IN THE LABOUR APPEAL COURT OF SOUTH AFRICA

(HELD AT BRAAMFONTEIN)

CASE NO JA44/2006

In the matter between:

CARSTENHOF CLINIC **APPELLANT**

and

COMMISSION FOR CONCILIATION MEDIATION

AND ARBITRATION **FIRST RESPONDENT**

BIERMAN D NO. **SECOND RESPONDENT**

DEMOCRATIC NURSING ASSOCIATION OF

SOUTH AFRICA **THIRD RESPONDENT**

VENTER M **FOURTH RESPONDENT**

JUDGMENT

Tlaletsi AJA

[1] There are two opposed applications for the condonation of instances of non compliance by the appellants with the rules of this Court. The first application relates to the appellants failure to comply with Rule 5(1). In terms of this rule the appellant was obliged to deliver the notice of appeal within 15 court days after leave to appeal had been granted. In this case notice of appeal was filed 27 days out of time. The second

application relates to a failure to comply with Rule 5(17). In terms of Rule 5(8) the record of appeal is required to be delivered to the Registrar within 60 court days of the date of the order granting leave to appeal unless the appeal is noted after a successful petition for leave to appeal in which case it must be delivered within the period fixed by the court under Rule 4(9). Rule 5(17) provides that:

> "*if the appellant fails to lodge the record within the prescribed period, the appellant will be deemed to have withdrawn the appeal, unless the appellant has within that period applied to the respondent or the respondent's representative for consent to an extension of time and consent has been given. If consent is refused the appellant may, after delivery to the respondent of the notice of motion supported by affidavit, apply to the Judge President in chambers for an extension of time. The application must be accompanied by proof of service on all other parties. Any party wishing to oppose the grant of an extension of time may deliver an answering affidavit within 10 days of service on such party of a copy of the application*".

In this case the complete record of the appeal was lodged 19 days out of time. The explanation given by the appellant for non compliance in both instances is that the attorney principally responsible for handling with the matter on behalf of the appellant had been disposed due to both bereavement and illness and the matter had then been entrusted to an attorney with no

experience in the practice of Labour law. The attorney says that lack of experience and failure to read and familiarise herself with the rules of this Court led her not to comply with the rules of this Court in the prosecution of the appeal. She, however, did request an extension of time from the respondent's attorney in terms of Rule 5(17) and same was refused. The respondent's attorneys adopted the attitude that the appeal had already lapsed. Her request to the respondent's attorney for an extension of time may well mean that she did read Rule 5(17) of the Rules which provides for the making of such a request.

[2] The periods of delay in the appellant's failure to comply with the rules of this Court as set out above are not excessive. The merits of the appellant's appeal are reasonably arguable. In so far as the explanation for the delay is concerned, the explanation may not be wholly satisfactory but, when all the factors are taken into account, I am satisfied that good cause has been shown for the appellant's failure to comply with the Rules of this Court. The merits of the appellant's appeal are reasonable accordingly, such failure is hereby condoned. This being the case, a proper case has been made out to justify an order reinstating the appellant's appeal after it was deemed to have been withdrawn by virtue of Rule 5(17). The condonation application is therefore granted and the appeal is reinstated

[3] This is an appeal against a judgment of the Labour Court in a review application brought by the second appellant against an arbitration award

issued by the second respondent under the auspices of the Commission for Conciliation, Mediation and Arbitration (CCMA) in a dispute referred to the CCMA by the third and the fourth respondent for arbitration in terms of sec 191 of the Labour Relations Act, 1995 (Act 66 of 1995) ("the Act"). The second respondent is a commissioner of the CCMA. The third and fourth respondents contended that the fourth respondent ("the employee") who was at all relevant times employed by the appellant was unfairly dismissed by the appellant. The appellant in turn contended that the dismissal of the employee was both substantively and procedurally fair. The employee is a member of the third respondent which is a registered trade union recognised by the appellant ("the union").

[4] The second respondent ("the commissioner") who arbitrated the dispute found that the dismissal of the employee for misconduct was procedurally fair but substantively unfair and issued an award in terms of which the appellant was to pay the employee an amount equal to 8 months remuneration (R73 960-32) as compensation within twenty one days. The commissioner made no award as to costs.

[5] Aggrieved by the finding and award of the commissioner, the appellant brought a review application in terms of section 145 of the Act seeking an order reviewing and setting aside the award and replacing it with an order to the effect that the dismissal of the employee was both substantively and procedurally fair. The Labour Court dismissed the application for review. It

subsequently refused the appellant leave to appeal to this Court. Further aggrieved, this time by the order of the Labour Court, the appellant petitioned the Judge President of this Court for leave to appeal against the order of the Labour Court. This Court granted such leave.

Factual background

[6] The facts in this matter are largely common cause. The appellant conduct its business as a private hospital. The employee was employed by the appellant as a member of its nursing staff. She was at the time of the incident that led to her dismissal employed as a night supervisor. This position was the most senior of the appellant's nursing staff on the night shift.

[7] It is common cause that the appellant had a written policy pertaining to emergency situations which had been distributed to all units. The policy was to the effect that once a nurse had diagnosed a respiratory or cardiac pulmonary arrest on a patient, he/she was to institute an effective Cardiopulmonary Resuscitation Procedure ("CPR") within two to four minutes and immediately alert the available doctor on the premises to the situation. If there was no doctor on the hospital premises, the paramedics had to be called in for assistance. The rationale of the policy was that there be effective resuscitation measures from basic life support up to advanced life support to be practised by each and every professional nurse. The policy provided further that the nursing staff should engage a doctor to certify a

patient dead. It was expected of each nurse to make sure that he/she was proficient in all aspects of the CPR prescribed by the policy.

[8] Mr N W Ndlovu ("Mr Ndlovu") was admitted at the appellant clinic in the Intensive Care Unit ("ICU"). He was a quadriplegic. Mr Ndlovu made a good progress towards full recovery. He was as a result transferred to ward 3. He was categorised as a patient who was not expected to die.

[9] In the early morning hours of 29 June 2001 Mr Ndlovu died unexpectedly. In accordance with standard practice at the appellant when a patient has died unexpectedly, an investigation into the events surrounding the death of Mr Ndlovu was conducted.

[10] Sister Lynn Cook ("Sister Cook") conducted the formal investigation into the circumstances surrounding the death of Mr Ndlovu. On the 3rd July 2007 she called upon all the parties concerned to prepare the necessary documentation for a formal enquiry. Arising from the investigation, Sister Cook held a *prima facie* view that Sister Warnet Tshabalala ("Sister Tshabalala"), and the employee were negligent in failing to give the patient the optimal chance of survival by complying with the appellants' prescribed policies. Sister Tshabalala was in charge of the ward in which Mr Ndlovu had been accommodated when he died

[11] It was then decided that a formal disciplinary enquiry be held. The following charges were preferred against the employee:

"1. Professional Negligence and Misconduct: on the sudden unexpected demise of Mr W Ndlovu (no 6288) ward 3 on 29.06.2001 at 02.20 hours. You did not

A: Initiate resuscitation and follow the hospital policy re÷ medical emergencies and Obtaining Emergency Assistance.

B: Obtain Certificate of Death by a Doctor at the time of death."

[12] The employee's disciplinary hearing was convened on 13 July 2001. The chairperson of the enquiry found that the appellant's policies relating to resuscitation were not complied with and found the employee guilty. The employee was dismissed.

[13] As pointed out already a dispute relating to the employee's dismissal became the subject of an arbitration which was held in January 2002. Prior to the arbitration the parties concluded a pre−arbitration minute in terms whereof they agreed, *inter alia,* that the appellant's policies relating to resuscitation were applicable in this case and were reasonable. Only two witnesses testified at the arbitration. The appellant tendered the evidence of Sister Cook who was its Nursing Services Manager at the time of the employees' dismissal. The employee testified on her own behalf.

[14] I am of the view that it would be more convenient for the purpose of this appeal to start with the evidence presented on behalf of the union and the employee. The employee testified that she started her nursing training in 1966 and that at the time of Mr Ndlovu's death she had 35 years experience. She had been a night matron at the appellant for seven years. She testified that on 30 June 2001 she took over from one Sister Viljoen in the evening. Sister Viljoen reported to her that Mr Ndlovu was being transferred from the ICU to the ward. She enquired from Sister Viljoen why they were transferring him at night. Sister Viljoen told her that the wards had been busy during the day and they had arranged for a "*special*" [nurse] for his assistance. The employee testified that she also saw Mr Ndlovu when he was being transferred to the ward. He looked fine and relaxed to her. She remembered that the previous evening Sister Cook had telephoned her and told her to keep an eye on the agency sister on duty as she was not doing her documentation properly. The employee testified that the hospital was busy that night and she spent most of her time in the casualty section as well as doing her routine rounds within the hospital.

[15] The employee testified that Sister Janet Coleman ("Sister Coleman") came to her in ward 2 and reported that ward 3 had phoned her earlier on and reported that Mr Ndlovu had a "*high hick-up*" and that she was on her way there. Sister Coleman was an agency sister who was working in the ICU. An agency nurse is someone who is not an employee of the appellant but

registered with an employment agency that was rendering services on behalf of the appellant. The employee then accompanied Sister Coleman to ward 3. Prior to this, nobody had made a report to her about Mr Ndlovu or that they were not satisfied with nurse Ncina. According to her it took about two to three minutes to move from ward 2 to ward 3 where Mr Ndlovu was accommodated. She said that they found sister Tshabalala standing at the door of ward 3, holding a "*nierbakkie*" (kidney dish). She said that Sister Tshabalala reported that Mr Ndlovu had died. When they entered the ward, the "*neusbuis*' (nostril tube) had already been removed and those whom she found in the ward were busy removing the "*drip*" from Mr Ndlovu. She said that Mr Ndlovu's pupils were enlarged and dilated and Mr Ndlovu appeared '*grey*' in complexion.

[16] The employee testified further that in all her years as a nurse there had never been an instruction issued to nurses to the effect that only a doctor should be called to certify a patient dead. She mentioned that as a sister she was also authorised to certify a patient dead. She testified that she had a look at Mr Ndlovu and was sure that he was already dead. She could only remember that Sister Coleman moved towards Mr Ndlovu's bed but could not see what she did at the bed. The employee testified that she also asked Nurse Ncina whether she knew how to remove the "*tracheostomi tube*" and Nurse Ncina removed it. She also mentioned that Sister Tshabalala had almost six (6) years experience at the appellant and knew all the policies.

[17] It is common cause that from the time that the employee arrived in ward 3 up until she left no one applied the CPR procedure on Mr Ndlovu. It is further common cause that there was no doctor present in the ward to attend to Mr Ndlovu. The employee stated that, if Sister Tshabalala felt that the CPR was necessary, she would have immediately initiated it. She said that she had trusted Sister Tshabalala. She said that from her experience at the appellant the doctors on duty did not like being called to certify patients dead. The practice, according to her, was that the sister in the ward would only telephone the sister in charge after telling "*everybody*" so that she could have the documents ready for the doctor to issue a death certificate.

[18] The employee confirmed that she had conducted many resuscitation procedures in her career. She said that these had been conducted mostly in the ICU. On the night of Mr Ndlovu's death she asked sister Tshabalala if she had informed the doctor as well as Mr Ndlovu's family about Mr Ndlovu's death and Sr Tshabalala confirmed to her that she had done so. However, the doctor did not come that night. The employee said that her knowledge of the procedure was that when the nursing staff discovered on arrival in the ward, that a patient had just stopped breathing, a CPR procedure had to be conducted and that the other staff as well as the doctor working in the casualty section would assist. However, she said, in the case of Mr Ndlovu, he was no longer breathing when they arrived at his ward and he also did not appear as a person who had just died. She said that she also

knew that he was not taking any medication that could have caused his pupils to be dilated. According to her the only medication that Mr Ndlovu was taking was for his depression. She also testified that she was also well aware that Mr Ndlovu did not want to live any more.

[19] With regard to the disciplinary inquiry the employee testified that she did not prepare herself properly for the disciplinary hearing. She was not aware that Sister Cook considered this incident to be very serious. She was shocked that a person had died. She mentioned that she did not think of resuscitation at the time but she said that as she thought back, she should have done CPR with each and every patient to whom she had to attend. She testified that she relied on Sister Tshabalala who was a trained and experienced nursing sister. She said that she accepted Sister Tshabalala's word that the patient had died.

[20] Under cross−examination the employee was referred to her hand─over report signed by her in which she stated that the patient "*passed away at "03:00*". She replied that she only accepted that the patient was dead and did not look at the time. She also admitted that she never contended at the disciplinary enquiry as well as in the internal appeal hearing that she was not given an opportunity to cross−examine the witnesses nor did she contend that she wanted to cross−examine the authors of the documents that were presented during the investigation. She agreed that her internal appeal hearing was not based on these grounds.

[21] The employee was further referred to the record of the disciplinary hearing where she was asked whether she was in the room at the time the patient "*apparently*" died and she had responded that "*I came into the room after, ,uhm, I do not know*". Her response was that she only said that she was not sure as she was depressed at the disciplinary enquiry. She was also referred to her evidence at the disciplinary enquiry in which she was asked whether, when one of her nurses told her that Mr Ndlovu had died, she had checked the patient as "a *backup for the nurse or do you take her word*?" To this she had responded "*No, I always checked*". Her comment was that, when she was telephoned, it was after some time as the nurses could not get hold of her as she was busy somewhere else.

[22] The employee was asked whether Mr Ndlovu was not supposed to be resuscitated. She replied that Mr Ndlovu would have been a "*koolkoop*" ("cabbage") had resuscitation been successfully conducted on him. She insisted though that resuscitation would not have succeeded. She conceded that she did nothing to ascertain whether the other nurses present who were not the appellant's employees knew of the resuscitation procedures. She further admitted that in the disciplinary enquiry she had said that she had not thought of resuscitation at the time, and none was done in her presence and that she knew she was wrong. The employee attributed the admissions she made at the disciplinary enquiry to her alleged depression and confusion during the enquiry. She mentioned that, given her experience in her work as

well as her experience in seeing dead people, she would still not have applied the resuscitation procedure on Mr Ndlovu.

[23] I now turn to the evidence tendered on behalf of the appellant. Sister Cook testified that she was employed in the nursing services team as Patient Services Manager. She described her main "*portfolio*" as being "*patient care specialist*." Her responsibilities entailed the "*holistic overall care of a patient*" aimed at making sure that quality service is rendered along with the safety of the patient. She testified that on 2 July 2001 she received a routine "*handover*" report from the Duty Manager who had been on duty for the weekend. The report was about the death of Mr Ndlovu. His death surprised her because she had seen him when he was still in the ICU where he was found to be "*predominantly*" well enough to be transferred from the ICU to the general ward for his rehabilitation.

Sister Cook testified that the word "*certificate of death*" in paragraph (b) of the charge above was a typographical error and should have read "*certification*" of death which meant physical certification that the patient was dead. The explanation by Sister Cook means that the employee was alleged to have been negligent in that she did not call a doctor to come to the ward and certify that Mr Ndlovu was, indeed dead. The charge did not relate to a death certificate.

[24] Sister Cook testified further that in order to ensure that all staff members had knowledge of the applicable policies; files containing the policies were kept

on all floors of the hospital building and in the wards. The files were also updated from time to time. She said that it was the responsibility of the most senior person to ensure that his or her subordinates knew the policies quite well and to see to it that they were followed. She stated that CPR training was a "*prerequisite*" and that all staff members who underwent an orientation programme had to pass the CPR. By staff she referred to all the employees employed on a full time basis which included "*domestic cleaners*". She confirmed that the employee was familiar with the procedures and that she had completed and passed her CPR training.

[25] Sister Cook testified that the CPR process that was taught to the professional staff prescribed that, if a member on entering a place, finds a person unconscious, he/she was to check for any hazards to himself or herself, check the responsiveness of that person by touching and talking to him or her in order to establish whether the person is in fact unconscious, or sleeping. She said that, if the person did not respond, the next step would be to open an airway to ensure provision of optimum oxygen to the person. One would then assess or see if there is a "*pulse*". She testified that the normal place in an adult patient to assess the pulse is on the "*Carotid*" which is the main artery on the neck. She said that the assessment entails pressing the artery for ten seconds to check whether or not there is a pulse. If there is no pulse, one would conduct a "*cardiac massage*" in an effort to get the heart pumping again and, immediately, alert the doctor who is on the premises.

[26] Sister Cook testified that on the night that Mr Ndlovu died, the employee did not at all initiate the resuscitation procedure and did not ask pertinent questions as to whether anybody had in fact initiated the resuscitation procedure prior to her arrival. Sister Cook said that Mr Ndlovu's death was categorised as unexpected as opposed to expected because he was not terminally ill. The patients who fall within the "*expected death*" category are patients who might have had a stroke and other major respiratory problems and who, on admission, might be declared by a doctor seriously ill and are not expected to live long. Although a doctor would be notified if such a patient die, it would not be necessary for the doctor to come to hospital in the early hours of a morning to see the patient. Mr Ndlovu was not in such a category. An "*unexpected death*" is where none of the above circumstances exists and although a patient is sick, recovery is expected. Should such a patient die, the doctor must be notified immediately and he or she would have to come and see whether something can be done. In this case Mr Ndlovu was removed from the ICU because of the progress he had already made towards full recovery.

[27] Sister Cook testified that in terms of the practice at the appellant there was always a doctor on the premises during the day and at night. It was imperative that a doctor be present during emergency to certify that a patient had in fact died and that resuscitation measures had been implemented but had failed and to give a go─ahead that the resuscitation process be

discontinued. The issuing of a death certificate could be done twenty four hours later as it was mainly a document that funeral undertakers had to have in order to arrange for either the burial or cremation of the deceased. Sister Cook confirmed that the employee was not charged with failure to obtain a death certificate but with failure to ensure that a doctor was called to physically certify that Mr Ndlovu was dead. She insisted that it was not within the province of a nurse to certify a person dead.

[28] Sister Cook confirmed that present on duty at the time of the death of Mr Ndlovu were Sister Coleman, (Nurse Ncina) and the employee. Indeed, this was common cause. Nurse Ncina was an agency employee who was arranged specifically to assist Mr Ndlovu because Mr Ndlovu was a quadriplegic and could do nothing for himself. The assistance that Nurse Ncina was required to render to Mr Ndlovu included moving him as and when required and attending to his needs. It is also common cause that Mr Ndlovu could only breathe with the assistance of a "*tracheotomy*" which was inserted in his throat. He, therefore, could not speak, shout or ring the bell when he needed help. Sister Cook testified that sister Coleman and nurse Ncina were not employed on the terms and conditions of employment of the appellant. The appellant could therefore not subject them to any disciplinary enquiry for misconduct. It could only report their conduct to their employer with whatever recommendation it could make. She confirmed that a disciplinary enquiry was however held for sister Tshabalala for her part in

the events of that night and that she was found guilty of misconduct and was summarily dismissed.

[29] Sister Cook testified that on the night of the incident the employee was working overtime. Her overtime duty was arranged with an "*in−house agency*". The agency was merely used as a vehicle to facilitate payment for services of permanent employees who worked overtime for the appellant. They, however, remained permanent employees of the appellant and were at all times subject to the rules, policies and regulations of the appellant.

[30] Under cross-examination Sister Cook was confronted with the fact that she did not call witnesses to testify at the disciplinary enquiry about the events that led to the patient's death. She responded that she initially conducted an enquiry at which all who were present including the employee gave account of the events of that night and that she presented her report at the disciplinary enquiry. She testified further that Mr Clinton Potter, who was the resuscitation officer but had not been present on the night of the incident, testified at the disciplinary enquiry in an advisory capacity. She further confirmed that nurse Ncina was merely an enrolled nurse who was not an independent practitioner and had to work under the direct supervision of a registered nurse.

[31] It was put to Sister Cook that there was a possibility that the patient was already dead when the employee arrived in the ward and that the employee could have arrived more than four minutes after Mr Ndlovu had died, and as

such it would not have been necessary to conduct the CPR process. She replied that during her investigation the employee told her that on arrival she found lots of people around Mr Ndlovu's bed, and that somebody mentioned that he had died. Sister Cook said that the employee stated that she could not recall who had said this.

[32] Sister Cook emphasised that the employee failed to ask some pertinent and important questions as the senior person in charge. Sister Cook said that the employee should have, for example, asked whether the doctor had been called and whether the prescribed policies and procedures for resuscitation had been complied with. Sister Cook stated further that it is not a nurse's call to say that a patient in the position of Mr Ndlovu has died but it is a doctor's call. It was expected of a nurse in the position of the employee to ensure that the policy relating to CPR was complied with and that a doctor was called.

[33] Sister Cook explained that the fact that Mr Ndlovu's pupils were fixed and dilated as alleged by the employee was irrelevant because nowhere in the relevant policies of the appellant were nurses required to examine the pupils of a patient. They were taught to follow the basic guidelines prescribed by the appellant. She mentioned further that it was for a doctor to conclude that a patient was "*biologically*" dead. She said that a nurse's obligation was to optimise the patient's chances of survival by following the "*chain of survival*". She emphasised that there was a doctor on the premises who should have been given the opportunity to have access to the patient and

make his own decision whether Mr Ndlovu was indeed dead. This is the arrangement that Sister Cook said that the employee as a senior nurse on duty should have made. Sister Cook reiterated that in this instance the issue was not when the patient died, but whether the employee was negligent in failing to adhere to the appellant's policies and procedures. This was in response to a number of questions and scenarios put to her under cross examination about whether she could say when the patient died and whether there was a need at that stage to apply the policy and procedure prescribed by the appellant.

The arbitration award

[34] The commissioner recorded in the arbitration award that the employee's contention that the dismissal was procedurally unfair was based on the allegation that, in the first place, the chairperson of the enquiry was biased, secondly that the initiator (Sister Cook) had lunch with the chairperson on the same day that the disciplinary hearing was conducted. The third ground for procedural unfairness was that the employee was not granted an opportunity to "*cross─question*" any witnesses which were "*directly involved on the night of the incident*." The appellant contended that the chairperson was not biased and that the appellant had only one cafeteria where all personnel went for their lunch. With regard to the third ground the appellant contended that it was open to the employee and her representative

to call whatever witness they wished to call to support their case. The appellant contended further that this point was never raised before the chairperson of the enquiry.

[35] The commissioner found that the employee was represented at the hearing and that they were on "*numerous*" occasions afforded an opportunity to call witnesses and challenge any evidence tendered at the disciplinary hearing. The commissioner found that the dismissal of the employee was procedurally fair.

[36] With regard to the substantive fairness of the dismissal the commissioner stated that the question that she had to deal with was whether the employee was negligent. He found that the dismissal was substantively unfair. In support of the finding that the dismissal was substantively unfair, he gave the following reasons.

(a) there was no certainty as to the procedure to certify a patient dead;

(b) the precise time of death could not be determined with certainty;

(c) the employee admitted that she did not follow the procedures due to the fact that she was under the impression that the other two nurses had already followed the procedure;

(d) that the employee's duty as the night Superintendent of the hospital was to ensure that the "*standard in the hospital was adhered to*";

(e) in his opinion the policies regarding CPR were the direct responsibility of nurse Ncina and Sister Tshabalala who were directly responsible for the care of Mr Ndlovu and not the employee who was not directly in charge of the patient;

(f) the policies could have been applicable had the employee been directly in charge of Mr Ndlovu;

(g) two qualified nurses informed the employee that Mr Ndlovu was dead already;

(h) the employee could not be dismissed for the professional negligence of the two nurses; and

(i) only the two nurses who had been dismissed already bore the responsibility to initiate the CPR.

Proceedings in the Labour Court

[37] In the Labour Court, the appellant relied on a number of grounds to have the award of the commissioner reviewed and set aside. These were that the commissioner÷

(a) did not apply his mind to the relevant issues ;

(b) failed to appreciate and give effect to his powers and duties in terms of the Act;

(c) based his factual conclusion on grounds which did not accurately or correctly reflect the evidence before him;

(d) misconstrued the evidence and misapplied relevant legal principles to an extent that was unreasonable and inappropriate; and

(e) reached conclusions which were not capable of reasonable justification.

Except for (e) these fall outside the grounds of review provided for in sec 145 of the Act. Accordingly, a CCMA award cannot be reviewed on the strength of anyone of them.

[38] The Labour Court held that the commissioner had correctly found that the employee could not be held responsible for the failure to apply the resuscitation process on Mr Ndlovu and that this decision was justifiable as to the reasons given for it. The Labour Court concluded that the commissioner had applied his mind to the evidence presented before him, could not find that he had misdirected himself nor that he committed any gross irregularity. It accordingly dismissed the application for review with costs.

The Appeal

[39] On appeal the appellant attacks the judgment of the Labour Court on four grounds. It contends that the Labour Court erred in finding that:

(a) the employee could not be held responsible for her failure to apply resuscitation on Mr Ndlovu;

(b) the decision of the commissioner was rationally related and justifiable in the light of the evidence before the commiossioner;

(c) the commissioner applied his mind to the evidence presented and, therefore, did not misdirect himself;

(d) the respondents are entitled to an order for costs.

[40] Before us counsel for the appellant submitted that a reasonable decision maker could never have arrived at the decision arrived at by the commissioner and that this Court should find that the dismissal of the employee was substantively fair. Counsel for the respondents submitted that the decision by the commissioner is not a decision that a reasonable decision maker could not have reached. He contended that the policy of the appellant on CPR could not mean that each and every nurse arriving at the scene must apply CPR. It was submitted that the circumstances of the situation would dictate whether there was a need to comply with the policy.

[41] Both parties relied on the decision of the Constitutional Court in **Sidumo and Another v Rustenberg Platinum Mines and Others 2008 (2) BCLR 158 (CC): (2007) 28 ILJ 24O5 (CC)** for their submissions. In **Fidelity Cash Management Service v CCMA & Others (2008) 29 ILJ 964 (LAC), [2008] 3 BLLR 197 (LAC)** Zondo JP, who wrote the judgment for the Court, held as follows at paragraph [102] with regard to unreasonableness as a ground of review for CCMA arbitration awards:

"What is the difference between the approach enunciated in Carephone and that enunciated in Sidumo with regard to the grounds of review set out in sec 145 of the Act? The difference seems to me to be two-fold. Firstly, Carephone sought to construe sec 145 so as to bring it in line with a constitutional imperative at the time which was to the effect that an administrative action had to be justifiable in relation to the reasons given for it whereas Sidumo seeks to construe sec 145 so as to meet the current constitutional requirement that an administrative action must be lawful, reasonable and procedurally fair. It seems to me that, even if there may have been a debate under Carephone and prior to Sidumo on whether a commissioner's decision for which he or she has given bad reasons could be said to be justifiable if there were other reasons based on the record before him or her which he or she did not articulate but which could sustain the decision which he or she made, there can be no doubt now under Sidumo that the reasonableness or otherwise of a commissioner's decision does not depend – at least not solely - upon the reasons that the commissioner gives for the decision. In many cases the reasons which the commissioner gives for his decision, finding or award will play a role in the subsequent assessment of whether or not such decision or finding is one that a reasonable decision-maker

could or could not reach. However, other reasons upon which the commissioner did not rely to support his or her decision or finding but which can render the decision reasonable or unreasonable can be taken into account. This would clearly be the case where the commissioner gives reasons A, B and C in his or her award but, when one looks at the evidence and other material that was legitimately before him or her, one finds that there were reasons D, E and F upon which he did not rely but could have relied which are enough to sustain the decision."

[42] It seems clear to me that the finding by the commissioner that the dismissal of the employee was substantively unfair was based on his opinion that the application of CPR policy was the direct responsibility of Nurse Ncina and Sister Tshabalala who were directly responsible for the care of Mr Ndlovu. The commissioner exonerated the employee solely on the basis that she was not "*directly in charge of the patient*." In this regard reference can be made to the finding by the commissioner that "*two nurses who [were] directly in charge of the patient that died [were] dismissed , I find it difficult to understand or [accept] that the [employee] had to be dismissed for the professional negligence of the two nurses as well.*" He further held that "*in my opinion in this case [the responsibility to institute CPR] had to stop at the two nurses who have been dismissed and further that 'if the [employee]*

was directly in charge of the patient, the policies would be applicable." (My emphasis)

[43] From the evidence it is not in dispute that all the parties had accepted that the appellant's resuscitation policies were applicable and that they were reasonable. It was also accepted that the employee was aware of the policies and that she was trained in the application of such policies. The employee was the most senior person at the time. The content of the policies as well as the procedures to be followed were not in dispute. It was also not in dispute that the resuscitation procedures had to be implemented within two to four minutes of diagnosis of respiratory or cardiac arrest and be continued with until those applying the resuscitation procedure were too tired to carry on, or the patient was certified dead by the doctor or was taken over by more qualified personnel.

[44] It must also be pointed out that neither in the disciplinary hearing nor at the arbitration did the employee or the union suggest that the employee was not directly in charge of Mr Ndlovu and that, for that reason, she was not obliged to attempt the resuscitation procedure on him. The employee's explanation and reasons at the disciplinary hearing for not attempting the resuscitation procedure were that she did not think of resuscitation and accepted that she was wrong for not doing so. She explained further that on previous occasions she had been called to the wards in emergency situations and had applied the resuscitation procedure on many occassions. She also

acknowledged that she had always "*checked*" patients on her own when told that a patient was already dead. The reason that she gave at the arbitration for not applying the resuscitation procedure on Mr Ndlovu was that in her opinion it was clear that Mr Ndlovu had been dead for some time prior to her arrival in the ward. She did not say that the reason why she did not apply the resuscitation procedure was because she was not directly in charge of Mr Ndlovu as the commissioner found. The question whether she was "directly in charge" of Mr Ndlovu was therefore never an issue to be determined by the commissioner.

[45] In determining whether the commissioner's decision was reasonable or not, it is necessary to emphasise the following facts or factors in this matter:

(a) the employee was in charge of the hospital as the night superintendent;

(b) the employee had the overall responsibility of ensuring that the policy relating to CPR was complied with;

(c) Mr Ndlovu was a patient who had made good recovery and was for that reason removed from the ICU. He was not categorised as a patient whose death was expected;

(d) the procedure relating to CPR was supposed to be conducted on Mr Ndlovu but was not;

(e) the employee on arrival failed to establish from Sister Tshabalala whether the CPR procedures had been applied on Mr Ndlovu, and

if indeed applied what the outcome thereof was, and if not applied what the reason therefore was;

(f) the employee relied on assumptions, without establishing the actual factual position from Sister Tshabalala;

(g) the employee's failure to ask the pertinent questions relating to the application of the CPR policy may well have deprived Mr Ndlovu of an opportunity for the application of the resuscitation procedure which may well have saved his life,

(h) the employee failed to ensure that a doctor was called in order to certify that Mr Ndlovu was dead.

There is no indication that the commissioner considered the above facts. In my view, had the commissioner considered the above he may well have come to the conclusion that the employee was negligent in that she failed to initiate the resuscitation procedure and apply the hospital policy on medical emergencies on Mr Ndlovu. The employee was also negligent in that she failed to facilitate the certification of Mr Ndlovu's condition by a doctor at the required time. Failure by the commissioner to consider these facts made her to come to a conclusion that the employee was not negligent and that it was only sister Tshabalala and Nurse Ncina who were negligent.

[46] The argument that the employee could have arrived after the period of four minutes had expired is speculative. I say so because the employee did not know when Mr Ndlovu suffer the attack. All that she was told by Sister

Coleman according to her, was that Mr Ndlovu had developed a high hick-up. Armed with this knowledge one would have expected her to make more enquiries about Mr Ndlovu's condition when someone remarked that he was dead. The enquiries would have included asking about the nature and duration of the hick-up and what was done to assist him.

[47] With regard to the explanation that Mr Ndlovu was already dead because his pupils were enlarged and dilated, Mr Potter testified at the disciplinary enquiry that the pupil response is only one test that can be done on the "*brain stem function and all the others have not been tested yet*." One can therefore not conclude that the patient is dead merely on the basis of pupil dilation. He mentioned that it was still necessary for the CPR to be applied and that the doctor is the only person that can certify a patient biologically dead. This evidence, tendered shortly after the incident, was not disputed by either the employee or her representative who were both given an opportunity to cross-examine Mr Potter.

[48] It was also important for the commissioner to be conscious of the fact that the policies in question were meant to apply in emergency situations to save lives. It *inter alia*, is for this reason, that the employee should have been more meticulous and ensured that the policy was implemented. It was not for her to make assumptions that other employees could have applied the resuscitation procedure without establishing the true state of affairs. Failure to comply with the resuscitation policy is indiputably a serious misconduct

because the plain purpose of the policy is to give patients optimum chance of survival and to save lives where possible.

[49] In my view, the Labour Court should have found that the decision reached by the commissioner is a decision that a reasonable decision maker could not have reached, given the issues in dispute, the evidence presented as well as the admissions made by the employee. The Labour Court should have granted the application for review and ordered that the dismissal of the employee was also substantively fair. The order of the Labour Court on costs is, in my view, in accordance with the requirements of the law and fairness.

[50] In the result I make the following orders:

(1) The application for condonation is granted;

(2) The appeal is upheld and the order of the Court a quo is set aside;

(3) The following order is substituted for the order of the Court a quo:

> " (a) that part of the commissioner's arbitration award which was to the effect that the employee's dismissal was substantively unfair is hereby reviewed and set aside.
>
> (b) The commissioner's award for compensation in favour of the employee is hereby reviewed and set aside.

(c) The commissioner's award that the employee's dismissal was substantively unfair is hereby replaced with the following order;

"(i) The employee's dismissal was substantively fair and her claim for unfair dismissal is hereby dismissed."

(ii) The employee's dismissal is found to have been both substantively and procedurally fair."

(d) There is no order as to cost either in this Court or the Court a quo

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Tlaletsi AJA

I agree

_____

Zondo JP

I agree

_____

Khampepe ADJP

For the Appellant: Mr C Orr

Instructed by: Webber Wentzel Bowens attorneys

For the respondent: Mr Van der Westhuisen

Instructed by: Macrobert Incorporated attorneys

Date of the judgment: 25 February 2009