IN THE HIGH COURT OF SOUTH AFRICA

KWAZULU-NATAL DIVISION, PIETERMARITZBURG

Case No: 13586/16P

In the matter between:

ADVOCATE BRETT KINGSLEY PHILLIPS N.O. obo
DAVID ROBIN SHEARER **FIRST PLAINTIFF**
JUSTINE SHEARER in her personal capacity and obo

D[….] G[….] W[….] T[….] and
K[….] R[….] **SECOND PLAINTIFF**

and

S MOHAN **FIRST DEFENDANT**
DR SANPERSAD G MAHARAJ R & ASSOCIATES **SECOND DEFENDANT**

ORDER

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1. The first and second defendants are found liable, jointly and severally the one paying the other to be absolved, to 65% of whatever damages the patient, Mr. Shearer, represented by the first plaintiff, might prove for injuries sustained by him as a result of the cardiac arrest and resultant brain damage which the patient, Mr. Shearer, suffered in the Emergency Unit of Life Westville Hospital in Durban on 27 December 2014.

2. The first and second defendants are jointly and severally, the one paying the other to be absolved, ordered to pay first plaintiffs costs of suit; including costs occasioned by the employment of two counsel where so employed, including the cost of preparation for, and attendance of all pre-trial conferences that were held and attended by them, as well as the drafting and settling of the pre-trial agendas and minutes; the plaintiffs' costs of obtaining the medico-legal reports of the plaintiffs' experts relating to the issue of liability including the cost of counsel for drafting the plaintiffs' expert summaries in respect of the issue of liability of whom notice has been given in terms of Rule 36 (9)(a) and (b); the cost of preparation, qualifying and reservation for liability trial of the following experts of the plaintiffs in respect of the issue of liability of whom notice has been given in terms of Rule 36 (9) (a) and (b) including the cost of consultations by the plaintiffs' legal representatives with these experts and the costs these experts in preparing for and holding joint meetings with their respective counterparts, and preparing joint minutes,(if any), namely; (a) Prof Andre Coetzee, (b) Prof Lee Wallace, (c) Prof Isabel Coetzee and Dr. Izak A J Loftus, and the fees of Prof Andre Coetzee for testifying at the liability trial as an expert witness for the plaintiffs, including the costs of having the proceedings of 28 May, 29 May, 3 June and5 June 2019 transcribed for purposes of the court and the argument submitted to the court.

3. The claims of the second plaintiff in her personal capacity, and in her representative capacity, on behalf of the minor children, D[….] and K[….], are postponed *sine die* to be determined together with the quantum of the first plaintiffs claim for damages against the first and second defendants.

JUDGMENT

Mngadi J:

[1] This is a claim for past and future medical expenses, past and future loss of earnings and general damages. The claim arose when a patient having

overdosed on an unknown quantity of drugs and alcohol, and following his admission and treatment by the first defendant in the emergency unit of the second defendant suffered cardiac arrest resulting in brain damage that left him in a vegetative state.

[2] The first plaintiff is Adv B K Phillips, a *curator ad litem* acting in his representative capacity as such for David Robin Shearer ('the patient'). The second plaintiff is Justine Shearer in her personal capacity as the wife of the patient and also claiming both on behalf of D[….] G[….] W[….] T[….], her minor biological son and on behalf of K[….] R[….], the minor foster son of the patient. The parties have agreed that the issues of the second plaintiff s claim in her personal capacity and her claims on behalf of the two minor children be separated from the issue of the first plaintiffs claim on behalf of Mr. Shearer. Further, in the claim of the first plaintiff, they have agreed to separate liability from quantum. This judgement relates to the liability part of the first plaintiff's claim.

[3] The first defendant is Dr S Mohan, a specialist physician that treated the patient. The second defendant is Dr Sanpersad G Maharaj and Associates, a practice of general medical practitioners in charge of the emergency unit wherein the patient was treated. Initially , the plaintiff also sued as a third defendant, Life Health Group (Pty) Limited, a private company with limited liability duly incorporated and registered in accordance with the law ('the third defendant'). The claim against the then third defendant was based on the contention that after the patient was in the emergency unit he was transferred to the Intensive Care Unit ('ICU') of the then third defendant wherein again he was not properly cared for. The then third defendant had issued third party notices against the first and second defendants and against the first plaintiff. The first plaintiff and the then third defendant settled the plaintiff's claim against the then third defendant. The first plaintiff withdrew its claim against the then third defendant. The then third defendant withdrew its claim against the third parties who were the first and second defendants and the first plaintiff.

[4] The action proceeded against the first and second defendants with the trial commencing on 28 May 2019. The parties agreed to a separation of issues as

envisaged in Uniform rule 33(4). The question of whether second plaintiff and the minor children suffered emotional shock and trauma, and if so, whether it was as a result of the brain injury sustained by the patient as well as the quantum of the claims was separated and postponed for later determination. Initially, the first and second defendants, by a notice in terms of s 2(8)(a)(iii) of the Apportionment of Damages Act 34 of 1956 ('the Act'), sought an apportionment in the event that damages are awarded against them in favor of the plaintiffs but subsequently withdrew the said notice.

[5] The basis of the action is that the first defendant formed a patient-doctor relationship with the patient from which arose a legal duty on the first defendant not to cause foreseeable harm to the patient, his wife and minor children by treating the patient with the required skill, care and diligence expected of a doctor in similar circumstances. The first defendant failed and or neglected to properly examine and evaluate the patient to assess his condition and timeously render appropriate treatment. He failed to ensure that the patient was continuously monitored. In particular, it is alleged, he failed to timeously ensure that the patient's airway was protected and that his ventilation was supported to prevent the onset of respiratory failure and/or hypoxia; he failed to ensure that the patient's Glasgow-Coma Scale ('GCS'), oxygen levels, heart rate, respiratory rate, oxygen saturation and level of consciousness were properly and continuously monitored, and that any deviations were properly noted and attended to.

[6] The plaintiffs against the second defendant alleged that as a result of the admission of the patient in the emergency unit operated and managed by the second defendant a legal duty arose in terms of which the second defendant undertook that the patient shall receive medical treatment of a standard expected of the medical facility in question.

However, it is alleged, the second defendant failed and/or neglected to ensure the

aforesaid obligation was carried out, thus resulting in the patient, his wife and minor children suffering damage.

[7] The first and second defendants in the plea denied that the second

defendant employed any nursing or medical personnel or that any nursing or medical personnel were under its control. They stated that the first defendant was a *locum tenens,* an independent medical practitioner. The then third defendant, it was alleged, employed the nursing personnel at the emergency unit and it exercised control over them.

[8] The defendants admitted that in terms of a duty of care, the first defendant undertook to render treatment with such care and skill as could be reasonably be expected of a general medical practitioner in an emergency unit. It was denied that the first defendant and/or the second defendant were in any way negligent. In the alternative, the first and/or second defendant pleaded that if they are found to be have been negligent, there was contributory negligence on the part of the patient entitling them to apportionment of damages.

[9] Further, in relation to the second defendant, it is claimed that the second defendant had a legal duty to the patient not to cause foreseeable harm to him, his wife and the minor children. The second defendant was bound to ensure that personnel in the facility took all reasonable steps to ensure that the patient was properly cared for to prevent the patient suffering any further insult or complication, but its medical personnel failed to ensure that the stated neglects and failures did not take place which resulted in the injury to the patient.

[10] The evidence in the trial was comprised of matters that are common cause; the medical records; the expert opinions of experts; joint minutes of experts; Exhibit 'A', a list of disputed entries in the hospital records; Exhibit 'B' list of admissions by the first and second defendants ; Exhibit 'C' being list of admissions from first and second defendants relating to the ICU; Exhibit 'D' order separating the issues; Exhibit 'E' CV of Dr Mohan; Exhibit 'F' adult cardiac arrest algorithm; Exhibit 'G' post cardiac arrest care algorithm. The plaintiffs lead oral evidence from one witness Prof Andre Coetzee, and the defendants lead oral evidence from one witness the first defendant, Dr. Mohan.

[11] The plaintiffs' case is that as a result of the negligence on the part of the first and second defendants, the patient suffered hypoxia and diffuse cerebral brain damage because of sustained and profound oxygen deprivation and circulatory collapse. The brain injury was the result of severe hypoxia (lack of

oxygen in the blood) which was as the result of hypoventilation (ineffective breathing), and/or airway obstruction. The combination of alcohol and an unknown quantity of drugs (medication) which the patient had reportedly taken, caused the hypoventilation and/or airway obstruction, and this in turn led to lack of oxygen in the blood. In the brain there is a specific area which automatically controls the breathing. Alcohol and drugs depress the specific area in the brain resulting in the interference with breathing. The breathing will become slower and eventually stop resulting in there being no air entering the lungs (apnoea). With no supply of the blood with oxygen to the brain, the brain gets damaged. The intervention is to take over the breathing of the patient and to get oxygen in the lungs. This is done by either using a mask attached to a bag into which oxygen is fed and pumped into the lungs or taking over the breathing for the patient by mechanical means, for example, a ventilator.

[12] What is common cause and evident from the undisputed evidence is the following: the patient who was 43 years' old at the time of the incident on 27 December 2014, was admitted to the emergency unit at 21h30, due to having taken an unknown quantity of tablets and alcohol, it being reported that empty sedation containers and tablets were found on the floor at his home. The patient was immediately triaged as 'orange' which meant that he should be seen by a doctor for urgent management within ten minutes.

The discriminator was listed as 'overdose'. The physical observations noted on the patient at 21h30 on admission in the emergency unit were the following: a heart rate of 108 beats per minute; a blood pressure of 146/82; a temperature 36.2°C; oxygen saturation was 93 percent, and the patient is recorded to have been asleep on a trolley. At 21h 35 the first defendant, who examined the patient, saw the patient and he noted the physiological observations made by the nursing staff. The first defendant claims to have adjusted the probe and the oxygen saturation moved to 98 percent (which is not agreed to by the plaintiffs and which is not recorded in the medical records). He applied oxygen on the patient via a facemask consisting of 40 percent oxygen. The chest of the patient was clear and his cardiovascular system and abdomen normal. He recorded a GCS at 13/15. On Dr. Mohan's' instructions, a dextrose saline with thiamine was

administered on the patient via an intravenous line. Dr. Mohan testified that before meeting with the patient at 21h35, he had earlier observed the patient refusing to be taken to the emergency unit, being loud and aggressive towards his wife. He testified that at 21h35 the patient was sleepy but not unconscious. He was calm and cooperated with him when he carried out the examination. The emergency unit medical records show that at 21h45 the patient's oxygen saturation level was 82 percent. It is not explained who made the entry and whether it was a contemporaneous recording or not.

[13] In the plea, the defendants specifically pleaded the following. On 27 December 2014 the patient presented with a history of depression, that he had intentionally taken an unknown amount of tablets and alcohol. The patient was timeously and properly examined by the first defendant. On examination, he had a blood pressure of 146/82 mm Hg; had a pulse of 108 beats per minute, had a temperature of 36.2°C, had oxygen saturation of 93 percent, was drowsy but co-operative, had agreed to the insertion of a drip and smelt of liquor. In addition, in the plea, it is stated that the patient's pulse oximeter was found to be incorrectly placed and when repositioned his oxygen saturation was 98 percent. The patient was immediately put on oxygen and the first defendant ordered a dextrose saline drip with 100 mg of thiamine added to the infusion, and a full blood count, urea and electrolytes, urine drug screen, paracetamol, salicylates and ethanol done. The first defendant satisfied himself that the patient was hemodynamically stable. The first defendant discussed the patient with the physician on call Dr Insam who authorized admission of the patient. The plea further states that at approximately 22h00 the first defendant was informed that the patient's condition had deteriorated. He immediately re- assessed the patient. The patient presented with shallow breathing and low blood pressure. The first defendant immediately commenced resuscitation with uninterrupted chest compressions; intubated the patient with infused quadruple strength adrenaline ; gave annexate and resuscitation fluids, namely, gelofusion. During the resuscitation he administered atropine, bicarbonate confusion and aminophylline. The intervention managed to restore circulation. The first defendant ventilated the patient with oxybag. He re-discussed the condition of the patient with Dr Insam and remained present during

the resuscitation until the patient was admitted to ICU.

[14] Apart from the note of lowered oxygen saturation of 82 percent at 21h45 to which no response is noted, no other observations of the patient are recorded between 21h35 and 22h00. The next noted observation by the nursing staff is at 22h00 when it was noted that the patient was unresponsive, pale and began to desaturase and peripheral pulses absent. The Vital Signs and Observations Chart noted that the patient had an asystole at 22h05, which is absence of electrical and mechanical activity in the heart. The records show that at 22h05 the patient suffered cardiac arrest. The first defendant commenced with resuscitation and continued until 22h30. The resuscitation revived the patient. At 22h40, whilst connected to monitors and ventilated on a portable ventilator, the patient was transferred to the ICU of the hospital.

[15] The first defendant admitted that the patient was his patient from the time he found him in the emergency unit up to the time he was transferred to the ICU. He admitted that as a consequence of the patient-doctor relationship that came into existence between the patient and the first defendant, the first defendant had a legal duty to the patient not to cause foreseeable harm by treating the patient with such care and skill one could reasonably be expected of a general practitioner in the trauma unit. Lastly, in the plea, the defendants pleaded that the patient intentionally ingested excessive quantities of drugs and alcohol. The injuries suffered by the patient and the *sequalae* of such injuries were caused by the said action of the patient. Alternatively, and in the event that the defendants are held liable to the plaintiffs, the patient is a joint wrongdoer as contemplated in the Act and the claim of the plaintiffs falls to be reduced.

[16] The first and the second defendant admitted the expertise of the following plaintiffs' experts, Prof Andre Coetzee a specialist anesthetist and critical care specialist, Prof Wallis an emergency care unit specialist, Prof Loftus a forensic pathologist, and Dr Coetzee a nursing expert. The experts filled expert summaries and joint meetings were held between the following experts and joint minutes were compiled and filed:

(a) Prof Andre Coetzee and Prof Wallis for the plaintiffs and Dr Hardcastle for the third defendant.

(b) Prof M Coetzee for the plaintiffs, and Prof Heyns for the third defendant, both nursing experts. The plaintiff also served and filed a summary of the expert evidence of Prof Loftus, a forensic and anatomical specialist pathologist. The first and second defendants reserve their right to disagree and challenge any aspect of expert evidence.

[17] It was agreed between the parties that documents contained in trial bundles including copies thereof are accepted as authentic and as being what they purport to be, as having been created on a date , if any , reflected thereon and signed by the person (if any) whose signature appears thereon subject, however to the right of any party to challenge the authenticity or accuracy or content thereof.

[18] The plaintiffs in their response to third defendant's Uniform rule 37(4) notice state that the patient did sustain brain damage after admission to the emergency unit and prior to his admission to the ICU. However, the two incidents which occurred in the ICU during the early morning of 28 January 2015 were probably further secondary insults following upon the hypoxia ischaemic brain damage already suffered in the emergency unit.

[19] Prof. Andre Coetzee called by the plaintiffs and admitted to be an eminent expert in the field of emergency care and critical care, whose evidence the defendants largely agreed with, was an impressive witness. He had thoroughly prepared himself by reviewing all the relevant records and reports. He explained clearly the basis of any opinion he ventured and he did so eloquently and logically showing no bias. Prof Andre Coetzee testified that the first defendant was faced with a patient who had possible overdose on alcohol and on unknown drugs. The risk with such patient is that the absorption into the bloodstream of the patient and the effect of the alcohol and drugs has not reached its peak. Alcohol and drugs depress the area of the brain which regulates breathing. It may cause the airway to collapse so that air cannot properly enter the lungs and cause apnoea Once there is no breathing, it results in lack of oxygen in the blood (hypoxia) which causes the heart to stop (asystole). The lack of blood supply to the brain damages the brain. He testified that the attending medical practitioner

must expect that the condition of the patient may deteriorate and he must ensure that signs of deterioration are noted on time for timeous intervention. This is what the first defendant failed to do. Prof Andre Coetzee testified that the deterioration of the condition of the patient is initially gradual and it then becomes sudden.

[20] The first defendant admitted that the history of consumption of substantial quantity of alcohol and possible unknown medication drugs was a dangerous combination. He stated that on admission in the emergency unit, the patient had a decreased level of consciousness; he was triaged 'orange'. Irrespective of that, it was common medical knowledge that a patient with a history of a medication and alcohol overdose with a depressed level of consciousness, is at a significant risk, *inter alia,* of further respiratory depression. He stated that a saturation of 93 percent in the absence of chronic lung disease was already close to the lower limit of acceptable oxygenation. Hypoxia is defined as a saturation less than 90 percent if the oxyhaemoglobin dissociation curve is normal.

[21] The first defendant admits that 93 percent oxygen saturation was recorded but when he repositioned the probe it improved to 98 percent. The difficulty with this explanation is that the prescribed report completed by the first defendant filed in the patient's file records 93 percent and there is no recording of 98 percent. The first defendant claimed that although there is no record and no notes he can remember that he adjusted the probe and it improved to 98 percent, but he could not explain why he wrote 93 percent if he determined it to be 98 percent. In my view, the first defendant's recollection, which is not supported by any other record and which is contradicted by the official records, falls to be discounted. The first defendant admits that he appreciated the significant risks posed by the condition of the patient and he had to take measures to mitigate against the risks.

[22] He testified that the measures that he took were that he instructed sister nurse Phillips, an experienced and competent nurse he had worked with for five years, to monitor the patient and to advise him of any deviation. Further, he ensured that the monitors for vital signs which sounds an alarm once critical levels are reached were on. He remained in the emergency unit which had six other patients at the time as well as the nursing staff. It is inexplicable to him why he was not called when the saturation of the patient deteriorated, and that even if

he was called two minutes earlier, he would have saved the patient from the cardiac arrest and the brain damage that he suffered.

[23] The first defendant testified that his clinical judgment was that the patient was stable and therefore there was no need for him to stay with the patient. He admitted that while stable, the patient was in a critical condition. He agreed with Dr Insam who instructed that the patient be transported to the high care unit. He was aware of the danger of the patient crashing but he did not expect it. The nurse was not in a position to intervene except to call him. He did not tell sister Phillips what the risks associated with the condition of the patient were, and he did not specifically instruct sister Phillips to never leave the patient alone. He admitted that if he had been called, he would have been able to attend to the patient immediately. He admitted that although he was attending to other patients in the emergency unit, if it was in his mind to constantly check on the patient, he would have done so.

[24] The medical records as stated above reflect that at 21h45 the patient's oxygen saturation was 82 percent. Nothing is recorded relating to other vital data that had been recorded at 21h30. The first defendant testified that he left the patient at 21h35 and only went back to him when he was called at 22h05. Medical records show that on admission the following was reported: 'patient took unknown amount of tablets (unknown) with alcohol. Patient found 30 minutes ago drowsy with empty sedation containers tablets also found on floor. Name and amount not known'. Prof Andre Coetzee testified that in taking a decision relating to continuous monitoring of the patient, the doctor must also take into account that the patient's neurological condition may well deteriorate further as more of the alcohol and unknown drugs are absorbed from the gut to the blood. The majority of therapeutic drugs and alcohol have longer rather than shorter effective half- lives and it was predictable that the neurological condition and the associated risks would get worse before improving.

[25] At 22h05 the patient's chest movements are recorded as flail chest, it was recorded that his skin was pale, with there being no peripheral pulse and with the patient being unresponsive to voice or pain and with his pupil equal reactive to light as sluggish. His blood pressure was recorded as 131 and pulse rate 58

dropping to 28. His respiration was nil, cardiac rhythm as asystole, temperature 36 and zero chest pain, the oxygen saturation was at 28 percent. Prof Coetzee notes, to which the first defendant agrees, that at 22h05 the patient suffered cardiac arrest.

[26] Prof. Andre Coetzee testified that when the patient started to desaturase after 21h35 and with his oxygen saturation decreasing to 82 percent at 21h45, continuous monitoring and personal observation would have ensured that the first defendant was called to timeously take over the resuscitation and apply oxygen to prevent hypoxia. This could have been done before 21h45. The cardiac arrest at 22h05 was probably caused by severe and sustained hypoxia. If hypoxia was prevented or acted upon timeously, the arrest would probably not have occurred and the patient would not have had suffered brain damage. The first defendant stated that if he was alerted he would have assessed the patient's condition and oxygenation and the hypoxic heart arrest would have probably been prevented.

[27] The first defendant testified that the patient at 21h35 had been connected to a monitor on the resuscitation bed on which the patient was lying. The monitors had an alarm which goes off at critical levels. A person may not hear the bleep of an alarm if he is in an enclosed part of the emergency unit. Once the alarm has gone off it keeps on bleeping until switched off. If placed on silent, it will recommence bleeping after two minutes. The alarm goes off in relation to each vital sign that is being monitored.

[28] The first defendant testified that he does not know why sister Phillips on this day lapsed in the performance of her duties. He did not enquire from her why she did not call him when the condition of the patient deteriorated. He does not know whether sister Phillips monitored the patient as instructed or not. He did not compile a report relating to what happened or report sister Phillips to those in charge of her. He stated that he also did not investigate whether there was any failure of the alarms of the monitors or not. He stated that he was merely */ocum tenens* and he was approached about the records of what happened only two years after the incident.

[29] It is common cause that starting from 22h05, the first defendant was able to resuscitate the patient but irreversible damage to the part of the brain had

occurred, this is evident from the GCS reading of the brain which never recovered from 3/15 which is a semi-unconscious state. The area of the brain responsible for automatic breathing recovered. This indicates that at an earlier stage it would have been much easier to ventilate and oxygenate the patient to arrest or prevent hypoxia.

[30] The first defendant accepts that the patient was his patient. It was his primary responsibility to take care of the patient. After he examined the patient at 21h35, it remained necessary that the patient be continuously monitored for early intervention in case of any deterioration of his condition. He testified that when he left the patient at 21h35 he did not expect to see the patient again, but he knew that the patient would not be transferred immediately to the ICU and he knew that the patient remained his responsibility until actually transferred to the ICU. He left what was happening to the patient to a nurse and the monitoring machines. Prof Andre Coetzee stated that the nurses would not have been able to appreciate the risks associated with the condition of the patient and they would not have been able to make any intervention. In fact, without being properly instructed, they would misconstrue the symptoms of the patient. The following is noticeable from the medical records, namely; the breathing rate of the patient, a critical vital was not noted from admission at 21h30 until the cardiac arrest at approximately at 22h05. The administration of oxygen without ensuring that it is inhaled into the lungs serves no purpose clarified Prof. Andre Coetzee. He testified that the nursing staff would interpret patient becoming unconscious as falling asleep whereas the deepening of the unconsciousness aggravates the effect of alcohol and it then becomes a negative spiral. Prof Andre Coetzee, further testified that connecting the patient to a monitor with an alarm is only as good as the response from the personnel and it should not result in a tendency for physiological observations to be compromised. The monitoring machines cannot be a replacement for continuous personal attention to the patient, it only serves to monitor and warn the staff of abnormalities.

[31] Prof Andre Coetzee testified that the condition of the patient was such that it could change for worse on short notice. It was critical that the point of notice be noted for a proper intervention. The doctor was appropriately trained and

knowledgeable to note the point of notice and carry out the necessary intervention. Even if the doctor did not remain with the patient at all times, it was critical for the doctor to check on the patient at short intervals until it was determined what was happening with the condition of the patient. To leave it to a nurse without giving her clear specific instructions was an invitation for disaster. The blind reliance on a monitor with an alarm, which itself can fail or not be responded to, is still part of an invitation for disaster.

[32] From 27 December to 23 January 2015, the patient remained in the ICU. On 23 January 2015 in the ICU at 8h30 the physiotherapist found the patient gasping for breath and his oxygen saturation had fallen to 54 per cent, as a result the patient had a severe decrease in his oxygen saturation which lasted for approximately 20 minutes during which time the patient was in life threatening distress. Prof Andre Coetzee testified that a tracheostomy had been done whilst the patient was in the ICU allowing for easy ventilation, suctioning and cleaning of the lungs of the patient. The procedure comprises an incision being made in the anterior portion of the patient's neck below the cricoid bone giving direct access to the trachea. A specific tube is inserted into the trachea. The tube has a cuff which is blown up to prevent secretions running into the lungs and contaminating the lungs. Whilst the cuff is inflated the patient cannot suck air and neither can air enter the lungs from the mouth; the patient is effectively choked. It would seem as if the nursing staff in the ICU neglected to release the cuff. It was reported that the patient experienced severe problems with breathing with the cuff being inflated whilst the cap of the tracheostomy tube was on, with the eyes of the patient bulging and the patient being unable to breathe. Alternatively, the tracheostomy tube became blocked with secretions. The patient managed a cough ejecting the blockage. Prof Andre Coetzee testified that this is a secondary insult which might well have aggravated the existing brain injury although it occurred about 20 days after the critical brain damage in the emergency unit on 27 December 2014. He states that allowing this incident to occur in an ICU constitutes substandard conduct on the part of the nursing staff who had either neglected to deflate the cuff of the tracheostomy tube and/or to properly suction the patient in circumstances where secretions were blocking the tracheostomy

tube. He concludes that whatever the case may be, this conduct by the nursing staff is not acceptable and should be regarded as negligent.

[33] The hospital medical records of the ICU indicate the following. On admission at the ICU on 27 December 2014 at 22h40 the patient showed a blood pressure of 150/62 mHg and a heart rate of 156 beat/minute with oxygen saturation at 99 percent, with the patient cold and pale. Blood gases obtained shortly after admission to ICU at 22h51, a PH of 7.28. a Pa02 of 80.8 kPa, PaCO2 of 6.09kPA and a base excess of 5.2. The blood glucose was 13mmol, and hemoglobin 13.8. At 23h25 the ICU nurse noted that as advised by Dr lnsam at 23h00, called Dr Mohan on progress. Dr Mohan instructed the nursing staff to switch the ventilator from SMIV to BIPAP ventilation based on blood gas result. A blood gas taken at 01h03 on 28 December 2014 showed a pH of 7.41 and PaO2 of 20.8kPa and a PaCO2 of 5.1 kPa. The blood glucose was 10.8 mmol/L at the time and the hemodynamics of the patient remained stable for the rest of the night. At 23h45 activated charcoal oxygen was given to the patient via a naso-gastric tube. Blood which was drawn at 23h06 on 27 December 2014 was sent for pathology and the patient's renal function and electrolytes were all normal. The benzodiazepines in the urine were recorded as 396ng/ml, which is elevated, and the serum ethanol (alcohol) level was 0.31 percent. The patient's GCS scale in the ICU from 22h00 on 27 December 2014 until the next morning at 06h00 remained at 3/15. The patient was seen by a doctor in the ICU at 07h30 on 28 December 2014.

[34] The plaintiffs, relating to second defendant, claimed that the patient was in the emergency unit located within the premises of the then third defendant's Life Westville Hospital, operated and managed by the second defendant. Because of the doctor-patient relationship that came into existence the second defendant had a legal duty to the patient not to cause foreseeable harm to him, his wife and dependent children. The second defendant, it is claimed, acting through first defendant and/or nursing and medical personnel in the employment or under control of second defendant, failed in their duty and thus acted negligently. It is common cause that, except the first defendant, the other medical personnel in the emergency unit were employed by and under the control of the then third

defendant and the liability of the second defendant, if any, relating to that staff falls away since the plaintiffs ' and third defendant have settled the issue.

[35] The issue for determination is the liability of the second defendant and the negligence of first defendant, if any. There was no doctor-patient relationship between the second defendant and the patient in the strict sense. The doctor who undertook treatment of the patient was the first defendant, although it took place in the facility operated and managed by the second defendant. Except the alleged negligence of the first defendant and the third defendant's nursing staff there was no other specific form of negligence that was, in my view, proved on the part of the second defendant. On the face of it, the basis on which the second defendant could be found liable for the damages suffered by the plaintiffs as a result of the negligence of the first defendant is vicarious liability. Vicarious liability entails that although no negligence on your part is proved, you are held liable for the negligence of your employees or those under your control and instructions at the time of the occurrence of the delict.

[36] The second defendant admits that it engaged the first defendant to render services at the emergency unit as a *locum tenens.* There was no written contract between the second and first defendant. The first defendant was required to and agreed to work wherever called upon and whenever available. The parties would agree which shift the first defendant would work and he would be paid for the shift that he worked. The first defendant testified that he was not subject to the control of any person. The second defendant would not take any disciplinary action against him if he was not satisfied with his work, he would simple not call him again. He was a registered and practicing medical practitioner. He was subject to his professional body. He had to carry out his duties to the best of his abilities as a medical practitioner.

[37] The second defendant had not hired the first defendant as an employee in the sense of having him available during certain hours and to carry out instructions given to him by the second defendant. The second defendant had not trained nor was he responsible for the training of the first defendant to be able to carry out duties of a medical practitioner in the emergency unit. The first defendant was hired because he was a qualified registered medical practitioner.

In my view, he was an independent contractor.

[38] The second defendant although it operated and managed the emergency unit in terms of the contract with Life Westville Hospital, it did so through nurses employed by the hospital and it did not have medical personnel of its own. The gist of the basis for vicarious liability is that as an employer, you engage employees determined by you to be competent to carry out the work, and you are responsible to train and skill them to do the work properly and you give them instructions as to how to carry out the work, and supervise them in the carrying out of their work. These features, in my view, were missing from the relationship between the first defendant and the second defendant. It is trite that the general rule in our law is that the principal is not liable for the wrongs committed by an independent contractor. See *Chartaprops 16 (Pty) Ltd & another v Silberman* 2009 (1) SA 265 (SCA) para 28. However , the relationship between the principal and the third party could be such that the principal, despite its employment of the independent contractor, retained the legal duty to ensure that harm is not caused to the third party.

Such a duty is referred to as 'a special responsibility or duty to see that care is taken'; see *Chartaprops* para 29. Such a duty arises where the principal's enterprise carries with it a substantial risk and the principal assumes a particular responsibility towards the third party. In such a case the law expects greater vigilance from the principal to prevent the risk of harm materializing. I have no doubt that a patient in the emergency unit would expect that the person operating and in charge of the emergency unit remains primarily responsible for ensuring that all reasonable measures are taken to ensure that harm is not caused to him. Taking into consideration the nature of the enterprise, the second defendant remained overall responsible. The question that remains is whether the second defendant put adequate measures in place to ensure that the patient was properly cared for in its emergency unit, being reasonable steps to guard against foreseeable harm to a patient in the position of the patient. In Grueber's work on *Lex Aquilia,* cited in *Fred Saber (Pty) Ltd v Franks* 1949 (1) SA 388 (A) at 405 it stated:

'... the conduct of the *diligens paterfamilias* implies only an average standard. No

one can reasonably expect from a man that he should be possessed of qualities which are rarely to be found amongst men, or that he should use the utmost strength of which he is capable, or that he should be as cautious and careful as a man can possibly be. The standard is, however, an objective one. It is true the conduct of a *diligens paterfamilias* will vary, but it will vary in accordance with the circumstances of the case: the amount of the skill, strength, foresight will always be determined by the nature of the business or work to be done, and in so far as the standard is one and the same for everybody under the same circumstance's.

In *Sea Harvest Corporation (Pty) Ltd & another v Duncan Dock Cold Storage (Pty) Ltd & another* 2000 (1) SA 827 (SCA) para 21, it was held that the 'true criterion for determining negligence is whether in particular circumstances the conduct complained of falls short of the standard of the reasonable person'. In *S v Kramer & another* 1987 (1) 887 (W) at 894F-H the court noted, by citing Boberg *The Law of Delict* (1984) vol I at 346, that:

'The standard . . . is not the highest level of competence: it is a degree of skill that is reasonable having regard to "the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs'.

In *Castell v De Greef* 1993 (3) SA 501 (C) at 511I-512B it was held that a decision involving 'a clinical judgment' that turned out to be an incorrect one would not mean the medical practitioner was negligent if the error was one which a 'reasonably competent practitioner' might have made.

[39] There is no evidence that the second defendant is liable for the damages to the patient in the manner it operated and managed the emergency unit. The failure of the nurses was taken up against the then third defendant ; it was not attributed to any failure on the part of the second defendant. There is no evidence that the manner in which the emergency unit operated or the equipment used in the emergency unit had anything to do with the injury suffered by the patient. As stated earlier in this judgment, the then third defendant settled with the plaintiffs the issue of the liability based on the failure on the part of the nurses to carry out their duties properly. The settlement resulted in the plaintiffs withdrawing the action against the third defendant. The then third defendant also

withdrew its third party notice against the plaintiffs and the first and second defendants. In the result, it remains unexplained what caused a patient in the emergency unit of the second defendant to be left unattended for an extended period when it was critical that he be closely monitored. It is for the second defendant to give an explanation and it has not done so. The onus is on the plaintiffs to prove negligence on the part of the second defendant. In my view, no evidence establishing negligence on the part of the second defendant has been adduced. There is no evidence that the nurses and the first defendant did not know of the protocols and procedures applicable in an emergency unit.

[40] In addition, the first plaintiff points out that the liability of the second defendant arises out of the breach of a legal duty arising out of a contractual relationship between the patient and the second defendant to provide to the patient medical treatment with diligence, care and skill required of a medical practitioner in a medical facility. It is correct that the patient did not choose the first defendant to be his doctor. The second defendant to render medical treatment to the patient in the facility operated and managed by the second defendant employed the first defendant. The patient paid the second defendant not the first defendant for the services rendered. The patient was admitted at the facility to which it was for the second defendant to decide which persons to admit. There is, in my view, force in the argument that there existed a contractual relationship between the second defendant and the patient. In terms of the relationship , the second defendant undertook to provide medical treatment to the patient with the required skill, care and diligence. The contractual relationship complemented the doctor-patient relationship formed with the first defendant. The contractual relationship with the second defendant gave rise to a legal duty on the part of the second defendant which duty was breached when the first defendant allegedly failed to treat him with the required skill , care and diligence. The second defendant cannot be allowed to both escape liability and take the money. The circumstances render it jointly and severally liable with the first defendant.

[41] The plaintiff is not entitled to be double-compensated for the same damage. The terms of the settlement between the then third defendant and the

plaintiff are not before this court. As against the plaintiff, the defendants, in my view, are each entitled to argue that 'I am only liable for the damage caused by my negligence which was part of the total negligence that caused your injuries'. Section 1 of the Act, provides the following:

'(1) (a) Where any person suffers damage which is caused partly by his own fault and partly by the fault of any other person, a claim in respect of that damage shall not be defeated by reason of the fault of the claimant but the damages recoverable in respect thereof shall be reduced by the court to such an extent as the court may deem just and equitable having regard to the degree in which the claimant was at fault in relation to the damage.'

In *South British Insurance* Co. *v Smit* 1962 (3) SA 826 (A) at 835H it was clarified that the court has to measure the conduct of 'all the parties whose fault caused the damage'. In *AA Mutual Insurance Association Ltd v Nomeka* 1976 (3) SA 45 (A) at 55D it was determined that as long as 'the plaintiff s fault is put in issue, an apportionment need not be specifically pleaded or claimed '. In my view, the same will apply if it is common cause between a plaintiff and defendant that there was contributory negligence from other wrongdoers that caused the damage.

[42] The first plaintiff admits that the nurses in the emergency unit were negligent in the manner in which they conducted their duties in that as nurses, despite what instructions were given by the first defendant, it was their primary duty to monitor properly the patient between 21h35 and 22h00. The evidence is that a phlebotomist not based in the emergency unit approached the patient with a view to draw his blood for the required tests. He found that the patient had passed out and he could not draw blood and he raised the alarm with sister Phillips. Sister Phillips then called the first defendant to attend to the patient.

[43] It is inexplicable that the nurses, and sister Phillips in particular, did not constantly check on the patient and see whether any changes were taking place in order to call the doctor. It is inexplicable why sister Phillips and the other nurses in the emergency unit did not respond to the alarm of the monitors monitoring the patient. The medical records show that at 21h45 the patient's oxygen saturation was 82 percent. The position of other vital signs is not recorded at that time and despite that significant drop from 93 percent or 98

percent nothing was done as intervention. This suggests that the nurses were significantly negligent but it is accepted as testified to by Prof Coetzee that at their level they were not in a position to fully appreciate the risks of the condition of the patient, in particular , in the absence of any specific instructions from the medical practitioner. Further, in my view, the first defendant was in charge of the patient. Due to his so-called wrong clinical judgement, he misconstrued the risk posed by the condition of the patient. He concluded that the patient was drunk and nothing needed to be done to him. Having formed that view and being the doctor in charge it would have been expecting too much from the support staff to monitor the patient otherwise. The issue is the diagnosis by the first defendant and the cause of treatment he prescribed. I am, therefore, of the view that minimal contributory negligence has been established on the part of nurses to reduce the culpability of the defendants.

[44] The defendants have pleaded for apportionment of damages claiming that the patient was a joint wrongdoer in the damage that he suffered. There was no evidence relating to the circumstances under which the patient took the tablets and alcohol. It was not clarified whether when he did so he was addressing any condition he was suffering from or whether he intended to harm himself. The background was that the patient was born on 16 June 1971. He married the second plaintiff on 13 December 2010. The parties have never separated and the marriage is based on friendship, love and mutual respect. The patient, prior to the injury, was employed as a technician earning R10 000 per month and had been so employed for seven months and his wife was employed as an Assistant Company Secretary earning R21 000 per month. The patient used to do gardening, cycling and he attended church. The medical notes by a doctor who had been treating the patient since 1986 indicates that in the last 12 months prior to 25 March 2015 he had prescribed Serdep 100g, 1 per day, Epilin CR 200 and Tririton 25y. On 7 July 2014 the patient had a major depression as a result of the death of his father and stressful work and he had fluctuating moods.

[45] A person is presumed to be in his normal mental condition until the contrary is shown. No evidence has been produced showing the contrary in relation to the patient. A high consumption of tablets and alcohol for no known

reason is a form of self-injury exposing one's life to danger. The danger to life eventuates, when in managing the condition, adequate measures are not employed resulting in the injury to life occurring. The fact that the danger was created by the unreasonable action on the part of the injured remains an underlying factor. However, in this case the patient on time presented himself to the defendants to extricate himself from the situation he had put himself in, and formed the doctor-patient relationship with the first defendant. All the defendants needed do was to ensure that air reached the patient's lungs by ensuring that his airway was not compromised or by manually pushing air into his lungs. Instead, he was misdiagnosed and not treated with the required skill, care and diligence. The patient was co-operative with the treatment and he did nothing that interfered with his treatment. In my view, minimal contributory negligence on the part of the patient relating to the damage that he suffered has been established. The issue is whether the actions of the patient in consuming a large quantity of alcohol and drugs is connected to the injury he sustained. These actions of the patient were the primary cause of the injury. The direct and immediate cause of the brain injury was the non-intervention by the first defendant although he was required to and expected to intervene on time. In the circumstances, policy considerations based on principles of reasonableness, fairness and justice dictate that the consequences should not in a large measure be imputed to the patient, in other words, the patient's actions were slightly the legal cause of the brain damage that he suffered. See Van Der Walt & Midgely *Principles of Delict* 3 ed (2005) at 242 par 169; *International Shipping* Co *(Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at 700-701; *General Accident Versekeringsmaatskappy SA Bpk v Uijs NO* 1993 (4) SA 228 (A) at 235O-E.

[46] The first plaintiff concedes that the nurses were negligent and contributed to the damage. However, contends the first plaintiff, the first and second defendants have abandoned their claim for apportionment of damages against the then third defendant, the entity that employed the nurses that worked in the emergency unit. The nursing experts Prof Isabel Coetzee and Prof Heyns stated the following in the joint minute:

'we are of the opinion that the monitoring and observations were not appropriate

in this matter. The first plaintiff was not appropriately monitored, applying monitors is not sufficient in this matter. An appropriately trained person has to constantly monitor and react to the monitor if the patient was continuously observed, it would have been an easy matter to mask ventilate the patient and hypoxia would not have occurred and the cardiac arrest and brain injury probably could have been prevented'.

They state, further, that the arterial oxygen tension measured in the ICU after the event show that the lung parenchyma was for all material purposes normal and hence oxygenation would have been restored with ease if the under-ventilation and apnea (stopping of breathing) were detected on time.

[47] The first defendant has argued that as he was the medical practitioner that assessed the patient at 21h35, he was in a better position to make a decision on what was to be done to the patient. It was within his clinical judgment that the patient was in a stable condition and that it was not necessary, in view of his other duties in the emergency unit, to personally check on the patient. He was entitled to and it was a correct decision to leave the patient in the care of the nurses and the monitors until transferred to the ICU. He must not be judged with hindsight wisdom which shows that the decision was not a correct decision due to what happened subsequently.

[48] Despite the first defendant being the medical practitioner in charge of the patient, who was obviously in a critical condition with his condition being, in all probability, likely to deteriorate, and despite the first defendant having had no other emergencies that would have caused him to be unable to constantly check on the patient until he had determined stability in his condition, the first defendant left the patient at 21h35 without handing him over to any other medical practitioner and without knowing when another medical practitioner would attend to him. He left no clear instructions to the nurses to impress upon them the critical condition of the patient and to impress on them to constantly check for any deviation and to immediately report to him. After about 25 minutes, which was a critical phase in the condition of the patient, and whilst in the care of the first defendant, the patient was left unattended which resulted in him suffering brain

damage. Proper monitoring of the patient would have shown that there was no effective oxygen absorption in the lungs. The required intervention was to maintain the patient's airway by intubating the trachea or by placing the patient on a ventilator. Prof Andre Coetzee testified that if the first defendant had seen the patient at any time during his decline from 21h35 until shortly before the cardiac arrest at 22h05 it would have been an easy matter to take over the breathing of the patient and to get oxygen into his lungs which would have prevented the brain injury which he suffered. The sustained and profound oxygen deprivation, and circulatory collapse resulted in the patient suffering hypoxia and diffuse cerebral brain damage. The patient's condition was not unredeemable. The first defendant's interventions from 22h05 revived his condition although irreversible brain damage had already occurred.

[49] In my view, the first defendant had no reason not to check the patient between 21h35 and 22h00. In addition, he took no measures to ensure that the patient was closely monitored as dictated by his condition. The first defendant's evidence that when he left the patient at 21h35 he did not expect to see him again although he knew that he would not be transferred to the ICU anytime soon is disconcerting. He appears to have misjudged the situation entirely, especially since he was a specialist physician with extensive experience in an emergency unit. It is completely unacceptable to leave a patient in a critical condition without knowing whether his condition is worsening or improving in the care of the nursing staff. It is my view that the first defendant either did not fully appreciate the risk which was posed by the condition of the patient which resulted in him not taking the appropriate measures to address the risk or he hoped that, while not taking appropriate measures to address the risk, the risk would not occur. In both instances, he did not act like a reasonable medical practitioner in the emergency unit faced with such a situation, and he was negligent. This is the essence of the opinion of the experts with which I agree. There is no doubt that his conduct fell short of the standard of a reasonable medical practitioner carrying out duties in the emergency unit. His negligence resulted in the injury sustained by the patient. See *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC) paras 45, 71 & 73.

[50] The second defendant managed and operated the emergency unit. The patients in the emergency unit are its responsibi lity. It is overall in charge to ensure that appropriately qualified staff operate the emergency unit, that it is properly equipped , and that proper procedures and protocols are observed. It is its responsibility to ensure that the staff in the emergency unit are properly supervised, and that the emergency unit functions smoothly. It was a major lapse to leave a patient in a critical condition at the critical time unmonitored from 21h35 to 22h00. The second defendant, despite being in charge and responsible for the medical facility, has not in any way explained the lapse, except that the first defendant whose duty it was did not do it and he did not ensure that it was done. The second defendant due to the relationship between him and the patient had a legal duty to take all reasonable measures to prevent harm being caused to the patient. It failed to do so since first defendant failed to do so, which constituted negligence on its part. In addition, in my view, the special relationship that existed between the first and second defendants, with both being responsible for the same patients, render the negligence of the first defendant in those situations attributable to the second defendant. In my view, the second defendant is jointly liable with the first defendant for what happened to the patient in the emergency unit. In the result, it is found that the first plaintiff on a balance of probabilities have proved the liability of the defendants.

[51] The first plaintiff has proved on the preponderance of probabilities that both defendants wrongfully and negligently breached the duty owed to them and caused him damage.

[52] What remains is to determine the degree of fault attributed to the first and second defendants. In terms of the Act, the degree of fault of other wrongdoers causally linked to the damage must be deducted. The plaintiffs have argued that it is not for this court to determine degrees of fault since the defendants have pleaded no contributory negligence, apart from that of the patient. I have already dealt with this contention. The degrees of fault of other wrongdoers are considered to determine the degree of fault of the defendant(s) who are being sued. The fault of the defendants, if any, and the extent thereof is the crux of the dispute between the first plaintiff and the defendants. Further, the first plaintiff

alleges in the pleadings contributory negligence on the part of the nursing staff in the emergency unit and in the ICU. The evidence in the admitted experts' reports and that of Prof Andre Coetzee called by the first plaintiff establishes the alleged negligence. The fact that as far as contributory negligence is concerned that evidence rebounds in favour of the defendants does not mean that it must be excluded.

[53] The totality of the evidence, in my view, establishes on a preponderance of probabilities that the patient overdosed on drugs and/or alcohol. There was no evidence of the patient's mental condition at the time he overdosed. It must be assumed that he was in his normal state of mind. There is also no evidence of what caused the patient to over consume drugs/alcohol. Again, it must be taken that he was in a normal men ta l state and he must have known, as a reasonable person would know, that to overdose on drugs and/or alcohol is creating a risk of injury. That injury eventuated and it resulted in the damage. In my view, the totality of the evidence establishes on the preponderance of probabilities that there was contributory negligence on the part of the patient. However, in view of the patient's intervention as detailed above the degree of fault on his part is minimal. In my view, it may be determined to be 15 percent.

[54] It was part of the primary responsibility of the nursing staff in the emergency unit to properly monitor patients so that if there was a need they would be able to immediately call the first defendant. They failed to carry out their duties. However, the evidence shows that it was beyond the capacity of the nursing staff to appreciate the risk in the condition of the patient. They must have relied on the first defendant to draw their attention to the risks associated with the condition of the patient. It is significant that the patient in an emergency unit was not attended to for about 25 minutes. In my view, the degree of fault on the part of the nursing staff in the emergency unit is determined at 15 percent.

[55] The injury suffered by the patient in the ICU due to the negligence of the nursing staff which constituted the failure to properly place a breathing tube and the failure to detect early that the tube was not correctly placed in the patient resulting in the patient suffering seizures and further brain damage is significant. However, the patient had already suffered irreversible brain damage. In my view,

the degree of fault of the nursing staff in the ICU is determined at 5 percent.

[56] In the circumstances, the degree of fault attributed to the first and second defendant jointly and severally the one paying the other to be absolved is determined at 65 percent. The first plaintiff has substantially succeeded. The evidence, which formed the basis of findings of contributory negligence reducing the degree of fault of the defendants, was at the instance of the plaintiffs. The plaintiffs, in my view, are entitled to their full costs of suit.

[57] Therefore, in the result, I make the following order:

1. The first and second defendants are found liable, jointly and severally the one paying the other to be absolved, to 65% of whatever damages the patient, Mr. Shearer, represented by the first plaintiff, might prove for injuries sustained by him as a result of the cardiac arrest and resultant brain damage which the patient, Mr. Shearer, suffered in the Emergency Unit of Life Westville Hospital in Durban on 27 December 2014.

2. The first and second defendants are jointly and severally, the one paying the other to be absolved, ordered to pay first plaintiff's costs of suit; including costs occasioned by the employment of two counsel where so employed, including the cost of preparation for, and attendance of all pre-trial conferences that were held and attended by them, as well as the drafting and settling of the pre-trial agendas and minutes; the plaintiffs' costs of obtaining the medico-legal reports of the plaintiffs' experts relating to the issue of liability including the cost of counsel for drafting the plaintiffs' expert summaries in respect of the issue of liability of whom notice has been given in terms of Rule 36 (9)(a) and (b); the cost of preparation, qualifying and reservation for liability trial of the following experts of the plaintiffs in respect of the issue of liability of whom notice has been given in terms of Rule 36 (9) (a) and (b) including the cost of consultations by the plaintiffs' legal representatives with these experts and the costs these experts in preparing for and holding joint meetings

with their respective counterparts, and preparing joint minutes,(if any), namely; (a) Prof Andre Coetzee, (b) Prof Lee Wallace, (c) Prof Isabel Coetzee and Dr. Izak A *J* Loft us, and the fees of Prof Andre Coetzee for testifying at the liability trial as an expert witness for the plaintiffs, including the costs of having the

proceedings of 28 May, 29 May, 3 June
and 5 June 2019 transcribed for purposes of the court and the argument submitted to the court.

3. The claims of the second plaintiff in her personal capacity, and in her representative capacity, on behalf of the minor children, D[….] and K[….], are postponed *sine die* to be determined together with the quantum of the first plaintiff's claim for damages against the first and second defendants.

MNGADI, J

APPEARANCES

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Heard	:	12 August 2020
Delivered	:	26 October 2020