

In the High Court of South Africa
KwaZulu-Natal Division, Pietermaritzburg

Case No: 3826/12

In the matter between:

Isabella Brink Beyers Smith

Plaintiff

And

The MEC for Health, Province of KwaZulu-Natal

Defendant

Judgment

Lopes J

[1] Mrs Smith, who was 79 years' of age, was experiencing problems with her left knee. Her doctor recommended that she undergo a complete knee replacement at Grey's Provincial Hospital in Pietermaritzburg. On the 4th May 2010 she was admitted to B ward at Grey's Hospital and underwent the knee replacement operation on the 5th May 2010. When the operation was complete, she was wheeled out of the operating theatre and into the recovery room. She asked the attending anaesthetist for a drink of water. The anaesthetist went into the nearby sluice room

and decanted what she thought was a cup of water from a container. She then returned to Mrs Smith and gave the cup to her to drink. Mrs Smith then 'glugged it down' (as she put it). She immediately reacted, and the anaesthetist quickly realised that she had given Mrs Smith a medicine cup of formalin to drink. The problem with formalin is that it contains formaldehyde and methanol, and is a noxious and corrosive substance. Mrs Smith's case is that she has been injured and greatly affected by the administration of the formalin. On the 14th May 2012, she caused a summons to be issued out of this court, initially claiming damages in the sum of R425 000. The action finally started before me on the 13th June 2016.

[2] The history of the conduct of this matter is as unfortunate as are the facts of the case. The defendant pleaded on the 25th January 2013, and whilst admitting that Mrs Smith had undergone a knee replacement operation at Grey's Hospital, denied the allegations of administering formalin to Mrs Smith. Despite the efforts of Mrs Smith's legal representatives in trying to get the action to trial, it was inordinately delayed. The history of the matter, as conveyed to me by Mr *Ramdass*, who appeared for Mrs Smith, is summarised as follows:

- a) Mrs Smith's attorney enrolled the action for a pre-trial conference before Poyo-Dlwati J on the 25th October 2014, but no representative of the State Attorney attended, and the conference was adjourned to the 27th October 2014 for the State Attorney to appoint a representative.
- b) On the 27th October 2014, a local correspondent of the State Attorney appeared and requested a one month adjournment of the pre-trial conference. This was opposed, and Poyo-Dlwati J adjourned the

conference to the 4th November 2014 and instructed the local correspondent that if she could not attend to the matter, then a representative of the State Attorney had to attend.

- c) On the 4th November 2014, and despite the instructions of Poyo-Dlwati J, an articled clerk attended at the pre-trial conference, and the pre-trial conference could not proceed.
- d) Poyo-Dlwati J then directed that a Rule 37 conference be held within two weeks and adjourned the pre-trial conference to the 18th November 2014, directing that an attorney from the State Attorney's office appear.
- e) On the 18th November 2014, Advocate *Mthembu* appeared for the defendant. The pre-trial hearing was adjourned to the 2nd December 2014 to enable the parties to finalise discovery and deliver expert reports.
- f) On the 2nd December 2014 Advocate *Mthembu* appeared and recorded that the defendant would not discover because there were no documents to discover. Mrs Smith's legal representatives recorded that they had obtained documents from the Northdale Hospital (pertaining to consequential treatment Mrs Smith had received) and tendered the documents to the defendant.
- g) Poyo-Dlwati J then certified the matter ready for trial, and dates were allocated in September/October 2015. Mrs Smith's attorney was then notified that Advocate *Mthembu* was only available in November 2015.
- h) The matter was then set down for hearing on the 2nd November 2015. Although the registrar was told to set the matter down for four days, it was only set down for two days.

- i) By consent, the matter was then adjourned to the 16th to 19th days of May 2016, in order to enable the defendant to obtain expert reports. The defendant was directed to pay the wasted costs occasioned by the adjournment, such costs to include the reasonable consultation fees and travelling expenses of Mrs Smith's expert and lay witnesses. Subsequently, only the so-called expert report of Dr Wilson was sent to Mrs Smith's attorney.
- j) On the 16th May 2016 the matter came before me in Pietermaritzburg. The parties were attempting to negotiate a settlement, and for that purpose the action was adjourned to Wednesday 18th May 2016. The matter was then adjourned on the 19th May 2016 to a date to be arranged with the Judge President. It subsequently came before me in Durban on the 13th June 2016, and I heard the matter for seven court days, finishing on the 23rd June 2016.
- k) On the 8th June 2016 (two court days before the trial started) a pre-trial conference was held in my chambers. At that conference I pointed out to the defendant's legal representatives that a letter dated the 5th October 2010 was contained in what was described as the 'Plaintiff's Second Trial Bundle'. That letter was addressed by both the Specialist Anaesthetist and the Chief Specialist Anaesthetist at Grey's Hospital to Dr Bilenge, who, I understand, was the Chief Medical Administrator at the hospital. The letter set out some of the circumstances surrounding the administration of the formalin to Mrs Smith. It was only at that stage that the defendant formally admitted that the anaesthetist who had attended to Mrs Smith on the day in question had administered formalin to her. This

admission was made by way of a formal admission of the contents of paragraphs 6 and 8 of Mrs Smith's particulars of claim. The defendant's representatives also then recorded that Mrs Smith had been treated for formalin ingestion and toxicity.

- l) Mr *Ramdass* complained that the defendant had never properly discovered. I was handed a bundle entitled 'Medical Notes Bundle of Documents' which contained what purported to be an expert report by the defendant's expert Dr Wilson, as well as hospital and treatment notes and records. Far from being an expert report, Dr Wilson had replied to a request that he answer 10 specific questions. Mr *Ramdass* recorded that those documents were sent to Mrs Smith's attorney under cover of a letter, and had not been accompanied by a proper discovery process. This was despite the fact that the medical records had repeatedly been requested.
- m) An expert, Dr Coka, had been engaged by Mrs Smith's attorney on the 16th August 2013. To enable his expert notice and summary to be compiled, Mrs Smith's attorneys made repeated requests for correspondence and medical records. Eventually the report of Dr Coka was delivered on the 8th April 2014 without his having had sight of all the medical records.
- n) On the 19th May 2016 the Grey's Hospital records suddenly surfaced. No explanation for them not having been produced earlier was given by the defendant's attorneys.
- o) On the 27th May 2016 and at the defendant's request, Mrs Smith was required to present herself to a gastro-enterologist and a psychologist. Although Mrs Smith's attorney objected to the lateness of this notice and

objected to the filing of any reports by the defendant's experts, Mrs Smith consented to an examination. On Friday 10th June 2016 at approximately 3.30pm reports were faxed to her attorney by the defendant's attorneys. Expert notices accompanied the reports, but were not signed. The reports were apparently provided by Dr Jozi and Dr Govindasamy. Attached to those reports were photographs in black and white, the quality of which was so poor that they were barely distinguishable.

- p) On the morning of the trial, the defendant's attorneys tendered coloured photographs of certain investigations carried out by Dr Jozi. Mrs Smith's attorney objected to the admission of those documents. No application for condonation for the late filing of them was delivered by the defendant. Although Mrs Smith consulted with the defendant's clinical psychologist on the 1st June 2016, by the time the trial started almost two weeks later, no report had been delivered.
- q) An actuarial report had been delivered by Mrs Smith's attorney. The defendant's attorneys had informed Mrs Smith's attorney that there was no need to call the actuary, and the defendant was invited to submit questions or items for clarification which could be dealt with by the actuary. By the start of the trial no issues had been raised by the defendant's attorneys. With regard to the medical records of Grey's Hospital, they were to be admitted by consent save for the nursing records which were compiled after the operation – i.e. from the 5th May 2010 to the 9th June 2010 when Mrs Smith was discharged.
- r) Mr *Chetty*, who appeared for the defendant, did not dispute any of these allegations, and recorded that he had nothing to add.

[3] Mrs Smith testified that she would turn 85 years of age in December of 2016. The doctor admitting her to Grey's Hospital told her that she would be in hospital for three days. She was given an epidural anaesthetic for her knee replacement operation, and after the operation when she was wheeled into the recovery room, she told the anaesthetist accompanying her that her mouth was dry and that she needed something to drink. The anaesthetist went off and returned with a cup which she gave to Mrs Smith. Mrs Smith 'glugged' it down. She then screamed out saying repeatedly 'You are killing me'. She told the court that the formalin which she had been given went up her nose and down her throat and into her stomach. She told those attending upon her that it was burning her. Approximately half an hour later, she was given some charcoal to drink. Thereafter she vomited. Eventually she was taken back to B ward where she started vomiting again. At this stage her nose, throat and stomach were burning and painful, and she was nauseous and felt very sick. This condition endured for most of the first night and she spent a lot of time vomiting and crying and in pain.

[4] The next morning two doctors came to her bed, Dr P Marè and Dr Bertie, looked at her and then left. At that stage she was still sore and very nauseous. She complained to both the doctors who came to see her, but nothing was done. She was not given anything to eat initially, and was only able to eat about three days later. When she tried to do so, it was too sore and she was unable to eat properly. Mrs Smith maintains that she still has difficulty eating. She recorded that when she

was admitted to hospital she had weighed 100 kilograms, but on discharge had weighed only 77 kilograms. Her diet during her stay in hospital had consisted of watery oats and tea. She could not eat because she felt nauseous all the time. She recalled having undergone a 'scope' in the Northdale Hospital a long time after ingesting the formalin, but she had been told by the doctors that they could not assist her. After being discharged from Grey's Hospital she lived on water and bananas and had difficulty in keeping anything down, even mashed bananas.

[5] Immediately after ingesting the formalin she had been put on a drip because she could not eat. She was discharged some six and a half weeks later on the 9th June 2010 and was told by the hospital staff that they could not discharge her earlier because she had ingested the formalin. Mrs Smith recorded that prior to going into hospital she had eaten out regularly, eating steaks and curries and that she had enjoyed her food. Now she was unable to do that and lived on a diet of bananas, samp, Cup-A-Soup, juice and coffee. She could only tolerate food which was soft and watery, like custard. She was unable to eat steak because she would feel nauseous and would choke on the meat. In addition she was always very tired which she put down to her loss of weight and her inability to eat properly.

[6] After her discharge Mrs Smith had visited Northdale Hospital for the following reasons:

- (a) Between the third and fifth days' after her discharge from Grey's Hospital she had woken up at approximately 3am with a severe nosebleed. Her nose

had bled profusely, and the blood had come out 'like long worms'. She was rushed to Grey's Hospital. The staff 'did nothing much' and sent her back to the Sunnyside Park Old Age Home ('the Home') where she lived. She had then gone to Northdale Hospital outpatients that night because the bleeding had continued. At the Northdale Hospital outpatients a doctor had plugged her nose to stem the bleeding. He had telephoned the medical staff at Grey's Hospital and told them that they had to attend to her. She was then sent to Grey's Hospital and waited for admission prior to staying there for approximately three days. She was told at Northdale Hospital by a doctor that her nosebleeds were caused by the ingestion of the formalin, and this should have been dealt with at Grey's Hospital. That went on for approximately a month.

- (b) To request them to help her keep her food down. A gastroscopy had been performed and they said that there was nothing they could do for her, so she just gave up. At the Northdale Hospital outpatients a doctor had plugged her nose to stem the bleeding. He had telephoned the medical staff at Grey's Hospital and told them that they had to attend to her. She had been sent to Grey's Hospital and had waited for admission prior to staying there for approximately three days. She was told at Northdale Hospital by a doctor that her nosebleeds were caused by the ingestion of the formalin, and this should have been dealt with at Grey's Hospital.

[7] Mrs Smith testified that she often recalled the incident and had nightmares about it which left her crying. She had a continual fear of doctors and nurses standing around her, as she claimed had happened in the recovery room when the

incident occurred. When she thought about these things she experienced heart palpitations. She had a continual feeling that she was going to die, and she believes that this feeds her nightmares. Mrs Smith said that prior to the operation she had loved music and dancing and going out. She had played tennis, exercised by walking, and did painting. She had now lost interest in all those things and does not do any of them.

[8] She testified that she was unable to dine out now because she was unable to keep her food down. She preferred to stay in her room most of the time, or walk in the garden at the Home. She does not go to the functions in the Home because she cannot eat, and she has no interest in what goes on. The meals with which she is provided at the Home are given away by her because, although she pays for them, she cannot eat them. She is compelled to buy her own food such as tea, coffee, milk, sugar and oats and soups out of the remainder of her pension which is left after paying for the Home.

[9] Mrs Smith also recalled that after she had been given the charcoal, her teeth had gone black and her stools were black as well. The nurses were very worried about this. She had resolved that she would never go back to Grey's Hospital and had nightmares about the place. With regard to her pre-admission medical condition, Mrs Smith testified that approximately 30 years ago she had been diagnosed with an hiatus hernia. She never really received treatment for it because it did not bother her. Prior to the incident she had not had a problem for years. She was given

asthma medication in hospital, which puzzled her, because she had never suffered from asthma.

[10] Mr *Chetty* put to Mrs Smith in cross-examination that upon her return to the recovery room after the operation, a nurse had put a blood pressure cuff on her arm, her blood pressure was checked, ECG pads were attached to her, and she was given an oxygen mask because her oxygen saturation levels were low. Mrs Smith denied having received this attention and stated that the only thing that was done was that she was given a drip. Mrs Smith maintained that she had felt 'funny' when she entered the recovery room and had said that she needed water. She could not remember the anaesthetist, and could not really remember the other people in the recovery room. She did, however, say that there was a nurse who was attending to the person in the bed next to her, and when she had screamed that nurse had told her to keep quiet.

[11] Mr *Chetty* suggested to Mrs Smith that the nurse who was assigned to her would say that when Mrs Smith tasted the formalin she had stated 'This doesn't taste right'. Mrs Smith denied this and reiterated that she had screamed. She conceded that she had been given a white plastic cup, but she was not certain. It was also suggested to her that she had sipped the liquid, but Mrs Smith dismissed this saying that she had drunk a big gulp because her mouth was very dry. It was also put to Mrs Smith that when she complained of the contents of the cup, the anaesthetist had taken it away and smelt it. This was denied by Mrs Smith. Thereafter Dr Bishop had attended upon her and she had been given milk to drink. Mrs Smith denied that she

had been given milk and maintained that she was only given charcoal and told to drink it within an hour.

[12] It was suggested to Mrs Smith that the nurses had kept a record during her stay at Grey's Hospital, and there was nothing in the record to indicate that she had continuously complained. Mrs Smith stated that if that was so, the records were wrong, and that she had complained to Dr P Marè all the time. She maintained that she had complained about pain all the time, and queried why she had been kept in hospital for six weeks if there was nothing wrong with her from the formalin which she was given. She laughed at the suggestion that she slept well in hospital and recorded that she still does not sleep well. With regard to the suggestion that she had taken meals well, Mrs Smith recorded that she had given her meals away in hospital and eaten oats and water.

[13] She maintained that she even had difficulty swallowing pills and had to bite them into pieces, and that this difficulty persists today. Mrs Smith denied the suggestion that prior to the incident she had suffered from reflux. She said she had had no reflux and had not suffered from asthma. Despite this they had given her asthma pumps and she had thought it was a joke because she had never suffered from asthma. She confirmed that she had seen Dr Elder and Dr Mohan in preparation for the trial.

[14] The next witness was Karen Elizabeth Erasmus who told the court that she had known Mrs Smith for about 26 or 27 years. Mrs Smith's daughter was one of her best friends. She said that prior to the incident Mrs Smith had been 'the life and soul of the party'. She had run a florist shop and done flower arranging at weddings and decoupage. She was very artistic, had loved ballroom and jive dancing and also taught dancing. She used to attend dancing clubs with a relative of hers.

[15] Mrs Erasmus told the court that during or about 2008, when Mrs Smith had to undergo two cataract operations, she had lived with Mrs Erasmus for about two weeks. During that time she ate everything. When Mrs Smith had gone to Grey's Hospital for the total knee replacement, Mrs Erasmus had intended to visit her between 3 and 4pm after the operation. She had received a call from a lady at the hospital who asked her to please come and visit Mrs Smith because she was not good. The person on the phone had repeated this and her anxiety alarmed Mrs Erasmus. She was led to believe that something had gone horribly wrong, and put on her hazard lights and drove to Grey's Hospital at what she described was 'quite a speed'. As she did so Mrs Erasmus thought that she would have to tell Mrs Smith's daughter that her mother had died. She said that this was brought on by the urgency in the voice of the lady who had phoned her.

[16] When Mrs Erasmus arrived at the hospital she found Mrs Smith in a very agitated state in the ward. She told her that they had given her something to drink in theatre and it had burned her from her nose to her stomach. Mrs Erasmus queried what Mrs Smith had said to her, and thought that Mrs Smith was simply confused

after the anaesthetic. She then noticed that Mrs Smith's teeth had black flecks in them and realised that she had been given something toxic. She had stayed with Mrs Smith for quite a while that evening because she was worried. All the time Mrs Smith was complaining that her throat was burning, and she was sweating profusely. Eventually Mrs Erasmus left and she returned every day to visit Mrs Smith.

[17] She said that when she saw Mrs Smith on the 6th May 2010 her face was very puffy on the right hand side. Her lip was droopy and she had spoken out of the side of her mouth. She was not sure whether she had eaten, but remembered that she looked unwell and was on a drip. A sister had explained to Mrs Erasmus that the puffiness and drooping of the right side of Mrs Smith's face was attributable to the fact that she had suffered a light stroke. Mrs Smith told her that she could not eat and was battling to swallow, particularly any meat, and that she was giving her food away.

[18] Mrs Erasmus arrived to take Mrs Smith home on the day when she was discharged, and as Mrs Smith put her clothes on, she bunched them in front of her in order to show Mrs Erasmus how much weight she had lost. Mrs Erasmus said that when she was admitted to hospital, Mrs Smith was what she described as 'an XXX – a really large lady'. Mrs Erasmus said that because of the weight which Mrs Smith had lost she had packed two rubbish bags with clothing which she could no longer wear, and had given them to charity. She had then purchased other clothes in the thrift shop at the Home.

[19] After Mrs Smith was discharged from hospital, Mrs Erasmus had visited her approximately once a month. She said that Mrs Smith was supplied at the Home with a midday meal, but no breakfast or supper. She would take Mrs Smith with her to the local Spar, where she would draw money from Mrs Smith's ATM card which Mrs Erasmus kept for her. At the Spar Mrs Smith would purchase bananas, milk, white bread, tea and cooldrink. Mrs Erasmus had also gone to visit Mrs Smith at Northdale Hospital when she had experienced bad nosebleeds. To her knowledge this had occurred on about five or six occasions. On one of the occasions, she had spoken to a doctor at Northdale Hospital, who told her that because of the formalin ingestion the capillaries in Mrs Smith's nose had been burnt. This was given as a reason for the nosebleeds.

[20] Mrs Erasmus knew that Mrs Smith had an hiatus hernia, but said that it had never bothered her although she had had it 'all her life'. She described Mrs Smith as currently being a bitter lady who does not have the joy which she had before. She is a recluse who stays in her room. She always finds her in her bedroom or the toilet. Mrs Smith has got thinner than she was and was not the same person any more. She was very anxious. After her discharge from hospital she had vomited a lot, and the hospital stay had distressed her, and she had never properly recovered. Mrs Erasmus was aware that Mrs Smith had not joined the groups in the Home and had become introverted. She had a continuing concern that she had ingested formalin and had become damaged beyond repair. In the hospital she had not known what medicines had been administered to her for the formalin ingestion, and neither did

the sisters in the ward. Mrs Erasmus had seen some files lying at the foot of Mrs Smith's bed and she had looked in them, and seen that there was a theatre file recording that Mrs Smith had been given formalin to drink. A sister or nurse had come up to Mrs Smith's bed whilst she was looking at them and asked how Mrs Erasmus dared to look at the files.

[21] In cross-examination by Mr *Chetty*, Mrs Erasmus said that at Grey's Hospital she had spoken to the sisters about Mrs Smith's condition on more than one occasion. She had also spoken to a doctor about Mrs Smith's condition and he had said that he would take note of it. She had never, however, been there when a doctor was attending to Mrs Smith. She said that when Mrs Smith was discharged, she was happy to get out of hospital. Mrs Smith had lost a lot of weight and maintained on a daily basis that she vomited and could only eat soft foods. Mrs Erasmus had not taken food to Mrs Smith in hospital because she knew she could not keep it down.

[22] The next witness for the plaintiff was Elmarie Judy Fynn Peters, a qualified registered nurse with 19 years' experience. She had worked extensively in the theatre environment in a supervisory capacity as part of her hospital control duties. She had attended theatre on an almost daily basis whilst on duty. She recorded that it was against the normal protocols of theatre to give a patient anything to drink in the recovery room. She testified that formalin was a corrosive substance and that she had had dealings with toxic ingestions by patients. Her view was that damage could still occur to Mrs Smith as a result of her ingestion of formalin in the form of

oesophageal or stomach cancer. This can happen in the latent period after the ingestion of any corrosive substance. In her view Mrs Smith would require ongoing treatment and an annual gastroscopy and that the fees for that would be approximately R600 for the consultation, R3 500 for the procedure, and R1 500 for the hospital fees. She was also of the view that Mrs Smith would need a dietician to advise her, and would need four consultations initially.

[23] In cross-examination Ms Peters told the court that she had worked in the emergency room and completed a diploma on the ingestion of corrosive substances which was part of her job. She had deduced the increased risk of cancer from an article referred to her, but did not have personal experience of this because she had never followed up on patients for long enough, mainly because they do not live that long. She could see from the medication recorded in the hospital records what the condition was that Mrs Smith was being treated for.

[24] Dr Kamal Mohan testified that he had qualified as a doctor in 1983, and in 1992 had completed post-graduate studies in ear, nose and throat, and head and neck areas, at the University of KwaZulu-Natal Medical School. He was a Fellow of the College of Surgeons of South Africa and a Fellow of the Sub-College of Enterology and Head and Neck Surgeons. He had been practising as an active ear, nose and throat surgeon since 1992 and had treated patients for injuries sustained as a result of the ingestion of corrosive substances. He had never treated a case of formalin ingestion because it was very rare for the liquid to be ingested. It was used as a fixative for tissues which are sent to pathologists.

[25] Dr Mohan had consulted with Mrs Smith in February 2016. She had complained about the loss of her ability to enjoy a meal, and she had to resort to ingesting liquids and sloppy foods. She still often vomited and could not finish meals. Fruit and cereal also presented a problem to her. She had described her experience in Grey's Hospital as 'six weeks of hell'. Dr Mohan stated that he had examined a bundle of hospital records and nursing notes, and had noted that Mrs Smith was allergic to Penicillin. She had been prescribed Amoxicillin, which was a broad spectrum antibiotic which was used for infections and taken orally and absorbed in the gastric intestinal tract. It belonged to the penicillin family and he would definitely not have prescribed it to Mrs Smith. Various side effects could have occurred from the administration of the Amoxicillin, including an itchy rash, swelling and a severe reaction, and it could be life-threatening if swelling of the larynx and vocal chords occurred.

[26] He examined Mrs Smith and found mucosal thickening of the posterior nasal space which was a space hidden behind the nose and not easily seen without an endoscope. When he had examined these areas the skin looked thicker and more scarred than normal. He regarded this as in keeping with an ingestion of a corrosive substance. He said that this would initially have caused a mucosal injury – a burning of the skin, with scarring in due course. This scarring can continue from the nasal cavity down the throat and at the back of the throat.

[27] Dr Mohan was referred to the results of a barium swallow which he had requested in order to evaluate Mrs Smith's pharynx and oesophagus. Dr Mohan said that he was not sure what the doctor who carried out the procedure was trying to say, and suggested that he may have been suggesting that there was no obstruction or stricture or narrowing of the throat, etc. He did not see the report as excluding a problem with swallowing. In his view there was no evidence of gastro-oesophageal reflux, although an hiatus hernia was indicated in the radiologist's report.

[28] Dr Mohan's comment on the ingestion of the formalin was that it was a toxic substance which could have been life-threatening if much of it had been swallowed and absorbed. He recorded that formaldehyde was quite toxic, and although Mrs Smith may have been given milk and charcoal and vomited, these would not detract from the effects of poisoning. The formalin ingestion would have resulted in discomfort during her stay in hospital, and her ability to eat and swallow had become a serious problem over a long period. This would all have contributed to her weight loss and hampered her recovery from major surgery. He regarded it as irresponsible behaviour on the part of the medical staff in the recovery room not to have noticed that the liquid was formalin before giving it to Mrs Smith. He was also of the view that Mrs Smith was psycho-socially affected by the ordeal.

[29] Dr Mohan's view of the nosebleeds suffered by Mrs Smith was that it was probably that the nasal cavity areas were traumatised by the toxic substance, both in the ingestion and the vomiting out of it. He agreed with the statement made to Mrs Erasmus by the doctor at Northdale Hospital that the capillaries in Mrs Smith's nose

could have been burnt. Dr Mohan was of the view that the formalin could not only have damaged her skin but exposed very friable capillaries which were well supplied with blood. This would explain the bleeding in the weeks after Mrs Smith's ingestion of the formalin. Dr Mohan was also of the view that the administration of Warfarin to Mrs Smith during her stay in hospital could have contributed to the number of nose bleeds.

[30] Dr Mohan stated that Mrs Smith's continued complaint, five years' after the operation, was that she experienced continued discomfort in trying to swallow. This had now become an issue with her and eating meals remained difficult. He said that the initial ingestion of formalin would have been quite painful and unbearable and would have taken time to overcome in much the same way as a burn would affect a person. He stated that the use of a stomach pump was indicated and would have been useful in preventing further toxic damage and absorption by Mrs Smith. He recorded that he was not aware of any studies relating to the concentration of formalin in this matter because the oral ingestion of it was a very rare event. Changes to the pulmonary function of persons exposed to formalin fumes have been recorded. He regarded the ingestion of the formalin as being more concentrated than it would have been if only the fumes were ingested.

[31] Dr Mohan was cross-examined on the hospital records and nurses' notes. He reiterated that there were instances in the notes where Mrs Smith complained of pain and discomfort. He did not regard the nursing records recording that Mrs Smith had been 'tolerating orally well' as reliable. That phrase had been used to describe that

Mrs Smith had been eating well. It was recorded in the notes that Mrs Smith had been given pain-relieving medication. In addition Dr Mohan referred to the fact that there was no reference whatsoever in the nursing notes to the formalin ingestion. He also referred to the fact that Morphine was administered to Mrs Smith on the days immediately following her operation. This opiate sedation would have given her relief from whatever pain she was experiencing. Dr Mohan stated that it was not routine for a doctor doing ward rounds to read the nurses' notes. A doctor was more likely to have gone by what the patient said. Nurses were not required to record everything, and only really need to record the important information. Whilst he agreed in cross-examination that he could not say that Mrs Smith had endured 'six weeks of hell' there were numerous occasions when she verbalised pain and discomfort, and it seemed to him that the analgesic medication administered to her indicated that she had been in a fair amount of discomfort for most of her stay.

[32] Dr Mohan conceded that a patient experiencing reflux over a long period of time may well have been left with scarring. He also agreed that reflux was a symptom of an hiatus hernia. The plaintiff's hernia was noted on the barium swallow results, but did not indicate any reflux of gastric fluids. With regard to the findings of the barium swallow that there were no obvious swallowing difficulties evident, Dr Mohan said that this was indicative of the fact that the passage of liquids could travel uninterrupted down Mrs Smith's throat to her oesophagus. In his view the barium swallow had been done in order to ascertain whether there were any structural or other abnormalities in the form of abnormal lesions, lumps or disease which would have prevented Mrs Smith from swallowing. What the barium swallow did not

establish was whether Mrs Smith was able to swallow a meal. The importance of the barium swallow was to eliminate strictures, tumours of the throat, etc.

[33] Dr Mohan stated that according to a pathology report made a few weeks after the gastroscopy was done, there were areas of inflammation (but no tumours) found in Mrs Smith's stomach. His view was that this was not caused by helicobacter pylori in Mrs Smith's stomach. This is the bacteria which one would expect to find where there are stomach or peptic ulcers. He regarded this, however, as outside his area of expertise.

[34] Dr Mohan was of the view that Mrs Smith's nosebleeds would have healed naturally with the passage of time. Scar tissue was laid down in order to take care of the wound. Dr Mohan was of the view that with the formalin passing through the lips, mouth, throat and going down to the stomach of Mrs Smith, he would have expected tissue to have undergone some physical reaction. He would also have expected there to be a greater reaction in her throat. This is because she would have tried to cough or spit out the liquid and she would feel it at the back of her nose. He pointed out that Mrs Smith did indicate that her entire throat and mouth felt burnt. He was also of the view that with the ingestion of the formalin, her natural reaction would have been to push the liquid to the back of her throat and it would not have had much contact with her tongue. Any injury of her tongue would not have lasted for more than a few days. Dr Mohan also regarded it as most unusual that there would be nursing notes recorded at 2am on the 7th May 2010, and stating that the patient was 'tolerating well orally meals'. Dr Mohan also recorded that it was possible for a

barium swallow to exclude functional problems and look normal, and yet the patient could have muscular problems. The presence of an hiatus hernia was asymptomatic in many patients.

[35] Jean Ernest testified that she was a private consulting dietician. (Mr *Chetty* recorded that her status as an expert in her field was not disputed). She had consulted with the plaintiff regarding her eating problems, including her inability to swallow or eat solids, indigestion, flatulence and constipation. These complaints had all started from the time Mrs Smith had ingested the formalin and her digestion has never been normal since that time.

[36] When she consulted with Mrs Smith, her diet was very limited, consisting of mashed bananas, milk, yogurt, tea and coffee. This was therefore a carbohydrate concentrated diet. She recommended a menu plan for Mrs Smith consisting of seven different breakfast and lunch options in a diet which consisted of protein, and carbohydrates, and which was low in fat. She also recommended snacks in-between. The problem which Mrs Smith experienced was that she was only able to eat soft foods. It was therefore necessary to blend whatever foods she intended to eat.

[37] With regard to the costs of a proper balanced diet, Ms Ernest recorded that a tin of Ensure cost R130, was available in different flavours and would last for six servings. In addition Mrs Smith could eat Futurelife cereal which was a high protein

cereal costing R68. She was also in need of a good probiotic and a box of 20 of those (taken at the rate of two per day) would cost R118. In addition she recommended that Mrs Smith take multi-vitamin products such as Vitathion which cost between R70 and R80 for a box of 20. She estimated Mrs Smith's nutritional expenses to be approximately R8 000 per month. She noted the importance of having a diet which was varied and was flavourful. She recommended the purchase of what is referred to as a 'smoothie-maker' manufactured by NutriBullet and available at a cost of R2 000. In addition Mrs Smith required to have a blender which would cost R3 000.

[38] Ms Ernest was cross-examined on the variety of meals which were available to Mrs Smith at the Home. Ms Ernest stated that these meals are generally very standard but not many of them could be blended in order to allow her to tolerate them. Meals such as bacon and eggs, or a cottage pie, could not be blended and retain any appeal to the person who would have to consume them. Ms Ernest emphasised the need for food to look, taste and smell nice in order for it to be appealing. She cited the example of ice-cream and fruit salad which could easily be blended and yet remain palatable and look appetising. She pointed out that in the six years that Mrs Smith had been at the Home, they had made no effort to assist her in providing a balanced and appetising menu.

[39] Dr Nirbernie Kumarason Elder testified that she was a clinical psychologist who practised as a counselling psychologist and a neuro-psychologist and was registered as a clinical psychologist with the Health Professions Council of South

Africa. She had compiled an expert report which she confirmed. In consulting with Mrs Smith she had looked at the cognitive areas of attention, concentration, memory processing and executive functions. She had also looked at affective or emotional aspects and had Mrs Smith complete a Mental Status Examination. Dr Elder found that Mrs Smith suffered from no cognitive deficits and regarded her as what she said was 'a feisty old lady with an excellent memory'.

[40] Dr Elder said that Mrs Smith carried a memory of being hurt, having had to undergo repeated blood tests and not being told precisely what was happening to her. She had told Dr Elder a list of post-traumatic problems and current problems suffered by Mrs Smith which Dr Elder articulated in her expert summary. Dr Elder said that during the four hour consultation with Mrs Smith, she had observed all the social niceties. For her lunch, Mrs Smith had eaten bananas. She had completed an MSE psychometric test which is designed to test whether a patient is malingering. She also completed a post-traumatic stress disorder check list.

[41] In the view of Dr Elder, Mrs Smith had changed from an adventurous, industrious person who interacted socially and flew around the world, into someone who had lost her meaning and purpose, and felt that something terrible had happened to her. Her life changed after she was discharged from hospital, and she has not been able to eat properly since then. She felt hurt and damaged both physically and psychologically. Dr Elder carried out a clinical enquiry using psychometric testing and diagnosed Mrs Smith in terms of DSM 5 (the Diagnostic and Statistical Manual of Mental Disorders). She diagnosed Mrs Smith as suffering

from post-traumatic stress disorder and that she fulfilled the criteria for a chronic psychiatric condition. In her view Mrs Smith was a 'test-book case' of post-traumatic stress disorder. This included a significant element of depression with symptoms of worthlessness, inadequacy, hopelessness, helplessness, being de-energised, failing to use coping behaviours, weeping, appetite loss and sleep disturbance. She recorded, however, that Mrs Smith's inability to eat solid food was not due to her depression.

[42] Dr Elder was of the view that the prognosis of Mrs Smith recovering from her condition was poor and said that she would never recover the years which she had lost in the interim. She did not see that Mrs Smith's quality of life would improve. Dr Elder said that every now and again she would see glimpses of Mrs Smith's pre-morbid condition when Mrs Smith grew orchids and flew around the world. She rated her impairment at the serious level in all areas of functioning.

[43] In Dr Elder's view Mrs Smith required to undergo 24 sessions of psychotherapy at R1 200 per session in order to help her to deal with her depression and nightmares. In cross-examination Dr Elder stated that the purpose of the psychotherapy would be to minimise Mrs Smith's suffering, but it would probably not restore her to her pre-morbid condition. She did not believe that Mrs Smith would be cured because of the period of physical suffering and pain which she had thus far endured. Assurances to Mrs Smith that no-one had actually intended to harm her, would be of no assistance in restoring her emotional state. She described Mrs Smith as tending to have become a 'social hermit'. In reply to questions by the court Dr

Elder stated that the tests which she had done in order to exclude the possibility of malingering were very basic and clever tests which clearly identify malingerers. She did not think it was possible to circumvent that testing procedure, and her view was that Mrs Smith was not faking her condition.

[44] Dr Sithembiso Cedric Coka testified that he had attained the MB ChB qualification from the University of KwaZulu-Natal, and had thereafter completed a certificate in nephrology. He was qualified as what is referred to as a Super Specialist Physician and Nephrologist. He had undergone special training in attending to acute medical admissions to hospital, including gastro-enterology. This process had given him a broad overview of all the medical disciplines. He reiterated that he was not a gastro-enterologist, but a nephrologist. Over the last four years he had dealt with the emergency treatment of formalin ingestion at the rate of two to three cases per year. He had trained in a referral centre and accordingly seen cases from outside his immediate area.

[45] Dr Coka described formalin as a colourless, clear liquid with a pungent and suffocating odour. It was a reactive agent containing approximately 30 per cent formaldehyde, and 10 to 15 per cent methanol. The ingestion of formalin would cause irritation of the pharynx and oesophagus with ulceration, and in the long term the formation of strictures. The stomach and duodenum would suffer inflammation giving rise to gastritis and duodenitis (inflammation of the duodenum, which was the first part of the intestine). In addition formalin ingestion could cause liver damage and in severe cases kidney damage leading to renal failure. The onset of lactic acidosis

which was the over-production of lactate, could result in lethargy, drowsiness, a coma and even death. If splashed in one's eyes it could cause irritation. It could also cause severe damage, and inhalational injuries would result in an asthma-like picture.

[46] Dr Coka said that there was an increased likelihood of chest injury where formalin was ingested and then vomited up. He said that the preferred emergency measure was not to induce emesis (vomiting). This was because there was a possibility of further injury to the upper areas of the throat and post-nasal pharynx damage. Dr Coka said that the symptoms of formalin ingestion would be an unpleasant taste, burning in the mouth, chest and abdominal pain. It could result in subsequent difficulties with swallowing and could persist to the extent that a patient could become anorexic. Nausea and vomiting formed part of this process.

[47] Dr Coka described the best treatment as not making a patient vomit, and giving them water/milk to drink. Dr Coka recommended the use of a nasal gastric tube in order to aspirate the formalin from the stomach. This could be done after diluting the formalin with approximately 240 millilitres of water. Aspirating the formalin in this way would prevent irritation in the stomach as well as protecting the nasal airways, mouth, etc.

[48] Dr Coka was of the view that an upper-endoscopy was necessary in order to assess the resulting injuries from formalin ingestion, and that this should be done

within 24 hours of the ingestion. In this way a doctor could visualise the oesophagus and stomach and small intestine and see and document any injuries. In addition a laryngoscopy would visualise upper airway and vocal cord damage.

[49] Dr Coka examined the medical records of Grey's Hospital and Northdale Hospital which had been made available to Mrs Smith's attorney. There was no indication of a gastroscopy within 24 hours, nor of an enterologist being called within 24 hours. He had consulted with Mrs Smith who told him she had undergone a traumatic experience, and after being given the fluid had experienced an immediate burning of the mouth, chest and stomach. She had reported this and tried to spit out some of the contents. With regard to the administration of activated charcoal to Mrs Smith, Dr Coka said that the recommended dosage was one gram per kilogram of body weight. In those circumstances Mrs Smith should have been given 100 grams of activated charcoal. He said that this should have been done even if she had only taken 'a sip' because that was an unquantifiable amount. He regarded the administration of charcoal as very important because it prevents further absorption by the body of the formalin, and the further irritation of the mucosa. He viewed the delay of one hour and 40 minutes before the administration of the activated charcoal as not being acceptable. He said that this should have been administered immediately, but the medical staff would probably have had to obtain the charcoal which may have taken some time.

[50] With regard to the fact that a note had been made to obtain a blood gas on the night following the ingestion of the formalin by Mrs Smith, Dr Coka said that this

was a rapid tool which looks at the acid-base status of a patient and their oxygenation and carbon dioxide levels. It can determine the presence of lactic acidosis and this should have been done immediately. The equipment is available in all theatres and intensive care units.

[51] Dr Coka also regarded the nursing records which depicted that Mrs Smith had slept well throughout the night and was 'tolerating well orally' as suspect. He said that Mrs Smith was plainly not tolerating meals. Mrs Smith had been prescribed Maxolon, which was an anti-emetic, and was not something one would expect to be given to a patient who was 'tolerating well orally'. He would not have done so. He noted that Maxolon was given in a 10 milligram dosage three times a day or when vomiting, and had been administered to Mrs Smith from the 6th to 9th, the 13th to the 15th, and the 20th to the 21st days of May of 2010. He regarded it as highly unlikely that Maxolon would have been given to Mrs Smith if she was 'tolerating well orally'.

[52] With regard to the notes of the 11th May 2010, which referred to Mrs Smith complaining of chest pains with a tight chest and palpitations, Dr Coka said that although she may have suffered from burning pains after the ingestion of the formalin, they were not likely to have precipitated a cardio-vascular event. Given the medication which Mrs Smith had been prescribed, he was of the view that she had not had heart problems or ischaemic heart disease.

[53] Dr Coka said that an endoscopy was indicated in cases of heartburn, melena (the passing of dark stools), anaemia and epigastric pain. His view was that the endoscopy had demonstrated that her oesophagus was normal, but that her stomach was mildly gastric and inflamed. Mrs Smith had presented with a fibrous, hard or rigid stomach, and there was a concern about cancer, which resulted in a biopsy being taken. Dr Coka recorded that formalin ingestion could cause bleeding in the upper gastro-intestinal tract and gastritis. With regard to the suggestion in the medical notes that Mrs Smith had ingested 10 millilitres of formalin, Dr Coka opined that this was not a sip and what he described as 'not a negligible amount'.

[54] Dr Coka stated that helicobacter pylori was positive with gastritis, but required a 'trigger factor' and, formalin, as a toxic substance, could definitely have been the trigger factor. Helicobacter pylori are organisms that exist in the gut of one in three persons, but can exist without causing any problems. Its existence does not mean that it caused the gastritis found in Mrs Smith..

[55] With regard to the other medication administered to Mrs Smith, Dr Coka was of the view that she should not have been given Amoxicillin (an anti-biotic to treat the gastritis) if she was allergic to penicillin. In addition, there was no point in giving her an antibiotic for two days and not completing the course. He concluded from the medication and medical notes that the attending doctors were not convinced that Mrs Smith suffered from helicobacter pylori which had been responsible for gastritis. Dr Coka conceded that the ingestion of a small 'sip' of formalin was unlikely to have

occasioned the result that Mrs Smith lost 23 kilograms in a month. As I understood the suggestion by him it was that the quantity, and accordingly the injury, must have been greater.

[56] Dr Coka was cross-examined on the fact that formalin is used as a fixative for specimens which are kept in the liquid until the specimen can be analysed or tested. He was unable to explain how body samples were preserved in a corrosive agent, but opined that tissue which had been removed from a body has no blood supply. The effect of formalin on a specimen removed from a body would give different results from the tissue of a live person to which formalin was administered. Dr Coka conceded that the formalin would not be as powerful as pure formaldehyde. He said, however, that the fact that it may have been a weaker solution did not mean that it would not cause harm. Dr Coka accepted that strictures in the oesophagus could be a long-term sequelae of formalin ingestion and that they would generally remain because they were constituted by fibrous tissue. Strictures could be indicated by difficulty with swallowing and heartburn, and could be ascertained by the use of a scope. He accepted that there was no mention of duodenitis in the scope report, but that gastritis had been present.

[57] Dr Coka conceded that the administration of charcoal was a correct treatment post-formalin ingestion, but that the dose given to Mrs Smith was approximately half of what she should have been given. It should also have been given within 30 minutes. Dr Coka opined that damage which was done to a patient following formalin ingestion, such as strictures or burning, could be remedied if proper treatment is

given, and the initial damage was not too severe. It was possible that one would not pick this up on a scope because an injury has been treated and repaired itself. He conceded that no strictures were seen on the gastroscopy done in 2010, although gastritis was present and Mrs Smith's stomach was rigid. Dr Coka said that it was difficult to be certain about this because there were other factors which could have contributed to this, and the whole of her stomach was tubular or rigid.

[58] Dr Coka was of the view that a barium meal should have been done in 2010 prior to Mrs Smith's discharge from hospital, but that it was not done. There was nothing to indicate why it had not been done. Under re-examination Dr Coka reiterated that the effect of formalin on living tissue was not the same as its effects on dead tissue. With regard to the epistaxis suffered by Mrs Smith, Dr Coka was of the view that it was not the ingestion per se, but the fumes from the formalin which may have precipitated this. He said in this regard that the Warfarin could have been an additive factor. Dr Coka stated that noses do not bleed spontaneously. There must be an event which causes the nose to bleed but Warfarin could have made it worse. There must, however, have been underlying damage.

[59] After the plaintiff's evidence had been led Mr *Ramdass* reiterated that it had been agreed that there was no need to call the actuary to testify unless the defendant raised queries. None had been raised. The plaintiff's case was then closed.

[60] Mr *Chetty* then indicated that the defendant wished to have its own actuarial report prepared which would be done as soon as possible. He would have to take instructions in this regard. He also wanted to discover the original hospital records, (additional to those already before me) which he now had possession of, and he wanted to have them admitted into evidence. In addition, Dr Govindasamy had examined the plaintiff, and the defendant wished to deliver an expert report from Dr Govindasamy. As none of these matters could be done immediately, the defendant requested an adjournment of the trial.

[61] Mr *Ramdass* pointed out that the matter of the actuary had been raised in opening, and nothing had been done until Mr *Chetty* made this application. He recorded that on the 18th November 2014, the defendant had been directed at the pre-trial conference to obtain expert reports. On the 2nd December 2014 the matter was certified ready for trial on the basis that the defendant would have all its witnesses available. With regard to hospital records, the plaintiff had made numerous requests for the hospital records to be made available. They were initially told that the Grey's Hospital records were missing, and the plaintiff had obtained the Northdale Hospital records directly from the hospital. A request for proper discovery had been made and had been raised in the pre-trial conference where Adv *Mthembu*, appearing for the defendant, had said that there was no discovery to be made because there were no records. The medical records before the court had been delivered late and not under cover of a discovery affidavit. The plaintiff's representatives had understood at that stage that that constituted the complete hospital record with the exception of the doctors' administration record which had been produced on the 4th May 2010.

[62] No explanation was proffered as to when the new hospital records, which Mr *Chetty* wished to adduce, had become available. In addition, only an application from the Bar had been made with no explanation as to why discovery had not been properly carried out previously. Mr *Chetty* conceded that with regard to the actuarial report, he could advance no reason why the defendant should be entitled to breach the agreement which it had concluded with the plaintiff. With regard to the original records he conceded that no proper application for condonation of the late discovery of those documents had been made thus far. In addition, no proper application for condonation of the late filing of an expert report of Dr Govindasamy had been made. It did not appear that that report was yet available.

[63] I considered the arguments advanced by the defendant for an adjournment. In my view it was inexcusable that the defendant should not have discovered properly and not produced proper expert notices and summaries timeously. No explanation whatsoever had been given to me for the statement by Adv *Mthembu* that there were no records to be discovered. When Mr *Chetty* made the application, he had before him a bundle of documents which clearly entailed considerably more than the documents which had already been used and handed up to me at the outset of the trial. In my view it was simply unacceptable that the State could conduct litigation in this manner. Mrs Smith is currently 85 years of age and was injured in May of 2010. Six years had elapsed during which the defendant had every opportunity properly to prepare its case. That it did not do so demonstrates that the defendant's case has

been recklessly prepared. I had no hesitation in dismissing all three of the applications by the defendant.

[64] The defendant then led the evidence of the anaesthetist who administered the formalin to Mrs Smith. She testified that she was an anaesthesiologist presently employed by the Albert Luthuli Hospital in the anaesthetic department. She works in the cardio-thoracic anaesthesia unit and has been practicing since 2013 as a specialist anaesthetist. In 2010 she was employed by the Department of Health as a Registrar at Grey's Hospital.

[65] She had been present on the 5th May 2010 and administered the anaesthetic to Mrs Smith when she had undergone her knee replacement surgery. At the outset she had spoken to Mrs Smith and taken down her medical history. She could not actually recall the consultation with Mrs Smith, nor the doctor who carried out the operation. After the operation during which Mrs Smith was given a regional spinal anaesthetic, Mrs Smith was taken into the recovery room and placed on the various monitoring devices. The anaesthetist said Mrs Smith had complained of nausea. The anaesthetist asked the nursing sister to provide Mrs Smith with Maxolon which was given intravenously. Whilst this was being administered Mrs Smith had stated that she had a hernia, and felt nauseous. She said that a glass of water would settle her. After Mrs Smith was given the Maxolon, the nurse arrived with water but the anaesthetist had discarded it because it was not needed.

[66] The plaintiff had again asked for water and the anaesthetist went to get it for her from a little room next to the recovery room. In the room was a sink, a tap and a liquid canister. As it looked like a normal water canister she dispensed the clear liquid into a cup and gave it to the plaintiff to drink. The plaintiff took a drink and stated that it had tasted funny. The anaesthetist said that she then took the cup away and had gone back to look at the liquid canister and seen the label in black writing 'FORMALIN' on it. She went back and told Mrs Smith what had happened. She was not sure of her words, but she recalled that she told Mrs Smith that she had given her something which was not water. She told the attending nurse, who brought milk which was given to Mrs Smith. This was about five to ten minutes after Mrs Smith had ingested the formalin. After drinking the milk, Mrs Smith had vomited, and the anaesthetist had asked her how she felt. She said she was fine and the anaesthetist asked her to open her mouth and she looked inside. Everything seemed normal.

[67] The anaesthetist then went and told Dr Bishop what had happened, and he took over the management of Mrs Smith. She had had no further involvement with Mrs Smith, save for recording her notes of what had happened, and going to see Mrs Smith in the ward the next day. She could not remember what sort of cup she had given to Mrs Smith but stated that Mrs Smith had taken 'a sip'. She could not be certain how much formalin had been ingested by Mrs Smith. She denied that Mrs Smith had screamed and said that it was burning her and that they were trying to kill her. The anaesthetist said that Dr Bishop had administered charcoal to Mrs Smith and had ordered a blood gas to be done during the night. This was to exclude metabolic acidosis, and the blood gas was normal and revealed that Mrs Smith was

not acidotic. The blood gas had been done by the night doctor. On the next day she spoke to Mrs Smith and made a note at 11.30am that she was still vomiting and nauseous and the anaesthetist topped up Mrs Smith's epidural.

[68] The anaesthetist conceded that the formalin she had given to Mrs Smith was poisonous. She disagreed that it had a noxious smell, and also disagreed that it was a corrosive substance. She said that the corrosive effect would depend upon the strength of the formalin. Dr Bishop had been the doctor on the floor and in charge of all the theatres which were operating at the time. He had spoken to Dr Farina, who was the head of department, about the incident. A report had been written by Drs Bishop and Farina approximately six months later. There had been no adverse incident reporting mechanism in place as a hospital protocol, and the matter had simply been discussed at the end of the week in a meeting with the other anaesthetists.

[69] The anaesthetist conceded that although it was important in her pre-operation notes to have recorded the weight of Mrs Smith, she had not done so. Initially she stated that her record of Mrs Smith's previous medical conditions had been obtained from her. However, when the medical expressions which she recorded were put to her, she conceded that she must have looked through her notes and seen Mrs Smith's previous conditions recorded in an outpatient's folder. She then said she was not sure where she had got the information from. The anaesthetist stated that although she had examined Mrs Smith clinically on the 4th May 2010, it had not been a full examination and she had not examined her abdomen. Had she done so, and

had epigastric tenderness been evident, she would have recorded it. She would also have recorded chest pains and gastric reflux if that had been complained of by Mrs Smith. She conceded that these were relevant questions to have put to Mrs Smith prior to her going into theatre.

[70] The anaesthetist said that in the recovery room there was one member of the nursing staff which was allocated to each patient returning from theatre. In cross-examination she said that she could not specifically remember giving Mrs Smith Maxolon. The anaesthetist said that she had caused the water brought by the nurse to be discarded because she thought Mrs Smith's nausea would subside after she was given Maxolon. She conceded that nowhere in her notes did she record that Mrs Smith had said that she suffered from an hiatus hernia and that water would have assisted her. She stated that she was relying on her memory for that statement. She was however unable to recall how long after she had administered Maxolon, she had given Mrs Smith the formalin to drink. She had noted that Mrs Smith had complained of a slight burning in the throat. She had recorded in her notes that Mrs Smith had been given ten millilitres of formalin, but that that was just an estimate by her. Although she said it was her call to decide on the medication to be given to Mrs Smith, she had given her milk in order to try to minimise the harm. She had had no experience at that stage and did what she thought was best.

[71] The anaesthetist stated that she had gone to visit Mrs Smith the next day, but was unable to recall her reaction. The only thing which she did recall was that she felt relieved. She stated that she had not treated Mrs Smith after Dr Bishop took

over, in order to carry on her work in theatre. The anaesthetist stated that the activated charcoal had been administered to Mrs Smith before 1.45pm. She could give no explanation for the fact that she had gone to get the water for Mrs Smith as opposed to the nurse having done so.

[72] At this stage in the trial, the matter was adjourned to the next court day. At the outset of that day's hearing Mr *Chetty* renewed his application for the admission of the hospital records which did not form part of the documents given to the plaintiff by the defendant's representatives. Mr *Ramdass* objected to the application. As no formal application had been prepared and presented, and as Mr *Chetty* could advance no other reasons other than he had done previously, I refused the application.

[73] The evidence of the anaesthetist continued. She admitted that in administering the formalin to Mrs Smith she had been negligent. She said that she had taken the formalin away from Mrs Smith when she complained that it had tasted 'funny' but could not recall whether she had tried to smell the liquid. Mrs Smith had vomited immediately upon drinking the milk which she gave to her. She was unsure whether this was caused by the formalin or the Maxolon which may not have been successful in causing the nausea to subside. (It appeared from her evidence-in-chief that she had discarded water initially brought by the nurse, because she believed that the Maxolon was working and the plaintiff's nausea had subsided.)

[74] Dr David Gray Bishop testified that he was the head of anaesthetics at Edendale Hospital in Pietermaritzburg during May of 2010. He was a qualified specialist anaesthetist and a fellow of the College of Anaesthetists. He had been working as the Senior Registrar in anaesthetics at Grey's Hospital. On the day in question he was co-ordinating the theatres as the senior assigned to that post. He was, in other words, the first port of call for doctors who experienced problems in theatre. He was called to the recovery room and told that Mrs Smith had been given formalin to drink. He was told that she had taken one sip, and that she had thereafter been given milk by a nurse. She had vomited after consuming the milk.

[75] Dr Bishop recorded that as formalin has no antidote, emergency management of ingestion consists of dealing with what has been ingested. He discussed the matter with the Chief Specialist of Anaesthetics and his senior, Dr Farina. They agreed on a management plan. They elected not to use gastric lavage but instead to administer activated charcoal. This comes in the form of black powder and looks and tastes like crushed charcoal. It absorbs the poison which will thereafter be passed by the patient.

[76] Dr Bishop and Dr Farina felt uncomfortable with the idea of using gastric lavage because it could precipitate one of a number of events for very little benefit. The charcoal treatment seemed the appropriate one where only a small amount of formalin had been ingested. He conceded that formalin was corrosive and during gastric lavage vomiting and aspiration could occur. Dr Bishop called the pharmacy from the recovery room in order to ascertain the strength of the formalin which was

used in the hospital. He then told the recovery room nurse to go and get the charcoal. He conceded that patients struggle with the charcoal because it is difficult to swallow. He thought that Mrs Smith had done very well under stress to drink the charcoal. He had asked her to drink it as quickly as possible, but within an hour. He said she had done so well within the time. Dr Bishop testified that after Mrs Smith had consumed the charcoal she was kept in the recovery room to see if the formalin had been absorbed into her system. She spent approximately three hours in total in the recovery room and was then discharged to the ward.

[77] Dr Bishop said that he had had no previous experience of formalin ingestion. He stated, however, that the administration of incorrect drugs was a relatively common occurrence in hospitals because, for example, 2 000 substances were given per week in the theatres at Grey's Hospital, and drug error is a problem in any hospital. Dr Bishop stated that he had informed Mrs Smith that she had been inadvertently administered formalin. He discussed what it could mean and what they would do in order to make sure that she came to no harm as a result. He said that when he told her she was co-operative and said she understood and would do what they asked her to do. He said that although Mrs Smith may have outwardly protested when the formalin was administered, she was calm when he arrived about five minutes later. Dr Bishop conceded that aqueous formalin does have a strong smell. He conceded that when he made his notes at 1.40pm, the charcoal had already been given to Mrs Smith. Dr Bishop stated that the administration of milk would have had two benefits. It would have diluted the formalin and when she vomited it up, some of the formalin would have come out. The milk would also reduce the corrosive element of the formalin. He stated that he had nothing to do

with the release of the documents to the defendant's attorneys, which had been handled by the hospital's medical management. He said that prior to writing the letter which he wrote together with Dr Farina, he had had access to Mrs Smith's in-patient records and theatre records.

[78] Sister Thasanee Govindasamy told the court that she had been a registered nurse since 1996 and had worked in the recovery Room at Grey's Hospital for ten years at the time of the incident. She was responsible for organising and fetching patients for theatre, checking their pre-operative notes and ensuring that they recovered post-operatively. She recalled the incident when Mrs Smith was administered formalin. She said that when Mrs Smith was wheeled into the recovery room she was comfortable but had complained of nausea. The anaesthetist had ordered Maxolon to be administered.

[79] Mrs Smith complained of being thirsty and the anaesthetist left the recovery room. She returned with a medical glass and Mrs Smith sipped the substance and said that it tasted funny. The anaesthetist smelt it and realised that it was formalin. Sister Govindasamy described the anaesthetist as looking shocked, very surprised and frightened. She immediately ordered the administration of milk to Mrs Smith which Sister Govindasamy obtained from her own private store of milk which she kept in a nearby fridge for tea.

[80] Sister Govindasamy denied that Mrs Smith had told them that it was burning her and that they were killing her. The anaesthetist left the recovery room and returned with Dr Bishop who ordered the activated charcoal to be administered to Mrs Smith. Sister Govindasamy maintained that Mrs Smith was given oxygen all the time that she was in the recovery room because her oxygen saturation levels had been low. She said that she had witnessed Mrs Smith drinking the activated charcoal.

[81] Under cross-examination Sister Govindasamy said that when the formalin was initially administered to Mrs Smith all the other medical staff present had gathered around her. She could not explain why this would have happened if Mrs Smith had been calm in her reaction to the administration of the formalin, but contented herself with saying that it was an open room, presumably intending to convey that others could easily have heard what was going on.

[82] Sister Govindasamy accepted that it was her duty to have recorded the administration of the formalin, because it was a negative incident, and the hospital protocols required that negative incidents were recorded by two parties. She had no explanation for the fact that she had not recorded the incident in the notes on Mrs Smith's condition during the anaesthetic. She had made a number of records under the heading 'Complications in Recovery Room', but none of them mentioned the administration of the formalin. She suggested that that had been done by a note made at the bottom of the page by another nurse. That note recorded that Mrs Smith had been given formalin to drink inadvertently and a reference was made 'see

patients (sic) notes for record'. The note continued to state that Mrs Smith had received charcoal at 1.48pm, and was signed by Sister Vessinger.

[83] Sister Govindasamy then said that she had made a statement and had informed Sister Ngcobo who was in charge of the recovery room as well as Sister Lehmena, and Sister Whittaker who were in charge of the theatre. She understood that copies of her report would have been made available to the medical superintendent and the quality assurance department of Grey's Hospital. She recorded that she had only ever spoken to the defendant's legal representatives approximately two weeks' before testifying. She had told them what she had written in the report. She did not know what happened to the report she had compiled. She was also unable to comment on the fact that hospital records had repeatedly been requested, but not been forthcoming.

[84] Sister Govindasamy was also cross-examined on the fact that she maintained that Mrs Smith was comfortable, although she did complain of burning in her throat. She was not at any stage hysterical or screaming. She could give no explanation as to why everyone would have gathered around her if this was the case. When further cross-examined on this issue, Sister Govindasamy stated that the nurses in the recovery room treating other patients had never left their patients but were aware of what was happening and were available to help. She conceded that, despite the fact that it was the protocol not to give any water to patients in the recovery room, 'a few sips' were given.

[85] In her evidence Sister Govindasamy maintained that she had gone off duty at 12.45pm. At that stage she was working half-days. When presented with the fact that the charcoal was only administered at 1.48pm, long after she had gone off duty, she appeared uncertain as to whether or not she had been present when the activated charcoal was given to Mrs Smith. She also suggested that it was possible that the entry recording the administration of the activated charcoal had only been made at 1.48pm. It was pointed out to her that it was the evidence of Dr Bishop that the charcoal was administered to Mrs Smith more than an hour after the formalin ingestion. If the formalin ingestion had been given at 12.10pm, it is unlikely that the activated charcoal would have been administered to Mrs Smith much before 1.15pm. Sister Govindasamy then stated that she had perhaps confused the administration of the milk with the administration of the activated charcoal to Mrs Smith.

[86] Sister Govindasamy was adamant that the anaesthetist had in fact smelt the liquid immediately after Mrs Smith had complained about it. She had immediately realised it was formalin. She also said that the suggestion by the anaesthetist that she had been sent off to fetch water for Mrs Smith, was not true.

[87] Sister Dududzile Ngcobo testified that she had been a professional theatre sister for 24 years, and was employed at Grey's Hospital in the theatre post-operative area in May of 2010. She said that the recovery room had five beds in it, and Mrs Smith was placed into the second bed when she arrived back from theatre.

Sister Ngcobo was assisting a patient who was in the third bed. She said that at some stage the anaesthetist had moved out of the bay where Mrs Smith was, and returned with a medicine glass and gave it to Mrs Smith. Sister Ngcobo's attention was drawn when Mrs Smith stated 'This tastes funny, Doctor'. The anaesthetist had then taken the medical cup, smelt it and moved away from the bed and away from the patient. At that stage Sister Govindasamy had reported to her that the patient had drunk something. Sister Ngcobo told Sister Govindasamy to call the consulting doctor who was Dr Bishop. He was in charge of all eight theatres on the floor. Dr Bishop then arrived and asked for a script, and requested charcoal to be fetched from the pharmacy.

[88] Sister Ngcobo denied that she had heard Mrs Smith saying that they were killing her or that her mouth was burning. All she heard her say was that the drink she was given tasted 'funny'. Sister Ngcobo amplified this to say that Mrs Smith had said that 'it doesn't taste like water'. Sister Ngcobo said that when Dr Bishop arrived, Mrs Smith was given Maxolon and activated charcoal. She had been talking to Sister Govindasamy, and Sister Ngcobo could not remember any unpleasantness.

[89] In cross-examination Sister Ngcobo conceded that it may have been the anaesthetist who had gone to fetch Dr Bishop, and not a nurse as she thought had been done. She said that her attention had been attracted to Mrs Smith only when she complained about the substance she was given to drink. She could not recall anything which Dr Bishop said to Mrs Smith. She could also not recall whether the Maxolon was administered before or after the formalin was ingested. She then

recalled that it had been requested prior to Dr Bishop arriving. She did not know which doctor had prescribed the Maxolon, and she only remembered Sister Govindasamy requesting it.

[90] She said that Sister Govindasamy had gone off at 1.00pm. She said that at no stage did she hear Mrs Smith complain that there was burning in her throat. Sister Ngcobo also said that water was not usually given in the recovery room, and if patients were thirsty the staff would crush an ice-cube and put it on the patients' lips to suck.

[91] When it was put to Sister Ngcobo that Sister Govindasamy had said that the nurses and staff had gathered around Mrs Smith, Sister Ngcobo agreed with this. She said, however, that it was an open space, and there were people all around Mrs Smith, 'but not against her'. She did not leave her patient in order to go and assist Sister Govindasamy. She confirmed that the anaesthetist had reacted when she had taken the medicine cup from Mrs Smith and smelt it. She described the anaesthetist as having been astonished.

[92] Sharon Brenda Pule testified that she has been a registered nursing sister for more than 15 years and had been employed at Grey's Hospital in Ward B1. She did not remember the incident when formalin was administered to Mrs Smith. She confirmed, however, that she had made various entries in the nursing records. She confirmed that the nursing records which were made at 3am were not done at the

patients' bedsides but at the nursing station. This was because they did not wish to switch on the lights at night-time and disturb the patients. She was unable to recall specific events which had taken place but was only able to testify about what generally happened. She said that the kitchen staff had administered meals to the patients and they would also clear the dishes away. She said that if a patient had not eaten a meal, the other patients would let the nurses know. She conceded that it was commonplace that matters were not recorded by nurses.

[93] Dr Douglas Paul Kinghurst Wilson testified that he was a specialist physician in the Department of Internal Medicine at Edendale Hospital in Pietermaritzburg. He had been made a Specialist Fellow of the College of Physicians in 1993 and was a Specialist in Infectious Diseases. His involvement in the action was to read the patient notes and comment thereon. He had been approached to do so by the defendant's legal services during October of 2015. He had never examined Mrs Smith. He had been given photocopies of the patients notes relating to Mrs Smith's medical admission at the time she was administered the formalin. He had been given the complete records of Mrs Smith's stay in hospital save for an admission note to B Ward, which was made on the 4th June 2010. He had not interviewed any staff.

[94] Dr Wilson said that formalin was a substance which was widely used to preserve specimens, and its purpose was to stabilise and preserve human samples to enable a histo-pathologist to cut slices and stain them and examine them under a microscope. He stated that a ten per cent buffered solution such as that which was

administered to Mrs Smith would have consisted of formaldehyde which had chemicals added to it by the pharmacist preparing the solution in order to make it less acidic. In certain contexts it remained corrosive, but his view that that was less so in a medical context, because it was needed to preserve specimens. He conceded that formalin could cause damage to the gastro-intestinal mucosa, but that a buffered solution was less likely to do so. He was also of the view that it could cause depression with impaired brain function and a coma. In this regard the molecules were very small and crossed membranes, and that a significant exposure could cause profound system effects throughout the human body. He regarded ingestion as rare because of the alarming odour and irritant effect of formalin. He said that by sniffing it, one could clearly tell that it was formalin.

[95] Dr Wilson's information regarding the effects of the formalin ingestion upon Mrs Smith had been exclusively obtained from the medical records. He confirmed that the purpose of the blood gas which was taken was to determine whether or not Mrs Smith had suffered a metabolic acidosis. The blood gas results were in the normal range and he concluded that the exposure was not very large otherwise metabolic acidosis would have developed. He opined that it was unlikely that Mrs Smith could now suffer from acidosis because the formalin molecules would have broken down, and as time passed, become less harmful.

[96] Dr Wilson maintained that a key symptom of a corrosive injury is pain. He was reassured by the entry on the 6th May 2010 that Mrs Smith was 'tolerating well orally'. His focus was on the fact that there was no pain in her mouth. His view was

that if the mucous membranes in her mouth had been stripped away by the formalin she would have been in pain because the nerve endings would have been exposed, as they would have been with a chemical burn. Dr Wilson maintained that the likelihood of the formalin burning the whole of Mrs Smith's mouth depended on the speed of swallowing, and there would have been burning if the exposure had been significant. He said that if Mrs Smith had 'gulped' down the formalin he would have expected there to have been mucosal injuries in her mouth, particularly those parts involved in swallowing and the voluntary muscles in the pharynx. He said that no injuries were noted and the nursing report that the plaintiff was 'tolerating well orally' was reassuring.

[97] Dr Wilson had looked at the notes of the gastroscopy conducted on Mrs Smith on the 18th May 2015. The endoscopy was indicated for heartburn, melena (black stools) anaemia (low haemoglobin) and epigastric pain. It had been carried out by Dr S Abraham who had recorded that it was a difficult endoscopy, without saying why. It recorded that Mrs Smith's oesophagus was normal as was the oesophageal/gastric junction (basically where the food pipe meets the stomach).

[98] The endoscopy report also recorded that Mrs Smith had mild gastritis but her stomach was tubular and rigid and a biopsy had been taken. Dr Wilson was of the view that gastritis could be caused by a number of things. The fact that Mrs Smith's stomach was tubular and rigid was an alarm bell because something was changing the nature of the stomach wall, and making it less flexible and bendy and distensible. Such rigidity could often be caused by cancer or a lymphoma or helicobacter pylori.

This was a transmissible bacteria which existed in about a third of persons. The symptoms are non-painful and the bacterial sequelae are controversial. It is difficult to establish cause and effect with helicobacter pylori. If treated however, the symptoms will improve.

[99] Dr Wilson said that if Mrs Smith's oesophagus had been damaged, the endoscopy would have noted that her oesophagus was eroded like a chemical burn – the lining would look abnormal. With an extensive burn, one would have expected to have seen microscopic changes. Scarring and malignancy could also cause strictures in the digestive tract, which would become narrowed by a ring of hard tissue. This could be a long-term consequence of exposure to formalin. Strictures were, however, a common finding on endoscopy reports. Dr Wilson was of the view that the endoscopy report gave him comfort that extensive harm had not been done to Mrs Smith. Dr Wilson was of the view that the ingestion of formalin was unlikely to cause helicobacter pylori. He also found it reassuring that there was a non-specific gastritis present.

[100] Dr Wilson also said that there was no ulceration of the lining of the stomach. He was puzzled by the fact that Mrs Smith's stomach was found to be rigid, but thought that was likely to be due to long-standing gastritis. He was of the view that Mrs Smith's heart had not been affected by the ingestion of the formalin, and that the doctors attending upon her had done a good job to avoid a worsening of her pre-existing ischemic heart condition. The records revealed an echocardiogram (a scan

of the heart), which showed her heart to be normal. This was despite some slow atrial fibrillation, an abnormality, which was recorded in the pre-operative notes.

[101] Dr Wilson was asked to comment on troponin levels found in Mrs Smith five days after the ingestion of the formalin. He said this was a screening test for myocardial ischemia, and was normally done in response to chest pain in order to test for a myocardial infarction. Mrs Smith's reading fell within the range compatible with possible myocardial damage. Dr Wilson said it was important to know the trend of the troponin levels. He regarded the result as being within the slightly concerning range but could detect no trend. It was compatible with long-standing or underlying heart disease. He noted that in a report also done on the 10th May 2010, Mrs Smith's creatine kinase, a marker of myocardial damage was recorded as being low, which was a good thing. Dr Wilson concluded that the various tests did not indicate heart problems, but regarded the results as slightly raised without a trend suggesting a long-standing problem and not an acute problem. He accordingly concluded that this had nothing to do with the ingestion of the formalin.

[102] Dr Wilson concluded that it was unlikely that Mrs Smith's heart would have been the cause of her complaints of chest pain. The endoscopy report of Dr Abraham had flagged heartburn as an indication for the procedure, and Dr Wilson felt that heartburn may well have been the cause of the chest pains. The heartburn could have been a result of a chronic ongoing reflux. He recorded that reflux was a transient phenomenon and accepted that an hiatus hernia may not cause problems to a patient for a considerable period of time.

[103] Dr Wilson conceded that Mrs Smith may have experienced burning in her digestive tract. That, however, would have depended upon the formalin concentration which had a low PH level and would accordingly have burned the food pipe. He was unable to opine on the ten per cent buffered solution. Burns would have been evident from an endoscopy only if they were extensive and deep. He conceded that problems with a person's food pipe would cause difficulty in swallowing.

[104] When asked whether he could explain why Mrs Smith had been admitted for a three day procedure on the 4th May 2010, and was only discharged on the 9th June 2010, Dr Wilson was of the view that two elements were playing out:

- (a) the treatment for atrial fibrillation and the administration of Warfarin which takes time to work; and
- (b) she was waiting for an echocardiogram – in this regard he noted that on the 1st June 2010 she was still on the waiting list to undergo this procedure.

[105] Dr Wilson stated that Warfarin inhibits the manufacture of clotting proteins by the liver and as a consequence blood takes longer to clot. This was administered to Mrs Smith to prevent a stroke. He said that this could be administered on an outpatient basis, but when a patient was in hospital already they would tend to keep the patient there. Dr Wilson referred to the echocardiograms which were contained in the medical notes bundle of documents. He said that these were tracings of

electrical activity of the heart and were extraordinarily helpful as a diagnostic test for cardiac disease. They had confirmed the atrial fibrillation and provide a clue that the patient has a problem conveying electrical impulses from the atria to the ventricles of the heart. This showed her heart was not normal. It was compatible with ischemic heart disease and the medication which she was taking on admission. These tests had enabled Dr Wilson to conclude that the plaintiff's heart had not been affected by the formalin ingestion.

[106] Dr Wilson recorded that the administration of the activated charcoal was essential in order to treat Mrs Smith for the formalin ingestion. He said that the published guidelines also recommended the drinking of milk. He said that he had never previously experienced an ingestion of formalin. Dr Wilson stated that formalin was a harmful substance because it contained formaldehyde which was dissolved in water and stabilised with methanol. He said that both formaldehyde and methanol were dangerous substances. Although he did not seem to be certain, he stated that the buffering of the formalin in the solution used in the hospitals was done by a benign chemical to raise the PH level of the formalin and make it less acidic, and less corrosive. Ultimately he was unable to comment on the formaldehyde concentration in the formalin.

[107] Dr Wilson emphasised that he was not a bio-chemist and he understood formalin to contain chemicals which have the potential to be harmful. He said that formalin ingestion was very rare and had not been studied in a structured way, and it was accordingly difficult to make decisions about the harm it could cause. Save for

stating that the ingestion of formalin could cause metabolic acidosis and harm, Dr Wilson was unable to comment on the effects of formalin on living tissue as opposed to tissue which had been removed from the body. His focus in examining Mrs Smith's report had been on the injuries which she had sustained. He accepted that Mrs Smith could have experienced burning in her throat, caused by the formalin. He also agreed that the dosage of activated charcoal given to Mrs Smith should have been higher in accordance with the recommended guidelines. It should also have been given within an hour. He accepted that a medical emergency had been created when Mrs Smith was given the formalin and that the activated charcoal would have limited any complications.

[108] In reply to the suggestion that Mrs Smith should have been given a gastroscopy within 24 hours of the ingestion of the formalin, Dr Wilson said that from a medico-legal perspective it would have been helpful if it had been done immediately. He thought, however, that it would have been a bit invasive to have done it immediately without alarming symptoms. He accepted that pharyngeal mucosal damage could be caused by the formalin, but stated that in the absence of ongoing and alarming symptoms, he could understand why an ear, nose and throat surgeon had not been consulted immediately. In response to the suggestion that it would be difficult to ascertain injuries unless a gastroscopy is done immediately, Dr Wilson opined that in the absence of severe pain and injuries it was reasonable not to carry out a gastroscopy immediately. Although he conceded that gastritis could have been caused by the formalin, his view was that the presence of *helicobacter pylori* was 'a smoking gun' in that regard. He viewed the ingestion of formalin as one of a number of possible explanations for Mrs Smith's chest pains. *Helicobacter pylori*

was a pathogen (an organism which can cause disease), but there was only an outside possibility that the formalin contributed to Mrs Smith's gastritis.

[109] Dr Wilson stated that nosebleeds are common, and the administration of Warfarin could have made them heavier. There was a remote possibility that the formalin had been responsible for the nosebleeds, but he did not regard this as probable.

[110] He was of the view that recurrent reflux could occur, but even bad reflux would not necessarily result in scarring which could be due to many factors. Dr Wilson accepted that the use by the nursing staff of the phrase 'tolerating well orally' was unreliable at best. With regard to formalin Dr Wilson stated that the PH component was likely to burn tissue and the methanol could cause renal failure or a coma. He was sceptical at the suggestion that Mrs Smith may have suffered a stroke, suggesting that the swelling to her face could have caused the apparent droopiness witnessed by Mrs Erasmus. Dr Wilson said that a stroke was caused when one of the arteries supplying oxygen or glucose to the brain is blocked or bursts. The presence of ischemic heart disease and atrial fibrillation was also a factor causing strokes. He said it was rare for a stroke to involve one side of the face without involving the limbs. It would at least involve an arm.

[111] With regard to the profuse sweating which Mrs Erasmus said she saw, Dr Wilson was of the view that this could have been brought on by anxiety and been the

activation of a sympathetic nervous system. He said that this would have been a fairly extreme medical condition and was not recorded in the medical records. Dr Wilson's attention was drawn to the dramatic increase in Mrs Smith's pulse rate as recorded in the medical notes at about the time the formalin was ingested. He said the formalin could have been responsible for this. He regarded her weight loss of 23 kilograms in approximately five weeks as being extreme and not normal. He said this was normally only seen where heart patients retain water and diuretics are used to help funnel the liquid through urine. Dr Wilson agreed that it was inappropriate to administer Amoxicillin to someone who was allergic to penicillin. Although a rash would normally emerge, more severe symptoms could be a drop in blood pressure and a swelling of the tongue. It was potentially, but rarely, fatal.

[112] With regard to the endoscopy Dr Wilson thought that if scarring still existed five years after the incident, he would have expected it to have been much worse. He regarded the onset of her nosebleeds after discharge from hospital as being worrying but it was not uncommon for Warfarin patients to bleed. He said that given the time lapse between her ingestion of formalin and the nosebleeds, Mrs Smith should have healed and if she was ulcerated, she would have complained.

[113] With regard to the time period which Mrs Smith said that was told she would spend in hospital, Dr Wilson said that three days for an elderly lady for a complete knee replacement seemed very quick. The evidence was that she was mobilising well in the ward and there is no suggestion by the physiotherapist that she should be discharged. In addition there was chest pain and the time taken to organise an

echocardiogram and endoscopy. (I note that in the doctors' notes contained in the Medical Notes Bundle of Documents, there are entries by the physiotherapist from the 12th May 2010 onwards, indicating that Mrs Smith was mobile, and by the 21st May 2010 Dr Bertie recorded that Mrs Smith was moving well, and that they should aim to discharge her on the 24th May 2010. These records were not dealt with by counsel during the trial).

[114] Mr *Chetty* then renewed his application (now for the third time) that the defendant's discovery affidavit be allowed to be supplemented by the addition of the outpatient records of Mrs Smith. This was supported by an affidavit by a director/manager of the defendant's legal services department. Paragraph 5 of that affidavit stated that the issue of liability was conceded during or about the 27th May 2016. The trial was then accordingly set down to proceed only on the issue of quantum. I pointed out to Mr *Chetty* that this was simply untrue. A concession had been made at the pre-trial conference in my chambers on the 8th June 2016 that the formalin had been administered to Mrs Smith. No admission was made that that had been done negligently.

[115] In addition, the supporting affidavit averred that a discovery affidavit was completed by a legal administrator and officer of the defendant, but that there was no indication that it had been delivered to Mrs Smith's attorney. The founding affidavit then records that it was only once it was apparent that the issue of liability was conceded, that it was agreed that the trial would proceed on the allocated dates on the issue of quantum. This statement is not a true representation of the facts.

[116] The suggestion which is contained in paragraph 8 of the affidavit is that Mrs Smith had attended Grey's Hospital for some years' prior to the incident. It was then alleged that these records '*had become of critical importance in dealing with the issue of quantum*'. This is disingenuous insofar as it tends to suggest that those records were not previously important.

[117] Similarly, the suggestion in sub-paragraph 9.2 that '*when the issue of liability was conceded, consideration was given to whether the plaintiff's present condition arose solely out of the ingestion of formalin or whether her medical condition, was pre-existing. This required consideration of the plaintiff's outpatient records at Grey's (sic) Hospital. It was, with respect not anticipated by the Applicant, that these records would be necessary, and given the late concession of liability and the early set-down of the trial in respect of quantum, the records were only received on the 15th June 2016.*' In my view this paragraph is also disingenuous. Mrs Smith's medical records were important from the outset. There is no suggestion that the trial was to have proceeded on the basis of liability only, and that the quantum would be dealt with as a separate issue, and later. The repeated requests by the plaintiff for discovery from the defendant, which was not denied by the defendant's legal representatives, and the production of an actuarial report are ample evidence of the fact that Mrs Smith's attorney always regarded the issue of quantum as important and something which would be dealt with at the hearing.

[118] In the remainder of the founding affidavit, no proper explanation was proffered for the lack of discovery, or the non-production of the necessary records. In addition, no explanation was given as to why Advocate *Mthembu* represented that there were no documents to be discovered. In his address on the application Mr *Chetty* conceded that the non-production of the records would inevitably lead to an adjournment of the trial. He accepted that the plaintiff, who was approaching 86 years' of age, would be prejudiced by the delay. He submitted, however, that the documents had a direct bearing, and related specifically to the matter in hand. He submitted that it was crucial in the interests of justice that medical records reflecting Mrs Smith's pre-existing conditions be admitted. In the absence of such documentation, a fair finding could not be made.

[119] After pointing out the obvious problems which were contained in the founding affidavit, a further affidavit was produced on the 23rd June 2016, in order to attempt to undo the misleading aspects I have referred to above. The excuse was made that the defendant's legal representatives were busy with the trial and the deponent did not have an opportunity to discuss with them the matters raised in the affidavit. It appears that it was only after the deponent had deposed to the original founding affidavit, that he was shown the minutes of the pre-trial conference which was held in my chambers. A concession was then made in the supplementary affidavit that the issue of liability was not in fact conceded.

[120] In my view this application and the supplementary affidavit, came too late in the day, and to have granted it would have occasioned too great a prejudice to Mrs

Smith. As stated in dismissing the other applications, Mrs Smith has waited six years to be able to tell her side of the story. The conduct of the defendant's legal representatives in not properly preparing the defendant's case is inexcusable. (In this regard I point out that Mr *Chetty* had only become involved in the matter shortly before the 16th May 2016). I accordingly dismissed the application.

[121] The defendant then called Margaret Rose Naicker, a medical technician employed in the histology laboratory at Grey's Hospital. She has a National Diploma in histological techniques and is the supervisor of the histological laboratory. She recorded that formalin was used by the laboratory for all tissue samples in order to ensure that they do not putrefy. The formalin in the recovery room would have been obtained from the laboratory, and it is sent to them by a company in Johannesburg. The formalin is made of formaldehyde gas that is dissolved up to 40 per cent in methanol, which was a stabiliser. Ten per cent of that 40 per cent is mixed with a phosphate buffer to create the buffered formalin used by the hospital.

The defendant then closed its case.

[122] Mr *Ramdass* submitted that there had, eventually been a clear concession of negligence by the anaesthetist. He submitted that Mrs Smith had immediately complained of burning and suggested that the staff were killing her. It is clear from the evidence that there was a flurry of activity by the recovery room staff in order to treat Mrs Smith. She had spent about two and a half hours in the recovery room

when it was normal to spend only 30 minutes. The ingestion of milk by Mrs Smith immediately induced vomiting, and she was then required to endure the administration of activated charcoal for approximately an hour. When Mrs Smith was admitted to the ward she was clearly ill. This is confirmed by Mrs Erasmus who records that Mrs Smith was sweating profusely, in pain and crying. A further telling factor was the phone call made to Mrs Erasmus by an anxious nurse. She had instilled such a sense of fear into Mrs Erasmus that she had driven to the hospital with her hazard lights on, and thought that something might have happened which would cause Mrs Smith to die. Mrs Smith maintains that she did not eat for approximately three days and was kept on a drip during that time. Five days later, she developed chest pains and abdominal and epigastric pain. Mr *Ramdass* submitted that the doctors must have been of the view that the pain was severe because they thought it was coming from her heart. They treated her by conducting various tests in order to determine the cause of the problem.

[123] On the 18th May 2010 Mrs Smith was given a gastroscopy. We know that the procedure was a difficult one because the report says so. The presence of gastritis (inflammation of the stomach) was noted. A gastroscopy is normally indicated for epigastric pain, heartburn and melena and upper gastrointestinal bleeding. That Mrs Smith had been bleeding was confirmed by the drop in her haemoglobin after the operation from 9.8 to 8.6.

[124] Mr *Ramdass* queried why the plaintiff was detained in hospital for five and a half weeks when the original admission was anticipated to be three days. When Mrs

Smith was discharged from hospital she had lost 23 kilograms in weight. She had given a very vivid and visual description of her weight loss to Mrs Erasmus. Approximately three days after her discharge from hospital Mrs Smith experienced severe nosebleeds. These were so bad that she was rushed to hospital and shuttled between Grey's Hospital and Northdale Hospital. One of the doctors at Northdale Hospital points to the formalin ingestion as having damaged Mrs Smith's nasal tissues, leading to the nosebleeds. Eventually there was a cauterisation of the blood vessels in Mrs Smith's nose to prevent any further bleeding.

[125] Mr *Ramdass* submitted that it was significant that there was no report of the administration of the formalin by Sister Govindasamy. It was her duty to have done so and she kept records, but not indicating the formalin ingestion. Mr *Ramdass* pointed to the fact that the nursing records indicated that Mrs Smith was on a full ward diet. However the truth was that she had lived on bananas, milk, tea, soup, etc. She could not tolerate solids and even her bananas and medication had to be mashed.

[126] Mr *Ramdass* submitted that it was significant to compare the pre-formalin Mrs Smith with the post-formalin Mrs Smith. The greatest impact upon her is what it has done to her both emotionally and psychologically. She is assisted by Mrs Erasmus, purchasing the items she needs to eat, and the list testified to by Mrs Erasmus demonstrated the condition in which Mrs Smith currently finds herself. Both Mrs Erasmus and Dr Elder painted a picture of a lady who formerly enjoyed life, dancing, running a florist shop, etc. Mrs Smith has now been reduced to a recluse who does

not join her fellow residents for meals or activities and no longer visits restaurants. Dr Mohan testified that she was now denied a basic human need – eating normally. Dr Elder's evidence, which was not disputed, was that Mrs Smith suffers from post-traumatic stress disorder and depression. Her post-traumatic stress disorder is chronic and untreatable. She had lived with it thus far and will have to do so for the rest of her life. Intellectually and cognitively Mrs Smith is fine, but she has been severely psychologically damaged. She has lost the enjoyment of being able to enjoy a normal meal, the activities she previously participated in of painting, dancing, floral arranging, etc and lives in constant anxiety and fear of being returned to hospital.

[127] Mr *Ramdass* submitted that Mrs Smith was a credible witness and that her evidence had the ring of truth. There is no doubt that formalin is a corrosive substance which injured her. Her initial reaction was to tell the recovery staff that the formalin was burning her. Mr *Ramdass* emphasised the fact that Mrs Smith continues to have problems swallowing and an inability to tolerate normal food. He submitted that the hospital staff had attempted to downplay and minimise the effects of the formalin on Mrs Smith. This could be seen in their description of the fact that Mrs Smith had only consumed 'a sip' of the formalin. Given the fact that Mrs Smith had not eaten or drunk anything from the night before, she would clearly have been thirsty when emerging from the theatre. Indeed, Dr Bishop's note says so. Mr *Ramdass* queries why Mrs Smith would have been given water for nausea and what prompted the evidence of Mrs Smith reporting a hiatus hernia as a reason for wanting water. There is no evidence of this in the retrospective record compiled by the anaesthetist.

[128] Mr *Ramdass* submitted that the evidence of Sister Govindasamy was unreliable because she had not recorded the incident as she should have done. She admitted that she bore an obligation to do so, and had not done so. In addition she maintained that she had left at 12.45pm which, on any version, was prior to the administration of the activated charcoal to Mrs Smith. On what basis did she then testify that she had been present when the activated charcoal was drunk by Mrs Smith? The only explanation she had given was that she could have confused this with the ingestion of milk.

[129] Mr *Ramdass* criticised the nursing staff notes which were clearly inaccurate. He said that absolutely no reliance could be placed on the repeated phrase 'tolerating well orally' especially when those notes had been made in the middle of the night alongside other notes recording that the patient had slept well throughout the night.

[130] Mr *Ramdass* submitted that Dr Wilson's evidence could not be relied upon because he had never interviewed the plaintiff and never seen the Northdale Hospital records. The ambit of his investigation was too narrow. The fact that certain questions had been directed to Dr Wilson, which he had answered, and that that had formed the basis of his expert summary was a blinkered approach. When one compared, for example, his evidence to that of Dr Coka, Dr Coka had experience of formalin ingestion. He was much better placed to be able to opine on

the consequences of formalin ingestion. Mr *Ramdass* submitted that Dr Wilson appeared to rely heavily on the fact that the formalin which was ingested was a buffered solution and not an undiluted solution. What we do know is that the plaintiff experienced nausea, vomiting, pain, a sore throat and pharyngeal mucosa injury. Dr Wilson's report gives no real explanation for these complaints. He regarded the presence of helicobacter pylori as the 'smoking gun' for the gastritis found in Mrs Smith. Dr Coka testified that although helicobacter pylori exists in many persons, in Mrs Smith's case the virulence of it was triggered by the formalin, and this had never been challenged in evidence. Mr *Ramdass* submitted that Dr Wilson attempted to explain Mrs Smith's chest pains in terms of myocardial damage, but did not actually deal with the impact of formalin on her chest pains, and did not exclude that the formalin could have caused the chest pains..

[131] With regard to the damages suffered by Mrs Smith, Mr *Ramdass* advanced only three claims, past and hospital expenses of R5 000, future hospital and medical expenses of R705 118 and general damages of R300 000. He recorded that Mrs Smith abandoned her claim for past medical expenses because she had no vouchers to substantiate them. The claim for future medical expenses was set out in the actuarial summary delivered in respect of Nielan Kambaran. The defendant had raised no queries about this and insofar as the individual items were justified in the evidence, the future medical expenses were proved. Ms Peters had motivated the need for annual consultations with a private gastro-enterologist, an annual gastroscopy, consultations with the dietician, both the need for four initial consultations and four more per annum. This was never dealt with in evidence by the defendant. In addition Ms Ernest had recorded the need for food supplements

and a food blender. Mr *Ramdass* conceded that no evidence had been led regarding the costs of the treatment for dysphagia and the psychology consultations.

[132] With regard to general damages Mr *Ramdass* referred to a number of cases, mostly relating to motor vehicle accident incidents. Ms *Ramdass* submitted that an award of general damages to Mrs Smith required that her loss of weight, stay in hospital, pain and suffering, vomiting and gastritis all needed to be taken into consideration. An award of R250 000 was appropriate for her post-traumatic stress disorder and depression alone. Mr *Ramdass* submitted that an amount of R340 000 would be a proper compensation for her general damages.

[133] With regard to costs, Mr *Ramdass* submitted that a punitive order of costs was warranted because there should have been an admission of the ingestion of the formalin in the plea. Denial had caused unnecessary costs and delays. The defendant had been requested to make that admission as early as 2013 and there was no reason for it not to have been made. He submitted that as a mark of this court's disapproval of the manner in which the defence had been conducted, a punitive order of costs was appropriate. This was evidenced by the total lack of proper preparation by the defendant, its desire continually to adjourn the matter and not deal with records which had not been discovered. In addition, no explanation had been offered for why that was not done.

[134] Mr *Chetty* submitted with regard to the factual injuries suffered by Mrs Smith, her mere say-so could not be relied upon to prove them. He submitted that the evidence of damage was simply not there, because Mrs Smith had not been injured. As she had suffered no gastro-intestinal injuries she was not entitled to payment. Mr *Chetty* submitted that Dr Coka did not conclusively say that her gastro-intestinal problems were caused by the formalin. The gastro-enterologist had found no strictures and no injuries. In addition Dr Coka had likened the injuries of Mrs Smith to those which could have been imposed by gastric reflux brought on by a condition which Mrs Smith had had before the operation – i.e. the hiatus hernia. Dr Mohan testified as to evidence of scarring, but he had not concluded that there was any damage to Mrs Smith's oesophagus. Although no evidence had been produced to rebut the finding of a post-traumatic stress disorder there was only one case which had dealt solely with that issue – *Potgieter v Rangasamy* [2011] JOL 27633 (ECP). The plaintiff had sustained injuries in that case but an award was made of R75 000 for post-traumatic stress disorder. Mr *Chetty* submitted that this was an appropriate award which could be made in this case.

[135] Mr *Chetty* stressed that it was rare that formalin was ingested and R100 000 would be suitable compensation for the general damages which she had suffered. This was particularly so because for example, the nosebleeds, Warfarin had been explained as a contributing factor.

[136] Mr *Chetty* recorded that the costs of the November 2015 adjournment had been reserved as had the costs of the hearing in May 2016. He recorded that at the

November 2015 hearing, the costs of the adjournment were tendered by the defendant. He pointed out that at that stage the plaintiff had no expert report from Dr Elder or any actuarial report.

[137] Mr *Chetty* queried why Dr Coka's travelling costs from Richards Bay should be paid as a Pietermaritzburg doctor should have been consulted. In addition, Ms Peters did not really contribute and was not an expert and those costs should accordingly not be allowed. He also submitted that the evidence of the dietician had been unnecessary because if there were no gastro-intestinal injuries, a dietician was not appropriate. With regard to the scale of costs, Mr *Chetty* conceded that the defendant's conduct of the action was not as it should have been. With regard to the costs of the 16th May 2016, Mr *Chetty* recorded that the matter had been adjourned to enable Mrs Smith to consider an offer.

[138] In reply Mr *Ramdass* pointed out that Dr Coka had been instructed whilst he was still practising in Pietermaritzburg at St Anne's Hospital. He had only subsequently moved to Richards Bay. He stated that Mrs Smith had made it clear that her chest pains and gastro-intestinal symptoms were due to the formalin she had ingested. The gastroscopy had showed a normal oesophagus but the scarring evident in the procedure could not have been caused by reflux because Mrs Smith had not suffered from reflux due to her hiatus hernia.

[139] Mr *Ramdass* submitted that the evidence of Ms Peters was important because she testified as to the cost of the annual visits to the enterologists. A dietician's evidence had been important because it was clear that Mrs Smith was not able to eat properly and normally after the ingestion of formalin.

[140] It is now common cause that the anaesthetist negligently administered formalin to Mrs Smith. I am required to decide:

- a) what consequences ensued as a result of the administration of the formalin;
- b) the amount of damages, if any, to which Mrs Smith is entitled to be paid.

[141] In assessing the evidence of the various witnesses;

- a) I found Mrs Smith to have been a good witness. There is no doubt, in common with all the witnesses who testified to what happened, that the intervening six year period did not assist in ensuring an absolutely accurate recollection of all the events. Thus, for example, Mrs Smith may well have been mistaken about the precise treatment administered to her in the recovery room, whether she was given an oxygen mask immediately, whether she was had her heartbeat monitored, whether she was given milk, etc. I have no doubt, however, about her recollection of her immediate reaction to the formalin. Her evidence in this regard has the ring of truth.
- b) Mrs Erasmus was also a good witness, despite the fact that she may have confused the date upon which she had observed Mrs Smith's drooping face, and was told that Mrs Smith had suffered a mild stroke. Her description of the

circumstances under which she was summoned to hospital was most convincing, and underscored the seriousness with which the hospital staff viewed the condition of Mrs Smith at that stage. Coupled with this was her evidence that Mrs Smith was in a very agitated state when she first visited her, and that she was complaining of burning in her throat and was sweating profusely. (Dr Wilson described this as 'a fairly extreme medical condition').

- c) Dr Mohan was a specialist ear, nose and throat surgeon, having practised as such since 1992. He had treated patients for the ingestion of corrosive substances, but not for formalin ingestion. He examined Mrs Smith, and had viewed the hospital records and the record of her gastroscopy. He had little doubt that the difficulty in swallowing and damage to her nasal passages was as a result of the ingestion of formalin. I have no reason to doubt his evidence.
- d) Dr Elder's evidence was very significant because she diagnosed Mrs Smith as having 'classic' symptoms of post-traumatic stress disorder as a result of the effects of the formalin. The fact that she tested Mrs Smith for the possibility of malingering was very significant. Even more significant was the fact that her evidence in this regard was in no way challenged or disputed. In my view she was an excellent witness.
- e) Dr Coka was the only expert witness who had previously dealt with cases of formalin ingestion. His training had qualified him as a Super Specialist Physician. His evidence confirmed the probability of the correctness of Mrs Smith's complaints about being unable to swallow, the burning sensations in her nose and throat, chest pains and gastritis. His view that the treatment administered to Mrs Smith was too little, and given too late, supported his

view of the damage to Mrs Smith. He also confirmed that the nosebleeds from which Mrs Smith suffered would not have been due to the Warfarin alone, and that the formalin was probably a trigger for both the nosebleeds and the gastritis. I viewed him as an excellent witness.

- f) The remaining witnesses for Mrs Smith dealt with her diet and the cost of various foods and items she would need in order to maintain a balanced lifestyle. I have no criticisms of any of them, and no reason not to accept their evidence.
- g) The evidence of the anaesthetist and the attending sisters in the recovery room contribute mainly to the admitted negligence. There is no doubt that their recollections have been dimmed by the passage of time. The anaesthetist remembered very little of the incident, save for the administration of the formalin and the fact that Mrs Smith complained of her hiatus hernia (as a reason for wanting water) and allegedly acted very calmly throughout. This did not accord with the probabilities. The complaint about Mrs Smith's hiatus hernia is not recorded in the notes made by the anaesthetist shortly after the incident. The anaesthetist's evidence in this regard was not corroborated by the attending sisters. The probabilities overwhelmingly favoured the version that Mrs Smith had reacted as she said she did.
- h) Dr Bishop spoke to the treatment given to Mrs Smith initially in the recovery room, where she was kept for three hours because of the incident. He related the dosage of activated charcoal which he had prescribed for Mrs Smith, and the administration of it. He had never thereafter examined Mrs Smith, and had only been contacted in October, 2015. He did not witness the ingestion of the formalin, and had no previous experience of dealing with formalin

ingestion. I have no difficulty with his evidence insofar as it relates to his own involvement in the matter.

- i) Dr Wilson testified as an expert, having been approached by the defendant's attorneys in October, 2015. He accepted that the ingestion of formalin could have caused damage to Mrs Smith, but opined that it was unlikely to have been responsible for the gastritis, or her problems with swallowing, or the nosebleeds. However, Dr Wilson conceded that formalin could cause damage to the mucosa, but was of the view that a buffered solution would be less likely to do so. His view of the endoscopy report was that it indicated that Mrs Smith had not suffered extensive harm. He attributed her chest pains to a pre-existing ischemic heart condition, or heartburn as a result of recurrent gastric reflux. He thought that the sweating witnessed by Mrs Erasmus was a result of anxiety on the part of Mrs Smith.

Notwithstanding the opinions of Dr Wilson:

- (i) He never consulted with, or examined, Mrs Smith.
- (ii) He had no previous experience with the ingestion of formalin. For this reason, perhaps, he downplayed the excessive sweating witnessed by Mrs Erasmus, dismissing it as a nervous reaction. He also downplayed the nosebleeds from which Mrs Smith suffered. In doing so, he completely ignored the evidence of Mrs Smith that the blood had emerged 'like long worms' from her nostrils. These were clearly not normal nosebleeds which she was experienced.
- (iii) He accepted that Mrs Smith could have experienced burning in her throat.

- (iv) He accepted that the dose of activated charcoal should have been higher, and should have been administered sooner than it was.
- (v) He accepted that the administration of Amoxicilin was inappropriate.
- (vi) He regarded Mrs Smith's weight loss as extreme and not normal. This would normally only occur where heart patients were treated with diuretics.

In my view Dr Wilson testified on the basis that his function was to provide possible explanations for Mrs Smith's complaints on any other basis than that they were brought on by her ingestion of formalin. In saying this I do not in any way intend to suggest that he was being disingenuous in his evidence. He admitted, in reply to a question from me, that no one had explained to him the role of an expert in testifying. I had asked the question because it seemed clear to me that that had not been done.

[142] Mrs Smith's particulars of claim list the following consequences suffered by her as a result of her ingestion of formalin:

- a) enduring pain and suffering;
- b) remaining in hospital for six weeks longer than she should have done;
- c) severe epistaxis;
- d) severe vomiting, abdominal pain and diarrhoea;
- e) the inability to enjoy a normal diet;

- f) further surgery for the epistaxis;
- g) a significant weight loss;
- h) that she had to undergo a gastroscopy;
- i) that she has become depressed and does not find life enjoyable anymore;
- j) that she will require future hospital and medical treatment for both her physical condition and her continuing altered mental state.

[143] There is no doubt that Mrs Smith has been left with a very severe disability as a result of the ingestion of the formalin – that is, her inability to eat properly. In this regard:

- a) Her evidence was that from the outset, she was placed on a drip because she could not tolerate the intake of normal food. Thereafter, she has had to live on a diet of food which has been reduced to a semi-liquid state. She endured, and continues to endure, bouts of vomiting if her diet is not controlled.
- b) Her evidence was supported by that of Mrs Erasmus. She not only testified to Mrs Smith's condition in hospital, but also to the fact that thereafter she has assisted Mrs Smith on a monthly basis to purchase the food supplies she needs.
- c) The only evidence which may be regarded as countering this, is that of the nurses' records, containing the oft-repeated phrase 'tolerating well orally'. The evidence revealed that the nurses do not have anything to do with the serving of meals in hospital, nor with the removal of plates, etc, afterwards. They appear to rely on what may be told to them by other patients as to whether a

particular patient is eating properly. Some of the records are made at 2 or 3am, and, as I understood the evidence, patient notes are gathered up and the entries are made in the nursing station. This can hardly be a satisfactory method of recording what has actually happened some seven or eight hours previously.

- d) Although Dr Wilson regarded the nurses' notes in this regard as reassuring, he accepted that the notes were 'unreliable at best'. This was also the view of Dr Mohan, whilst Dr Coka described the notes as being suspect. Dr Coka did so because Mrs Smith had repeatedly been prescribed Maxolon (an anti-emetic) whilst in hospital, and he opined that this would not have been done if Mrs Smith had been 'tolerating well orally'.
- e) Mrs Smith's evidence with regard to all her complaints is substantially supported by the evidence of Dr Elder to the effect that Mrs Smith was not malingering. Indeed, no suggestion that she was doing so was pertinently raised, despite Mr *Chetty's* closing submissions that she had not been injured.

[144] I was also left in no doubt that the nosebleeds from which Mrs Smith suffered after leaving hospital had their origin in damage caused by the formalin. Although the administration of Warfarin may have contributed to the quantity of bleeding, I am satisfied on the evidence before me, that it was not the primary cause.

[145] It is more difficult to be certain about the cause of the chest pains and the gastritis, but in my view it has been established on a balance of probabilities that the

formalin was primarily responsible for those complaints. Mrs Smith was adamant in her evidence that she had not suffered from reflux as a result of her hiatus hernia. There was no evidence to contradict this. Indeed, I regard the references to Mrs Smith's hiatus hernia by the anaesthetist to have been an inaccurate reconstruction, based upon the pre-admission notes of Mrs Smith and done probably to attempt to explain the anaesthetist's breach of protocol in seeking to administer water to Mrs Smith.

[146] Having regard to the evidence of Ms Peters, Ms Ernest, and the actuarial report, Mrs Smith had established her entitlement to damages for future medical and other expenses in the sum of R 550 741. I have arrived at this figure as follows :

<u>Actuarial calculation</u> :	R705 118
<u>Less</u> : Items 1, 2 and 7 of the actuary's calculation – not proved :	<u>R188 620</u>
	R516 498
<u>Add</u> : (1) gastroenterology consultation	2 993
(2) R5 000 for operation procedure and hospital fees	
(all at the same present values used by the actuary)	26 250
(3) Nutribullet smoothie-maker	2 000
(4) Blender	<u>3 000</u>
TOTAL:	<u>R550 741</u>

[147] The quantification of any claim for general damages is always a difficult decision, with previous awards serving mainly as a guide. Ultimately I have to award an amount which I find to be fair and reasonable. I have considered all the cases referred to me by counsel. Whilst they are helpful, the particular circumstances of this case must be borne in mind. I have no doubt that Mrs Smith endured a thoroughly unpleasant stay in hospital, accompanied by pain, discomfort and the very real fear of what the future might bring. Since then she had to suffer the pain and distress involved in the nosebleeds with a further return to hospital and an operation. Then there is the matter of her inability to swallow and the post-traumatic stress disorder brought about by the whole experience. Her future is bleak, and her advancing years will no doubt contribute to her fears and inhibit the prospect of a proper recovery.

[148] In my view justice would be served were Mrs Smith to be awarded the sum of R 340 000 for pain and discomfort, loss of the amenities of life and her disability in being unable to lead a full and happy life. Although Mrs Smith's Particulars of Claim only sought general damages in the sum of R300 000, the parties have agreed to an amendment of that amount to R340 000 (without conceding the appropriateness of such an award).

[149] With regard to the question of costs, it is in my view appropriate to award Mrs Smith her costs on an attorney and client scale. I do so as a measure of displeasure at the defendant's conduct and the conduct of his/her attorneys in defending the action in the manner which they did, as I have set out in detail in this judgment.

I accordingly make the following order:

The defendant is ordered to pay to the plaintiff:

- a) the sum of R 890 741;
- b) her taxed or agreed costs, calculated on the scale as between attorney and client, such costs to include all costs which were reserved in the action (save for the costs of adjourning the matter from the 16th May 2016 to the 18th May 2016, and the 19th May 2016 where the parties will each bear their own costs).

Dates of hearing: 13th, 14th, 15th, 17th, 20th, 21st and 23rd days' of June 2016.

Date of judgment: 2nd August 2016.

For the plaintiff: Mr R Ramdass (instructed by Siva Chetty and Company).

For the defendant: Mr Chetty (instructed by The State Attorney).