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

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"Allegations of maladministration in the matter between Ms Sithebe Dlamini and the Chris Hani Baragwanath Academic Hospital; Ms Sithebe Dlamini and the South African Police Service"

REPORT ON AN INVESTIGATION INTO ALLEGATIONS OF MALADMINISTRATION AND IMPROPER CONDUCT BY THE CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL FOR ITS FAILURE TO INFORM THE SITHEBE FAMILY OF THE DEATH OF MR THEMBA MILTON SITHEBE. THE SUBSEQUENT LOSS OF THE DECEASED'S CORPSE, AS WELL AS THE FAILURE BY THE SOUTH AFRICAN POLICE SERVICE TO INVESTIGATE OR FINALISE THE CASE OF A MISSING CORPSE

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EXECUTIVE SUMMARY

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

(ii) The report communicates findings and appropriate remedial action taken in terms of section 182(1)(c) of the Constitution, following an investigation into allegations of maladministration by the Chris Hani Baragwanath Academic Hospital (BARA) for its failure to inform the Sithebe family of the death of Mr Themba Milton Sithebe (the deceased); the subsequent loss of the deceased's corpse, as well as the failure by the South African Police Service (SAPS) to investigate or finalise the case of a missing corpse.

(iii) A complaint was received on 19 October 2018 from Ms Sithebe Dlamini (the Complainant) against BARA and the SAPS respectively.

(iv) **In the main, the Complainant alleged *inter alia* that:**

(aa) The deceased, Mr Themba Milton Sithebe, was her uncle. He had been admitted to BARA and while in the care of the hospital he had disappeared.

(bb) The deceased was taken to BARA on 26 May 2013 by his son, Mr Andile Charles Mavi (Mr Andile Mavi) and upon being admitted at BARA, a patient file was opened for him and registered under File No: GP09041477.

(cc) After some time (date unknown), when the deceased's son made enquiries at BARA regarding the whereabouts of the deceased, the officials at BARA advised him that they could not find him.

(dd) It was only when the deceased's daughter, Ms Thuli Sithebe, approached BARA (date unknown) to make enquires, was she advised that an investigation would be conducted into the matter.

(ee) Subsequently, (date unknown), BARA contacted Ms Thuli Sithebe and advised her that her father had passed away on 28 May 2013. However, BARA did not provide her with information as to what became of the deceased's remains. BARA informed her that they were still conducting further investigations into the matter.

(ff) On 23 March 2017, BARA concluded its internal investigation into the matter. The Sithebe family were then invited to a meeting with officials from BARA who informed them that the investigation had not revealed anything concrete. As a result, the Sithebe family were advised to open a criminal case of a missing body/corpse with the SAPS.

(gg) The Complainant approached BARA (date unknown) again to make enquiries regarding the whereabouts of the deceased's corpse. BARA informed her that it did not have any information on the matter as it did not have any record of Mr Themba Sithebe on their database.

(hh) The Deputy Director of Security at BARA, Mr L J Mnisi, commissioned Mr I M Mashudu and Mr I Nyembe to investigate the matter. The investigators at BARA concluded that the deceased received a pauper's burial, but unfortunately BARA did not have the details of the funeral parlour that may have arranged the burial.

(ii) BARA failed to provide the Complainant with a response as to how it continued with disposing of the remains of the deceased without tracing his family.

(jj) The Complainant then approached the Department of Home Affairs in order to verify whether or not the deceased was still recorded as being alive. The Complainant discovered that the Department did not have a death certificate on record for the deceased as he is still reflected as alive.

(kk) The Complainant then approached the South African Social Security Agency (SASSA) in order to verify when the deceased last received his social grant. The Complainant discovered that the deceased was last paid his pension during May 2013.

(ll) On 04 June 2017, the Sithebe family approached the Diepkloof SAPS in order to open a case of a missing body and it was registered under Diepkloof CAS 67/6/2017. The case was allocated to Warrant Officer, IE Mathebula (W/O Mathebula) as the investigating officer;

(mm) Warrant Officer Mathebula unduly delayed to revert to the Complainant with a progress report on the investigation. The Complainant subsequently submitted a formal complaint to Captain Nel, at the Gauteng Provincial Office of the SAPS, Management Complaints Investigations.

(nn) Captain Nel assured the Complainant that the matter would be taken into consideration and that an adequate response would be furnished to her regarding the matter, however nothing materialised.

(v) The investigation was conducted in terms of section 182(1)(a) of the Constitution which gives me the power to investigate alleged or suspected improper or prejudicial conduct in state affairs, to report on that conduct and to take appropriate remedial action; and in terms of section 6(4) of the Public Protector Act, which regulates the manner in which the power conferred by section 182 of the Constitution may be exercised in respect of government at any level.

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

(a) Whether there was maladministration and improper conduct by BARA in its alleged failure to inform the Sithebe family of the death of their family member and the loss of the deceased's corpse;

(b) Whether there was a failure by the SAPS to investigate or finalise the case of the missing corpse of the deceased; and

(c) Whether the Complainant or any other person suffered improper prejudice as a result of the conduct of BARA and the SAPS under the circumstances.

(vii) Having considered the submissions made and evidence uncovered during the investigation against the relevant regulatory framework, the following adverse findings are made against the BARA:

(a) Regarding whether there was maladministration and improper conduct by BARA in its alleged failure to inform the Sithebe family of the death of their family member and the loss of the deceased's corpse:

(aa) The allegation that there was maladministration and improper conduct by BARA to inform the family of the death of Mr Sithebe and the loss of his corpse, is substantiated.

(bb) BARA failed to ensure that all the requisite information was completed on the death notification report of Mr Sithebe and also failed to inform the next of kin and/ or the SAPS of the death of Mr Sithebe.

(cc) Similarly, BARA upon being made aware of the failure by the staff to follow due process in the handling of Mr Sithebe's corpse, also failed to take any action against the officials implicated.

(dd) Sister Maile's failure to adequately record the information of Mr Sithebe on the death report book, her failure to inform the next of kin and / or the SAPS about the death of Mr Sithebe and to ensure that there was a proper hand over of the outstanding duties to report the death to the family or the SAPS when there was a change of shifts with her colleagues in ward 20 amounted to negligence. As the corpse of Mr Sithebe is still missing, it is clear that the conduct of Sister Maile resulted into the Complainant and her family suffering prejudice as they could not arrange a proper burial.

(ee) The BARA failed to ensure that stringent and effective standard operating procedures, policies and regulations were complied with by BARA staff in the handling of Mr Sithebe's death and the removal of his corpse and also failed to ensure that the hospital maintained accurate patient records.

(ff) The conduct of BARA amounts to gross negligence as the notice of death of Mr Sithebe was used to release the body of a Mr Mlumbi.

(gg) The conduct of BARA contravened Section 195(1)(a)(e) and (g) of the Constitution, Section 22(1) of the Births and Deaths Registration Act, Paragraph 2, 3 and 7 of the BARA Nursing Service Guidelines for the procedure to follow when reporting a death, Regulation 29 of the Regulations Relating to the Management of Human Remains and Regulation 32(29) Regulations regarding the Rendering of Forensic Pathology Service, the Preamble and the purpose statement of the Code of ethics for nursing practitioners in South Africa.

(hh) Accordingly, the conduct by BARA amounts to improper conduct in terms 182(1)(a) of the Constitution and maladministration as envisaged in section 6(4)(a)(i) of the Public Protector Act.

(b) Regarding whether there was a failure by the SAPS to investigate or finalise the case of the missing corpse of the deceased.

(aa) The allegation that SAPS failed to investigate the case of the missing body of Mr Sithebe, is unsubstantiated.

(bb) The SAPS investigated the complaint of the missing corpse within a reasonable standard that is expected in terms of the law and their powers. Therefore, SAPS adhered to the duty imposed on them by the Constitution in the investigation of the matter.

(cc) Accordingly, the conduct of SAPS does not amount to improper conduct in terms 182(1)(a) of the Constitution and maladministration as envisaged in section 6(4)(a)(i) of the Public Protector Act.

(c) Regarding whether the Complainant or any other person suffered improper prejudice as a result of the conduct of BARA and the SAPS in the circumstances.

(aa) The allegation that the Complainant, or any other person suffered prejudice as a result of the conduct of BARA, is substantiated. However, the allegation that the Complainant or any other person suffered prejudice as a result of the conduct of the SAPS, is not substantiated.

(bb) The Mortuary Supervisor (BARA): Ms Mohomane, Detective Group Commander: Diepkloof SAPS, Lt Swalivha and the internal investigation conducted by BARA, confirmed that there was maladministration by BARA in the handling of the death and removal of the corpse of Mr Sithebe.

(cc) Sister Maile's failure to properly complete the death report book and failure to inform Mr Sithebe's next of kin and the SAPS regarding his death, resulted in prejudice suffered by the Complainant and her family in that they could not arrange a proper burial for the deceased.

(dd) Furthermore, the BARA mortuary staff also failed to request SAPS to trace the next of kin of Mr Sithebe or for them to collect the corpse.

(ee) Moreover, the mortuary auxiliaries in the employ of BARA failed to ensure that the corpse of Mr Sithebe was properly documented, as there was a lack of documentary proof that the body was collected from the mortuary.

(ff) BARA hospital ought to have recorded Mr Sithebe's residential address and information regarding his next of kin in the patient file to enable them to trace his family. As a result, the failure by BARA to keep proper records resulted in the Complainant and her family being unable to bury the deceased.

(xx) The appropriate remedial action that the Public Protector is taking in pursuit of section 182(1)(c) of the Constitution is the following:

(a) The Acting Head of Department of Health, Mr Arnold Lesiba Malotana and the Chief Executive Officer: BARA, Dr Nkele Lesia must ensure that:

(aa) Within sixty (60) working days from the date of this report, ensure that a register system is put in place containing information which expressly indicates the full names and designations of officials at the wards and detailed information regarding who is responsible for patients from entry to the exit of the patients in the wards. The data register must clearly show a chain of events in the wards, the date, time, details of patient involved and all the staff involved in the handling of the patients at the wards.

(bb) Within a period of sixty (60) working days after the date of this report the staff must be trained on the data register, specifically compliance with the completion of the register. Furthermore, the monitoring and evaluation of the data register at all wards of the hospital.

(cc) Within sixty (60) working days from the date of this report, initiate a disciplinary process against Sister Maile who is responsible for the violation of section 195(1) of the Constitution, section 22 (1) of the Births and Death Registration Act, Paragraph 2, 3 and 7 of the BARA Nursing Service Guidelines, Clause 29 and 32 of the Regulations relating to the Management of Human Remains, Regulations on the rendering of Forensic Pathology Service. Furthermore, Sister Maile violated the Preamble and Purpose Statement of the Code of Ethics for Nursing Practitioners in SA, which all resulted in the failure to inform the Sithebe family of the death of

their family member, loss of the deceased's corpse and improper prejudice to the Complainant.

(dd) Within sixty (60) working days from the date of this report, provide training to the nursing staff at BARA in terms of the proper completion of patient information on files on admission to the hospital and specifically the keeping of accurate information regarding the next of kin.

(ee) Within a period of sixty (60) working days after the date of this report staff must be trained on the BARA Nursing Service Guidelines, specifically the completion of death notification reports and the process of reporting of deaths to the families of the deceased and unclaimed, unidentified bodies at the hospital to SAPS.

(ff) Within a period of thirty (30) working days after the date of this report, issue a formal written apology to the Complainant regarding the hospital`s failure to inform her about the death of Mr Sithebe and the subsequent loss of his corpse.

(gg) Within a period of sixty (60) working days after the date of this report submit a report on the measures that BARA will put in place to monitor the efficient and effective process of quality assuring and auditing the record keeping process especially in relation to the accurate completion of patient files on admission at the hospital, accurate completion of death reports and the adherence of the process by the hospital staff.

(hh) Within a period of sixty (60) working days after the date of this report train mortuary auxiliary staff on proper record keeping of deceased patients and proper record keeping of the movement of the deceased bodies in and out of the hospital mortuary.

(ii) Within a period of sixty (60) working days after the date of this report submit a report on the measures that BARA will put in place to monitor the efficient and effective processes of quality assuring and auditing the proper record keeping of the movement of deceased bodies' in and out of the hospital mortuary and the adherence to the process by the mortuary auxiliary staff.

REPORT ON AN INVESTIGATION INTO ALLEGATIONS OF MALADMINISTRATION AND IMPROPER CONDUCT BY THE CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL (BARA) FOR ITS FAILURE TO INFORM THE SITHEBE FAMILY OF THE DEATH OF MR THEMBA MILTON SITHEBE (THE DECEASED), THE SUBSEQUENT LOSS OF THE DECEASED'S CORPSE, AS WELL AS THE FAILURE BY THE SOUTH AFRICAN POLICE SERVICE (SAPS) TO INVESTIGATE OR FINALISE THE CASE OF A MISSING CORPSE

1. INTRODUCTION

1.1 This report of the Office of the Public Protector is 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 23 of 1994 (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 my investigation and to implement the remedial action:

1.2.1 The Premier of Gauteng Province, Mr David Makhura;

1.2.2 The MEC of Health, Dr Nomathemba Mokgethi;

1.2.3 The Acting Head of Department: Gauteng Department of Health, Mr Arnold Malotana;

1.2.4 The Chief Executive Officer of the Chris Hani Baragwanath Academic Hospital, Dr Nkele Lesia;

1.2.5 Professional Nurse of the Chris Hani Baragwanath Academic Hospital, Sister Cecelia Maile;

1.2.6 SAPS Provincial Commissioner, Lieutenant General Elias Mawelela; and

1.3 A copy of the report is also provided to Ms Sithebe Dlamini to inform her about the outcome of the investigation.

2. THE COMPLAINT

2.1 The complaint was lodged with the office of the Public Protector on 19 October 2018, by Ms Nokuthula F Sithebe-Dlamini (the Complainant).

2.2 The Complainant alleged the following:

2.2.1 Her uncle, Mr Themba Milton Sithebe, was admitted to BARA, and while in its care, he disappeared.

2.2.2 Mr Sithebe was taken to BARA on 26 May 2013 by his son, Mr Andile Charles Mavi (Mr Andile Mavi) and upon being admitted at BARA, a patient file was opened for him and registered under File No: GP09041477.

2.2.3 After a while (date unknown), when Mr Sithebe's son made enquiries at BARA regarding the whereabouts of his father, the officials at BARA advised him that they could not find Mr. Sithebe.

2.2.4 Mr Sithebe's daughter, Ms Thuli Sithebe, thereafter approached BARA (date unknown) to make enquires. She was advised that an investigation would be conducted into the matter.

2.2.5 After a period of time (date unknown), BARA contacted Ms Thuli Sithebe and advised her that her father had passed away on 28 May 2013. However, BARA did not provide her with information as to what had happened to her father's remains. BARA informed her that they were still conducting further investigations into the matter.

2.2.6 On 23 March 2017, BARA concluded its internal investigation into the matter. The Sithebe family were then invited to a meeting with officials from BARA and they were informed that the investigation had not revealed anything concrete. As a result the Sithebe family was advised to open a criminal case of a missing body/corpse with the SAPS.

2.2.7 The Complainant approached BARA (date unknown) again to make enquiries regarding the whereabouts of her father's mortal remains. BARA informed her that it did have any information on the matter as it did not have any record of Mr Themba Sithebe on their database.

2.2.8 The Deputy Director of Security at BARA, Mr L J Mnisi, commissioned Mr I M Mashudu and Mr I Nyembe to investigate the matter. The investigators at BARA concluded that the deceased received pauper's burial, but unfortunately BARA did not have the details of the funeral parlor that may have arranged the burial.

2.2.9 BARA failed to provide the Complainant with a response as to how it continued with the burial of the deceased without tracing his family.

2.2.10 The Complainant approached the Department of Home Affairs in order to verify whether or not the deceased was still recorded as alive. Complainant discovered that the Department did not have a death certificate on record for the deceased, as the system reflected that he is still alive.

2.2.11 The Complainant then approached the South African Social Security Agency (SASSA) in order to verify when the deceased last received his social grant. The Complainant discovered that the deceased was last paid his pension during May 2013.

2.2.12 On 04 June 2017, the Sithebe family approached the Diepkloof SAPS in order to open a case of a missing body and it was registered under Diepkloof CAS 67/6/2017. The case was allocated to Warrant Officer, IE Mathebula, (W/O Mathebula), as the investigating officer.

2.2.13 Warrant Officer Mathebula unduly delayed to revert to the Complainant with a progress report on the investigation. The Complainant subsequently submitted a formal complaint to Captain Nel, at the Gauteng Provincial Office of the SAPS, Management Complaints Investigations.

2.2.14 Captain Nel assured the Complainant that the matter would be taken into consideration and that an adequate response would be furnished to her regarding the matter, however nothing materialised.

3. POWERS AND JURISDICTION OF THE PUBLIC PROTECTOR

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

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

> "*The Public Protector has the power as regulated by 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 legislation.

3.4 The Office of 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 the power to resolve disputes through mediation, conciliation, negotiation or any other appropriate alternative dispute resolution mechanism.

3.5 In the ***Economic Freedom Fighters v Speaker of the National Assembly and Others: Democratic Alliance v Speaker of the National Assembly and Others*** the Constitutional Court per Mogoeng CJ held that the remedial action taken by the Public Protector has a binding effect. [1] The Constitutional Court further held that: "*When remedial action is binding, compliance is not optional, whatever reservations the affected party might have about its fairness, appropriateness or lawfulness. For this reason, the remedial action taken against those under investigation cannot be ignored without any legal consequences."*[2]

[2] *Supra* at para [73].

3.6 The quote further stated that:

3.6.1 Complaints are lodged with the Public Protector to cure incidents of impropriety, prejudice, unlawful enrichment or corruption in government circles (paragraph 65).

3.6.2 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 (paragraph 67).

3.6.3 Taking appropriate remedial action is much more significant than making a mere endeavour 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 (paragraph 68).

3.6.4 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 (paragraph 69).

3.6.5 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 (paragraph 70).

3.6.6 The Public Protector's powers 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 (paragraph 71).

3.6.7 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, (paragraph 71(a)).

3.6.8 She has the power to determine the appropriate remedy and prescribe the manner of its implementation (paragraph 71(d)).

3.6.9 "*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 (paragraph 71(e)).

3.7 In the matter of the ***President of the Republic of South Africa v Office of the Public Protector and Others, Case no 91139/2016 (13 December 2017),*** the Court held as follows:

(a) The Public Protector, in appropriate circumstances, has the power to direct the President to appoint a commission of enquiry and to direct the manner of its implementation. Any contrary interpretation will be unconstitutional as it will render the power to take remedial action meaningless or ineffective (paragraphs 85 and 152).

(b) *There is nothing in the Public Protector Act that prohibits the Public Protector from instructing another entity to conduct further investigation, as she is empowered by section 6(4)(c)(ii) of the Public Protector Act (paragraphs 91 and 92).*

(c) *Taking remedial action is not contingent upon a finding of impropriety or prejudice. Section 182(1) afford the Public Protector with the following three separate powers (paragraphs 100 and 101).*

(i) *Conduct an investigation;*
(ii) *Report on that conduct; and*
(iii) *To take remedial action.*

(d) *The Public Protector is constitutionally empowered to take binding remedial action on the basis of preliminary findings or prima facie findings (paragraph 104).*

(e) *The primary role of the Public Protector is that of an investigator and not an adjudicator. Her role is not to supplant the role and function of the court (paragraph 105).*

(f) *The fact that there is no firm findings on the wrong doing, does not prohibit the Public Protector from taking remedial action. The Public Protector's observations constitute prima facie findings that point to serious misconduct (paragraphs 107 and 108).*

(g) *Prima facie evidence which point to serious misconduct is a sufficient and appropriate basis for the Public Protector to take remedial action (paragraph 112)."*

3.8 Both the BARA and the SAPS are organs of state and its conduct amounts to conduct in state affairs, and as a result of this, the matter falls within the ambit of the Public Protector's mandate.

3.9 It is noted that the jurisdiction of the Public Protector was not disputed by any of the parties in this matter.

3.10 Section 6(9) of the Public Protector Act, 1994 provides that_

"Except where the Public Protector in special circumstances, within his or her discretion, so permits, a complaint or matter referred to the Public Protector shall not be entertained unless it is reported to the Public Protector within two (2) years from the occurrence of the incident or matter concerned".

3.20. In the case between ***South African Bureau of Standards v The Public Protector, the North*** *Gauteng High Court 34290/15Â) [2019] ZAGPPHC 101 (27 March 2019)* the court held that-

"As with most claims and complaints, there is for good reason, time-frames within which such must be instituted or laid. In this instance, the Public Protector Act has set a time-limit of 2 years. Entertaining a complaint which is older than 2 years certainly calls for exceptional circumstances. The underlying reason for time-frames is the trite maxim; justice delayed is justice denied. Underpinning this principle is the prejudice parties suffered when time has lapsed. To mention, but a few; no finality of a matter, evidence lost, memories failing and legislation and policies evolving."

3.11 As supplementary jurisprudence in regard to the issue of "special circumstances" it is clear that in the case between ***Gordhan v Public Protector and Others [2020] ZAGPPHC 777*** *(17 December 2020) the* North Gauteng High Court held that-

"In view of the provisions of section 6(9) and the fact that the complaints emanate from a decade ago, one would expect the Public Protector to set out why she had jurisdiction to entertain this complaint."

3.12 Therefore, regarding the exercise of the Public Protector`s discretion in terms of section 6(9) to entertain matters which arose more than two (2) years from the occurrence of the incident, and in deciding what constitutes '*special circumstances'*, some of the special circumstances that was taken into account to exercise the Public Protector's discretion favourably to accept this complaint, includes the nature of the complaint and the seriousness of the allegations; whether the outcome could rectify systemic problems in state administration; whether the Public Protector would be able to successfully investigate the matter with due consideration to the availability of evidence and/or records relating to the incident(s); whether there are any competent alternative remedies available to the Complainant and the overall impact of the investigation; whether the prejudice suffered by the Complainant persists; whether a refusal to investigate perpetuates the violation of section 195 of Constitution; whether any remedial action will redress the imbalances of the past. What constitutes '*special circumstances'* depends on the merits of each case.

3.13 In this instance, the special circumstances that the Public Protector took into account was the fact that the family of the deceased was not informed about the death of their family member, the whereabouts of his body is still unknown to this day, and as a result the family was not able to bury the deceased. The Sithebe family only became aware of his death during 2017.

3.14 Based on the complaint form dated 19 October 2018, submitted to the office of the Public Protector by the Complainant, the family became aware that Mr Sithebe's corpse was missing only during 2017. The Complainant also indicated that the reason she had not approached the Public Protector earlier in order to lodge a complaint was because the family was not aware that Mr Sithebe was deceased. The Complainant further submitted that the family did not reside in the same area as the deceased and that he would usually visit them and they became worried when he stopped the visits.

3.15 Furthermore, the Complainant also advised the Public Protector that Mr Sithebe had not wanted to provide the family with his contact details or to have any of his family members visit him where he was residing, hence the family was not aware of his whereabouts.

3.16 Admittedly, in terms of section 6(9) of the Public Protector Act, the Public Protector is barred from entertaining complaints reported after two years from the date of an incident unless special circumstances exist. However, the mere fact that the incident occurred more than two years before being reported does not, in itself, bar the Public Protector from investigating. Instead, it is mainly the interest of justice that dictates whether it should be investigated or not. In this case, it is in the interest of justice to investigate and establish how the body of the deceased was lost at BARA and to ensure that such incident does not occur in future.

3.17 Since the incident or matter concerned occurred more than **two years**[1] prior to the reporting of the matter to the Public Protector, he/ she has exercised his/ her discretion in terms of section 6(9) of the Act to entertain the

[1] If applicable

complaint based on the following special circumstances[2] as envisaged in Rule 10(1) of the Public Protector Rules -

"(a) The Complainant provided sufficient and compelling information with prima facie evidence of alleged or suspect improper or prejudicial conduct;

(b) The nature of the complaint and grievance reveals the possibility of un-remedied prejudice or injustice…"

3.18 Under the circumstances the Complainant provided sufficient information with prima facie evidence of alleged or suspect improper or prejudicial conduct by the BARA. It also follows that, the nature of the complaint and grievance reveals the possibility of un-remedied prejudice or injustice suffered by the Complainant as a result of the conduct of BARA.

4 THE INVESTIGATION

4.1 Methodology

4.1.1 The investigation was conducted in terms of section 182(1)(a), (b) and (c) of the Constitution which gives the Public Protector the power to investigate alleged or suspected improper or prejudicial conduct in state affairs, to report on that conduct and to take appropriate remedial action; and in terms of section 6(5) of the Public Protector Act, regulating the manner in which the power conferred by section 182 of the Constitution may be exercised in respect of public entities.

[2] As actually recorded and captured by the Assessor (COO/ EM/ PR) who exercised the delegated discretion on behalf of the PP – vide *Minister of Home Affairs v The Public Protector* (308/2017) **[2018] ZASCA 15** (15 March 2018

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. Section 6 of the Public Protector Act gives the Public Protector the authority to resolve a matter without conducting an investigation and resolve a complaint through appropriate dispute resolution (ADR) measures such as conciliation, mediation and negotiation.

4.1.3 During the investigation process, notices in terms of section 7(9)(a) of the Public Protector Act (section 7(9) notices), dated 11 December 2020 were served on Mr Arnold Malotana, the Acting Head of Department: Gauteng Department of Health, Ms Phumla Sekhonyane, Chief of Staff: Office of the Premier, on behalf of Premier Makhura, Cllr Mzwandile Masina and Cllr Patricia Khumalo, to afford them an opportunity to respond to my provisional findings. A notice was also served on Sister Maile, and she duly responded thereto on 12 February 2021.

4.2 Approach to the investigation

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

4.2.1.1 What happened?

4.2.1.2 What should have happened?

4.2.1.3 Is there a discrepancy between what happened and what should have happened and does that deviation amounts to maladministration or other improper conduct?

4.2.1.4 In the event of maladministration or improper conduct, what would it take to remedy the wrong or to right the wrong occasioned by the said 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. Evidence was evaluated and a determination made on what happened based on a balance of probabilities. The Supreme Court of Appeal[3] (SCA) made it clear that it is the Public Protector's duty to actively search for the truth and not to wait for parties to provide all of the evidence as judicial officers do.

4.2.3 In this particular case, the factual enquiry primarily focused on whether or not there was maladministration by the BARA for its failure to inform the Sithebe family of the death of Mr Themba Milton Sithebe (the deceased), the subsequent loss of the deceased's corpse, as well as the failure by the SAPS to investigate or finalise the case of a missing corpse.

4.2.4 The enquiry regarding what should have happened, focuses on the applicable legal prescripts that regulate the standard that should have been met by the BARA to prevent improper conduct and/or maladministration as well as prejudice. In this case, key laws and policies taken into account to determine if there had been maladministration by the BARA and prejudice to the Complainant were principally those imposing administrative standards that should have been complied with by BARA or its officials when it failed to inform the Sithebe family of the death of Mr Themba Milton Sithebe (the deceased), the subsequent loss of the deceased's corpse.

[3] *Public Protector versus Mail and Guardian, 2011(4) SA 420 (SCA),*

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

4.2.6 In the case of conduct failure as was the case in this matter, remedial action seeks to right or correct identified wrongs while addressing any systemic administrative deficiencies that may be enabling or exacerbating identified maladministration or improper conduct.

4.2.7 The substantive scope of the investigation focused on compliance with the law and prescripts regarding the complaint and allegations.

4.3 **On analysis of the complaint, the following issues were identified to inform and focus the investigation:**

4.3.1 Whether there was maladministration and improper conduct by BARA in its alleged failure to inform the Sithebe family of the death of their family member and the loss of the deceased's corpse.

4.3.2 Whether there was a failure by the SAPS to investigate or finalise the case of a missing corpse of the deceased; and

4.3.3 Whether the Complainant or any other person had suffered improper prejudice as a result of the conduct of BARA and the SAPS under the circumstances.

4.4 **The Key Sources of information**

Correspondence sent and received

4.4.1 The complaint form dated 19 October 2018;

4.4.2 A copy of the medical file of the deceased Mr Sithebe opened and registered by BARA;

4.4.3 Various correspondence letters to the Complainant from the Public Protector;

4.4.4 Email received from the Diepkloof SAPS addressed to the Gauteng Provincial Office of the Public Protector dated 02 April 2019;

4.4.5 Correspondence submitted by Ms Maureen Motjelele from the Gauteng Department of Health dated 12 , 16 and 29 April 2019;

4.4.6 Correspondence submitted by Mr Nkuna from the Gauteng Department of Health dated 07 and 13 May 2019;

4.4.7 Progress report received submitted by Lt Col Swalivha from the Diepkloof SAPS dated 17 May 2019;

4.4.8 Further information submitted by Ms S Hartley from SASSA dated 28 May 2019;

4.4.9 Further information submitted by Mr Thulani Mavuso from the Department of Home Affairs dated 28 May 2019;

4.4.10 Correspondence submitted via email from Captain Mukansi from the Diepkloof SAPS dated 11 June 2019;

4.4.11 An email regarding the Standard Operating Procedures submitted by Ms Malebana Mpolokeng from the Gauteng Department of Health dated 14 August 2019;

4.4.12 An email correspondence from Mr Z Ndabula from the Gauteng Department of Health dated 15 August 2019;

4.4.13 Progress report submitted via email by Lt Col Swalivha from the Diepkloof SAPS dated 07 November 2019;

4.4.14 Email correspondence submitted by Ms Mathapelo Sekele from Diepkloof SAPS dated 15 November 2019; and

4.4.15 Email received regarding a comprehensive investigation report submitted by Captain Mukansi from the Diepkloof SAPS dated 18 December 2019.

Various supporting documents obtained during the investigation

4.4.16 Allegations and information request letter addressed to the former Gauteng Head of Department, Professor M Lukhele dated 19 March 2019;

4.4.17 A copy of the appointment letter of Mr I M Mashudu and Mr L Nyembe by the Deputy Director: Security (BARA), Mr L J Mnisi for the investigation of the missing corpse of Mr Themba Milton Sithebe, dated 27 January 2017

4.4.18 Comprehensive investigation report approved by the Director : Logistics (BARA), Mr L Van der Westhuizen dated 31 May 2017;

4.4.19 A copy of an outcome into an investigation of theft of the corpse of Mr Themba Milton Sithebe registered under Cas 67-06-2017 dated 20 July 2018 addressed to Ms Nokuthula Sithebe from Detective Group Commander: Diepkloof SAPS , Lt Col Swalivha;

4.4.20 Minutes of interviews held on 15 April 2019 with the Complainant Mrs Sithebe Dlamini and Andile Charles Mavi;

4.4.21 An undated copy of the Standard Operating Procedure document of BARA submitted by Mr Mulaudzi and Westhuizen

4.4.22 A copy of the Guidelines for signing a death notice dated September 2014;

4.4.23 A copy of Last Offices Policy(BARA) dated 04 March 2008;

4.4.24 A copy of a sworn affidavit submitted by Mr Louis Tourin from the JMPD dated 02 May 2019;

4.4.25 Response letter dated 02 April 2019 submitted to the Public Protector by Section Commander: Diepkloof SAPS, Lt Col C I Batchelor;

4.4.26 Progress Report submitted by Diepkloof SAPS Lt Col Swalivha 07 November 2019;

4.4.27 Response of Department of Home Affairs submitted by Mr Thulani Mavuso dated 28 May 2019;

4.4.28 Response of SASSA submitted by Ms S Hartley dated 28 May 2019;

4.4.29 Recordings of an interview held with the Chief Executive Officer: BARA, Dr Nkele Lesia on 01 August 2019;

4.4.30 Recordings of interviews held with the Manager of Quality Assurance : BARA, Mr Zenzo Ndabula on 08 August 2019;

4.4.31 Recordings of interviews held by the PPSA investigation team and Mr B Mulaudzi and Mr Westhuizen on 13 August 2019;

4.4.32 Recordings of interviews held with Ms L Mohomane the Mortuary Supervisor : BARA: BARA, on 15 August 2019;

4.4.33 Recordings of interviews held with a Professional Nurse :BARA, Sister Cecilia Maila and Ms Thabitha Kgobe on 19 August 2019; and

4.4.34 Section 7(9)(a) notice dated 11 December 2020 sent to the Acting Head of Department: Gauteng Department of Health, Mr Malotana;

4.4.35 Section 7(9)(a) notice dated 11 December 2020 sent to the Chief Executive Officer: Chris Hani Baragwanath Academic Hospital (BARA) , Dr Nkele Lesia;

4.4.36 Section 7(9)(a) notice dated 11 December 2020 sent to the Gauteng Province Premier, Mr David Makhura;

4.4.37 Section 7(9)(a) notice dated 11 December 2020 sent to the Gauteng Speaker, Dr Nomathemba Mokgethi;

4.4.38 Section 7(9)(a) notice dated 11 December 2020 sent to SAPS Provincial Commissioner; Lieutenant General Mawelela;

4.4.39 An acknowledgement to a section 7(9)(a) notice dated 21 December 2020 from Mr Malotana, submitted to the Public Protector's office;

4.4.40 Response to the Section 7(9)(a) notice dated 02 February 2021 was submitted by Chief Executive Officer: BARA, Dr Lesia.

4.4.41 Section 7(9)(a) notice dated 11 December 2020 sent to Professional Nurse: BARA, Sister Maile; and

4.4.42 Response to the Section 7(9) (a) notice dated 12 February 2021 received from Professional Nurse: BARA, Sister Maile.

Interviews conducted

4.4.43 A meeting between the Public Protector investigation team and Mr Z Ndabula, Manager: Quality Assurance (BARA) held on 06 August 2019;

4.4.44 A meeting between the investigation team and Mr Van der Westhuizen, Director of Logistics: BARA held on 13 August 2019;

4.4.45 A meeting between the investigation team and Mr Baldwin Mulaudzi, the Acting Senior Nursing Manager: BARA held on 13 August 2019;

4.4.46 A meeting between the investigation team and Ms Lucky Mohomane, the Mortuary Supervisor : BARA held on 26 August 2019;

4.4.47 Interview session held between the investigation team with Lt Col Swalivha and Captain Mukansi on 26 April 2019;

4.4.48 A meeting between the investigation team and Ms Cecilia Maile, a Professional Nurse: BARA held on 26 August 2019.

Legislation and other legal prescripts

4.4.49 The Constitution of the Republic of South Africa, Act 108 of 1996

4.4.50 The Public Protector Act, 23 of 1994

4.4.51 Births and Deaths Registration Act, 51 of 1992

4.4.52 The South African Police Service Act, 68 of 1995.

4.4.53 The BARA Nursing Service Guidelines adopted on 08 April 2008.

4.4.54 Regulation 29 of the Regulations Relating to the Management of Human Remains no R 363 May 2013 read with Regulation 32, of the Regulations regarding the Rendering of Forensic Pathology Service No R 636 July 2007.

4.4.55 The preamble to the Code of Ethics for Nursing Practitioners in South Africa under the provisions of the Nursing Act, 2005.

4.4.56 The purpose statement of the Code of Ethics for nursing in South Africa under the provisions of the Nursing Act, 2005.

Case Law

4.4.57 Economic Freedom Fighters v Speaker of the National Assembly and Others; Democratic Alliance v Speaker of the National Assembly and Others 2016 (5) BCLR 618 (CC); 2016 (3) SA 580 (CC);

4.4.58 President of the Republic of South Africa v Office of the Public Protector and Others, Case no 91139/2016 [2017] ZAGPPHC 747;

4.4.59 Public Protector v Mail and Guardian, 2011(4) SA 420 (SCA)

4.4.60 Gordhan v Public Protector and Others [2020] ZAGPPHC 777;

4.4.61 South African Bureau of Standards v The Public Protector, the North Gauteng High Court 34290/15Â) [2019] ZAGPPHC 101;

4.4.62 Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd 2000 (1) SA 827 (SCA) 4.

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

5.1 Whether there was maladministration and improper conduct by BARA in its alleged failure to inform the Sithebe family of the death of their family member and the loss of the deceased's corpse.

Common cause issues

5.1.1 On 26 May 2013, Mr Sithebe was admitted at the BARA and was registered under patient File No: GP09041477.

5.1.2 Mr Sithebe died whilst he was a patient at BARA and he was certified dead by a Dr Bilal Bobat as per death report dated 28 May 2013, which was submitted to the Public Protector by the Chief Executive Officer, Dr Nkele Lesia.

5.1.3 On 30 April 2019, an information request letter was sent to the South African Social Service Agency (SASSA) with the objective of determining when last the deceased collected his social grant.

[4] At par 21

5.1.4 According to the response letter dated 28 May 2019, submitted to the Public Protector by Ms Shahida Hartley (Ms Hartley), the Customer Care Manager at SASSA, it was confirmed that SASSA records reflected that Mr Sithebe last collected his old age grant in May 2013, then it was unclaimed for three months and then another payment was made in September 2013.

5.1.5 Ms Hartley indicated that the grant was not stopped by anyone but it systemically lapsed due to the failure of Mr Sithebe to collect the grant for three consecutive months, as prescribed in the Regulations promulgated in accordance with the Social Assistance Act, 13 of 2004.

5.1.6 She also submitted that SASSA records showed that the deceased never reported to SASSA to claim his grant after it had lapsed, as such SASSA did not have any information in its possession to assist the family in locating him.

5.1.7 However, Ms Hartley submitted that SASSA was not in a position to provide any information regarding who collected the deceased's pension during September 2013 under voucher number 57809717.

The pension monies collected in respect of the deceased were as per the following table:

Voucher No	Pay Period	Amount	Voucher Status and Contractor
57809717	September 2013	R1 260.00	Paid Out: Gauteng
46757023	August 2013	R3 788.00	Received back as Unpaid
37241558	July 2013	R 1 260.00	Cancelled-carried over
26093006	June 2013	R 1 260.00	Cancelled- carried over
14467447	May 2013	R 1 260.00	Paid Out

Voucher No	Pay Period	Amount	Voucher Status and Contractor
3857770	April 2013	R 1 260.00	Paid Out
93221576	March 2013	R 1 200.00	Paid Out
82541003	February 2013	R 1 200.00	Paid Out
71903022	January 2013	R 1 200.00	Paid Out
61444573	December 2012	R 1 200.00	Paid Out

Issues in Dispute

5.1.8 The Complainant argued that the family was not informed about Mr Sithebe's death at BARA.

5.1.9 The Complainant further submitted that in a meeting between BARA management and the deceased's family on 23 March 2017, BARA informed the family that the corpse/body could not be found due to the lapse of time and that the family should approach SAPS for further investigations.

5.1.10 It was also submitted by the Complainant that a case was subsequently opened at Diepkloof Police Station on 04 June 2017, and registered under Diepkloof CAS 67/6/2017.

5.1.11 On 01 August 2019, the Public Protector investigation team held an interview with the Chief Executive Officer of BARA, Dr Nkele Lesia (Dr Lesia). Dr Lesia submitted during the interview that the deceased was admitted at BARA on 26 May 2013.

5.1.12 Dr Lesia indicated that the deceased was brought to BARA by his son, Mr Andile Mavi, who is an official at the Johannesburg Metropolitan Police Department (JMPD) and that the patient file reflected that the next of kin of the patient was "Ronny" but there was no surname and no contact details captured in the file, except for Ronny's name.

5.1.13 However, during the interview with Dr Lesia, it was noted that in 2010, BARA had opened and registered a medical file for the deceased. Therefore, the hospital should have captured his residential address and the relevant contact details of the next of kin on the file which would have enabled the hospital to trace the deceased's place of residence and/or family.

5.1.14 During the interview held with Dr Lesia, she affirmed that the deceased was admitted to medical ward 20 on the 26th of May 2013 and transferred to medical ward 24 where he subsequently died on 28 May 2013, in the early hours of the morning.

5.1.15 The nurse in charge of the ward, Sister Cecelia Maile (Sister Maile), reported the death as per the death report, however she did not complete the details of the person who was informed about the demise of the Mr Sithebe.

5.1.16 Dr Lesia further indicated that the sister in charge of the ward had an obligation to inform the next of kin and a death notification report should have been completed by a professional nurse entailing the following:

5.1.16.1 The name of the patient;
5.1.16.2 The hospital number;
5.1.16.3 The ward;
5.1.16.4 The date of death;
5.1.16.5 The diagnosis; and

5.1.16.6 The person who was informed about the death, as per the hospital processes.

5.1.17 However, Sister Cecelia Maile who was the sister in charge, did not inform the family about the death of the patient, as the evidence revealed that such information was not completed on the death notification report.

5.1.18 There was also no indication on the death notification report that the SAPS were informed, in the event that the hospital was not able to reach the next of kin.

5.1.19 Dr Lesia averred that the body of Mr Sithebe was collected from the ward, together with the medical records and transferred to the mortuary.

5.1.20 Dr Lesia further submitted that during 2017, the Complainant lodged a complaint regarding the whereabouts of her uncle and that an internal investigation was conducted by the hospital to establish what had happened to the deceased.

5.1.21 Dr Lesia further provided the Public Protector with a comprehensive internal investigation report dated 05 June 2017, approved by the Directors of Logistics: Messrs L Van der Westhuizen, I Nyembe and I M Mashudu, who were commissioned by the Deputy Director: Security: Mr L J Mnisi, to conduct an investigation into the allegations of the missing corpse of the deceased.

5.1.22 The comprehensive internal investigation report submitted by Dr Lesia revealed the following:

“(a) *The BARA medical records of the deceased noted that he was admitted as a patient at the hospital on 25 September 2010, 09*

January 2011 and 26 May 2013, respectively.

(b) The report indicated that Mr Sithebe was treated at the BARA until 28 May 2013, when he passed away. Upon being confirmed dead by Dr Parbhoo, an entry was made in the file to notify the family about the death.

(c) A copy of the death report reflected the signature of Sister Cecelia Maile but the part where the relatives are notified or the means of contacting the family was left blank, which seems to indicate that the family was not contacted.

(d) The copy of the death notification report, that originally the B1663 was compiled with the details of the deceased for the registration of death and the death was certified by Dr. Bilal Bobat with Health Professional Council of South Africa registration number: MP0615447.

(e) On 01 August 2013, the particulars of the (the next of kin of the patient/deceased) were noted as that of Ms Pamela Mathebula who was the daughter of the deceased.

(f) The body of the deceased was collected by Mr Isaac Sithole who was employed as an undertaker, Funeral Assist 24 CC on 01 August 2013." (sic)

5.1.23 On 30 April 2019, the Public Protector also engaged the Department of Home Affairs (DHA), through an information request letter. A response letter from the DHA dated 28 May 2019, was submitted by the Acting Director-General, Mr Thulani Mavuso (Mr Mavuso). In his response, Mr Mavuso advised that the records of the National Population register revealed that the deceased was, according to its records, still alive.

5.1.24 Mr Mavuso further submitted that there was no death registered with the DHA and as a result, no death certificate issued. Furthermore, a verification process was undertaken to check whether the deceased had a passport and might have left the country, but it was discovered that he never had a passport.

5.1.25 A copy of the notice of death as per the BI1663 form provided by Dr Lesia on 01 August 2019, showed that the name of Mr Sithebe was scratched out and replaced with that of Mr Sydney Mphithizeli Mlumbi, but the ID number and address of Mr Sithebe were still reflected.

5.1.26 The investigation further revealed that Mr Mlumbi passed away on 25 July 2013, at BARA. Dr Lesia provided the Public Protector with a copy of the list of unclaimed corpses from 01 January 2013 to 30 April 2013, in order to show that that the details were never captured on the list of unclaimed corpses by the hospital in May 2013. Furthermore, that a copy of the list unclaimed corpses was compiled by the former mortuary supervisor, Mr France Sibisi.

5.1.27 It was noted that the list contained the names of 16 deceased people and the name of the later Mr Sithebe did not appear anywhere on the list.

5.1.28 The same list contained an unknown handwritten note indicating that there were 3 named deceased people and 3 unknown deceased people. However, it could not be confirmed if Mr Sithebe was one of the unknown deceased persons on the list.

5.1.29 According to the pauper burial list dating back from 04 December 2012 to 07 May 2013, which was also compiled by Mr Sibisi, Mr Sithebe’s name did not appear on the said list. BARA could not retrieve the list for the rest of May 2013, when Mr Sithebe was certified to have passed away.

5.1.30 During the interview held with Dr Lesia, it was noted that BARA did not have any records of pauper burials arranged by the hospital for the period 08 May 2013 to 28 May 2013, when the deceased passed away.

5.1.31 It is therefore evident, based on the abovementioned information relating to the pauper burials arranged by BARA during 2013 that the details of Mr Sithebe were not on the lists compiled by the mortuary supervisor, Mr Sibisi.

5.1.32 Furthermore, the details of the deceased could not be retrieved on the list dating to his death on 28 May 2013, as the hospital did not have the information in its possession.

Interview with Mr Z Ndabula, Manager: Quality Assurance

5.1.33 On 06 August 2019, an interview was held at the Public Protector's offices with Mr. Z Ndabula (Mr Ndabula), the Manager: Quality Assurance at BARA and the following information was submitted:

5.1.33.1 He was employed by the BARA on 01 October 2016, which was after the incident relating to the missing corpse of Mr Sithebe.

5.1.33.2 He confirmed that upon a complaint being lodged by the family of the deceased on 18 January 2017, the matter was referred to the Deputy Director: Security (BARA), Mr Mnisi at BARA who allocated the matter to investigating officers for further investigation.

5.1.33.3 The investigating officers or security officers did not have any specialized training, as they primarily dealt with petty crimes like patients stealing medication or members of the public bribing staff in order to be attended to first by BARA staff.

5.1.33.4 The nature of the matter necessitated investigation as it was of a serious nature, in that it related to a missing corpse of a patient who had been admitted and died at the hospital.

5.1.33.5 On 28 February 2017, the Internal Investigation Officer: Security Manager, Mr L Nyembe addressed a memorandum regarding a preliminary investigation report dated 24 February 2017 to the Acting Chief Executive Officer of BARA, Dr Maseko.

5.1.33.6 Mr Ndabula scheduled another meeting on 23 March 2017 with the family of the deceased, in order to provide them with a progress report regarding the internal investigation conducted by the BARA and they were advised to approach SAPS for further assistance as the matter was complex, and that the preliminary internal investigation by BARA revealed the following:

5.1.33.7 The details of the deceased did not appear on the pauper register dated May 2013;

5.1.33.8 There were gaps of information on the pauper register as it reflected pauper burials conducted during 2010. The pauper register did not have information on burials relating to 2011, 2012 and 2013;

5.1.33.9 The pauper register in possession of the hospital continued from 2014 to date and there was a name of a patient by the name of Mr Sydney Mphesheni who also resided at F17 Thembelihle but the age difference between him and Mr Sithebe caused confusion to the hospital as it was speculated that Mr Sithebe could have been buried as a pauper; and

5.1.33.10 According to the records of the Department of Home Affairs, Mr Sithebe was not registered as deceased.

5.1.33.11 Mr Ndabula indicated that when a patient was admitted at the casualty ward of the hospital, a patient file was opened and the patient's details are entered into a register book.

5.1.33.12 The patient would be transferred to the ward and in the case of Mr Sithebe, the death report indicated that he was admitted to Ward 20 and then later transferred to Ward 24, bed 23.

5.1.33.13 All patients admitted at BARA are admitted to Ward 20 prior to being transferred to the relevant wards.

5.1.33.14 Upon the death of a patient, the doctor would be called in by the sister in charge to certify the individual's death, and in the case of Mr Sithebe, the doctor certified him as dead on 28 May 2013. In this instance, the name of the deceased was scratched out and it is unknown who scratched it out.

5.1.33.15 The sister in the ward would write in the register that a patient had died and that the family were notified regarding the death but in this instance, the name of the official did not appear as there was only a signature. It was not noted that the family was informed about the death.

5.1.33.16 He indicated that in the event that the hospital could not locate the family, the SAPS would be informed about the death of a patient and the SAPS would then locate and notify the family.

5.1.33.17 According to the Guidelines for signing of death notifications as well as the collection of corpses of the BARA dated 25 November 2014, it is stipulated that the process at BARA is that the mortuary would deploy a mortuary attendant to the ward to collect the corpse from the ward.

5.1.33.18 Mr Sibisi, the former mortuary supervisor, who has since passed on, was notified of the death of Mr Sithebe, but there is no record regarding which mortuary attendant was deployed to collect Mr Sithebe's body from the ward.

5.1.33.19 It was indicated that in the ward, there would be records as to which mortuary attendant collected the body, but Mr Ndabula was not in a position to provide the said records to my office.

5.1.33.20 Mr Ndabula could also not provide an affirmative answer as to whether or not there was a register or documentary evidence in the ward wherein details were populated to reflect which mortuary attendant collected the body from the ward and transferred it to the mortuary.

5.1.33.21 During the interview held with Mr Ndabula, the administrative lapse at BARA was noted as the forms used by the staff only provided for signatures of persons who handled the patients and that expressly excluded the noting of the names of BARA officials in print form.

5.1.33.22 It was submitted by Mr Ndabula that the mortuary building does not have any cameras at the facility and BARA would not have invested in any security measures as the building was made of asbestos. According to the health and safety requirements, the building should be demolished as it was dilapidated.

5.1.33.23 It was highlighted that the only security measure relied upon by BARA at the mortuary facility at that time and currently, was that the family would arrive at the premises with the undertaker, with the objective of identifying the corpse and to collect the body of the deceased.

5.1.33.24 He also indicated that the other security measures relied on was the completion of the registers by the officials in the employ of BARA and the

identification of the corpse by the family members. In addition to that, he submitted that the undertaker was not allowed to collect the body of any deceased patient without the relevant family members being present.

5.1.33.25 However, Mr Ndabula could not provide the mortuary attendance register comprising of the details of the mortuary supervisor and all the mortuary staff that reported for duty on 28 May 2013.

5.1.33.26 Mr Ndabula further submitted, that he did not have any idea what could have happened to Mr Sithebe's body.

Interview with Mr van der Westhuizen: Director of Logistics

5.1.34 During an interview on 13 August 2019 held at the Public Protector's offices with Mr L van der Westhuizen, the Director of Logistics: BARA, the following was submitted:

5.1.34.1 Upon a patient's death in the ward, the auxiliary nurse must certify the patient as deceased in conjunction with the doctor and a death report entailing the details of the patient must then be completed comprehensively by the auxiliary nurse.

5.1.34.2 In this instance, the death report was not completed in full by the auxiliary nurse as the information relating to the time of death of the patient, the notification of the family and/or next of kin about the death of Mr Sithebe, which was not on the report.

5.1.34.3 It was submitted that during the internal investigation conducted by BARA, the investigators could not ascertain from the attendance register as to which auxiliary nurse had completed the death report of Mr Sithebe, as there was only a signature on the report.

5.1.34.4 Furthermore, Mr van der Westhuizen stated that in 2013, there were no guidelines or SOP's for the mortuaries and therefore BARA relied on the verbal information provided by the staff.

5.1.34.5 He further stated that normally, there could be three or four auxiliary nurses working in the ward, but the shift register and attendance register which is kept for a period of five (5) years before being archived, could not be provided to the Director of Logistics.

5.1.34.6 Messrs. I Nyembe and I M Mashudu, the internal investigators, were requested to solicit the archived shift and attendance registers of the auxiliary nurses at Ward 24, but same could not be provided.

5.1.34.7 It was submitted that the doctor who certified Mr Sithebe's death was Dr. Bilal Bobat.

5.1.34.8 According to BARA processes, the auxiliary nurse had an obligation to inform the SAPS about the death of the patient in the event that she could not locate the family or next of kin.

5.1.34.9 The auxiliary nurse had to directly inform the mortuary or log a call at the call center about the death of the patient, in order for a mortuary attendant to be dispatched to the ward to collect the body.

5.1.34.10 The body is usually collected from the ward together with the bed letter, but BARA could not trace which mortuary attendant was dispatched for the collection of the body.

5.1.34.11 Mr Van der Westhuizen could not verify what time the body was collected from the ward, as a deceased patient could be left in the ward for a period of almost ten (10) hours prior to collection.

5.1.34.12 There was no record in the ward to verify which mortuary attendant was dispatched to collect the body, as there were no procedures and guidelines in place relating to the collection of corpses.

5.1.34.13 At the mortuary there was a manual control register and a spreadsheet which did not provide for information regarding mortuary attendants who were dispatched to collect bodies. It was indicated that the mortuary attendants used mortuary vehicles to collect bodies from the ward.

5.1.34.14 During the time in question, the mortuary supervisor was the late Mr France Sibisi, who was later moved to patients' registrations as he was not deemed to be suitable for the position at the mortuary.

5.1.34.15 Mr L Van der Westhuizen further contended that there were numerous problems at the hospital at the time and there was no clear policy regarding pauper burials. There was also improper supervision at mortuary level, as there were no weekly and monthly reports relating to the number of patients who had died, whether the family was informed about the death, the number of bodies that were in the fridge for a period of ten (10) days or one (1) month; the supervisor was not firm in dealing with issues and there were no policies or guidelines in place at the BARA to remedy such occurrences.

5.1.34.16 It was also noted that Mr Mavi showed minimal interest in soliciting information regarding the whereabouts of his father, despite the fact that he had taken Mr Sithebe to BARA on 26 May 2013.

5.1.34.17 During the investigation, it was noted that Mr Mavi ceased cooperating with the BARA investigators as they were soliciting further information regarding his father.

5.1.34.18 The investigators could not retrieve any removal letter of the corpse of Mr Sithebe from the security of the hospital.

5.1.34.19 Mr van der Westhuizen indicated that in the state sector there was room for corruption and collusion as it was speculated that security could have been bypassed without proper documentation as the mortuary attendants also collected bodies from other clinics who did not have mortuaries on their premises.

5.1.34.20 Mr Van der Westhuizen affirmed that there was no specific person that the investigation team could identify as the mortuary attendant deployed to collect the body in Ward 24 on 28 May 2013.

5.1.34.21 Upon perusing the mortuary register, it was noted that the ID number, next of kin, the details of the body received from the ward and the body removed for post-mortem and the undertaker in respect of Mr Sithebe were not completed.

5.1.34.22 Mr Van der Westhuizen indicated that currently BARA implemented the following corrective measures to curb the occurrence of bodies going missing at the hospital:

5.1.34.22.1 Submission of comprehensive death reports on B1663 forms;

5.1.34.22.2 The adoption of Standard Operating Procedures and guidelines for mortuaries approved by the former Chief Executive Officer, Dr Mfenyane;

5.1.34.22.3 Weekly and monthly reports regarding the bodies handled;

5.1.34.22.4 The timeframes wherein the bodies were collected and turnaround times of collection of bodies were reduced; and

5.1.34.22.5 Adoption of the pauper burial policy of 2018, approved by Dr Mfenyane was being utilised by BARA.

5.1.34.23 It was submitted that there was speculation that the body of Mr Sithebe could have been smuggled out of BARA, as there were no control measures at the mortuary during the time in question as Mr France Sibisi was not a strict administrative officer. Based on the evidence in possession of BARA, it was probable that there was internal collusion with external parties and the ICT system on the premises was not working properly and also did not cover the entire hospital parameter.

5.1.34.24 It was indicated that in order to successfully curb incidents relating to bodies going missing at BARA, it was imperative to adopt a biometric system for the release of corpses whereby there would be a thumbprint scan of the finger of the deceased and that of the person deployed to collect the body from the mortuary.

5.1.34.25 Furthermore, that it was imperative that there were stringent rules to regulate the attendance of BARA staff with regard to their access to all the wards within the parameters.

<u>Interview with Mr Mulaudzi: Acting Senior Nursing Manager</u>

5.1.35 During an interview held on 13 August 2019, with Mr Baldwin Mulaudzi (Mr Mulaudzi), the Acting Senior Nursing Manager: BARA, the following submissions were made:

5.1.35.1 Mr Mulaudzi indicated that he became aware of the matter in July 2019, when the SAPS requested information from one of his subordinates, Sister Cecelia Maile.

5.1.35.2 He submitted that upon the death of a patient, the role of the nurse would be to inform the doctor about the death, so that he could declare the patient dead.

5.1.35.3 The body would be left in the ward for at least a minimum period of an hour to allow the family to visit the ward in order to pay their last respects once the patient had been declared dead.

5.1.35.4 The shift leader or the sister in charge would contact the family in order to inform them that the patient had passed on, but in the event that there were no contact details in the file, the nearest police station would be contacted in order for SAPS to locate and to inform the family of the death of the patient.

5.1.35.5 Mr Mulaudzi advised that during the period of Mr Sithebe's death, Sister Maile was in charge of Ward 24 and although she had previously resigned, she was re-employed and is currently working in Ward 34.

5.1.35.6 He indicated that the death notification report was completed by Sister Maile and that she had also attested to that fact upon being questioned.

5.1.35.7 In the case of Mr Sithebe, it was confirmed that there was no family who came to the hospital to pay their last respects.

5.1.35.8 Upon interviewing Sister Maile regarding the manner in which she had completed the death notification report, the information obtained was sketchy as she could not recall whether or not she had called the family in order to notify them of the death of Mr Sithebe or the nearest SAPS as the ward was allegedly extremely busy during the day in question.

5.1.35.9 There was an omission on the part of Sister Maile regarding the handling of the corpse of Mr Sithebe as the standard operating guidelines of BARA

clearly entails that the guidelines requires the auxiliary nurses to adequately complete the death report and to inform the family and/or SAPS about the death of a patient.

5.1.35.10 Sister Maile contacted the mortuary in order for the mortuary attendant to collect the body of Mr Sithebe but there was no further information regarding which mortuary attendant removed the body from the ward.

5.1.35.11 There is a control book in the ward which requires the mortuary attendant to complete his details so as to record the official who had removed the body from the ward.

5.1.35.12 In light of the gaps in the standard operating procedure document, the standard practice at BARA requires the sister in charge to record on the patient's file the details of the person who collected the body and the state the corpse was in when it was collected. In this particular case, Sister Maile did not record such information on the file.

5.1.35.13 Once the body is collected from the ward, it is then removed to the mortuary.

5.1.35.14 It was indicated that the body of Mr Sithebe was collected from the ward and moved to the mortuary as the details of the deceased were recorded on the database of the mortuary as per the mortuary register.

5.1.35.15 Furthermore, it was admitted that the conduct of Sister Maile in the completion of the death notification report and omitting to contact the family or the SAPS as an alternative, did not comply with the requirements of BARA.

5.1.35.16 It was confirmed that there was no disciplinary nor consequence management undertaken by the nursing department against Sister Maile

upon realising the omissions that she had made in respect of the handling of Mr Sithebe's corpse.

5.1.35.17 Mr Mulaudzi further provided my office with a death report of Mr Sithebe that was completed by Sister Maile which reflects that the next of kin of the deceased were not informed of his death.

Interview with Ms Lucky Mohomane: Mortuary Supervisor

5.1.35.18 During an interview held on 26 August 2019, with the Mortuary Supervisor at BARA: Ms Lucky Mohomane, the following was submitted:

5.1.35.18.1 Ms Mohomane advised that she became aware of the matter of the late Mr Sithebe in 2016, when a complaint was lodged by a family member by the name of Dudu with BARA regarding the whereabouts of the patient.

5.1.35.18.2 In order to ascertain the whereabouts of the late Mr Sithebe, she retrieved information regarding the patient from the database of the mortuary and discovered that the patient had been admitted at BARA.

5.1.35.18.3 The records reflected that Mr Sithebe passed away at BARA on 28 May 2013 and verification was made as per the notes on the death register at the mortuary, in order to check whether the body was removed from the ward.

5.1.35.18.4 It was noted that the details of Mr Sithebe appeared on the mortuary /death register but there was no information relating to whether or not the body of the patient was removed.

5.1.35.18.5 According to the internal processes at the mortuary, logging the information of corpses on the death register is done on a daily basis in the morning by

the Mortuary Supervisor or the administration officers deployed in the mortuary.

5.1.35.18.6 As there was no information regarding Mr Sithebe on the death register, she opted to contact the records department to request any information on record in relation to Mr Sithebe. The records indicated the notice of death of the patient, and information of a person who was said to be the daughter of the deceased. The records also showed that the body was removed from the mortuary but there were no details of the person who removed it.

5.1.35.18.7 Upon contacting Dudu, she advised her what she had discovered on the file and the family member indicated that they had no knowledge of the body being removed from BARA.

5.1.35.18.8 As the family member requested the file, she was then referred to the Motor Vehicle Accident (MVA) department for further handling and she discovered that the person who was removed from the mortuary was not Mr Sithebe but a patient by the name of Mr Mlumbi.

5.1.35.18.9 According to the death notice at the mortuary, the details of Mr Sithebe were scratched out and replaced with those of Mr Mlumbi. In other words, the death notice which initially comprised of Mr Sithebe’s details, including his ID number, was used to release Mr Mlumbi’s body from the mortuary. Furthermore, Ms Mohomane confirmed that Mr Mlumbi and Mr Sithebe shared the same body number but that the patients did not pass away on the same date.

5.1.35.18.10 She highlighted that the death notice was part of the documents the doctors had to sign.

5.1.35.18.11 According to standard procedure, the notice of death would be completed by the mortuary supervisor or the mortuary attendant, the person or family

member and the undertaker. In order for the document to be completed correctly, the correct identity number of the deceased and the date of death had to be provided.

5.1.35.18.12 The notice of death is completed in duplicate so as to provide the family of the deceased with a copy in order to allow them to submit it to the Department of Home Affairs (DHA) for the purpose of obtaining a death certificate.

5.1.35.18.13 Ms Mohomane indicated that the death notice in the file did not have any deletions but the one that was given to the family to allow them to obtain a death certificate had some information scratched out.

5.1.35.18.14 Ms Mohomane stated that there was maladministration in the manner in which the death notice of Mr Sithebe was completed and used to release the body of Mr Mlumbi. Mr Gideon Ntshwane, the mortuary attendant who released the body of Mr Mlumbi using the death notice which contained Mr Sithebe's details, was no longer in the employ of BARA, as he had since resigned.

5.1.35.18.15 According to the standard procedure, the mortuary attendant had an obligation to ensure that adequate care and caution was exercised to release the bodies of both Mr Sithebe and Mr Mlumbi, as per the details entailed in the death register.

5.1.35.18.16 Ms Mohomane contended that the undertaker might have signed out the body of Mr Mlumbi and scratched out Mr Sithebe's details thereon.

5.1.35.18.17 Ms Mohomane confirmed that the body of Mr Sithebe was taken to the mortuary. However, the body of Mr Mlumbi was released from the mortuary, using Mr Sithebe's details on file as they could not locate Mr Mlumbi's file.

5.1.35.18.18 Ms Mohomane indicated that there was an undated copy of a draft pauper list completed by Mr Sibisi which contained the details of the deceased, but he did not populate the details of the deceased on the final documentation of the pauper list for May 2013.

5.1.35.18.19 Furthermore, there was no information regarding which mortuary attendant collected the body of Mr Sithebe from the ward and removed it to the mortuary, but according to the attendance register, Mr Malaka and Mr Chonco were not on duty on 28 May 2013.

5.1.35.18.20 According to the submission of Ms Mathebula, her uncle Mr Mlumbi died on 31 July 2013 and the body was released from the mortuary on 02 August 2013. It is clear that the corpse of Mr Sithebe had been in the mortuary for some time and the corpse may still have been there on 02 August 2013 as his file was used to release the body of Mr Mlumbi.

5.1.35.18.21 It was also indicated that there were incidents where people would undertake the collection of deceased persons unrelated to them with the objective of submitting insurance claims.

Interview with Ms Cecilia Maile

5.1.36 On 26 August 2019, an interview was held with Ms Cecilia Maile, a Professional Nurse who was deployed to Ward 24 as a team leader where Mr Sithebe was treated. She was assisted by the Legal Officer, Ms Thabitha Kgobe.

5.1.37 As indicated supra, Ms Maile could not recollect the chain of events at the time of the occurrence of this incidence and had to depend mainly on the available records to confirm her involvement in the matter and she submitted as follows:

5.1.37.1 On 28 May 2013, she was deployed as a Professional Nurse and team leader at medical ward 24 where Mr Sithebe was treated, as per the death report.

5.1.37.2 As the matter dates back to 2013, she could only rely on the death report book where her signature appeared and she was able to affirm that she was on duty on 28 May 2013.

5.1.37.3 She speculated that on 28 May 2013, she was on day duty and that she was working with Sister Lando, who worked for an agency.

5.1.37.4 She indicated that when a patient dies, the doctor would be advised accordingly and once the patient is certified as dead on the bed letter, the actual time of such certification would be recorded, which would serve as the time of death.

5.1.37.5 It is worth noting that the oral evidence by Sister Maile was vague as she indicated that she could not remember the sequence of events due to the lapse of time. Therefore, her evidence was very limited and she could not provide further evidence regarding the steps taken to try and inform the next of kin about the demise of Mr Sithebe. As a result, her interview could not advance the investigation further.

Response received on the Section 7(9) notice from the Chief Executive Officer of BARA, Dr Lesia

5.1.37.6 A section 7(9) notice was served on the Acting Head of Department, Mr Malotana, on 14 December 2020 and the Chief Executive Officer of BARA, Dr N Lesia, on 30 January 2021 notifying them of the intended findings on this matter. A written submission was received from Dr Lesia dated 02 February 2021. In essence, Dr Lesia did not dispute the findings and instead concurred in principle with the findings as contained in the notice.

5.1.37.6.1 Mr Mavi (son of the deceased) alleged that he went to the hospital on Monday, 29 May 2013 but was informed by an unknown staff member at the hospital that his father was discharged to a home. However, Dr Lesia indicated that the hospital noted that Mr Mavi did not contact the hospital at any stage to get clarity on the matter.

5.1.37.6.2 Dr Lesia indicated that the B1663 death notification report was completed by Dr Bilal Bobat, but an incorrect family informant was captured thereon as Ms Mathebula, who is not a relative of the deceased. According to the submission of Dr Lesia, she submitted that the hospital did not know whether the captured information was a genuine error or a deliberate act of collusion to hide the truth about the matter.

5.1.37.6.3 According to the response letter submitted by Dr Lesia, the same B1663 form completed by Dr Bilal Bobat was used to release the corpses of both Mr Sithebe and Mr Mlumbi.

5.1.37.6.4 She indicated that the hospital noted that the corpses of Mr Sithebe and Mr Mlumbi were collected by a person by the name of Isaac Sithole, who was employed by Funeral Assist 24 CC Undertakers located at 703 Old Pretoria Road, Wynberg.

5.1.37.6.5 Dr Lesia indicated that the contact details provided by Mr Sithole displayed under section E of the notice of the death form (B1663) are different from the contact details displayed on the company stamp.

5.1.37.6.6 The death of Mr Mlumbi was registered by Ms Dorah Lenah Matlakale at the Department of Home Affairs, Alexandra branch, who used the scratched out forms that were initially used to register the death of Mr Sithebe.

5.1.37.6.7 Dr Lesia also submitted that the original B1663 form completed to register the death of Mr Sithebe was never submitted to Home Affairs, hence the absence of a death certificate.

5.1.37.7 Upon perusal of the preliminary report of the Public Protector and available documents, Dr Lesia indicated that the following conclusions were made:

5.1.37.7.1 Hospital Management accepts the finding that the Professional Nurse Cecilia Maile failed to notify the family about the death of Mr Sithebe and failed to document all the relevant information in the death report book.

5.1.37.7.2 BARA accepts the finding that the Nursing Management failed to take any disciplinary steps to reprimand Sister Maile for the act of omission;

5.1.37.7.3 BARA accepts the finding that there was poor record keeping at the level of the ward and the mortuary.

5.1.37.7.4 Even though there was a system in place to notify the family and to capture relevant information on the mortuary register, BARA accepted that under the circumstances there was a failure by its staff members to comply with the existing system.

5.1.37.7.5 However, in respect of the latest findings from the perusal of the documents regarding the missing body, Dr Lesia indicated that Management will call the family to disclose the latest information at their disposal that indicates the body was collected by a known person, taken to a known funeral parlor to be buried at Avalon Cemetery on a specified date.

5.1.37.7.6 Dr Lesia indicated that the hospital appealed to the SAPS to follow up on this investigation to assist the family to get closure as she indicated that

people have colluded to conceal the death of Mr Sithebe which the hospital considers to be a criminal act.

5.1.37.7.7 In conclusion, Dr Lesia further submitted that the hospital management has since put measures in place to strengthen the system in order to promote accountability at the level of the ward and the mortuary.

Response received on Section 7(9) notice from a Professional Nurse of BARA, Sister Maile

5.1.37.8 A section 7(9) notice was served on a Professional Nurse: Bara, Sister Maile on 11 February 2021, notifying her of the intended findings on this matter.

5.1.37.9 On 12 February 2021, the Public Protector received a written submission from Sister Maile. In essence, Sister Maile did not dispute any findings but instead concurred in principle with the findings contained in the notice.

5.1.37.10 Based on the submission of Sister Maile, she confirmed that she was on duty on 28 May 2013 when Mr Themba Milton Sithebe died in Ward 24. According to the death book, there were no entries of the next of kin of the deceased, and no entry indicating that the SAPS members were informed of the death.

5.1.37.11 Sister Maile advised the Public Protector that unfortunately she could no longer remember the finer details of what transpired on the day in question when the Mr Sithebe passed away, as Ward 24 is a 68 bed ward.

5.1.37.12 According to the response letter submitted by Sister Maile, she indicated that after 16h00, she was the shift leader at Ward 24 and was tasked with over-seeing one professional nurse, one enrolled nurse, and three Enrolled Nursing Auxiliaries.

5.1.37.13 Sister Maile affirmed that there were no entries of the next of kin of the deceased or any notification to the SAPS. She conceded to the fact that she should have notified the family members of the death of Mr Sithebe and that includes expressly noting the time and the contact numbers of the family that were notified. In the event that the family could not be reached, she had a responsibility to ensure that the SAPS was notified about the death of Mr Sithebe.

5.1.37.14 It was acknowledged by Sister Maile that she was familiar with the death notification process as entailed in the Standard Operating Procedure policy of the hospital.

5.1.37.15 Sister Maile also confirmed that the body was collected and taken to the mortuary as reflected on the Mortuary register. However, she indicated that it was regretful that the body of Mr Sithebe was found to be missing from mortuary and that the family was not notified of his death.

5.1.37.16 Sister Maile conceded that her failure to notify the family of the deceased about the death constituted an omission on her part. This is despite the fact that she only became aware of the missing body of Mr Sithebe after a period of six (6) years since the incident occurred.

5.1.37.17 Furthermore, Sister Maile further indicated that she accepts the Public Protector`s findings.

Application of the relevant law.

5.1.38 Section 195(1) of the Constitution provides that public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:

(a) A high standard of professional ethics must be promoted and maintained;
(b) …;
(c) ...;
(d) …;
(e) Public administration must be accountable; and Transparency must be fostered; and
(f) Transparency must be fostered by providing the public with timely, accessible and accurate information.

5.1.39 Healthcare Practitioners are required to perform their duties in a professional and ethical manner. In this instance, it follows that the hospital did not inform the family of Mr Sithebe about his death and such conduct was not only unethical, but also unprofessional as it was not in line with the spirit of the Constitution.

5.1.40 Section 22 (1) of the births and deaths registration Act [5]provides -

"(1) A notice of death must be given within 72 hours of the death by the informant –

(a) on Form DHA-1663 illustrated in Annexure 14 to the Director-General, where a cause of death certificate contemplated in

[5] Act 51 of 1992

section 15(1) or (2) of the Act was issued by a medical practitioner; or

(b) on Form DHA-1680 illustrated in Annexure 15 where a cause of death certificate contemplated in section 15(1) or (2) of the Act was not issued by a medical practitioner; and

(c) be accompanied by the following supporting documents:

(i) A certified copy of the identity document or valid passport of the informant;

(ii) the biometrics of the deceased and the informant must be affixed in the appropriate space provided on Form DHA-1680 illustrated in Annexure 15 and in the case where the biometrics cannot be affixed, an affidavit containing the reasons as to why such biometrics were not affixed must be attached; and

(iii) a certified copy of the identity document of the informant."

5.1.41 Further, BARA had a responsibility to be transparent with the Sithebe family by timeously notifying them of the passing of Mr Sithebe and provide them with the death notice. Sister Maile also had an obligation to ensure that accurate information was captured on the death notification report in order to enable the family to approach the Department of Home Affairs to register the death of Mr Sithebe and subsequently issue the family with a death certificate.

5.1.42 Paragraph 2 of BARA Nursing Service Guidelines which prescribes the procedure to follow when reporting a death[6] provides that-

"The family of the deceased or next of kin must be notified telephonically or verbally about the death of the patient."

5.1.43 According to the above-mentioned Nursing Service Guidelines it is clear that BARA had an obligation to inform the family of Mr Sithebe telephonically or verbally about his death.

5.1.44 BARA did not notify the family of Mr Sithebe of his death once the doctor had certified him as dead. Furthermore, there was no evidence submitted by the hospital to the Public Protector which disclosed that the family of Mr Sithebe was notified about his death either telephonically or verbally.

5.1.45 Even though the medical records of Mr Sithebe showed that the hospital had captured the contact details of *"Ronny"* as his next of kin on the file and on the patients' database, it follows that in this particular instance, BARA did not utilise the information to trace the family of Mr Sithebe. As a result, the conduct of the hospital was not in line with the spirit and intent of BARA's Nursing Service Guidelines for the Procedure to follow when reporting a death.

5.1.46 Paragraph 3 of BARA Nursing Service Guidelines for the Procedure to follow when reporting a death states that-

"If there are no contact numbers, you may convey the message to the nearest police station via switchboard."

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[6] Adopted 08 April 2008

5.1.47 Based on the mentioned Guidelines, BARA had an obligation to convey the message to the nearest police station that Mr Sithebe had died, but in this case, there is no evidence that was submitted to the Public Protector to show that BARA had informed the SAPS about the passing of Mr Sithebe.

5.1.48 Paragraph 7 of the BARA Nursing Service Guidelines for the Procedure to follow when reporting a death stipulates that-

"Write a full report on TPH 114/2B and notify the supervisor after the corpse has been removed."

5.1.49 According to the above mentioned proviso, it is clear that the nursing service at BARA, in particular Sister Maile, had an obligation to ensure that a full report on the TPH 114/2B was completed and as the team leader in the ward at the time, she also had a responsibility to ensure that the supervisor was duly notified after the corpse was removed from the ward by the mortuary personnel.

5.1.50 Regulation 29 of the Regulations Relating to the Management of Human Remains[7] read with Regulation 32, of the Regulations Regarding the Rendering of Forensic Pathology Service[8] stipulates that:

"(29) Any unclaimed bodies or unidentified human remains must be dealt with in accordance with the provisions of regulations 32 and 34 of the Regulations Regarding the Rendering of Forensic Pathology Service; published in the Government Notice No. R 636 of July 2007.

[7] No R 363 May 2013
[8] No R 636 July 2007

"(32) A body that has not been identified must be moved to a freezer within seven days of admission and if such body remains unidentified for 30 days, the local municipality under whose jurisdiction the designated facility is, must provide for a pauper burial or cremation of such a body."

5.1.51 According to the medical records of the deceased, Mr Sithebe died on 28 May 2013 and his body was moved to the mortuary on the same day. Evidence obtained by the Public Protector shows that the family of Mr Sithebe was not notified about his death, therefore they could not have known about his demise nor identify his body in order to bury him.

5.1.52 There was also no evidence submitted by the hospital to confirm that the local municipality was informed by BARA about the unidentified remains of Mr Sithebe to enable them to commence with the process of the pauper burial or cremation of the deceased.

5.1.53 The preamble to the Code of Ethics for Nursing Practitioners in South Africa under the provisions of the Nursing Act, 2005, states that:

"*The Code of Ethics does not only provide guidance to nurses in the process of their ethical decision-making but is a binding document, the content of which must be complied with".*

5.1.54 *The purpose statement* of the Code of Ethics for nursing in South Africa under the provisions of the Nursing Act, 2005, indicates that:

"This Code of Ethics is the foundation of ethical decision-making and is aimed at informing Nursing Practitioners and the public of the following

ethical and moral principles applicable to Nurse Practitioners in the performance of their duties".

5.1.55 The Purpose statement provides that the Code assists both the practitioners and healthcare users with:

(a) Identifying ethical values and principles that form the foundation for professional conduct;

(b) …….;

(c) ……; and

(d) Indicating to the public, stakeholders and healthcare users the standards and ethical values they can expect nurses to uphold.

5.1.56 As professionals, Nursing Practitioners will be personally accountable for all actions and omissions while carrying out their responsibilities in their profession and must always be able to justify all decisions taken and carried out."

5.1.57 The Code guides nursing Practitioners on the ethical decision-making that they are required to uphold in the process if carrying out their professional responsibility. Further, the code holds the Nursing Practitioner personally accountable for all their actions and omission while carrying out their responsibilities in the profession.

<u>Conclusion</u>

5.1.58 Based on the evidence traversed above, it is clear that in this particular instance, BARA did not have stringent record keeping measures in place and this weakness at the administration of the hospital resulted in the body of Mr Sithebe going missing.

5.1.59 It is evident under the circumstances that the abovementioned regulations and procedures for the handling of a deceased person were not adhered to by the staff of both BARA hospital and the mortuary.

5.2 Whether there was a failure by the SAPS to investigate or finalise the case of a missing corpse of the deceased.

<u>*Common Cause issues*</u>

5.2.1 The reporting of the case of the missing corpse to the SAPS was one of the recommendations made in the comprehensive internal investigation report issued by BARA on 05 June 2017.

5.2.2 According to the progress reports dated 02 April 2019, submitted to the Public Protector’s office by Lt Colonel Swalivha, it was indicated that a case regarding the missing corpse of Mr Sithebe was reported to the Diepkloof SAPS on 04 June 2017.

5.2.3 A case of theft of a corpse was opened and registered by the Diepkloof SAPS under Cas-67-06-2017.

5.2.4 The case of the missing corpse was initially allocated to warrant officer IE Mathebula, and thereafter subsequently reallocated to Captain Mukansi for further handling.

5.2.5 According Lt Colonel Swalivha, the progress report indicated that the matter was referred to the SAPS Legal Department where it was resolved that the matter should be taken to the Senior Public Prosecutor for determination.

5.2.6 The office of the Senior Public Prosecutor at Orlando Magistrate's Court made a determination that the case could not be prosecuted due to lack of evidence.

Issues in Dispute

5.2.7 The Complainant alleged that there was failure by SAPS to investigate the case of a missing body of Mr Sithebe since 2017.

5.2.8 According to a response letter dated 14 November 2018, submitted to the Public Protector by the Detective Group Commander: Lieutenant Colonel Swalivha (Lt Swalivha), he denied that SAPS failed to investigate the case of the missing corpse of Mr Sithebe.

5.2.9 Lt Swalivha affirmed that a case of theft of a corpse of Mr Sithebe was reported at the Diepkloof SAPS on 04 June 2017, by Ms Nokuthula Sithebe, and that the matter was investigated by the Diepkloof SAPS as the deceased's corpse could not be traced at BARA since 28 May 2013.

5.2.10 The Diepkloof SAPS opened and registered a docket under CAS 67-06-2017. The case was allocated to Warrant Officer IE Mathebula and later reallocated to Captain Mukansi for further investigation. The SAPS investigation revealed the following:

5.2.10.1 Ms Nokuthula Sithebe discovered that her uncle was missing from BARA on 28 May 2013 when she was informed by, Mr Mavi who is the son of Mr Sithebe.

5.2.10.2 Upon making enquiries at the Department of Home Affairs (DHA), she discovered that the records indicated that he was still, according to its records, alive.

5.2.10.3 She lodged a complaint at BARA on 18 January 2017 and during February 2017, she was advised that her father, Mr Sithebe had passed away.

5.2.10.4 According to the BARA mortuary register, Mr Sithebe was registered and the date of death was captured as 28 May 2013.

5.2.10.5 There was no information which indicated that the family was notified about the death and or that the body of the deceased was collected by the family or an undertaker as the register did not have any signature or information of collection of the body.

5.2.10.6 The Diepkloof SAPS noted that there was no paper trail at BARA which indicated what had happened to the body of the deceased at the mortuary.

5.2.10.7 That the employees who were working at the mortuary during the time in question, were no longer in the employ of BARA. Mr Ntshwane, an auxiliary worker, has already retired; Mr France Sibisi, the former mortuary Supervisor passed away and Mr Z M Chonco, also an auxiliary worker no longer worked at the hospital.

5.2.10.8 The details of Mr Sithebe did not appear on the pauper burial list and his death was never registered.

5.2.10.9 The death notification report registered with the details of Mr Sithebe was scratched out and replaced with the details of Mr Sydney Mphithizeli

Mlumbi. However, the address and the ID number on the report were those of Mr Sithebe.

5.2.10.10 That Funeral Assist 24 in Alexandra was in possession of the scratched out copies of the death notification report and the undertaker also confirmed that the corpse they collected was that of Mr Sydney Mphithizeli Mlumbi who resided at No. 718 Chiawelo, Soweto. However, Mr Isaac Sithole from the undertakers who had collected the corpse from BARA had since resigned from the company and could not be traced to be interviewed.

5.2.10.11 The family of Mr Sydney Mphithizeli Mlumbi confirmed that on 25 July 2013 they brought him to BARA casualty, but he passed away on the same day.

5.2.10.12 The family of the deceased Mr Sydney Mphithizeli Mlumbi verified that they buried the correct body as they had to identify the corpse at BARA mortuary. Further, that they had to visit the premises of Funeral Assist 24 in order to prepare the body for burial.

5.2.10.13 On 31 July 2013, the body of Mr Sydney Mphithizeli Mlumbi was collected by Ms Pamela Mathebula who was also in possession of the scratched out copy of the death notification report.

5.2.10.14 According to Soko/TD Funeral Parlour in Mogale City, there was a pauper burial conducted for Mr Sydney Mphesheni from Thembelihle F1, who allegedly passed away on 15 March 2014 but on the hospital records, the person had passed away on 15 March 2015.

5.2.10.15 The funeral parlour could not provide any clarification regarding the contradicting two dates of death as there was uncertainty as to when Mr Sydney Mphesheni died.

5.2.10.16 That the investigation was completed and the case docket was taken to the Senior State Prosecutor at Orlando court after consultation with the SAPS Legal Service. Lieutenant Swalivha submitted that the outcome of the investigation was communicated to the Complainant.

5.2.10.17 Furthermore, the Senior State Prosecutor decided that based on the records of BARA, the case was *nolle prosequi.*

5.2.11 A progress report submitted by Lieutenant Colonel Swalivha dated 02 April 2018 to the Public Protector confirmed that there was a recommendation that the case docket should be discussed with Colonel Chowels, the Johannesburg West Cluster detective coordinator and the Detective Section Head of the Diepkloof SAPS, Col Reyneke.

5.2.12 According to the abovementioned progress report, it was resolved that the docket should be discussed with the Senior Public Prosecutor on 20 November 2018, to determine whether a court order for the exhumation order for the body of Sydney Mphesheni from Thembelihle F1, who was buried as a pauper, could be conducted in order to establish whether or not that body was not that of Mr Sithebe.

5.2.13 However, Lieutenant Colonel Swalivha informed the Public protector that the exhumation never continued as the court order was not obtained by SAPS because of the decision of the Senior State Prosecutor.

5.2.14 During the interview with Colonel Swalivha and Captain Mukansi on 26 April 2019, the officials affirmed that a case of theft of a corpse at the BARA was opened, registered and investigated by the SAPS.

5.2.15 Lieutenant Colonel Swalivha and Captain Mukansi also outlined the process SAPS followed from the commencement of the investigation until the matter was referred to the Senior Prosecutor.

5.2.16 According to a tele-communique discussion the Public Protector team held with Lieutenant Colonel Swalivha on 26 May 2020, he submitted correspondence to the Public Protector indicating that the Senior Prosecutor did not provide any further instructions to the investigating officer to comply with the issue of exhumation. Lieutenant Colonel Swalivha further indicated that the case was *nolle prosequi*, and as a result the issue regarding exhumation was dismissed.

5.2.17 On 27 May 2020, Lieutenant Colonel Swalivha submitted a progress report to the Public Protector which indicated that the court decided that the docket must be filed at the station.

5.2.18 Lieutenant Colonel Swalivha also indicated that with regards to the suspicion by the BARA internal investigation that the body of Mr Sydney Mphesheni could be that of Mr Sithebe, the suspicion was dismissed due to the time lapse between his date of death and that of Mr Sithebe who died in 2013, hence the exhumation order was not granted.

5.2.19 Lieutenant Colonel Swalivha submitted that the body of Mr Sydney Mphesheni was collected and buried as a pauper by Soko Funeral Parlour on 25 September 2015. Further that the SAPS was of the opinion that the deceased and Mr Mphesheni was not one and the same person.

Application of the relevant legal framework

5.2.20 Section 205 of the Constitution provides that:-

"(1) …

(2) …

(3) The objects of the police service are to prevent, combat and investigate crime, to maintain public order, to protect and secure the inhabitants of the Republic and their property, and to uphold and enforce the law."

5.2.21 It is clear that the SAPS had a responsibility to ensure that they investigate any criminal conduct that may have ensued or been reported, as well as ensure the enforcement of the law.

5.2.22 In this instance, SAPS complied with their Constitutional obligations by investigating the case of the missing corpse of Mr Sithebe. The matter was taken to the Senior Public Prosecutor for a decision, and the Prosecutor declined to prosecute due to a lack of evidence.

5.2.23 Section 13 of the South African Police Service Act[9], indicate that :-

"(1) Subject to the Constitution and with due regard to the fundamental rights of every person, a member may exercise such powers and shall perform such duties and functions as are by law conferred on or assigned to a police official;

(2) …;

(3)(a) A member who is obliged to perform an official duty, shall, with due regard to his or her powers, duties and functions, perform such duty in a manner that is reasonable in the circumstances; and

[9]Act 68 of 1995

(b) …"

5.2.24 The extrapolated section above states that the members of the SAPS have a duty to investigate the reported complaint of the missing corpse within the parameters of the law and their powers. Therefore it was found that SAPS adhered to the duty imposed by the above section and the Constitution in investigating the matter and seeing it to finality.

Conclusion

5.2.25 Based on the above mentioned evidence in our possession, the office of the Public Protector is unable to find any wrongdoing on the part of SAPS. Even though the investigation by SAPS did not yield any positive results regarding the missing corpse of Mr Sithebe, the matter was fully investigated in terms of SAPS prescripts and the outcome of the investigation was communicated to the Complainant.

5.3 Whether the Complainant or any other person had suffered improper prejudice as a result of the conduct of BARA and the SAPS under the circumstances.

Common Cause issues:

5.3.1 The late Mr Sithebe was admitted as a patient at BARA on 26 May 2013 and a patient file was opened by the hospital. According to the hospital records, he passed away on 28 May 2013.

5.3.2 The family or next of kin of Mr Sithebe did not receive any notification regarding the death of Mr Sithebe.

5.3.3 The SAPS was also not informed about the death of Mr Sithebe by Sister Maile, who was the nurse in charge of the ward at the time.

5.3.4 A complaint was lodged by the Complainant with BARA regarding the missing corpse of Mr Sithebe and that prompted BARA to conduct an internal investigation.

5.3.5 The SAPS conducted a criminal investigation into the missing corpse of Mr Sithebe and upon the conclusion of the investigation on the matter, the docket was referred to the Senior State Prosecutor for a determination, who declined to prosecute due to lack of evidence.

Issues in Dispute

5.3.6 The Complainant argued that the family suffered prejudice due to BARA's poor handling of the death of Mr Sithebe and removal of his body, which deprived them an opportunity to bury their family member.

5.3.7 The internal investigation report of BARA dated 06 June 2017, furnished by Dr Lesia, and the submissions of Mr Mulaudzi and Mr Leon van der Westhuizen, during the interview sessions held at the Public Protector's office on 01 August 2019 and 13 August 2019 respectively, all confirmed that BARA did not adhere to standard procedures as prescribed in its policy.

5.3.8 Sister Maile also confirmed the signature appended on the death report book as her own and further acknowledged that she was on duty on 28 May 2013 when Mr Sithebe died.

5.3.9 Ms Mohomane also confirmed that there was maladministration in the manner in which the notice of death of Mr Sithebe was completed and utilised to release the body of Mr Mlumbi, as the death notice comprised of the ID number of Mr Sithebe and not that of Mr Mlumbi.

5.3.10 According to the submission of Lieutenant Colonel Swalivha, the Diepkloof SAPS Detective Group Commander on 26 April 2019, he was also of the opinion that there was maladministration by BARA in the handling of the corpse of Mr Sithebe, but he denied that there was a delay by SAPS to finalise the investigation into the missing corpse.

Response received on the Section 7(9) notice from the Chief Executive Officer of BARA, Dr Lesia

5.3.11 A section 7(9) notice was served on The Acting Head of Department: Mr Malotana on 14 December 2020 and the Chief Executive Officer: BARA, Dr N Lesia on 30 January 2021 notifying them of my intended findings on this matter. A written submission from Dr Lesia dated 02 February 2021 was received. In essence, Dr Lesia did not dispute any findings and instead concurred in principle with the findings contained in the notice.

5.3.12 Dr Lesia indicated that the hospital appealed to the SAPS to follow up on this investigation to assist the family to get closure as she indicated that people had colluded to conceal the death of Mr Sithebe which the hospital considers to be a criminal act.

<u>*Application of the Relevant Legal Framework*</u>

5.3.13 Section 30 of the Constitution provides that:-

"Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights."

5.3.14 According to the above mentioned proviso, it is clear that everyone has a right to participate in the cultural life of one's own choice.

5.3.15 In this instance the poor administration at BARA prevented the family of the deceased from practicing their cultural beliefs, in arranging a proper burial when the hospital could not locate the body of the deceased for burial.

5.3.16 Section 31 of the Constitution stipulates that :-

"(1) Persons belonging to a cultural, religion or linguistic community may not be denied the right, with other members of that community –

(a) to enjoy their culture, practice their religion and use their language; and

(b) …"

5.3.17 The abovementioned provision of the Constitution affords a clear protection of the traditional privileges accorded to every individual belonging to a certain culture. It is clear under the circumstances that BARA had a responsibility to ensure that the family of Mr Sithebe enjoyed the right to practice their culture and religion and bury their family member with dignity.

5.3.18 However, in this particular instance the hospital did not ensure that the above mentioned right was upheld as BARA was not able to provide the corpse of Mr Sithebe to the family.

5.3.19 Paragraph 7 of the BARA Nursing Service Guidelines for the Procedure to follow when reporting a death stipulates that-

“Write a full report on TPH 114/2B and notify the supervisor after the corpse has been removed.”

5.3.20 According to the above mentioned proviso, it is clear that Sister Maile had the responsibility to ensure proper record keeping of the patients who met their demise at the hospital; ensure the removal of their bodies from the ward by the auxiliary mortuary officials as prescribed in the guidelines by completing the TPH 114/2B report and notifying the supervisor about the movement of a corpse.

5.3.21 However, in this instance, there was no evidence submitted by BARA, which expressly showed that upon compilation of a comprehensive written report on the TPH 114/2B, Sister Maile notified her supervisor that the corpse of Mr Sithebe was removed from the ward by the auxiliary personnel.

5.3.22 According to a further response letter dated 17 April 2020 which was submitted by Dr Lesia, it was indicated that based on the records which were in possession of BARA, the hospital could not confirm whether the supervisor was informed about the removal of the corpse of Mr Sithebe by Sister Maile as the matron’s report used to record such information could not be found at archives.

5.3.23 In *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* 2000 (1) SA 827 (SCA) [10], the Appeal Court reiterated that **:**

"The benchmark for negligence is what a reasonable person would have done in the same circumstances as the defendant experienced..."

5.3.24 In the circumstances, it is clear that the officials in the employ of BARA did not conduct themselves in a manner that could have been expected of a reasonable person, when they handled the death and removal of the corpse of the deceased.

Conclusion

5.3.25 Based on the abovementioned evidence, it is apparent that BARA did not ensure that the rights of the family of the deceased were protected as the hospital was unable to ensure that the corpse was handed over to them for a respectful and proper burial.

5.3.26 It follows that BARA had a responsibility to ensure that there was proper and efficient administration of its record keeping relating to the movement of deceased patients within its premises as per BARA Nursing Service Guidelines in terms of the procedure to follow when reporting a death. In this instance, the officials in the employ of BARA did not effectively and efficiently carry out their duties as per the standards contained in the policy of the hospital, which resulted in the family of the deceased suffering prejudice as they were not provided with an opportunity to bury their loved one in terms of their cultural practices.

[10] At par 21

6 FINDINGS

Having considered the submissions made and evidence uncovered during the investigation against the relevant regulatory framework, the following adverse findings are made against the BARA

6.1. Regarding whether there was maladministration and improper conduct by BARA in its alleged failure to inform the Sithebe family of the death of their family member and the loss of the deceased's corpse.

6.1.1. The allegation that there was maladministration and improper conduct by BARA to inform the family of the death of Mr Sithebe and the loss of his corpse, is substantiated.

6.1.2. BARA failed to ensure that all the requisite information was completed on the death notification report of Mr Sithebe and also failed to inform the next of kin and/ or the SAPS of the death of Mr Sithebe.

6.1.3. Similarly, BARA upon being made aware of the failure by the staff to follow due process in the handling of Mr Sithebe's corpse, also failed to take any action against the officials implicated.

6.1.4. Sister Maile's failure to adequately record the information of Mr Sithebe on the death report book, her failure to inform the next of kin and / or the SAPS about the death of Mr Sithebe and to ensure that there was a proper hand over of the outstanding duties to report the death to the family or the SAPS when there was a change of shifts with her colleagues in ward 20 amounted to negligence. As the corpse of Mr Sithebe is still missing, it is clear that the

conduct of Sister Maile resulted into the Complainant and her family suffering prejudice as they could not arrange a proper burial.

6.1.5. The BARA failed to ensure that stringent and effective standard operating procedures, policies and regulations were complied with by BARA staff in the handling of Mr Sithebe's death and the removal of his corpse and also failed to ensure that the hospital maintained accurate patient records.

6.1.6. The conduct of BARA amounts to gross negligence as the notice of death of Mr Sithebe was used to release the body of a Mr Mlumbi.

6.1.7. The conduct of BARA contravened Section 195(1)(a)(e) and (g) of the Constitution, Section 22(1) of the Births and Deaths Registration Act, Paragraph 2, 3 and 7 of the BARA Nursing Service Guidelines for the procedure to follow when reporting a death, Regulation 29 of the Regulations Relating to the Management of Human Remains and Regulation 32(29) Regulations regarding the Rendering of Forensic Pathology Service, the Preamble and the purpose statement of the Code of ethics for nursing practitioners in South Africa.

6.1.8. Accordingly, the conduct by BARA amounts to improper conduct in terms 182(1)(a) of the Constitution and maladministration as envisaged in section 6(4)(a)(i) of the Public Protector Act.

6.2. Regarding whether there was a failure by the SAPS to investigate or finalise the case of the missing corpse of the deceased.

6.2.1. The allegation that SAPS failed to investigate the case of the missing body of Mr Sithebe, is unsubstantiated.

6.2.2. The SAPS investigated the complaint of the missing corpse within a reasonable standard that is expected in terms of the law and their powers. Therefore, SAPS adhered to the duty imposed on them by the Constitution in the investigation of the matter.

6.2.3. Accordingly, the conduct of SAPS does not amount to improper conduct in terms 182(1)(a) of the Constitution and maladministration as envisaged in section 6(4)(a)(i) of the Public Protector Act.

6.3. Regarding whether the Complainant or any other person suffered improper prejudice as a result of the conduct of BARA and the SAPS in the circumstances.

6.3.1. The allegation that the Complainant, or any other person suffered prejudice as a result of the conduct of BARA, is substantiated. However, the allegation that the Complainant or any other person suffered prejudice as a result of the conduct of the SAPS, is not substantiated.

6.3.2. The Mortuary Supervisor (BARA): Ms Mohomane, Detective Group Commander: Diepkloof SAPS, Lt Swalivha and the internal investigation conducted by BARA, confirmed that there was maladministration by BARA in the handling of the death and removal of the corpse of Mr Sithebe.

6.3.3. Sister Maile's failure to adequately record the information of the Mr Sithebe on the death report book, the failure to inform the next of kin and / or the SAPS about the death of Mr Sithebe and to ensure that there was a proper hand over of the outstanding duties to report the death to the family or the SAPS when the there was a change of shifts with her colleagues in ward 20 amounted to negligence. As the corpse of Mr Sithebe is still missing, it is clear that the improper conduct of Sister Maile resulted into the Complainant

and her family suffering prejudice as they could not arrange a proper burial. Furthermore, such impropriety has not been remedied by BARA.

6.3.4. Furthermore, the BARA mortuary staff also failed to request SAPS to trace the next of kin of Mr Sithebe or for them to collect the corpse.

6.3.5. Moreover, the mortuary auxiliaries in the employ of BARA failed to ensure that the corpse of Mr Sithebe was properly documented, as there was a lack of documentary proof that the body was collected from the mortuary.

6.3.6. BARA hospital ought to have recorded Mr Sithebe's residential address and information regarding his next of kin in the patient file to enable them to trace his family. As a result, the failure by BARA to keep proper records resulted in the Complainant and her family being unable to bury the deceased.

7 REMEDIAL ACTION

The appropriate remedial action that the Public Protector is taking in pursuit of section 182(1)(c) of the Constitution is the following:

The Acting Head of Department of Health, Mr Malotana and the Chief Executive Officer (BARA), Dr Lesia must ensure that:

7.1 Within sixty (60) working days from the date of this report, ensure that a register system is put in place containing information which expressly indicates the full names and designations of officials at the wards and detailed information regarding who is responsible for patients from entry to the exit of the patients in the wards. The data register must clearly show a chain of events in the wards, the date, time, details of patient involved and all the staff involved in the handling of the patients at the ward.

7.2 Within a period of sixty (60) working days after the date of this report the staff must be trained on the data register, specifically compliance with the completion of the register. Furthermore, the monitoring and evaluation of the data register at all wards of the hospital.

7.3 Within sixty (60) working days from the date of this report, initiate a disciplinary process against Sister Maile who is responsible for the violation of section 195(1) of the Constitution, section 22 (1) of the Births and Death Registration Act, Paragraph 2, 3 and 7 of the BARA Nursing Service Guidelines, Clause 29 and 32 of the Regulations relating to the Management of Human Remains, Regulations on the rendering of Forensic Pathology Service. Furthermore, Sister Maile violated the Preamble and Purpose Statement of the Code of Ethics for Nursing Practitioners in SA, which all resulted in the failure to inform the Sithebe family of the death of their family member, loss of the deceased's corpse and improper prejudice to the Complainant.

7.4 Within thirty (30) working days after the release of this report, provide training to the nursing staff at BARA in terms of completion of patient`s information on the files on admission to the hospital and specifically the capturing of accurate information regarding the next of kin.

7.5 Within a period of thirty (30) working days after the release of this report, staff must be trained on the BARA Nursing Service Guidelines, specifically the completion of death notification reports, the process of reporting deaths to deceased families, as well as the process of reporting deaths of unknown or unidentified patients at the hospital to the SAPS.

7.6 Within a period of thirty (30) working days after the release of this report, issue a formal written apology to the Complainant regarding the hospital`s

failure to failure to inform her about the death of Mr Sithebe and the subsequent loss of his corpse.

7.7 Within a period of sixty (60) working days after the release of this report, submit a report on the measures that BARA will put in place to monitor the efficient and effective process of quality assuring and auditing the record keeping, especially in relation to the accurate completion of patients files on admission at the hospital, accurate completion of death reports and the adherence of the process by the hospital staff.

7.8 Within a period of sixty (60) working days after the release of this report, train mortuary auxiliary staff on record keeping of deceased patients by staff and record keeping of the movement of the deceased bodies in and out of the hospital mortuary.

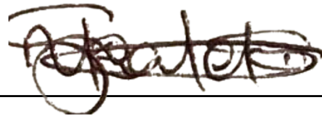
7.9 Within a period of sixty (60) working days after the release of this report, submit a report on the measures that BARA will put in place to monitor the efficient and effective process of quality assuring and auditing the record keeping of the movement of the deceased bodies in and out of the hospital mortuary and the adherence of the process by the mortuary auxiliary staff.

8. MONITORING

8.1 The Acting HOD and The CEO of BARA must submit an Implementation Plan to the Public Protector within thirty (30) working days from the date of this report indicating how the remedial action referred to in paragraph 7 above will be implemented.

8.2 The Public Protector wishes to bring to your attention that in line with the Constitutional Court Judgement in the matter of ***Economic Freedom Fighters v Speaker of the national Assembly and other; Democratic***

***Alliance v Speaker of the national Assembly and others* [2016] ZACC 11**, and in order to ensure the effectiveness of the Office of the Public Protector, the remedial actions prescribed in this Report are legally binding unless you obtain an *Interim Interdict* or *Court Order* directing otherwise.



ADV. KHOLEKA CGALEKA
ACTING PUBLIC PROTECTOR OF THE
REPUBLIC OF SOUTH AFRICA
DATE: 30 March 2021

Assisted by:
Ms Winnie Manyathela and Ms Mantu Ramakgwakgwa
Gauteng Provincial Office