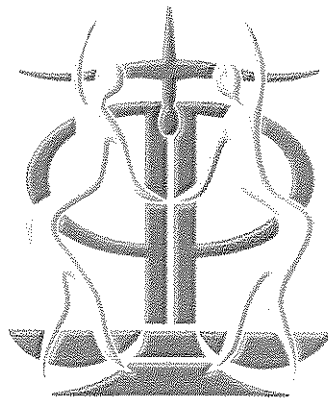


**REPORT OF THE PUBLIC PROTECTOR IN TERMS OF SECTION
182(1)(b) OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH
AFRICA, 1996 AND SECTION 8(1) OF THE PUBLIC PROTECTOR
ACT, 1994**



**PUBLIC PROTECTOR
SOUTH AFRICA**

REPORT NO. 9 OF 2010/2011

**REPORT ON AN INVESTIGATION INTO ALLEGATIONS OF FAILURE
AND/OR REFUSAL TO DISCLOSE THE CAUSE OF DEATH OF A PATIENT
BY THE CHRIS HANI-BARAGWANATH HOSPITAL**

INDEX

Executive Summary	3
1. INTRODUCTION	5
2. THE COMPLAINT	5
3. JURISDICTION OF THE PUBLIC PROTECTOR	7
4. THE INVESTIGATION	8
5. KEY SOURCES OF INFORMATION	8
6. LEGAL AND REGULATORY FRAMEWORK	11
7. OBSERVATIONS	16
8. FINDINGS	17
9. REMEDIAL ACTION	17
10. MONITORING	18

Executive Summary

- (i) The Public Protector conducted an own initiative investigation into allegations of failure and/or refusal to disclose the cause of death of a patient, Mr Patrick Ndlovu by the Chris Hani Baragwanath Hospital.
- (ii) It was alleged that Patrick Nkosi, age 61, of White City, Jabavu was admitted to the hospital on 8 February 2008 for a minor operation. The operation was carried out on 9 February 2008 and the next day the patient passed away.
- (iii) The nursing staff contacted the family and informed the deceased's son of the death but did not explain what actually happened to the patient during the operation and what the cause of death was.
- (iv) The deceased's son went to the hospital and when he inspected the body at the hospital mortuary, he discovered that the deceased's left leg was amputated at the hip and there was a gaping hole in his stomach.
- (v) The family was not warned by the nursing staff beforehand of the seriousness of the operation that was performed on the deceased, nor were they informed of the condition of the corpse. They were shocked and traumatised by the gruesome discovery, as the deceased was only admitted for a minor operation.
- (vi) The following findings were made:
 - (a) The hospital failed to inform the family about the cause of death or offered any form of counseling. As a result, the family was exposed to a traumatic experience of seeing the deceased's body in the condition it was;

- (b) The hospital failed to offer an explanation or apologise to the family until they were approached by the media. It was only then that they undertook to investigate the incident, and
 - (c) The hospital had an obligation to communicate with the family soon after the death and to provide them with a full explanation as to the cause of death.
- (vii) The remedial action to be taken is that the hospital must implement its own undertaking to ensure that:
- (a) Sufficient and relevant information is provided to patients and/or family members on issues such as the nature of their condition, the complexity of treatment, the risk associated with the treatment or procedure and the patient's own wishes, as well as the health care practitioner's rights and obligations to take informed decisions on behalf of the patient in terms of the Health Professions Act, 1976; and
 - (b) The disclosure of information after a patient's death to interested parties in compliance with -
 - (aa) the Health Professions Act, 1976;
 - (bb) the National Health Act, 2003;
 - (cc) the Ethical Rules of the Health Professions Council of South Africa;
 - (dd) the National Patient Rights Charter; and
 - (ee) the Professional Association's Code of Conduct.

REPORT ON AN INVESTIGATION INTO ALLEGATIONS OF FAILURE AND/OR REFUSAL TO DISCLOSE THE CAUSE OF DEATH OF A PATIENT BY THE CHRIS HANI-BARAGWANATH HOSPITAL

1. INTRODUCTION

- 1.1 This report is submitted to the Member of the Executive Council (MEC) responsible for Health in the Gauteng Provincial Government, the Head of the Department (HOD) of the Department of Health and the Chief Executive Officer (CEO) of Chris Hani Baragwanath Hospital in terms of section 182(1)(b) of the Constitution of the Republic of South Africa, 1996 (the Constitution) and section 8(1) of the Public protector Act, 1994 (the Public Protector Act).
- 1.2 It relates to the failure and/or refusal by the Chris Hani Baragwanath Hospital to properly inform a family of the outcome of an operation that was carried out as well the cause of death of a patient that was admitted at the hospital.

2. THE COMPLAINT

- 2.1 This is an own initiative investigation which emanated from an article that was published in the "Sowetan" newspaper of 25 February 2008.
- 2.2 The said article stated that *"a Soweto family is seeking answers from the Chris Hani-Baragwanath Hospital about a relative who ended up dead with a leg missing"*.
- 2.3 Patrick Nkosi (the deceased), age 61, of White City, Jabavu, was admitted to the hospital on 8 February 2008 to remove an abscess that had developed in his buttocks.

- 2.4 The following day, on 9 February 2008, the family received a telephone call from the hospital to come and sign a consent form for an operation. The deceased's sister went and signed a consent form as requested by the hospital.
- 2.5 Later that same evening at about 19h00, the family of the deceased, received a call from the hospital, informing them that Mr Nkosi had passed away. Mr Linda Nkosi, the deceased's son, went to the hospital on 10 February 2008 but he was told by the nursing staff to return the next Tuesday with an undertaker. When he asked what happened to his father, the nurses informed him that the doctor was not there and no information was offered to him. He was not allowed to see the corpse.
- 2.6 On Thursday 14 February 2008, the deceased's son and his uncle accompanied the undertaker to the hospital to fetch the corpse. When they inspected the body, they were met with a gruesome sight of a mutilated body without one leg and a gaping wound on the stomach. The family was so shocked and traumatised that they bolted out of the mortuary.
- 2.7 The deceased's son attempted to obtain an explanation from the hospital but the nurses referred him to Orlando police station for any further information he may require.
- 2.8 According to the deceased's son, the hospital only offered an explanation and an apology after the story was published in the newspaper. He was invited to attend a meeting at the hospital which was attended by the Baragwanath Hospital Communication Officer, the management and the Hospital's legal representatives.

2.9 The Communication Officer apologised on behalf of the hospital and acknowledged their mistake. She also informed him that that the clinical director was asked to launch an investigation into the matter. According to the Complainant the outcome of this investigation was never communicated to him.

3. JURISDICTION OF THE PUBLIC PROTECTOR

3.1 The institution of the Public Protector was established in terms of Chapter 9 of the Constitution as one of the bodies that supports constitutional democracy. The functions of the Public Protector are encapsulated in section 182(1) of the Constitution, which provides as follows:

“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 result in any impropriety or prejudice;*
- (b) to report on that conduct; and*
- (c) to take appropriate remedial action.”*

3.2 In terms of section 6(4) of the Public Protector Act, the Public Protector shall be competent to investigate, on his/her own initiative or on receipt of a complaint any alleged act or omission by a person in the employ of government at any level, or a person performing a public function, which results in unlawful or improper prejudice to any other person.

3.3 The complaint against the Chris Hani- Baragwanath Hospital falls within the jurisdiction of the Public Protector.

3.4 The Public Protector was concerned about the gravity of the allegations that were levelled against the hospital and also how the family of the deceased were allegedly treated by the hospital staff during a very difficult time in their lives. This investigation seeks to verify the allegations and if found to be true, to establish the cause and to ensure that the hospital addresses the issue in order to prevent future occurrences of this nature.

4. THE INVESTIGATION

4.1 The investigation was conducted in terms of sections 6 and 7 of the Public Protector Act and comprised:

4.1.1 Assessment of the complaint;

4.1.2 Consultations with the Sowetan journalist, the Department of Health and the deceased's son; and

4.1.3 Consideration of the relevant legislation, the National Health Act, 2003, and the response from the Department of Health, Gauteng Provincial Government.

5. KEY SOURCES OF INFORMATION

5.1 Inquiries with the Sowetan

5.1.1 A telephone inquiry was made to the Sowetan journalist, Sibongile Mashaba to get more clarity on the matter and also the contact details of the deceased's family.

5.1.2 She informed the Public Protector that the family of the deceased contacted her about the unexplained cause of death of their father.

5.1.3 According to her, they were shocked when they arrived at the government mortuary to find him without a leg and with a gaping hole in his stomach.

5.1.4 Upon enquiring as to what had happened to him, they were told to contact the Diepkloof Police Station.

5.2. Correspondence with the Deceased's Son

5.2.1 A telephone call was made to the deceased's son Linda Nkosi with whom the contents of the article was discussed. He confirmed the facts as it appeared in the story.

5.2.2 He advised the Public Protector that they were not informed of what happened to their father.

5.2.3 Apparently, they were shocked when they arrived at the government mortuary to find him without a leg and with a gaping hole in his stomach.

5.2.4 Upon enquiring as to what had happened to him, they were told to contact the Diepkloof Police Station.

5.3 Correspondence with the Department of Health

5.3.1 A letter of enquiry was sent to the Department of Health soliciting response to the allegations and they advised as follows:

5.3.2 Mr Nkosi was admitted on 8 February 2008 at Chris Hani-Baragwanath Hospital and died the next day at 03h00.

- 5.3.3 The deceased had a renal failure and had difficulty in breathing.
- 5.3.4 Consent for the operation was obtained from his daughter after an explanation was provided to her as to the purpose thereof.
- 5.3.5 After doing the first incision, the surgeons however found that he had developed further complications.
- 5.3.6 The Senior Consultant Surgeon was contacted in theatre and he gave permission for the amputation of the patient's leg.
- 5.3.7 He then passed away four hours after the operation at 03h00.
- 5.3.8 The family was contacted at 03h00 by telephone and informed of the death.
- 5.3.9 The surgical unit held a meeting to discuss the matter and the following decisions were taken:
- 5.3.9.1 there is a need to explain to patients/family members during the obtaining of any consent for an operation, that the surgeons may proceed with further or alternative operative measures as may be found necessary during the course of the operation, and
- 5.3.9.2 there is a need to communicate with the family of a patient regardless of the time of the day.
- 5.3.10 The Public Protector sent a follow up enquiry as to whether the decision by the surgical unit can bind the hospital or not and they responded that the surgical unit was not aware of the provisions of section 7(1)(e), of the National Health Act, 2003, which allows the provision of health service to

the user without consent if any delay may result in his or her death or irreversible damage to his or her health.

6. LEGAL AND REGULATORY FRAMEWORK

6.1 National Health Act, 2003

6.1.1 Section 6(1) states that:

“Every health care provider must inform a user of-

- (a) the user’s health status except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interest of the user;*
- (b) the range of diagnostic procedures and treatment options generally available to the user;*
- (c) the benefits, risks, costs and consequences generally associated with each option; and*
- (d) the user’s right to refuse health services and explain the implications, risks, obligations of such refusal.”*

6.1.2 Section 6(2) states that *“the health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user’s level of literacy.”*

6.1.3 Section 7 (1) provides as follows: “7(1) Subject to subsection 8, a health service may not be provided to a user without the user’s informed consent, unless-

(a) the user is unable to give informed consent and such consent is given by a person-

(i) mandated by the user in writing to grant consent on his or her behalf; or

(ii) authorised to give such consent in terms of any law or court order;

(b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;

(c) the provision of a health service without informed consent is authorised in terms of any law or a court order;

(d) failure to treat the user, or a group of people which includes the user, will result in a serious risk to public health; or

(e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.”

6.1.4 Subsection (2) states that a health care provider must take all reasonable steps to obtain the user's informed consent.

6.1.5 Subsection (3) states that *"for the purposes of this section" "informed consent" means consent for the provision of a specific health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6."*

6.2 Batho Pele Principles

6.2.1 Background

The Batho Pele Principles were developed to serve as acceptable policy and legislative framework regarding service delivery in the public service. These principles are aligned with the Constitutional ideals of:

- (a) promoting and maintaining high standards of professional ethics;
- (b) providing service impartially, fairly, equitably and without bias;
- (c) utilising resources efficiently and effectively;
- (d) responding to people's needs, the citizens are encouraged to participate in policy-making; and
- (e) rendering an accountable, transparent, and development-oriented public administration.

6.2.2 The Batho Pele principles applicable to this matter are as follows:

6.2.2.1 Consultation

There are many ways to consult users of services including conducting customer surveys, interviews with individual users, consultation with groups, and meetings with consumer representative bodies, NGOs and CBOs. Often, more than one

method of consultation will be necessary to ensure comprehensiveness and representativeness. Consultation is a powerful tool that enriches and shapes government policies such as the Integrated Development Plans (IDPs) and its implementation in Local Government sphere.

6.2.2.2 Setting Service Standards

This principle reinforces the need for benchmarks to constantly measure the extent to which citizens are satisfied with the service or products they receive from departments. It also plays a critical role in the development of service delivery improvement plans to ensure a better life for all South Africans. Citizens should be involved in the development of service standards.

Required are standards that are precise and measurable so that users can judge for themselves whether or not they are receiving what was promised. Some standards will cover processes, such as the length of time taken to authorise a housing claim, to issue a passport or identity document, or even to respond to letters.

To achieve the goal of making South Africa globally competitive, standards should be benchmarked (where applicable) against those used internationally, taking into account South Africa's current level of development.

6.2.2.3 Ensuring Courtesy

This goes beyond a polite smile, "please" and "thank you". It requires service providers to empathise with the citizens and treat them with as much consideration and respect, as they would like for themselves.

The public service is committed to continuous, honest and transparent communication with the citizens. This involves communication of services, products, information and problems, which may hamper or delay the efficient delivery of services to promised standards. If applied properly, the principle will help demystify the negative perceptions that the citizens in general have about the attitude of the public servants.

6.2.2.4 Providing Information

As a requirement, available information about services should be at the point of delivery, but for users who are far from the point of delivery, other arrangements will be needed. In line with the definition of "customer" in this document, managers and employees should regularly seek to make information about the organisation, and all other service delivery related matters available to fellow staff members.

6.2.2.5 Openness and Transparency

A key aspect of openness and transparency is that the public should know more about the way national, provincial and local government institutions operate, how well they utilise the resources they consume, and who is in charge. It is anticipated that the public will take advantage of this principle and make suggestions for improvement of service delivery mechanisms, and to even make government employees accountable and responsible by raising queries with them.

6.2.2.6 Redress

This principle emphasises a need to identify quickly and accurately when services are falling below the promised standard and to have

procedures in place to remedy the situation. This should be done at the individual transactional level with the public, as well as at the organisational level, in relation to the entire service delivery programme.

Public servants are encouraged to welcome complaints as an opportunity to improve service, and to deal with complaints so that weaknesses can be remedied quickly for the good of the citizen.

7. OBSERVATIONS

- 7.1 The deceased was admitted to hospital for a minor operation, however, he developed complications that required further surgical interventions and in spite of attempts by the surgeons to save his life, he died soon after the operation.
- 7.2 Even though the deceased was admitted for what was supposed to be a minor operation, it appeared that he developed complications that justified further surgical interventions.
- 7.3 The hospital conducted an internal investigation and undertook to correct the situation and prevent future occurrences of similar incidents by implementing the following measures:
 - 7.3.1 the hospital staff will improve communication with family members regarding the cause of death by utilising counseling rooms that are available in the wards, and
 - 7.3.2 it will be explained to patients that doctors will perform any other surgery necessary during the course of the operation.

8. FINDINGS

- 8.1 The hospital failed to inform the family about the cause of death or offered any form of counseling. As a result, the family was exposed to a traumatic experience of seeing the deceased's body in the condition it was.
- 8.2 The hospital failed to offer an explanation or apologise to the family until they were approached by the media. It was only then that they undertook to investigate the incident.
- 8.3 The hospital, had an obligation to communicate with the family soon after the death and to provide them with a full explanation as to the cause of death.

9. REMEDIAL ACTION

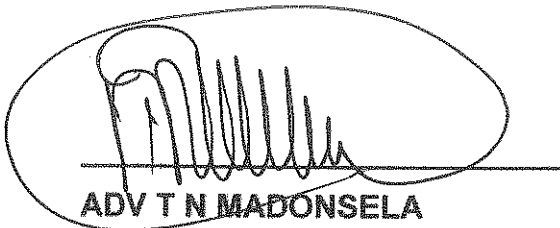
In terms of section 182(1)(c) of the Constitution, the remedial action to be taken is that the hospital must implement its own undertaking to ensure that:

- 9.1 Sufficient and relevant information is provided to patients and/or family members on issues such as the nature of their condition, the complexity of treatment, the risks associated with the treatment or procedure and the patient's own wishes, as well as the health care practitioner's rights and obligations to take informed decisions on behalf of the patient in terms of the Health Professions Act, 1976; and
- 9.2 The disclosure of information after a patient's death to interested parties in compliance with -
- 9.2.1 the Health professions Act, 1976;

- 9.2.2 the National Health Act, 2003;
- 9.2.3 the Ethical Rules of the Health Professions Council of South Africa;
- 9.2.4 the National Patient Rights Charter; and
- 9.2.5 the Professional Association's Code of Conduct.

10. MONITORING

- 10.1 The Head of Department should submit a report regarding action to be taken in response to this report by 31 October 2010;
- 10.2 The Head of Department should submit a report indicating action taken with regard to the implementation of this report by 30 November 2010.
- 10.3 The Public Protector will monitor the implementation process on an ongoing basis.



ADV T N MADONSELA
PUBLIC PROTECTOR OF THE
REPUBLIC OF SOUTH AFRICA

Date: 2010-09-21

Assisted by: Lebea CP
Senior Investigator
Gauteng Provincial Office

ISBN 978-1-920456-08-5