



9 February 2015

**DRAFT REPORT OF THE SELECT COMMITTEE ON PETITIONS AND EXECUTIVE UNDERTAKINGS ON THE HEARING OF THE PAUL MKHIZE PETITION, HELD ON 5 NOVEMBER 2014 AT PARLIAMENT**

**1. BACKGROUND**

The petition was submitted by Mr Mkhize (Mkhize) and tabled on the ATC on 26 September 2011 and thereafter referred to the Select Committee on Petitions and Executive Undertakings (Committee) for consideration. The petition relates to the death of his late wife Ms Matiwane (the deceased). The petitioner was married to the deceased in terms of customary law and on 1 April 2004, the deceased died at Groote Schuur Hospital in Cape Town (GSH) after giving birth to their daughter. The death of the deceased was treated as a natural death and attributed to the medical complications she experienced prior to her death. The petitioner is of the belief that she did not die from medical complications but died as a result of medical negligence on the part of the attending doctors and nurses at Mowbray Maternity Hospital (MMH) (where she was admitted before being transferred to GSH). It is for this reason that the petitioner requests the assistance and intervention of the Committee in re-opening the inquest on his late wife's death.

**2. PURPOSE OF THE HEARING**

The purpose of the hearing was to give Mkhize an opportunity to appear before the Committee and make oral submissions in relation to the petition he submitted to the NCOP.

**3. COMMITTEE AND OFFICIALS**

The following Committee Members were present at the hearing of the petition:

- Hon S G Thobejane, ANC, Limpopo;
- Hon M J Mohapi, ANC, Free State;
- Hon LPM Nzimande, ANC, KZN;
- Hon M T Mhlanga , ANC, Mpumalanga;
- Hon G M Manopele, ANC, Northern Cape;
- Hon D L Ximbi, ANC, Western Cape;
- Hon T Wana, ANC, Eastern Cape'
- Hon Michalakis, DA, Free State;
- Hon J W W Julius, DA, Gauteng; and
- Hon M Chetty, DA, KZN.

The Members at the hearing were supported by Mr T Madima, the Committee Secretary.

#### **4. STAKEHOLDERS IN ATTENDANCE**

In addition to Mr Mkhize (Mkhize) other stakeholders were present at the hearing, namely:

2.1 Ms S Brink, legal adviser, Department of the Premier in the Western Cape;

2.2 Ms N R Rhoda, new born care improvement adviser; and

2.3 Mr J Kgatla, Parliamentary Officer in the National Department of Health.

The above stakeholders made no submissions to the Committee.

#### **5. SUBMISSIONS BY MKHIZE**

Mkhize began his submissions by pointing out to the Committee that when his late wife died he was resident in both the Western Cape and in Kwazulu-Natal (KZN). He further related how the deceased attended at St Mary's Hospital in KZN after falling pregnant and was never warned about her health. The family later decided to relocate to Cape Town however before their relocation the deceased collected a referral letter from a Dr Matelengisa.

After settling in Cape Town, the petitioner's wife fell ill and went to MMH for medical attention. Where she was told she would not be attended to until she brought documentation relating to her medical history and her husband's personal details and that of his workplace. When she was eventually treated at MMH she was diagnosed with GPH or pre-eclampsia. And because her condition was so poor the specialist doctors that examined her decided to admit her in the high care area of the hospital. An emergency caesarean was also performed on her after there was an attempt to induce her. The deceased was later transferred to the intensive care unit of Groote Schuur Hospita (GSH and died there. Her death was attributed to complications associated with pre-eclampsia.

The various specialist doctors who attended to her prior to her death include Dr Dietrich who admitted her to the high care area; Dr Lowe who observed her during the day on an hourly basis; and Dr Dlamini who attended to the deceased in consultation with Dr Fawcus, a senior specialist at MMH. According to the petitioner, the latter is said to have prescribed induction of labour on the deceased. The petitioner further contends that other doctors in a similar position would have not have tried to induce labour in the circumstances but would opted to only perform the emergency caesarean.

Mkhize also indicated that he had doubts around the circumstances leading to the death of his wife because:

- Her death is attributed to medical complications yet these complications are not clearly outlined;
- MMH has a reputation of accepting late referrals; and
- There is evidence to suggest the specialist doctors who had attended her had been negligent.

As such he is of the firm belief her death was largely due to negligence on the part of MMH and the nurses and specialists who attended to her at MMH. And as such the hospital and the concerned specialists should be held accountable her death.

On a personal level, the petitioner expressed a wish to clear his own name given that some of his late wife's family members were blaming him for her death. He also revealed that he was facing challenges with his ten year-old daughter and as a result she is now in the care of his congregation. Mkhize submitted he had incurred a lot of expenses in the course of trying to re-open the inquest into the deceased's death. In this respect he indicated he had spent approximately R12, 450.00 for 490 pages of case documents. He further informed the Committee he had quarrelled with his legal representatives.

Mkhize also submitted that on 3 March 2006 he had filed a statement with the South African Police Services (SAPS) and opened a case of negligence against MMH's medical and nursing staff. An investigation was conducted but it yielded no results. What is more, the Cape Town Magistrates Court had dismissed his claims on 26 December 2008 and he proceeded to request the findings of the case since he wanted to undertake his own investigations and further approach the Judge President of the Western Cape High Court. In addition, Mkhize claims he has approached the Minister of Justice for assistance and he has received no assistance.

It is also worth noting that the petitioner raised a number of frustrations with the initial inquest carried out on the death of his wife. His frustrations are mainly that:

- The circumstances surrounding the death of his late wife are strange and doubtful, particularly more so because she died under the influence of anaesthetic;
- His wife's inquest was the first inquest case in 13 years;
- The presiding magistrate over the inquest was Ingrid Freitag and she cleared MMH of any wrongdoing;
- It was difficult to obtain the post-mortem report following the deceased's death and this grossly violated his human rights and was against the interests of justice;
- The inquest magistrate did not summon the state Pathologist, Dr Linda Liebenberg, who stated the deceased's grandmother signed a consent in relation to an academic autopsy.
- He has no access to the records of all the telephone calls made during the concerned period. Nor does he have access to the register of entries and exit at MMH;
- The nursing sister in charge at the time the deceased died had not given evidence as well as the clerk, the social worker and the doctors who were present at the time the deceased died;
- He cannot access the copy of the alleged consent letter signed by the grandmother of the deceased in relation to the academic autopsy; and
- The investigator who investigated the case he opened at SAPS had not given evidence and neither had inspector Jones of SAPS; and
- The fact that there was delay in transferring his wife to GSH was ignored during the inquest.

Mkhize reiterated to the Committee that he requires its assistance and intervention in re-opening the inquest into the death of his late wife, in terms of section 17A of the Inquest Act (Act No 58 of 1959). The said section of the Act provides that the Minister of Justice may, after the determination an inquest, request the Judge President of the Supreme Court's provincial division to designate any Supreme Court judge to re-open an inquest.

## 6. RECOMMENDATIONS

The Committee made the following recommendations on the basis of the submissions made by the petitioner:

- 6.1 All supplementary documents in possession of the petitioner be handed to the Committee Secretary.
- 6.2 Other implicated hospitals and health facilities to make submissions – these are MMH GSH, Kloof Hospital and St Marys' Hospital.
- 6.3 The Office of the Premier of the Western Cape be appraised of the petition through the Office of the Chief Director of the Department of Health.
- 6.4 The legal adviser from the Office of the Premier of the Western Cape, Ms S Brink, be given 21 days within which to update the Committee on the matter. [It is important to note that the Committee is still awaiting an update from Ms S Brink in this regard and has endeavoured to Ms S Brink reminding her that the Committee is awaiting her update letter].
- 6.5 Committee to receive advice from the Provincial Government as regards the investigation conducted against MMH.
- 6.6 All the stakeholders in attendance to provide the Committee with written reports on the petition (following the submissions made by the petitioner) through the Office of the Premier.

*Report to be tabled for consideration.*