IN THE HIGH COURT OF SOUTH AFRICA

(EASTERN CAPE LOCAL DIVISION, BHISHO)

Case No: 517/2015

In the matter between:

M[…] M[…] *obo* E[…] L[…] M[…] Plaintiff

and

MEC FOR HEALTH EASTERN CAPE Defendant

JUDGMENT

TOKOTA J

[1] In this matter the plaintiff, acting in her capacity as the representative and natural guardian of her son, E[…] L[…] M[…], *(hereinafter sometimes referred to as E[…])* instituted an action against the Member of the Executive Council for Health, Eastern Cape *(the MEC)* for damages arising from the alleged medical negligence at

the hands of the Frere Hospital officials who were acting within the course and scope of their employment with the MEC. The MEC defended the action.

[2] At the commencement of the hearing the parties agreed that it would be convenient to separate the merits of the matter from the issue of quantum and sought an order to that effect in terms of Rule 33(4) of the Uniform Rules of Court. It was so ordered. The facts of the case are largely common cause as a result the parties agreed that the only witnesses to be called would be expert witnesses.

***BACKGROUND*:**

[3] The background facts are either noted in the available hospital records or from expert reports for both parties. The plaintiff was admitted at Frere Hospital and subsequently gave birth by caesarean section to E[…] at 18h25 on 18 October 2010. Amongst other things, the baby had tachypnoea *(fast breathing)* and the paediatrician was notified to come and examine him. The baby was admitted to the nursery for possible Transient Tachypnoea of the new born.

[4] On 19 October 2010 the baby was comfortable and was transferred to his mother. On 20 October 2010 jaundice was detected in the baby. This was confirmed by the laboratory reports that showed that the total serum bilirubin (TSB) level was 506 micromol/L. The specimen was registered at 7h41 approximately 37 hours after birth of the baby.

[5] The discovery of jaundice in the baby necessitated immediate exchange blood transfusion to prevent complications. It was discovered that the baby's blood group was incompatible with that of his mother causing the destruction of red blood cells resulting in the TSB level to become very high. Dr Lombard's evidence which was never challenged was that this should have been treated as an emergency. The baby urgently needed fresh blood for transfusion. According to him it is not an elective treatment.

[6] Once jaundice was identified, Frere Hospital staff commenced the treatment procedure by giving the baby intravenous haemoglobulin called polygam in order to reduce the bilirubin level. In addition intensive phototherapy treatment was also done.

[7] On 20 October 2010 at 23h00 the level of bilirubin was reduced from 506 to 498 and on the morning of 21 October 2010 at 08h24 the level was at 493.

On 21 October 2010 the hospital records disclose that *'no significant drop in total serum bilirubin overnight despite triple phototherapy and polygan. Blood for exchange transfusion ordered from P. E. At this stage neonatal is neurologically sound with no sign of kernicterus and no seizure.'*

At about lunch time on the same day the plaintiff requested a transfer of the baby to Life Beacon Bay Private Hospital. Blood transfusion was done at Life hospital at approximately 20h00 on that day.

[8] In his report Dr Lombard who was the only witness for the plaintiff had this to say:

"Hyperbilirubinemia develops when the production exceeds the baby's ability to excrete it. In severe cases, the bilirubin can then cross the blood brain barrier and cause irreversible brain damage. In the acute phase the condition is called bilirubin encephalopathy and the term kernicterus is used for the chronic manifestations. For the most part bilirubin encephalopathy should be a preventable condition...."

'According to the guidelines, the level of TSB at which an exchange transfusion should be done at 37 hours of life is 365. The guidelines state: "Immediate exchange is recommended if signs of bilirubin encephalopathy are present or is more than 85 micromol/L above threshold.''

Ethan's bilirubin was 141 micromol/L above the threshold. According to the guidelines an exchange should have been done immediately.

The guidelines further state: 'Infants who present with TSB above the threshold should have exchange done if the TSB is not expected to be below the threshold after 6 hours of intensive phototherapy.

In Ethan's case the TSB was repeated more than 11 hours after the initial result was phoned to the ward."

"The best opportunity to treat the hyperbilirubinemia and prevent possible complications was on 20-10-2010."

I assume that the treatment referred to in his conclusion is the exchange of blood transfusion.

Dr Lombard and Dr Mzizana*(paediatrician of the defendant)* agreed that "*the cause for E[…]'s cerebral palsy was hyperbilirubinemia in the neonatal period which caused bilirubin encephalopathy and subsequent kernicterus. The hyperbilirubinemia occurred due to an incompatibility between Ms M[…]'s blood group (0+) and that of E[…] (B+) which caused haemolysis (destruction of red blood cells) of E[…]'s red blood cells resulting in an increase in the total serum bilirubin (TSB)."*

Both experts concluded by saying that although E[…] received appropriate treatment at Frere Hospital the delay in ordering the blood for transfusion was for an unacceptable period.

[9] The defendant called one witness, Dr Harper, a paediatrician. He testified that in October 2010 he was a consultant paediatrician and Head of the clinical unit for neonatal section at Frere hospital. He testified further that he recalls this case because it was quite unusual and quite stressful. According to him when it was discovered that E[…]'s TSB level was extremely high they tried other alternative treatment because there was no blood available in East London. Blood was then ordered from Port Elizabeth.

[10] On 20 October 2010 when the baby was jaundiced he was moved to the N3 nursery where Dr Harper was based. The blood results came to the ward and they

realised that the TSB level was very high. Because of the age and the "*gestational age*" of the baby it was a "*term baby***."**After the results came they wanted to do exchange transfusion because the bilirubin level was significantly beyond the exchange transfusion level for a child at that particular age of only 37 hours. Dr Harper believes that the blood bank was contacted because that would be the first line of treatment in such a situation. The doctors were informed that there was no fresh whole blood in the blood bank in East London.

[11] Dr Harper further testified that during the course of the day further blood results came indicating the cause of jaundice. The level of jaundice was extremely high. The reason for this was that the blood groups of the baby and the mother were incompatible as a result there was destruction of red blood cells causing jaundice level, the bilirubin level, to be very high. The baby was then given intravenous haemoglobulin sometimes called polygam. During the course of that morning they had already started the phototherapy treatment. The baby was also well hydrated and was given a medication called phenobarbitone which sometimes assists the liver process and reduces the level of bilirubin. Despite all this there was no significant reduction of bilirubin level.

[12] According to Dr Harper on 21 October 2010 whilst they were still waiting for the blood from Port Elizabeth and before they could perform the exchange transfusion a request was made to transfer the baby to a private hospital. It was about lunch time. They facilitated the transfer. He instructed a junior doctor in the nursery to write a summary of what had happened in the referral form to be completed.

***ANALYSIS*:**

[13] Mr Zilwa for the defendant argued that the plaintiff's case was based on undue delay in ordering the blood. He contended therefore that she failed to prove

her case in that she produced no evidence that there was a delay. He contended further that the plaintiff has failed to prove that there was undue delay in ordering the blood. The nub of his argument was that it was clear from Dr Harper's evidence the blood was immediately ordered after the level of TSB was discovered to be very high.

[14] Regrettably, I cannot agree that the blood was ordered immediately upon discovery of jaundice in E[…].

[15] The plaintiff's case, according to pleadings, is that the hospital staff allowed E[…] to develop kernicterus in that they failed to prevent bilirubin encephalopathy from developing when they had ample opportunity to do so. It is further alleged that the hospital staff failed to initiate exchange transfusion when signs of bilirubin encephalopathy were present. I quote excerpts from paragraph 7 of the plaintiff's particulars of claim wherein it is alleged that the hospital:

"*7.6 Failed generally to act as would be expected of medical practitioners when complications arose;*

7.9 They failed to take heed of the fact that Liso was at high risk for developing kernicterus due to inter alia maternal blood incompatibility, and failed to act accordingly;

7.10 They allowed Liso to develop kernicterus;

7.11 They failed to prevent bilirubin encephalopathy from developing when they had sufficient opportunity to do so;

7.12 They failed to initiate exchange transfusion when signs of bilirubin encephalopathy were present;"

[16] In answer to the allegations by the plaintiff alluded to above the defendant merely pleaded that it had no knowledge of these allegations and was not admitting the same leaving it to the plaintiff to prove them. In paragraph 7 of his plea the defendant pleads:

*"**AD PARAGRAPH 7.1-7.17***

The Defendant has no knowledge of the allegations made herein, does not admit same and accordingly puts the Plaintiff to the proof thereof."

The essence of the defendant's plea is therefore lack of knowledge of the allegations constituting negligence on the part of hospital staff.

[17] The evidence led by the plaintiff was that the blood transfusion process was only commenced on 21 October 2010 instead of 20 October 2010. This evidence was based on the notes retrieved from the hospital record because an entry about the order of blood from Port Elizabeth only appeared on 21 October 2010. Dr Harper for the defendant testified that he gave instructions on 20 October 2010 that blood should be ordered. He does not remember to whom and when exactly such instructions were given.

[18] Regard being had to the pleadings, I did not understand the plaintiff's case to be based on undue delay *per se*. I pointed out to Mr Zilwa that according to the pleadings the defendant failed to exchange blood transfusion immediately upon detection of jaundice. Dr Lombard's evidence, which was not challenged, was that once that was discovered the defendant had no option but to immediately exchange blood transfusion. This is not an elective process.

[19] Regard being had to the above, the plea by the defendant to the plaintiff's allegations calls for comment. Where a party is alleged to have failed in its duty to perform an obligation it is expected of that party to either deny or aver that it complied with its obligation or if necessary, admit its failure or confess and avoid. The defendant simply pleaded lack of knowledge of the failure to perform what the plaintiff alleges ought to have been done. Since the purpose of pleadings is to define issues so that each party knows exactly what case it has to meet at the trial, in a case where the defendant pleads lack of knowledge of the allegations one wonders what evidence will be led at the trial to rebut the plaintiff's evidence. The simple

answer to this question is that, depending on facts alleged to be unknown, there is no room for evidence to contradict the allegations.

[20] Litigation is not a game of chance where a party will play with its cards close to its chest in order to surprise or ambush the other party. It has been held that:

"A pleader cannot be allowed to direct the attention of the other party to one issue, and then at the trial attempt to canvass another."[1]

The purpose of the pleadings is to bring clearly to the notice of the court and the parties to an action the issues upon which reliance is to be placed. Marais AJ[2]*(as he then was)* stated as follows with regard to the distinction between denying and not admitting an allegation:

"To my mind, there is a clear notional distinction between these two stances' (i.e. between denying and not admitting an allegation).

A plaintiff faced with a positive denial must anticipate and prepare for the leading by defendant of rebutting evidence which contradicts the allegations he has made. A plaintiff faced with a non-admission need not anticipate and prepare to meet contradictory evidence to be adduced by the defendant. Indeed, there is authority for the proposition that he need not even anticipate a limited challenge by way of cross-examination of his witnesses. See Ntshokomo v Peddie Stores 1942 EDL 289 at 298. While that may conceivably be going too far (and again I refrain from deciding the point), I think, with respect, that the decision is undoubtedly correct insofar as it confirms that a denial (and, I would say, a fortiori a plea of non-admission) because of a lack of knowledge, will not entitle the pleader to contradict the plaintiff's averments by leading evidence to the contrary at the trial. In my view a plaintiff is entitled to know which of these two stances a defendant is adopting and a plea which leaves that in doubt is vague and embarrassing."'

In the circumstances I am of the view that if the defendant intended to adduce evidence that he indeed performed his duty by initiating exchange transfusion within the medically accepted norms of standards when signs of bilirubin encephalopathy were present this should have been pleaded.

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[1]*Kali v Incorporated General Insurances Ltd* 1976 (2) SA 179 (D) at 182A;*Imprefed (Pty) Ltd v National Transport Commission* 1993 (3) SA 94 (A) at 107C.
[2]*Standard Bank Factors Ltd v Furncor Agencies (Pty) Ltd & Others* 1985 (3) SA 410 (C) at 417I-418B.

[21] In my view it was incumbent on the defendant to plead that indeed the blood was ordered on 20 October 2010. The hospital records show that an entry about the order of fresh blood was only made on 21 October 2010. Despite the evidence of Dr Harper that he gave instructions on 20 October 2010 there is no entry to that effect on that date. Furthermore no witness was called to confirm this instruction. Dr Harper wanted this court to rely on his memory. Notwithstanding his explanation as to why he remembers this case I am not persuaded that this case was outstandingly different from others. He testified that this case "*stands out"* because as the consultant in charge he was placed "*in a very stressful situation where we had a new born baby who we recognised with a particular problem, being jaundice."*

It is highly improbable that in a big hospital like Frere, and for that matter a referral hospital in many cases, this was a novel situation.

Most importantly his evidence goes on:

"MR ZILWA: Now just on that point at what stage did you request or order the whole fresh blood?

*Mr HARPER: M'Lord, it was not me personally ordered it. I would have given an instruction to the doctor in the nursery to order the blood in order to do an exchange blood transfusion, so I did not personally fill out that form so I cannot tell you exactly what time it was completed." (*My emphasis)

Furthermore under cross-examination the following is recorded:

"MR AUSTIN: Yes Doctor, would it not have been prudent –no let me start with a different question. You've given evidence that you simply told somebody, and you don't know who, to order the blood;

MR HARPER: That is correct. I would have ordered, asked one of my interns or medical officers to order the blood from the blood bank."

Accordingly, I cannot agree that this evidence of Doctor Harper was clear and '*undented*'. He was specifically challenged that no blood was ordered on 20 October 2010. He is not the author of the note that shows that blood was ordered on 21 October 2010. The author thereof has not been called as a witness.

[22] Mr Austin argued that an adverse inference be drawn for failure to call certain witnesses by the defendant. The drawing of inferences in favour of one party upon his opponent's failure to call a witness is not always that simple.[3]It depends on whether the witness would have been able either to advance or destroy the party's case who is failing to call him. In other words an inference adverse to the party who fails to call a material witness can only be drawn where that which is sought to be inferred can be regarded as an inference and not mere speculation. For an inference to be drawn there must be objective facts from which to infer the other facts sought to be established.[4]

[23] It may be that Dr Harper honestly believed that he would have given instructions to order blood on 20 October 2010. However, one must bear in mind that human intellect is fallible and memories fade with the passage of time.

In the words of Cory J[5]:

"There can be no doubt that memories fade with time. Witnesses are likely to be more reliable testifying to events in the immediate past as opposed to events that transpired many months or even years before the trial."

The events in this case occurred more than 8 years ago. The recorded notes that were before this court do not support Dr Harper's recollection.

[24] Documentary evidence serves many purposes. These include recording of historical events for the future and for those who were not initially involved. This is particularly so in hospitals where doctors and nurses change shifts and those who take over are, by way of reference to the recorded notes, put in a position to see the history of the patient and take the necessary steps to cater for any emergency situations where applicable. Ailments and treatment of patients are recorded for

[3]*Galante v Dickinson* 1950 (2) SA 460 (A)at 465; *Jordaan v Bloemfontein Transitional Local Authority* 2004 (3) SA 371 (SCA) [2004] 1 All SA 496 (SCA) para.20.
[4]*Motor Vehicle Assurance Fund v Dubuzane* 1984 (1) SA 700 (A) at 706B – D. See also Great River Shipping *Inc v Sunnyface Marine Ltd* 1994 (1) SA 65 (C) at 75I – 76C.
[5]*R v Askov* (1991) 49 CCR 1 (Supreme Court of Canada at 20).

verification and usually the dates and time are specified in the notes. Keeping of such records also serves as a point of reference for future disputes. Documentary evidence is the best evidence and almost invariably carries greater weight than the unsupported human memory.

[25] Furthermore, the evidence of Dr Harper is not in accordance with what was pleaded by the defendant. In my view the hospital staff failed to order the blood timeously for the immediate exchange blood transfusion. Instead they decided to treat the jaundice in E[…] by other means in the hope that the level thereof would be reduced. It was only after it was observed that '*no significant drop in TSB overnight despite triple phototherapy and polygam'*(during the night of 20 October 2010) that a decision to order blood was taken. I find that on the evidence before me this was done on 21 October 2010 instead of 20 October 2010.

[26] In the joint minute by Dr Mzizana and Dr Lombard the two doctors agree that under the guidelines immediate exchange transfusion must be done once the baby's TSB level is more than 85 micromol/L above the threshold level for exchange. They both agree that in the case of Ethan the TSB level was 141micromol/L above the recommended threshold. Further the guidelines state that infants who present with TSB above the threshold should have an immediate exchange transfusion if the TSB is not expected to be below the threshold after 6 hours on intensive phototherapy but in E[…]'s case the TSB was only repeated 11 hours later and at that stage it was still 103 micromol/L above the threshold. I therefore find that members of staff at Frere hospital were negligent in not ordering the blood immediately upon detection of jaundice.

[27] Lest it be said that the joint minute should not have been taken into account let me deal with it. On the morning of the trial date a note was handed up in which Dr Mzizana, a potential expert witness for the defendant, purported to resile from the joint minute. In this note Dr Mzizana said: *'I have taken time to again consider the joint minute that we signed on 10 October 2018, upon my reflection I have noticed that on the*

following two aspects there was no factual evidence produced [NHLS Blood results that you referred to] in the paginated 222 pages of medical records bundle submitted to me, to substantiate or support these assertions:

"paragraph 6.....Blood was only ordered for an exchange transfusion at least 21 hours after he presented (sic) with a TSB that was high enough to qualify an immediate exchange transfusion".'

She then concluded by saying she was therefore retracting from the joint minute.

[28] The reason for the retraction by Dr Mzizana is factually incorrect as it is not supported by the evidence adduced in court. On 1 August 2018 an email to which the National Health Laboratory Service results (NHLS) were attached, was sent to her by Dr Lombard. Besides proof that the emails were sent to her, which formed part of the plaintiff's bundle of documents, Dr Lombard confirmed that the emails were sent by him. He also gave evidence that there were different communications via email and short message service (sms) which culminated in them finally writing the agreed joint minute. Dr Mzizana was not called as a witness to refute this evidence and it could not be challenged in cross-examination. Dr Lombard impressed me as a reliable witness who, mostly backed up his testimony either with authority or documentary evidence. He made concessions where this was necessary. For example he conceded that in the absence of blood the treatment that was given to E[…] was proper and that Life Beacon Bay hospital was also not free from blame. In the premises I have no reason to disbelieve him. In any event it would be grossly unfair and improper, in the light of his unchallenged evidence, not to believe him.[6]

[29] Where the experts have reached a sensible agreement in a joint minute limiting the disputed issues, the plaintiff is entitled to rely on such minute and prepare for the evidence needed to be led on the basis thereof. If the defendant for any

[6]*Van Tonder v Kilian NO* 1992 (1) SA 67 (T) at 73; *R v M* 1946 AD 1023 at 1028 per Davis AJA, Watermeyer CJ, Greenberg JA and Schreiner JA concurring; *Small v Smith* 1954 (3) SA 434 (SWA) at 438E - H; *S v Govazela* 1987 (4) SA 297 (O) at 298J - 300B; *S v Van As* 1991 (2) SACR 74 (W) at 109B-G; *Van Tonder v Killian NO en 'n Ander* 1992 (1) SA 67 (T); *President of the RSA v SARFU* 2000 (1) SA 1 (CC); (1999 (10) BCLR 1059 [1999] ZACC 11 para61.

reason did not wish to be bound by such limitation, he should have given a fair warning to that effect. In the absence of proper repudiation (i.e. fair warning), the plaintiff was entitled to run the case on the basis that matters agreed upon between the experts were not in issue.[7]

[30] Consequently there is no legal basis upon which the repudiation can be accepted. The opinions expressed in the joint minute are based on the facts presented to the doctors. The value thereof is strengthened by the overwhelming evidence.

Was the negligence of members of staff at Frere hospital linked to the harm suffered by the plaintiff?

[31] Corbett JA *(as he then was)* has on occasion stated:[8]

"Causation in the law of delict gives rise to two rather distinct problems. The first is a factual one and relates to the question whether the negligent act or omission in question caused or materially contributed to . . . the harm giving rise to the claim. If it did not, then no legal liability can arise and caditquaestio. If it did, then the second problem becomes relevant, viz. whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether, as it is said, the harm is too remote. This is basically a juridical problem in which considerations of legal policy may play a part."

Regard being had to the evidence of Dr Lombard and the joint minute it is clear to me that the Frere hospital staff were negligent in not ordering the fresh blood immediately upon discovery of jaundice on E[…]. The failure to act immediately contributed and/or caused the harm suffered by the plaintiff.

[32 In the premises I find that the plaintiff is entitled to judgment in her favour. There remains the question of costs.

[7]*Bee v Road Accident Fund* 2018 (4) SA 366 (SCA) para.66.
[8]*Minister of Police v Skosana* 1977 (1) SA 31 (A) at 34E-G.

Costs

[33] The general rule is that costs must follow the result unless there are exceptional circumstances justifying a departure therefrom. The costs of 22 October 2018 were reserved. Mr Austin for the plaintiff argued that those costs should be borne by the defendant. He argued that the defendant's expert retracted on the morning of the trial date. The plaintiff was at all times under the impression that there would be no objection to the use of the NLHS reports since Dr Mzizana was in possession thereof.

[34] For a fair trial no litigant should be taken by surprise in the proceedings before a court of law. Any party desiring to use any document or tape must give a warning to the other party by discovering such document or tape if it intends to rely on it at the trial. Rule 35(4) of the Uniform Rules of court provides that a document or tape recording not discovered may not, save with the leave of the court granted on such terms as to it may seems meet, be used for any purpose at the trial by the party who was obliged but failed to disclose it, provided that any other party may use such document or tape recording.

[35] The mere fact that the other party was aware of the existence of the document or in possession thereof does not change the situation.

[36] At the beginning of the trial Mr Zilwa brought to my attention that he was not aware of these reports and that they were not discovered. I asked Mr Austin whether he wished to continue with the matter in the circumstances. He indicated that he was ready and would not use the reports. In the middle of the trial he changed his mind after the witness had commenced with his evidence and sought a postponement in order to discover the documents. I expressed my displeasure in creating a part-heard matter when he should have known that he needed to use those documents.

[37] In my opinion there is no reason why the defendant should be mulcted with the costs occasioned by the postponement of 22 October 2018. It follows therefore that the plaintiff should bear those costs.

[38] The plaintiff has asked for costs which will include qualifying costs of her experts Professor Lotz, Dr Gericke, Ms Hugo, Dr Lombard and Dr Murray. Mr Zilwa for the defendant made no submissions in this regard.

[39] In the result I make the following order:

39.1 The defendant is liable to pay such damages as may be proved by the plaintiff, in her representative capacity as the guardian of her minor son, E[…] L[…] M[…], arising from the medical negligence that occurred at Frere hospital in October 2010;

39.2 The plaintiff must pay the reserved costs occasioned by the postponement on 22 October 2018;

39.3 Save for the costs in paragraph 38.2 above, the defendant shall pay the plaintiff's costs on a party and party scale either as taxed or agreed, such costs to include the costs of obtaining medico-legal reports and joint minutes, reservation and/or qualifying fees of the following experts:

(i) Professor Lotz,

(ii) Dr Gericke,

(iii) Ms Hugo,

(iv) Dr Lombard and

(v) Dr Murray

39.4 Costs of two Counsel where applicable is allowed.

39.5 Determination of quantum is postponed *sine die*.

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B R TOKOTA

JUDGE OF THE HIGH COURT

***Appearances*:**

For the Plaintiff: Mr G Austin

Of Gary Austin Inc.

For the Defendant: Advocate Zilwa SC *instructed by*

State Attorney

EAST LONDON

Heard on: 22 October 2018, 3 June 2019, 4 June 2019, 12 July 2019 and 21 October 2019.

Date judgment delivered: 19 November 2019.