**REPORT OF THE PUBLIC PROTECTOR IN TERMS OF SECTION 8(1) OF THE PUBLIC PROTECTOR ACT, 1994**

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# ADVISORY REPORT ON AN INVESTIGATION OF FAILURE BY THE FUNCTIONARIES OF THE STELLENBOSCH HOSPITAL TO INFORM PARENTS OF A MINOR FEMALE PATIENT ABOUT AN ALLEGED INCIDENT OF RAPE AND THE ALLEGED DELAY TO REPORT IT TIMEOUSLY

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## LIST OF ACRONYMS

| ACRONYMS / ABBREVIATIONS | DESCRIPTIONS |
|---|---|
| **Constitution** | The Constitution of the Republic of South Africa, 1996 |
| **Public Protector Act** | The Public Protector Act, 23 of 1994 |
| **SAPS** | The South African Police Services |

## 1 INTRODUCTION

1.1 This is the Advisory 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 published in terms of section 8(1) of the Public Protector Act, No. 23 of 1994, (the Public Protector Act).

1.2 This Advisory Report communicates the findings and recommendations in respect of an investigation into allegations of a failure by the Stellenbosch Hospital Management (the Hospital Management), to report an alleged rape incident that occurred in the hospital involving a 15-year-old minor (Patient X), with a 19-year-old male adult on 23 September 2021. Both Patient X and the adolescent male were admitted for mental health care and observation at the Stellenbosch Hospital (the Hospital), when the incident occurred.

1.3 The investigation was conducted in terms of section 182 of the Constitution, which gives the Public Protector the power to investigate any alleged or suspected improper or prejudicial conduct in state affairs, to report on that conduct and to take appropriate remedial action.

## 2 THE COMPLAINT

2.1 This is an own initiative investigation in terms of section 6(4)(a)(i) and (v) of the Public Protector Act, following media reports of 30 September 2021, by eNCA (https://www.addtoany.com/share) and 01 October 2021, by the Cape Times, respectively.

2.2 On 30 September 2021, eNCA reported amongst others, that:

2.2.1 The South African Police Services (SAPS) was investigating a complaint of rape, after a 15-year-old was allegedly raped by a fellow patient in a Psychiatric Ward at the Hospital. It is further reported that the Hospital Management was accused of negligence and of trying to cover up the

alleged rape. It was also reported that the Western Cape Health MEC, Ms Nomafrench Mbambo (Ms Mbambo), stated that the Department's internal investigation will seek to establish why a male and female patient were in the same Ward, including confirmation that SAPS was investigating the alleged rape and related matters.

2.3 On 01 October 2021, the Cape Times reported amongst others, that:

*"An internal investigation is expected into the alleged rape of a 15 year old at Stellenbosch Hospital. Health MEC Nomafrench Mbombo on Thursday visited the hospital, which has been accused of negligence and trying to cover up the sexual assault matter that happened on September 16- by only informing the parents nine days later. The teenager was admitted at the hospital after she tried to commit suicide. Ms Mbambo met with the minor's family, while the hospital management has since apologised on behalf of Stellenbosch health workers''.*

2.4 The news article further quoted Ms Mbombo stating that, "I *was informed on Wednesday that a teenager who is a patient at the hospital was allegedly sexually assaulted by another patient. I asked for a report from the department which I received, hence the visit". (sic)*

2.5 The Public Protector commissioned an own initiative investigation of the incident following its publication by the two (2) media houses. The investigation required the Investigation Team of the Public Protector to conduct an inspection *in loco* at the Hospital to gather information in order to determine the merits of the media reports and the manner in which the investigation will be conducted.

2.6 On 12 October 2021, the Investigation Team held a meeting with the Hospital Management and conducted an inspection *in loco* at the Ward, where the incident occurred.

2.7 During the information gathering process, it was established that the incident occurred on 23 September 2021. The Hospital Management informed the mother of Patient X of the incident on 25 September 2021. It was also submitted by the Hospital Management that the incident was reported to SAPS by the mother of Patient X, on 27 September 2021.

2.8 Based on the information gathered during the meeting and inspection *in loco* conducted, the Public Protector's view was to proceed with an own initiative investigation with a view to unearth the full truth of what happened and hold those who were found to have breached the applicable legislative prescripts, accountable.

## 3 POWERS AND JURISDICTION OF THE PUBLIC PROTECTOR

3.1 The Public Protector is an independent state institution established under section 181(1)(a) of the Constitution to strengthen constitutional democracy through amongst others, investigating and redressing improper conduct in state affairs or public administration and take appropriate remedial action.

3.2 Section 182(1) of the Constitution provides that:

"*The Public Protector has the 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) of the Constitution directs that the Public Protector has additional powers and functions prescribed by the Public Protector Act. The Public Protector's powers are regulated and amplified by the Public Protector Act which states, amongst others, that the Public Protector has

the powers to investigate and redress maladministration and related improprieties in the conduct of state affairs as well as any act or omission by a person in the employ of government at any level, which results in unlawful or improper prejudice to any person.

3.4 Section 6(4)(c)(ii) of the Public Protector Act provides that the Public Protector "*shall be competent at any time prior to, during or after an investigation, if he or she deems it advisable, to refer any matter which has a bearing on an investigation, to the appropriate public body or authority affected by it or to make an appropriate recommendation regarding the redress of the prejudice resulting from or make any other appropriate recommendation he or she deems expedient to the affected public body or authority.*"

3.5 The Public Protector Act further confers on the Public Protector the sole discretion to determine how to resolve a dispute of alleged improper conduct or maladministration.

**4. ISSUE IDENTIFIED FOR INVESTIGATION**

4.1 Based on the analysis of the media reports, information gathered during the inspection *in loco* and meeting held with the Hospital Management, the following issue was investigated:

4.1.1 Whether the Hospital Management failed to inform the parents of Patient X and SAPS about the alleged rape incident that occurred at the Hospital and if so, whether their conduct constituted improper conduct as envisaged in section 182(1) of the Constitution and maladministration and improper prejudice as envisaged in section 6(4)(a)(i) and (v) of the Public Protector Act.

## 5. THE INVESTIGATION

### 5.1 The investigation process

5.1.1 The investigation was conducted in terms of section 182(1) of the Constitution read with sections 6 and 7 of the Public Protector Act.

5.1.2 The approach to the investigation included the conducting of an inspection *in loco*, obtaining of documents, meetings held between the Investigation Team and the Hospital Management, analysis of the relevant documentation and consideration and application of the relevant laws, and prescripts.

### 5.2 The Investigation approach

5.2.1 The investigation was approached using an enquiry process that seeks to determine:

5.2.1.1 What happened?

5.2.1.2 What should have happened?

5.2.1.3 Is there a discrepancy between what happened and what should have happened and does that deviation amount to maladministration, abuse of power or other improper conduct or prejudice?

5.2.1.4 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.

5.2.1.5 In this particular case, the factual enquiry principally focused on whether the Hospital Management failed to inform the parents of Patient X and SAPS about the alleged rape incident that took place, in breach of the relevant legislative and policy prescripts regulating admission, monitoring

and supervision of patients admitted for mental health care and observation in the Hospital.

5.3 **Key sources of information and documentation**

5.3.1 **Copies of documents received**

5.3.1.1 A copy of the Standard operating procedure for admitting children and adolescent to Stellenbosch Hospital, approved on 20 December 2021;

5.3.1.2 Mental Health Quality Improvement Plan, signed on 24 December 2021;

5.3.1.3 Disciplinary measures applied;

5.3.1.4 Emergency Centre Notes Adult Triage form, STB 19797794; and

5.3.1.5 Incident Report- Patient KKM 1979779, dated 14 October 2021.

5.3.2 **Copies of correspondences exchanged**

5.3.2.1 Copy of Incident Report-Patient KKM 1979779, received from Dr Blanckenberg, on 14 October 2021;

5.3.2.2 Allegations letter sent to the Head of Department on 04 February 2022; and

5.3.2.3 Response from the Head of Department, dated 23 February 2022.

5.4 **Legislation and other prescripts**

5.4.1 The Constitution of the Republic of South Africa, 1996;

5.4.2 The Public Protector Act, 1994;

5.4.3 Mental Health Care Act, 2002;

5.4.4 Criminal Law (Sexual offences and related matter), 2007;

5.4.5 Children's Act, 2005;

5.4.6 Western Cape Department of Health Standard Operating Procedure No A007: Informed consent for medical and surgical procedures, investigations and specific therapies;

5.4.7 Standardised Guidelines for the Management of Survivors of Rape or Sexual Assault; and

5.4.8 Policy Guidelines on 72-hour assessment of involuntary mental health care users.

## 6. DETERMINATION OF ISSUES IN RELATION TO THE EVIDENCE OBTAINED AND CONCLUSION MADE WITH REGARD TO THE APPLICABLE LAWS AND PRESCRIPTS

### 6.1 Whether the Hospital Management failed to inform the parents of Patient X and SAPS about the alleged rape incident that occurred at the Hospital and if so, whether such conduct constituted improper conduct as envisaged in section 182(1) of the Constitution and maladministration and improper prejudice as envisaged in section 6(4)(a)(i) and (v) of the Public Protector Act

*Common cause*

6.1.1 Patient X was admitted at the Hospital on 18 September 2021, as reflected in the *Emergency Centre Notes Adult Triage Form, STB 19797794*. It is also recorded in the *Emergency Centre Notes Adult Triage Form* that Patient X was brought to the Hospital by her mother.

6.1.2 Patient X was found by a Professional Nurse engaging in an act of coitus with another 19-year-old male patient in the toilet on 23 September 2021,

at approximately 16h30, as reflected in page 6 of the *Problem-Orientated Patient Record*. The toilet is shared by both males and females in Ward A and B.

6.1.3 The Professional Nurse, who witnessed the incident, recorded it in Patient X's file. The Hospital Management informed the mother of Patient X about the incident via a telephone call on 25 September 2021. A criminal case was opened with SAPS, against the male patient by the mother of Patient X, on 27 September 2021, with CAS 532/09/2021.

6.1.4 Dr Blanckenberg only reported the incident to the Mental Health Review Board on 01 October 2021 and Patient X was only transferred to Tygerberg Hospital Adolescent Psychiatric Unit on 06 October 2021.

6.1.5 Disciplinary action was taken against Ms T Madlana (Ms Madlana), the professional nurse responsible for the Adolescent Psychiatric Unit, for not reporting the incident to the doctor in charge at the time when the incident occurred. Disciplinary action was also taken against Dr G Cornelissen (Dr Cornelissen) for not immediately informing the family of Patient X or SAPS about the incident. He was also given a corrective counselling sanction.

6.1.6 During the inspection *in loco* conducted by the Investigation Team on 12 October 2021, the Hospital Management submitted that although Ward A, where Patient X was admitted housed both male and female patients sharing one toilet, female patients are housed in separate rooms from the males in the Ward from the males.

*Issue in dispute*

6.1.7 The issue for the Public Protector's determination was whether the Hospital Management failed to report the alleged rape incident to the parents of Patient X and SAPS timeously, and whether the Hospital Management negligently dealt with the incident.

*Inspection in loco and meeting held with the Hospital Management*

6.1.8 An inspection *in loco* and a meeting was held on 12 October 2021, between the Hospital Management and the Investigation Team for purposes of gathering information and evidence about the incident. During the engagement, the Hospital Management through Dr Blanckenberg advised the Investigation Team *inter alia* that:

6.1.8.1 The hospital disputed that it failed to inform the parents of Patient X timeously, contending that several attempts to contact the mother were made without success;

6.1.8.2 The hospital disputed further that it failed to report the incident to SAPS timeously, contending that it reported the incident to the Social Worker in conformity with the relevant provisions of the Children's Act No 41 of 2007;

6.1.8.3 Patient X was admitted on 18 September 2021, as an involuntary patient in terms of the Mental Health Care Act;

6.1.8.4 On 23 September 2021, Patient X and a 19-year-old male patient were found by Ms Madlana at about 16h00 engaging in coitus in a toilet that was shared by both male and female patients in the Ward. Ms Madlana, who witnessed the incident, did not immediately inform the Operational Manager or Dr Cornelissen, the doctor on duty at the time;

6.1.8.5 However, Ms Madlana wrote on Patient X's file that, she was found engaging in an act of coitus with a male patient in the toilet;

6.1.8.6 Ms Madlana informed the nightshift manager about the incident, who later telephonically informed Dr Cornelissen about the incident. Dr Cornelissen advised the nightshift manager, Ms Osman that Patient X, be administered with an emergency contraceptive and prophylaxis to prevent pregnancy and sexually transmitted infections;

6.1.8.7 It was further submitted by the Hospital Management that Dr Cornelissen contacted Dr B Williams (Dr Williams), who was on standby, and informed him about the incident. Dr Cornelissen also informed the hospital social worker, Ms L Sassman (Ms Sassman), who was already off duty, about the incident via a telephone call;

6.1.8.8 It was also stated that Dr Cornelissen was further advised by Dr Williams to investigate the incident the following day (24 September 2021), before informing Patient X's parents;

6.1.8.9 It was the submission of the Hospital Management that Dr Blanckenberg was informed about the incident telephonically, by Dr Williams on 24 September 2021, at approximately 18H00. Dr Blanckenberg advised Dr Williams to immediately contact Patient X's family to inform them about what happened;

6.1.8.10 Dr Williams, as advised by Dr Blackenberg, attempted to contact Patient X's mother telephonically on 24 September 2021, but unfortunately could not get hold of her. On 25 September 2021, the mother was reached and informed of the incident. She was invited to go to the Hospital on 26 September 2021, but she indicated that she would be able to visit the Hospital on 27 September 2021;

6.1.8.11 On 27 September 2021, a meeting was held between the parents of Patient X, Dr Cornelissen and Ms Sassman, wherein the parents of Patient X were again informed in person about the incident. Ms Sassman advised the parents of Patient X, to open a criminal complaint against the 19 year old male patient;

6.1.8.12 It was also stated that disciplinary action was taken against Dr Cornelissen, as he did not contact Patient X's parents as advised by Dr Williams; and

6.1.8.13 The Hospital Management further submitted that the Hospital neither has a Psychiatrist Unit nor a Psychiatric Ward, but has an Observation Unit for mental health patients as it was a District Hospital.

*HoD's written response to the allegations*

6.1.9 After the inspection *in loco* and meeting was held on 12 October 2021, the Head of Department for the Western Cape Provincial Department of Health (the Department), Dr Keith Cloete (Dr Cloete), was informed about the investigation through a letter dated 04 February 2022. Dr Cloete responded to the Public Protector's letter on 18 February 2022, stated amongst others that:

6.1.9.1 The Department views the attitude of staff in a serious light as they are expected to uphold the values of the Department and as such disciplinary measures were taken against Ms Madlana, who witnessed the incident and neglected to report to the supervisor. The sanction decided upon was not severe, because her omission arose from an error of judgment, her experience and she was distracted by an incident of another acutely disturbed patient who required sedating, in another Ward;

6.1.9.2 Disciplinary measures were also taken against the medical officer who failed to inform Patient X's parents, the Manager: Medical Services or SAPS. The sanction imposed was corrective counselling on the basis that he was not officially on duty when he was informed about the incident;

6.1.9.3 He had no direct information on what happened as the professional nurse did not report the incident directly to him and therefore he was not in a position to act on what he considered as hearsay. Upon coming on duty the following morning, he reported the incident to the senior doctor, who later reported it on the same day to the Manager: Medical Services. The medical officer did not report the matter to the SAPS, however, he immediately reported the incident to the hospital social worker, who was also not on duty when the incident took place;

6.1.9.4 No disciplinary action was taken against the Manager: Medical Services on the basis that as soon as she was informed about the incident, she instructed the doctor on duty to inform the parents of Patient X. It took many

attempts to reach the parents of Patient X via telephone. The Manager: Medical Services neither enquired if the incident was reported to SAPS, nor instructed the doctor on duty to report the incident to SAPS, but she was aware that the incident was reported to the hospital's social worker, who would then take the matter further. The action of the Manager: Medical Services was guided by section 110(1) of the Children's Act 35 of 2007 which provides that; *"Any…medical practitioner…who on reasonable grounds concludes that a child has been…sexually abused…must report that conclusion in the prescribed form to a designated child protection organisation, the provincial department of social development or a police official"*; and

6.1.9.5 The incident was reported to SAPS on the Monday morning following the incident being 27 September 2021. The Manager: Medical Services also reported the incident to the District Director as soon as she became aware of it. The Manager: Medical Services was new at the Hospital. The Manager assumed duty on 1 September 2021 and the incident occurred three weeks thereafter.

*Interventions by the Department*

6.1.10 In addition to the response above, Dr Cloete further reflected on the immediate and long-term interventions taken by the Department to minimise the risk of future occurrence of similar incidents by submitting amongst others that:

6.1.10.1 The Standard Operating Procedures (SOPs), for the admission of children and adolescents have been developed and implemented to prevent children under 18 years of age, being admitted to the mental health care Ward, unless the degree of their behavioural disturbance makes it impossible to nurse them safely in an open Ward;

6.1.10.2 In-Service-Training has been provided to staff on reporting patient safety incidents. The SOP was issued on 20 December 2021, to the Hospital

Management and implemented on the same date. The objective of the SOP was to provide clarity to "admitting staff", as to where and how to admit children and adolescents into the hospital for mental observation;

6.1.10.3 A Quality Improvement Programme for Mental Health Care has been developed and implemented and significant improvement in care and compliance with the Mental Health Care Act has been observed;

6.1.10.4 Ward A, where the incident occurred, remains a mixed Ward, however, male and female patients are never accommodated in the same room. A staff toilet in Ward A, was given up and designated as a female toilet to ensure that there is separation of male and female toilets;

6.1.10.5 A Ward program is in place, which dictates the hours when the shower room can be used by male and female patients. Access to the bathroom area is controlled and monitored by staff;

6.1.10.6 A security guard is posted/stationed at Ward A every shift;

6.1.10.7 An Employee Assistance Programme, to debrief the staff, was conducted by a service provider on 7 October 2021;

6.1.10.8 A renovation and refurbishment project was due to commence during the 2022 financial year, which will include an area for psychiatric patients; and

6.1.10.9 A new Acute Psychiatric Unit is required to provide appropriate short-term accommodation for medium and high acuity psychiatric patients within a dedicated secure environment with no direct access to the rest of the hospital Wards. It will provide a space where highly disruptive or behaviourally disturbed patients can be contained and managed without disruption to the general Ward patients in the Hospital. A proposal was submitted by the Hospital Management to convert Ward A for this purpose and all the rooms identified for this use will be fitted out identically and based on the standard for a high acuity seclusion rooms, described as:

(a) Seclusion rooms X4 will be provided;

(b) Dedicated shower room with toilet and basin to serve the seclusion rooms;

(c) A secure open-air courtyard for the psychiatric patients, provided off the common area within the unit, the infrastructure will comply with the prescribed specifications. Close Circuit Television (CCTV) system will be part of this; and

(d) There is now a Security Guard stationed permanently in the mental health care Ward. The small size of the Ward enables direct observation of patients by walking amongst them and it is preferable to CCTV. The effective monitoring of a CCTV system would require the full attention of a member of staff on every shift.

6.1.11 In substantiating his above response, Dr Cloete also submitted a copy of a report prepared by Dr Blanckenberg, dated 14 October 2021, titled *Incident Report-Patient KKM 19797794-aged 15, hereafter referred to as Patient K* (the Report), referred to as Patient X by the Public Protector, wherein it was stated amongst others that:

6.1.11.1 The coitus incident occurred on 23 September 2021 and neither the parents of Patient X were informed immediately about the incident nor was the incident immediately reported to SAPS. Attempts to reach the parents of Patient X were made without success, on 24 September 2021. The mother of Patient X was reached on 25 September 2021 and informed about the incident. She was also invited to come to the hospital to be physically informed about the incident. The mother of Patient X and other family members were then informed about the incident in a meeting held at the hospital premises on 27 September 2021;

6.1.11.2 On 23 September 2021, there were nine (9) psychiatric patients in Ward A. Ms Madlana was on duty and two nursing assistants. The Operational

Manager for Ward A and D was on duty until 16H00. One of the patients broke a window in the ward and escaped through the emergency exit and the two (2) nursing assistants and security ran after the patient, leaving Ms Madlana alone to attend to other remaining eight (8) patients;

6.1.11.3 Whilst Ms Madlana was conducting the rounds checking whether all patients were present, she discovered that Patient X and a nineteen (19) year old male patient were not in their respective rooms. She continued checking and found the two patients engaged in an act of coitus in the patients' toilet in the Ward;

6.1.11.4 It was the observation by Ms Madlana that the manner in which they were engaged in the act of coitus, made her to believe that it was a mutual consensual act;

6.1.11.5 Patient X later told Ms Madlana that the male patient was her boyfriend. Dr Cornelissen, who was the doctor on duty in Ward A, was not informed Ms Madlana about the act of coitus involving Patient X;

6.1.11.6 Ms Madlana recorded the incident in Patient X's file and did not think it was necessary to report the incident to the nursing manager on duty. However, Ms Madlana informed the nightshift staff manager about the incident during the handover process at about 19H00 and then she went off duty for the weekend;

6.1.11.7 Upon being informed about the incident by Ms Madlana during the hand over process, the nursing manager, who was in charge of the night shift staff, contacted Dr Cornelissen, who was already off duty and informed him about the incident involving Patient X;

6.1.11.8 The further findings of the report are that:

*(a)* "*There was an initial delay of approximately 24 hours in trying to make contact with the parents and in reporting the incident to the Head of the Institution. This may be due to a failure to recognise the seriousness of the event because of the apparent consensual nature*

*of the sexual encounter, even though the one patient was both psychotic and under age. The nurse who witnessed the incident was both inexperienced-as a community service nurse-and occupied with another disruptive event in the ward at the time of the incident;*

*(b) There was also an initial reluctance by the doctor to report the event to the parents based on hearsay, as the witness of the event had not spoken to the doctor directly;*

*(c) The incident was not reported to the SAPS over the weekend. There was no clarity among the clinical staff about whether it was necessary to report it to SAPS over the weekend, or to allow the social worker to take care of any necessary legal processes on the Monday morning;*

*(d) Stellenbosch Hospital does not have adequate infrastructure for the care and containment of behaviourally disturbed psychiatric patients"*

6.1.11.9 The Report also stated that disciplinary action, in the form of corrective counselling, was taken against Ms Madlana for failing to report the incident to her manager, and Dr Cornelissen on duty for not immediately trying to contact the patient's parents.

*Follow up meeting and inspection in loco*

6.1.12 Following the receipt of the response from Dr Cloete and the assessment of the interventions that were alleged to have been put in place to correct the situation, the Investigation Team regarded it as prudent to conduct a follow up inspection *in loco* and meeting with the Hospital Management to observe the interventions that have been put in place. The follow up inspection *in loco* and meeting was conducted on 20 December 2022 and the following was established:

6.1.12.1 A renovations and refurbishment project of a new Ward was in progress and it was observed that the Ward will have four toilets;

6.1.12.2 A security guard was permanently placed in the mental health care Ward. Although there is no CCTV in the Ward, there is CCTV in the seclusion rooms; and

6.1.12.3 Dr Blackenberg informed the Investigation Team that although a criminal case was opened against the male patient with SAPS by the mother of Patient X, the National Prosecuting Authority declined to prosecute for lack of evidence on the basis of criminal incapacity for the criminal act of rape (sexual assault).

*Applicable law and prescripts*

**The Constitution of the Republic of South Africa, 1996**

6.1.13 The constitutional values and principles governing public administration enshrined in section 195(1) of the Constitution require amongst others that a high standard of professional ethics as well as the fostering of transparency must be promoted in public administration by providing the public with timely, accessible and accurate information.

**Criminal Law (Sexual offences and related matters), 2007**

6.1.14 Section 54 of the Act, requires that anyone who has knowledge that a sexual offence has been committed against a child to report it to a police official immediately.

**Children's Act, 2005**

6.1.15 Section 110(3) of the Children's Act requires that any person who report a sexual assault incident involving a minor, is to substantiate that conclusion or belief to the provincial Department of Social Development or SAPS.

*Analysis of evidence*

6.1.16 The evidence before the Public Protector revealed that the incident occurred on 23 September 2021 and was reported to the mother of the Patient X on 25 September 2021. The mother of Patient X reported the incident to SAPS on 27 September 2021, three (3) days after the incident occurred.

6.1.17 According to the SOP of the Hospital, Ms Madlana was duty bound to report this incident to Dr Cornelissen. However, she only recorded it on Patient X's file and informed the nightshift staff, who informed Dr Williams and subsequently Dr Cornelissen was informed.

6.1.18 In this instance, the incident was reported to the SAPS by the mother of Patient X, who was not present during the incident, instead of the report to be made by Ms Madlana.

*Conclusion*

6.1.19 The evidence submitted reflects that:

6.1.19.1 Ms Madlana witnessed the coitus incident, recorded it in Patient X's file and informed the night staff manager about the incident. Attempts to contact the parents of Patient X were made on 24 September 2021, without success and the parents were eventually reached on 25 September 2021 and informed about the incident;

6.1.19.2 The parents of Patient X were also invited for a meeting, which took place on 27 September 2021 and it was also reported to SAPS on the same day by the mother of Patient X. The Department implemented interventions to mitigate the risk of similar or related incidents from happening. Disciplinary action was taken against all staff members, who were found to have acted improperly;

6.1.19.3 Dr Cornelissen and Ms Madlana failed to make immediate attempts to inform the parents of Patient X, timeously about the incident in line with the provisions of section 195(1) of the Constitution; and

6.1.19.4 Ms Madlana did not report the incident to SAPS in line with the provisions of section 54 Criminal Law (Sexual offences and related matters), 2007.

## *7.* FINDINGS

7.1 Having considered the evidence obtained as well as the information obtained and analysed, the following findings are made:

7.1.1 **Whether the Hospital Management failed to inform the parents of Patient X and SAPS about the alleged rape incident that occurred at the Hospital and if so, whether their conduct constituted improper conduct as envisaged in section 182(1) of the Constitution and maladministration and improper prejudice as envisaged in section 6(4)(a)(i) and (v) of the Public Protector Act**

7.1.2 The allegation whether the Hospital Management failed to inform the parents of Patient X and SAPS about the alleged rape incident that occurred in the Hospital is substantiated.

7.1.2.1 Attempts to reach parents of Patient X, by Dr Williams on 24 September 2021, were unsuccessful due to the fact that the only contact number, which was submitted to the hospital during the admission of Patient X, was not reachable and there was no alternative contact number available on the file;

7.1.2.2 The parents of Patient X were informed about the incident on 25 September 2021, via a telephone call and during a meeting held on 27 September 2021, between the Hospital Management and the parents of Patient X. The parents were also advised to open a criminal case with SAPS against the male patient;

7.1.2.3 Corrective actions were taken against Dr Cornelissen for delaying to immediately make efforts to contact the parents of Patient X, as advised by Dr Williams and against Ms Mandlana for failing to inform her supervisor about the occurrence of the incident;

7.1.2.4 The media reports suggesting that the parents of Patient X were only informed nine (9) days after the occurrence of the incident and that there was negligence in the manner in which the incident was dealt with or that the Hospital Management wanted to cover up the occurrence of the incident are not correct;

7.1.2.5 The Department has put measures in place to mitigate the risk of future occurrence of similar or related events and a contractor has been appointed to refurbish and renovate the Ward to ensure that it conforms to the Guidelines regulating the admission of mental health care patients;

7.1.2.6 When the incident occurred, there was neither CCTV nor security personnel, however, during the inspection *in loco* held on 20 December 2022, it was established that there is currently a security personnel permanently posted in the Ward. The hospital indicated that it was unable to install CCTV due to financial constraints; and

7.1.2.7 A SOP has been developed and implemented and In-Service-Training for staff has been conducted.

## 8. OBSERVATIONS

8.1 Despite the above interventions, there is still a need to develop and put measures in place stipulating the timeframes within which an emergency and/or any eventuality, which may befall patients in the care of the Hospital, is to be reported to the patients’ immediate family member(s) and/or relevant authorities. Currently there are no written turnaround times stipulating the timeframe upon which hospital staff should report such incidents to relevant stakeholders or parties.

8.2 The file of Patient X, did not contain sufficient information to enable the Hospital Management to get in contact with the family of Patient X or other immediate family members.

8.3 It was through the own initiative investigation by the Public Protector, which commenced following the publication of the incident in the print media, that the hospital developed and implemented certain interventions to mitigate the risk of future occurrence of a similar or related incident in the Hospital.

## 9 RECOMMENDATIONS

9.1 The following recommendations are made in terms of section 6(4)(c)(ii) of the Public Protector Act.

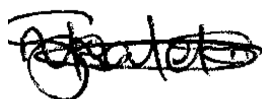
**Within sixty (60) days of receiving this Advisory Report, the HoD should:**

9.1.1 Develop and implement a directive stipulating the timeframes within which an emergency and/or any eventuality that may befall patients in the care of the Hospital is reported to the patients or immediate family member(s) and/or relevant authorities or parties; and

9.1.2 Ensure that patient files contain sufficient contact information and addresses, including alternative contact details to ensure that immediate family members of patients are easily contactable and provided with accurate information timeously, to ensure that professional ethical conduct and transparency is promoted in accordance with the values and principles enshrined in 195(1) of the Constitution.

## 10. CONCLUSION

10.1 The Public Protector considers this matter finalised. Should any party wish to challenge this decision they are at liberty to approach a court of law and lodge an application for a judicial review of the matter.



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**ADV KHOLEKA GCALEKA**
**ACTING PUBLIC PROTECTOR OF**
**THE REPUBLIC OF SOUTH AFRICA**
**DATE: 31 MARCH 2023**

*Assisted by: Adv Deon Barnard*
*Executive Manager: PII Coastal*