IN THE LABOUR COURT OF SOUTH AFRICA

HELD AT DURBAN

Reportable

Case No: D695/14

In the matter between:

DR LUBKA IVANOVA **Applicant**

and

THE DEPARTMENT OF HEALTH: KWAZULU-NATAL **First Respondent**

ANAND DORASAMY N.O. **Second Respondent**

THE PUBLIC HEALTH AND SOCIAL DEVELOPMENT SECTORAL BARGAINING COUNCIL **Third Respondent**

MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH IN KWAZULU-NATAL **Fourth Respondent**

Heard: 08 May 2015

Delivered: 29 December 2015

Edited: 18 January 2016

Summary: Review – misconduct – reinstatement when employee already reached retirement age on date of order - where an employee is unfairly dismissed he or she suffers a wrong and the dictates of fairness and justice require that such a wrong be appropriately redressed. Restoration of the *status quo ante* where appropriate provides the fullest redress – misconduct – alleged acts of negligence not proved.

JUDGMENT

CELE J

Introduction:

[1] The Applicant brought an application to have an arbitration award of the Second Respondent ("the Commissioner") to the effect that her dismissal by First Respondent ("the Department") was substantively and procedurally fair, be reviewed, set aside and substituted in terms of section 145 (2) of the Labour Relations Act,[1] ("the Act"). The application was opposed by the First and Fourth Respondents as the erstwhile employers of the Applicant.

Factual Background

[2] The Applicant is a qualified medical practitioner. She came to South Africa from Bulgaria in 1992. In Bulgaria she held the position of a specialist in surgery and orthopaedics. Upon arrival in South Africa she registered with the HPCSA as a medical practitioner working in government services. She worked in various public hospitals in South Africa since 1999 but commenced at G J Crookes

[1] Act Number 66 of 1995.

Hospital, in Scottsburg in September or October 2010 as a Medical Officer grade 3.

[3] GJ Crookes Hospital ("the Hospital") is a district hospital with the doctors who work as medical officers of different grades. There are no specialists or surgeons. Patients who require urgent major surgery are transferred to other public service hospitals. On 2 June 2012, a Saturday, the Applicant was on duty, having started a 12 hour shift at 08h00 which was scheduled to end at 20h00. The Applicant was the day doctor on first call, meaning that in the event of a patient arriving in the casualty department requiring emergency attention and treatment, she would be contacted first to attend to the patient. The Applicant also had to attend to her normal duties as a medical officer on 2 June 2012.

[4] On 2 June 2012 at approximately 16h30 a Mr JH Grobler ("Mr Grobler") was involved in a very serious motorbike accident. Mr Grobler sustained multiple traumatic injuries. The lower extremity of his left leg was hanging "*from strings"* as a result of a severe open compound fracture. The wound associated with the fracture of Mr Grobler's left femur was bleeding profusely. His friend, a Mr JJ Odendaal ("Mr Odendaal") arrived at the accident scene. He attended to the injured Mr Grobler by applying two belts as a tourniquet to stop the bleeding.

[5] The emergency rescue services ("the EMRS") staff arrived at the accident scene to find the tourniquet on. They also put a cervical collar on Mr Grobler's neck, placed him on a trauma board, and recorded in their "*Patient Report Form"* that the "*leg was mangled"*, that a "*tourniquet was put on by a bystander"* and that the leg "*was partially amputated"*. Mr Grobler had serious compound grade 3C injuries to his left leg. He was a poly trauma patient, meaning that he suffered from a multiplicity of serious injuries.

[6] The EMRS staff also put up an intravenous line infusing ringers lactate to support Mr Grobler's circulation. Mr Grobler was taken to GJ Crookes by the EMRS staff where he was admitted at a minor operating theatre (MOT) in the casualty department at approximately 17h50/18h00 of 2 June 2012. The Applicant was contacted to assist with Mr Grobler's case and she came to attend to him at the MOT. The nature of the examination conducted by the Applicant on Mr Grobler is part of the bone of contention in this matter. Subsequent to examining the wound on Mr Grobler's left leg, The Applicant concluded that there was a major vascular injury requiring intervention and assistance by a vascular surgeon. Such a referral to a specialist would be in accordance with Advanced Trauma Life Support Principles. There were nurses who attended to him as well and they packed the wound with gauze and applied a pressure bandage. The tourniquet was left in place to prevent bleeding from a major vessel. Mr Grobler was talking at the time. His Glasgow Coma Scale score was recorded as 15/15.

[7] At about 18h30 the Applicant telephonically discussed the situation and condition of Mr Grobler's left leg with a Dr Wella an orthopaedic surgeon at Port Shepstone Hospital as GJ Crookes Hospital had no surgeons or specialists that could assist the Applicant. Dr Wella recommended the Applicant discuss the case with a vascular surgeon at Inkosi Albert Luthuli Central Hospital. It is the practice to transfer patients once stabilised to hospitals where appropriate specialist treatment is available and again this practice is recommended in life-threatening cases particularly in a situation where the patient was first treated in a district hospital where the necessary resources and skills might be lacking.

[8] Ms Buddan was the hospital Radiographer. There is also a dispute between the parties on whether the Applicant made any arrangements for an X-ray examination of Mr Grobler. The nurses complained to the night matron, NM Dlamini that the Applicant refused to send Mr Grobler for X-ray examination. At about 19h00/19h10 Matron Dlamini had a discussion with the Applicant about

the issue of the X-rays. The Applicant frequently left the MOT to go and talk on the telephone. Arrangements were then made for Mr Grobler to be taken to the X-ray department. Mr Odendaal and friends of Mr Grobler assisted to take Mr Grobler to the X-ray Department. A porter also assisted by carrying the oxygen bottle. Mr Grobler was moved from the trauma stretcher to the X-ray bed by Ms Buddan, assisted by Mr Odendaal. It was difficult to move Mr Grobler as he was a big and hefty person. The X-ray examination started but could not be completed as Mr Grobler complained of difficulty in breathing. An attempt was made to telephonically report to the Applicant the worsening condition of Mr Grobler. Ms Buddan succeeded in making contact with the nurses VS Ngcobo and L Mkhize who immediately went to the X-ray Department.

[9] At approximately 19h45, The Applicant received a call on the second phone in the casualty Department and was informed of the deterioration of Mr Grobler's condition in the X-ray Department where after she also immediately went to the X-ray Department. The Applicant was still on the phone with Dr Mukhendi when she received this call. The Applicant saw the nurses wheeling Mr Grobler back to the MOT. This was at about 19h50/20h00. Ms Buddan also came to the minor operating theatre with the X-rays that she was able to complete prior to Mr Grobler's condition deteriorating in the X-ray Department. Ms Buddan showed The Applicant the X-rays that she completed. Not all the X-rays were completed. There was no chest X-ray.

[10] More doctors came to the MOT to attend to Mr Grobler, including Drs Mncwango, Mbhele, Mqadi who was the Acting Medical Manager. Dr Mqadi entered the minor operating theatre a few minutes later and on realising that one of the two intravenous lines was not running set up a third line in Mr Grobler's right foot. In the end there were three intravenous lines. Mr Grobler's condition deteriorated further and after he complained that he could not breathe Dr Mqadi attempted a few times to intubate Mr Grobler. She failed and Dr Mbhele later intubated the patient successfully. Chest compressions were also done by Drs

Mqadi and Mbhele. Attempts to resuscitate Mr Grobler failed and he was certified dead at approximately 21h00. According to a post-mortem report Mr Grobler died of multiple injuries.

[11] The Applicant was subsequently charged by the Department with misconduct in relation to the events of 2 of June 2012. The charges raised by the Department against her were that:

"…

It is alleged that on the 2nd of June 2012 while performing your duties in Outpatient/Casualty Department you were negligent in the following:-

- Failed to do a full standard examination of a patient in an emergency by the name of Mr J Grobler registration no.: 12024/12 received from EMRS at 17h50 who was complaining that he had a difficulty in breathing, and in your notes you recorded that the chest was clear.

- Failed to examine the wound and stop the bleeding even when the doctor from Inkosi Albert Luthuli Central Hospital insisted that you do so.

- Insisted that the nurses should check the bleeding wound without even arresting bleeding and you left the patient with a tourniquet in situ without proper precautions.

- Informed the patient's friends that you did not know what to do and you phoned other doctors which was the first sequence in your patient examination.

- Initially refused to do X-rays in a patient with polytrauma suggested by the nurses until you were eventually convinced by the night matron.

- Further failed to request/insist on a (BSU) bedside unit for a polytrauma patient.

- When the patient's situation got complicated in X-ray department, the radiographer called you, you cut the call and did not inform them on the immediate care.

- Allowed nurses to go alone to the critically ill patient in X-ray with respiratory distress.

- When the nurses arrived in minor operating theatre with a distressed patient you did not help at all or resuscitate the patient.

- When the X-rays were received you failed to recognise fractured ribs, pneumothorax and surgical emphysema which the patient would have benefitted from insertion of intercostal drain.

- By such actions you conducted yourself in an improper and unacceptable manner, and contravened the code of conduct for the public service.

…"

[12] In an internal disciplinary hearing the Applicant was found guilty of the charge in relation to all the allegations of negligence as it appear in the charge sheet and summarily dismissed. The Applicant thereafter referred a dispute, with the assistance of the South African Medical Association, to the Third Respondent. Conciliation failed to resolve the dispute where after the matter was referred to arbitration. The Second Respondent arbitrated in the dismissal dispute between the First Respondent and the Applicant and he found that the reason for

dismissal as given by the chairperson of the disciplinary hearing and the procedure followed were fair. He then confirmed the dismissal.

Doctrine of effectiveness

[13] In opposing this application the First and the Fourth Respondents, hereafter referred to as the Respondents, submitted that the order sought by the Applicant is not capable of being given effect to as the Applicant reached age 65 years on 12 March 2015. It is trite that, in terms of the Government Employees Pension.[2] Act,[3] the age of retirement is 60 years and 65 years in respect of government employees. Upon the arbitration award being reviewed and set aside, if the Applicant is successful, she seeks to have an order of reinstatement. By reinstatement the Applicant contended that the Court is entitled to reinstate a dismissed employee whose employment has been found to be substantively unfair subject to retirement of the employee on her normal retirement date. The Applicant has not asked the Court to extend her employment beyond her retirement date.

[14] The submission by the Respondents is that a question that had to be answered was whether the Applicant has established the effectiveness of the order she sought as the Respondents said that it was inconceivable that the Court could pronounce an order in her favor post her retirement age. They said that the Court's order in favor of the Applicant would legally not be given effect to as the Applicant had reached her retirement age and that therefore the court lacked jurisdiction to pronounce on the relief sought which in law was not sustainable as the court order cannot be effected.

[15] It is now trite that this Court must require the employer to reinstate or reemploy the dismissed employee as a primary remedy when the Court finds that the

[2] See *Konono MEC for the Department of Education Eastern Cape Province and Others* (278/2011) [2013] ZAECGHC 105 (1 October 2013).
[3] Act Number 21 of 1996.

dismissal is substantively unfair. The norm is to order reinstatement or reemployment and the denial of the primary remedy should occur only as an exception.[4] Where an employee is unfairly dismissed he or she suffers a wrong and the dictates of fairness and justice require that such a wrong be appropriately redressed. Restoration of the *status quo ante* where appropriate provides the fullest redress. Court held in *Equity Aviation Services (Pty) Ltd*[5] that section 193 (1) (a) confers a discretion on the commissioner or court to determine the extent of retrospectivity of the reinstatement and that the only limitation is that reinstatement cannot be fixed at a date earlier than the actual date of dismissal. Reinstatement can be ordered from the date of dismissal but there is accordingly, no limitation up to when it can take effect. The doctrine of effectiveness raised by the Respondents is therefore not a valid defense to this application.

The merits of the review application

Evidence

[16] Evidence of witnesses on the medical attention given to Mr Grobler from the time of his arrival at the MOT, when he was taken to do the x-rays examination and back to the MOT depends on the evidence of Mr Odendaal, Nurse Ngcobo, Nurse Mkhize, Dlamini (the matron), Dr Mqadi, Dr Mncwango and the Applicant. I prefer to give an outline of the evidence given by Nurse Ngcobo, Mkhize, Matron Dlamini Dr Mncwango and the Applicant. The evidence of the Respondent was essentially that not much was done by the Applicant to Mr Grobler and that she moved about with the file making telephone calls. In particular, Nurse Ngcobo said that on arrival at the MOT Mr Grobler's left leg was covered in bandages but the bandages were soaked and blood was seeping through the bandages. The Applicant instructed the night shift team that had just come on duty to wrap up the leg in bandages and gauze, a process called packing. The Applicant was asked if she was not going to open up the wound and see what was going on and

[4] See *Numsa v Henred Fruchauff Trailers (Pty) Ltd* 1995 (4) SA 456 (AD) and *NCBAWU v MF Woodcraft (Pty) Ltd* [1997] 1 BLLR 43 (LAC).
[5] *Equity Aviation Services (Pty) Ltd v CCMA & others* [2008] 12 BLLR 1129 (CC).

suture the wound at that time but the Applicant declined to do so and they continued to bandage the leg, concealing the bleeding at that point, which had not stopped. They just concealed the bleeding. They put up a second drip, that is, a second line because the patient initially came in with a line that the EMRS people had put up. The two running lines put up were of Ringer's Lactate and Voluven for increasing the blood pressure.

[17] Nurse Ngcobo said that she asked the Applicant if she was going to arrange for the patient to do the x-rays examination but the Applicant said that it was not necessary. The Applicant took the file walked away saying she was trying to transfer the patient. When Matron Dlamini came up the nurses told her that the Applicant refused to arrange for the x-ray examination. Matron Dlamini convinced the Applicant and the Radiographer was called to come to hospital. Nurse Ngcobo said that she was however not there when Matron Dlamini spoke to the Applicant. Nor was she there when the Applicant telephoned the Radiographer. The Applicant arranged for all the blood units for the patient to be transfused. The x-ray personnel phoned to let the nurses know that the radiographer was available for the patient to be brought up to the x-ray room and the patient was taken up to the x-ray examination room on the fourth floor. At that time the patient was not stable and there was no active bleeding visible. Then Nurse Ngcobo received a call from the x-ray personnel reporting that the patient was restless as he could not breathe. The patient had crashed on the x-ray table, meaning his saturation was getting worse. Soon after Nurse Ngcobo received the call she went up to the Applicant who was on another telephone line, to informed her of the status of the patient. The Applicant scolded her for the interruption while she was busy on a call.

[18] Nurse Ngcobo, said that nurse Blose, nurse Mkhize and herself then went up to X-Ray room to find that Mr Grobler was already on the stretcher. The patient said that he could not breathe. He was twisting and turning on the stretcher bed and the leg wound was then bleeding as blood was seeping through the bandages. His condition had drastically changed. The nurses simply took the stretcher and

went down back to the MOT. On their way down, they met the Applicant who was on her way up and then she followed the nurses who were carrying the patient. When they got to MOT, they connected the patient to the cardiac monitor. By then his oxygen saturation level had dropped as well as his pulse and the blood pressure. The Applicant stood by the door and she then walked out. Nurse Ngcobo started telephoning for Dr Mncwango who had been busy with a Caesarean action and Dr Mbhele who was to come on night duty. When she tried to telephone Dr Mqadi and Matron Dlamini, the switchboard personnel said he had already informed them and they were on their way down. She said that when a patient started experiencing breathing problems, it was practice to call other doctors to come and assist.

[19] She said that by the time the doctors came down, the patient's condition had deteriorated and that was when they started the cardio-pulmonary resuscitation (the CPR) process. Dr Mncwango opened up the wound on the left leg and was trying to suture it whilst others were doing compressions and bagging the patient, Dr Mqadi and Dr Mbele were alternating, trying to intubate the patient by putting up an endotracheal tube to help him breathe. To do compressions, nurses and doctors took turns because Mr Grobler was of big built and they were getting tired with the compression. Nurse Ngcobo said that the Applicant was in the room with the rest and she at one point did the compressions. Dr Mbele was finally able to put up the endotracheal tube for the patient. The CPR was done for some time but when doctors stopped it, they pronounce the patient dead. As a result of the incident of 2 June 2012 she wrote two statements, one on 3 June 2012, the Matron's Report and the second on 21 June 2012 the incident Report. The incident report was in the main, in line with the evidence given by Nurse Ngcobo. The Matron's report read thus:

> "A 48 year old male was brought in by EMRS with friends with history of being involved in a motorbike accident. Patient was taken to minor OT. Dr Ivanova was informed on arrival. On patient's arrival, vital signs were 97, BP, pulse was 112; temperature, 32.6; HB, 12.3; GM, 10.6mmol. Doctor came in, ordered bloods, X-Rays, opened the wound and packed the wound and said to take

patient to X-Rays. Catheter was put in and the IV lines. Patient came into casualty with them. We got a call from X-Ray because patient collapsed and was brought back to minor OT. Patient's vitals dropped, pulse down to 40 beats per minute, pulse Oximeter had no reading. CPR was commenced because patient started gasping. CPR commenced at 20:25. Dr Mqadi, Dr Mbele, Dr Mncwango were called to assist. Dr Mbele tried to intubate but failed. Dr Mbele put it in at 20:30 and oxygen was given via ambubag. Dr Mqadi ordered one dose adrenalin at 20:30, one amp IVI, second dose as pulse dropped from 109 to 35 beats per minute, given at 20:40. Third dose of adrenalin, one amp was given, IVI at 20:50. Patient become asystolic from 20:55. Patient certified dead at 21:00. Family was informed and Scottburgh Police Station was informed."

[20] Nurse Mkhize also testified and in some respects confirmed the evidence of nurse Ngcobo. Upon her arrival at the MOT at about 18:00, she said that she observed patients and reported her findings to the Applicant. Then she went to check if there were any suturing pegs, stuff to do the stitches since she had noticed blood and so thought she was to check that quickly but could not find anything. She went to where they kept such stuff, a place called CSSD. She was then aware that there were injured patients who needed medical attention. One of those was Mr Grobler who was receiving attention from the day shift staff and the paramedics. When she left the MOT, there were two nursing sisters and the paramedics who were busy with Mr Grobler's left limb that was injured or bleeding. They were hands on because they were putting gauze and bandages over the limb, packing on the bleeding left limb. They were with the Applicant who was giving instructions. She was standing behind them telling them to bandage. On her return to the MOT nurse Mkhize continued doing the observations because it was normal when the patient was critically ill or injured to keep continuous observation, to continue checking the BP, the sugar levels, the temperature and oxygen saturations. So she did that, continuously re-checking and recording.

[21] When the doctors Mqadi, Mbele and Mncwango arrived at the MOT, the Applicant was either there or she was busy with the telephone calls because she

used two phones. There was one phone in MOT she used and she moved again to use the one which was in the casualty department. The Applicant said that she was trying to make a transfer of the patient. Nurse Mkhize was not sure who the Applicant told about the transfer but she ended up knowing that the Applicant was transferring Mr Grobler because nurse Mkhize answered one of the calls and she spoke to a male doctor who said he was calling from Chief Albert Hospital and wanted to speak to the Applicant. When he was told that the Applicant was busy on the other phone the doctor told nurse Mkhize to pass a message to the Applicant that she was to stabilise and suture the patient but not to send the patient because he might die on the way. Nurse Mkhize went to the Applicant and told her what the doctor had said. The Applicant did not suture the patient. At no stage did she see the Applicant touching the wound of Mr Grobler.

[22] A catheter was fitted on the patient and nurses checked the urine and they suggested to the Applicant that an X-Ray examination be booked for him because there was an obvious injury on the left limb but then nurses thought the doctor had to know if there were any other or injuries which were not obvious but she refused, saying the x-rays were not necessary as there was an obvious injury. She said that nurses were suggesting a chest or skull or spine x-ray and one of the nursing sisters reported the refusal to a night matron because the patient was complaining of chest pains as he was still talking. Later the Applicant filled the x-ray forms and the patient was taken by the porters and by Mr Grobler's friends. She had no memory of who authorized that the patient be taken at that time for the x-ray examination.

[23] Nurse Mkhize said that as soon as the patient was taken away, she went to the casualty department to continue with the work because there were other patients waiting to be seen by the doctors due to the emergency. So while she was busy with those patients, a call was received from the x-rays department saying that the patient's condition was getting worse. Nurse Mkhize said that she did not go up to fetch Mr Grobler but he was brought back to MOT and she left the casualty for the MOT. When she was cross-examined, it came to light that at the

disciplinary hearing, she had said that she also went up to fetch Mr Grobler. She said that the Applicant later came to join them at the MOT. Other doctors also arrived and a lot took place to help the patient.

[24] Doctors Mqadi and Mbele assisted by intubating the patient, then they did the examination and then Dr Mncwango opened the left limb, removed the bandages while nurse Mkhize was holding that limb. Dr Mncwango first asked Nurse Mkhize to prepare a sterile suture tray for him. She did and then upon his instruction she open and remove all the bandages and everything. Then he asked her to hold Mr Grobler's left limb that was badly injured, for the doctor who started to clean the wound and then sutured it. The rest of her evidence has similarities to that of nurse Ngcobo.

[25] As a witness Matron Dlamini said that she received a report from a nurse whose particulars she could not recall and in the course of the rounds she was taking she met the Applicant at MOT and suggested to her that it would assist Mr Grobler if the x-ray examination were conducted on him. The Applicant said nothing and merely took out some forms, which Matron Dlamini assumed were for an x-ray examination request, and completed them. Matron Dlamini said that she thought that she heard the Applicant saying that she was busy with the transfer arrangements for Mr Grobler but she said that she could be mistaken about the source of that information as it might have come from someone else.

[26] The Radiographer Ms Buddan testified and she said that Thulani, the Hospital Switchboard Operator, called her on her cellular telephone at about 18h31 telling her that the Applicant needed her to do an emergency x-ray examination on a patient. So she left home and came to the Hospital at about 18h55 where she switched on the machines, then called down to casualty and the Applicant answered the phone. She asked the Applicant if she could send the patient up for x-rays but the Applicant said that the patient was involved in a motorbike accident, was unstable and could not come up. Ms Buddan asked her if she

wanted a portable x-ray or if Ms Buddan was to come down. At that stage she did not know whether it was a child or adult patient. Neither did she know what x-rays were needed. The Applicant said no the patient would come up but that she had another patient for Ms Buddan to do in the meantime. That patient came up and x-rays were taken and then Ms Buddan called down to casualty again to see if the patient was ready to come up and the nurse that answered said that the patient was stable and they would send him up. The patient came up with his relatives and a porter pushing the oxygen cylinder.

[27] She said that Mr Grobler was quite a big sized patient but had to be moved onto the x-ray table. She explained to him where he was and that they were going to do some x-rays and then she started taking x-rays. After she took a few of the lot they normally took, she went to process them and then came back from the dark room to carry on. She could hear him becoming restless and groaning and moaning and so she went over to see what problem there was. He kept telling her that he could not breathe. So she checked to see if the oxygen was working and found it fine as it was on. She told him that she was going to call casualty to come and get him. When she telephoned the line was busy. She asked the switchboard to put her through to the Applicant's cellular telephone which he did. When the Applicant answered the phone, Ms Buddan told her that her patient was going into respiratory distress, but before she could even get to respiratory distress, the call got cut. She quickly phoned casualty again and told whoever picked up the phone that the patient was going into respiratory distress and they need to come up. The nurses came up. Ms Buddan and the nurses moved Mr Grobler back from the x-ray table onto the stretcher and they took him down to MOT.

[28] She picked up the x-rays that she had processed and took a few cassettes down to finish up the rest when the patient got stable for the portable machine and she went after them. When she got down, she gave the x-rays to the Applicant, telling her that the patient crashed on the table and so she did not complete the x-rays

and there were cassettes to complete the x-rays when the patient was stable. Then she waited. She said that the bedside unit (BSU) was not the ideal to use for Mr Grobler due to his body size. The use of the BSU, she said, depended on which parts of the body were to be x-rayed and the radiation dose that might be needed. The BSU machine at G J Crookes could only do a trauma series on children and not on adults. So for Mr Grobler, she would only be able to get a femur, the left tibia or fibula, the cervical spine and the chest. She would probably not be able to get the pelvis and the chest because of his quite big size. She would still have to take the cassettes to the dark room for processing. She had brought along the x-ray plates and had just left them in the MOT because she was waiting for the doctors to stabilise the patient. There was a viewing box facility close by for the doctors to view the plates. She was not aware of any doctors that looked at the plates as she was waiting outside.

[29] Dr Mncwango testified and confirmed receiving a call from the Applicant who asked him to come and assist her by intubating a patient. She indicated to him that the patient was still talking. He then met Dr Mqadi who had arrived to assume night duty and told her of the request by the Applicant. Both met near the reception area and they proceeded to the MOT. He arrived first at the patient who was still talking, complaining about the shortness of breath and about pains. Without talking to the Applicant, he went to the lower limbs of the patient and started to suture the left limb assisted by nurses. At that stage he did not consider intubation to be necessary as the patient was still talking. Dr Mqadi soon joined in and he heard her listening to the chest and calling for the tube to begin intubating and resuscitation on the upper torso of the patient. Dr Mbele also arrived to join them and he helped Dr Mncwango with the suturing. He later released Dr Mbele to go and assist Dr Mqadi with compression and with CPR. As they were working on the patient the Applicant stood with folded hands some 1.5 metres from the patient. At about 40 to 45 minutes later, the other doctors called off the resuscitation of the patient and pronounced him dead. So he had to stop what he was doing.

[30] He said that if he had been the first doctor to attend to that patient he would allow the nurses to do what they often did, that is, to take vital information, that's his blood pressure, temperature, sugar, saturation, to inserted the IV lines and sometimes to take blood samples. They call a doctor once they had done that but if he were there on arrival, of the patient he was going to issue orders for the gathering of such vital information. He would then conduct a very quick secondary survey, that is, to check from head to toe just to see where the main problems were. Then he would do quick secondary survey, to check if the patient had a patent airway and whether he was breathing. In this case he was talking so he had patent airways and was breathing. The next step is to check if the patient was bleeding and if so to stop it but if that is difficult assistance of other doctors is then called for to stabilize the patient. Blood is then taken from the patient for examination and classification of the patient. Once the patient is stable a radiographer is called to do x-ray examination. Once there are results of the x-ray and blood examination, then a discussion of the patient with other doctors from the tertiary or regional hospital may be done to elicit advice. If the doctor spoken to accepts the patient, an ambulance is called to transfer the patient. If an urgent transfer is called for a helicopter is called for.

[31] In addition to the common cause facts, the Applicant testified and said that it was at 18h10 that she arrived at MOT and by that time Mr Grobler had been at the Hospital for some 30 minutes without a doctor attending to him as she had been busy with a caesarian action. Nurses and paramedics were attending to him. From the history given to her the patient was ejected from motorbike as a result of which he sustained high velocity injury. She inspected the patient and found that there was an injury on his left lower limb of what was mangled and crushed with two belts applied of proximal part of the leg to make a tourniquet. Two intravenous lines were running and he had a cervical collar to support the cervical spine. Due to the compound open fracture of the femur, there was extremely possible vascular injury impinging the artery or the wind passage, meaning that a major vessel was probably damaged. She considered that

immediately consultation with vascular surgeon or surgeon with experience had to be conducted because there was a life threatening injury. On clinical examination of the patient, his vital signs were blood pressure, 86/36 on the record, oxygen saturation, 97 percent, pulse, 118. She however clarified that her notes were extremely short as she had intention to complete them a little later. But she did not have time due to the demise of the patient and she had to fill the form for the death and an order for the patient to be sent to the pathologist. She could not find the file of the patient on the next day as it vanished and she could not put her notes in it.

[32] She removed the cervical collar to examine the patient. His Glasgow coma scale, GCS, was 15/15 which meant that the patient's opening his eyes, his motor function and his verbal function, were all five, five, five, meaning he communicate with ease, and was not confused. She spoke to the patient who showed understanding of his whereabouts. She found that the patient's chest was clear after she elevated his white shirt and listened to the chest with the middle axillar line in both the left and the right sides of the chest using a stethoscope. She examined both lungs and the cervical spine because there could be extreme injury and after removal of the cervical spine collar, she noticed that the patient did not have cervical spine injury, however she did order the X-Ray of the cervical spine because cervical spine and chest X-Ray were part of the Advanced Trauma Life Support Manual principles, with acronym ATLSM, that was very essential for management of trauma patients.

[33] She said that she used a stethoscope to listen to the heart sounds and found them normal. That was reference to S1 and S2 in her report she was reading from. Her report referred to no peritoneum tenderness which she said meant that the patient did not have abdominal injury, what can be very common in that type ejection from the motorbike. There was no clinical notice for rupture of spleen or rupture of the liver or blunt abdominal injury involving intestines, which can happen in those conditions. To determine this, she did the palpation of the abdomen and after that she did the auscultation, to notice that the sound of

bowels was present. The patient did not complain about any respiratory problems. She authorized blood transfusion as the patient was in heavy hypovolemic shock, meaning that he lost about two and a half litres of blood. The nurse left and returned immediately with blood and transfusion was done. To support the airways she ordered the oxygen mask because she determined that there was no reason for endotracheal intubation of the patient at the time. His oxygen saturation was 97 percent and his respiratory rate was 24 per minute.

[34] She advised the paramedic and the day nurses to pack the wound with gauze. She said that she prescribed 2g of Ranzol, tetanus toxoid and pethidine as painkillers. That prescription was not recorded in her notes that she read from but she said that such could be found in the records of the nurses. Also, she put in a urinary catheter to check the urine output because it was important to see whether the patient responded to the infusion of the fluids and to see that the amount of urine was adequate. With a lot of blood that was lost by the patient it could not be anticipated that blood pressure would immediately rise but she was satisfied that what was done was extremely good resuscitation with IV fluids, with both the left and the right arm. After examination on the patient, she went to the main casualty at about 18h30 to telephone Ms Buddan. She did not want to speak in front of the patient about his condition. She took an x-ray form from the cupboards in the cubicles and filled it to request chest x-ray, cervical spine x-ray, x-ray of the tibia and x-ray of the femur. She tried to speak to Ms Buddan but due to MTN connectivity problems, she was unable to get through to her and the switchboard operator undertook to find Ms Buddan for her. She also called the lab technician who had to be called from home and she was able to speak to him. He was to come and take blood tests for the HB and to determine what was the patient's level of haemoglobin, what is called the full blood count and urea and electrolytes with acronym FBC, U & E. The results bearing the time 19h35 indicated the sodium as 132; Kalium 3, urea 102; it was normal urea. There was some creatinine. Then, HB, was 10.3 which meant that the patient reacted negatively as a result of loss of blood. It was at 18h55 that Ms Buddan telephoned her, having arrived at Hospital from her home. She told Ms Buddan

that the patient was not stable enough to be sent to the x-ray department because he was still in shock, due to the big hemorrhage he suffered.

[35] She said that they could not keep cases such as of Mr Grobler in G J Crookes Hospital. There was also an instruction from ATLSM course that every practitioner who examined a suspected vascular injury should immediately have to draw the attention of a vascular surgeon or at least a surgeon of such patient. She then telephoned Dr Wella an Orthopedic Surgeon of Port Shepstone Hospital, which was their Regional Hospital. Dr Wella told her to discuss the case with the vascular surgeon in Inkosi Albert Luthuli Hospital. She telephoned Inkosi Albert Luthuli Hospital to speak to Dr Govender but he was not available and it was said that she was to call back after an hour. At that stage she went back to observe the patient and noted that there was no significant change in his condition as he was with good respiration, he had two IV lines, and he had two oxygen masks. At about 19h10 she telephoned the maternity ward for assistance from any available doctor but none was available as they were still busy with caesarean action.

[36] At about 19h15 the Applicant communicate with Dr Govender and she explained the nature of the injury that there was a possibility of vascular injury, that the left lower limb was also some transection in the posterior part of the calf, meaning that there was surely vascular injury of the tibia being a fracture. She said that the tourniquet was put on at about 16h40. Dr Govender told her that she was going to admit the patient but she said that the Applicant was rather to discuss the condition of the patient with ICU trauma unit also at Inkosi Albert Luthuli Hospital. She then returned to the side of the patient so as to check the oxygen saturation which was 96/97. Blood transfusion was ongoing, and the patient was not in respiratory distress. His respiratory rate was 24, so she simply told the nurses to continue with resuscitation of the patient and returned to casualty room from where she made a call to Inkosi Albert Luthuli Hospital at 19h30. She spoke to Dr Mukendi a trauma doctor, who asked her different questions about the patient, about his x-ray results of the HB which was not yet done. He also asked

about the blood gas analysis which she was not sure if it had been done. She discussed with him regarding the tourniquet, saying there was a vascular injury, that the leg was mangled and crushed and he said that when the patient stabilised, he would be admitted at Inkosi Albert Luthuli Hospital for amputation. He specifically said that the tourniquet was to be left in place and they were to stabilise the patient and that the patient could be transferred for management.

[37] Without the Applicant being told of it, the patient was taken to the x-ray department. She received a call from her private telephone and the call was simply cut without her knowing who was on the other side. Then she received another call from a second extension telling her that the patient deteriorated in the x-ray department. She was surprised because she had just checked the patient who was fine. She was still talking to Dr Mukendi and she told him that the patient had deteriorated and she then immediately went to the x-ray but could not walk fast and she came across the nurses wheeling the patient back to MOT. She could not walk fast because she had some operation in her right knee a couple of years ago and a Baker's cyst was removed from her knee under general anaesthesia. She could see that the patient was breathing with difficulty and had tachypnea and dyspnoea meaning that the patient was fast breathing and irregularly. The oxygen saturation was dropping and she decided to intubate the patient. She then immediately made a call to Dr Mncwango for assistance as the patient had a big neck and she anticipated a very difficult intubation. She told the nurses to prepare the set for intubation.

[38] Dr Mncwango arrived and he walked past and he queried why intubation was to be done to a patient who was breathing or talking. She could not understand him. Dr Mncwango considered that the patient did not need intubation because he was talking and breathing or something like that. Dr Mqadi entered immediately and she heard this conversation. Dr Mncwango said something about the bleeding and he went immediately to the leg where he removed the dressing. He started to suture. She tried to explain to Dr Mqadi that the patient was breathing with difficulty. However, Dr Mqadi considered the advice of Dr Mncwango that

the patient did not need intubation and she was talking Zulu language with the nurses. She did not take in consideration the request of the Applicant.

[39] Ms Buddan brought the developed x-ray photos to the Applicant and said that the x-rays were incomplete. The Applicant reviewed the x-ray of the femur, the tibia, cervical spine and cervical spine with open mouth. The chest x-rays were not there. Ms Buddan took the envelope with the x-rays away with her. CPR was performed for approximately half hour after the doctors came to the MOT. That was the time for the intubation and this was approximately from 20h30 to 21h00 when the patient demised. Ms Buddan later brought the x-rays inside the MOT and put them in the cupboard but as she was leaving the Applicant told her that the patient had passed away. She left the Hospital at approximately 23:30 and she was on duty on the next day also. As she had been on night call on 31 May and on 1 June, she said that she was totally devastated. Six weeks later she was served with a copy of the charge sheet and the chest x-ray results from which she discern that the patient had pneumothorax, meaning that some air was able to penetrate into the lungs cavity, possibly as a result of a broken rib. She conceded that she did not think of using the bedside unit to x-ray the patient but she maintained that there was no one to blame for the belated discovery of the pneumothorax.

Evaluation

[40] It remained common cause that the Applicant was found guilty and dismissed by the Respondent after a properly convened disciplinary hearing. The Respondent had then to prove the fairness of the dismissal. What is to be determined is whether any of the acts of negligence alleged in the charge sheet were proved by the Respondent through its evidence. This matter depends on the probabilities of the evidence led. For a proper consideration of the review application it is prudent to firstly set out the facts found proved by the totality evidence led.

Facts found proved

[41] The following are facts found proved in this matter either because they were not

disputed or if disputed, were not very seriously contested:

- It was at 18h20 on 2 June 2012 that the Applicant arrived at the MOT and Mr Grobler was presented to her. It was not at 17h55 as the Commissioner found in his award.[6] Mr Grobler was talking at the time and was breathing normally. His Glasgow Coma Scale score was 15/15 and his vital signs were also continuously recorded and observed on monitors. Except for Mr Grobler's blood pressure which was low, all other vital signs remained under control and stable. The tourniquet on his left leg minimised bleeding from the injury that was packed with gauze.
- The Applicant prescribed scheduled drugs to be administered as medical treatment on Mr Grobler. She also ordered blood tests to be carried out and that blood transfusion was to be done for him. She ordered that Mr Grobler be catheterized and it was done.
- At about 18h30 the Applicant contacted Ms Buddan, who was at home to make arrangements for Mr Grobler to be x-rayed. She also called the laboratory technician who had to be called from home to come and take blood tests for Mr Grobler. Also, at about 18h30 the Applicant telephonically discussed the situation and condition of Mr Grobler's left leg with a Dr Wella an orthopaedic surgeon at Port Shepstone Hospital as GJ Crookes Hospital had no surgeons and/or specialists that could assist Mr Grobler. She was referred to a vascular surgeon at Inkosi Albert Luthuli Central Hospital. Dr Govender, a vascular surgeon was unavailable at the time;
- It was acceptable practice for Medical Officers to consult specialists in their own hospitals, or other hospitals for advice in cases with complicated life-threatening injuries. It was also the practice to transfer patients once stabilised to hospitals where appropriate specialist treatment was available and again this practice was recommended in life-threatening cases particularly in a situation where the patient was first treated in a district hospital where the necessary resources and skills were often lacking. The Applicant was a Medical Officer.

[6] See para 13.2 under analysis in the award.

- The Applicant kept a constant check on Mr Grobler who was still hypovolemic and being administered fluids through two intravenous lines and blood transfusion was ongoing. He had not yet stabilised. At about 19h00 Ms Buddan telephoned to report that she had arrived at the Hospital and was ready to do Mr Grobler's x-rays. The Applicant informed her to wait as he had not yet stabilised. Instead another patient was sent to the x-ray department in the meantime for x-rays. At about 19h00 Matron Dlamini had a discussion with the Applicant about the issue of the X-rays. The nurses had complained to her saying that the Applicant refused to send Mr Grobler for X-rays. By then the Applicant had already asked Ms Buddan at approximately 18h30 to come to Hospital for x-rays.
- The Applicant again left the MOT at approximately 19h15 to contact Dr Govender who after being told of the situation advised the Applicant to contact an ICU/trauma unit. The Applicant returned to the MOT and instructed the nurses to continue administering fluids and blood to Mr Grobler and to continue to support breathing by way of oxygen mask. At approximately 19h30 the Applicant left the MOT to contact Dr Mukhendi, the trauma specialist, and she discussed Mr Grobler's condition. Dr Mukhendi advised The Applicant not to remove the tourniquet and to leave it in place due to the vascular injury.
- At approximately 19h40 Ms Buddan contacted the minor operating theatre enquiring about Mr Grobler's condition. One of the nurses informed her that Mr Grobler's condition was stable enough for the x-rays to be taken. Without the Applicant's knowledge and instruction the nurse then made arrangements for Mr Grobler to be taken to the x-ray department. Mr Odendaal and friends of Mr Grobler assisted to take Mr Grobler to the x-ray Department. A porter also assisted. The porter carried the oxygen bottle. At the x-ray department Mr Grobler was moved from the trauma stretcher to the X-ray bed by Ms Buddan, assisted by Mr Odendaal. It was difficult to move Mr Grobler, being a big person. Some x-rays were taken of Mr Grobler and needed to be processed.

- Whilst Ms Buddan was processing the x-rays in the dark room, Mr Grobler, for the first time, started complaining about respiratory problems and his condition then changed drastically. He was twisting and turning on the x-ray bed. Ms Buddan attempted to contact the Applicant telephonically to inform her that Mr Grobler's condition was deteriorating but was unsuccessful as the line was cut. At that stage the Applicant was not aware that Mr Grobler was in the x-ray Department and had no idea of his deteriorating condition as she was discussing his case with Dr Mukhendi on another telephone line. She informed Dr Mukhendi of the complication and then proceeded to the x-ray department only to come across nurses wheeling Mr Grobler back to the MOT as Ms Buddan had succeeded in making contact with them. The Applicant followed them. Mr Grobler was reconnected to the monitor and resuscitation measures were resumed on him. The Applicant soon left the MOT to telephone other doctors to immediately come to assist her. She spoke to Dr Mncwango and described the problem asking him to come and assist with the intubation process.
- Doctor Mncwango met Dr Mqadi and he told her of the report he received from the Applicant. Though Dr Mncwango was about to knock-off, he and Dr Mqadi rushed to the MOT.
- Dr Mncwango entered the minor operating theatre and expressed a view that it was not necessary to intubate Mr Grobler given that he was still able to talk. He went straight to the left leg of Mr Grobler and began to remove gauze and sutured it. Dr Mqadi soon also came in and attended to the upper torso of Mr Grobler. She began with the intubation process which gave her difficulties. In the meantime Dr Mbhele had arrived and he went to assist Dr Mncwango but when seeing the difficulties in the intubation process went to assist with it. He succeeded. By then the patient was restless, saying he could not breathe. The doctors began with cardio-pulmonary resuscitation. The whole process took about 30 minutes but at the end of it, at about 21h00 Mr Grobler was certified dead.

- Mr Grobler had seven broken ribs with pneumothorax, surgical emphysema and haemothorax.

The review test

[42] The law governing the test for review has become trite. Simply stated the question is whether the decision reached by the Commissioner is one that a reasonable decision – maker could not reach.[7] Of interest, in *Herholdt v Nedbank Ltd*[8] the following was stated by the Supreme Court of Appeal concerning the review of CCMA arbitration awards:

> "In summary, the position regarding the review of CCMA awards is this: A review of a CCMA award is permissible if the defect in the proceedings falls within one of the grounds in s 145(2)(a) of the LRA. For a defect in the conduct of the proceedings to amount to a gross irregularity as contemplated by s 145(2)(a)(ii), the arbitrator must have misconceived the nature of the inquiry or arrived at an unreasonable result. A result will only be unreasonable if it is one that a reasonable arbitrator could not reach on all the material that was before the arbitrator. Material errors of fact, as well as the weight and relevance to be attached to particular facts, are not in and of themselves sufficient for an aware to be set aside, but are only of any consequence if their effect is to render the outcome unreasonable."

[43] Paragraphs 13 to 21 of the Labour Appeal Court decision in *Gold Fields Mining South Africa (Pty) Ltd (Kloof Gold Mine) v CCMA & Others*[9] also provide an essential guide for a review test. I shall however, refer only to paragraph 21 which reads:

> "[21] Where the arbitrator fails to have regard to the material facts it is likely that he or she will fail to arrive at a reasonable decision. Where the arbitrator fails to follow

[7] *Sidumo & Another v Rustenburg Platinum Mines* (2007) 28 ILJ 2405 (CC).
[8] [2013] 11 BLLR 1074 (SCA) at [25].
[9] (2014) 35 ILJ 943 (LAC).

proper process he or she may produce an unreasonable outcome (see Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others 2006 (2) SA 311 (CC)). But again, this is considered on the totality of the evidence not on a fragmented, piecemeal analysis. As soon as it is done in a piecemeal fashion, the evaluation of the decision arrived at by the arbitrator assumes the form of an appeal. A fragmented analysis rather than a broad-based evaluation of the totality of the evidence defeats review as a process. It follows that the argument that the failure to have regard to material facts may potentially result in a wrong decision has no place in review applications. Failure to have regard to material facts must actually defeat the constitutional imperative that the award must be rational and reasonable – there is no room for conjecture and guesswork."

[44] A proper enquiry therefore simply turns on whether the factual conclusions reached by the Commissioner in the award are reasonable in the light of the evidence before him or her. If so, it is the end of the probe. If not, and there is a glaring discrepancy between the evidence presented and the conclusion reached by the commissioner then the award is unreasonable.[10]

Grounds for review

[45] When summarised the grounds for review are that the Commissioner issued an unreasonable award by misconstruing evidence led at arbitration in relation to:

- Mr Grobler having complained that he could not breathe when he was examined at about 18h20;

- The results of the chest x-rays and what the Applicant could possibly know thereabout;

[10] See also *Nampak Corrugated Containers (Pty) Ltd v Commissioner for Conciliation, Mediation and Arbitration & Others* 2009 (30) ILJ 647 (LC).

- The Applicant informing Mr Grobler's friends that she did not know what to do and that she phoned other doctors which was the first sequence in her patient examination;

- The Applicant initially refusing to do X-rays on a patient with poly-trauma suggested by nurses until she was eventually convinced by the night matron;

- Mr Grobler's condition getting complicated in the x-ray Department, Ms Buddan calling the Applicant who cut the call and did not inform them on the immediate care;

- The decision at 19h40, taken by an unidentified nurse, to take Mr Grobler to the X-ray Department;

- The Commissioner being bias against the Applicant;

- Ignoring the Applicant's discretion in the treatment of Mr Grobler;

- The alleged failure to do a full examination;

- The alleged failure to check the bleeding wound;

- The use of the bedside unit;

- The alleged failure by the Applicant to assist when Mr Grobler arrived back in the minor operating theatre.

[46] In opposing this application the First and Fourth Respondents contended that the Applicant did not prove on the balance of probabilities that the Second Respondent committed any irregularity for the reasons, inter alia, that:

- The Applicant failed to do a full standard examination of Mr J Grobler she received from EMRS at 17h50, who was complaining that he had difficulties breathing and yet the applicant reported in her notes that the chest was clear;

- The chief post-mortem report recorded that Mr Grobler suffered from fractured ribs, air and blood in the chest cavity. The Applicant ordered x-rays and did not view them until some 1 and a month later;
- The above is inconsistent with Applicant's allegations that she examined the patient by use of a stethoscope, the Second Respondent correctly and reasonably held that in all factors considered if indeed the Applicant examined the patient's chest then it 'would have been clear that not everything was right. It is thus inconceivable that a patient report form would record that Mr Grobler did not have respiratory problems in light of the post mortem report and the fact that by the Applicant's own admission, Mr Grobler had an abrasion on the side of his body, consistently in the rib area;

- Under cross examination, the Applicant was asked why the bedside unit was not used and her answer was that it did not come to her mind and she did not think of using the bedside unit. The Applicant further conceded that had the bed side unit been used, the chest injuries would have been picked up, identified and the necessary intervention would have been made. By all accounts the Applicant further conceded that the patient had a bruising on his chest and nobody could have missed

that and the Applicant missed it because she did not use the bed side unit;

- The Applicant could not give a proper account of what she exactly did for the patient except spending what appeared to be an inordinate time seeking advice from other doctors and spent quite some time on the telephone. The above rightfully gave Mr Odendaal an impression that nothing was being done for Mr Grobler and same is consistently corroborated by the evidence of the nurses that they had to beg the Applicant to submit Mr Grobler for X-Rays which she admitted she later relented to albeit after a considerable amount of time;

- What appears on the Applicant's affidavit is the recordal of times of examination in an attempt to convince the court that she was at all times material vigilant in monitoring and examining Mr Grobler and yet she also admitted that she was constantly seeking advice from what appears to be quite a number of doctors. A glaring contradiction is found herein. When did the Applicant find time to examine and seek advice from other doctors and more especially in a case of being asked 'many questions' by Dr Mukhendi which it can then be inferred that the Applicant spent a considerable amount of time on the telephone with the said doctor. She displayed an adverse ineptitude by failing to exercise duty of care;

- It is certainly an incredulous excuse by the Applicant in alleging that she was not aware that the patient was taken to x-ray when she herself agreed after being convinced that the patient be taken for x-rays and having completed an x-ray form. The Second Respondent correctly held that the Applicant did not give clear instructions to the nurses in respect of managing the patient;

- What is crystal clear to the Second Respondent is that indeed the Applicant failed to stabilize the condition of Mr Grobler;

- The Applicant failed to exercise duty of care and failed to take control of the situation. Therefore the decision of the Second Respondent is not reviewable as no other arbitrator could reasonably come to a different conclusion as that of the Second Respondent and that the Applicant failed to prove irregularity and that such irregularity led to an unreasonable conclusion.

[47] It has correctly been submitted by the Applicant that there was no evidence that Mr Grobler complained about having difficulty in breathing up until he was taken to the x-ray room. None of the witnesses of the Respondents testified to the contrary. The first time the issue of a breathing problem arose was when Mr Buddan came out of the darkroom. Surely a patient with a breathing problem would not normally be removed from the life supporting system in order to take him to the x-ray room. The unknown nurse who authorised taking Mr Grobler to the x-ray room would have assumed that the patient was then stabilised, meaning he had no breathing problems. A finding by the Commissioner suggesting that Mr Grobler already had a breathing problem is not supported by evidence.

[48] The Commissioner found that the Applicant negligently failed to give Mr Grobler medical treatment. Yet, while Mr Grobler was connected to the monitor he was given medical treatment that only a doctor could prescribe. He received blood transfusion and the only evidence on record is that it was ordered by the Applicant. She put in a urinary catheter to check the urine output because it was important to see whether the patient responded to the infusion of the fluids and to see that the amount of urine was adequate. The Matron's report submitted by Nurse Ngcobo, which the Commissioner did not even consider, bears reference to these findings when it says:

> "….Doctor came in, ordered bloods, X-Rays, opened the wound and packed the wound and said to take patient to X-Rays. Catheter was put in and the IV lines…"

[49] The Applicant was said to have acted negligently by not suturing the injury on the left leg. She had two options either to suture the injury or to pack it with gauze and she went for the latter. Thereafter there was no active bleeding. She used her medical discretion on what was best for the patient. If the Applicant was as none participant in treating Mr Grobler as testified to by witnesses of the Respondents, it becomes difficult to understand how she prescribed all the treatment given to Mr Grobler. I am accordingly bound to find, as I do, that witnesses of the Respondents have been very stingy with the truth on the role played by the Applicant in the treatment of Mr Grobler.[50] The arrival of Ms Buddan at Hospital is yet another pointer to the truth. It remained common cause that soon after the Applicant was presented with Mr Grobler she asked the switchboard to call Ms Buddan and the Laboratory Technician to come to the Hospital, they duly responded. This was around 18h30. To say that the Applicant called for a radiographer but did not want to have x-ray examination conducted is devoid of any logic. There is no evidence of what else Ms Buddan did in Hospital so as to suggest that she was not called for the x-rays. Ms Buddan's evidence was that she was called from home at the instance of the Applicant and once she arrived at Hospital the Applicant informed her that Mr Grobler was not stable enough to be taken up for the x-rays. In this regard her evidence materially supported that of the Applicant. Again, witnesses of the Respondents lied about the attitude of the Applicant on the taking of the x-rays. The fact that the Applicant, at some stage found Mr Grobler not fit to be taken to the x-ray room must not be construed as a refusal to have x-ray examination conducted.

[50] It remained common cause that, while the Applicant set up a stage for Ms Buddan to take x-rays on Mr Grobler, the Applicant formulated an opinion that

time for that was not yet opportune. She expected Mr Grobler to respond positively to the treatment given to him by being medically stable. She then left him to respond positively to this treatment and went to make consultative telephone calls. Anyone outside of Hospital experience who did not know and understand the limitations within which medical officers at this Hospital worked might be excused for thinking that the Applicant spent unnecessary time on the telephone. With the condition in which Mr Grobler presented himself, the Applicant was medically and legally bound to consult specialist doctors.

[51] The transferring of Mr Grobler to the x-ray room is another important development in this matter. It was clearly done without the consent and authority of the treating doctor, the Applicant. The very important life supporting systems that were put to stabilise Mr Grobler had to be removed from him to wheel him away from the MOT. No sooner had this been done than did he react negatively. It is not surprising that the identities of those nurses who were involved in this unauthorized conduct suddenly became a secret. They were confronted with a reality that the Applicant was all along correct in restricting the movement of Mr Grobler until he would be stable enough. Those nurses are the ones responsible for the complication in Mr Grobler's health. There was no basis for holding the Applicant responsible for allowing nurses to go alone to the critically ill patient in the x-ray room. She did not even know about that movement of nurses. Those nurses were confronted with having to correct their own mischief of disrespecting a doctor's instruction to first stabilise the patient.

[52] The evidence of Ms Buddan is essential in describing the condition of Mr Grobler. As she came from the dark room she found him twisting and turning. That had never happened before. Clearly therefore by moving Mr Grobler from a bed in the MOT to a stretcher, wheeling him up to the x-ray room and removing him from the stretcher to an x-ray bed caused a movement of his thoracic cage which had been damaged during the accident. The movement of Mr Grobler exacerbated his medical condition. That was precisely what the

Applicant sought to avoid by delaying the x-ray examination. Even the packed gauze was probably disturbed by the twisting and turning re-opening the wound.

[53] When Ms Buddan attempted to telephone the Applicant the telephone line was cut even before she could speak and reveal her identity. The problem with telephone lines was a common feature of the Hospital. There is no evidence on record that the Applicant deliberately and rudely cut the line. The Commissioner's contrary finding in this regard is a clear example of a grievous misdirection.

[54] Once Mr Grobler was wheeled back to the MOT, he was in a hysterical condition which needed an urgent intervention. He complained about his inability to breathe. The Applicant saw this condition. She was held to blame for doing nothing to rescue the situation. It is common cause that she went out to telephone other doctors to come to her assistance. Her explanation was that the patient had a thick and short neck which would make endotracheal intubation difficult. What is lacking in the evidence is whether the nurses could not assist her in holding the patient to a proper position for her to insert a laryngoscope into the mouth of the patient and be guided by it to insert the breathing tube and keep it in place so that oxygen could then be pumped directly into the wind pipe and to the lungs. Placing a wrestles patient into a proper position for intubation is notoriously difficult. It might very well be unfair and improper to hold it against the Applicant that she did not immediately initiate intubation before other doctors arrived to help her. After all, Dr Mncwango avoided intubation on his arrival at the MOT and he went for something that was hardly urgent. He was called to assist with intubation and not to suture the wound. Also, Dr Mqadi tried to intubate with no success until the intervention of Dr Mbhele. Neither Dr Mqadi nor Dr Mncwango was disciplined for their failures.

[55] Ms Buddan conceded that she had not processed the chest x-rays when the condition of Mr Grobler took a turn for the worse. At that time and until Mr Grobler died therefore, there were no chest x-rays available for the Applicant to examine. This is yet another gross misdirection in the findings of the Commissioner. The chest x-ray examination was conducted but the results thereof were in the cassettes that Ms Buddan was yet to process.

[56] The Applicant was held to blame for failing to request a bedside unit. The evidence was never clear as to when it was opportune to use this unit. With hind sight it became clear that Mr Grobler was not to be move about until he stabilised. This allegation could have merits had Mr Grobler first stabilised. The Applicant would then be faced with an option of either sending him up to the x-ray room or tell Ms Buddan to come down to the MOT to do the examination there. In respect of the x-rays taken by Ms Buddan, the chest x-rays were processed after Mr Grobler had died. She might probably have done the same thing with processing the x-rays for the bedside unit. Therefore blaming the Applicant was mere conjecture.

[57] The Applicant is said to have told the patients' friends that she did not know what to do. A closer examination of what the Applicant did evinced convincingly that she knew what she was about and was on the right tract until her plan was changed by nurses who misjudged the situation.

[58] The findings I have made indicate with no doubt that the Applicant was never proved to have acted negligently in treating Mr Grobler. The Commissioner failed to have regard to the material facts in this matter. He also failed to evaluate facts presented at the hearing with the consequence that he came to conclusions that were unreasonable in justifying his decision. No meritorious submissions have been made in assailing the procedure followed at the arbitration. However, this award cannot stand. It has to be reviewed, set aside and substituted.

[59] The following order shall issue, taking into account the fairness of the costs

order, being mindful of the trouble unnecessarily caused to the Applicant in this matter:

1. The arbitration award of the Second Respondent in this matter is reviewed, set aside and substituted with a finding that the dismissal of the Applicant by the First and Fourth Respondents was substantively unfair.
2. The First and Fourth Respondents are directed to reinstate the Applicant to her employment with effect from the date of her dismissal with no loss of income and benefits that she would ordinarily be entitled to but for the dismissal, subject to the retirement of the Applicant on her normal retirement date, that is at the end of March 2015.
3. The First and the Fourth respondents are ordered to pay the costs of this application, the one paying the other to be absolved.

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Cele J

Judge of the Labour Court of South Africa.

APPEARANCES:

For the Applicant: Mr G van der Westhuizen

Instructed by MacRobert Inc, Durban

For the Respondents: Mr S Giba

Instructed by the State Attorney, Durban, KZN.