

INVESTIGATION REPORT INTO ALLEGATIONS OF DENIED PROVISION OF CARE RESULTING IN THE DEMISE OF A PATIENT



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Office of the Health Ombud
Kantoro ya Mosekaseki wa Maphelo



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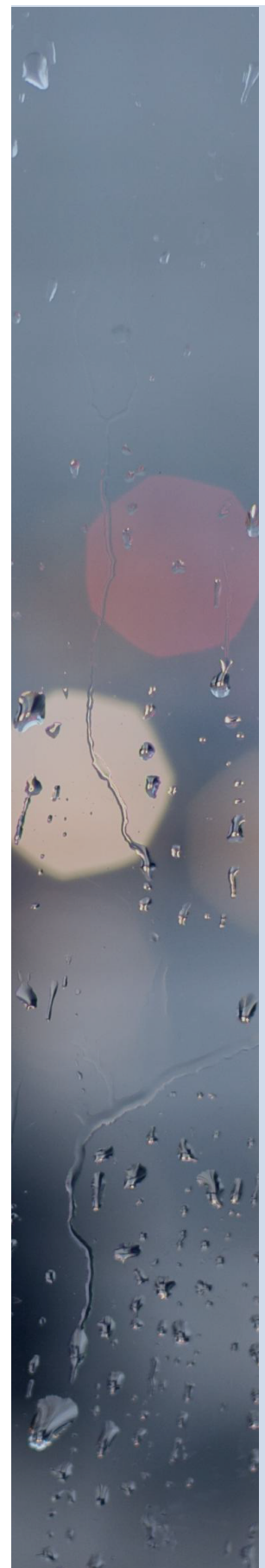


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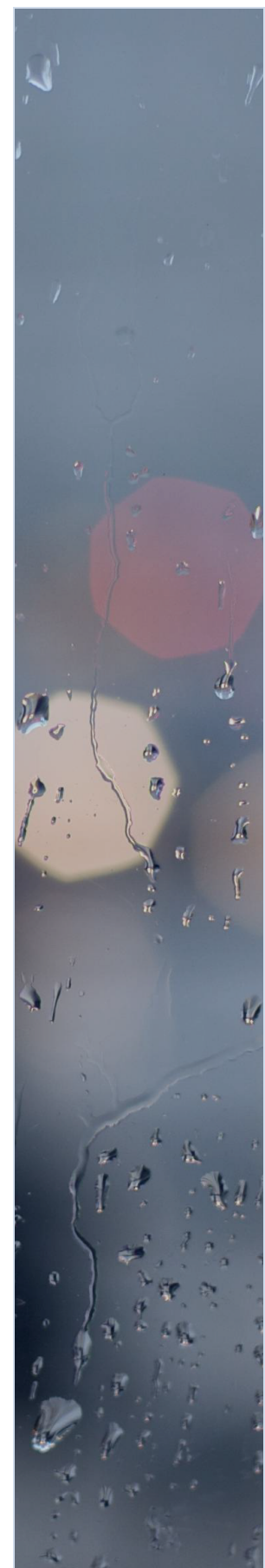
The Health Ombud gratefully acknowledges the contributions made by all individuals during the course of this Investigation and all who contributed to the finalisation of the Investigation report through provision of comments, clarification or confirmation of the facts.

LIST OF ABBREVIATIONS / ACRONYMS

AEA	Ambulance Emergency Assistant
APC	Adult Primary Care
APRF	Ambulance Patient Report Form
BAA	Basic Ambulance Assistant
BP	Blood Pressure
CCW	Community Care Workers
CIU	Complaints Investigation Unit
CSC	Community Service Centre
DA	Democratic Alliance
DENOSA	Democratic Nursing Organisation of South Africa
DNH	Dora Nginza Hospital
DNTC	Dora Nginza Thutuzela Centre
EC	Eastern Cape Province
ECDoH	Eastern Cape Department of Health
EMS	Emergency Medical Services
ENA	Enrolled Nursing Assistant
EN	Enrolled Nurse
ECPG	Eastern Cape Provincial Government
FA	First Aid
FCS	Family Violence, Child Protection, and Sexual Offences Unit
FN	Forensic Nursing
GN	General Nursing
GPS	Global Positioning System



HE	Health Establishment
HIV	Human Immunodeficiency Virus
HoD	Head of Department
HTC	HIV Testing and Counselling
ILS	Immediate Life Support
LRA	Labour Relations Act
MCHC	Motherwell Community Health Centre
NBM	New Brighton Mortuary
NEHAWU	National Education Health and Allied Workers Union
NHAA	National Health Amendment Act
NMBD	Nelson Mandela Bay District
NMBDH	Nelson Mandela Bay District Health
NMM	Nelson Mandela Metro
PAR	Patient Administration Record
PBPA	Post Basic Pharmacy Assistant
PEP	Post Exposure Prophylaxis
PFMA	Public Finance Management Act
PN	Professional Nurse
PRC	Patients Rights Charter
RCC	Rape Crisis Centre
SGH	Security Guard House
SGT	Sergeant
STI	Sexually Transmitted Infections
SMH	Shadow Minister of Health
SMS	Senior Management Services
SOP	Standard Operating Procedure
VSC	Victim Support Centre
WHO	World Health Organisation
WSSS	Woolhope Senior Secondary School



EXECUTIVE SUMMARY

The Final Investigation Report of the Office of the Health Ombud (the Ombud) issued in terms of Section 81A (11) of the National Health Amendment Act (NHAA), 12 of 2013, read with Regulation 48(a) of the Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance (OHSC) and Handling of Complaints by the Ombud, 02 November 2016, to inform the complainant and the health establishment of his findings and recommendations.

The investigation into this case was conducted following an investigation into the matter by the Eastern Cape Provincial Department of Health (ECPDoH), and in parallel with the criminal case conducted by Motherwell Police Station Community Service Centre (MPS CSC) under Motherwell CAS 151/09/2022. The MPS CSC is still waiting for a decision by the Deputy Director of Public Prosecution regarding whether or not any of the suspects will be charged. However, the Deputy Director of Public Prosecutions in Gqeberha, Adv. I Goberdan, gave the Ombud permission to release the Report “as the release of the report will not compromise the criminal investigation.”

The Report communicates the findings and recommendations of the Ombud following a complaint into allegations of denied provision of care resulting in the demise of a patient.

The complaint was lodged by the Democratic Alliance’s (DA) Shadow Minister of Health (SMH), Honourable Michéle Clarke, MP (Hon. M Clarke) against Motherwell NU 11 Clinic, in the Eastern Cape (EC) Province on 30 September 2022. The complaint was risk-rated extreme and allocated Reference No: 36048.

The complaint was also prompted by a referral from the Minister of Health, Dr. MJ Phaahla, MP (the Minister) on 04 October 2022. In the referral, the Minister requested the Ombud to investigate potential negligence and suboptimal care at Motherwell NU 11 Clinic.

In the main, Hon. M Clarke alleged that:

- a. Motherwell NU 11 Clinic failed to assist a 15-year-old sexual assault victim, Ms. Zenizole Vena (Ms. Z
- b. Ms. Z Vena was turned away by Motherwell NU 11 Clinic and died a short while later at MPS CSC while trying to report the sexual assault.

The Ombud deployed a team of two Investigators, i.e., Mr. Douglas Mapheto and Ms. Madithapo Masemola, accompanied by a Legal Intern, Mr. Ngcebo Gumede in terms of Section 81(3)(c), of the NHAA to investigate the complaint.

On analysis of the complaint and the allegations, the following issues were identified and investigated:

- a. Whether Ms. Z Vena was denied provision of care at Motherwell NU 11 Clinic;
- b. Whether Motherwell NU 11 Clinic failed to refer Ms. Z Vena to the next level of care; and
- c. Whether the death of Ms. Z Vena was due to negligence of the healthcare workers at Motherwell NU 11 Clinic.

The investigation was conducted in terms of Section 81A (1) of the National Health Amendment Act (NHAA), 12 of 2013, which gives the Ombud the powers to consider, investigate and dispose of the complaint relating to breaches of the norms and standards in a fair, economical and expeditious manner; and in terms of Regulation 42 of the Procedural Regulations, which regulates the powers conferred upon the Ombud by Section 81A(1) of the NHAA must be exercised.

The investigation was conducted through analysis and triangulation of information and documentary evidence received from Motherwell NU 11 Clinic, Eastern Cape Provincial Department of Health (ECPDoH), Nelson Mandela Bay District Health (NMBDH), onsite visits, and interviews with relevant personnel, and application of the relevant legislation to enable the Ombud to make a decision regarding a resolution of the complaint.

Interviews were conducted with 13 witnesses between 28 February 2023 to 27 March 2023. The other 10 interviews were conducted by the Ombud and the investigation team from 15 to 19 May 2023. Eight witnesses were re-interviewed from 15 to 19 May 2023 and did not contradict themselves. Statements from three witnesses were also received from the MPS CSC and analysed.

The Ombud's investigations established the following

Whether Ms. Z Vena was denied provision of care at Motherwell NU 11 Clinic

The allegation that Ms. Z Vena was denied the provision of care at Motherwell NU 11 Clinic is substantiated and confirmed.

It is common cause that Ms. Z Vena was sexually assaulted and she confided in her friends, Ms. Sinalo Makinana (Ms. S Makinana) and Ms. Sandiswa Ntantiso (Ms. S Ntantiso). She was escorted to Motherwell NU 11 Clinic by Ms. S Ntantiso. According to Ms. S Ntantiso, she and Ms. Z Vena arrived at Motherwell NU 11 Clinic on Wednesday, 21 September 2022 at 7:00. The sexual assault allegations were supported by Ms. Z Vena's friend Ms. Sinalo Makinana (Ms. S Makinana). In her testimony, Ms. S Makinana stated that Ms. Z Vena, her boyfriend Mr. Liyabona Rooi (Mr. L Rooi) and Mr. Luxolo Tatase (Mr. L Tatase) (also known as Deep) went to Mr. L Tatase's place where she was raped. Mr. L Tatase forced Ms. Z Vena to sleep with him and beat her up. Ms. Z Vena consented to sexual intercourse with Mr. L Rooi but did not consent to sexual intercourse with Mr. L Tatase. Ms. S Makinana said Mr. L Tatase wrote her a text message on Facebook saying "he actually wanted to sleep with me (Ms. S Makinana) and not Zeni (Ms. Z Vena)."

The fact that Ms. Z Vena had sexual intercourse with Mr. L Rooi was also confirmed by the witness statements provided by Mr. L Tatase and Mr. S Magalela in their sworn statements provided to the SAPS on 22 September 2022.

All these statements confirmed that Ms. Z Vena was sexually assaulted. The nurses should have prioritised and managed her in accordance with the Adult Primary Care Manual / Booklet 2019/2020, which requires that patients presenting with recent rape or sexual assault must be given urgent attention.

Ms. S Ntantiso indicated that on arrival at Motherwell NU 11 Clinic, Ms. Z Vena was attended to by two nurses, Sister NJ Ntlanjeni (Sr. NJ Ntlanjeni) and Sister Zoleka Ndongeni (Sr. Z Ndongeni). Ms. S Ntantiso indicated that she and Ms. Z Vena stood outside the consultation room with Sr. NJ Ntlanjeni, while Ms. Z Vena was explaining what had happened. Ms. Z Vena narrated her story by saying that "she was called by a friend who told her that she lost her mother. She then decided to visit her to comfort her. On arrival there was no one but her friend. When she wanted to leave later, her friend asked her not to as she was afraid to be left alone. Later, her friends boyfriend came in and a quarrel erupted between them, when she wanted to intervene but the boyfriend told her not to. Afterwards two guys came in and were introduced to her by her friend. On the morning on 21 September 2022, she was then raped by the two guys and then left after. She then noticed that it was only herself and the two guys in the house."

Sr. NJ Ntlanjeni and Sr. Z Ndongeni did not touch nor examine Ms. Z Vena but instead, they asked her whether she had washed/showered following the sexual assault, to which Ms. Z Vena answered "NO". Sr. NJ Ntlanjeni instructed Ms. S Ntantiso and Ms. Z Vena to go to MPS CSC because "the nurses do not touch the rape victims to avoid tampering with evidence."

Sr. NJ Ntlanjeni indicated that she took the vital data on Ms. Z Vena which she recorded as follows: B/P 110/80, Pulse 70, and Temperature 36.5. However, no file was opened by Sr. NJ Ntlanjeni, and the vital data observations taken by Sr. NJ Ntlanjeni were written in a personal diary and not in the approved Patient Administration Record (PAR). This finding was corroborated by the investigation report of the Head of Department (HoD), Dr. Rolene Wagner (Dr. R Wagner) dated 14 November 2022. In the report, it was stated that: "According to Ms. Ntantiso, the escort, neither vital signs nor clinical assessment was performed. This narration by Ms. Ntantiso was upheld due to the non-availability of clinic records to give an account of what was done for the victim at the clinic. Although Professional Nurse Ntlanjeni claimed to have done the patient's vitals, this information is written in her diary. The Facility Register is also devoid of such information. The investigation team did not accept the account given by Professional Nurse Ntlanjeni in her statement."

Both Sr. NJ Ntlanjeni and Sr. Z Ndongeni believed that every sexual assault case was a police case that should have been referred to the police. This was also confirmed by the Acting Operational Manager at Motherwell NU 11 Clinic, Mr. Zakhiwo Velebayi (Mr. Z Velebayi) said: "My understanding of the protocol on rape is that if a person is raped, I will tell her this is a police matter. In my understanding, we must call the police and keep the patient in a safe room. The police must come and fetch the patient to be examined by the police doctor. The biggest challenge is that the nurses do not know what to do."

Despite their belief, the two nurses did not arrange transport to take Ms. S Ntantiso and Ms. Z Vena to MPS CSC nor call the police to come to Motherwell NU11 Clinic to take over Ms. Z Vena's case. Ms. S Ntantiso and Ms. Z Vena were referred to MPS CSC without a referral letter. A similar finding was also made by Dr. R Wagner in her investigation report whereby she stated that: "According to information gathered during the investigation, the two professional nurses believed that the patient had to go to Thutuzela Centre in Dora Nginza Hospital via the Police Station; thus, the patient was directed as such. The patient's social, psychological, and physical state were not considered. The escort and rape victim did not have money for the taxi fare. The only option they had was to walk to the police station, which was approximately two kilometers from the clinic."

According to the Nelson Mandela Bay Department of Health (NMBDH) Sub-District Coordinator, Ms. Nomathemba Patricia Qabaka (Ms. NP Qabaka), when a sexual assault patient presents to the clinic, the healthcare workers must assess the status of the patient. A full history and physical examination must be conducted to check if there are bruises or scars and take the patient's history. The healthcare workers must also assess whether the patient is emotionally disturbed. If the patient needs an emergency referral to a doctor, they must provide HIV Testing and Counselling (HTC) to the patient and also pre-exposure prophylaxis. They should give emergency (morning after pill) and explain the procedure to the patient, to enable the patient to open a case. The police will take the patient to Thutuzela Centre and the health care worker will report a case to the Sub-District.

Ms. S Ntantiso and Ms. Z Vena left the clinic on foot at 07:25 to go to MPS CSC after being instructed by Sr. NJ Ntlanjeni. Ms. S Ntantiso and Ms. Z Vena did not have money for transport. They walked a distance of 2.3 kilometers from Motherwell NU11 Clinic to Motherwell Police Station. Along the way to MPS CSC, Ms. Z Vena collapsed, wet her pants, and started having seizures. The driver of a local taxi (also known as 'jikeleza') gave them a lift to the Police Station as Ms. Z Vena could no longer walk or talk.

In terms of Section 27(1) of the Constitution of the Republic of South Africa, 1996, everyone has the right to access health care services, including reproductive health care; no one may be refused emergency medical treatment.

Access to health care services means the ability to obtain health care services such as prevention, diagnosis, treatment, and management of diseases, illnesses, disorder, and other health conditions. According to the District Manager of Nelson Mandela Bay District (NMBDH), Ms. Sonia Lupondwana (Ms. S Lupondwana), there was no doctor at Motherwell NU 11 Clinic on the day Ms. Z Vena came.

This explanation is not accepted because the absence of doctors does not absolve the nurses from providing the necessary care to the patients.

Ms. S Ntantiso and Ms. Z Vena arrived at the MPS CSC charge office at 08:00 in the morning still alive. Ms. S Ntantiso indicated that: "When I arrived at the charge office I explained to someone at the window counter about the condition of Ms. Z Vena but she never paid attention, she told me to go and sit down." This submission was disputed by Sgt. V Mbongo who said Ms. S Ntantiso did not explain what was happening to Ms. Z Vena.

Sgt. V Mbongo said she went to check on Ms. Z Vena laying on the floor in the charge office at 09:30, and noticed that she was no longer crying. That is when she realised that Ms. Z Vena had passed on. This means Ms. Z Vena waited 1h30 minutes to get assistance at the charge office. No first aid assistance was offered to Ms. Z Vena despite the fact that she arrived at the charge office being carried by two females because she was unable to walk, and she was crying and fitting. Sgt. V Mbongo opened the inquest docket only after Ms. Z Vena had demised.

Sgt. V Mbongo said that she was not trained to use the First Aid Kit (FAK) nor offered first aid assistance to Ms. Z Vena when she was laying down and fitting. However, she confirmed that the police station has the FAK. She also indicated that she does not remember being orientated on how to use the FAK, nor does she know whether there is a Health and Safety Representative at the police station.

From the first-hand accounts of Sgt. V Mbongo and Ms. S Ntantiso, it is evident that despite the fact that Ms. Z Vena was distressed and in a poor clinical state, there was no attempt at securing her airway or cardio-pulmonary resuscitation at any time. It is quite disturbing and mind-boggling that a basic human instinct to assist a person in distress, particularly a child, does not seem to exist within the South African Police Service in Nelson Mandela Bay District.

According to the Emergency Medical Services (EMS) Patient Report Form, the emergency call received was at 9:11, and they arrived at the scene at 9:38. Ms. Z Vena was declared dead at 9:45. However, the date of the incident was recorded as 22 September 2022, whereas the incident occurred on 21 September 2022. The date of 22 September 2022 was confirmed by the Operational Manager: EMS, Mr. Ashwell Botha as a typing error, and the correct date of the incident was 21 September 2022.

Based on the information gathered, it was confirmed that Ms. Z Vena was denied the provision of care at Motherwell NU 11 Clinic. Dr. R Wagner also indicated that the Clinical Manager, Dr. Machi had an apology letter but the apology letter was never given to the family of Ms. Z Vena.

Whether Motherwell NU 11 Clinic failed to refer Ms. Zenizole Vena to the next level of care

The allegation that Motherwell NU 11 Clinic failed to refer Ms. Z Vena to the next level of care was substantiated and confirmed.

Ms. S Ntantiso and Ms. Z Vena were instructed by Sr. NJ Ntlanjeni to go to MPS CSC without being accompanied by a health professional, referral letter, or reasons for referral.

The ECDoH Referral SOP (May 2020) (the Referral SOP) describes a referral as a process in which the treating physician or registered nurse at a lower level of the health service, has inadequate skills by virtue of his or her qualification or fewer facilities to manage a clinical condition, seeks the assistance of a better equipped or specially trained person with better resources at a higher level to guide him or her in managing or taking over the management of a particular episode of a clinical condition.

The Referral Standard Operating Procedure (SOP) requires patients to be referred from a clinic with a referral letter and clear report on reasons for referral, namely full patient details, address, diagnosis, condition, reasons for referral, investigations, and indicate the referring and the receiving doctors. Referral should be done after confirmation of bed availability.

Ms. Z Vena was instructed to go to MPS CSC to report the rape, without a referral letter and a report detailing reasons for referral. This was confirmed in the investigation report of the HoD, Dr. R Wagner, in paragraph 6.1.4 below.

This finding was corroborated by Dr. R Wagner's investigation report of 14 November 2022, in which it was found that: "the two professional nurses believed that the patient had to go to Thutuzela Centre in Dora Nginza Hospital via the Police Station; thus, the patient was directed as such. The patient's social, psychological, and physical state were not considered. The escort and rape victim did not have money for the taxi fare. The only option they had was to walk to the police station, which was approximately two kilometers from the clinic".

Both Sr. Z Ndongeni and Sr. NJ Ntlanjeni failed to follow the proper referral procedure, instead, Ms. S Ntantiso and Ms. Z Vena were instructed to go to the nearest SAPS station to report the rape. Transport arrangements for continuity of care were not made for Ms. S Ntantiso and Ms. Z Vena. Ms. Z Vena was referred to MPS CSC without a referral letter.

The psychological and emotional needs aspects of Ms. Z Vena were not established by Sr. Z Ndongeni and Sr. NJ Ntlanjeni, and neither was emotional support provided to Ms. Z Vena.

According to the Global Positioning System (GPS) navigation maps, the distance walked by Ms. S Ntantiso and Ms. Z Vena between Motherwell NU11 Clinic and MPS CSC was 2.3 kilometers and five minutes drive by car.

Regulation 5(1) of the Norms and Standards Regulations provides that: "the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition. Sub-regulation (2) provides that: "for sub-regulation (1), a health establishment must (a) implement a system of triage; (b) ensure access to emergency medical transport for users requiring urgent transfer to another health establishment, and that they are accompanied by a health care provider; and (c) adhere to clinical guidelines on stabilising users presenting in an emergency before referring them to another health establishment."

According to Sr. NJ Ntlanjeni, her assessment of Ms. Z Vena was based on the fact that she was able to walk and talk, and she felt that there was no need to arrange transport for Ms. Z Vena and Ms. S Ntantiso to the next level of care.

Based on the oral and documentary evidence gathered and considered, it can be concluded that both Sr. Z Ndongeni and Sr. NJ Ntlanjeni failed to refer Ms. Z Vena to the next level of care when in need.

Failure by Motherwell Clinic to refer Ms. Z Vena to the next level of care means that Ms. Z Vena was not attended to in a manner that is consistent with the nature and severity of her health condition at Motherwell NU 11 Clinic.

The conduct of Sr. NJ Ntlanjeni and Sr. Z Ndongeni in failing to refer Ms. Z Vena to the next level of care was in violation of the provisions of Regulation 5(1) and (2)(b) of the Norms and Standards Regulations.

Whether the death of Ms. Zenizole Vena was due to negligence of the nurses at Motherwell NU 11 Clinic

The allegation that the death of Ms. Z Vena was due to the negligence of the nurses at Motherwell NU 11 Clinic was substantiated and confirmed.

Negligence is failure to act with the level of care that someone of ordinary prudence would have exercised under the same circumstances. Such behavior consists of actions (commission) but can also consist of omissions when there is a duty to act. A reasonable person test is used to establish negligence. For example, 'if a reasonable person would have foreseen the reasonable possibility of harm and would have taken reasonable steps to prevent such harm, and the person in question did not do so, negligence is established'.

Sexual assault and or rape is a violent crime where victims are harmed by or threatened with violence. As health professionals, Sr. NJ Ntlanjeni and Sr. Z Ndongeni had a duty to care for patients, including Ms. Z Vena. They were expected to know the management of sexual assault cases and provide proper care to Ms. Z Vena but failed to do so. A reasonable person in the position of Sr. NJ Ntlanjeni and Sr. Z Ndongeni would have foreseen the harm by holistically examining Ms. Z Vena in terms of the management of sexual assault victims instead of instructing her to go to MPS CSC where she could have met with her perpetrators on the way to the police station and expose her to further harm.

According to the statements obtained from both Sr. NJ Ntlanjeni and Sr. Z Ndongeni, they did not touch Ms. Z Vena to avoid tampering with evidence. Ms. Z Vena was instructed to go to the police station and was later supposed to be taken to the Dora Nginza Thutuzela Centre (DNTC).

The Death Certificate of the late Ms. Z Vena indicates that: "the cause of death is still under investigation." The post-mortem report dated 06 October 2022 could not determine the cause of death as it is still pending Toxicology results. The physical examination of Ms. Z Vena's body by Dr. LJ Mostert revealed that she had abrasions on her toes and on the back of one thigh. The fact that there were no visible injuries on the genital area does not exclude sexual assault.

According to Dr. LJ Mostert, the Toxicology report uncovered a white substance in the stomach that looked like tablets. There were no severe injuries that might have caused the death, and the suspected cause of death could be in keeping with a high level of Trimethoprim drug also known as Co-trimoxazole, in the stomach content, the blood, eye fluids, and bile. These levels were much higher than the normal levels in people taking this medication. It appeared that Ms. Z Vena ingested a lot of Trimethoprim tablets. According to Dr. LJ Mostert, "the toxicology results, the cause of death will be consistent with Trimethoprim overdose."

The Toxicology Report dated 23 February 2023 found the trimethoprim substance in Ms. Z Vena's body as follows:

- 4960 mg/l in the stomach contents;
- 7 mg/l in the blood;
- 3 mg/l in the eye fluid; and
- 48 mg/l in the bile.

The Toxicology Report also showed that the concentration of alcohol in the blood specimen was 0.00 grams per 100 millilitres. However, the concentration of sodium fluoride in the blood specimen was 1.7 grams per 100 millilitres.

Based on the evidence obtained, it can be concluded that Ms. Z Vena was not attended to in a manner that is consistent with the nature and severity of her health condition at Motherwell NU 11 Clinic.

During their re-interview on Wednesday, 24 May 2023, Sr. NJ Ntlanjeni and Sr. Z Ndongeni conceded that they had mismanaged Ms. Z Vena when she presented at Motherwell NU 11 Clinic and could have done things differently.

Therefore, Sr. NJ Ntlanjeni and Sr. Z Ndongeni were negligent by failing to provide the necessary care consistent with the nature and severity of Ms. Z Vena's health condition. Consequently, the cause of death of Ms. Z Vena can be attributed to the negligence of the two nurses at Motherwell NU 11 Clinic.

Dr. R Wagner indicated in the report of 14 November 2022 that: "the conduct of the two professional nurses is condemned, they violated the frameworks and guidelines of professional ethics concerning the management of rape victims. After the internal investigation, the recommendation was that disciplinary processes be undertaken. Labour Relations has initiated the disciplinary process."

However, during the interview with Sr. NJ Ntlanjeni on 27 March 2023, she confirmed that she has neither been charged nor subjected to a disciplinary hearing. She has been on sick leave since 23 September 2022, when the community of Motherwell Ward 58 got angry and threatened them, and closed the clinic.

Despite the undertaking to take disciplinary action against Sr. NJ Ntlanjeni, no charges have been preferred against her to date.

Dr. R Wagner said she issued instructions to Mrs. Ngada to inform the District Manager, Ms. S Lupondwana to implement the disciplinary action with the expectation that they will follow the instructions. When she followed up, she was informed that Sr. NJ Ntlanjeni was still on sick leave. She requested labour relations for advice on what must happen and was advised to proceed with the second nurse. No disciplinary action has been instituted against Sr. Z Ndongeni and Sr. NJ Ntlanjeni.

ADDITIONAL FINDINGS

Adult Primary Care (APC) Training offered to nurses by ECDoH

During a group discussion with Professional Nurses (PNs) at Motherwell NU 11 Clinic when conducting in loco inspection, the common complaint was while APC training is offered online, there is no proper mentoring or monitoring for compliance. Both Sr. NJ Ntlanjeni and Sr. Z Ndongeni attended online training on APC, under Traumatized/Abused patients, but failed to implement it as required. The training was conducted before the incident occurred. The date of the training was not specified.

No proper signposting of services and clinic hours

The investigators observed that while driving towards Motherwell NU 11 Clinic, there were no signposts on the streets indicating directions to the clinic.

Arriving at the clinic, there was no board that indicated the menu of services offered by the clinic nor the indication of working times at the clinic.

The investigation also noted that this posed a problem as patients would have to stand in the queue without knowing whether the services required were provided. This might lead to patients losing confidence in the public health service. During the investigation, Ms. NP Qabaka mentioned that the NMBDH was aware of the challenge but nothing was done to address the problem. (No evidence was provided by Ms. NP Qabaka in this regard).

In terms of Regulation 4(1) of the Norms and Standards Regulations, the health establishment must ensure that users are provided with adequate information about health care services available at the health establishment and information about accessing those services.

The rotational schedule of doctors at Motherwell NU 11 Clinic

Motherwell NU 11 Clinic does not have full-time doctors working daily at the clinic. The clinic relies on sessional doctors available only on Mondays and Fridays.

If there are no doctors, the nurses call the doctor and present the patient by phone and wait for the doctor's instructions to refer the patient to Motherwell Community Health Centre (MCHC) or Dora Nginza Hospital (DNH) where doctors are available on a full-time basis.

Security Services

The investigation established that Motherwell Township has a high crime rate. Motherwell NU 11 Clinic does not have twenty-four-hour security at the clinic. The security guards work between 06:00 – 16:00, from Monday to Friday.

Patients preferring to be first in the queue are forced to wait outside the clinic yard as the gate only opens at 07:30 when the nurses arrive.

There are two security guards on duty and not well-equipped to deal with the threats posed to the clinic or clinic personnel.

There was a safety incident three years ago, a bakkie from a pharmaceutical company delivering medication at was hijacked at the gate of the clinic. In another incident, the nurses at Motherwell NU 11 Clinic were attacked during the day and robbed of their cell phones and money.

Underutilisation of staff

The staff complements at Motherwell NU 11 Clinic comprises:

1. Seven PNs and three of those are employed on contracts ending in March 2023. The PNs had to alternate to see patients in the consulting rooms as there was an inadequate number of consulting rooms to examine patients;
2. One Enrolled Nurse (EN);
3. One Enrolled Nursing Assistant (ENA);
4. One Data Capturer;
5. Two Administrative Clerks (One of the clerks is the regional chairperson of the National Education Health and Allied Workers Union (NEHAWU). Due to the position he holds, he is sometimes not at the clinic as he is expected to attend union meetings scheduled within the region. This poses a challenge to the clinic especially if the other clerk is on leave.
6. One Post Basic Pharmacy Assistant (PBPA); and
7. Two Cleaners. One (1) cleaner is permanently employed and the other is employed on contract which ends in March 2023.

The staff for a Clinic that opens from 07:30 to 16:00 was adequate, but there was a need to increase the number of cleaners due to the high volume of patients seen per day, to keep the Clinic clean, and better management of the administration clerks to ensure that the file room is always staffed.

Sexual Assault Standard Operating Procedure

During the investigators' walkabouts at Motherwell NU 11 Clinic, health professionals indicated that they were not aware of Motherwell NU 11 Clinic's sexual assault SOP. The available SOP they confirmed was of the DNTC and was not specific to Motherwell NU 11 Clinic.

There were no flowcharts on the notice boards in the consulting rooms to guide nurses on the steps to follow when dealing with sexual assault cases.

Motherwell NU 11 Clinic contravened Regulation 7(1) of the Norms and Standards Regulations by failing to establish and maintain clinical management systems, structures, and procedures that give effect to national policies and guidelines.

Infrastructure Challenges

Motherwell NU 11 Clinic was built in 1996. The infrastructure capacity of the clinic cannot cope with the number of patients treated over the years. There are only two consulting rooms for a staff complement of seven PNs. Patient privacy is compromised as the consulting rooms are such that patients pass through one room to access the other.

There is not enough space for disabled patients. Motherwell NU 11 Clinic is currently using a storeroom to attend to disabled patients.

The registration room is too small to keep the patient files safely. A request was made from the clinic to NMBDH in August 2022 for more space. The NMBDH sent people to take the measurements for bulk files but nothing has been done to date.

There are only four air conditioners at Motherwell NU 11 Clinic to maintain fresh air, temperature, humidity, and purity. However, the air-conditioners are reportedly always faulty and non-functional.

Access to telephone

The investigation established communication challenges at Motherwell NU 11 Clinic as they had no functional landline telephone, as they are frequently affected by load-shedding.

The investigation also revealed that the work cell phone was still in the possession of Sr. NJ Ntlanjeni was on sick leave since 23 September 2022. The Acting Facility Manager at Motherwell NU 11 Clinic, Mr. Sakhiwo Velebayi (Mr. S Velebayi) was not provided with a work cell phone, making it difficult to communicate. As a result staff had to utilise their personal cell phones in most instances when referring patients or seeking information.

Ms. NP Qabaka highlighted that the office cell phone contracts were not paid for some time in the NMBDH, and finance was dealing with the issue.

Supervision of clinics within Sub-District A

During the walkabouts, the investigation learned that there was no proper supervision of the clinics from Sub-District A. While they confirm that there are periodic telephone inquiries regarding challenges experienced by the clinic, the physical availability of staff from Sub-District A conducting visits to monitor, evaluate, and mentor was non-existent.

During the interviews, Ms. NP Qabaka cited transport challenges as one of the key issues for not being physically at the clinics. She stated that Sub-District A was allocated only one car, which made it impossible to access due to competing priorities.

Ms. NP Qabaka stated that sometimes she had to use her car for work-related matters, for which she did not receive compensation.

Acting in the key positions

During the briefing session, the investigation team was made aware that the key positions were staffed by acting personnel. Ms. S Lupondwana mentioned that this poses a serious challenge as it discourages staff from doing their best because they are not financially compensated for acting in those positions.

The Acting Facility Manager at Motherwell NU 11 Clinic, Mr. S Velebayi has been acting since 23 September 2022. Based on the fact that the post is still occupied by Sr. NJ Ntlanjeni who is still on sick leave.

Lack of proper Redress of Family / Supporting persons

During the interview with the mother of the deceased, Ms. Nomathamsanqa Vena (Ms. N Vena) on 02 March 2023, she submitted that she was invited to a meeting on 02 November 2022 by the District Manager of NMBDH and attended with her two brothers, Mr. Dumisani Vena and Mr. Mziyanda Vena.

The meeting considered to be a redress but did not achieve its primary objective as Ms. N Vena was never provided with information on the circumstances that led to the death of Ms. Z Vena. According to Ms. N Vena, the meeting lasted approximately five minutes and was adjourned.

In terms of the National Guidelines to Manage Complaints, Compliments, and Suggestions in the Health Sector of South Africa (the National Guidelines to Manage Complaints), version 2 of 2022, it was expected of the NMBDH to investigate the circumstances surrounding the death of Ms. Z Vena and redress her family. The redress aims to reach a fair and reasonable resolution in an amicable manner.

By failing to properly redress the family of Ms. Z Vena, the NMBDH was in breach of the provisions of the National Guidelines to Manage Complaints.

The NMBDH did the right thing by arranging psychosocial assistance for Ms. N Vena scheduled for Wednesday, 22 February 2023. However, Ms. N Vena did not attend the session due to financial constraints and lack of transport.

Ms. N Vena has a responsibility in terms of the Patient Rights Charter (PRC) to comply with the prescribed treatment or rehabilitation procedures.

Failure by Motherwell Police Station Community Service Centre to assist Ms. Z Vena

Ms. S Ntantiso and Ms. Z Vena arrived at the MPS CSC charge office at 08:00 . Ms. S Ntantiso said: “When I arrived at the charge office I explained to someone at the window counter about the condition of Ms. Z Vena but she never paid attention, she told me to go and sit down.”

This submission was disputed by Sgt. V Mbongo said Ms. S Ntantiso did not explain what had happened to Ms. Z Vena. Sgt. Mbongo said at 09:30 she went to check on Ms. Z Vena was laying on the floor in the charge office, and noticed that she was no longer crying. That is when she realised that Ms. Z Vena had passed on.

This means Ms. Z Vena waited for 1h30 minutes to be assisted at the charge office. No first aid assistance was offered to Ms. Z Vena despite the fact that she arrived at the charge office being supported by two females because she was unable to walk, and she was crying and fitting. Sgt. V Mbongo confirmed that she opened the inquest docket only after Ms. Z Vena had demised.

Sgt. V Mbongo said that she did not open the First Aid Kit (FAK) nor offer first aid assistance to Ms. Z Vena when she was laying down and fitting because she is not trained in the use of the first aid. However, she confirmed that the police station has the FAK. She also said she does not remember being orientated on how to use the FAK, nor does she know whether there is a Health and Safety Representative at the police station.

It is a requirement in terms of Section 17 of the Occupational Health and Safety Act, 85 of 1993, that “employers employing 20 or more workers on premises must appoint a representative to monitor health and safety conditions.” None of the police officers that were interviewed knew whether MPS CSC had a Health and Safety Representative or his/her name. This means there is no Health and Safety Representative at MPS CSC.

Failure by MPS CSC to appoint a Health and Safety Representative to monitor the health and safety conditions at the police station amounts to a violation of Section 17 of the Occupational Health and Safety Act.

Following the demise of Ms. Z Vena, Sgt V. Mbongo opened an inquest docket to investigate a case of rape and murder. During the re-interview on 18 May 2023 Sgt. B Gwili confirmed that the South African Police Services managed to arrest three suspects, Mr. Luxolo Tatase (17 years old), Mr. Liyabona Rooi (17 years old), and Mr. Sibabalwe Magalela (18 years old) for questioning regarding the murder and rape inquest, and warning statements were obtained from Mr. Luxolo Tatase and Mr. Sibabalwe Magalela. Sgt. B Gwili said Mr. Liyabona Rooi wanted to make a confession regarding the rape but he was stopped by his father. As a result, no warning statement was obtained from him.

Salient and concurrent features from the two warning statements include the fact that Ms. Z Vena and Mr. Liyabona Rooi left together and had sexual intercourse and given that Ms. Z Vena was observed to have taken some “pills” before she left.

The three suspects have since been released in the care of their parents on the basis that they are juvenile offenders, and the SAPS was awaiting the results of the toxicology report and the DNA from the rape kit to determine the cause of death. The results of the rape kit are still outstanding. Once these results are available, Sgt. B Gwili will await the decision of the Senior Public Prosecutor regarding whether any of the suspects will be held accountable and criminally charged and if so, on what charges.

Engagement with the Senior Public Prosecutor (Mr. Siyolo) on 26 June 2023 revealed that there was ongoing consultation with the Deputy Director of Public Prosecutions, Adv. Indhrambal Goberdan would decide on whether to prosecute the case or not.

CONCLUSION

- a. It was not in dispute that Ms. Z Vena was sexually assaulted, hence she presented herself at Motherwell NU 11 Clinic accompanied by Ms. S Ntantiso on 21 September 2022 for medical services. This fact was also supported by the findings on the post-mortem examination conducted by Dr. LJ Mostert on 06 October 2022. The physical examination revealed that Ms. Z Vena's body had abrasions on her toes and the back of one thigh, and no visible injuries observed. However, this does not exclude rape, especially if someone already had sexual intercourse before. Also, Mr. Liyabona Rooi (Mr. L Rooi) confirmed to have had sexual intercourse with Ms. Z Vena which she alleged was not consensual.
- b. It is also confirmed that Sr. NJ Ntlanjeni and Sr. Z Ndongeni did not examine Ms. Z Vena to confirm whether indeed she had been raped and be managed in accordance with the Adult Primary Care Manual/Booklet 2019/2020, which requires that patients presenting with recent rape or sexual assault must be given urgent attention. Both Sr. NJ Ntlanjeni and Sr. Z Ndongeni informed Ms. S Ntantiso and Ms. Z Vena that nurses "do not touch rape victims to avoid tampering with evidence". The conduct of both Sr. NJ Ntlanjeni and Sr. Z Ndongeni violated Ms. Z Vena's Constitutional rights in terms of Section 27(1) of the Constitution.
- c. It was also confirmed that Sr. NJ Ntlanjeni and Sr. Z Ndongeni did not examine Ms. Z Vena to confirm if indeed she had been sexually assaulted. Both Sr. NJ Ntlanjeni and Sr. Z Ndongeni informed Ms. S Ntantiso and Ms. Z Vena that the nurses "do not touch rape victims to avoid tampering with evidence". The conduct of both Sr. NJ Ntlanjeni and Sr. Z Ndongeni was in violation of Ms. Z Vena's Constitutional rights in terms of Section 27(1) of the Constitution.
- d. It was expected of both Sr. NJ Ntlanjeni and Sr. Z Ndongeni to prioritise Ms. Z Vena by taking her history to determine whether she requires referral to the doctor, in accordance with the Adult Primary Care Manual/Booklet 2019/2020, which requires that patients presenting with recent rape or sexual assault must be given urgent attention.
- e. It was also confirmed that the nurses failed to arrange transport for Ms. Z Vena to take her to the next level of care. In so doing, the nurses failed to ensure that Ms. Z Vena was attended to in a manner that was consistent with the nature and severity of her health condition at the clinic. The conduct of Sr. NJ Ntlanjeni and Sr. Z Ndongeni violated the provisions of Regulation 5(1) and (2)(b) of the Norms and Standards Regulations.
- f. No disciplinary action was instituted against Sr. NJ Ntlanjeni or Sr. Z Ndongeni regarding their misconduct. The ECPDoH did not issue an apology to the family of Ms. Z Vena.

RECOMMENDATIONS

Disciplinary Inquiry

The District Manager of the NMBDH should institute a disciplinary inquiry within one month, in line with recommendations made by the Eastern Cape HoD in November 2022, in terms of the prevailing policy and compatible with the Labour Relations Act (LRA), 66 of 1995 against the following personnel:

- Sr. NJ Ntlanjeni for her failure to holistically assess Ms. Z Vena, and use proper channels of referral within the district. Her failure to advocate on behalf of the patient placed the life of Ms. Z Vena in danger.
- Sr. NJ Ntlanjeni also used her personal diary to record the vital data observations of Ms. Z Vena, instead of the appropriate Patient Administration Record (PAR). There was no evidence to indicate that Ms. Z Vena was consulted at the Motherwell NU 11 Clinic on 21 September 2022, as her name was not registered anywhere.

Sr. Z Ndongeni for her failure to advocate for Ms. Z Vena. During the interview, she indicated that she heard the conversation between Sr. NJ Ntlanjeni and Ms. Z Vena but failed to intervene when Sr. NJ Ntlanjeni was instructing Ms. Z Vena and Ms. S Ntantiso to go to the MPS CSC.

As a PN registered with the South African Nursing Council (SANC), she had the responsibility to take the total health of Ms. Z Vena into consideration and maintain the utmost respect for human life, as a promise made freely and upon her honor during her nursing pledge.

Referral of the two nurses to the South African Nursing Council (SANC) for investigation regarding professional misconduct.

Security challenges

The HoD must within three months submit to the CEO of the OHSC a security plan to protect users, healthcare personnel, and clinic property from security threats and risks, and to ensure that security staff is capacitated to deal with security incidents, threats, and risks. This will ensure that state property, healthcare workers and patients are protected from harm, in compliance with Regulation 17 (1) and (2) of the Norms and Standards Regulations.

Adult Primary Care Training offered to nurses by ECDoH

The District Manager of NMBDH must ensure that healthcare workers are mentored by attending Adult Primary Care (APC) training within two months. This will ensure all the nurses are kept abreast of the new developments in the management of sexual assault cases.

No proper signposting of services and clinic hours

The District Manager of NMBDH and HoD must, within six months procure a service provider to install a Service/Notice Board at the Motherwell NU 11 Clinic indicating the health care services provided by the clinic and working times at the clinic.

Signposts should be installed on the road to guide healthcare users about the direction and location of the clinic. This will ensure that Motherwell NU 11 Clinic complies with Regulation 4(1) of the Norms and Standards Regulations.

Rotational schedule of doctors at Motherwell NU 11 Clinic

The HoD should within three months increase the number of doctor's visits at the clinic to three days per week. The monitoring of doctors working at the clinic should be done to ensure that they work for the time frame allocated at the clinic.

Staff complement

The NMBDH and ECDoH should prioritise the appointment of an extra permanent cleaner at Motherwell NU 11 Clinic within three months in line with the Human Resources Management Policy.

This will ensure that there is a person at the clinic to maintain the cleanliness of the clinic and surrounding areas and avoid possible infections.

Sexual Assault Standard Operating Procedure

The District Manager of NMBDH must within one month ensure the Standard Operating Procedure for the management of sexual assault cases is developed and in-service training is provided to the staff at Motherwell NU 11 Clinic. This will ensure that all staff members are conversant with the SOP and the management of sexual assault cases.

Prioritisation of Motherwell NU 11 Clinic Infrastructure

The Premier of the ECPD should within six months ensure that Motherwell NU 11 Clinic is prioritised for refurbishment. Mobile containers are procured to cater to extra consultation rooms. To fast-track the process of procuring the land next to the clinic to enable the extension of the clinic infrastructure, as highlighted by Ms. NP Qabaka. This will minimise the overcrowding and patients waiting under open shelters inside the clinic compound. There should be the improved provision of quality health services and ensure that Motherwell NU 11 Clinic complies with Regulation 8 (1) of the Norms and Standards Regulations.

Supervision of clinics within Sub-District A

The HoD should within six to twelve months ensure the provision of extra motor vehicles in Sub-District A to enable the Sub-District Coordinator to support and monitor the implementation of health care services in the clinic.

In instances where staff utilise their motor vehicles for work-related matters, they should be compensated financially as guided by the Public Finance Management Act (PFMA).

Employees not part of the Senior Management Service (SMS), using their own motor vehicles for work-related purposes, should be indemnified in case of accidents.

Acting in key positions

The HoD must within six months ensure the acting positions within the NMBDH are advertised and filled to ensure continuity and accountability. This will ensure a sense of security amongst staff and encourage them to be responsible and develop innovative ideas to improve health care service within NMBDH.

Redress of family/supporting persons

The District Manager of NMBDH

Arrange a meeting with the family within 30 working days, to explain the conditions and events that led to the death of Ms. Z Vena and offer an apology to facilitate closure. Arrange counseling for the family of Ms. Z Vena within 30 working days, to facilitate closure regarding her death. All arrangements should include the provision of transport and other support logistics for the family, where necessary by the NMBDH district office.

Mother and family of Ms. Z Vena

Attend a redress meeting when invited by the District Manager of NMBDH for an explanation regarding the events that led to the death of Ms. Z Vena. Attend counseling offered by the District Manager of NMBDH to assist with closure regarding Ms. Z Vena's death.

Non-compliance with Section 17 of the Occupational Health and Safety Act, 85 of 1993

The HoD of the Eastern Cape Department of Labour must within 30 working days conduct routine inspections at Motherwell Police Station CSC to ensure compliance with Section 17 of the Occupational Health and Safety Act, 85 of 1993, and take appropriate action/sanction if found to be non-compliant. The Ombud is to be furnished with a copy of the inspection report immediately after the inspection has been conducted.

Sexual Assault Referral Policy

The District Manager of NMBDH must develop and disseminate a practical and realistic sexual assault referral policy within two months. This policy must be developed to coordinate processes and operations between Health facilities, Thutuzela Care Center(s), Family Violence, Child Protection, and Sexual Offences Unit, and SAPS charge offices and other facilities. The Ombud is to be furnished with a copy of the Sexual Assault Referral Policy within six months of the date of this report.

The MPS CSC

In view of the “laissez-faire” or “yekelela” attitude and culture currently prevalent within all echelons of the SAPS in NMBDH, regarding persons in clinical distress, the following is recommended:

- i. Plans be put in place that all SAPS employees engaging with the public are trained in First Aid or have physical access to first responders 24 hours a day. This should be implemented within twelve months of the finalisation of this report.
- ii. Improve record-keeping processes to improve transparency and accountability, within two months of finalisation of this report.
- iii. Provide proof of progress in the implementation of (i) and (ii) above to the Health Ombud within two months of such implementation.

BREACHES OF THE NORMS AND STANDARDS

No.	Investigation Findings	Related Norms and Standards
1.	Motherwell NU 11 Clinic does not have a service board informing the health service users of the working hours at the clinic. The tender is still to be advertised.	Regulation 4(1) provides that: “health establishment must ensure that users are provided with adequate information about the health care services available at the health establishment and information about accessing those services.” Sub-regulation (2) provides that: “for sub-regulation (1), a health establishment must, provide users with information relating to (i) the health care services provided by the health establishment, (ii) service opening and closing times. (iii) visiting hours where relevant, and (iv) complaints, compliments and suggestions management system.”
2.	There is no Triage system at Motherwell NU 11 Clinic. The patients are not prioritised and attended to based on the level of their illnesses.	Regulation 5(1) provides that: “the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition. Sub-regulation (2) provides that: “for the purposes of sub-regulation (1), a health establishment must (a) implement a system of triage; (b) ensure access to emergency medical transport for users requiring urgent transfer to another health establishment, and that they are accompanied by a health care provider; and (c) adhere to clinical guidelines on stabilising users presenting in an emergency before referring them to another health establishment.”

3.	The nurses at Motherwell NU 11 Clinic denied Ms. Z Vena access to the provision of care by instructing her to go to MPS CSC to open a rape case without examining her.	Regulation 5(1) provides that: "the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition. Sub-regulation (2) provides that: "for the purpose of sub-regulation (1), a health establishment must (a) implement a system of triage; (b) ensure access to emergency medical transport for users requiring urgent transfer to another health establishment, and that they are accompanied by a health care provider; and (c) adhere to clinical guidelines on stabilising users presenting in an emergency before referring them to another health establishment".
4.	Motherwell NU 11 Clinic does not have a Standard Operating Procedure (SOP) to deal with sexual assault patients. All the healthcare workers interviewed confirmed that they had never seen a SOP on sexual assault patients. The available SOP talks to the Thuthuzela Care Center, it is not specific to Motherwell NU 11 Clinic	Regulation 7(1) provides that: "the health establishment must establish and maintain clinical management systems, structures, and procedures that give effect to national policies and guidelines." Sub-regulation (2) provides that: "for the purpose of sub-regulation (1), a health establishment must- (a) ensure that clinical policies and guidelines for priority health conditions issued by the national department are available and communicated to health care personnel; and (b) establish and maintain systems, structures, and programs to manage clinical risks."
5.	Motherwell NU 11 Clinic does not have security at night and on weekends. The security operates between 6:00 – 16:00, Monday to Friday. There is no security on weekends to protect the clinic from threats and risks.	Regulation 17(1) provides that: "the health establishment must have systems to protect users, health care personnel and property from security threats and risks. Sub-regulation (2) provides that: "for the purposes of sub-regulation (1), the health establishment must ensure that security staff is capable to deal with security incidents, threats, and risks."
6.	There are four (4) air conditioners at the health establishment but they are not always working. They are always faulty and require constant maintenance.	Regulation 14(1) provides that: "the health establishment and their grounds must meet the requirements of the building regulations". Sub-regulation (2) requires that a health establishment must as appropriate for the type of buildings and grounds of the establishment (d) have a ventilation system that maintains the inflow of fresh air, temperature, humidity, and purity of the air within specified limits set for different service areas such as theatres, kitchen, and isolation units.

DEFINITIONS

- **Constitution** means the Constitution of the Republic of South Africa, 1996
- **Health Establishment** means a whole or part of a public or private institution, facility, building, or place, whether for profit or not, that is operated or designated to provide inpatient or outpatient treatment, diagnostic or therapeutic intervention, nursing, rehabilitative, palliative, convalescent, preventative or other health services.
- **Health and Safety Representative**, also known as a SHE Rep, is a person appointed in the workplace to represent his/her fellow employees to ensure that all risks and hazards are identified and dealt with as far as reasonably practicable.
- **'In loco'** inspection or onsite investigation means on-site inspection of the place where an incident connected with the complaint being investigated occurred.
- **Juvenile offenders** are children under the age of 10 years and are not criminally liable. Those aged between 10 to 14 years are presumed not criminally liable unless proven otherwise. Children from 14 to 18 years old are criminally liable and can be prosecuted in normal courts.
- **Minister of Health:** means the Cabinet member responsible for Health.
- **National Health Act:** means the National Health Act, 2003 (Act No.61 of 2003);
- **National Health Amendment Act:** means the National Health Amendment Act, 2013 (Act No 12 of 2013).
- **Norms and Standards Regulations applicable to different categories of health establishments** means the Norms and Standards Regulations published on 02 February 2018.
- **Office of Health Standards Compliance (OHSC):** means a regulatory body established in terms of Section 77 (1) of the National Health Act.
- **Ombud:** means a person appointed as the Ombud in terms of Section 81 (1) of the National Health Act.
- **Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud** means the Procedural Regulations published on 02 November 2016.
- **Prone position** means a patient position used during surgical procedures that provides surgical access to the dorsal aspects of the patient's body. In a prone position, the patient is positioned face down with their head in a neutral position without excessive flexion, extension, or rotation.
- **Rape** means unlawful, intentional sexual intercourse with an individual without consent.
- **Sergeant** means a rank that is used in the police services

INTRODUCTION AND BACKGROUND

Motherwell NU 11 Clinic was built in 1996 in Ward 55 of the Motherwell NU 11 township and is a Primary Health Care Clinic (PHCC), level 1. The clinic operates from 07:30 to 16:00, Monday to Friday and closed over the weekend.

The clinic serves a catchment population of 436, 474 individuals in the Nelson Mandela A Health sub-district (**Annexure A**). The Motherwell NU 11 Clinic has a staff complement of 15 staff members. There are 11 permanent posts and four contract posts.

The infrastructure at Motherwell NU 11 Clinic is inadequate to cater for the load of patients seen on a daily basis. The building is too small and there is a need for extra consultation rooms to ensure the privacy of patients. The investigation learned that the nurses alternate to see patients in the available consultation rooms. The setups of the nurses are not fully utilised as one has to wait for the other while busy with a patient. The consultation rooms are built in such a way that the nurses and the patients have to pass through one consultation room to access the other. A request was made for more space in August 2022, with NMBDH but nothing has been done to address the problem. (Proof of requisition was not provided to the Investigators).

Sr. NJ Ntlanjeni, the current Operational Manager at Motherwell NU 11 Clinic, started acting as the Operational Manager in October 2012 and was appointed to the post in October 2016.

During the onsite investigation, the Investigators learned that Sr. NJ Ntlanjeni has been on sick leave since 23 September 2022, following threats from the community of Motherwell. The clinic was forced to close due to the anger from the community and unsafe conditions for the staff (time frame of closure not stated).

The investigators also learned that staff members had been transferred to other facilities for fear of being targeted by the community.

The Investigators also learned that Motherwell Township has a high level of crime and that there is a tendency of community members to take matters into their own hands.

The investigation also learned that when the incident happened, Ms. Z Vena was staying with her biological paternal grandmother, Ms. Kubayo (initials unknown). She left her biological mother's home in July 2022 to visit her biological paternal grandmother at Motherwell Township where she stayed until she died on 21 September 2022. According to Ms. N Vena, Ms. Kubayo last saw Ms. Z Vena on Saturday, 17 September 2022, when she left to go to school. Ms. Z Vena was a learner at Woolhope Secondary School doing Grade 9. According to Ms. N Vena, no missing person case had been reported at the MPS CSC before she died.

SUMMARY OF THE COMPLAINT

The complaint was lodged by the Democratic Alliance's (DA) Shadow Minister of Health (SMH), Honourable Michéle Clarke, MP (Hon. M Clarke) against Motherwell NU 11 Clinic, in the Eastern Cape (EC) Province on 30 September 2022. The complaint was risk-rated extreme and allocated Reference No: 36048. The complaint was referred to the Complaints Investigation Unit (CIU) on 04 October 2022 (**Annexure B**).

The complaint was also prompted by a referral from the Minister of Health, Dr. MJ Phaahla, MP (the Minister) on 04 October 2022. In the referral, the Minister requested the Ombud to investigate potential negligence and suboptimal care at Motherwell NU 11 Clinic (**Annexure C**).

A parallel investigation of the criminal case was conducted by the Motherwell Police Station Community Service Centre (MPS CSC) under Motherwell CAS 151/09/2022. The MPS CSC is still waiting for a decision by the Deputy Director of Public Prosecution regarding whether or not any of the suspects will be charged. However, the Deputy Director of Public Prosecutions in Gqeberha, Adv. I Goberdan, gave the Ombud permission to release the Report as she is of the view that the release of the report will not compromise the criminal investigation (**Annexure D**).

In the main, Hon. M Clarke alleged that

- a. Motherwell NU 11 Clinic failed to assist a 15-year-old sexual assault victim, Ms. Zenizole Vena (Ms. Z escorted by an elderly lady to seek health care at Motherwell NU 11 Clinic.
- a. Ms. Z Vena was turned away by Motherwell NU 11 Clinic and died a short while later in Motherwell Police Station's (MPS) Community Service Centre (CSC) while trying to open a case of sexual assault.

Issues identified for investigation

- a. Whether Ms. Z Vena was denied provision of care at Motherwell NU 11 Clinic;
- b. Whether Motherwell NU 11 Clinic failed to refer Ms. Z Vena to the next level of care; and
- c. Whether the death of Ms. Z Vena was due to negligence of the nurses at Motherwell NU 11 Clinic.

POWERS AND JURISDICTION OF THE HEALTH OMBUD

- The Ombud derives his powers in terms of Section 81A (1) of the NHAA, 2013 (Act No.12 of 2013). The mandate of the Ombud stipulates that: "the Ombud may, on receipt of a written or verbal complaint relating to norms and standards, or on his or her initiative, consider, investigate, and dispose of the complaint in a fair, economical and expeditious manner."
- In terms of Section 81A (2) of the NHAA, a complaint referred to in subsection (1) may involve an act or omission by a person in charge of or employed by a health establishment or any facility or place providing a health service.
- Section 81B (2) of the NHAA provides that: "When dealing with any complaint in terms of this Act, the Ombud including any person rendering assistance and support to the Ombud - (a) is independent and impartial; and (b) must perform his or her functions in good faith and without fear, and favour, bias, or prejudice."
- Motherwell NU 11 Clinic is a public health establishment. The investigation of this complaint falls within the scope of the Ombud's mandate as the Ombud has jurisdiction to investigate all health establishments in South Africa, both private and public, including an act or omission by a person in charge of or employed by the health establishment.

METHODOLOGY AND APPROACH TO THE INVESTIGATION

01. On 04 October 2022, the Complaints Call Centre of the Ombud sent a referral of the complaint in terms of Section 18(1) of the National Health Act, 61 of 2003, to the ECDoh's Customer Care Consultant, Ms. Pamela Mahanjana and the Head of Department, Dr. R Wagner, to allow the opportunity to investigate the complaint (**Annexure E**).
02. On 14 November 2022, Dr. R Wagner furnished the Ombud with an investigation report detailing their findings and recommendations (**Annexure F**).
03. On 20 February 2023, a notification of investigation was sent to the HoD, Dr. R Wagner, and the District Manager of NMBDH, Ms. S Lupondwana to inform them of the Ombud's intention to conduct onsite investigations from 28 February 2023 (**Annexure G**).
04. The Ombud, in terms of Section 81A(3)(a)(b)(i)-(iv) of the National Health Amendment Act (NHAA) 12 of 2013, authorised Investigators, Mr. Douglas Mapheto (Mr. D Mapheto), and Ms. Madithapo Masemola (Ms. M Masemola), accompanied by Legal Intern, Mr. Ngcebo Gumede to gather the necessary information and peruse any documentation that has a bearing on the case at Motherwell NU 11 Clinic.
05. Upon their arrival at NMBD on 28 February 2023, the investigation team reported to the District Manager, Ms. S Lupondwana's office to give a briefing regarding how the investigation was going to unfold and to request additional documentation that was not submitted.
06. From 28 February 2023 until 03 March 2023, face-to-face interviews were conducted with the following: Motherwell NU 11 Clinic staff, the mother of Ms. Z Vena, the elderly lady, Ms. S Ntantiso escorted Ms. Z Vena to the clinic, the members of MPS CSC, the EMS personnel, and NMBD staff to provide evidence.

Based on the advice given by Ms. S Lupondwana during the briefing session, highlighting the high crime and unpredictability of the Motherwell NU 11 community, the interviewees were cross-examined where it was deemed safe to do so at the time, especially since the Investigators were not known to the community. Other witnesses were interviewed at their respective places of employment, except for Dr. LJ Mostert and Sr. NJ Ntlanjeni was interviewed on 24 and 27 March 2023 respectively, online via TEAMS meeting.

The Teams meeting interviews conducted were as a result of the fact that Sr. NJ Ntlanjeni was still on sick leave, whereas in the case of Dr. LJ Mostert, the investigation team did not have toxicology results and post-mortem report. Hence a decision was taken to arrange an interview with the forensic pathologist who conducted the post-mortem examination.

In total, 13 interviews were conducted with 13 witnesses between 28 February 2023 and 27 March 2023. The other ten interviews were conducted by the Ombud and the investigation team from 15 to 19 May 2023. Eight witnesses were re-interviewed from 15 to 19 May 2023 and did not contradict their earlier evidence. Three witness statements were also received from the MPS CSC and analysed.

INVESTIGATIONS INTERVIEWS

Sister. Z Ndongeni (Sr. Z Ndongeni) was interviewed on 28 February 2023 at NMBD Offices.

Sr. Z Ndongeni indicated that on Wednesday, 21 September 2022, she arrived at Motherwell NU 11 Clinic at 07:00 and waited in the car for the second nurse to arrive. The second nurse, Sr. NJ Ntlanjeni arrived at 07:10 and informed Sr. Z Ndongeni that there was a rape child at the gate escorted by her grandmother. Sr. NJ Ntlanjeni asked the Security Officer to let both Ms. S Ntantiso and Ms. Z Vena inside the clinic.

Ms. Z Vena and Ms. S Ntantiso entered the clinic and went to consultation room no. 2. Sr. Z Ndongeni was in consultation room 1. Sr. Ntlanjeni came to consultation room no. 1, to take the Blood Pressure (BP) machine. Sr. Z Ndongeni went to consultation room no. 2 where Sr. NJ Ntlanjeni attended to Ms. Z Vena and asked Ms. Z. Vena if she had washed and her response was "No", then she left.

Sr. Z Ndongeni heard Sr. NJ Ntlanjeni instructing Ms. Z Vena and Ms. S Ntantiso to go to the MPS CSC where they would be taken to DNTC. Ms. Z Vena and Ms. S Ntantiso left the clinic on foot at 07:25. *(Annexure H)*

Mr. Thembela Gladman Milisi (Mr. TG Milisi) was interviewed on 28 February 2023 at NMBD Offices

Mr. TG Milisi is a qualified Immediate Life Support (ILS) personnel employed by the Nelson Mandela Metro in the Eastern Cape Provincial Government (ECPG). He started working for the Emergency Medical Services (EMS) in 1987 as a Basic Ambulance Assistant (BAA) and progressed to Ambulance Emergency Assistant (AEA). Mr. TG Milisi has gone through the ranks and has vast experience in EMS.

Mr. TG Milisi indicated that his key performance areas include taking responsibility for the patient by stabilizing and conveying the patient. On the day of the incident Mr. TG Milisi was working the day shift with Mr. Ernest Bhelwana (Mr. E Bhelwana) working overtime.

Mr. TG Milisi also indicated that he and Mr. E Bhelwana were dispatched to the scene at MPS CSC. He was not sure of the time and who dispatched the ambulance. He also said, "on arrival at the scene, we assessed the patient and there was no pulse, no breathing, eyes were fixed and dilated. He then certified the patient dead and recorded that there were no bleeding and/or visible injuries based on his assessment".

Mr. TG Milisi also indicated that he noticed a white foam coming out of her mouth. Mr. TG Milisi further indicated that after certifying the patient dead, they completed an incident report that confirmed that Ms. Z Vena was dead when they arrived at MPS CSC. The Ombud was furnished with the Ambulance Patient Report Form (APRF) dated 22 September 2022, however, the correct date was 21 September 2022. The APRF shows that the ambulance was activated at 09:11 and it arrived at the scene at 09:38. The patient was declared dead at 09:45 *(Annexure I)*.

Ms. Sindiswa Ntantiso (Ms. S Ntantiso) was interviewed on 01 March 2023 at Motherwell Community Health Centre

Ms. S Ntantiso is an elderly community member and is not biologically related to Ms. Z Vena. She was interviewed at Motherwell Community Health Centre (MCHC) because of safety concerns at Motherwell NU 11 Clinic. The NMBDH provided transport for her to MCHC which was nearer to her home. Ms. S Ntantiso escorted Ms. Z Vena to Motherwell NU 11 Clinic on 21 September 2022, at 07:00 after she informed her that she had been sexually assaulted. At that time Ms. Z Vena was able to walk and talk.

Ms. S Ntantiso indicated that there was a nursing sister identified as Sister Zoleka Ndongeni (Sr. Z Ndongeni) sitting in her car inside the clinic yard when they arrived at Motherwell NU 11 Clinic. Later another nursing sister identified as Sister NJ Ntlanjeni (Sr. NJ Ntlanjeni) came. The Security Officer opened the gate and she and Ms. Z. Vena walked into the clinic with Sr. NJ Ntlanjeni.

Ms. S. Ntantiso indicated that while inside the clinic, they were attended to by Sr. NJ Ntlanjeni but she was standing outside the consultation room when Ms. Z. Vena was explaining what had happened. Sr. NJ Ntlanjeni did not touch Ms. Z. Vena but instead, she asked her if she had washed, to which Ms. Z. Vena answered "NO". Sr. NJ Ntlanjeni then told them to go to the MPS CSC as they 'do not touch the rape victims'.

Ms. S Ntantiso indicated that she and Ms. Z Vena walked to the MPS CSC and along the way Ms. Z. Vena collapsed, wet her pants, and had fits. She said they were assisted by a local taxi driver who gave them a lift to the MPS CSC as they could no longer walk. There were two Police Officers at the MPS CSC when they arrived at the MPS CSC. One of the Police Officers instructed them to go back to the clinic whereas the other Police Officer said they would arrange transport to take them to the hospital. The names of both Police Officers are unknown to Ms. S Ntantiso as they did not introduce themselves.

Mr. Zukisani Mati (Mr. Z Mati) was interviewed on 01 March 2023 at Motherwell Community Health Centre

Mr. Z Mati is employed by Silver Solutions Security (date of appointment unknown) contracted to provide security services at Motherwell NU 11 Clinic. Mr. Z Mati confirmed that was on duty on 21 September 2022 at Motherwell NU 11 Clinic with Security Officer, Mr. Khwezi Manqupu.

According to Mr. Z Mati, Ms. S Ntantiso and Ms. Z Vena arrived at Motherwell NU 11 Clinic at 06:40. Ms. S Ntantiso reported to Mr. Z Mati that Ms. Z Vena had been sexually assaulted. Mr. Z Mati informed Ms. S Ntantiso that the Sister in charge, Sr. NJ Ntlanjeni had not yet arrived. While Mr. Z Mati was busy talking to Ms. S Ntantiso, Sr. NJ Ntlanjeni arrived at the clinic at 07:15 and Mr. Z Mati approached her to report the incident.

Mr. Z Mati further indicated that Sr. NJ Ntlanjeni told him to bring both Ms. S Ntantiso and Ms. Z Vena inside the clinic. In his opinion, both Ms. S Ntantiso and Ms. Z Vena might have spent more or less 15 minutes in Motherwell NU 11 Clinic before walking out of the clinic.

Mr. Khwezi Manqupu (Mr. K Manqupu) was interviewed on 01 March 2023 at Motherwell Community Health Centre

Mr. K Manqupu is also employed by Silver Solutions Security (date of appointment unknown) which is contracted to provide security services at Motherwell NU 11 Clinic.

Mr. K Manqupu confirmed that he was on duty on 21 September 2022 at Motherwell NU 11 Clinic. He said that on 21 September 2022 in the morning, Ms. S Ntantiso and Ms. Z Vena arrived at Motherwell NU 11 Clinic at 6:45 and the clinic was still closed.

Sr. Z Ndongeni was informed about the incident and she indicated that the security should await the arrival of the Sister in charge as she was in possession of the clinic keys. At 07:15 security opened the gate for Ms. S Ntantiso and Ms. Z Vena when Sr. NJ Ntlanjeni arrived.

Mr. Z Mati informed Sr. NJ Ntlanjeni that there was a rape victim accompanied by an elderly lady in the queue. Sr. NJ Ntlanjeni told Mr. Z Mati to open the clinic and asked Ms. S Ntantiso and Ms. Z Vena to come into the clinic ahead of other waiting patients.

According to Mr. K Manqupu, Ms. S Ntantiso and Ms. Z Vena went to consultation room no. 2. Mr. K Manqupu also indicated that both Ms. S Ntantiso and Ms. Z Vena were attended to by Sr. NJ Ntlanjeni.

In Mr. K Manqupu's opinion, Ms. S Ntantiso and Ms. Z Vena spent more or less 15 to 20 minutes with Sr. NJ Ntlanjeni and left the clinic. Ms. Z. Vena was walking without support with no visible bleeding or torn clothes. Despite the above submission by Mr. K Manqupu, there was no mention of him being inside the clinic consulting room during Sr. NJ Ntlanjeni's consultation with Ms. Z Vena.

Ms. Nomathamsanqa Vena (Ms. N Vena) was interviewed at Motherwell Police Station Community Service Centre on 02 March 2023

Ms. N Vena is the mother of the deceased, Ms. Z Vena. According to Ms. N. Vena, Ms. Z Vena was staying at Motherwell NU 11 Clinic with her biological paternal grandmother, Ms. Kubayo (initials unknown). She alleged that Ms. Kubayo last saw Ms. Z Vena on Saturday, 17 September 2022, when she left to go to school. Ms. Kubayo never reported Ms. Z Vena to be missing at the MPS CSC.

Ms. N Vena indicated that on the morning of Wednesday, 21 September 2022, she saw a message on Facebook posted by one of Ms. Z Vena's friends, Ms. Sinalo Makinana stays in a shack where Ms. Z Vena was sexually assaulted. Ms. S Makinana said she met Ms. Z Vena and indicated to her that she had been sexually assaulted but she couldn't assist or escort Ms. Z Vena to the clinic as she was taking her child to school. Ms. Z Vena met Ms. S Ntantiso and she reported the sexual assault incident to her and immediately Ms. S Ntantiso took Ms. Z Vena to the clinic.

Ms. N Vena also indicated that Ms. S Ntantiso informed her that at the clinic "Sr. Ntlanjeni never helped or touched her and did not even give her anything and she did not even call the police. Sr. NJ Ntlanjeni told both Ms. S Ntantiso and Ms. Z Vena that rape is not "my case", rape victims must go to the police station. Then Ms. S Ntantiso and Ms. Z Vena walked out of the clinic unassisted.

On the way to the MPS CSC, Ms. Z Vena collapsed and started having fits and was assisted by the local residents carried her into the police station. Ms. Z Vena died in the charge office while waiting to be assisted. Following her death, MPS CSC went to fetch Ms. N Vena from her house. She arrived at the police station at 09:00.

Ms. N Vena further alleged that she was invited to a meeting by the District Manager of NMBDH on 02 November 2022, which she attended with her two brothers, Mr. Dumisani Vena and Mr. Mziyanda Vena. In the meeting, the District Manager of the NMBDH heard that Sr. NJ Ntlanjeni did not assist Ms. Z Vena or examine her but they had not yet spoken to Sr. NJ Ntlanjeni. The meeting was nothing serious, the NMBDH officials said they were just explaining that "they have been sent to confirm indeed they met Ms. Z Vena's family." According to Ms. N Vena, the meeting lasted for approximately five minutes and was adjourned **(Annexure J)**.

The District Manager also informed Ms. N Vena that the NMBDH had arranged psychosocial assistance for her and scheduled for Wednesday, 22 February 2023. However, Ms. N Vena could not attend due to financial constraints.

Detective Sergeant Bongani Gwili (Sgt. B Gwili) was interviewed on 02 March 2023 at Motherwell Police Station Community Service Centre and re-interviewed on 18 May 2023 at NMBDH Offices

Sgt. B Gwili confirmed that he is the Investigating Officer assigned to investigate a criminal case of rape under Motherwell CAS 151/09/ 2022. Sgt. B Gwili also indicated that the two suspects have been apprehended but not yet charged on their system until the toxicology results were received.

Sgt. B Gwili said they had received the post-mortem report but because the case was still under investigation, he was not in a position to share a copy of the report with the Investigators unless permission was granted by his superiors. At that time, Sgt. B Gwili also confirmed that the post-mortem examination was not final/conclusive as it could not determine the cause of death pending receipt of the toxicology report. Sgt. B Gwili also indicated that the Toxicology Report was still outstanding.

After the interview Sgt. B Gwili spoke to his supervisor, Col TH Njadayi and advised that the investigators send an email to request the post-mortem report to keep proof of documentation and to avoid any leaking of information.

Dr. Lambert Jacobus Mostert (Dr. LJ Mostert), was interviewed on March 2023 via TEAMS meeting and re-interviewed on 16 May 2023 at NMBDH Offices

Dr. LJ Mostert is a Medical Officer in Forensic Pathology in Port Elizabeth. He specialised in Forensic Pathology at Tygerberg Hospital in Stellenbosch in 2017. Dr. LJ Mostert also indicated that he has been working in the position of Medical Officer in Forensic Pathology since March 2022, but has been practicing Forensic Pathology in the EC since 2017.

According to Dr. LJ Mostert, he conducted a post-mortem examination on the late Ms. Z Vena on 22 September 2022 at New Brighton Mortuary (NBM). Dr. LJ Mostert indicated that on examination he could not determine the cause of death. Dr. LJ Mostert indicated that physical examination alone could not determine the cause of death, hence a post-mortem examination was necessary.

The following injuries were noted on the body in the report:

- “A small, scabbed wound on the lateral aspect of the right proximal upper arm;
- A small abrasion over the posterior aspects of the 3rd, 4th, and 5th metacarpophalangeal joints of the left hand;
- A small abrasion on the posteromedial aspect of the proximal part of the left thigh;
- A small, round contusion was noted in the middle part of the posterior aspect of the thigh;
- A small scabbed wound on the anterolateral aspect of the middle part of the right thigh;
- A small abrasion on the dorsal surface of the 1st toe on the right foot; and
- A small abrasion on the dorsal surface of the 1st toe on the left foot. A small abrasion was noted on the lateral aspect of the dorsal surface of the left foot.”

According to Dr. LJ Mostert the stomach contained “light brown fluid, intermixed with a white substance. This white substance was reminiscent of dissolved tablets. The genital organs were examined externally and swabs were taken for the Sexual Assault Evidence Collection Kit before an internal examination was performed. No injuries were identified on the vulva, labia, perineal, or peri-anal area. A smear of white mucoid discharge was noted in the introitus, the fornix, and in the uterus. A pelvic block dissection was performed. No evidence of soft tissue injury was present in the vagina, anus, rectum, or the surrounding soft tissues. The hymen was absent”. There were no severe injuries that might have caused the death, and the suspected toxicology cause of death could be in keeping with a high level of Trimethoprim drug also known as Bactrim in the stomach content, the blood, eye fluids, and in the bile. These levels were much higher than the normal therapeutic levels of people taking drugs. It appeared that Ms. Z Vena had ingested several Trimethoprim tablets. According to the Toxicology Report results, the cause of death will be consistent with Trimethoprim overdose. (Annexure K)

Dr. LJ Mostert further explained that the Trimethoprim drug interaction with other drugs can cause or be associated with severe life-threatening hyperglycemic incidents if taken at high levels. This drug is usually used as an antibiotic and is a combination of Trimethoprim and Sulfamethoxazole. Trimethoprim is just one component of this drug. At this stage, the Trimethoprim drug is confirmed as the cause of death of Ms. Z Vena. “The post-mortem examination did not find any other dramatic cause of death on the body of Ms. Z Vena.”

Dr. LJ Mostert also explained that there were other examinations conducted for Toxicology including alcohol, as well as DNA analysis as part of the sexual assault evidence collection; the results for these tests are still pending. A request for the toxicology results was made to Lieutenant Colonel JG Paxton on 03 April 2023 but no response has been received yet.

A literature review of the Co-Trimoxazole (Trimethoprim-Sulfamethoxazole) medication established that it can cause the following side effects: increased thirst, dry mouth, fruity breath odor, new or worsening cough, fever, trouble breathing, high blood potassium, nausea, weakness, tingly feeling, chest pain, irregular heartbeat, loss of movement, low blood sodium, headache, confusion, problem with thinking or memory, weakness, feeling unsteady, amongst others.

Co-trimoxazole, a fixed-dose combination of two antimicrobial drugs (sulfamethoxazole and trimethoprim), is used to treat a variety of bacterial, fungal, and protozoan infections. In South Africa, in accordance with the 2014 amended World Health Organization (WHO) guidelines, it is used as prophylaxis to prevent the occurrence of opportunistic infections, particularly in Human Immunodeficiency Virus (HIV)-infected individuals in adults, adolescents, and children. (WHO, 2014).

In South Africa, Post-Exposure Prophylaxis (PEP) is given within 72 hours of being exposed to possible HIV. For the victims of sexual assault PEP is critical, to prevent infection with HIV from the perpetrator/s.

Ms. Z Vena gave a history that she was sexually assaulted and the possibility of being exposed to HIV was high. The Motherwell NU 11 Clinic should have given PEP as prophylaxis for potential exposure to HIV. The evidence given by Ms. S Ntantiso indicates that nothing was done or provided to Ms. Z Vena at Motherwell NU 11 Clinic.

Dr. LJ Mostert in the post-mortem report indicated that there was a white substance that was reminiscent of dissolved tablets in Ms. Z Vena's stomach, and there is a possibility that some sort of tablets could have been ingested before her death.

The question as to why Ms. Z Vena had high doses of co-trimoxazole in her stomach remained unanswered because, during interviews with Ms. N Vena, she stated that she was not aware of any treatment Ms. Z Vena was taking at that time nor was Ms. Z Vena on any chronic medication at the time of her death.

The Toxicology Report dated 23 February 2023 found a foreign substance "Trimethoprim" in Ms. Z Vena's body as follows:

- 4960 mg/l in the stomach contents;
- 7 mg/l in the blood;
- 3 mg/l in the eye fluid; and
- 48 mg/l in the bile.

The Toxicology Report also shows that the concentration of alcohol in the blood specimen was 0.00 grams per 100 millilitres, whereas the concentration of sodium fluoride in the blood specimen was 1.7 grams per 100 millilitres. (Annexure L)

Sergeant Vuyokazi Mbongo (Sgt. V Mbongo) was interviewed on 02 March 2023 at Motherwell Police Station Community Service Centre and re-interviewed on 19 May 2023 at NMBDH Offices

Sgt. V Mbongo submitted that on the day of the incident on 21 September 2022, she was stationed at MPS CSC as a Community Service Centre Commander. She also indicated that she wrote a statement which was submitted to the Investigating Officer, Sgt. B Gwili, to give an account of what transpired on the day of the incident (Annexure M). Sgt. V Mbongo indicated that she was working at the reception at the charge office, when "a lady was supported by two females on both sides was brought to the charge office". Sgt. V Mbongo said during a re-interview on 19 May 2023 that "she did not do anything to help Ms. Z Vena by either registering her complaint or giving her first aid because she is not trained to use the First Aid Kit. All she did was call for an ambulance". Sgt. V Mbongo said in the charge office the lady was put on the floor. Sgt. V Mbongo then asked for the name of the lady and Ms. S Ntantiso told her that it was Ms. Z Vena.

Sgt. V Mbongo said she tried to call the ambulance but she couldn't go through because they were on strike. She also called the EMS Control room for assistance at 08:45 and the ambulance arrived at 09:38. The ambulance was called on the 10177 number. The Motherwell SAPS CSC radio control was also used to call the ambulance on 10111. No telephone records were provided to support this submission. The telephone records provided belonged to other police officers and not Sgt. V Mbongo. (Annexure N)

According to Sgt. V Mbongo's observations, Ms. Z Vena could not walk, had fits, was crying and had white foam on her mouth. Sgt. V Mbongo confirmed that Ms. Z Vena was laying on the floor with her head facing down. Sgt. V Mbongo said she started taking a statement from Ms. S Ntantiso and that is when she became aware that Ms. Z Vena had been sexually assaulted. During a re-interview on 19 May 2023, Sgt. Mbongo said that she opened a case (Inquest into death) after Ms. Z Vena was certified dead by the ambulance crew.

When asked whether she had First Aid (FA) experience, Sgt. V Mbongo indicated that she did not have FA experience but there is an FA kit in the charge office. Sgt. Mbongo said it was 09:30 when she noticed that Ms. Z Vena was no longer crying; she went to check on her and realised that Ms. Z Vena had passed on.

Sgt. V Mbongo said she asked Warrant Officer George Arthur Baker (WO. GA Baker) to call Lieutenant Colonel Jesvin Arends (Lt. Col. J Arends) to the charge office. Upon the arrival of Lt. Col. J Arends at the charge office, the area was cordoned off as a crime scene. The ambulance (EMS) arrived at 09:36 and certified Ms. Z Vena dead.

In response to a question about the assistance provided to sexual assault/rape victims, Sgt. V Mbongo indicated that rape victims are interviewed in a specific room by the Victim Support Centre (VSC) personnel if the rape victim is a minor. In the event of an adult victim, a normal case is opened and information regarding the case is obtained. Copies of the docket are made, and the victim is taken to Dora Nginza Hospital and thereafter to the Rape Crisis Centre (RCC).

During her re-interview, Sgt. V Mbongo said that she was not aware that Ms. Z Vena was raped. If she had known, she would have opened a case and handled it according to the guidelines on the management of rape victims by referring Ms. Z Vena and Ms. S Ntantiso to the Victim Support Centre. Sgt. V Mbongo said in the event of rape, the victim must start at the Police Station. If the victim is at the clinic already, the nurses must contact the Police as they are not supposed to attend to the victim until the police arrive.

Lieutenant Colonel Jesvin Arends (Lt. Col. J Arends) was interviewed on 02 March 2023 at Motherwell Police Station Community Service Centre and re-interviewed on 19 May 2023 at NMBDH Offices

Lt. Col. J Arends submitted that on 21 September 2022 he was working the day shift as a relief commander. His responsibilities were to supervise the activities of the members inside, outside, and in the holding cells. When reporting for duty, it is his responsibility to inform members where they are going to work. On the day of the incident, there were two members deployed in the charge office, i.e. Sgt. V Mbongo deployed as CSC Commander as well as floor manager. The other member, Ms. Thando Nhleni was deployed as a data typist responsible for registering complaints.

Lt. Col. J Arends said he was attending a Crime Combatting meeting which was chaired by Brigadier L Ngalo, the Station Commander when WO. GA Barker came into the meeting to inform Brigadier L Ngalo that “someone has passed on at the charge office”. Brigadier L Ngalo asked Lt. Col. J Arends to “go and find out what exactly happened”. He could not remember what time it was when WO. GA Baker came to their meeting but confirmed that the meeting started at 08:30 and had just started.

On arrival at the charge office, Lt. Col. J Arends found a person laying on the floor, on her stomach with the head facing down. There was white foam coming out of her mouth. Sgt. V Mbongo briefed Lt. Col. J Arends about what had happened. Sgt. V Mbongo informed Lt. Col. J Arends that the ambulance had already been activated. According to Lt. Col. J Arends, the ambulance did not take too long to arrive but he assumed that the person had already passed on because she was not moving. Sgt. V Mbongo also informed Lt. Col. J Arends that the lady was a student at Woolhope Senior Secondary School (WSSS) in Grade 9.

Lt. Col. J Arends confirmed that MPS CSC has a FA kit for the victims of crime but no one within the MPS CSC has been trained on the provision of first aid. However, the MPS CSC has a Safety Representative. Lt. Col. J Arends also said that the police have not been trained on how to treat people in need emergency care.

Lt. Col. J Arends also indicated that when victims of sexual assault come to the station, they will be referred to the special room and obtain information regarding what happened. Thereafter the sexual assault victim is referred to Thuthuzela Care Centre to open a file.

Lt. Col. J Arends also said that the incident was reported to the Station Commander to explain what happened. A copy of the incident report with Serial No. 1322 dated 21 September 2022 at 11:30 was provided to the Ombud. (Annexure O)

Warrant Officer George Arthur Baker (WO. GA Baker) was interviewed on 02 March 2023 at Motherwell Police Station Community Service Centre

WO. GA Baker said he was working at the Supply Chain Management section of MPS CSC under Brigadier L Ngalo. He mentioned that his duties are to ensure that the property of MPS CSC is in place and accounted for.

On the day of the incident, WO. GA Baker said he was working on his normal office duty and he went to the charge office to inspect the firearms in the safe. He said as he approached the charge office, Sgt. V Mbongo informed him that somebody had passed on at the charge office. WO. GA Baker said he was asked by Sgt. V Mbongo to call Lt. Col. J Arends attending a meeting with Brigadier L Ngalo.

According to WO. GA Baker's observation, the body was laying down on its stomach next to the bench in the charge office, with the head facing down. WO. GA Baker also confirmed that Lt. Col. J Arends arrived immediately at the scene in the charge office.

Ms. Nomathemba Patricia Qabaka (Ms. NP Qabaka) was interviewed on 03 March 2023 at Motherwell NU 11 Clinic

Ms. NP Qabaka is a Sub-District A Coordinator at NMBDH. Her qualifications are General Nursing, midwifery, Nursing Administration, and APC. She confirmed that she had attended an APC training online. The training covered the following modules: TB, sexual assault and primary health care. However, neither she nor other nurses have been trained in Forensic Nursing.

Ms. NP Qabaka said she is responsible for coordinating and conducting sub-district meetings, facilitating management of leave, arranging sub-district forums, and supporting the District management with the improvement of their indicators.

Ms. NP Qabaka said she has been in the position for six months having started on 13 August 2022. Ms. NP Qabaka supervises 17 clinics and supports them when there are challenges with staff complement. Since she was appointed she has not been able to supervise the clinics physically. She does the supervision telephonically and uses her personal phone as she does not have an official phone, and uses her own vehicle. There is only one vehicle in the sub-district to 'do everything for all the facilities.'

When asked how the nurses are supposed to assist sexual assault/rape victims, she said "The nurses are supposed to assess the status of the patient, to check whether the patient has scars or not. They take a history of the patient and assess whether the patient is emotionally disturbed. If patients need an emergency referral to a doctor, the nurses are supposed to check for HTC for patients and give the emergency morning-after pill. They are also expected to explain the procedure to the rape victim to assist them to open a case. The police will take the patient to Thuthuzela Care Centre and the nurses report the case to the sub-district."

Ms. NP Qabaka confirmed that both Sr. Z Ndongeni and Sr. NJ Ntlanjeni were trained on APC which was conducted online and knew what they were supposed to do but did not do what they were supposed to do. No proof of APC training attended by either Sr. Z Ndongeni or Sr. NJ Ntlanjeni was provided.

Ms. NP Qabaka mentioned the following shortcomings of her position:

- Physical visit of the facilities;
- Transport (there is only one car in the district);
- The Sub-District A Coordinator is the only one responsible for 17 clinics;
- There is no cell phone to perform the facility functions (the Departmental cell phone has not been working since October 2022);
- Infrastructural limitations of the clinics;
- Security (there is no night security, only day security and none on weekends) ;
- The Acting Facility Manager has been acting since 23 September 2022. The post is not vacant and the current incumbent is not paid an acting allowance;
- There were two Data capturers before the incident but currently there is only one. The other Data capturer left due to safety reasons during the community protest;
- On normal days, there are seven nurses on the floor and come to work every day. If one is going on leave, the number reduces;
- There is no Midwifery Nurse at Motherwell NU 11 Clinic; and
- There is only one Facility Manager at the clinic with Primary Health Care training whose contract is coming to an end on 30 March 2023.

Sister Nomakhaya Janet Ntlanjeni (Sr. NJ Ntlanjeni) was interviewed on 27 March 2023 via TEAMS meeting

Sr. NJ Ntlanjeni has been the Operational Manager at Motherwell NU 11 Clinic since October 2016. She acted as Operational Manager at Motherwell NU 11 Clinic between December 2012 and November 2016.

Sr. NJ Ntlanjeni's responsibilities include Human Resources Management, staff allocation and rotation, data management, and submission of monthly reports.

During the interview, Sr. NJ Ntlanjeni indicated that on the day of the incident 21 September 2022, she arrived at Motherwell NU 11 Clinic at 7:15. She said while still in the car, she was informed by one of the Security Officers, Mr. Z Mati about the patient raped and escorted by an elderly lady.

Sr. NJ Ntlanjeni said she and Sr. Z Ndongeni attended to the patient in consultation room 2. The patient and the elderly lady introduced themselves as Ms. Z Vena and Ms. S Ntantiso respectively. Sr. NJ Ntlanjeni said after Ms. Z Vena explained what had happened, she explained to Ms. Z Vena and Ms. S Ntantiso that 'the nurses do not touch rape victims to avoid tampering with evidence' and instructed them to go to MPS CSC to open a rape case. Sr. NJ Ntlanjeni also indicated that it was Sr. Z Ndongeni asked Ms. Z Vena if she had washed.

When asked what she meant when she said 'the nurses do not touch the rape victims to avoid tampering with evidence', she responded by saying that she meant the "examination on the private parts of the patient for discharge and visible bleeding" and confirmed that this was not done.

Sr. NJ Ntlanjeni also said she took Ms. Z Vena's vital data and recorded them in her personal diary because the Clerk, Ms. Sandiswa Dyantyi had not yet arrived at the clinic (**Annexure P**). She had intended to make a late entry in the brown file as she was saving stationery since the clinic had a shortage of pink and blue files. (A copy of the brown file was never provided).

Sr. NJ Ntlanjeni further indicated that after taking history, Ms. Z Vena was stable clinically, hence she referred her to MPS CSC where she would be taken to DNTCC.

She confirmed that Motherwell NU 11 Clinic does not have an SOP or Policy dealing with the management of sexual assault victims. She further indicated that when a sexual assault patient presents at the clinic, the patient has to go to the Police Station. The clinic uses sessional doctors but the nurses refer the patients to MCHC or DNTCC where doctors are available. In this case, no transport arrangements were made to refer Ms. Z Vena to MCHC or Dora Nginza Hospital because "Ms. Z Vena did not indicate that she needed transport."

Sr. NJ Ntlanjeni further explained that the NMBDH arranged an APC workshop on sexual assault which was conducted online over two days, after the incident. (She could not remember the date of the workshop). She indicated that she did not attend the workshop as she was on sick leave.

Ms. Ziyanda Sidzumo (Ms. Z Sidzumo) was interviewed on 15 May 2023 at NMBDH Offices

Ms. Z Sidzumo is Ms. Nomathamsanqa Vena's (Ms. Z Vena's mother) friend. She has not known Ms. Z Vena for a long time. She is a hairdresser and Ms. Z Vena's mother used to take Ms. Z Vena to her for a hairdo and that is how she knew Ms. Z Vena. It has been almost two years since she knew Ms. Z Vena.

She said she went to her house (shack) with her older child at 7:00 to fetch her younger child's school clothes. She was wearing a hoodie because it was cold that morning. She saw a young lady coming from another street close to her shack, crying. She did not see the young lady's face but her older child realised that it was Ms. Z Vena, she stopped and asked Ms. Z Vena what had happened. Ms. Z Vena told her that she was coming from another shack where the boys had locked her up and raped her. She told Ms. Z Vena to go straight to her mother and that she would call Ms. Z Vena's mother because she was rushing to take her child to school. Ms. Z Vena mentioned four names of the boys who raped her but she only remembers one. She sent a text to Ms. Z Vena's mother on Facebook to inform her about the incident.

Ms. Z Sidzumo stated that two hours later, Ms. Z Vena's mother gave her a call to ask where she was and she told her that her daughter had passed away. At 13:00 Ms. Z Vena's mother came with the police to ask her to show them the shack where Ms. Z Vena was coming from and also give them the direction to the shack where Ms. Z Vena had been raped. The police found some of the suspects in that shack which was later destroyed by angry community members after the incident.

She said she knew Ms. Z Vena was a very sweet young lady always laughing and smiling. She said according to her knowledge, Ms. Z Vena was not taking drugs or drinking alcohol. She said she was surprised that Ms. Sinalo Makinana was Ms. Z Vena's friend because she was not attending school and taking drugs but she did not know the type of drugs she was smoking.

She said she knew Ms. Sinalo Makinana through her aunt is her neighbour. She said her neighbour always complained about Ms. Sinalo Makinana, whose mother passed away a long time ago. Her neighbour also told her about Ms. Z Vena's plan to lie about the school excursion that did not exist, so that she could go out with her friends.

Mr. Zakhiwo Velebayi (Mr. S Velebayi) was interviewed on 15 May 2023 at Nelson Mandela Bay District Health Offices

Mr. Z Velebayi is the Acting Operational Manager at Motherwell NU 11 Clinic after he volunteered to act on 21 October 2022 in the absence of Sr. NJ Ntlanjeni on sick leave. He served a notice to terminate his acting period on 01 May 2023.

Mr. Z Velebayi said on Wednesday 21 September 2022 he was not on duty but Sr NJ Ntlanjeni and Sr. Z Ndongeni were on duty, and Sr. NJ Ntlanjeni opened the clinic. Mr. Z Velebayi said he came back to work on Thursday, 22 September 2022, and saw police officers coming in and out of the Motherwell NU 11 Clinic. When he asked the receptionist what was going on, he was told they were looking for a register to see whether Ms. Z Vena was registered in the clinic register. Mr. Z Velebayi said he heard rumours about the rape story and that Sr. NJ Ntlanjeni referred her to the police station.

He said on Friday 23 September 2022 while they were busy working, they heard that the community forum was coming to take the staff out because they said Ms. Z Vena died at the nurses' hands. He said the two ladies from the community forum went to the clinic kitchen and demanded to see the Operations Manager and the latter said she did not want to see them. At around 10:30 he saw a mob chanting outside the clinic singing "We don't want to see police, we want Sr. NJ Ntlanjeni out, she is a killer". The staff was taken out and they all went to Motherwell Community Health Centre and all the staff reported at the NMBDH offices due to unsafe conditions at Motherwell NU 11 Clinic.

He said there are six (6) clinics in NMBDH and all the Motherwell NU 11 Clinic staff were distributed to other clinics, except for Sr. Z Ndongeni and Sr. Mkhendwana went to another clinic outside Motherwell Township, citing unsafe working conditions.

When asked about the protocol for rape victims that the Motherwell NU 11 Clinic follows, Mr. Z Velebayi indicated "he does not know any protocol, and according to his understanding, if a person comes to the clinic being raped, he will tell that person that it is a police matter". He confirmed that he and other nurses at Motherwell NU 11 Clinic don't do basic examinations to identify whether the rape victim is normal or abnormal. They just send the rape victim to the police and the police will send the rape victim to the doctor. He also confirmed that in this case the police were not called to inform them about the case. What he was told is that Sr. NJ Ntlanjeni instructed Ms. S Ntantiso and Ms. Z Vena to go to the police station without first calling and informing the police. The nurse's challenge is that they do not know what to do when faced with a rape victim, they just refer the patient to the police. Mr. Z Velebayi said that he does not know what the police do after the nurses have referred the rape victim to them.

Mr. Z Velebayi also said he heard the rumours that Ms. Z Vena was supposed to go on a school excursion (School Sports trip) but apparently the trip was canceled and she went to a place where she and her friends were smoking drugs. He could not confirm whether Ms. Z Vena also smoked drugs.

When asked what kind of support he has been getting from the district during his six months of acting, he said "After the incident, the District Manager, Ms. S Lupondwana promised to make sure that Motherwell NU11 Clinic staff get support and constantly visit the clinic with members of the Community Forum. The Supervisor and Ms. NP Qabaka have been visiting Motherwell NU 11 Clinic to check on the staff, even on WhatsApp."

Mr. Z Velebayi said after the incident on 21 September 2022, training was provided to staff in December 2022 and was attended by Sr. Ncwayi at Motherwell NU 11 Clinic. Sr. Ncwayi gave feedback to staff on the training she attended and informed staff that they must refer to page 77 of the APC manual when dealing with sexual assault incidents henceforth. Mr. Z Velebayi also said since the incident with Ms. Z Vena Motherwell NU 11 Clinic had another incident of rape and the victim was attended to by him. He said he attended to the patient by doing the following: "I checked the child and called Dora Nginza Thuthuzela Care Centre. I called the District Manager, Ms. S Lupondwana and she called the doctor to inform him about the case. The doctor then told me what to do, and I performed an observation and I called Dora Nginza Thuthuzela Care Centre. I checked blood pressure, temperature, and blood tests for HIV. I transported the rape patient in my own car to Dora Nginza Thuthuzela Care Centre. The rape patient was accompanied by a neighbour and uncle when transported to Dora Nginza Thuthuzela Care Centre". He stated that they did not open a file at the Clinic, the staff was using papers which is not proper filing. He said the files were out of stock but they do have them now, though they get finished very quickly.

Mr. Z Velebayi stated that the case of Ms. Z Vena was mishandled because the nurses should have at least called the doctor.

Mr. Z Velebayi indicated that one of the challenges experienced at Motherwell NU 11 Clinic is the infrastructure. The clinic is small and the community it serves is too big for the space at the clinic. The clinic has space where rooms can be built and a request was made for containers. In January 2023 during the presentation of the state of the clinic, five clinics were identified for urgent attention, and Motherwell NU 11 Clinic was among these clinics. Mr. Baartman applied for the land next to the clinic, and he was waiting for a response from the Municipality.

According to Mr. Z Velebayi, the health conditions in the province have deteriorated, the staff morale is down and no one wants to work in this province. There is no support from the Provincial Department of Health. According to Mr. Z Velebayi, the Department of Health in the Eastern Cape is "very dysfunctional and everyone wishes to go to work in Cape Town". There are still a lot of cases of malnutrition in the Eastern Cape.

Ms. Sinalo Makinana (Ms. S Makinana) was interviewed on 16 May 2023 at NMBDH Offices

Ms. S Makinana said she is a Grade 10 learner at Mncedo High School. She knew Ms. Z Vena through a mutual friend. They have been friends for about four to five months. She said Ms. Z Vena used to visit her friend Lihle after school and that is how they met each other.

She said their boyfriends smoke a white-like salt drug, in the township they call it "Tik". The drug keeps them awake at night and they cannot sleep after smoking. She said she last met with Ms. Z Vena at Motherwell NU 29 at her father's house where she used to stay but came back to visit. At 20:00 before going home, Ms. S Makinana received a text message on Facebook from Mr. Sibabalwa Magalela (Mr. S Magalela) whom she was dating, telling her that "I am going to commit suicide because of you". She told Ms. Z Vena that Mr. S Magalela used to do this (threatening to kill himself) and she was not going to give him the attention he wanted. Ms. Z Vena begged her to go and see what was going on. When they arrived at 'Mjondolo' (the name of the section where Mr. S Magalela was staying), they knocked on the door but no one opened. Ms. S Makinana said she kicked the door open and found Mr. S Magalela with his friend Mr. Liyabona Rooi (Mr. L Rooi). Mr. L Rooi was sitting on the couch and Mr. S Magalela was sleeping on the bed. She tried to wake him up and found a plastic bag full of tablets that looked like panado with different colors, some of which he drank. When Ms. S Makinana asked Mr. L Rooi how Mr. S Magalela drank overdose pills without reprimanding him, he said he did not see him. There were three people in the shack, i.e. Mr. S Magalela; Mr. L Rooi, and Mr. Luxolo Tatase (Mr. L Tatase) and they tried to wake Mr. S Magalela up but he could not wake up, instead he was vomiting and foaming in the mouth, but he was eventually fine. When Ms. S Makinana asked him why he was doing that, he started beating her.

Mr. L Tatase wanted to leave the shack to go home and Mr. L Rooi and Ms. Z Vena accompanied him. It was at 5:00 when Ms. Z Vena went to Mr. L Tatase's home and came back at 6:00 after she was raped. When asked how she knew Mr. L Tatase raped Ms. Z Vena, Ms. S Makinana said: "Zeni came to me and told me that Luxolo forced her to sleep with him and beat her". Ms. S Makinana asked Mr. L Rooi what happened and the latter told her that: "Zeni and I agreed to have sexual intercourse but Zeni never agreed to sleep with Luxolo".

Ms. S Makinana said she was not aware that Ms. Z Vena took any pills. She said Ms. Z Vena told her about the rape and ran out of the shack. Mr. L Tatase sent her (Ms. S Makinana) a message on Facebook saying "I wanted to sleep with you and not Ms. Z Vena". She described Ms. Z Vena as someone who did not use drugs.

Ms. S Makinana said when Ms. Z Vena came to her shack the following morning after the rape, she had marks on her neck, her jeans were not zipped and was carrying her jacket in her hand. She said Ms. Z Vena had been gone for about an hour after she, Mr. L Tatase and Mr. L Rooi left her and Mr. S Magalela in the shack. She confirmed the nicknames of the three suspects as follows: Mr. L Tatase is called "Deep", Mr. L Rooi is called "Taliana" and Mr. S Magalela is called "T-man".

Ms. S Makinana said that she does not smoke but drinks alcohol only on long weekends with her friends Luthando, Lihle (19 years old), and Ms. Z Vena. She said she felt heartbroken about Ms. Z Vena's death because "Zeni was a good friend". She confirmed that Ms. Z Vena told her that she was previously raped when she was 11 years old but she did not tell her who raped her. She said Ms. Z Vena told her mother about the rape then but she did not believe her. She mentioned that Ms. Z Vena told her that her relationship with her stepfather was not good and her mother chose her stepfather over her.

She denied having sent Ms. Z Vena a message informing her that her mother had passed away. She said Ms. Z Vena knew that her mother passed away a long time ago because they often talk about those things when they are together.

Dr. Lambert Jacobus Mostert (Dr. LJ Mostert), was re-interviewed on 16 May 2023 at NMBDH Offices

During the re-interview, Dr. LJ Mostert confirmed that he conducted a post-mortem on this case. During the examination of the body, there were no genital injuries that Ms. Z Vena had but she had abrasions on her toes and abrasions on the back of one thigh. However, this does not mean she was not raped. If someone already had sexual intercourse before, one might not see any genital injuries, especially if the victim was intoxicated. He said even if he did not see any trauma that points to rape, it does not exclude rape.

Dr. LJ Mostert said that based on the evidence that he obtained, he cannot confirm or exclude the rape. If there was lots of trauma he could say conclusively that there was rape, but it's not always possible to see trauma. He disputed the evidence of one witness mentioning that Ms. Z Vena had marks on the neck. According to Dr. LJ Mostert's observation, there were no marks on the neck of Ms. Z Vena, "he can remember pretty well".

Dr. LJ Mostert indicated that he conducted a DNA kit on the same day he did the autopsy. He said he arrived at the mortuary in the morning and the investigating officer, Sgt. B Gwili arrived early and explained the case to him. He said Sgt. B Gwili gave him a rape kit and he did the case immediately in the morning. He said the report of the DNA kit is normally given to the police. He was not sure how long it takes for the results to come out but they follow up on the results.

Dr. LJ Mostert said he did not find much in this case. Ms. Z Vena did not have major injuries, no internal injuries like brain injuries or something that could have killed her. He said Ms. Z Vena had very small injuries (abrasions) that she had. In the stomach, there was a white substance that looked like tablets. The Toxicology Report showed "Trimethoprim drug" is for HIV positive people. Ms. Z Vena took lots of Trimethoprim drug tablets. It is not common for the Trimethoprim drug to kill a person, the possibility is very rare. In this case, we found Trimethoprim tablets in the stomach and there was drowsiness and vomiting that might be the cause of death. Dr. LJ Mostert is of the opinion that Trimethoprim drug overdose could be the primary cause of death. The Supplementary Report on a Medico-Legal post-mortem examination (Supplementary Report) dated 16 May 2023 was provided to the Ombud. It is stated on the Toxicology Report that, "This case is concluded after review of outstanding Toxicology and Blood Alcohol results. The Toxicology results for specimen TO263353 show the following results:

	Trimethoprim
Stomach contents	4960mg/l
Blood	7mg/l
Eye fluid	3mg/l
Bile	48mg/l

Blood Alcohol concentration: PMK0027177: 0 mg/dl

The Supplementary Report also concluded that “after review of the outstanding results, the cause of death was determined to be: Consistent with Trimethoprim overdose, (unnatural)” (**Annexure Q**).

According to Dr. LJ Mostert’s observation, the drugs were orally ingested. The level of drug content in the bile fluid was high. Also, the level of drug content in the stomach and blood was found to be high. The highest level was found in the stomach. Dr. LJ Mostert said because Ms. Z Vena had no big injuries, it is possible that she could have appeared normal at Motherwell NU 11 Clinic, but she was under great emotional stress based on his experience.

Ms. Sonia Lupondwana (Ms. S Lupondwana), the District Manager at Nelson Mandela Bay District Health, was interviewed on 16 May 2023 at NMBDH Offices

Ms. S Lupondwana said she was not briefed about this matter because she did not get a handover report from the previous District Manager. When asked about her view on what happened at Motherwell NU 11 Clinic, she said the two nurses must face disciplinary charges because they had a role to fulfill but they did not. There was also an issue of recording that was not done and there is a personal diary recording because if it is not recorded it is not done.

When asked whether the primary caregivers at the Motherwell NU 11 Clinic performed their duties according to her analysis, she said that the guidelines say assess patients and that is where training comes in because this person (the Facility Manager, Sr. NJ Ntlanjeni) was trained on knowledge hub. The understanding is that when you put people to train online, there must be a support system of mentorship in place. The nurses were placed in a knowledge hub but there were no knowledge systems that were put in place. The guideline gives you the option to go to Thuthuzela Rape Management Crisis Centre. I even called the police to enquire about it and I found that there is a victim-friendly room that is part of the Gender-based Coordination Structure. In Motherwell NU 11 Clinic, there had been two (2) cases of rape in 2019. It is only this case (involving Ms. Z Vena) and the other one that happened in December 2022.

When asked what healthcare workers assist people coming to Motherwell NU 11 Clinic presenting with a rape case, she said that there is Form 308 and there is Form J88 where if you were raped, you must give consent. There are gaps in the system because the clinic does not have doctors 8 hours a day, the doctors are only available on two days i.e. Mondays and Fridays in a week. My understanding is that if a child is raped, a healthcare worker should call the police to come to the clinic or should arrange an ambulance to take the child to the police station or to the Dora Nginza Thuthuzela Care Centre. According to Ms. S Lupondwana, the nurses failed to discharge their responsibilities.

When asked about what action taken against the nurses who denied Ms. Z Vena care. She indicated that Sr. NJ Ntlanjeni has been on sick leave since 23 September 2022, and the basic procedure is that you cannot institute disciplinary action against the person who was off sick. No action was taken against the other nurse, Sr. Z Ndongeni because they did not know what to charge her with because she was not involved in the care of Ms. Z Vena. Ms. S Lupondwana said she is still waiting for direction from the ECPDoH regarding whether to charge Sr. Z Ndongeni and if so, with what charge.

When asked what the NMBDH has done since Ms. Z Vena’s incident. She said that when she came in October 2022, she facilitated the investigation, opened the clinic, and visited the family of Ms. Z Vena. A redress meeting was also held with the family, including Ms. Z Vena’s mother, with the assistance of the wellness team. The family was also offered counseling.

Mr. Ashwell Botha (Mr. A. Botha), Operations Manager: Emergency Medical Services (EMS), was interviewed on 16 May 2023 at NMBDH Offices

Mr. A. Botha indicated that he is a Deputy Sub-District Manager for EMS in NMBDH and is reporting to the District Manager for EMS in the District.

Mr. A. Botha said he was not actually physically involved with the case as a manager. In preparation for the meeting with the Ombud, he had to go back and review the paperwork to make himself aware of the circumstances. He also prepared a Report with the subject “Enquiry into unnatural death- SAPS Motherwell”, dated 12 May 2023, and handed it over to the Ombud (**Annexure R**).

He said EMS is currently overwhelmed with the volume of calls that come through the EMS Call Centre. To curb the bottleneck of the problem, they advise the public community to call the 10111 Police Call Centre number, if they cannot go through the EMS. They also placed an ambulance person inside the SAPS 10111 Call Centre and any call directed to the EMS via the Police 10111, will be directed to the EMS in that domain.

There is no information regarding the time the call was logged but the first time of ambulance dispatch was recorded as 08:30. The information given to EMS was, “a person with query convalescence, the patient is a known epileptic”. When the EMS received the call, we regarded the convalescence as a medical emergency that we tried to put as a priority. The first vehicle that was available was activated at 09:11 and the vehicle arrived at the scene at 09:38. According to the ambulance records, when they arrived at the scene, the patient was lying face down. The ambulance crew assessed the patient but there was no pulse, breathing, and no audible heart sounds. Based on their observation they came to the conclusion that the patient has passed on. The crew prepared the necessary documentation and the patient was declared dead at 09:45. The case was then taken over by Sgt. V Mbongo.

Mr. A. Botha said he had no idea who logged the call. When asked how many ambulances are there in the District, he said that the District is short in terms of ambulances. On the day of the incident, there were 13 ambulances that were running NMBDH, two (2) rescue vehicles, six (6) patient transport buses, and (8) response vehicles.

Regarding the delayed response time to emergency services, Mr. A. Botha responded by saying that their response time is not exactly where they want it to be. He said they have a reporting tool that assesses their service, but based on a low number of ambulances, they cannot get all the cases within 15 minutes but they reach 90% of the emergency cases within 30 minutes. Their response time to emergency services within 15 minutes is 50%.

When asked why it took the EMS crew 1 hour and 6 minutes to arrive at the scene after they received the call, Mr. A Botha said that this was priority 3 and resource constraints played a big role in terms of their response time. He said that they are currently understaffed in terms of personnel. He said the EMS also functions as a patient transfer system but there is no partnership agreement with the private sector, they can access the Provincial Offices to inform them about the patient who has been waiting for a long time and then contact the private service.

When asked how his department will be able to function in the future, he said they are basing their operations on the World Health Organisation (WHO) guideline which provides that for ambulances to function efficiently, there must be 1 available ambulance for 10 000 citizens. The NMBDH has a population of 1.2 million currently and according to WHO guidelines, we are supposed to run 120 ambulances in 12-hour shifts, compared to 13 that are available.

When asked how they transport patients who had to go to other provinces, he said there are lots of surgeries that have to be done in the Western Cape. The bulk of them are walk-in cases, either sent home while awaiting appointment dates. Those ones are brought to the hospital the night before and then we ask the patient transport bus to take them to Cape Town by road on a 12-hour trip.

Mr. A Botha confirmed that the Call Centre does not have a recording when calls are coming in and there is an outcry from the health facilities that they cannot get through to the Call Centre. In order to overcome that, they currently have a WhatsApp Group number where a call can be logged on WhatsApp as a message. The EMS does not have its own SOP, they use the Provincial SOP.

According to Mr. A. Botha’s own opinion, if the Ambulance crew could have arrived at the scene in 10-15 minutes, the patient could have been saved subject to intervention.

Dr. Pumla Mhlaba (Dr. P Mhlaba), Manager for Casualty at Dora Nginza Thuthuzela Care Centre, was interviewed on 17 May 2023 at NMBDH Offices

Dr. P Mhlaba said that she is a medical practitioner and has completed a Clinical Forensic Post-Graduate Diploma. She has been practicing as a medical practitioner since 1998 after she qualified. She obtained her qualifications from Medunsa and she was an Intern in 1999 and did Comserve in 2000. She said she started working as a Junior Medical Officer at Dora Nginza Casualty Department (DNTCC).

She said she had no knowledge of the case, she only heard rumors or hearsay because the case never came to DNTCC. When asked regarding what should have happened in this case, she said DNTCC is a specialised unit because they examine the evidence collected either by the forensic nurse or the doctor, which is different from how the clinic works. They manage sexual assault cases through the National protocol which only applies to DNTCC because they do not have the Provincial protocol. A copy of the National protocol referred to was not provided to the Ombud despite undertaking from Dr. P Mhlaba.

In response to how DNTCC manage sexual assault cases, she responded that: "We normally have workshops that we refer to as Protocol Development Workshops which have different stakeholders". They also have a specialised unit that falls under SAPS, they also have the Family Violence, Child Protection and Sexual Offences Unit (FCS), which is a family unit responsible for violence, children protection, and sexual offense protection. With rape cases, there are people who are aware that a case needs to be opened, but others do not know. Some victims will go to the clinic whereas others will go to DNTCC because we do have walk-ins as well as those that are brought in by the police.

She also said that as a multi-disciplinary team including the Department of Health, there is a Rape Crisis Committee that provides counsellors, to assist rape victims who walk in. The counsellors receive and do crisis containment and give information on the package service we provide before being seen by a health professional. She said DNTCC deals with more or less 100 cases of rape a month. Apart from rape cases, they also deal with cases of abnormal discharge or any suspicion that a mother might have. If there is a history of rape, they do the examination.

She said when the victim comes with the police, the police will normally have a docket because the first person to contact is the police official. The police will receive the docket and the client because the client has to provide consent for examination to the police official. The client will go to the counselor and nurse to take a history, do the vitals, get HIV consent, and explain to the client. The client will go to the forensic nurse or to the doctor for further history taking, physical examination, collection of specimen, completion of J88 document, and when all that is done, the documents will be sent back to the Investigating Officer at SAPS.

She further said when the rape victim is referred from the clinic, she/he is supposed to come with the referral letter of history of the service they provided. The referrals differ from person to person depending. Some come with the vitals and others do not. When referring patients, the clinic uses Memos or referral forms. All the clinics in Port Elizabeth refer patients to them. The clinic was trained before COVID-19 by Dr. Moodle on how to refer patients to DNTCC.

Dr. Litha Matiwane (Dr. L Matiwane) Deputy Director-General in the Eastern Cape Cape Department of Health, was interviewed on 17 May 2023 at NMBDH Offices

Dr. L Matiwane said that the incident that happened at Motherwell NU11 Clinic was a sad story to the ECPDoH and the Department did not know about it until they received a report from the NMBDH. The report was from Ms. Bulelwa Ngada in which it was stated that a 15-year-old patient visited Motherwell NU 11 Clinic before the Clinic opened. The reports also stated that the patient was seen by the nurses but there was no formal recording that the patient was seen.

Dr. L Matiwane said the investigation was conducted to look into what happened at the Clinic because it was expected that the Clinic should assist the patient and it was found that there was negligence in terms of how the patient was managed. The two nurses were supposed to have at least opened a file to record history and vitals, but they did not prioritise the case as an emergency. Dr. L Matiwane also said that the investigation found that there was no recording of history and vitals and the patient was not treated as an emergency case. Based on the findings, it was recommended that disciplinary action should be instituted against the two nurses, but none of the nurses went through the disciplinary process. One of the nurses, Sr. NJ Ntlanjeni has been on sick leave since 23 September 2022.

Dr. L Matiwane also said that the NMBDH has a protocol for the management of sexual assault cases called the Post-Exposure Prophylaxis (PEP) Guideline, which was published in October 2021 (**Annexure S**). There is also the directorate within the province dealing with Gender-Based Violence. He also said ECPDoH has a good relationship with Thuthuzela Care Centre.

Dr. Rolene Wagner (Dr. R Wagner), Head of Department: Eastern Cape Department of Health, was interviewed on 17 May 2023 at NMBDH Offices

Dr. R Wagner indicated that she became aware of the case when the Community shut down Motherwell NU 11 Clinic. When she enquired she was informed that it was due to a 15-year-old girl allegedly gang raped and the Community found that the clinic staff was uncaring by sending her to the police station where she subsequently died. She said she made the first contact with the District Manager, Ms. S Lupondwana, to find out what happened and to check whether the staff was safe. She deployed a Quality Assurance team to support and investigate the matter. Mrs. Ngada went to the District to support the Quality Assurance initiating the process. There were two things happening, one was the issue of instability with the community shutting down the clinic which was followed by a series of engagements with the District Manager keeping in touch with the Provincial Office. A meeting with the family was also arranged and she was informed that there was going to be an investigation.

She said that the investigation was conducted and a preliminary report was issued which was followed by a final report. The report found a couple of issues and confirmed that when the patient arrived at the Clinic, there was already the first nurse, Sr. Ndongeni waiting in the car for Sr. Ntlanjeni to open the clinic. The nurse did not open a file whereas the recording in the clinic must be done in the file. The nurse wrote in her personal diary and the nurse also allegedly told the young lady with the old lady accompanying her to go to MPS CSC. The second issue was that there was no proper referral, and the victim was not provided with psychological and emotional support.

The District has a referral policy that says we must refer to either DNTCC or SAPS. They also found that the nurses do not have the rape kits but SAPS have. The mitigating factor which the nurses had was that they were trained in the management of rape victims. However there was no monitoring. Secondly, the clinic never had a sexual assault case in many years, but the general ethics should have informed them to act appropriately. The preliminary results identified some administrative challenges that the nurses were not professional. The final report issued on 19 October 2022 confirmed the allegations. The report recommended that the two nurses must be placed on precautionary suspension, they should go to a training program before being allowed back into the system. The training was conducted in October and November 2022, unfortunately, Sr. NJ Ntlanjeni had been on sick leave from the date of the incident. The other nurse was not suspended because the District Manager felt that the misconduct was against Sr. NJ Ntlanjeni. The documentary evidence indicates that the Gender-Based Violence Training was conducted on 30 November 2022 and Customer Care Programme was conducted on 01 December 2022. Both Sr. NJ Ntlanjeni and Sr. Z Ndongeni did not attend the two trainings (**Annexure T**).

She said she issued instructions to Mrs. Ngada to inform the District Manager, Ms. S Lupondwana to implement the disciplinary action with the expectation that they will follow the instructions. When she followed up, she was informed that Sr. NJ Ntlanjeni was still on sick leave. She requested labour relations for advice on what must happen and was advised to proceed with the second nurse.

Dr. R Wagner also said the meeting was held with the family and allowed them to ask the Forensic Pathologist questions to get closure and an apology was offered to the family. Another component was Quality Improvement. Training was provided in all of Nelson Mandela Bay on how to manage rape cases, staff attitude, and so on. On the Quality Improvement Plan, the referral policy needs to be updated to say patients must be referred to DNTCC or first assist the patient if not stable.

Dr. R Wagner also said that the family was provided with redress where they were allowed to ask questions in order to know what happened to Ms. Z Vena, and the Clinical Manager, Dr. Machi had an apology letter. It was recorded in that meeting that the family accepted the apology.

Dr. Nomakhosazana Meth (Dr. N Meth), Member of the Executive Council (MEC) of the ECPDoH was interviewed on 17 May 2023 at NMBDH Offices.

The MEC had an opportunity to meet with the Ombud to shed light on the incident that happened at Motherwell NU 11 Clinic. However, no evidence was obtained from the MEC.

Mrs. Tasmeen Ayoob (Mrs. T Ayoob), A School Registrar at Woolhope Senior Secondary School (WSSS), was interviewed on 18 May 2023 at NMBDH Offices

Mrs. T Ayoob said Ms. Z Vena was a learner at WSSS and was in Grade 9E. She enrolled at the school from Imbasa Primary School in Motherwell. She said she had been with Ms. Z Vena from the start when the teachers met with the parents of the learners to inform them about the school rules regarding the subjects, uniforms, school fees, etc. The parents were taken through orientation around the school to meet the teachers and leadership from the school. She has known Ms. Z Vena for two years. She said Ms. Z Vena used to go to her office when she was hungry, and when she was not feeling well. Mrs. T Ayoob believes that Ms. Z Vena was comfortable around her.

The first thing Ms. Z Vena said to her was that “she was raped”, that was in July or August 2022 when she told her about the rape and that she was raped by “her mother’s boyfriend” (stepfather). Mrs. T Ayoob said she informed Ms. Z Vena’s teacher and the school Principal called a meeting to discuss the matter. It was decided in that meeting that Social Services should be engaged in the matter due to the limited knowledge of the teachers in rape cases. When they could not get hold of Ms. Z Vena’s mother to attend the meeting, Ms. Z Vena’s paternal grandmother was invited to the meeting and she confirmed in the meeting that she knew about the allegations of rape by Ms. Z Vena’s stepfather but did not do anything to assist Ms. Z Vena. When Ms. Z Vena’s mother was eventually contacted, she denied the allegations because her boyfriend was not allowed to come into their house.

According to Mrs. T Ayoob’s observations, Ms. Z Vena was a troubled child who wanted some attention. Ms. Z Vena wanted to stay with her paternal grandmother but her mother did not approve of it because Ms. Z Vena’s grandmother had a soft spot for her whereas Ms. Z Vena’s mother was strict. She said Ms. Z Vena once told her that she was diagnosed with breast cancer and when she asked her the following Monday, she said she was cured of cancer and did not attend chemotherapy or radiation or take any medication. She said she realised then that Ms. Z Vena was lying to her and she did not believe her stories.

According to Mrs. T Ayoob, Ms. Z Vena did not drink or smoke because she never came to school drunk or having taken drugs. The school had a drug testing machine. The testing for drugs is done with the consent of the parents especially when the teachers see the child behaving differently. Ms. Z Vena was never tested for drugs because she did not act like someone using drugs, therefore, there was no need.

Mrs. T Ayoob mentioned that Ms. Z Vena also told her grandmother that she was going on the school excursion from Friday, 16 September 2022, and over the weekend. She packed her bag and asked for R200.00 from her grandmother but there was no school excursion.

Mrs. T Ayoob described Ms. Z Vena as warm, intelligent, and lovely. She was involved in various school activities. Mrs. T Ayoob said she last saw Ms. Z Vena at the school on Tuesday, 13 September 2022 and she was absent from school from Friday, 16 September 2022 until they heard about her death on Wednesday, 21 September 2022. Mrs. T Ayoob furnished the Ombud with a “learner absentees” document showing the dates on which Ms. Z Vena was absent from school (**Annexure U**).

Mrs. T Ayoob also said that Ms. Z Vena was not taking any chronic medication because the school was giving medication such as panado to the learners when they had headaches and she never gave Ms. Z Vena any medication.

Ms. Darlene de Vos (Ms. D de Vos), Chief Director: District Management, was interviewed on 18 May 2023 at NMBDH Offices.

Ms. D de Vos said that she received an email from Ms. NP Qabaka on 26 September 2022 informing her about what happened on 21 September 2022 at Motherwell NU 11 Clinic. Prior to receiving the email, Ms. D de Vos received a call from Sr. NJ Ntlanjeni informing her that the Community of Motherwell NU 11 was marching outside the Clinic and demanding to see the Operational Manager. The Operational Manager indicated that the march was precipitated by an incident that happened at the Clinic relating to the death of the patient seeking assistance at the Clinic and was instructed to go to the Motherwell SAPS CSC. The multi-disciplinary meeting consisting of Counsellors, District Management, Facility Management, Sub-District Management, and Clinic Committee members was convened.

In that meeting, the Operational Manager, Sr. NJ Ntlanjeni indicated that on 21 September 2022 when she arrived at Motherwell NU 11 Clinic at 07:10, she was approached by the Security Officer informing her that there was a child patient raped. The Operational Manager requested the Security Officer to open the Clinic gate and called the escort together with the patient to come into the Clinic for assistance. According to the Operational Manager, she took history and vitals and found the patient to be clinically stable according to her assessment.

Ms. D de Vos said that she enquired with Sr. NJ Ntlanjeni whether there was a file for the patient, and the answer was “No” and only a personal diary was used to record. She said during a consultation with Sr. NJ Ntlanjeni, she was extremely emotional and crying. Ms. D de Vos said she asked why Sr. NJ Ntlanjeni instructed the patient to go to the police station without assisting her, she answered by saying “There was nothing wrong with the patient, the patient was physically stable”. In a meeting on 23 September 2022, a resolution was taken that the Clinic would be opened the following Monday, 26 September 2022 and the Councillors would intervene in terms of Community engagement. It was also agreed that Sr. NJ Ntlanjeni would be removed from Motherwell NU 11 Clinic and report at Motherwell Community Health Centre for her own safety. Sr. NJ Ntlanjeni was since booked off-sick for emotional distress. On 29 September 2022, Ms. D de Vos instructed the Quality Assurance Manager to conduct a full investigation and prioritise Motherwell NU 11 Clinic.

Ms. D de Vos agreed that Sr. NJ Ntlanjeni provided sub-standard care to Ms. Z Vena and is of the view that the nurse should have called an ambulance or called the SAPS to fetch Ms. Z Vena. Sr. NJ Ntlanjeni does not need guidance because she is a trained professional knowing that a child is a priority, not only a child but any abused person. The District ensures that the nurses working in the Clinic go through the APC Guideline courses and Sr. NJ Ntlanjeni has attended the course. Ms. D de Vos also said that all the nurses working in the Clinics have the APC Manual as a guide on how to manage cases. Sexual assault cases are not a common phenomenon. Generally, the cases of rape would go to the police station rather than the Clinic. The Police will take them to the DNTCC. “The APC Guideline states that sexual assault cases are a priority and APC speaks about referring all those cases”. When asked whether there is a link between Thutuzela Care Centre and Motherwell NU 11 Clinic, she said “The clinic refers directly to Thutuzela Care Centre if the patient did not go to the police station. Also, the nurses should contact the SAPS when they suspect sexual abuse rather than leave the patient because it is the responsibility of the nurses to open a case.”

In response to the general belief amongst the healthcare workers at Motherwell NU 11 Clinic that “every rape case is treated as a police matter”, she responded by saying that “the belief comes from the fact that a rape case is a crime and the victims become evidence. However, it remains that the patient must first be assessed by a professional nurse, and a referral is made to the SAPS that there is a victim. If the victim is stable enough SAPS will fetch the victim and transfer him/her to Dora Nginza Thutuzela Care Centre”. The nurses should not have turned away the patient, they should have called SAPS and not sent the patient to the police station.

Ms. D de Vos also said that staff attitude contributed to the incident at Motherwell NU 11 Clinic because many patients at the Clinic indicated that they wait for long periods. The nurses seem to think that their personal issues are more important than clients’ issues.

Witness statements made to the MPS CSC (*Annexure V*).

Mr. Liyabona Rooi (Mr. L Rooi)

Declined to provide a statement in the absence of an attorney following the advice of his father.

Mr. Luxolo Tatase (Mr. L Tatase)

On 21 September 2022 at 00:20, two females (Ms. S Makinana and Ms. Z Vena) approached him and informed him that Mr. S Magalela had ingested pills and tried to kill himself. He accompanied them to Mr S Magalela’s shack where they were joined by Mr L Rooi and a friend (Ayema). They cooked some food and smoked dagga together. After this, Mr. S Magalela argued with and assaulted Ms. S Makinana.

Following this, Mr. L Rooi, Mr. L Tatase, Ayema, and Ms. Z Vena left together. Mr. L Tatase and Ayema went to smoke, while Mr. L Rooi and Ms. Z Vena went together to a separate shack where it was apparent that they had sex. After some time Ms. Z Vena left and went to Mr. S Magalela's shack where she took some pills, collected her clothes, and left. Mr. L Rooi, Mr. L Tatase, and Ayema also went to Mr. S Magalela's shack where Mr. L Rooi confirmed that he and Ms. Z Vena had consensual sexual intercourse. A while later, Ms. S Makinana informed them that Ms. Z Vena said she had been raped by Mr. L Rooi and Mr. L Tatase. Mr. L Tatase denied "doing anything to that lady".

Mr Sibabalwe Magalela (Mr S Magalela)

He was in his shack on 20 September 2022 with Mr. L Rooi. Ms. S Makinana and her friend Ms. Z Vena came to his shack at 22:00 with some meat, which they then cooked and ate. Following this, Mr. L Tatase, Mr. L Rooi, and Ms. Z Vena left together at 02:00. Approximately 2 hours later Ms. Z Vena returned to his shack and informed him that Mr. L Tatase and Mr. L Rooi had raped her. She took her clothing, and had some water, presumably with some pills - a container of which was found on the floor and left. When Mr. L Tatase and Mr. L Rooi returned to his shack, Mr. L Rooi confirmed that he and Ms. Z Vena had consensual sexual intercourse. Mr. L Tatase did not confirm that he spent time with Ms. Z Vena.

FINDINGS

Whether Ms. Z Vena was denied provision of care at Motherwell NU 11 Clinic

The allegation that Ms. Z Vena was denied the provision of care at Motherwell NU 11 Clinic was substantiated and confirmed.

Ms. S Ntantiso during interviews submitted that Sr. NJ Ntlanjeni never touched Ms. Z Vena. This meant that Sr. NJ Ntlanjeni did not do a holistic evaluation of Ms. Z Vena on admission as expected.

After failing to fully examine and take vital data observations of Ms. Z Vena, Sr. NJ Ntlanjeni referred both Ms. S Ntantiso and Ms. Z Vena to MPS CSC without considering calling an ambulance to transfer the patient to DNTCC, which caters for survivors of rape. Sr. NJ Ntlanjeni also failed to notify the police about Ms. Z Vena's rape.

The above finding was corroborated by the Head of Department (HoD), Dr. Rolene Wagner's (Dr. R Wagner) investigation report dated 14 November 2022, in which she stated that: "According to Ms. Ntantiso, the escort, neither vital signs nor clinical assessment was performed. This narration by Ms. Ntantiso is upheld due to the non-availability of clinic records to give an account of what was done for the victim at the clinic. Although Professional Nurse Ntlanjeni claimed to have done the patient's vitals, this information is written in her diary. The Facility Register is also devoid of such information. The investigation team did not accept the account given by Professional Nurse Ntlanjeni in her statement. According to information gathered during the investigation, the two professional nurses believed that the patient had to go to Thutuzela Centre in Dora Nginza Hospital via the Police Station; thus, the patient was directed as such.

The patient's social, psychological, and physical state were not considered. The escort and rape victim did not have money for the taxi fare. The only option they had was to walk to the police station, which was roughly two kilometers from the clinic".

Following these instructions, Ms. S Ntantiso indicated that she and Ms. Z Vena started walking to MPS CSC as they did not have money for transport. Along the way to MPS CSC, Ms. Z Vena collapsed, wet her pants, and started having seizures. A local taxi driver gave them a lift to the Police Station as Ms. Z Vena could no longer walk or talk. On arrival at the MPS CSC charge office, Ms. S Ntantiso said she reported the rape to the police officer (unknown) in the charge office. She also explained to the police officer that Ms. Z Vena and her have been to Motherwell NU 11 Clinic and the Sister in charge instructed them to come to MPS CSC, as they "do not touch the rape victims". The police officer told Ms. S Ntantiso that "rape victims are taken to the clinic". Ms. S Ntantiso pleaded with the police officer for help and the police officer told her "We will arrange transport to take the rape victim to the hospital".

It was correct for Sr. NJ Ntlanjeni and Sr. Z Ndongeni to determine if Ms. Z Vena had washed to establish if evidence was not tampered with, but as health professionals, they failed to examine Ms. Z Vena and take history to ensure that Ms. Z Vena was in a stable physical condition, but chose to refer her to MPS CSC.

While Sr. NJ Ntlanjeni, during the interview, indicated that the condition of Ms. Z Vena was stable clinically based on the vital data observations recorded, B/P 110/80, Pulse 70, and Temperature 36.5. Sr. NJ Ntlanjeni should have known better as a health professional to understand the emotional and psychological trauma that rape victims undergo. The vital data observations as indicated were not adequate to be used to determine the health condition of Ms. Z Vena at the time.

The vital data observations taken by Sr. NJ Ntlanjeni were written in a personal diary and not in the approved Patient Administration Record (PAR). A file was not opened for Ms. Z Vena, making it questionable as to the authenticity of the recordings. The excuse that the Administration Clerk providing patients with their files had not yet arrived, has no basis. This record is not admissible as a legal document and may have been completed post facto. As a health professional, Sr. NJ Ntlanjeni knows that patient clinical records are critical and need to be safeguarded.

Ms. S Ntantiso confirmed that no first aid assistance was offered to Ms. Z Vena. However, she was not certain whether the police officer called an ambulance because she went to call Ms. Z Vena's uncle who works at Spar Supermarket. When Ms. S Ntantiso came back to the charge office, she saw Ms. Z Vena laying on the floor and later died in the charge office.

Sr. NJ Ntlanjeni indicated that there was no need to arrange a doctor for an assessment on the same day, based on her own assessment that Ms. Z Vena "was stable and was able to walk and talk." Hence she referred her to MPS CSC, where she would be referred to Dora Nginza Thutuzela Care Centre.

It was found that Sr. NJ Ntlanjeni's referral of Ms. Z Vena to the MPS CSC by herself, was unprofessional and endangered the life of Ms. Z Vena.

At MPS CSC, Warrant Officer, George Arthur Barker (WO GA Barker) confirmed that on the day of the incident on 21 September 2022, he came to the charge office and saw somebody laying on her stomach with her face facing downwards. He went to call Lt. Col. J Arends, was in a meeting with the Station Commander. Lt. Col. J Arends left the meeting and immediately came to the charge office to attend to the crime scene.

Sgt. V Mbongo said on the day of the incident, 21 September 2022 she was deployed at the charge office as a Community Service Centre Commander. She saw a lady being carried by two females into the charge office. She said the lady couldn't walk, and she was crying and fitting in the charge office. The two females put the lady on the floor. Sgt. Mbongo said she asked for the name of the lady and was told it was Zenizole. She tried to call an ambulance but couldn't go through. She then asked for the address of Zenizole to give to the ambulance people when they arrived. She eventually took a statement from Ms. Ntantiso but the latter did not mention that Ms. Z Vena had been raped. According to Sgt. V Mbongo, Ms. Z Vena, and Ms. S Ntantiso arrived at MPS CSC at 8:00. When Sgt. V Mbongo asked WO. GA Barker to call Lt. Col. J Arends, it was 9:00 and the ambulance crew certified Ms. Z Vena dead at 9:36.

According to the APRF, the emergency call was received at 9:11 and the ambulance arrived at the scene at 9:38. Ms. Z Vena was declared dead at 9:45. However the date of the incident is recorded as 22 September 2022, whereas the incident occurred on 21 September 2022.

Sgt. V Mbongo said that she did not try to help Ms. Z Vena when she was laying down and fitting but confirmed that the police station has a First Aid Kit (FAK). She also said she does not remember being orientated about the use of FAK, nor does she know whether there is a Health and Safety Representative at the police station.

Sgt. V Mbongo also said she tried to call the ambulance but she could not go through because there was a strike going on. She also called the EMS Control room for assistance at 08:45. No telephone records were received from Sgt. V Mbongo to support this submission, despite a request and a reminder. The telephone records obtained belonged to other police officers and not Sgt. V Mbongo.

During a re-interview on 19 May 2023, Sgt. V Mbongo confirmed that she opened a case (Inquest into death) after Ms. Z Vena was certified dead by the ambulance crew.

Lt. Col. J Arends said he was called by WO. GA Barker while he was attending a meeting with the Station Commander. He said he immediately left the meeting to go to the charge office. On arrival at the charge office, he found a person laying on the floor, on her stomach. Sgt. V Mbongo explained to him what had happened and she said the ambulance was already activated.

Lt. Col. J Arends said though the ambulance did not take time to arrive, one could see that the person had already died because she was not moving. He also said in the past MPS CSC used to have FAK but does not know whether it still exists, or has enough first aid equipment. However, he stated that the police station does have a Health and Safety Representative. He also stated that nobody at MPS CSC was trained on how to use the FAK.

6.1.20 It is a requirement in terms of Section 17 of the Occupational Health and Safety Act, 85 of 1993, that “employers employing 20 or more workers on premises must appoint a representative to monitor health and safety conditions”. None of the police officers that were interviewed knew whether MPS CSC had a Health and Safety Representative or his/her name. This means there is no Health and Safety Representative at MPS CSC.

6.1.19 Failure by MPS CSC to appoint a Health and Safety Representative to monitor the health and safety conditions at the police station amounts to a violation of Section 17 of the Occupational Health and Safety Act.

6.1.20 Sgt. B Gwili confirmed during the re-interview on 18 May 2023 that they managed to arrest three (3) suspects, Mr. Luxolo Tatase (17 years old); Mr. Liyabona Rooi (17 years old), and Mr. Sibabalwe Magalela (18 years old) for questioning regarding the murder and rape inquest, and warning statements were obtained from Mr. Luxolo Tatase, and Mr. Sibabalwe Magalela. Sgt. B Gwili said Mr. Liyabona Rooi wanted to make a confession regarding the rape but he was stopped by his father, as a result, no warning statement was obtained from him.

6.1.21 The three suspects have since been released in the care of their parents on the basis that they are juvenile offenders and there was no toxicology report. Now that the toxicology report has been obtained, Sgt. B Gwili is waiting for the decision of the Senior Public Prosecutor regarding whether or not any of the suspects must be criminally charged and if so, for what.

6.1.22 According to the Adult Primary Care Manual/Booklet, 2019/2020, patients presenting with recent rape or sexual assault must be given urgent attention, and managed by:

- “Arranging same-day doctor assessment, ideally at a designated facility for management of rape and sexual assault;
- Complete required forms and registers;
- if severe vaginal or anal bleeding, refer urgently;
- Prevent HIV and hepatitis;
- Prevent STIs give a single dose each of ceftriaxone 250mg, azithromycin 1g orally, and metronidazole 2g orally. If severe penicillin allergy, omit ceftriaxone and increase the azithromycin dose to 2g orally; and
- Prevent pregnancy: do a pregnancy test. If pregnant 138. If not pregnant, not on reliable contraception, and 5 days since the rape, give emergency contraception” (**Annexure W**).

The investigation found the submission made by Mr. K Manqupu during interviews to be unreliable. The investigation team made an observation that when someone is inside the Security Guard House (SGH) at the gate, it is not possible to see what is happening inside the consulting rooms.

The investigation determined that the distance between Motherwell NU 11 Clinic and MPS CSC was 2.3 kilometers. On the way to MPS CSC, Ms. Z Vena collapsed and Ms. S Ntantiso was assisted by a local taxi driver who offered to take them to MPS CSC. On arrival at the MPS CSC, Ms. S Ntantiso and Ms. Z Vena were assisted by two Police Officers, one of whom tried to arrange transport to take them to hospital.

Sr. Z Ndongeni indicated that she heard Sr. NJ Ntlanjeni telling Ms. S Ntantiso and Ms. Z Vena to “go to the Police Station and the police will take them to Dora Nginza Thuthuzela Care Centre at Hospital (DNH)”. Transfer of patients from a primary health facility to the next level remains the responsibility of the health facility and not of the police.

The fact that Sr. NJ Ntlanjeni confirmed during an interview that she attended the APC training on how to deal with sexual assault/rape cases, indicates her failure and omission to treat Ms. Z Vena as expected.

In terms of Section 27(1) of the Constitution of the Republic of South Africa, 1996, everyone has the right to access health care services, including reproductive health care; no one may be refused emergency medical treatment.

Access to health care services means the ability to obtain health care services such as prevention, diagnosis, treatment, and management of diseases, illnesses, disorders, and other health conditions.

Based on the oral and documentary evidence gathered and considered, it can be concluded that Ms. Z Vena was denied access to health care services at Motherwell NU 11 Clinic.

The conduct of Sr. NJ Ntlanjeni in failing to provide health care services to Ms. Z Vena was in violation of the provisions of Section 27(1) of the Constitution.

Regulation 5(1) and (2)(b) and (c) of the Norms and Standards Regulations provides that: “the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition. Sub-regulation (2) provides that: “for the purposes of sub-regulation (1), (b) ensure access to emergency medical transport for users requiring urgent transfer to another health establishment, and that they are accompanied by a health care provider; and (c) adhere to clinical guidelines on stabilising users presenting in an emergency before referring them to another health establishment”.

Sr. NJ Ntlanjeni also violated the patient’s right to access health care as enshrined in the Patient Rights Charter (PRC). The PRC guarantees everyone’s right access to healthcare services that include, receiving timely emergency care at any healthcare facility that is open, regardless of one’s ability to pay.

Dr. R Wagner said that the Clinical Manager, Dr. Machi had prepared an apology letter. No proof was provided that the apology letter was issued to the family of Ms. Z Vena.

Whether the nurses at Motherwell NU 11 Clinic failed to refer Ms. Z Vena to the next level of care

The allegation that the nurses at Motherwell NU 11 Clinic failed to refer Ms. Z Vena to the next level of care was substantiated and confirmed.

Ms. S Ntantiso and Ms. Z Vena were instructed by Sr. NJ Ntlanjeni to go to MPS CSC without the accompaniment of the health professional, referral letter, or reasons for referral.

According to the ECDoh Referral SOP (May 2020), a referral described as a process in which the treating physician or registered nurse at a lower level of the health service, having inadequate skills by virtue of his or her qualification or fewer facilities to manage a clinical condition, seeks the assistance of a better equipped or specially trained person with better resources at a higher level to guide him or her in managing or taking over the management of a particular episode of a clinical condition (**Annexure X**).

The Referral SOP requires patients to be referred from a clinic with a referral letter and clear report on reasons for referral, namely full patient details, address, diagnosis, condition, reasons for referral, investigations, and referring and receiving doctors. Referral to be done after confirmation of bed availability.

6.2.6 Ms. Z Vena was instructed to go to MPS CSC to report the rape, without a referral letter and a report detailing reasons for referral. This was confirmed in the investigation report of the HoD, Dr. R Wagner, in paragraph 6.1.15 above.

Ms. S Ntantiso, escorted Ms. Z Vena to Motherwell NU 11 Clinic, confirmed that she and Ms. Z Vena were forced to walk a distance of 2.3 kilometers from the clinic to MPS CSC, as no other option was provided.

The investigation report of Dr. R Wagner dated 14 November 2022, corroborated the submission by Ms. S Ntantiso. The report stated that: "According to information gathered during the investigation, the two professional nurses believed that the patient had to go to Dora Nginza Thutuzela Care Centre via the Police Station; thus, the patient was directed as such. The patient's social, psychological, and physical state were not considered. The escort and rape victim did not have money for the taxi fare. The only option they had was to walk to the police station, which was roughly two kilometers from the clinic."

The findings of the Ombud were also confirmed in the newspaper article which was published by GroundUp Media dated 30 September 2022, titled "Health department investigates clinic after teen rape victim dies at the police station" (**Annexure Y**).

Both Sr. Z Ndongeni and Sr. NJ Ntlanjeni failed to follow the proper referral procedure. Instead, Ms. S Ntantiso and Ms. Z Vena were to go to the nearest clinic to report the rape. Transport arrangements for continuity of care were not made for Ms. S Ntantiso and Ms. Z Vena. Ms. Z Vena was referred to MPS CSC without a referral letter.

6.2.10 Assistance of Psychological and emotional aspects of Ms. Z Vena by Sr. Z Ndongeni and Sr. NJ Ntlanjeni could not be established, neither was there emotional support provided to Ms. Z Vena.

6.2.11 The distance walked by Ms. S Ntantiso and Ms. Z Vena between Motherwell NU11 Clinic and Motherwell Police Station, according to the GPS navigation maps was 2.3 kilometers and five minutes drive by car.

6.2.12 Regulation 5(1) of the Norms and Standards Regulations provides that: "the health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition. Sub-regulation (2) provides that: "for the purposes of sub-regulation (1), a health establishment must (a) implement a system of triage; (b) ensure access to emergency medical transport for users requiring urgent transfer to another health establishment, and that they are accompanied by a health care provider; and (c) adhere to clinical guidelines on stabilising users presenting in an emergency before referring them to another health establishment".

6.2.13 According to Sr. NJ Ntlanjeni, her assessment of Ms. Z Vena was based on the fact that she was able to walk and talk, and she felt that there was no need to arrange transport for Ms. Z Vena and Ms. S Ntantiso to the next level of care.

6.2.14 Based on the oral and documentary evidence gathered and considered, it can be concluded that both Sr. Z Ndongeni and Sr. NJ Ntlanjeni failed to refer Ms. Z Vena to the next level of care when in need.

6.2.15 Failure by Motherwell NU11 Clinic to refer Ms. Z Vena to the next level of care means that Ms. Z Vena was not attended to in a manner that is consistent with the nature and severity of her health condition at Motherwell NU 11 Clinic.

6.2.16 The conduct of Sr. NJ Ntlanjeni and Sr. Z Ndongeni in failing to treat and refer Ms. Z Vena to the next level of care was in violation of the provisions of Regulation 5(1) and (2)(b) of the Norms and Standards Regulations.

6.2.17 The conduct of Sr. NJ Ntlanjeni and Sr. Z Ndongeni in failing to treat and refer Ms. Z Vena to the next level of care was an act of omission and they violated the framework and guidelines of professional ethics concerning the management of sexual assault victims.

6.2.18 The conduct of Sr. NJ Ntlanjeni and Sr. Z Ndongeni in failing to treat and refer Ms. Z Vena to the next level of care also violated Ms. Z Vena's right to continuity of care as enshrined in the PRC, which provides that "no one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health."

Whether the death of Ms. Z Vena was due to negligence of the nurses at Motherwell NU 11 Clinic

The allegation that the death of Ms. Z Vena was due to the negligence of the nurses at Motherwell NU 11 Clinic was substantiated and confirmed.

Negligence is described as a failure to act with the level of care that someone of ordinary prudence would have exercised under the same circumstances. Such behaviour consists of actions (commission) but can also consist of omission when there is a duty to act. A reasonable person test is used in order to establish negligence. For example, 'if a reasonable person would have foreseen the reasonable possibility of harm and would have taken reasonable steps to prevent such harm, and the person in question did not do so, negligence is established.'

Sexual assault and or rape is a violent crime where victims are harmed by or threatened with violence. As health professionals, Sr. NJ Ntlanjeni and Sr. Z Ndongeni had a duty to care for all patients, including Ms. Z Vena. They were expected to know how to manage sexual assault cases and provide proper care to Ms. Z Vena but failed to do so.

The Toxicology Report dated 23 February 2023 found the Trimethoprim substance in Ms. Z Vena's body as follows:

- 4960 mg/l in the stomach contents;
- 7 mg/l in the blood;
- 3 mg/l in the eye fluid; and
- 48 mg/l in the bile.

The Toxicology Report also shows that the concentration of alcohol in the blood specimen was 0.00 grams per 100 millilitres, whereas the concentration of sodium fluoride in the blood specimen was 1.7 grams per 100 millilitres.

Based on the evidence obtained, it can be concluded that Ms. Z Vena was not attended to in a manner that is consistent with the nature and severity of her health condition at Motherwell NU 11 Clinic.

Therefore Sr. NJ Ntlanjeni and Sr. Z Ndongeni were negligent by failing to provide the necessary care consistent with the nature and severity of Ms. Z Vena's health condition. Consequently, the cause of death of Ms. Z Vena can be attributed to the negligence of the two nurses at Motherwell NU 11 Clinic.

Dr. R Wagner also agreed in her report of 14 November 2022 that "the conduct of the two professional nurses is condemned, they violated the frameworks and guidelines of professional ethics concerning the management of rape victims. After the internal investigation, the recommendation was that disciplinary processes be undertaken. Labour Relations has initiated the disciplinary process."

However, during the interview with Sr. Ntlanjeni on 27 March 2023, she confirmed that she has neither been charged nor subjected to a disciplinary hearing. She has been on sick leave since 23 September 2022, when the community of Motherwell Ward 58, got angry and threatened them and closed the clinic. Despite the undertaking to take disciplinary action against Sr. NJ Ntlanjeni, no charges have been preferred against her to date.

Both Sr. NJ Ntlanjeni and Sr. Z Ndongeni, confirmed that they did not touch Ms. Z Vena "to avoid tampering with the evidence". Sr. NJ Ntlanjeni and Sr. Z Ndongeni failed to holistically evaluate Ms. Z Vena, without fully knowing her health status and instructed her to go to MPS CSC, which was 27 minutes walking distance from the clinic, from where she supposed to be taken to Dora Ngizwa Thutuzela Care Centre (DNTCC).

A reasonable person in the position of Sr. NJ Ntlanjeni and Sr. Z Ndongeni would have foreseen the harm by holistically examining Ms. Z Vena in terms of the management of sexual assault prescripts, instead of instructing her to go to MPS CSC where she may have met her perpetrators on the way to the police station.

At MPS CSC, Ms. Z Vena had to wait for over an hour for transportation to the hospital, before meeting her untimely death. Based on the limited health care experience on the part of the police, Ms. Z Vena was not properly positioned while having epileptic fits, which might have worsened the situation based on the assertion made by Sgt. V Mbongo indicating that Ms. Z Vena's head was facing downwards while she lay on the floor.

Based on the above evidence, it can be concluded that Ms. Z Vena had a higher chance of survival had she been admitted to a health facility, where she would have received proper medical care.

The investigation also found that both Sr. NJ Ntlanjeni and Sr. Z Ndongeni violated the SANC Nurses' Pledge, 2022, which stipulates that "I solemnly pledge myself to the service of humanity and will endeavour to practice my profession with conscience and with dignity. I will maintain, by all the means in my power, the honor and noble tradition of my profession. The total health of my patients will be my first consideration. I will hold in confidence all personal matters coming to my knowledge. I will not permit consideration of religion, nationality, race, or social standing to intervene between my duty and my patients. I will maintain the utmost respect for human life. I make these promises solemnly, freely, and upon my honour."

Dr. R Wagner said she issued instructions to Mrs. Ngada to inform the District Manager, Ms. S Lupondwana to implement the disciplinary action, with the expectation that they will follow the instructions. When she followed up, she was informed that Sr. NJ Ntlanjeni was still on sick leave. She requested labour relations for advice on what must happen and was advised to proceed with the second nurse. No disciplinary action was instituted against both Sr. NJ Ntlanjeni and Sr. Z Ndongeni regarding their misconduct.

ADDITIONAL FINDINGS

Adult Primary Care (APC) Training offered to nurses by ECDoH

During a group discussion with PNs at Motherwell NU 11 Clinic when conducting in loco inspection the common complaint was that although the APC training is offered online, there is no proper mentoring or monitoring for compliance. Both Sr. NJ Ntlanjeni and Sr. Z Ndongeni attended online training on APC, under Traumatized/Abused patients, but failed to implement it as required. The training was conducted before the incident occurred. The date of the training is not specified.

No proper signposting of services and clinic hours

- The investigators observed that while driving toward Motherwell NU 11 Clinic, there were no signposts on the streets that gave directions to the clinic.
- Arriving at the clinic, there was no board that indicated the menu of services offered by the clinic nor the provision of the working times at the clinic.
- The investigation also noted that this posed a problem as patients had to stand in the queue without knowing which services were provided. This might lead to patients losing confidence in the public health service. During the investigation, Ms NP Qabaka mentioned that the NMBD was aware of the challenge but nothing was done to address the problem. (No evidence was provided by Ms. NP Qabaka).
- In terms of Regulation 4(1) of the Norms and Standards Regulations, the health establishment must ensure that users are provided with adequate information about health care services available at the health establishment and information about accessing those services.

The rotational schedule of doctors at Motherwell NU 11 Clinic

- Motherwell NU 11 Clinic does not have full-time doctors working daily at the clinic. The clinic relies on sessional doctors available only on Mondays and Fridays (**Annexure Z**).
- If there are no doctors, the nurses present the patient by phone and wait for the doctor's instruction to refer the patient to Motherwell Community Health Centre (MCHC) or DNH where there are doctors available.

Security services

The investigation established that Motherwell Township has a high crime rate. The security personnel at Motherwell NU 11 Clinic operate between 06:00 – 16:00, from Monday to Friday during weekdays. There is no security at night and on weekends as required in terms of Regulation 17(1) of the Norms and Standards Regulations.

There was a safety incident in 2020, where a bakkie from a pharmaceutical company delivering medication at the clinic was hijacked at the gate of the clinic. In another incident, nurses at the clinic were attacked during the day and robbed of their cell phones and money.

Underutilisation of Staff

The staff complement at Motherwell NU 11 Clinic is as follows:

7 x Professional Nurses (PN). Three Professional Nurses are employed on contracts ending in March 2023. There was no certainty as to whether the contracts will be renewed.

- 1 x Enrolled Nurse (EN)
- 1 x Enrolled Nursing Assistant (ENA)
- 1 x Data Capturer
- 2 x Administrative Clerks
- 1 x Post Basic Pharmacy Assistant (PBPA)

2 x Cleaners. One cleaner is permanently employed and the other is employed on a contract until the end of March 2023. There is a need for two permanent cleaners because when one cleaner is on leave, a Community Care Worker (CCW) is asked to assist, although this is not their responsibility.

Sexual Assault Standard Operating Procedure

Motherwell NU 11 Clinic does not have an SOP to deal with sexual assault patients, as required by Regulation 7(1) of the Norms and Standards Regulations. All the healthcare workers interviewed confirmed that they have never seen an SOP dealing with patients sexually assaulted. The available SOP refers to DNTCC, it is not specific to Motherwell NU 11 Clinic.

Infrastructure challenges

Motherwell NU 11 Clinic is in need of extra rooms. There is no privacy at the clinic as all the nurses share two consultation rooms.

There is not enough space for disabled patients, Motherwell NU 11 Clinic is currently using a storeroom to attend to disabled patients.

The registration room is too small to keep the patient files safely. A request was made in August 2022, for more space. According to Ms. NP Qabaka, "The district sent people to take the measurements for bulk files but nothing has been done to date".

There are in total four air conditioners at Motherwell NU 11 Clinic to maintain fresh air, temperature, humidity, and purity of the air. The air conditioners are placed in the pharmacy storeroom; records room; dispensary room and in the Office. The air conditioners are always faulty and not in good working condition.

The investigation established that the anti-natal clinic is the worst ward at the clinic in need of extra rooms. Patients are returned from the clinic unattended. The counselor promised to provide one but to date, nothing has been done. Sr. NJ Ntlanjeni had been trying to get containers before the incident happened but in vain.

Access to a telephone.

The investigation established that communication at Motherwell NU 11 Clinic was a challenge as they had no functional landline telephone. Landline telephones are frequently affected by load shedding.

The investigation also learned that the work cell phone was still in the possession of Sr. NJ Ntlanjeni was on sick leave since 23 September 2022. The Acting Operational Manager at the clinic was not provided with a work cell phone, making it difficult to communicate. This means that staff has to utilize their personal cell phones in most instances when referring patients or seeking information.

Ms. NP Qabaka also highlighted that the cell phone contracts were not paid for some time in the NMBD and finance was dealing with the issue (**Annexure AA**).

Supervision of clinics within Sub-District A

During the walkabouts, the investigation learned that there was no proper supervision of the clinics from Sub-District A. While they confirm that there are periodic telephone inquiries regarding challenges experienced by the clinic, the physical availability of Sub-District A to the clinic to monitor, evaluate, and mentor was non-existent.

During interviews with Ms. NP Qabaka, she cited transport challenges as one of the key issues for not being physically at the clinics. She stated that Sub-District A was allocated only one car which made it impossible to access due to competing priorities.

Ms. NP Qabaka stated that sometimes she had to use her own car for work-related matters and does not receive compensation for this.

Acting in the key positions

During the briefing session, the investigation team was made aware that there were acting staff in the key positions. Ms. S Lupondwana said this poses a serious challenge as it discourages staff from doing their best because they are not financially compensated for acting in those positions.

The Acting Facility Manager at Motherwell NU 11 Clinic Mr. Sakhiwo Velebaya (Mr. S Velebaya) has been acting since 23 September 2022. Based on the fact that the post is still occupied by Sr. NJ Ntlanjeni, was on sick leave, no acting allowance is paid for his services.

Lack of Redress for Family/Supporting Persons

During the interview on 02 March 2023 with Ms. N Vena, she submitted that she was invited to a meeting on 02 November 2022, which she attended with her two brothers, Mr. Dumisani Vena and Mr. Mziyanda Vena.

The meeting which was considered to be a redress meeting did not achieve its primary objective because Ms. N Vena was never provided with information regarding the circumstances that led to the death of Ms. Z Vena. According to Ms. N Vena, the meeting lasted for approximately five minutes and was adjourned. There were no minutes to confirm the discussions held during the purported 'redress meeting.'

In terms of the National Guidelines to Manage Complaints, Compliments, and Suggestions in the Health Sector of South Africa (the National Guidelines to Manage Complaints version 2 of 2022), it was expected of the NMBDH to conduct an investigation into the circumstances surrounding the death of Ms. Z Vena and redress her family. The aim of the redress is to reach a fair and reasonable resolution in an amicable manner.

By failing to properly redress the family of Ms. Z Vena, the NMBDH was in breach of the provisions of both the National Guidelines to Manage Complaints and the National Complaints Management Protocol on the redress of patients.

Though the NMBDH did the right thing by arranging psychosocial assistance for Ms. N Vena scheduled for Wednesday, 22 February 2023, Ms. N Vena did not attend the session due to financial constraints.

Ms. N Vena has a responsibility in terms of the Patient Rights Charter (PRC) to comply with the prescribed treatment or rehabilitation procedures

Failure by MPS CSC to assist Ms. Z Vena

Ms. S Ntantiso and Ms. Z Vena arrived at the MPS CSC charge office at 08:00. Ms. S Ntantiso said, “When I arrived at the charge office I explained to someone at the window counter about the condition of Ms. Z Vena but she never paid attention, she told me to go and sit down”.

This submission was disputed by Sgt. V Mbongo by indicating that Ms. S Ntantiso did not explain what had happened to Ms. Z Vena. Sgt. Mbongo said at 09:30 she went to check on Ms. Z Vena laying on the floor in the charge office and noticed that she was no longer crying. That is when she realised that Ms. Z Vena had passed on.

This means Ms. Z Vena waited 1h30 minutes to be assisted at the charge office. No first aid assistance was offered to Ms. Z Vena despite the fact that she arrived at the charge office being carried by two females because she was unable to walk, and she was crying and fitting. Sgt. V Mbongo opened the inquest docket only after Ms. Z Vena had demised.

Sgt. V Mbongo said that she did not open the First Aid Kit (FAK) nor offer first aid assistance to Ms. Z Vena when she was laying down and fitting because she is not trained to use first aid. However, she confirmed that the police station has the FAK. She also said she does not remember being orientated on how to use the FAK, nor does she know whether there is a Health and Safety Representative at the police station.

It is a requirement in terms of Section 17 of the Occupational Health and Safety Act, 85 of 1993, that “employers employing 20 or more workers on premises must appoint a representative to monitor health and safety conditions”. None of the police officers that were interviewed knew whether MPS CSC had a Health and Safety Representative or his/her name. This means there is no Health and Safety Representative at MPS CSC.

Failure by MPS CSC to appoint a Health and Safety Representative to monitor the health and safety conditions at the police station amounts to a violation of Section 17 of the Occupational Health and Safety Act.

COMMENTS ON THE PROVISIONAL REPORT

- a. On 16 October 2023, the Ombud issued a Provisional Report to the following people: the District Manager of Nelson Mandela Bay District Health, Ms. S Lupondwana; Acting Head of Department of Eastern Cape Provincial Department of Health, Ms. S Gede, and the Station Commander of MPS CSC, Brigadier L Ngalo, to give implicated people withing their respective offices the opportunity to comment on the findings and provide evidence to vary/disprove what the Ombud has found.
- b. The Provisional Report was also submitted to the Minister of Health, Honourable Dr. M.J. Phaahla (MP), and the Complainant, Honourable Ms. Michéle Clarke (MP) for noting.
- c. No comments were received from all the implicated parties. As a result, the Report is finalised without the comments from the implicated parties.

CONCLUSION

It is not in dispute that Ms. Z Vena was sexually assaulted, hence she presented herself at the Clinic accompanied by Ms. S Ntantiso on 21 September 2022 for medical services. This fact was also supported by the findings on the post-mortem examination conducted by Dr. LJ Mostert on 06 October 2022. The physical examination of Ms. Z Vena’s body revealed she had abrasions on her toes and the back of one thigh. No visible injuries were observed. However, this does not exclude rape, especially if someone already had sexual intercourse before. Also, Mr. Liyabona Rooi (Mr. L Rooi) confirmed to have had sexual intercourse with Ms. Z Vena which she alleged was not consensual.

The evidence collected confirms that the nurses at Motherwell Clinic failed to provide Ms. Z Vena with medical services when she presented herself at the clinic

It is also confirmed that Sr. NJ Ntlanjeni and Sr. Z Ndongeni did not examine Ms. Z Vena to confirm if indeed she had been raped and be managed in accordance with the Adult Primary Care Manual/Booklet 2019/2020, which requires that patients presenting with recent rape or sexual assault must be given urgent attention. Both Sr. NJ Ntlanjeni and Sr. Z Ndongeni informed Ms. S Ntantiso and Ms. Z Vena that the nurses “do not touch rape victims to avoid tampering with evidence”. The conduct of both Sr. NJ Ntlanjeni and Sr. Z Ndongeni was in violation of Ms. Z Vena’s Constitutional rights in terms of section 27(1) of the Constitution.

It was expected of both Sr. NJ Ntlanjeni and Sr. Z Ndongeni to prioritise Ms. Z Vena by taking history to determine whether she requires referral to the doctor, in accordance with the Adult Primary Care Manual / Booklet 2019/2020, which requires that patients presenting with recent rape or sexual assault must be given urgent attention.

It is also confirmed that the nurses failed to arrange transport for Ms. Z Vena to take her to the next level of care. In so doing, the nurses failed to ensure that Ms. Z Vena was attended to in a manner that was consistent with the nature and severity of her health condition at the clinic. The conduct of Sr. NJ Ntlanjeni and Sr. Z Ndongeni is in violation of the provisions of Regulation 5(1) and (2)(b) of the Norms and Standards Regulations.

No disciplinary action was instituted against both Sr. NJ Ntlanjeni and Sr. Z Ndongeni regarding their misconduct. Also, the ECPDoH did not issue an apology to the family of Ms. Z Vena.

RECOMMENDATIONS

Disciplinary Inquiry

The District Manager of the NMBDH should institute a disciplinary inquiry within one month, in terms of the prevailing policy and compatible with the Labour Relations Act (LRA), 66 of 1995 against the following personnel:

Sr. NJ Ntlanjeni for their failure to holistically assess Ms. Z Vena, and to use proper channels of referral within the district. Her failure to advocate on behalf of the patient placed the life of Ms. Z Vena in danger.

Sr. NJ Ntlanjeni also used her personal diary to record the vital data observations of Ms. Z Vena, instead of the appropriate Patient Administration Record (PAR). There was no evidence to indicate that Ms. Z Vena was consulted at the Motherwell NU 11 Clinic on 21 September 2022, as her name was not registered anywhere.

Sr. Z Ndongeni for her failure to advocate for Ms. Z Vena. During the interview, she indicated that she heard the conversation between Sr. Nj Ntlanjeni and Ms. Z Vena but failed to intervene when Sr. NJ Ntlanjeni was instructing Ms. Z Vena and Ms. S Ntantiso to go to the MPS CSC.

As a PN registered with the South African Nursing Council (SANC) she had the responsibility to take the total health of Ms. Z Vena into her consideration and maintain the utmost respect for human life as a promise made freely and upon her honor during her nursing pledge.

Referral of the two nurses to the South African Nursing Council (SANC) for investigation regarding professional misconduct.

Security challenges

The HoD must, within three months, submit to the CEO of the OHSC a security plan to protect users, healthcare personnel, and clinic property from security threats and risks and ensure that security staff is capacitated to deal with security incidents, threats, and risks for 24 hours daily including weekends and holidays.

This will ensure that state property, healthcare workers, and patients are protected from harm, in compliance with Regulation 17 (1) and (2) of the Norms and Standards Regulations.

Adult Primary Care (APC) Training offered to nurses by ECDoH

The District Manager of NMBDH must, within two months ensure that mentoring is provided to the healthcare workers attending the APC training.

This will ensure that all the nurses are kept abreast of the new developments in the management of sexual assault cases.

No proper signposting of services and clinic hours

The District Manager of NMBDH and HoD must, within six months procure the service provider to install the Service/Notice Board at the Motherwell Clinic that indicates the health care services provided by the clinic and indication of working times at the clinic.

Signposts should be installed on the road to guide healthcare users about the direction and location of the clinic.

This will ensure that Motherwell NU 11 Clinic complies with Regulation 4(1) of the Norms and Standards Regulations.

Rotational schedule of doctors at Motherwell NU 11 Clinic

The HoD should within three months increase the number of doctors' visits at the clinic to three days per week.

The monitoring of doctors working at the clinic should be done to ensure that they work for the time frame allocated at the clinic.

Staff complement

The NMBDH and ECDoH should prioritise the appointment of an extra permanent cleaner at Motherwell NU 11 Clinic within three months in line with the Human Resources Management Policy.

This will ensure that there is a person at the clinic to maintain hygiene of the clinic and surrounding areas and avoid possible infections.

Sexual Assault Standard Operating Procedure

The District Manager of NMBDH must within one month ensure the Standard Operating Procedure for the management of sexual assault cases is developed and in-service training is provided to the staff at Motherwell NU 11 Clinic.

This will ensure that all staff are conversant with the SOP and know what is expected of them in the management of sexual assault cases.

Prioritisation of Motherwell NU 11 Clinic Infrastructure

The Premier of the ECPD should within six months ensure that Motherwell Clinic is prioritised for refurbishment.

Mobile containers to be procured to cater to extra consultation rooms. To fast-track track process of procuring the land next to the clinic to enable the extension of the clinic infrastructure as highlighted by Ms. NP Qabaka.

This will minimise the overcrowding and patients waiting under open shelters inside the clinic compound. There would be an improved provision of quality health services and ensure that Motherwell NU 11 Clinic complies with Regulation 8 (1) of the Norms and Standards Regulations.

Supervision of clinics within Sub-District A

10.9.1 The HoD should within six to twelve months ensure the provision of extra motor vehicles in Sub-District A, to enable the Sub-District Coordinator to support and monitor the implementation of health care services in the clinic.

10.9.2 In instances where staff utilise their own motor vehicles for work-related matters, they should be compensated financially as guided by the Public Finance Management Act (PFMA).

10.9.3 Employees not part of the Senior Management Service (SMS), using their own motor vehicles for work-related purposes, should be indemnified in case of accidents.

Acting in the key positions

10.10.1 The HoD must within six months ensure that posts occupied by people acting within the NMBDH are advertised and filled to ensure continuity and accountability.

This will ensure a sense of security amongst staff and encourage them to be responsible and develop innovative ideas to improve health care service within NMBDH.

Redress of Family/supporting persons

The District Manager of NMBDH

- a. Arrange a meeting with the family within 30 working days, to explain the conditions and events that led to the death of Ms. Z Vena and offer an apology in order to facilitate closure.
- b. Arrange counseling to the family of Ms. Z Vena within 30 working days, to facilitate closure regarding her death.
- c. To assist Ms. N. Vena with transport as necessary in order to facilitate her attending meetings and counseling sessions as contemplated in (a) and (b) above.

Ms. Z Vena's Mother, Ms. Nomathamsanqa Vena

- a. Attend a redress meeting when invited by the District Manager of NMBDH for an explanation to be offered regarding the events that led to the death of Ms. Z Vena.
- b. Attend counseling offered by the District Manager of NMBDH to assist in obtaining closure regarding Ms. Z Vena's death.

Non-compliance with Section 17 of the Occupational Health and Safety Act, 85 of 1993

The HoD of the Eastern Cape Department of Labour must within 30 working days conduct routine inspections at MPS CSC, to ensure compliance with Section 17 of the Occupational Health and Safety Act, 85 of 1993, and take appropriate action/sanction if found to be non-compliant.

The Ombud should be furnished with a copy of the inspection report immediately after the inspection has been conducted.

Sexual Assault Referral Policy

It is imperative for the District Manager of NMBDH to develop and disseminate a practical and realistic sexual assault referral policy within two months. This policy is to be developed in order to coordinate processes and operations between Health facilities, DNTCC, Family Violence, Child Protection, and Sexual Offences Unit, and SAPS charge offices and other facilities.

The Ombud is to be furnished with a copy of the Sexual Assault Referral Policy within six months of the date of this report.

MPS CSC

In view of the “laissez-faire” or “yekelela” attitude and culture currently prevalent within all echelons of the SAPS in NMBDH, regarding persons in clinical distress, the following is recommended:

- Plans be put in place that all SAPS employees engaging with the public are trained in first aid or have physical access to first responders 24 hours a day. This should be implemented within twelve months of finalisation of this report.
- Improve record-keeping processes to promote transparency and accountability, within two months of finalisation of this report.

REFERENCES

- i. The Constitution of the Republic of South Africa, 1996.
- ii. The National Health Amendment Act (NHAA), 2013 (Act No.12 of 2013).
- iii. Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, published on 02 November 2016.
- iv. Department of Health (2011). National Core Standards for Health Establishments in South Africa.
- v. Adult Primary Care Manual/Booklet, 2019/2020.
- vi. Batho Pele Principles
- vii. National Guidelines to Manage Complaints, Compliments, and Suggestions in the Health Sector of South Africa, version 2 of 2022.
- viii. World Health Organization. (2014) Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents, and children: recommendations for a public health approach. Geneva, Switzerland.
- ix. Patients Rights Charter
- x. South African Nursing Council - Nurses' Pledge, 2022.
- xi. Eastern Cape Department of Health Referral SOP, May 2020.
- xii. Post-Exposure Prophylaxis (PEP) Guideline, October 2021

LIST OF ANNEXURES

Annexure A	Population sub-district A in 2022 (NMBDH)
Annexure B	Complaint lodged by Ms. Michel Clarke, Democratic Alliance Shadow Minister of Health (30 September 2022).
Annexure C	Referral letter from the Minister of Health, Dr. MJ Phaahla (04 October 2022).
Annexure D	Letter from the Deputy Director of Public Prosecution in Gqeberha dated 18 July 2023
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Annexure F	Investigation report from HoD, Dr. R Wagner (14 November 2022)
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Annexure H	Written statement by Sr. Z Ndongeni (undated)
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Annexure S	Post-Exposure Prophylaxis Guideline published in October 2021.
Annexure T	Attendance register for the Gender-Based Violence Training conducted on 30 November 2022 and Customer Care Programme conducted on 01 December 2022.
Annexure U	Report of learner absenteeism from Woolhope Senior Secondary School showing the dates on which the learner was absent from school.
Annexure V	SAPS written statements obtained from Mr. Luxolo Tatase and Mr. Sibabalwe Magalela.
Annexure W	Adult Primary Care Manual/Booklet (2019/2020)
Annexure X	Attendance register for the Customer Care Programme Workshop conducted (01 December 2022)
Annexure Y	GroundUp Media newspaper article dated 30 September 2022.
Annexure Z	Motherwell NU 11 Clinic doctors' schedule for July – September 2022.
Annexure AA	Motherwell NU 11 Clinic's unpaid cellphone contracts.

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Office of the Health Ombud
Ithovisi Lokulandela Amaphelo Eziphele

