IN THE LABOUR COURT OF SOUTH AFRICA, CAPE TOWN

Not Reportable
Case no: C713/17

In the matter between:

DANIELS CLIVE DOUGLAS	**Applicant**
and	
COMMISSION FOR CONCILIATION, MEDIATION AND ARBITRATION	**First Respondent**
JOSEPH WILSON THEE *N.O.*	**Second Respondent**
MELOMED HOLDINGS	**Third Respondent**

Date heard: 6 November 2019
Delivered: 3 December 2019

JUDGMENT

CONRADIE, AJ

Introduction

[1] This is an application to review and set aside an arbitration award under case number WECT9773 -17 where the second respondent (the arbitrator) upheld a final written warning against the applicant (the employee). The employee submits that the arbitrator erred in his assessment of the evidence and that he did not apply his mind to the evidence. The employee seeks to have the award reviewed and set aside on the above grounds.

Background facts

[2] The employee is a registered pharmacist and was employed as such by the third respondent (the employer).

[3] On 5 January 2017 an order was placed by the Life Skills Ward (the ward) to the pharmacy for *inter alia* 10 Phenergan ampoules (the medication).

[4] On 6 January 2017 the employee delivered the medication to the ward where it was received and signed in as accurate on the requisition form and the register by the registered nurse on duty, Sister Kiza (Kiza).

[5] On 13 January 2017, the Pharmacy Manager, Letitia Prins (Prins), delivered a further 5 Phenergan onto the ward, which was received by registered nurse and Unit Manager, Mr Dux Maseti (Maseti).

[6] From 6 January 2017 up to and including 13 January 2017 the register indicates that a patient Robertson (the patient) in the ward received 7 dosages of the medication, from multiple nurses. All administrations of the medication were co-signed by a witnessing nurse confirming the administration of the correct medication.

[7] From 13 January 2017 to 9 February 2017 a number of stock checks on the medication took place and each time the nurse on duty would sign the stock off as accurate (as it reflected in the medication register).

[8] On 9 February 2017 a stock check was performed on the scheduled medication cupboard and a discrepancy was discovered. According to the register, the balance of the Phenergan should have been 9 in the medication cupboard and there were only 5 on hand. There were also 4 ampoules

Hydroxyzine hydrochloride discovered in the medication cupboard however there was no record of the Hydroxyzine having been recently ordered by requisition and there was no Hydroxyzine listed on the register.

[9] An internal incident report was compiled by Prins, the employee's manager. This report found the employee dispensed the incorrect medication in the ward which was subsequently administered to the patient. The conclusion was reached prior to taking any statements of the nurses in the ward.

[10] An investigation by the Group Pharmacy Manager, Edries Adams (Adams), concluded that the employee was the most likely cause of the incorrect medication having been delivered to the ward. The employee was subsequently called to a counselling meeting and was found guilty of negligently dispensing the incorrect medication and was issued with a final written warning valid for 12 months.

[11] Aggrieved with this outcome, the employee lodged a grievance and appealed the final written warning

[12] Evan Swart (Swart), the Hospital Manager and a pharmacist, was requested to conduct an investigation to confirm if the final written warning was warranted. Swart upheld the final written warning on the basis of the statements made by nurses who alleged that they administered the incorrect medication (Hydroxyzine) between 6 and12 January 2017 instead of Phenergan.

[13] Subsequent to his unsuccessful appeal, the employee referred the matter to the CCMA as an unfair labour practice. Conciliation failed. The matter was then referred to arbitration where the arbitrator upheld the final written warning. It is this final written warning that is the subject of the review.

The arbitration

[14] At the arbitration the employer called Edries Adams (Adams), Dux Maseti (Maseti), Siyambonga Solwandle (Solwandle), Nonhlanhla Mabaso (Mabaso) and Evan Swart (Swart), to testify on its behalf.

Adams

[15] Adams' had initially been alerted by Prins of the discrepancy and was later requested by the CEO, Mr Allie, to conduct an investigation into the incident. The requisition form, for ordering medication from the pharmacy to the ward, contains the names and signatures of the nurse who placed the order, the nurse who received the order and the pharmacist who delivered the order.

[16] Phenergan/Promethazine is a schedule 2 substance, but is treated as a schedule 5 substance since it is locked in the scheduled medication cupboard. Promethazine is a different brand name to Phenergan, but is essentially the same substance.

[17] A scheduled medication register is maintained by the nurses. When a patient is prescribed medication, the nurses will look at the script, dosage, the patient's prescription number, the prescribing doctor and what the required strength of the dosage is that needs to be administered. One nurse takes the medication out and checks the medication against the script and another nurse administers the substance, the new balance is updated in the register and both nurses sign the register.

[18] Hydroxyzine is not prescribed in the ward and is a slow-moving substance which is primarily used as a relaxant in the Maternity Ward. Promethazine is often prescribed to patients in the ward for its sedative effects. The two substances have different therapeutic effects.

[19] When generic medication is issued to the ward, in place of the original medication prescribed, the pharmacist is required to note that the generic medication is equal to the original medication. The nurses are fully aware of this procedure.

[20] Under cross-examination, Adams conceded that the medication delivered by the employee was all recorded and signed off as accurate.

[21] Adams was asked whether Prins, who delivered the same medication to the ward on 13 January 2017, could have delivered the incorrect medication and if so, why she was not investigated. He replied that there was only one

administration of medication to the patient following Prins's delivery to the ward, whereas there were six administrations of medication following the employee's delivery to the ward.

[22] When a pharmacist delivers medication to the ward the procedure is that the pharmacist and the nurse go to the medication cupboard and conduct a stock check to identify the on-hand balance of the medication being delivered, add the new stock, update the register to reflect the new on-hand balance and the register is then signed by the nurse and the pharmacist. When asked if Prins followed the above procedure when she delivered medication to the ward, Adams said that he was uncertain, but that it is the procedure that should have been adhered to. It was put to Adams that had Prins followed the above procedure that the discrepancy would have been picked up on 13 January 2017. Adams conceded that she would have noticed.

[23] The employee directed Adams to the daily scheduled medication checklist and stated that the list was checked morning and evening and it reflects the accurate balance of Phenergan and the expiry dates. Adams however stated that there was insufficient space to record additional expiry dates and, in any event, that the daily checklist was not a pharmacy document, but a document belonging to the ward.

[24] It was put to Adams that when generic medication is issued by the pharmacy and it is not stated as such on the label it is high risk for the nurses to administer the medication and the nurses therefore would have to ensure that what they are administering is in fact the correct medication. Adams conceded that this was correct and that he had been *"so surprised because they signed it off for an entire month as correct and that's why I brushed it off initially because they must do checks, if for an entire month it has gone out"* (sic). It was further put to Adams that it is not supposed to be then that the nurses would administer Hydroxyzine as opposed to Promethazine, to which Adams responded, not unless the nurses believed it was a generic medication. It was then put to Adams that in such a case the nurse would need to confirm with a pharmacist if it was generic medication. Adams agreed.

[25] Adams conceded his investigation never found the employee guilty, it merely suggested that the employee was the most probable person to have delivered the incorrect medication. This conclusion was reached primarily on the basis of the movement of the stock between the ward and pharmacy and the difference of the missing Hydroxyzine and Phenergan in the pharmacy and in the ward.

Maseti

[26] He testified that he received the delivery of 5 Phenergan from Prins on 13 January 2017. Neither himself nor Prins followed the correct procedure, since they did not count the stock in the scheduled medication cupboard before adding the new medication. He was adamant that he received 5 Phenergan from Prins.

[27] On 9 February 2017 Maseti and Sister Samantha Hastie (Hastie) conducted a stock check on the scheduled medication in the ward which revealed 4 unaccounted for Hydroxyzine hydrochloride ampoules and the equivalent number of missing Phenergan.

[28] He conducted an investigation during which he spoke with all the employees in the ward. The employees all indicated they had been administering Hydroxyzine in place of Phenergan. The employees said that when they administered the Hydroxyzine, which was presented in a 100mg ampoule, they would administer 25mg to the patient and then discard the balance of the medication (75mg).

[29] He concluded that it must have been correct that the Hydroxyzine was issued in place of Phenergan on 6 January 2017, because Kiza, who received the medication on 6 January 2017, said she received Hydroxyzine and there was a time when the Phenergan was out of stock.

[30] When asked in cross-examination why more than a month went by before the error was picked up, Maseti stated that he had been on leave for three weeks and only returned to work on 13 January 2017.

[31] It was put to Maseti that when the pharmacist signs the register it is to indicate that the stock has been checked. That every drop of medication used or discarded must be witnessed and recorded and the register must be kept meticulously in this regard. Maseti agreed.

[32] All the nurses are trained to record discarded schedule 5 medication given that it is a highly controlled medication. When asked how 6 registered nurses all failed to pick up the error, Maseti responded that from his investigation he understood that Kiza confessed to there being confusion about the medication and that she had Googled the medication (Hydroxyzine and Phenergan) and found the substances to be similar. When asked if Maseti, as a professional nurse, would have done the same, he responded "*I would have gone as far as to call you [the pharmacist]*".

[33] When questioned about the expiry dates recorded in the daily register, Maseti stated that the ward is not very strict on checking the expiry dates on receipt of the medications. He went on to say that the most important thing to the receiving nurse is that the correct medication and the amount thereof is accurate. According to him *"all we want to know is did you deliver what we ordered".*

[34] When asked why the nurses did not create a new column for Hydroxyzine, if as alleged they received the incorrect medication, he responded that it was his first question during his internal investigation as well. Maseti said that the nurses were under the mistaken impression that the Hydroxyzine was the generic to Phenergan/Promethazine.

[35] It was put to Maseti: *"you telling me everybody thought it was a generic, nobody asked, 6 administrations, 6 witnesses everybody thought it was a generic?"* Maseti responded, "*that is what the register said*".

[36] The medication registers are checked twice a day, when the day nurse hands over the shift to the night nurse and vice versa. Maseti also checks the cupboard from time to time "*I do it on a two weekly basis*".

[37] In re-examination Maseti confirmed that all the nursing staff knew the procedure on how to handle generic medication, but that Kiza, on 6 January

2017, had trusted the employee when she received the stock, as opposed to following procedure.

Solwandle

[38] Solwandle testified that he administered the Hydroxyzine while under the mistaken impression that it was in fact the generic equivalent to Phenergan. He discarded the balance of unused medication after each administration in front of a witness, but never recorded it anywhere.

[39] He administered Hydroxyzine twice and Phenergan once. The employer's representative, Sameera Gamiet (Gamiet) asked the following leading question - *"And on the 13th, you administered the correct medication because on that day you didn't discard anything?"* to which he replied *"yes"*.

[40] It was a regular occurrence to receive generic medication in place of the original medication prescribed by doctors, and the nurses did not question this.

[41] When asked who told him to use the Hydroxyzine in place of the Phenergan, he stated that it was the day staff who told him to do so.

[42] He heard from Kiza that the employee delivered the incorrect medication to the ward.

[43] When asked why he felt the need to Google the medication, he stated that it was because he had previously worked in the public sector and the medication is different in the private sector. He therefore Googled to check the side effects of the medication.

[44] When asked when exactly Kiza advised him that it was the incorrect medication, he responded that "*I continue with Hydroxyzine without knowing about the incident up until the matron that was in charge was counting the drugs and then she said, what is this now you see" (sic)*.

[45] When asked why, if the employer's version was correct and there were 10 Hydroxyzine and 1 Phenergan in the ward on 6 January 2017, the nurses ignored the single ampoule of Phenergan yet they started administering the Hydroxyzine, Solwandle responded that it must have been administered

between 6 and12 January 2017. When the arbitrator asked him if he said it was administered, he responded, *"I think so"*.

Mabaso

[46] Mabaso testified that she worked with Kiza and witnessed her drawing the requisite amount of medication, administering the medication to the patient and discarding the balance.

[47] When asked under cross-examination if she signed the register to say that there were 10 Hydroxyzine in the cupboard, she said yes.

[48] When asked if there were no Promethazine present in the cupboard, she said that it was a long time ago and she could not recall.

[49] When asked if it is correct that when you place your signature on the register to declare that there is an amount of a particular medication that it meant you had to have done a physical stock check in the cupboard, she agreed.

[50] When asked if she saw 10 Hydroxyzine in the cupboard she responded: *"On that day, I don't want to lie I didn't go and check with Sister Kiza"* When the employee put it to her that because of her having signed the register to confirm checking the medication that she was in fact now indicating that she had lied, Mabaso changed her version and said it was a long time ago. The arbitrator asked Mabaso if she was not simply handed the sheet and asked to sign, to which she responded that she always counts and then signs. Mabaso then categorically stated that she had counted the medication and thereafter signed the register

[51] During her testimony, Mabaso had selective memory. At times she would remember facts clearly and at times she would state that it was a long time ago and could not remember.

[52] Mabaso testified that she remembered the withdrawal of a specific amount of medication from the ampoule, during one of the administrations. Thereafter, she was asked how it was that she could remember the withdrawal of the medication from such a long time ago if this was something that she does on a daily basis, yet she could not remember whether or not there was

Hydroxyzine in the cupboard. It took nine pages of the record for Mabaso to understand the simple question if she regularly witnessed the administration of medication. Her eventual response was that it was part of her job.

Swart

[53] Swart testified that the register which was signed by the administering nurse and co-signed by a witness, and the requisition form, did not prove the employee's guilt.

[54] The registers are meant to be a reflection of what is in the scheduled medication cupboard.

[55] His conclusion to uphold the final written warning of the employee was based primarily on the statements of the nurses and his taking into consideration of the fact that the nurses signed warnings for their errors in the administration of the incorrect medication. All the nurse's statements indicated the incorrect medication was administered between 6 and12 January 2017. Based on this evidence, Swart concluded that it could not be that the delivery of the medication on 13 January 2017 had anything to do with the incorrect medication being in the ward. He also had an opportunity to interview Kiza and Mabaso.

[56] His assessment was that it could definitely not have been Prins.

[57] When asked under cross-examination whether it was possible that the incorrect medication could have been delivered to the ward on 6 or 13 January 2017, Swart conceded that it was possible, but that he believed that the person who delivered the medication on 6 January 2017 was the most likely person.

The employee

[58] The employee testified that he delivered the correct medication to the ward on 6 January 2017. It was received by Kiza. They conducted a stock check in the schedule medication cupboard to check that the balance of the Promethazine on hand was correct. He issued the medication to Kiza and

requested her to check the expiry dates. Kiza and the employee signed the register.

[59] On 10 February 2017 the employee was approached by Prins who informed him of a medication discrepancy in the ward. He was asked to write an incident report. In his report he confirmed that he delivered the correct medication.

[60] He was subsequently called to a meeting in which he was informed that he was found guilty of negligently dispensing the incorrect medication to the ward. When he questioned how the employer had arrived at this conclusion, Gamiet presented him with Kiza's statement which alleged that he had delivered the incorrect medication to the ward. The employee was then presented with a final written warning which he refused to sign. Adams and Prins signed the warning on his behalf.

[61] The employee then appealed the warning. An appeal meeting was held and was chaired by Swart. At the appeal hearing he was presented with a number of statements from nurses of the ward who all indicated that he dispensed the incorrect medication and as a result they all administered the incorrect medication. The employee said that Swart had told him that the paper trail did not prove his guilt, but given the statements of the nurses, the final written warning was upheld.

[62] He believed Prins was responsible for the delivery of the incorrect medication on 13 January 2017 and that a nurse may have incorrectly administered Hydroxyzine to a patient from that delivery.

[63] Prins wrote an incident report on 17 February 2017 prior to the statements being made by the nurses.

[64] There were 7 administrations of medication to the patient and if the employer's version is correct that he delivered the incorrect medication and it was subsequently administered incorrectly to the patient there should be a balance of 3 Hydroxyzine remaining and not 4.

The arbitration award

[65] In the view of the arbitrator, the employee could not escape the finding of misconduct and the final written warning was upheld for the following reasons:

65.1 The respondent followed a fair procedure;

65.2 There was evidence to conclude that the employee dispensed the incorrect medication;

65.3 The employer's version was more plausible on a balance of probabilities;

65.4 The witnesses were all credible and consistent in their testimonies, with the exception of Mabaso to a limited extent which was not material to the dispute;

65.5 The witnesses consistently testified that the incident occurred when the employee was on duty;

65.6 The applicant tried to deviate and confuse the process by introducing irrelevant points;

65.7 The warning was fair as the employee had a warning for a similar offence;

Grounds of review and evaluation

[66] The employee's grounds of review have not been neatly packaged into review grounds. This is understandable as the employee prepared his own papers and represented himself in this court. The Constitutional Court held in *Xinwa & others v Volkswagen of South Africa (Pty) Ltd*[1] that:

"Pleadings prepared by laypersons must be construed generously and in the light most favourable to the litigant. Lay litigants should not be held to the same standard of accuracy, skill and precision in the presentation of their case required of lawyers. In construing such pleadings, regard must be had to the purpose of the pleading as gathered not only from the content of the

[1] [2003] 5 BLLR 409 (CC) at para 13.

pleadings but also from the context in which the pleading is prepared. Form must give way to substance."

[67] Given that the grounds of review are not that long, I repeat the contents thereof as they are presented and deal with the pertinent points accordingly.

"the Commissioner, in his report, declares that I challenged procedural and substantive fairness, but he would not allow me to state the procedure that was followed to sanction me with a final written warning."

"the Commissioner would not consider the argument that the wrong medication discovered in the drug cupboard could have been dispensed by Prins."

"the Commissioner states that I declared dispensed the wrong medication which is not true."

"that the Commissioner completely missed the core issue of the dispute and dismiss my evidence as irrelevant and was totally disinterested in my physical evidence."

"the Commissioner declares that I was on a warning for a similar offence, implying the same offence, which was not true".

"that the Commissioner made numerous errors in his report and I am totally dissatisfied with the arbitration award. In favour of Melomed Holdings."

[68] Medication was delivered to the ward on 6 and13 January 2017. Both deliveries were recorded as having been received correctly on the requisition form and in the register. The medication was administered to the patient multiple times up to and including after the second delivery on 13 January 2017.

[69] Multiple stock checks were conducted and signed off as the accurate medication being in the ward by a number of nurses on duty between 6 January 2017 and 9 February 2017. More than a month later a discrepancy was found.

[70] At no point did any of the nurses come forward to ask if the Hydroxyzine was the generic equivalent of Phenergan.

[71] There was never a recordal of the incorrect medication having been received in the ward by requisition or in the register.

[72] There was no recording of the disposal of the balance of the incorrect medication.

[73] Solwandle administered the medication on 3 occasions (9,10 and 13 January 2017) and claims that the first two occasions were Hydroxyzine and the last was Phenergan.

[74] Mabaso witnessed Kiza administer the medication on two occasions. However, Mabaso's memory was also not very reliable in arbitration and appeared fuzzy on certain details.

[75] Both Solwandle and Mabaso signed the medication off as Phenergan on more than one occasion.

[76] The evidence of the two managing pharmacists, Adams and Swart, were both to the effect that on paper it cannot be proven that the employee was definitely guilty of dispensing the incorrect medication.

[77] The fact is that the incorrect medication could very well have been delivered by Prins on 13 January 2017. When Prins delivered the medication (5 Phenergan) to the ward, she did not follow procedure, in that, neither she nor Maseti counted the existing stock of Phenergan in the ward. This left open the question whether there was in fact Hydroxyzine present in the ward on 13 January 2017. Subsequent to Prins' delivery of the medication to the ward, the patient received another administration of medication. According to the register and requisition forms, which were signed off by two employees, there was an existing supply of Phenergan in the ward. This left open the possibility that Prins in fact delivered the Hydroxyzine on to the ward on 13 January 2017. Prins was never investigated for this possibility.

[78] Prins was a critical witness in this matter, since she was directly implicated in the incorrect delivery of the medication. She was not called to corroborate her version against that of the employee.

[79] Similarly, Kiza did not testify. She was a critical witness, since she was the nurse who received the medication in the ward on 6 January 2017, and who at the outset, allegedly began to administer the incorrect medication to the patient under the mistaken belief that it was the generic equivalent of Phenergan/Promethazine. Kiza was required to corroborate the testimony of all the witnesses.

[80] The arbitrator was alive to the importance of Kiza's testimony, when he made the following remark:

"Can I just say at this stage the version that was projected to you, I haven't heard the evidence, from the Sister herself so we must accept it as hearsay evidence, that Sister is the same sister that gave birth to the child, she is not here so whatever she told me during conciliation cannot be a part of the record of proceedings… I just want to remind the parties. around the table, but is the proposition that he put for you and I hope for the case for the sake of fairness and justice she will eventually come and testify you know (sic)".

[81] It is clear that Prins and Kiza were two important witnesses, who were both directly involved in the matter. Their statements and actions were extensively referred to during arbitration, yet neither came to testify.

[82] There was also no documentary evidence that proved that the employee was guilty of the misconduct apart from the testimonies of the very nurses who:

82.1 administered the medication and signed it off as the correct medication;

82.2 never sought the advice of a pharmacist to clarify their uncertainties whether Hydroxyzine was in fact a generic medication, being alive to the procedures and the potential risk of administering the incorrect medication;

82.3 did not record that any surplus medication had been disposed of;

82.4 conducted stock checks in the medication cupboard over a period of more than a month and signed the checks off as accurate; and

82.5 never mentioned that they had received, administered or disposed of the incorrect medication, prior to the discovery and reporting of the discrepancy by Maseti and Hastie.

[83] Further, the arbitrator incorrectly states in his award that *"it was common cause that the wrong medication was issued and that it was wrongly administered by the nursing staff on that day in question"*. It appears the arbitrator failed to consider the evidence. The employee's entire case was premised on the fact that he did not deliver the incorrect medication on 6

January 2017 and it was therefore not administered over the period prior to the delivery of further medication to the ward by Prins on 13 January 2017. Based on this, it is clear that this was in fact not common cause. It is surprising that the arbitrator would make this statement because at one point during the arbitration he even mentioned that the bulk part of the employee's case was that he never administered the incorrect medication on 6 January 2017 and that it was Prins who delivered that wrong medication.

[84] When discussing Maseti's evidence the arbitrator states that:

"It was discovered afterwards that the wrong medication was issued. They went to the room and counted the drugs. In a previous case the applicant did the same."

[85] The arbitrator refers to a previous warning, which was not introduced into evidence at the arbitration. He further stated that:

"Hydroxyzine was written under Phenergan The Sister thought it was the same strength and administered it."

[86] There was no basis for this statement since Maseti's evidence under cross-examination was that he was confused as to why the nurses did not make a separate column and insert the word Hydroxyzine if they all believed it to be Hydroxyzine.

[87] When discussing Mabaso's evidence, the arbitrator states that:

"She was present on 8 February 2017 when sister Khoza administered the 10mg sample of Hydroxyzine. They did research on google on the drug and administered thereafter (sic)."

[88] The arbitrator got the dosage and date wrong and Mabaso never testified to Googling the medication before administration nor was this contained in her written statement.

[89] When discussing Swart's evidence the arbitrator states that:

"*This resulted in Ms. Roberson being issued with the wrong drug. "…This could only have happened between 6 and 13 January 2017…" (sic).*

[90] Swart testified that the nurses all indicated 6-12 January 2017, this is what he based his finding on in order to uphold the final written warning and

thereby found that it could not have been Prins who delivered the incorrect medication.

[91] During the discussion of Swart's evidence the arbitrator refers to Kiza's version, when he states that:

"*Sister Khoza's version was that it was not the correct drug. She admitted her guilt and was given a warning. Under cross examination he stated that all nine drugs were Hydroxyzine. It was more probable that 6 January was the correct date. It was dispensed on 2 February 2017 (sic).*"

[92] Kiza's version was not before the arbitrator as she did not testify. The last sentence in the paragraph also makes no sense.

[93] It is also difficult to believe, having been acknowledged by Maseti, Adams and Swart that Phenergan is a substance that is frequently used in the ward, that the nurses did not know that the equivalent for Phenergan was Promethazine.

[94] It also appears that at one stage Gamiet conceded that Prins was 'partly implicated' in the delivery of the incorrect medication and that Prins being partly implicated had mistakenly created an incident report which Adams was privy to, prior to him conducting his investigation, but that Adams' investigation was nevertheless independent.

[95] Based on the evidence before him, and importantly the critical evidence of Kiza and Prins which was not before him, there is no way that the arbitrator could come to the conclusion that it was fair for the company to issue the employee with a final written warning. No reasonable arbitrator would have come to such a conclusion.

[96] In the circumstances, the review must succeed. That being the case I must consider whether the employee is entitled to any relief in respect of the unfair labour practice that was committed against him.

[97] Taking the circumstances of the imposition of the final written warning into account it is clear that the company did not conduct a fair investigation into the incident in question. For reasons only known to the company, it ignored

the fact that Prins could have been the culprit and to make matters worse pulled her into the investigation against the employee.

[98] The impact of what was essentially a finding of gross negligence against the employee, in a field that demands attention to detail, must undoubtedly have serious consequences for his professional reputation.

[99] In the circumstances, I believe that an award of six months compensation is reasonable.

[100] The following order is made:

Order

1. The arbitration award issued under case number WECT9773-17 is reviewed and set aside.
2. The arbitration award is replaced with an award that:
   2.1 The Third Respondent committed an unfair labour practice when it issued the Applicant with a final written warning on 19 April 2017.
   2.2 The Third Respondent is ordered to pay the Applicant six months compensation equal to the normal remuneration which the employee was entitled to in terms of his last pay advice received from the company.[2]
3. There is no order as to costs.

BN. Conradie

Acting Judge of the Labour Court of South Africa

[2] I have structured it this way as it was disclosed in the company's answering affidavit that the employee was subsequently dismissed.

Appearances:

For the applicants:	In person
For the third respondent:	Advocate MS Banderker Ismail Mohamed Attorneys.
Instructed by:	Ismail Mohamed Attorneys