IN THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL LOCAL DIVISION, DURBAN

Case No: 4401/2014

In the matter between:

A. B. M. **PLAINTIFF**

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH KWAZULU NATAL **DEFENDANT**

JUDGMENT

DELIVERED ON:

POYO DLWATI J:

[1] On 14 October 2009, A. B. M. (Ms M.), the mother and natural guardian of A. V. M. (the baby), received the tragic news that her daughter was blind as she had developed stage 5 retinopathy of prematurity (ROP). She believes that the doctors and

nurses at King Edward Hospital in Durban were negligent in treating her child and are therefore responsible for her blindness hence this action. The parties agreed in terms of Rule 33 (4) that only the issue of liability be determined at this stage.

[2] The evidence has established that on 24 May 2009, Ms M., whilst about 28 weeks pregnant, was admitted at King Edward Hospital in Durban (the hospital) for premature and prolonged rupture of membranes. On [.....] 2009 at 19H12 she gave birth to her baby by caesarean section. The baby was born prematurely at 28 weeks gestation, before the 40 weeks gestational period of a normal baby. She weighed 1.13 kg. She was transferred to the neonatal intensive care unit as she was distressed at birth and had to be ventilated. She suffered from a severe respiratory distress syndrome. She was given surfactant and intermittent positive pressure ventilation for about 48 hours. Thereafter she was taken off the ventilators and was placed on nasal prong oxygen. On 1 June 2009 she was transferred to the high care unit as the ventilators were no longer needed.

[3] The baby was thereafter dependant on oxygen for about 28 days until 24 June 2009. It is common cause between the parties that although the oxygen saturation levels were monitored, they were consistently high and above the required levels of 92%. During this period the baby required additional respiratory support and was placed on continuous positive airway pressure (CPAP). She was also treated for suspected sepsisand received at least two blood transfusions as she was anaemic. She was also managed for a suspected patent ductus arteriosus, a heart congenital abnormality. A cranial ultrasound of the brain revealed an agenesis of the corpus callosum. The CT scan of her brain confirmed that she had colpocephaly which is a congenital structural abnormality of the brain.

[4] On 25 June 2009 Ms M. and the baby were discharged from the hospital. Both the medical and nursing staff discharge notes make reference to bookings for various follow up appointments including ophthalmology at Inkosi Albert Luthuli Central Hospital for ROP screening on 29 June 2009, cardiac clinic on 1 July 2009, audiology clinic on 14 July 2009 and a neonatal follow up on 23 July 2009. On 14 October 2009 the baby was seen by an ophthalmologist, Dr Visser, the defendant's expert, at the eye clinic at Inkosi Albert Luthuli hospital (Inkosi hospital). She was diagnosed with bilateral stage 5

ROP. Dr Visser, in his report handed in by consent between the parties as exhibit B, commented that the baby was seen too late by Inkosi hospital and no intervention could be done. After some considerable time, Ms M., having tried to seek for answers from the hospital and the defendant, launched this action.

[5] The issue in this matter is whether the blindness of the baby was caused by the negligent conduct of the medical and nursing staff at the hospital during their treatment and care of the baby. Central to this enquiry is whether the oxygen saturation levels that were administered to the baby were within the acceptable levels of 86% - 92% as prescribed by the National Guidelines on Prevention of Blindness in South Africa issued by the Department of Health in 2002 and amended in 2013 (these were attached to Prof Smith's report contained in bundle B from page 30 onwards). Secondly, is whether Ms M. was advised and given a letter when she was discharged at the hospital to attend an eye clinic at Inkosi hospital for her child to be screened for ROP and thereby preventing the ROP from developing to stage 5.

[6] With regards to the first issue, Professor J Smith, a paediatrician and neonatologist, and also the plaintiff's expert witness, together with Dr N Mckerrow, also a paediatrician and the defendant's expect witness and Dr R Singh, a paediatrician and a neonatologist that was amongst the doctors that treated the baby, all agreed in a joint minute handed in by consent between the parties during the trial as exhibit B1 that the oxygen saturation levels maintained on the baby were consistently higher than 95% which is regarded as a safe upper limit for such saturations. Prof Smith and Dr Mckerrow further agreed that there was no evidence on the hospital records that showed that any action was taken to reduce the high levels of oxygen saturations. They concluded that the hospital failed in the primary prevention of the development of ROP in that they failed to adjust the administered concentrations of oxygen according to actual patient requirements and therefore failed to follow reasonable protocol to avoid development of ROP. However, Dr Singh disagreed.

[7] Her view was that the doctors' and nurses' notes as indicated on the hospital records showed that attempts were made to wean the baby off oxygen but it was difficult since the saturation levels would drop to between 77 and 80%. During her testimony, Dr Singh was asked to point to a file note that suggested that the oxygen

levels were reduced and that they did drop. She first testified that the oxygen levels had dropped but the medical registrars did not record this in their notes. She further testified that if one looked at page 254 of exhibit A, it becomes evident in that blood gas form under column FiO2 (fraction of inspired oxygen), that the oxygen was weaned from 60 - 40 - 30 – 25% and the baby was extubated to nasal prong oxygen. However on my observation of that form there is only one instance where the oxygen saturation levels were recorded as 77 % and that was on 3 June 2009. At all the other times the levels were fluctuating between 97 and 100 % with the majority being at 100%.

[8] Furthermore, even though it was not disputed, there was no evidence tendered as to who the author of page 254 was. Dr Singh testified that various medical registrars would have made the notes in page 254 but she personally never made those notes. Whilst Dr Singh testified that they were concerned by the high levels of oxygen saturation on the baby, there is no note throughout the baby's hospital records that shows or records that this was the case. It is my view in fact that the doctors that treated the baby at the hospital were not concerned with the high oxygen saturation levels. One wonders whether they knew that the oxygen saturation levels were not supposed to be above 92%. Prof Smith's undisputed evidence was that the oxygen saturation levels are easily monitored by placing a clip with a built in alarm on the finger of the baby which gives an instant reading. Once the alarm is switched on and the saturation level is higher than the acceptable level then the alarm would beep. There was no evidence that this was done on this baby. In one of her articles,[1] Dr Singh has written that all neonates receiving supplemental oxygen should be monitored with a pulse oximeter and SaO2 should be recorded. Oxygen should be humidified. An oxygen saturation guideline should be displayed in the neonatal ICU. It was not the evidence before me that this was complied with at the hospital. Dr Singh therefore fell short on her own standards. I am also not persuaded that attempts were made to reduce the oxygen saturation levels.

[1] South African medical journal No.2 Vol 103 February 2013 at page 117 handed in as part of bundle E at page 15

[9] In this regard Dr Singh's evidence was not objective but subjective. She was more defensive than assisting the court in revealing the truth. She was argumentative in the witness box and she tried to mislead the court but was caught out under cross examination. For instance, in her report handed in by consent during the trial, she states that visual defects can be associated with colpocephaly but under cross-examination she conceded that colpocephaly does not cause ROP which has nothing to do with the brain but is the result of the failure of the retinas to develop (page 49 of bundle B). Her evidence was unsatisfactory and I was unimpressed by her as a witness.

[10] In my view and as submitted by Mr *Pillay* SC who appeared with Mr *Oliff* on behalf of the plaintiff, Dr Singh's evidence does not qualify as one of an expert but a mere witness of the defendant.[2] She was one of the doctors that treated the baby. She was and still is the head of the Neonatology department at the hospital. It is understable, and her evidence revealed as much, that she would not like to see her department or hospital for that matter to be portrayed in a bad light. I therefore agree with the experts, Prof Smith and Dr Mckerrow, that the hospital failed to adjust administered concentrations of oxygen according to the child's requirements and therefore failed to follow reasonable protocol to avoid development of ROP as prescribed in the national guidelines for blindness. According to Prof Smith, and his evidence was undisputed in this regard, these guidelines are available in all government hospitals and the doctors are taught this in their undergraduate degrees. They therefore failed to exercise reasonable care and skill in treating the baby and were therefore negligent.[3]

[11] That, however, is not the end of the matter. It was common cause between the experts and Dr Singh that because the child was born prematurely at 28 weeks gestation, weighed 1.3 kg, had at least two blood transfusions and suffered from severe distress syndrome, she was at high risk to develop ROP. As a result, according to Dr Singh, an eye clinic for ROP screening was booked for 29 June 2009 at Inkosi hospital, three days after the date of discharge. According to Dr Singh the mother of the child did not honour the appointment after having been advised of the appointment and its

[2] *Pricewaterhousecoopers Incorporated and Others v National Potato Co-operative Ltd and Another* [2015] 2 All SA 403 (SCA) paras 98 and 99.
[3] *Goliath v MEC for Health, Eastern Cape* 2015 (2) SA 97 SCA para 8.

importance. Dr Singh however, had no personal knowledge that the mother was advised of the ROP appointment.

[12] However, Ms M. testified that when she was discharged at the hospital, she was never advised of any appointment that she had to attend after being discharged. She testified that only when she arrived at her home did she discover two letters that were in a packet that had the baby's medication which she was given by a nurse. One letter was written 'audiology' whilst the other was written 'cardiology'. She testified that on the morning when she was being discharged, Dr Nair advised them at about 06H00 that all children were going home that day as there was a doctor's strike. The very sick children would be sent to private hospitals. She testified that that was the last time she saw Dr Nair that day. She was thereafter discharged by a nurse who never told her of any appointments she had to attend.

[13] She testified that two or three days after she was discharged from the hospital the child became sick and distressed and she took her to Port Shepstone hospital. She gave the two letters she saw in the packet with the baby's medication to the doctors and nurses at Port Shepstone. There they rebooked those appointments. She was adamant that there was no letter written 'ROP' or 'eye clinic' in that packet. She denied that she was discharged by Dr Nair and given the letters during the discharge process. She testified that had she known about the ROP appointment she would have attended as she was concerned with her baby's health

[14] Dr Nair, who was the attending doctor on the day that Ms M. was discharged testified that she did not have an independent recollection of the matter but after having refreshed her memory by reading the medical records, she now remembered the matter. She testified that she probably would have seen the patient between 09H00 and 10H00 that morning but not at 06H00 as testified to by Ms M.. She testified that once she deemed the child fit for discharge, she ensured that she counselled the mother about the importance of all the follow up appointments. She could not recall that she was at work at 06H00 as alleged by the plaintiff. She also did not recall making the announcement that all babies would be discharged that morning and only very sick babies would be transferred to private hospitals as there was a doctor's strike during that period.

[15] She did however confirm that there was indeed a doctor's strike during that period and a decision had been made to discharge all the babies and those that were critical would be sent to private hospitals as they had skeleton staff in the ward. She further testified that only doctors discharged patients but not nurses as alleged by Ms M.. She recalled that the only appointment she had to book for Ms M. was for the audiology clinic as the dates of appointment for ROP and cardiology were already written on the patient's file. Under cross-examination she testified that she could not say that the plaintiff's evidence was false when she said nobody gave her the letters and the two she found were on the packet that was handed to her. On why Ms M. would not hand over the letter for ROP at Port Shepstone hospital when she was admitted there, Dr Nair testified that maybe she did not see the letter. Contrary to Dr Naidoo's evidence that the discharge summary is kept in the patient's file, she testified that she gave a copy of that summary to Ms M. during the discharge process. This summary, according to her, would have a follow up date for Ms M. to attend the neonatal clinic.

[16] From the evidence of Ms M., that summary was not in that packet. She was also asked as to why she never recorded that she had counselled Ms M. about the appointments during the discharge process and her response was that she did not? always recorded that she had done counselling. On perusal of the nursing staff notes on Bundle A, the nurses always recorded the identity of a doctor that attended to Ms M. except the one made on 25 June that she was seen during doctors' rounds. There is therefore a ring of truth to Ms M.'s testimony that she was discharged by a nurse and not Dr Nair. She was adamant that she was not discharged by Dr Nair as she knew her and also pointed her out in court as the doctor that made the announcement early that morning. The question really is why would Ms M. not attend the eye clinic appointment if she knew about it and was told about its importance and the consequences if she failed to attend.

Commented [SB1]: Not sure what this is meant to mean?

[17] There are two irreconcilable versions on this issue. I have to make a finding on the credibility of the two witnesses, their reliability and the probabilities.[4] I was impressed by Ms M. in the witness box. She clearly remembered the events whilst she

[4] *Stellenbosch Farmers' Winey Group Ltd and Another v Martell et Cie and Others* 2003 (1) SA 11 (SCA) para 5.

was at the hospital more so the events on 25 June 2009 when she was discharged. Her evidence was clear and in my view she was a credible witness. It is probable that Dr Nair did announce that all babies would be discharged that day and the very sick children would be transferred to private hospital, otherwise how would she have known about it? In any event Dr Nair and Dr Naidoo both confirmed that this was discussed amongst the doctors but they do not recall the announcement about it. Ms M. recalled that the announcement was made whilst they were bathing their children and that must have been early in the morning. She infact testified that it was 06H00. All that Dr Nair said in this regard is that she did not recall being at work at 06H00. In my view, it is probable that she would have been at work early as there was a doctor's strike. She would have been there before all the striking people would arrive.

[17] Dr Nair did not have an independent recollection of the events of 25 June 2009 and yet Ms M. clearly remembered them. Dr Nair testified about what her usual routine was but on that day it was not usual because of the doctor's strike. In my view she must have written the notes and advised the nurses of what needed to be done which they never did. I am satisfied that Ms M. was not discharged by Dr Nair but by a nurse as per her testimony. The nurse did not explain to her about the appointments she had to attend and she was not given the letter for the ROP appointment. In fact it is my finding that she was not given the letters and they were merely put in her medication packet. It is for that reason that she was not counselled about the appointments she had to attend. Had she been advised of the appointments, it is my view that she would have attended the ROP appointment as she appears to me as having been quite concerned about her child.

[18] Further, in my view, had it not been for the fact that there was a doctor's strike during that period, Ms M. and the baby would not have been discharged but would have waited for the appointment of 29 June 2009. I agree with Prof Smith that it would have been safer and reasonable for the doctors, especially knowing the high risk of ROP that the baby was facing, to keep Ms M. and the baby at the hospital as her appointment was only four days later and in any event she had stayed at the hospital for almost a month. In my view, it was negligent for the hospital to have discharged her on that day instead of transferring her to the private hospital. They were aware of the risk that the

baby was facing and should have taken precautionary steps to ensure that the risk was mitigated but they failed to do so. I am therefore satisfied that the negligent conduct of the doctors at the hospital in ensuring that acceptable oxygen saturation levels were maintained on the baby and their failure to advise Ms M. of the appointment for ROP screening of the baby caused the baby to develop stage 5 retinopathy.

[19] Finally, Mr Pillay has urged me to award a punitive costs order against the defendant. His submission was that the defendant's expert witness, Dr McKerrow, had advised them to concede liability but they persisted in defending the matter, therefore wasting the state resources. However, in my view the defence by the defendant was not mala fides. There was a dispute of facts on whether the plaintiff had been advised of the ROP appointment at Inkosi hospital and I had to make a finding on that issue. I am therefore not persuaded that this is an appropriate matter where punitive costs must be awarded.

[20] Accordingly, I make the following order:

(a) The defendant is liable for all of the plaintiff's proven or agreed damages arising out of the blindness of A. V. M., a girl born on [.....] 2009;

(b) the defendant is liable for all the plaintiff's reasonable costs of suit as agreed or taxed including:

(i) costs consequent upon the employment of two counsel where employed.

(ii) reasonable costs of the reports, consultation fees including costs of attending pre-trial conferences plus qualifying and attendance fees including costs of travelling for the plaintiff's expert witnesses, namely Prof Smith and Dr Sara.

(c) The matter is adjourned sine die for the determination of quantum.

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POYO DLWATI J

APPEARANCES

Case Number	:	4401/2014
Plaintiff	:	A. B. M. (**ref M2469**)
Represented by	:	Adv M Pillay SC with Mr Oliff
Plaintiff's Attorneys	:	Justice Reichlin Ramsamy - **031 305 3844**
Defendant	:	The Member of The Executive Council for Health Kwazulu-Natal (**ref 24/004232/14/M/P10)**
Represented by	:	Mr TSI Mthembu
Defendant's Attorney	:	State Attorneys Office - **031 365 2559**
Date of Hearing	:	27, 28, 29 January and 05 February 2016
Date of Judgment	:	15 February 2016