of the Complainants had contracted occupational diseases that needed to be reported to the CF through a report from Dr. Coombs. Although the claims were apparently forwarded to the CF by Dr. Coombs, it was NECSA's responsibility to ensure that these claims were indeed reported to the CF in terms of section 68(2) of COIDA.

5.2.6 Dr. Joubert also reviewed two hundred and seven (207) files and examined forty nine (49) individuals after the ex-employees of NECSA complained to ELA that they were suffering from occupational diseases due to their employment with NECSA. In her conclusion, Dr. Joubert indicated there was no conclusive evidence to indicate an abnormal prevalence of reportable occupational diseases emanating from exposure to occupational hazards at NECSA.

5.2.7 Notwithstanding the above, Dr Joubert identified most of the cases to be around noise exposure. In this regard, she identified a total of 15 reportable or reported
cases to the CF. It is not clear if the reportable cases which were identified by Dr. Joubert were referred to the CF in compliance with section 68(2) of COIDA, i.e. within fourteen (14) days.

5.2.8 In an attempt to understand whether NECSA had reported any claims to the CF, the Public Protector requested information in this regard. On 10 November 2014, the Public Protector received letters from NECSA which were sent by CF relating to CF claims that were submitted for further processing. Most of the letters were requesting outstanding information from NECSA on the claims received by the CF. In terms of section 40(2) of COIDA, NECSA was obligated to furnish any further particulars as requested by the CF.

5.2.9 Through a letter dated 21 January 2015, the Public Protector requested NECSA to explain why outstanding information requested by the CF regarding the claims was not provided. NECSA response dated 6 February 2015 indicated that the ex-employees were required to be examined by the Appointed Medical Practitioner (AMP) in order to furnish the CF with the necessary information. NECSA further submitted that:

“Various attempts (e.g. invites via the media as well as visits to the supplied physical addresses of the claimants) were made by NECSA in order to contact the claimants and request them to visit NECSA for a medical examination.”

5.2.10 Furthermore, NECSA submitted proof that they had requested the Complainants to avail themselves to medical examinations in order to gather the necessary information for the CF claims. Information submitted to the Public Protector showed that some of the Complainants were traced and availed themselves to this process, whereas others could not be traced or refused to subject themselves to medical examinations arranged by NECSA.
5.2.11 Although NECSA submitted information to the Public Protector highlighting the efforts made in order to gather the outstanding information as requested by the CF, there was no evidence showing that the information was submitted to the CF. In this regard, the CF reported that many claims from NECSA could not be processed and finalized because of the outstanding information.

5.2.12 On 25 January 2015, the Public Protector requested NECSA to provide a list of all CF claims which they had reported to the CF. In their response dated 6 February 2015, NECSA submitted a list titled "ex NECSA claims reported to Compensation Commissioner".

5.2.13 In the response above NECSA indicated that they had reported a total of two hundred and seventy three (273) claims to the CF of which thirty (30) were issued with claim numbers, four (4) were accepted. However, on close scrutiny, the list only contained a total number of one hundred and sixty seven (167) claims. This list also reflected only eleven (11) names with the CF claim numbers and most of the ID numbers were reflected as incomplete. Upon receipt of the list, the Public Protector forwarded a list to the CF for further enquiries.

5.2.14 On 29 September 2016, the Public Protector sent a comprehensive list of four hundred and seven (407) names to NECSA in order to verify whether NECSA had registered claims with the CF with respect to the ex-employees contained in the list. A response dated 03 March 2017 was received from NECSA, and is summarised as follows:

<table>
<thead>
<tr>
<th>Claims accepted</th>
<th>42</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims not accepted</td>
<td>21</td>
</tr>
<tr>
<td>Deceased</td>
<td>50</td>
</tr>
<tr>
<td>Employees not found or incomplete information</td>
<td>277</td>
</tr>
<tr>
<td>Appears on other list</td>
<td></td>
</tr>
<tr>
<td>Currently employed by NECSA</td>
<td>17</td>
</tr>
</tbody>
</table>
No proof of employment at NECSA | 03
Remainder | 53

*Application of the relevant law*

5.2.15 As already indicated in the provisions quoted above, NECSA was obligated to report incidents which they became aware of in terms of sections 39(1) and 68(2) of COIDA.

5.2.16 Section 68(2) reads as follows:

"An employer shall within 14 days after having so received notice or having learned in some other way that an employee has contracted a disease referred to in section 65(1), report such disease in the prescribed manner to the commissioner or mutual association concerned, as the case may be, irrespective of whether he may be of the opinion that the employee did not contract such disease in his employ or in the employ of a previous employer”

5.2.17 Section 40(2) COIDA provides that:

"An employee or employer shall, at the request of the Director-General, furnish such further particulars regarding the accident and injuries concerned as the Director-General may require”.

5.2.18 The section above enjoins both the employer and the employee to provide information so as to enable the CF to process the claim. In this instance, NECSA did not provide proof that the information gathered from the Complainants was accordingly submitted to the CF.

5.2.19 NECSA made a valid statement to the Public Protector in its letter dated 10 November 2017, that reporting an occupational disease should be accompanied by medical evidence to support the claim. NECSA however experienced
difficulties referring the former employees due to a level of non-cooperation from the ex-employees. Under normal circumstances where a complainant is cooperative, fourteen days as per 68(2) of COIDA is practical.

Conclusion

5.2.20 NECSA could not furnish evidence showing compliance with the seven (7) and fourteen (14) days prescribed in sections 39(1) and 68(2) of COIDA respectively.

5.2.21 The evidence availed to the Public Protector showed that NECSA indeed took some steps to gather the outstanding information from the Complainants, as requested by the CF, but no evidence was presented proving submission of the information gathered to the CF.

5.3 Regarding whether due process was followed by the CF in the way the CF matters were dealt with and does this constitute maladministration.

5.3.1 During the course of the Public Protector's investigation, it was discovered that there should have been claims arising either from sustaining occupational injury or occupational disease that should have been lodged with the CF by NECSA or the Complainants. Notwithstanding the aforementioned, the Complainants did not make any specific allegations against the CF but instead, the Public Protector elected to investigate whether the CF had discharged its obligation in terms of COIDA.

5.3.2 The Public Protector requested the CF on 26 January 2015, to report on the status and progress of the one hundred and sixty seven (167) claims submitted by NECSA.
5.3.3 The CF’s response dated 6 March 2015 stated that they were unable to assist the Public Protector as NECSA’s list contained incomplete identity numbers. On the same date, however, the CF later reported that only twenty eight (28) claims were traced from their system but they could not give progress on the claims.

5.3.4 The CF reported on 5 June 2015 that:

"...Please take note that various lists with the names and ID numbers of employees were submitted to us, but without any valid claim numbers. The Public Protector could only trace claim numbers for certain employees and feedback is only provided on those claims. It seems that the other claims were not submitted for registration by the employer and can no feedback be provided in those cases…"

5.3.5 Through the correspondence above, the CF provided feedback in respect of fifty seven (57) claims from the list of one hundred and sixty seven (167) received from NECSA. A summary of the feedback is reflected in the table below:

<table>
<thead>
<tr>
<th>Claims finalised</th>
<th>Claims Repudiated</th>
<th>Claims with Outstanding information</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>8</td>
<td>38</td>
</tr>
</tbody>
</table>

5.3.6 On 22 August 2016, a comprehensive list totalling four hundred and seven (407) names was sent to the CF requesting it to provide a full status report and on 27 September 2016, they reported as follows:
<table>
<thead>
<tr>
<th>CLAIM STATUS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepted Claims</td>
<td>42 claims have been registered and liability of the claims has been accepted by the Fund. Out of 42, only 2 claims were for Occupational diseases (OD) and comments were made of what needs to be submitted. The other 40, are for physical injuries.</td>
</tr>
<tr>
<td>Not Accepted Claims</td>
<td>23 claims were registered but liability of the claims was not accepted by the Fund. Out of the 23 claims, 4 claims are for physical injuries and 19 are for OD. Comments were made on the spreadsheet of what is outstanding/or what is needed to adjudicate the claims.</td>
</tr>
<tr>
<td>Not found/or ID Incomplete</td>
<td>277 claims were not found on the system and others the ID numbers are incomplete.</td>
</tr>
<tr>
<td>Repudiated</td>
<td>10 claims were repudiated. A second email will be sent with copies of those repudiation letters.</td>
</tr>
<tr>
<td>Finalised</td>
<td>7 claims were finalised and paid.</td>
</tr>
<tr>
<td>Deceased and not registered</td>
<td>50 queries are for those employees who are deceased. Out of the 50, only 2 have claims numbers that have been registered for OD but were not finalised because of outstanding medical reports. The rest of the 48 queries were never registered for OD with the Fund.</td>
</tr>
</tbody>
</table>

5.3.7 The above summary of the status of the claims from CF is evidence that the majority of claims were not registered or finalised due to insufficient information at the CF’s disposal.
Application of the relevant law

5.3.8 Section 39(1) of COIDA directs the CF to consider and adjudicate claims lodged with them. In this regard, the CF attended to the claims which were submitted to it.

5.3.9 Section 40(1) of COIDA empowers the CF to make any enquiries to enable it to decide on the claim or liability of the CF. The CF requested NECSA and/or the Complainants to furnish further particulars.

Conclusion

5.3.10 The CF attended to the claims reported to them in terms of the applicable prescripts.

5.4 Regarding whether the CF properly adjudicated on the fatal claim of Mr Victor Motha, and did his family suffer improper prejudice:

Common cause

5.4.1 It is common cause that the fatal claim of Mr. Victor Msibose Motha (deceased) was registered with the CF under claim number A1/154527 in terms of COIDA. The claim was only finalised on 10 September 2015.

5.4.2 The deceased’s father, Mr. Jabulani Clive Motha, received a lump sum of R7829.53 in terms of section 54(1)(e) of COIDA and an amount of R6 490.00 for burial expenses on 22 February 2005, in terms of section 54(2) of COIDA.
5.4.3 The issue that the Public Protector had to consider was whether the CF correctly determined compensation payable to Mr. JC Motha.

Application of the relevant law

5.4.4 Section 54 of COIDA provides that in the event of a death of an employee as a result of an injury caused by an accident, compensation shall be payable as follows:

“(d) if the employee leaves no dependants referred to in paragraph (a), (b) or (c) of this subsection but a dependant referred to in paragraph (e) of the said definition, excluding a child over the age of 18 years who is unable to earn an income owing to a physical or mental disability, and-
(ii) who was partly financially dependent upon the employee and there is no dependent as contemplated in subparagraph (i), a lump sum as set out in item 9 of Schedule 4”.

5.4.5 The information at the Public Protector’s disposal is that the deceased’s father was defined as partially dependent on the deceased and qualified for lump sum as calculated in terms of section 54(1)(d)(ii) of COIDA. The information submitted by the CF indicated that the formula employed by the CF was consistent with the above provision.

Conclusion

5.4.6 The CF adjudicated the fatal claim of Mr. Victor Motha in terms of the provisions of COIDA.

5.5 Regarding whether there was a failure by NECSA to conduct a proper investigation into the death of Mr Victor Motha and did his family suffer prejudice

Common cause
5.5.1 The article in Noseweek\(^1\) titled "Dead Man Walking" regarding Mr Victor Motha read:

"... When Victor Motha went to work at the NECSA Pelindaba complex, on the morning of 8 November 2001, it seemed to be a normal day ... but when the 21 year came home that night , he suffered from nausea, a burning throat and chest... he started vomiting. His father rushed him to hospital where he died. Fluorine inhalation was the cause, the post-mortem examination concluded. To process uranium as a fuel in nuclear reactors, fluorine a highly toxic gas is used... four years later Motha's family was given a cheque from NECSA by way of compensation for his death..."

5.5.2 Dr. Servaas Hofmeyr Rossouw determined the cause of death to be "Long-edeem vereensiwigbaar met die gevolg van die inaseming van fluoorgas" which refers to the collapse of the lungs due to the inhalation of fluoride gas.

5.5.3 It was also noted that a former Minister of Minerals and Energy, the Honourable Phumzile Mlambo Ncquka, wrote a letter of condolences to Motha family indicating that she was extremely concerned that an accident could occur and death could come in this fashion. The Minister further gave the family the assurance that no stone will be left unturned in the high level investigations conducted by both NECSA and the Department of Labour.

5.5.4 It is common cause that NECSA sanctioned an investigation into the death of Mr. Motha. The investigation resulted into a report dated 19 November 2001, compiled by Mr AC van der Bijl and checked by Mr CM Posthumus Meyjes and Mr AA Ponelius (hereinafter referred to as the van der Bijl Report).

5.5.5 The van der Bijl report referred to above, stated that:

\(^1\) http://www.noseweek.co.za/article/3195/Dead-men-walking
"...The purpose of this document is to report on the findings of the team that investigated the death of Mr Victor Motha... Building C1 is a hazardous chemical substance area where hard hats, safety spectacles and safety shoes, as well as covered arms, body and legs are mandatory. The investigation team determined that Mr Motha removed the torch from the system and most probably inhaled a hazardous chemical substance during this activity, which may have caused his death. There is also a possibility that the quench probe was still operation or that deposits were still present when the torch was removed. Solid deposits falling out of the quench probe could decompose on the hot reactor lining to form hazardous chemicals, to which Mr Motha would have been exposed when he opened the assembly by removing the torch ... Normally the electrodes of the torch are removed and examined (after each test run) after the system has been flushed with CF4 and nitrogen to clean the process volume.

The following findings indicated that this procedure may not have been followed: The data sheet indicates 14h15 flushing evaporator with CF4; 14h20 stop plasma. There is, therefore, a discrepancy of 5 to 10 minutes on the purging procedure. Analysis of a sample of the filter contents taken after the incident indicated the presence of CF4. This indicates potentially improper/incomplete flushing with N2... a series of experiments were conducted every day from 2001/11/05 to 2001/11/08. The last experiment was started at 08h56 on Thursday, 8 November 2001 ... The most probable cause of Mr Motha’s death was exposure to a hazardous substance, or hazardous substances, such as PFIB ... leaks at the GC could possibly be inhaled by the GC operator”; The vacuum pump system could be a cause of leakage e.g. the outlet. The outlet pipes of the GC are kept in position by pinching them with the ventilation suction damper to the wall of the ventilation duct, this might cause the ventilation in the particular area to be inadequate ... The possibility exists that the flushing operation (with N2) was not completed or that it was ineffective ... Mr Motha removed the torch and gave it to Mr Apane. Mr Motha would therefore be in direct path of any remaining
chemical substance exiting the device. He probably inhaled a hazardous substance, or hazardous substances, which led to his death..."

5.5.6 The Public Protector noted that the van der Bijl report also proposed corrective measures which NECSA should consider to prevent similar accidents.

5.5.7 In their response to the Public Protector dated 06 February 2015, NECSA confirmed that the investigation report was not specific on the use of RPE and the role of the supervisor for the full duration of the task.

5.5.8 NECSA also complied with the provisions of the Occupational Health and Safety Act, General Regulations Section (8) and (9) by reporting and conducting the investigation in accordance with Annexure 1 of the Act. In terms of these sections, there is no indication or set standard of what constitutes a proper investigation. The guide as set out in Annexure 1 was covered in the van der Bijl investigation.

5.5.9 Due to media reports, NECSA’s Board appointed the Mogwera Commission on 22 June 2005. The Commission was required to present its findings and recommendations to the NECSA Board to enable it to respond to media allegations and also to deal with health and safety issues within NECSA. In terms of the Commission Engagement Agreement between NECSA and Mogwera M E G Khothoane, the Consultant was solely responsible for carrying out an investigation and to make recommendations to the Board on:

(a) Events leading to Victor Motha’s death and to review all the previous internal and external investigations relating thereto;

(b) Specific incidents and accidents, which resulted in abnormal exposure to radiation within specific reference to approximately 123 former NECSA employees who worked at NECSA at various time periods;
(c) Fatalities and other reportable health cases with specific reference to approximately 123 former NECSA employees who worked at NECSA at various time periods;

(d) The adequacy of employees' medical records or non-existence of such medical records (i.e. records in general relating to current and former employees);

(e) Any potential occupational diseases as ascertained from the employees' medical records (i.e. the approximately 123 former NECSA employees who worked at NECSA at various time periods).

(f) The adequacy of training;

(g) NECSA's Health, Safety and Environment (HSE) programme inadequacy, thus resulting in employee exposure to radiation; and

(h) Non-issuing of protective equipment to employees and/or black employees within NECSA.

5.5.10 Notwithstanding the above-mentioned scope, the Public Protector could not find any evidence that an investigation as outlined in the terms of reference of the Mogwera Commission was conducted and or that a report on its outcome was submitted to the NECSA Board. The information provided to the Public Protector was that the NECSA's Board terminated the mandate of the Mogwera Commission, and at the time of termination an amount of R240 244.00 was apparently paid for services rendered.
5.5.11 It was noted that an invoice for an amount of R240 224.00 from Mogwera Commission was submitted to NECSA on 05 June 2006. The description of services was indicated as “Objective 1-Milestone 1 of Approved Project Plan: Review, analysis, comment on all reports and data”. Further information regarding confirmation of the services rendered and a breakdown of the amount was requested from NECSA and this information has not been provided by NECSA.

Application of the relevant law

5.5.12 In terms of section 8(1)(2)(a) - (d) of the Occupational Health and Safety Act 181 of 1993 (hereinafter referred to as OHSA) every employer shall provide and maintain as far as is reasonably practicable a working environment that is safe and without risk to the health of employees. This includes the following:

(a) Provision and maintenance of systems of work, plant and machinery that is as far as reasonably practicable safe and without risk to the health of employees;

(b) Taking reasonable steps to eliminate or mitigate any hazard or potential hazards to the health and safety of employees;

(c) Establishing as far as is reasonably practicable, what hazards to the health or safety of persons attached to any work which is performed, any article or substance which is produced, processed, used, handled, stored or transported and any plant or machinery which is used in the business and establish as far as is reasonably practicable what precautionary measures should be taken;

(d) Providing information, training and supervision as may be necessary to ensure as far as is reasonably practicable, the health and safety of employees;
5.5.13 Therefore, in terms of the above legislation, an employer also has a duty to report any incident or accident that resulted in death.

5.5.14 Furthermore, in terms of NECSA’s Safety Health Environment Quality-INS 5300: Written Safe Work Procedure, Instructions, Orientation and task training (hereinafter referred to as the SHEQ INS 5300) last review date 27 October 2011, the manager shall do the following:

(a) “The safe use, handling and operation of machinery and equipment under the managers control as well as activities carried out by the managers group shall be assessed with a view to identify the safety hazards carried out by the managers group and to determine the risks associated therewith;

(b) As far as is reasonable possible, measures shall be taken to reduce/eliminate/control the hazards associated with the use of machinery or the activities so as to make workplace conditions safe;

(c) Where safeguarding is not possible, measures shall be taken to reduce the risk to as low as practicably possible;

(d) Provide PPE and emergency facilities free of charge to the employees reporting to the manager and maintain it in a clean and effective condition to ensure that employees exposed to hazards are safeguarded; and

(e) Ensure that employees are trained in and familiar with the correct use, maintenance and limitations of PPE…”

5.5.15 Further in terms of NECSA’s SHEQ-INS-2490 Issue and Control over Personal Protective Equipment (last review date 22 August 2012), the Supervisor has the responsibility to ensure that workers working in identified areas or carrying out
identified activities shall be permanently issued with the prescribed PPE and use them in the identified areas or during the execution of the identified activities.

5.5.16 In terms of OHSA and NECSA’s internal polices cited above, the manager had a duty to ensure that the safe use, handling and operation of machinery and equipment under the managers control as well as activities carried by the manager’s group was assessed with a view to identify the safety hazards and to determine the risks associated therewith. The manager failed to carry out this task. The manager, as far as is reasonably possible, should have taken measures to reduce/eliminate/control the hazards associated with the use of machinery or the activities so as to make workplace conditions safe. The Manager was required to have taken measures to reduce the risk to as low as practicably possible.

5.5.17 The Manager had a duty to provide PPE’s to ensure that employees exposed to hazards are safeguarded and he had to ensure workers working in identified areas or carrying out identified activities shall be permanently issued with the prescribed PPE’s.

5.5.18 The late Mr Motha should have been using the prescribed PPE’s in this identified area during the execution of his duties. The manager should have ensured that the late Mr Motha was using the prescribed PPE’s, observing the safety rules and instructions and that the prescribed protective clothing was used as he was working with hazardous Chemicals.

5.5.19 As regards the investigation of this matter, it was noted during the investigation that NECSA paid the Mogwera Commission an amount of R240 244.00, despite confirmation from NECSA that the Commission did not finalise or submit the report. The invoice indicated that the payment was for “Objective 1-Milestone 1 of Approved Project Plan: Review, analysis, comment on all reports and data.”
5.5.20 NECSA did not submit a detailed breakdown of the services rendered and a cost breakdown for such services. The evidence submitted was a one page project plan. In terms of the Agreement, the Consultant’s remuneration was R400.00 per hour and the evidence of a one page project plan does not justify the amount of R244 244.00 paid to the Mogwera Commission. If one should divide the amount paid by the hourly rate, it means that the Consultant rendered services for six hundred hours (600) hours (which is about three (3) months). It follows therefore, that the work done by the Mogwera Commission, does not justify the cost.

5.5.21 Apart from the failed commission which was supposed to have investigated the death of Mr. Motha, NECSA had already conducted an internal investigation which did not sufficiently deal with the matter.

5.5.22 The van der Bijl report attributed the death of Mr. Motha to the incident that took place at NECSA, Pelindaba Complex, on the morning of 8 November 2001. However, the investigation did not deal with the accountability of either the supervisor and/or the deceased.

Conclusion

5.5.23 NECSA failed to conduct a proper investigation into the death of Mr. Victor Motha.

6 FINDINGS

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

6.1 Issue one: Whether the Complainants suffered adverse medical conditions as a result of their employment with NECSA and did this cause them to suffer improper prejudice?
6.1.1 The Public Protector could not make any findings regarding whether the Complainants suffered adverse medical conditions as a result of their employment with NECSA, or that it caused them to suffer improper prejudice;

6.1.2 The majority of Complainants were never tasked to deal with hazardous materials and furthermore none of the Complainants had any security clearance to access high risk areas. The available information shows that they were not exposed to hazardous chemicals;

6.1.3 Quite a substantial period of time had passed between the period that the Complainants left NECSA’s employment and the time when they started complaining about this issue;

6.1.4 Pre 2000 NECSA had no policies or regulations regulating pre- employment and exit medical examinations for NECSA employees. Currently however, pre- and exit- medical interviews are conducted on all employees of NECSA;

6.1.5 Inadequate medical records of employees were kept by NECSA prior 2005;

6.1.6 There was no conclusive evidence presented to the Public Protector indicating that there were any employees who had died because of radiation exposure. The evidence in the form of death certificates only revealed that the deaths were as a result of natural cause; and

6.1.7 The Public Protector is accordingly unable to conclude whether the conduct of the NECSA constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in term of section 182(1) of the Constitution.
6.2. Regarding whether due process was followed by NECSA in the way the CF matters were dealt with and does this constitute maladministration?

6.2.1 The allegations that NECSA failed to follow due process when dealing with the CF matters is substantiated;

6.2.2 There were a few CF matters which had been reported to the CF over the years, but the bulk of complaints relating to the Complainants were reported to the CF in 2007 after the investigation by Dr Joubert. However, the reporting of these claims to the CF was not done in compliance with sections 39(1) and 68(2) of COIDA in that NECSA did not report the accident or occupational disease within seven (7) and fourteen (14) days of having received notice of the accident; and

6.2.3 Therefore, the Public Protector accordingly finds that the conduct of the NECSA constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in terms of section 182(1) of the Constitution.

6.3. Whether due process was followed by the Compensation Fund in dealing with the claims lodged and does this constitute maladministration?

6.3.1 The allegation that the CF failed to follow due process when dealing with the Complainants’ claims could not be substantiated.

6.3.2 The CF processed all claims received from NECSA in accordance with section 39(1) and 40(1) of COIDA; and

6.3.3 Therefore, the Public Protector is unable to find that the conduct of the CF constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in term of section 182(1) of the Constitution.
6.4. Whether the CF properly adjudicated the fatal claim of the late Mr. Victor Motha and did his family suffer improper prejudice?

6.4.1 The allegation that the CF improperly adjudicated on the fatal claim of the late Mr. M Victor Motha could not be substantiated;

6.4.2 The Public Protector established that liability for the payment of compensation as well as reasonable medical expenses was accepted by the CF. Compensation to the amount of R 7829.53 was paid by the CF on 12 July 2006 in favour of Mr Motha’s father, Mr Jabulani Motha, and an amount of R6 490.00 towards burial expenses on 22 February 2005;

6.4.3 The calculation of the compensation received by the deceased’s father was in accordance with sections 54(1)(e) and 54(2) of COIDA; and

6.4.4 Therefore, the Public Protector is unable to find that the conduct of the CF constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in term of section 182(1) of the Constitution.

6.5. Whether there was failure by NECSA to conduct a proper investigation into the death of Mr Victor Motha and did his family suffer prejudice?

6.5.1 The allegation that NECSA failed to conduct a proper investigation into the death of Mr. Victor Motha is substantiated.

6.5.2 NECSA failed to ensure that the Mogwera Commission undertakes the investigation it was commissioned to conduct and the subsequent investigation by Dr Joubert did not carry through all the terms of reference which were given to the Mogwera Commission;
6.5.3 The van der Bijl investigation was not specific on the use of Reflective Protective Equipment (RPE) and the role of the supervisor for the full duration of the task; and

6.5.4 Therefore, the Public Protector finds that the conduct of NECSA constitutes maladministration as envisaged in section 6(4)(i) of the Public Protector Act and improper conduct in term of section 182(1) of the Constitution.

7. REMEDIAL ACTION

7.1 The appropriate remedial action the Public Protector is taking in pursuit of section 182(1)(c) of the Constitution, with a view of placing the Complainants as close as possible to where they would have been had the improper conduct or maladministration not occurred, is the following:

7.1.1 The NNR and NECSA must within 60 days of this report subject the employees identified in Mzansi Energy Solutions and Innovations (Pty) Ltd (MZESI) report for further evaluation as recommended by MZESI. NECSA has identified its commitment to this remedial action, subject to the availability and cooperation of the identified Complainants. NECSA also confirmed to pay for all specialist medical costs to investigate the occupational disease claimed by the Complainants. NNR also accepted the proposed remedial action.

7.1.2 NECSA must provide all employees with a copy of the exit certificate and the exit certificates must also be placed in their files.

7.1.3 In terms of the PPE issued and training on the use thereof, there should be strict compliance with the register that is kept by managers. This should be audited annually.

58
7.1.4 All Sub-contractors must be subjected to on-going training on all risk factors within the scope of their employment. NECSA has already indicated that it will ensure that all sub-contractors are trained on risk factors associated with work at NECSA. NECSA also committed to continue to ensure enforcement of the safety requirements as per the Act due to the vicarious liability of NECSA to acts and omissions that can put the health of the sub-contractor employees at risk section (8) and (9) of the OHS Act.

7.1.5 NECSA should within 30 days of this report submit to the CF all outstanding information and documents at their disposal relating to the Complainants’ claims.

7.1.6 NECSA should issue a written apology to Mr Motha’s family for failure to conduct a proper investigation into the death of Mr Motha.

7.1.7 NECSA must within three (3) months from date of this report, consider paying to the Motha family an ex gratia payment amount as determined as reasonable consolatory payment for the frustration and distress they have suffered as a result of failure by NECSA to conduct a proper investigation into the death of Mr. Victor Motha.

8. MONITORING

8.1 The Public Protector will require the Group Chief Executive Officer of NECSA to advise on NECSA’s action plan in respect of the remedial action to be taken, indicating timelines, within 30 days of the issuing of this report.
8.2 The Public Protector will monitor the remedial action in terms of this report within one month of its signature, and thereafter, every three months.

ADV BUSISIWE MKWEBANE
PUBLIC PROTECTOR OF THE
REPUBLIC OF SOUTH AFRICA
DATE: 09/05/2018

Assisted by:

Adv E De Waal
Adv J Singh
Adv A Dathi
Ms S Van Wyk
Ms A Sombhani