

SOUTH AFRICA / JUDGMENT

Zonele v Member of the Executive Council of the Department of Health of the Eastern Cape Government Bhisho (241/2012) [2014] ZAECHC 17 (23 December 2014)

[2014] ZAECHC 17

COURT

Eastern Cape High Court, Bhisho

BEFORE

M Roberson

CASE / FILE NUMBER

241/2012

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IN THE HIGH COURT OF
SOUTH AFRICA
EASTERN CAPE LOCAL
DIVISION, BHISHO

CASE NO: 241/2012

DATES HEARD: 23/04;

24/04;

25/04; 20/10/2014

DATE DELIVERED:

23/12/2014

In the matter between

BONGANI

ZONELE

PLAINTIFF

and

MEMBER

OF THE EXECUTIVE COUNCIL

OF

THE DEPARTMENT OF HEALTH

OF

THE EASTERN CAPE GOVERNMENT

BHISHO

DEFENDANT

JUDGMENT**ROBERSON J:-**

- [1] On 18 August 2010, a Wednesday, the plaintiff, who was at the time employed on a farm, fell into a lucerne mixing machine and suffered an open fracture of the right tibia. He was first treated at Grey Hospital, King Williams Town, from where he was transferred to Frere Hospital, East London, where he received further treatment. During November 2010, following further treatment in a private hospital, the plaintiff's leg had to be amputated below the knee. The plaintiff now claims delictual, alternatively contractual damages from the defendant. He alleges that personnel at both hospitals, who were employed by the defendant, were negligent and failed to treat him with the required professional skill and diligence, resulting in the amputation.
- [2] There were a number of grounds of negligence. Chief amongst them for the purposes of this judgment were the failure to administer antibiotics at the earliest possible moment at both hospitals, failure to irrigate the wound at Frere Hospital, and failure to perform a re-debridement.
- [3] The defendant denied the allegations of negligence and failure to treat the plaintiff with the required professional skill and diligence, and pleaded that the plaintiff was given proper medical care in a professional, skilful and diligent manner.
- [4] I ordered that the issue of liability be tried separately, with quantum to stand over.
- [5] The plaintiff testified that he fell into the mixing machine at about 10h30 and was taken to Grey Hospital by his employer. There he received an injection and fell asleep. He said that he did not see a doctor but it was common cause that he was seen by a doctor. It was put to him that he was given antibiotics at Grey Hospital but he said he did not remember. Nor did he remember a drip being put up at Grey Hospital. He was unable to dispute that his

wound was cleaned with water, Savlon, and a Betadine solution. He awoke in the ambulance which was taking him to Frere Hospital.

At Frere Hospital he received an injection for pain and after some hours was seen by a doctor in theatre. He thought it was now about 7 or 8 pm. He was unable to dispute that he was seen by a doctor before 4 pm, or that he had been given antibiotics on that day. He fell asleep and woke up the next morning. His leg was bandaged and there was a plaster of paris on the underside of his leg. Before breakfast four men, whom he assumed were nurses because they were wearing name badges, arrived and removed the bandage and the plaster. He felt pain and a woman said he should have pain medication, but the four men said they were in a hurry because there was a strike on and told him to be strong. They replaced the bandage but did not clean the wound. During that day he was given tablets for pain. He did not see a doctor and he did not remember that anyone came to assess his condition at 11h30.

[6] In the following three days, that is the Friday, the Saturday and the Sunday, he was not seen by a doctor, his bandage was not replaced, and his wound was not cleaned. He was told on Friday 20 August 2010 that he was to be taken to theatre but he was not taken. There were nurses who came to the ward but they did not remain there. He agreed that even though there was a strike some nurses were available and helped him by giving him pain medication. During that time he noticed that his leg was emitting an offensive smell. He reported this to a nurse who told him that he should

pray to see a doctor because his leg was becoming rotten. She changed the sheet and put a piece of plastic under his leg.

[7] On the Monday afternoon he was taken to theatre where he fell asleep after receiving an injection. When he awoke he found his bandage had been replaced. The next day, the Tuesday, he was taken to St. Dominic's Hospital where he was seen by Dr. Pieter Olivier. On the Thursday he was transferred to Life Beacon Bay Hospital where he remained until November 2010. His leg was amputated during that month.

[8] Dr. Olivier testified that he took over the treatment of the plaintiff after he was transferred to St. Dominic's Hospital. Dr. Olivier is an orthopaedic surgeon and his qualifications and expertise were not in dispute. He described the plaintiff's injury as a type 3 B injury, which occurs when there is a large contaminated wound associated with devitalised tissue. It is often associated with serious complications such as deep, or bone, infection. Deep infection is in turn associated with a poor outcome. Dr. Olivier described the "pillars" of treatment for such an injury.

[9] Antibiotics must be administered within 3 hours after the injury and followed up for at least 48 hours. The wound must be thoroughly irrigated as soon as possible to get rid of foreign bodies and dead tissue. Irrigation can be performed by a general practitioner in a peripheral hospital. It involves the use of 9 litres of fluid and the whole area around the bone must be covered. A debridement procedure must take place. Debridement is the physical or surgical removal of all dead tissue. Tissue can become non-viable within a short time after an injury and non-viable tissue acts as a growth medium for bacteria. Such tissue must therefore be removed in order to prevent infection. An initial

debridement is not sufficient. Suspect tissue can become non-viable within a day or two and a re-debridement is necessary

within 24 hours. Sometimes it is necessary to perform three or four debridements. Further debridements following the initial debridement are necessary because antibiotics need viable tissue to be effective. They are carried in the bloodstream and they cannot reach organisms via dead tissue. The purpose of further debridements is to create living tissue so that antibiotics can be effective. These further debridements are especially necessary in a type 3 B injury. A re-debridement is critical to the prevention of deep infection. Debridement takes about one and a half hours and the patient must be anaesthetised. It must be performed in a proper sterile facility because the purpose is to reduce the risk of infection. Lastly the fracture must be immobilised

and the wound has to be closed within 24 to 48 hours in order to create a barrier against external infection.

- [10] Reduction of the risk of infection requires urgency and dedication but requires no special equipment. The antibiotic cephalosporin is readily available, irrigation only requires sterile fluid, and a debridement requires no specialist surgical skills. The treatment protocol of a type 3 B fracture applies worldwide and the treatment a patient receives at a private hospital will not differ from that at a public hospital.
- [11] With reference to the Grey Hospital records, Dr. Olivier said that there was no reference to the administration of an antibiotic. The records reflected that other medication had been administered, namely anti-tetanus toxoid, valium (a sedative), pethidine (for pain), and ringers lactate, which is fluid given intravenously to restore the volume of blood or for rehydration. The administration of antibiotics must be noted in case the patient has an adverse reaction and the specific antibiotic must be identified. If a patient developed wound infection after the administration of antibiotics, the infection may be a result of resistance to the particular antibiotic. Hence the antibiotic should be identified in order to determine the effectiveness of subsequent treatment. Dr. Olivier said he would also have expected that the Grey Hospital referral letter to Frere Hospital would have mentioned that antibiotics had been administered because it is important with regard to follow up treatment.
- [12] It was put to Dr. Olivier in cross-examination that a Dr. Mlanduli had administered cephalosporin to the plaintiff at Grey Hospital at 11h00 but that Frere Hospital's policy is not to use cephalosporin because there is some resistance to it. Therefore a different antibiotic was used at Frere hospital. Dr. Olivier was not aware of resistance to cephalosporin but in his opinion there was negligence involved because even if antibiotics were given at Grey Hospital, which the clinical notes did not reflect, it was crucial that it was recorded in the clinical notes because if cephalosporin was not to be continued, the new regime should have started at Frere Hospital as soon as possible. The delay in only giving the first antibiotic at Frere Hospital at 20h00 on 18 August was important with regard to the development of infection. The doctor at Frere Hospital was informed at 15h30 on 18 August about the plaintiff's open fracture and had more than enough time to ensure that antibiotics were given. If cephalosporin had been continued at Frere Hospital, the next dosage should have been given at 19h00. However Dr. Olivier said he did not know how Frere Hospital would have known what antibiotic had been administered at Grey Hospital. According to him it is bad practice to follow up one antibiotic with another because if the patient develops wound infection one does not know which one was ineffective.
- [13] It was further put to Dr. Olivier that Dr. Mlanduli was in constant contact with Dr. Ally of Frere Hospital regarding the management of the plaintiff, but they did not discuss the specifics of the antibiotics administered by Dr. Mlanduli. Dr. Olivier's response was that if Dr. Mlanduli had not written in the clinical notes what she had given to the plaintiff as well as the exact dosage, there was miscommunication regarding a crucial aspect of the plaintiff's management which could contribute to the development of deep infection. The receiving

hospital should have the necessary information. If there had been communication between Dr. Mlanduli and Dr. Ally it should have been recorded in the clinical notes.

- [14] Dr. Olivier concluded from the Frere Hospital records that a Dr. Swartbooï gave an instruction on 18 August at 16h50 for the plaintiff to be given pethidine and that the plaintiff was first seen by Dr. Swartbooï at 19h15 on 18 August. The first clinical note that antibiotics were prescribed was at 03h15 on 19 August. The words “new orders” were used in relation to the prescription. This was included in the plaintiff’s progress record note that the plaintiff was back from theatre after a debridement was performed. There was no indication in the operating notes that the plaintiff received antibiotics during the operation.
- [15] It appeared from the form headed “therapeutic regimen” (the form recording what medication was to be administered, the dosage and the intervals between dosages, which was also referred to as the medication chart) that on 18 August the plaintiff received antibiotics at 20h00, although the time of 20h00 was written in the column reserved for the pharmacist. Dr. Olivier was not sure if 20h00 was the time the antibiotics and other medication were ordered or when they were administered. If antibiotics had been given, the time was not recorded. According to the medication chart the next dosage of antibiotics was given at 06h00 on 19 August. Dr. Olivier said that this dosage would not have been effective because antibiotics must be administered six hourly in order for the proper concentration of antibiotics in the blood to be achieved. Antibiotics cannot reach that concentration if not correctly administered. The medication chart reflected that the plaintiff only received three dosages of antibiotics on 20 August and only the time of 20h00 was recorded. On 21 and 22 August he received the correct dosage at the right times. Not all the times the antibiotics were administered on 23 August were recorded. There were also gaps in the temperature, pulse and respiration chart.
- [16] There was no indication in the Grey Hospital records that an irrigation was performed. The records reflected “cleaned wound”. Dr. Olivier said this was not the same as irrigation and the word “clean” was not a medical term and did not indicate a procedure. In his view cleaning a wound means cleaning it with Dettol or Savlon in order to sterilise it. There was no note that 9 litres of fluid were used and the word “irrigation” was not used. Usually the amount and type of fluid will be recorded as well as the presence of contamination in the wound. Medical personnel are trained to record in this manner.
- [17] According to the Frere Hospital records a washout and initial debridement procedure was performed in theatre, commencing at 01h30 on 19 August and ending at 02h30. Dr. Olivier was of the opinion that the doctor who performed this debridement had good intentions and tried his best. It was not performed within the “golden” 6 hours but it was within 24 hours of the fracture.
- [18] Dr. Olivier was referred to a document headed “Consent to medical procedure/examination” which reflected that on 19 August the plaintiff had consented to a procedure described as “relook/washout/ex-fix right tibia”, and that either a spinal or general anaesthetic could be

administered. Dr. Olivier explained that “relook” is a short term for re-debridement and that “washout” is another word for irrigation. “Ex-fix” is an abbreviation for external fixator. There was a note in the records on 20 August that the plaintiff was awaiting surgery. With reference to that note Dr. Olivier said that the re-debridement should have been performed then or the plaintiff should have been referred to a private hospital or another public hospital. The costs of a private hospital would have been covered because the plaintiff was injured on duty. The price of postponing a re-debridement might be amputation. To do nothing when the procedure is necessary is the last option. In his view the big difference between success and failure in the plaintiff’s case was that the intended re-debridement never occurred. A debridement can be performed without the assistance of a nurse, although such assistance makes it easier.

- [19] An entry in the plaintiff’s progress record on 21 August stated “dressing greenish and offensive smell”. Dr. Olivier said that the entry could only have meant a “quite overwhelming wound infection”. Pus is usually green with an offensive smell and if the pus is visible outside a dressing one can assume that there is a significant amount of pus underneath the dressing. The pus and smell indicated infection of the wound and possibly the bone. A nurse would realise from these symptoms that infection was present and the nurse should have reported them to the sister or have contacted a doctor. The symptoms required urgent attention and there was nothing in the clinical notes from which one could sense that the condition had received urgent attention. Dr. Olivier said that at that stage treatment would have made a difference. Infected tissue forms an abscess which could have been drained, and the wound could have been washed out.
- [20] When it was put to Dr. Olivier in cross-examination that in a strike situation negligence could not be ascribed to a doctor, he said that if it is a duty team of doctors’ weekend off, one of the team will do ward rounds in the mornings or evenings, even if not on call. A doctor is still responsible for his patients even on his weekend off, especially if he is part of a team. There was no indication in the records that the plaintiff was seen by a doctor on 21 or 22 August. Dr Olivier said it was inexcusable that the plaintiff was left unattended by doctors over the weekend.
- [21] The relook was only performed on 23 August in a procedure room. Dr. Olivier said that the re-debridement was never done. There was no evidence in the clinical notes or in the history obtained from the plaintiff. A post-operation form reflected that on 23 August the operation consisted of “change of dressing right leg and fibreglass cast applied and manipulation”, and that the operation ended at 13h50. Dr. Olivier said that this treatment was inappropriate. The records further reflected that at 14h00 “wound debrided and washed out, necrotic tissue ++ refer Dr. Olivier”. Dr. Olivier thought that what happened was that the plaintiff was taken to the procedure room and that the procedure which was planned was not possible and that the plaintiff needed more aggressive treatment because of the necrotic tissue. The procedure which was performed on 23 August was inadequate and too late.

[22] When Dr. Olivier took over the plaintiff's treatment he found signs of extensive necrotic muscle tissue. From the outset Dr. Olivier was pessimistic because the bone was already infected and he and the plaintiff discussed the possibility of amputation. He agreed that by the time he took over the plaintiff's treatment the damage was already done. He confirmed the conclusion he and the defendant's expert Dr. Hannah had reached in the joint minute, which was as follows:

"The inadequacy of the debridement procedure and the delay in antibiotics has played a crucial role in the outcome and would probably have made a difference between success and failure."

In the plaintiff's case the risk of deep infection and amputation could have been significantly reduced to a rate between 5% and 10%.

[23] Dr. Phumela Mlanduli testified that she obtained her MBChB degree in

2005. From 1 June 2010 she was a fulltime medical officer at Grey Hospital. She independently recalled examining the plaintiff on 18 August 2010. It is an almost daily occurrence that patients are referred from Grey Hospital to Frere Hospital. When asked if she recalled each patient she said that some are more vivid than others and if you treat them yourself they are not difficult to remember. There were some patients that she did not remember. She saw the plaintiff at 10h35 at the casualty department. She remembered the specific time of 10h35 because she had just finished her ward rounds and was entering the casualty department. She also remembered the time because she had referred to her notes. The plaintiff had come in with an open wound on the left lower leg. During cross-examination when reminded that she had said the left leg, she looked at her notes and saw that it was the right leg. She agreed it was sometimes difficult to remember things and had forgotten that it was the right leg because she was "panicking" (presumably at the time of testifying and not at the time of treating the plaintiff). She agreed that the difficulty in remembering things was the reason why medical personnel are required to record what they observe and

what treatment is given. She agreed that it was required protocol to record the administration of antibiotics, including the type and quantity, and the irrigation procedure, including the type and quantity of fluids which were used in the irrigation. She agreed that her clinical notes were incomplete.

[24] As she approached the plaintiff she could see bone, muscles and torn skin, and that he was in pain. Analgesics and a sedative were administered intravenously and Dr. Mlanduli also verbally ordered antibiotics. The antibiotics were 1g of cephalosporin and 500 ml of beta-lactamase. They were in powder form and the sister had to mix the powder with sterile saline so that it could be intravenously administered. They were put into the intravenous line which was already flowing. The reason for ordering the antibiotics was to protect the plaintiff against infection in the open wound. She said antibiotics must be given for all compound open wounds. When asked why the order for antibiotics had not been recorded in the form which reflected orders for other medication and treatment, namely anti tetanus toxoid, valium, pethidene, ringers lactate and an oxygen mask, Dr. Mlanduli said that

pethidine and valium are scheduled drugs kept in a separate cupboard and cannot be taken out before they are written up, unlike an antibiotic which can be ordered verbally. The sister had written down her order for pethidine and valium and Dr. Mlanduli countersigned the order.

- [25] There was a piece of the plaintiff's clothing trapped between the bones which were not well aligned. She cut off the leg of the plaintiff's trousers and put a bowl under his leg. She poured three 1 litre pre-packed saline solutions over the surface which was injured in order to clean it, and using a second bowl poured 3 litres of Savlon solution over the wound to clean it. She then cleaned the wound with gauze. Thereafter she poured 3 litres of Betadine solution over the wound and cleaned it. Her reason for this thorough cleaning was that there was a rag trapped in between the bone, which classified the wound as dirty. The wound was also exposed. She said that in performing this procedure she was irrigating the wound and did not record all the details in the clinical notes. According to Dr. Mlanduli "irrigation" is a medical term and a procedure, and "cleaning" is an action, for example cleaning a room. The wound was big and she had to bring the skin close together in order to suture the wound. She cleaned the sutured wound with gauze and Betadine lotion and put a small bandage on top of the wound before applying the plaster of paris back slab.
- [26] Thereafter she discussed the plaintiff's condition in detail telephonically for 30 minutes with Dr. Ally, the orthopaedic doctor at Frere Hospital. The plaintiff could not be treated at Grey Hospital and had to be referred to a higher institution. Dr. Mlanduli told Dr. Ally that the plaintiff's condition was an orthopaedic emergency. She described the wound to Dr. Ally and told him what treatment she had given. She told him that she had sedated the plaintiff, had given antibiotics intravenously (she told him the type of antibiotics), had cleaned the wound in three steps (mentioning the various solutions), had sutured the wound and put the leg on a back slab. Dr. Ally did not tell her that they did not use cephalosporin at Frere Hospital. She did not know of this policy at Frere Hospital and was surprised to hear of it.

She completed a referral form and continued with her other work for that day. The referral form indicated that she had made telephonic

arrangements with Dr. Ally. She recorded in the referral form that the plaintiff had been injured that morning by a food mixer and that his right leg had a 5 x 9cm degloving wound with a compound fracture and a 7cm laceration which was cleaned and sutured. She further recorded that the patient had been sedated and the bone re-aligned with a back slab and that analgesics had been given intravenously. There was no mention in the referral form that antibiotics had been given.

- [27] Sister Linda Khondo testified that she is a nurse employed at Grey Hospital. When she was asked in chief if she recalled the events of 18 August 2010 relating to the plaintiff, she asked for a document so that she could see what happened concerning the plaintiff. When asked if she did not have an independent recollection without the documents, she said that she just wanted to be certain that this was the "real patient" because she works with so many

patients in the hospital. She said she recalled the plaintiff, but not his name. She remembered all that happened but she wanted to be certain that this was the patient she was going to speak about. She wanted to see the name of the patient and what she had written. The first time she had a reason to recall the events of that day was during 2013 when a matron told her that there was a complaint concerning one of the patients they had dealt with. She told the matron that everything that was supposed to be done was done, without specifying precisely what was done.

- [28] She was referred to the various Grey Hospital records pertaining to the plaintiff. She recognised her handwriting on the form where the orders for medication were recorded and the time the medication was administered. She read in the notes that the plaintiff had been injured and the bone was exposed. She recalled seeing him that day and said she was shocked by his injuries as he entered. She was assisting Dr. Mlanduli, who was attending to the plaintiff, by bringing her what she asked for. Dr. Mlanduli asked for pethidine and valium. When asked if Dr. Mlanduli had asked for anything else, she said she brought her whatever she asked for. She was asked if she remembered what Dr. Mlanduli asked for and said

that Dr. Mlanduli had asked her to fetch antibiotics because she wanted to give them to the plaintiff. Sister Khondo took the antibiotics out of a drawer in the casualty unit. It was 1g of ceftriaxone which is classed under cephalosporin, and 5 million units of penicillin, which is classed under betalatamine. Sister Khondo mixed these antibiotics and gave them to Dr. Mlanduli. They were given intravenously, through the drip which Dr. Mlanduli had put up. She did not see Doctor Mlanduli giving the valium, the pethadine and antibiotics to the plaintiff.

- [29] Sister Khondo did not sign on the form on which the medication was recorded, although she was supposed to. She said it was busy that day and that she had made a mistake in not signing. She said she also made a mistake by not recording on the form that the antibiotics had been given to the plaintiff. When asked when she first remembered that antibiotics had been administered, she said that when a patient's bones are exposed or crushed, protocol has to be followed and antibiotics have to be administered. When asked what it was in the records which reminded her of what type of antibiotics had been administered, she said when she looked at the document her full memory came back to her because she was involved in the whole process. This full memory included the type of antibiotics which were administered. When asked if this was the first time she remembered the type of antibiotics, she said that when she was informed during 2013 of the complaint, her memory came back to her in full, including which antibiotics were used. She remembered because she had attended to the plaintiff "wholeheartedly"

and she was concerned that he had laid a complaint.

- [30] Dr. Mlanduli ordered Sister Khondo to fetch water so that she could clean the wound. She first said she should bring 1 litre of irrigation water, and then a second litre of irrigation water. This is sterile water used to clean wounds. She brought 3 litres of irrigation water to

Dr. Mlanduli. She did not assist Dr. Mlanduli in cleaning the wound, she was just assisting in bringing Dr. Mlanduli whatever she wanted. The plaintiff was asleep at this time, as a result of the valium which had been administered. Sister Khondo said in cross-examination that she did not record the use of the irrigation water because it was used in cleaning, and it did not occur to her to record it although she knew that irrigation was important. She said that it was a failure on her part not to record the irrigation but later said that it was the responsibility of the doctor to record it because she was just assisting the doctor. The most important thing to record was the medication given to the plaintiff. She mentioned at that stage that it was 9 litres of water and that she had not forgotten that it was 9 litres. When asked why she had not mentioned 9 litres in her evidence in chief, she said she knew that there was a second 3 litres of water and Savlon, and a third 3 litres of water and Betadine. She had not mentioned the second and

third 3 litres because she was not asked further about the irrigation water.

- [31] Sister Khondo also assisted Dr. Mlanduli by bringing the flesh around the wound closer together while Dr. Mlanduli was suturing the wound. After suturing the wound, Dr. Mlanduli dressed it with Betadine, bandaged it and put on a back slab. The plaintiff was then transferred to Frere Hospital.
- [32] Ms Vuyiswa Mgcokoca testified that she is a professional nurse, having qualified in 1971. She has been employed in the orthopaedic unit at Frere Hospital since 2004. She remembered that the plaintiff had been a patient there. She was referred to the progress record of the plaintiff where she had recorded her assessment of the plaintiff at 20h00 on 18 August. The note included that he had been given pethidene. When she was asked if she had given anything else to the plaintiff at this time, she said that it was antibiotics, namely penicillin and cloxacillin which were ordered by the doctor. When it was put to her that the administration of antibiotics was not mentioned in her assessment, she said they were written on the medication chart. She indicated a place on the chart where the time of 20h00 was written in the column which contained the words “pharmacy use only”. This time was written in line with the portion of the form prescribing pethidene 8 hourly. She explained that the form did not belong to the pharmacy but belonged to the ward and the nurses sign in that column. The pharmacy uses the form when the doctor has ordered medication which is not available in the ward. Pethidene, which is a schedule 7 drug, must be written in the patient’s progress record but the antibiotics are written in the medication chart. Antibiotics and tablets are schedule 1, 2, 3, and 4 drugs.
- [33] When asked where the doctor’s orders for antibiotics were recorded (that is prior to the orders at 03h15 on 19 August, referred to by Dr. Olivier) she referred to the medication chart. She said the doctor had ordered the antibiotics from the casualty unit and she did not know the time of the order. She administered the medication at 20h00. When a patient comes out of theatre, the treatment will be written on the medication chart and when he is given schedule 6 or 7 drugs this will be written on the progress record.

- [34] Reading from the plaintiff's progress record, Ms Mgcokoca said that she and a colleague prepared the plaintiff for theatre. He returned from theatre at 03h15 and the antibiotics which were prescribed by the doctor, as recorded in the note at 03h15, were given to the plaintiff "plus minus four to six", meaning 4am to 6am. She explained that at 4am they wash the patients and then round about 04h30 they start the routine of giving injections and tablets. The medication is given before 6am by which time they have finished their routine. The plaintiff had been given his medication before 6am. She was referred to a form which was a continuation of the medication chart which reflected the date and times when the various medications were given, starting on 19 August. (Dr. Olivier also referred to this form. See paragraph
- [15] above.) The form covered the period 19 to 24 August. On 19 August it was recorded that the plaintiff was given the cloxicillin and penicillin at 06h00, 10h00, 18h00, and a time which was not recorded. On 20 August the antibiotics were administered apparently three times, but only the time of 20h00 was recorded. On 21 and 22 August they were administered at 06h00, 10h00, 18h00 and 22h00 and on 23 August at 06h00, 10h00, 18h00 and an unrecorded time. Ms Mgcokoca explained that when the medication is given to the patients she does not look at the time. Once all the patients have been given their medication the time is recorded as 06h00, although it is not the exact time that they have been given their medication. She said that the plaintiff had been given his first medication at 04h30 on 19 August. She knew that because of the routine of washing the patients and then starting the administration of medication. She said the exact time cannot be recorded because there are so many patients, and the time recorded is already written in on the chart, by someone who is "keen" to do so, so that mistakes are not made.
- [35] Following on her evidence that antibiotics had been administered at 20h00 on 18 August, it was put to her in cross-examination that the next dosage should have been given at 02h00 because it was supposed to be six hourly. She said the plaintiff was in theatre at that time. It was put to her that the next dosage would then have been 08h00 but she said she had given it before that time. It was put to her that if the first dosage had been given at 06h00 the next one should have been given at 12h00. She was unable to answer because by that time she was at home. When asked if there was a record of the antibiotics being given at 12h00 she said it was recorded that they were given at 10h30. She agreed that according to the record the next dosage was given at 18h00. When it was put to her that there were gaps of more than 6 hours between dosages on various days, she said that medication meant for 12h00 is recorded under 10h00. The process of injections starts
- from 10h00 and ends at 12h00. The patients due for medication at 12h00 are recorded as having received it at 10h00, because there are so many of them. The person who gives injections knows that medication due to be administered at 12h00 will be recorded as given at 10h00.
- [36] It is necessary to make a factual finding concerning the administration of antibiotics to the plaintiff, both at Grey Hospital and Frere Hospital. Despite the evidence of Dr. Mlanduli and Sister Khondo, I find on the probabilities that antibiotics were not administered at Grey

Hospital. Dr. Mlanduli acknowledged that it was protocol to record the administration of antibiotics and the type prescribed, but not only was her clinical note silent about antibiotics, so was her referral note to Frere Hospital. With regard to medication, the referral note only mentioned that the plaintiff had been sedated and that analgesics had been given intravenously. Dr. Mlanduli must have known the importance of giving accurate and complete information to the receiving hospital. In addition, while it was put to Dr. Olivier that she and Dr. Ally had not discussed the specifics of the antibiotics, her evidence was that she told Dr Ally the type and the dosage. Even if she did, and I think that she did not, she could not be certain that he would be the doctor treating the plaintiff on arrival at Frere Hospital. The fact that other medication was recorded, as well as the ringers lactate and oxygen, leads to the compelling conclusion that the administration of antibiotics was not recorded because they were not given. The same applies to the details of the irrigation. All that was recorded was “wound cleaned” which is a far cry from irrigation which Dr. Mlanduli acknowledged is a medical term and a procedure. Again she acknowledged that the details should have been recorded in the clinical notes and again I am of the view that the reason they were not recorded is that the irrigation procedure was not performed.

- [37] Sister Khondo was not an impressive witness and clearly did not have an independent memory of the plaintiff. She was ill at ease and at times an apparently reluctant witness. When testifying in chief, the use of antibiotics had to be prised out of her and she only mentioned in cross-examination that 9 litres of fluid had been used for irrigation. Her reasons for not mentioning 9 litres earlier was not persuasive and leads to the conclusion that she had been told about the need to use 9 litres and did not remember them independently.
- [38] I would add that I find it highly improbable that three years eight months after the event (that is when they testified) Dr. Mlanduli and Sister Khondo would have an independent recollection of the plaintiff at all, let alone the precise antibiotics which were administered, and the precise volume and type of fluids used for irrigation. A benign view of their evidence is that they might have been testifying about what they assumed had been done. However in my view there is an overwhelming probability that their evidence about the antibiotics and the irrigation was fabricated in order to protect the defendant against liability. The alleged failure to administer antibiotics at an early stage was crucial to the plaintiff's claim. Their omission in the clinical records at Grey Hospital and in the referral letter to Frere Hospital was glaringly apparent. Even the defendant's expert witness, Dr. Hannah, referred in the joint minute to the delay in the administration of antibiotics. The joint minute was signed on 10 April 2014, long after the plea denying negligence was delivered. And yet, despite the joint minute, and the defendant's expert witness's opinion that there had been a delay in the administration of antibiotics, witnesses were called to testify that antibiotics had been administered at an early stage at Grey Hospital.

- [39] Dealing now with what happened at Frere Hospital, I found it at times difficult to follow Ms Mgcokoca's evidence. She too seemed ill at ease and at times reluctant. It is also improbable that she remembered the plaintiff after such a long time. However at least she had some medical records to support her evidence relating to the administration of antibiotics. Those records however were at best unclear about when antibiotics were first administered at Frere Hospital. Dr. Olivier referred to the fact that the first indication that antibiotics were prescribed was the note in the progress report at 03h15 on 19 August. There was no prior note that antibiotics were prescribed and Ms Mgcokoca merely said that they had been prescribed by the doctor at the casualty unit, but she did not know when. She indicated that the record of this prescription was contained in the medication chart. The type of medication, dosage and time intervals were written on the chart by the doctor. If that was the case, then the first dosage of antibiotics was, according to the chart, only due at 06h00 on 19 August. The time of 20h00 on 18 August was recorded but only alongside the doctor's orders for pethidine, which coincides with the note in the progress record at 20h00 that pethidine was indeed administered. One would imagine that if the order for antibiotics was recorded in the progress record at 03h15, a prior order for antibiotics would have been recorded.
- [40] Further, if antibiotics had been ordered for 20h00, then the next dosage would have been due at 02h00 on 19 August, but there is no record that further antibiotics were administered until 06h00 on 19 August (or 04h30 according to Ms Mgcokoca). I find Ms Mgcokoca's explanation that pethidine is recorded in the progress record but antibiotics are recorded in the medication chart unpersuasive, when the order for antibiotics was recorded at 03h15 in the progress record. What is more, the medication orders recorded on the medication chart coincide exactly with the "new "orders" recorded at 03h15. I am therefore of the view that Ms Mgcokoca's evidence that she administered antibiotics at 20h00 is questionable and that it is more probable that antibiotics were administered for the first time on the morning of 19 August, following the orders recorded at 03h15.
- [41] Even if I am wrong, and antibiotics were administered on 18 August at 20h00, then in accordance with Dr. Olivier's evidence, there was too long a time gap, even if antibiotics had been given at Grey Hospital at 11h00. Having found that antibiotics were not administered at Grey Hospital, it means that at best for the defendant antibiotics were administered for the first time at 20h00 on 18 August, some 9½ hours after the plaintiff's arrival at Grey Hospital. Further, as Dr. Olivier said, even if cephalosporin was administered at Grey Hospital, and it was not used at Frere Hospital, the new regime should have begun at Frere Hospital as soon as possible. As he pointed out, according to the Frere Hospital records, the doctor there was informed about the plaintiff at 15h30 on 18 August.
- [42] In respect of the administration of antibiotics, I accordingly find that no antibiotics were administered at Grey Hospital, and that antibiotics were administered for the first time at Frere Hospital on 19 August 2010 in the morning, at 06h00, or even if I accept Ms Mgcokoca's evidence, at 04h30. As already mentioned, if I am wrong about the time antibiotics were first

administered at Frere Hospital, then they were administered at 20h00 on 18 August. As far as re-debridement is concerned, Dr. Olivier's evidence that there was no re-debridement was not disputed. The joint minute confirmed that this was also Dr. Hannah's opinion.

[43] In *Castell v De Greef* 1993

(3) SA 501 (C) at 512A-B Scott J (as he then was) said the following:

"The test remains always whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of a reasonably competent practitioner in his field. If the error is one which a reasonably competent practitioner

might have made, it will not amount to negligence."

[44] Dr. Olivier testified that a type 3 B injury is often associated with bone infection and this was repeated in the joint minute. The joint minute stated that:

"The goal of open fracture management treatment is therefore to achieve bony union and to minimize complication such as deep infection."

Dr Olivier's evidence concerning the pillars of treatment for a type 3 B fracture was not disputed and again, these pillars were repeated in the joint minute. Dr. Olivier's explanation of why these pillars were important was cogent and logically

understandable. A failure to adhere to these pillars, especially in this case the early administration of antibiotics and

re-debridement, consequently carries the substantial risk of deep infection occurring, which in turn can result in amputation.

This is what happened to the plaintiff. There was no suggestion that his ultimate condition of bone infection and amputation was attributable to any other cause. Dr. Olivier made it clear that these pillars of treatment are accepted worldwide and are obtainable at a public hospital. He also made it clear that if there was going to be a problem because of an inability to carry out a re-debridement in time then the plaintiff should have been transferred to a private hospital sooner. The anticipated

surgery did not take place on 20 August as it should have and the plaintiff could at that stage have been transferred to a private

hospital. The nurses' strike was of no causative consequence.

[45] In my view, Dr. Olivier's evidence leads to the conclusion that a "reasonably competent practitioner" would have treated the plaintiff according to the accepted pillars of treatment. Failure to adhere to these pillars in the manner I have found, equally leads to the conclusion that the treatment or lack thereof which the plaintiff received at Grey Hospital and Frere Hospital fell below the required standard, and caused the ultimate bone infection and amputation.

[46] This matter should not have proceeded to trial. It must have been clear to the defendant or the relevant official dealing with the claim that the plaintiff's treatment was sub-standard. The records at Grey Hospital made it clear that no antibiotics were administered. The presence of infection over the weekend was apparent from the Frere Hospital records (the greenish bandage and offensive smell). It was never in dispute that a re-debridement was not performed in time. I should mention that the lack of attention to the plaintiff over the weekend was shocking. When the nurse discovered the greenish bandage and offensive smell, immediate action should have been taken. Instead the plaintiff was told to pray for a doctor. It is almost unbelievable that this could be said to a patient in a hospital. No doctor attended to the plaintiff over that weekend. The doctor(s) treating the plaintiff prior to the weekend obviously knew that a further re-debridement was necessary on 19 or 20 August because that was the protocol as described by Dr. Olivier. That is why the plaintiff signed the consent form on 19 August and was awaiting surgery on 20 August. The surgery could have been

performed or the plaintiff could have been transferred. Yet nothing was done until it was too late. I trust this judgment

will be brought to the attention of the defendant and the relevant official(s) in his department who dealt with the claim and instructed

the defendant's legal team, in particular the official(s) who gave the instruction that Dr. Mlanduli and Sister Khondo were

available to testify that antibiotics were administered to the plaintiff at Grey Hospital.

[47] The following order will issue:

[47.1] The defendant is liable for such damages as the plaintiff may prove or as may be agreed.

[47.2] The defendant is ordered to pay the costs of the action to date, as well as interest on such costs at the legal rate from a date 14 days after date of allocatur to date of payment, such costs to include the qualifying expenses of Dr. P. Olivier.

J M ROBERSON

JUDGE OF THE HIGH COURT

Appearances: For the Plaintiff: Adv SSW Louw, Instructed by Niehaus McMahon Attorneys, East London For the Defendant: Adv XS Nyangiwe. Instructed by the State Attorney, King Williams Town

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