IN THE NORTH WEST HIGH COURT

(MAFIKENG)

CASE NO.: 308/2011

In the matter between:

GALALETSANG URSULA M KGOSIEMANG **PLAINTIFF**

and

MEMBER OF THE EXECUTIVE COUNCIL FOR THE DEPARTMENT OF HEALTH, NORTH WEST PROVINCE **DEFENDANT**

JUDGMENT

LANDMAN J:

Introduction

[1] The plaintiff is Galaletsang Ursula Manana Kgosiemang, a female, born on 6 July 1993. The plaintiff is assisted by her mother and natural guardian,

Mrs Kearata Patricia Kgosiemang. The plaintiff and her mother live at Rakgoto, Bodibe in the district of Molopo, North West Province.

[2] The defendant is the Member of the Executive Council for Health (previously known as Health and Social Development) in the North West Government. The defendant is cited in an official capacity.

[3] The plaintiff claims damages from the defendant on account of the alleged negligence of the medical staff employed by the defendant and for whose actions, it is admitted, the defendant is vicariously liable.

Separation order

[4] The parties have agreed and I have ordered that the merits, negligence and liability be separated from the quantum of damages.

Steven Johnson's Syndrome (SJS)

[5] It is common cause that the plaintiff suffered from a condition known as Steven Johnson Syndrome (SJS) in a severe form as a reaction to a drug. It is therefore desirable, at this stage, to set out the cause, nature and consequences of this condition.

(a) SJS is said to be a severe, at times fatal, mucocutaneous illness characterised by extensive eruption with areas of epidermal detachment and systemic symptoms. It is life threatening and has a mortality rate of 5%. In its minor form "Erythema Multiforme" it causes targetiod lesions and pathognomonic (lesions may be blisters).

(b) The more serious major form of SJS , Erythema Multiforme Major, causes multiforme with mucosal involvement. It affects the mouth in 100% of cases, the eyes in 70-90% of cases and the genitalia in 60-90% of cases.

(c) In its most serious form, Toxic Epidermal Necrolysis (TEN), causes sheet-like loss of epidermis ie skin peels like burns.

(d) SJS or TEN is a rare severe often fatal allergic reaction caused mostly by drugs especially Sulfa drugs and anti-epiletics/anti-convulsants of which Barbiturates (Phenobarbital) is one of the commonest or leading causes. This is common cause. Vaccination has been anecdotally reported as a cause. Phenotion also falls within this category. SJS has, at least in one case, been caused by the administration of Epilim.

(e) SJS and the related disorder TEN are rare conditions. The incidence of SJS is 1-6 cases per million person years. The overall mortality for SJS is 5%-12%.

(f) Late ophthalmic complications are seen in 20-75% of patients and there is a correlation between the initial severity of the eye changes and the long term sequelae.

(g) Vulva and vaginal complications are not uncommon and may lead to dyspareunia in later life. Nail changes and loss of nails is common. Symptoms of posttraumatic stress disorder are not uncommon.

Some of this information appears in Fitzpatrick's **Dermatology in General Medicine**, 7th edition, volume 1, (2008).

Hospital and medical treatment

[6] I set out the treatment received by the plaintiff in its chronological order which does not reflect the order in which the witnesses testified. Where hearsay

evidence was provided eg as case history, I have incorporated that in the chronology. The evidence of the expert witnesses will appear separately.

Bodibe Clinic

[7] The plaintiff accompanied by her mother consulted Dr Theart at the Clinic towards the end of March 2003 because the plaintiff was suffering from headaches and diziness. Her mother says Dr Theart prescribed medication. She immediately received some pills in a white plastic container, pouch/envelope from a man at the clinic and was told to return for the balance at the end of the month. She was told to give the plaintiff one pill per day which she did.

[8] Dr Theart does not recall the plaintiff or the facts of her case. Dr Theart conducted a session at Bodibe Clinic during the time period in question although not on the day alleged by Mrs Kgosiemang. The records of the Clinic are missing and Dr Theart has no medical notes for that period.

[9] Dr Theart said she would not administer Phenobarbitone without having a detailed and reliable history indicating that the plaintiff suffered from a form of epilepsy which would indicate that this drug be prescribed. If the drug had been prescribed it would be dispensed by the Thusong Hospital dispensary and then be sent to the Clinic for collection. A period of a week or two would generally elapse.

[10] The plaintiff attended the Clinic on 8 April 2003 for completion of a "Road to Health card" and she received booster vaccinations. She alleges she also received an injection of an unknown substance. She developed a rash all over her body and mouth. She reported to the Clinic on 11 May 2003 and was transferred to Thusong Hospital.

[11] The professional nurses at the Clinic testified. Sister Kaitsane knows the plaintiff. She was brought to the clinic in March 2003. Phenobarbitone is a schedule 5 medicine and was not kept at the Clinic. Nurses may not prescribe this drug.

[12] Sister Kaitsane saw the plaintiff again on 11 April 2003 when the plaintiff was on a stretcher. The plaintiff had a high temperature and a discharge from the eyes and mouth. She says Dr Theart also saw her and wrote a referral note to the Thusong Hospital. The Clinic did not keep cards and files. The receptionist kept a register. Sister Mosenogi related that she saw the plaintiff at the time she was transferred to Thusong Hospital (the first admission).

[13] Sister Kaitsane saw that Phenobarbitone had been prescribed for the plaintiff as it was recorded in one of the documents in her file at the Thusong Hospital. She visited the hospital in 2010 in the course of studying SJS. Phenobarbitone when prescribed is sent from Thusong Hospital and is kept locked in a consultation room. It takes two weeks for a prescription for the medication to be filled and sent to the Clinic. Other scheduled medicine, schedule 5 (Valium), 6 and 7 drugs are kept in a locked cupboard in the matron's office.

Thusong Hospital (first admission)

[14] The plaintiff was admitted to the Thusong Hospital and remained there until she was transferred on 13 April 2003 to Mafikeng Provincial Hospital (also known as the Bophelong Hospital). The medical case sheet of the Thusong Hospital reflects a provisional diagnosis of measles. And, *inter alia*, that the plaintiff was referred by a local clinic with rash and lethargy. "Febrle conjunctivus with discharge. No mrnig foc. Papulr rubric face and trunk clear P

encirciled see Rx". Dr Ratseane on 11 April 2003 noted "newly diagnosed epileptic. Has been on Phenobarbitone from 28 March 2003".

[15] Sister Van Wyk saw the plaintiff, but not her mother, on the first admission of the plaintiff to Thusong Hospital. Sister Van Wyk was a nursing sister on duty in the paediatric ward. She denies that Mrs Kgosiemang gave her the medicine supplied to the plaintiff by the Clinic. She was aggressive when she was cross-examined and was disinclined to answer questions.

[16] The plaintiff was transferred to Mafikeng Hospital on 13 April 2003.

Mafikeng Hospital

[17] On her arrival at the Mafikeng Hospital the plaintiff was admitted to the Intensive Care Unit for approximately two weeks. Then she was transferred to the paediatric ward where she remained for another week. According to hospital records, the nurses recorded at different times, on different dates generalized body rash, blisters, all over the body including the hands and soles of feet, peeling of lips. The Doctors' recorded at different times erythematous lesions, mouth, bleeding, difficulty swallowing, raw lips, denuded raw areas, sores on the tongue, conjunctivitis, painful tearing, vaginal involvement, and that her condition was critical.

[18] The plaintiff was diagnosed (or more accurately confirmed) as Steven Johnson's Syndrome or Toxic Epidermal Necrolysis at the Mafikeng Hospital. She was treated by several Doctors, including a Paediatrician. No Dermatologist, Gynaecologist or Ophthalmologist was consulted or involved at any stage during the plaintiff's stay in the Mafikeng Hospital.

[19] Dr Rauf is a Principal Medical Officer Mafikeng Hospital. He worked in ICU at the time he testified and had done so in 2003. He prescribed ointment for the plaintiff's eyes. She was transferred from ICU to Paediatric Ward. He did not treat the Plaintiff in this ward.

[20] Dr Rauf says patients in ICU are stabilized and he attends to complications but may refer patients to specialists. But he does not refer patients to specialist as a rule. He offered an opinion on the causes of eye problems. His opinion is based on the opinion of another specialist. Phenotion can give rise to SJS but clinics, he says, do not stock it.

[21] Dr Islam is also a Principal Medical Officer. He saw the plaintiff in 2003 at the Mafikeng Provincial Hospital. He worked with a paediatrician, Dr Kekesi, in the paediatric ward.

[22] He went through his notes in preparation for this trial. He found a reference to epilepsy but he was satisfied that the plaintiff was not epileptic.

[23] The plaintiff was properly cared for and treated. She was discharged after her mother had made such a request. He noted this in the file.

[24] Dr Kekesi is a paediatrician. She worked at the Mafikeng Hospital during the period in question. She said that she cannot remember much about the plaintiff. It is too long ago. According to the records available she treated the plaintiff together with other medical staff including Dr Islam who was supervised by her.

[25] Dr Kekesi said that as a paediatrician she was trained to treat SJS and to look out for and recognise complications. If she can no longer manage the

patient then she refers the patient to a specialist or she consults other specialists. If there are no complications she treats the patient but if there is a complication then she is able to seek help and that is exactly what she did for this patient.

[26] Dr Kekesi relied only on her notes to explain the plaintiff's treatment. The plaintiff was admitted to the ICU. She was a very sick child and had multi-systemic problems. Dr Kekesi would have done ward rounds, seen the patient in ICU and probably, as the condition improved, she would have left the medical officer to follow up but she would keep an eye on the patient. Dr Kekesi wrote the loads, which means that she would have examined the plaintiff herself to make sure that the things that she was concerned about were addressed.

[27] The joint minutes of a telephonic discussion between Drs Botha and Promnitz with regard to the plaintiff were placed before Dr Kekesi. They read:

> "Her stay in hospital was a direct result of having been given this medication and the delay in the diagnosis of this condition. There was a delay in the diagnosis and treatment of this condition. The patient should have been under the care of an ophthalmologist at the time of her admission to the Mafikeng Hospital and this would have prevented the disastrous eye complications that occurred..."

[28] Dr Kekesi said that there was no delay in diagnosing the patient. The diagnosis of SJS was made and the medical staff treated the patient. They did not have an on-site ophthalmologist. But she and her colleagues knew about the possible eye complications and were looking after the patient and if they had seen eye complications they would definitely have consulted an ophthalmologist even while the patient was in hospital.

[29] Dr Kekesi says she did not only concentrate on the eyes. The chest was also involved as well as the gastrointestinal system. The liver becomes involved as does the kidneys, the urogenital system and the cardiac system. SJS is a very

debilitating disease and doctors have to look out for all the complications. There is no cure for SJS. One simply treats the symptoms as they occur.

[30] Dr Kekesi testified at length about her treatment of the plaintiff. I record only a number of instances which represent the sort of treatment administered by the medical staff to the plaintiff.

[31] Dr Kekesi stopped the administration of steroids. She said that according to the referral letter from Thusong Hospital the plaintiff was started on steroids at 50 milligrams daily but the use of steroids in SJS is controversial. One has to weigh the risks against the benefits. Steroids have effects. Steroids can cause infections, they can increase the blood pressure of a patient or they can increase the blood glucose. She stopped the steroids because the plaintiff's skin was denuded and the plaintiff was running a temperature.

[32] The plaintiff was cleaned using warm saline. Saline is a salt solution that can be used intravenously. It is used in cleaning wound and to irrigate the skin especially where the skin is denuded. This is because one cannot use ointments that will be absorbed and cause toxicity to the skin. Saline is a very safe thing to use. It is not absorbed and it keeps the skin moist and it also acts as a barrier towards infections.

[33] After irrigating the skin Jelonet, which is a Vaseline-like dressing, was applied to help keep the skin moist and also to act as a barrier towards infections on the skin. Orabase was applied to the plaintiff's lips. Orabase is an ointment used on denuded areas on the skin. It contains some steroid in it but the staff were on the alert for infections. It was the safest thing that could be used for the plaintiff because it is also anti-inflammatory and would help to reduce inflammation of the oral cavity. Vaginal cream was used to prevent

secondary infections and also to lubricate the vagina to prevent scar formation and to keep it moist.

[34] Daktarin and doxycycline gel was prepared and applied. Daktarin, which is an antifungal, and doxycycline, which is an antibacterial, were mixed for use inside the oral cavity. The use of antibiotics and steroids would likely lead to the patient getting oral candidiasis or severe candida infection of the mouth and throat because the throat also gets denuded. The gel would help prevent infections.

[35] Chloramphenicol eye ointment was used for the plaintiff’s eyes. It is an antibacterial eye ointment that would keep the eye moist and also prevent secondary infections. A 10 percent Mentalite solution maintained the plaintiff's fluid needs for the day. The plaintiff was probably not eating as, according to the notes, the patient was unable to swallow. The throat was denuded and had blistering. Neolite was permitted as an option should there be no Mentalite available.

[36] Oral sips were prescribed. The nursing staff were instructed to ensure that the plaintiff received 50 millilitres four hourly of milk or juice. This would be done, even if the plaintiff was on a drip, to keep the oral cavity going. Dr Kekesi explained that if that area is not used there is the likelihood that strictures will form in the oesophagus. The 50 millilitres sips ensure that as a patient swallows, the gut is able to move and does not atrophy.

[37] Urea and electrolytes was too be measured daily or every other day. The extensive skin peeling meant the plaintiff was likely to lose a lot of electrolytes and water through the skin and there could be renal complications.

[38] Clindamycin was prescribed and at one stage a note was added to the file that: "If the temperature spikes, stop Clindamycin, do cultures and add Vancomycin." Clindamycin would cover mild Gram-negative infections. If the temperature spikes despite the fact that the child is on adequate broad-spectrum antibiotics then it means that the more sinister bacteria, Staphylococcus, is present. Clindamycin does not treat Staphylococcus but Vancomycin would. But first cultures must be done. As 24 to 72 hours is required to culture the bacteria in the blood, Vancomycin is started because then everything is covered except Staphylococcus and if the patient is not treated for Staphylococcus then the likelihood of the patient going into septicaemia and dying is very high.

[39] The plaintiff was to be seen at night by the doctor, who was second-on-call, daily.

[40] The plaintiff's urine output, blood pressure and pulse were to be monitored. These are some of the vital signs that are checked. The urine output is an indicator of the kidney function. The blood pressure is measured because the cardiac system can also be compromised by SJS. The pulse will also indicate what the cardiovascular system is doing.

Discharge from Mafikeng Hospital

[41] The plaintiff was discharged from the Mafikeng Hospital on 2 May 2003. Dr Kekesi repeated that she did not remember much about the plaintiff. She said that because Dr Islam was her junior he would not have discharged the plaintiff without consulting her. This causes her to believe that he did consult her and she would have considered or discussed it with him. Dr Kekesi cannot say whether or not she saw the plaintiff's mother on 2 May 2003, the date of discharge.

[42] The discharge summary is completed in duplicate. One copy remains in the file and, if the patient has been referred, for example by a hospital and the hospital comes to fetch the patient, then it is given to the person who collects the patient. If a patient discharges him or herself or decides to use their own transport, the patient is given a copy of the discharge summary.

[43] Dr Kekesi completed the discharge summary. When she did so, according to the notes, the plaintiff had markedly and significantly improved. The patient was up and about. She examined the plaintiff and was satisfied and that given the fact that her mother wanted her to be discharged and that she would have discussed it with her mother. She would have told her what the doctors were concerned about. Dr Kekesi was satisfied that the condition was no longer life threatening and in no danger as long as she followed the advice and the instruction given to her on discharge and took the medication. The plaintiff would not have been completely safe because probably she would have been discharged with antibiotics and other medication. There was also a review plan in place.

[44] Dr Kekesi was questioned on the entries on the discharge summary. "Steven Johnson Syndrome; vision normal on discharge; skin lesions healed; some residual oral ulcers." This states that there were still some raw lesions in the mouth. This was not a reason to keep the plaintiff in hospital. When the plaintiff was admitted she could neither eat nor swallow. By the time she was discharged she was able to eat solid food. Patients who are able to eat solid food are able to take oral medication.

[45] Dr Kekesi said that sometimes, even though a patient is not completely recovered, the patient may be sent home if the parents convince her that they

will do what it takes to look after the child. So, a few oral ulcers are not an indication not to discharge the child.

[46] Dr Kekesi said she cannot remember this case thoroughly but thought that one reason for keeping the plaintiff may have been because she wanted the patient to be seen by Mafikeng Hospital's own eye clinic. Residual oral ulcers are not a reason to keep a child in hospital; especially a public hospital where there are lots and lots of patients with infections coming in.

[47] It was put to Dr Kekesi that the number of patients that she had to treat in the hospital apparently played a role in her decision to discharge the plaintiff. Dr Kekesi denied it, saying that if taking the child out of the hospital would compromise the life of the patient then she normally would explain everything that needed to be explained including the possible complications and then have the parents sign a statement that they refuse hospital treatment. This did not happen in the plaintiff's case. She believes the parent must have given her a reason to trust her to do what the doctors asked her to do and to bring the child back in case of complications.

[48] The discharge summary specified "review own hospital ophthalmology". Dr Kekesi explained why she would have decided on this. The plaintiff was referred by Thusong Hospital to us and was referred back as one of the complications of SJS is corneal ulceration. This condition cannot be seen with the naked eye or a torch. It needs an ophthalmology examination. Thusong and Mafikeng Hospitals both had trained nurses that worked with ophthalmologists in various hospitals. If the mother had requested the discharge then, because of her concerns, Dr Kekesi says she would have told her to take the child to Thusong Hospital ophthalmology clinic and they would have examined the child and probably have taken it from there.

[49] Dr Kekesi says she would have examined the plaintiff's eyes before discharge. The plaintiff had conjunctivitis. Dr Kekesi was aware of the complications of SJS as far as eyes are concerned and she would have examined the eyes using an ophthalmoscope and have looked inside the eye and at the pupil to determine whether it was regular or irregular. She would look to see whether there were obvious scars that one can see outside and also do a crude visual acuity test to see that the patient was able to see with both eyes. The plaintiff's vision was
normal on discharge.

[50] Dr Kekesi was asked to comment on the mother's evidence that the plaintiff could see properly but had a yellowish discharge from her eyes. Dr Kekesi says that the doctors examined the child's eyes on a daily basis and the child was able to open her eyes. The child was able to see and there was no symblepharon at any time after discharge because one can argue that it is gradual formation. On discharge the plaintiff did not have symblepharon. There was no discharge from the plaintiff's eyes on the date of discharge.

[52] Under cross-examination Dr Kekesi added that she wanted the child to be seen by an eye specialist and would probably have kept the child in hospital for longer until she had a date for an ophthalmologist to see her or something like that. Asked whether she could not have arranged an appointment with an eye specialist during the period that the plaintiff was in Mafikeng Hospital, Dr Kekesi replied that there were other matters also involved; it was not only the eyes. They were dealing with more serious issues concerning this patient than just the eyes at the time. But a routine examination by an eye specialist was required to make sure that the child had a clean bill of health. It was necessary that a specialist examine the child and opine on the condition of the plaintiff's eyes.

[55] Mafikeng Hospital had an eye clinic. Dr Kekesi does not recall whether she asked its staff to have a look at the child. There is no note in the file. She agreed that on probabilities that would have been noted in the file; likewise if she had contacted an eye specialist for assistance.

[56] Dr Kekesi was satisfied with the vision. The eyes were not sticking together; the lids were not sticking to the conjunctiva but because the cornea is broad, she was concerned that there might be a small ulcer there that she could not see with the naked eye or with a torch. If it was not treated then it may progress.

[57] Asked whether she had the assurance that the mother or the child would in the future see an eye specialist, Dr Kekesi said she would have explained to the mother what she must do (and she believe the mother must have agreed to take the child to the ophthalmologist). Otherwise she would not have just allowed them to go.

[58] The Thusong Hospital has a dedicated eye clinic where they have trained nurses. Doctors, when they encounter eye problems, refer patients to eye nurses and they talk directly to eye specialists. The Sisters at the Thusong Hospital would have examined the plaintiff or they would have directed the child to an ophthalmologist. It is much easier when it is done by the nurses who work with ophthalmologists. They know who to talk to and where the clinics are.

[59] It was put to the doctor that she sent the mother and her child to an eye clinic at the Thusong Hospital where the eye nurse would decide whether the plaintiff should receive the assistance of an ophthalmologist. Dr Kekesi replied that it was not for the eye nurse to decide. She said the discharge summary says

the patient is to be seen by an ophthalmologist to exclude ulcers. The eye nurses are trained to look for ulcers. They would be able to say whether there are ulcers. Dr Kekesi said that she herself was not trained to look for ulcers. She did not know to what degree eye nurses were trained.

[60] Doctors would not consult directly with an ophthalmologist. They send patients to eye clinics and if the eye nurse decides that a patient needs to be seen in Klerksdorp Hospital or St John's Hospital then they would refer the patient there. Dr Kekesi believes that eye nurses were adequately trained to know the conditions that they can treat and what conditions that they cannot treat.

[61] It was put to Dr Kekesi that she would not have control over the process of the plaintiff going to the eye clinic at the Thusong Hospital. Dr Kekesi replied that the mother undertook to do this.

[62] The plaintiff was discharged from the Mafikeng Hospital on 2 May 2003. Her mother denies that she requested the medical staff to discharge the plaintiff. Her mother says she was given ointment to take with her and was instructed how to apply it. Her mother says that the plaintiff’s skin was becoming greyish, blood was coming out of her mouth and there was a yellow discharge from her eyes. Her mother was told to take the plaintiff back to Thusong Hospital if there are any problems. Mrs Kgosiemang says she was not told to take the plaintiff to the eye clinic at Thusong. The only document or letter she was given on discharge was a letter to obtain eye ointment.

Bodibe Clinic (May 2003)

[63] The plaintiff went to school but was told to return home until she had recovered. When the plaintiff could not open her left eye, Mrs Kgosiemang took her back to the Clinic who referred her to Thusong Hosiptal with a transfer note.

Thusong Hospital (second admission)

[64] The plaintiff was admitted to the Thusong Hospital on 14 May 2003 (the second admission) and attended to by Dr Krug a paediatrician, Dr Musonda and seen by Sister Molusi an eye nurse.

[65] Dr Krug, a paediatrician, who visited the Thusong Hospital that day noted the presence of conjunctivitis and seems to have queried the history of convulsions or at least to have flagged this information for verification or further investigation. Dr Krug diagnosed the plaintiff as having SJS. Dr Krug prescribed medication which was appropriate for the skin and eye complaints.

Dr Krug was not called as a witness.

[66] Dr Joyce Musonda testified that she assisted the paediatrician. This was the first time that she had encountered a case of SJS. She said that she read up on the condition but does not recall the source. In view of the time lag no adverse inference can be drawn. Dr J Musonda sent the plaintiff home on 16 May 2003. Her note reflects that the patient said she had no complaints that day. She says she did not consult Sister Molusi prior to discharge of plaintiff. She opined that it was too late to do anything as the plaintiff's eyes had developed their complications and therefore it was unnecessary to obtain an expedited date for a consultation with an ophthalmologist. She did not contact an

ophthalmologist although could have done so. She says she would do things differently if it happened again.

[67] Sister Molusi saw the plaintiff on 15 May 2003 at Thusong Hospital. Sister Molusi operates the eye clinic at that hospital. She received her training in eye nursing at St John's Hospital. She did not refer plaintiff to ophthalmologist on 15 May 2003 as the condition of plaintiff's eye, even with symblepharon because it was not an emergency. Surgery would be required to be done by an ophthalmologist.

[68] Sister Molusi says she thought that the plaintiff had been treated by an ophthalmologist at the Mafikeng Hospital. She vacillated between saying that there was such a specialist in Mafikeng at the time but eventually said she was not sure. She also said that she would have referred the plaintiff (as a non-urgent case) to an eye specialist had the plaintiff not been discharged from Thusong Hospital by Dr J Musonda on 16 May 2003.

[69] The plaintiff's eye was so painful that she could not attend school. She again consulted Dr J Musonda at Thusong Hospital on 23 May 2003. Dr J Musonda prescribed Panado and sent her home to attend a clinic.

[70] Sister Molusi saw the plaintiff again at Bodibe Clinic, on 11 June 2003. She made an appointment for the plaintiff with an ophthalmologist by contacting the nursing sister at Klerksdorp Hospital. She also prepared a referral note which was signed by the Superintendent Dr Musonda (not Dr J Musonda). The appointment was for 24 June 2003.

[71] The plaintiff attended at Klerksdorp Hospital on 24 June 2003 to see an ophthalmologist.

[72] The plaintiff was transferred to St John's Eye Hospital for her eye complaints. The plaintiff underwent a left lower lid mucous membrane graft (MMG) on 13 August 2003. She developed a descementocele in the left eye. On 13 August 2003 she was admitted with a perforated left cornea that needed a scleral patch. In October 2003 she had another mucous membrane graft to the left lower lid and lacrimal retention cyst drainage and marsupilization in the right eye.

[73] In 2004 an examination under anaesthesia was done at St John's Hospital and the following was discovered:

- Bilateral severely scarred tarsal plates.
- Lashes epilated and excision of two right upper lid lashes.
- Inferior fornix's seemed adequate post mucous membrane graft.

[74] Later it was noted that she developed triciasis in both eyes; punctual occlusion and a canunal scar in the right eye. In September 2004 she had a conformer exchange in the left eye and removal of sutures with examination under general anaesthesia.

[75] In December 2004 she saw Dr Gill private ophthalmologist in Klerksdorp.

[76] The Orbital Clinic (St John's Hospital) noted as regards the right eye:

> "[A] ciccatricial entropion, Trichiasis, scar of caruncle and Punctual occlusion. The following was noted as regards the left eye: A neovascularized opaque cornea, with iris plugging perforation site, and thickened left lower lid with MMG."

[77] In 2006 the plaintiff underwent a revision of the left lower lid. In 2007 she underwent a right symblepharon with inferior hazy cornea, Pannus and symblepharon in the left eye, and a pseudo-pterygium formed in the left eye.

[78] In 2008 a left eye entropion repair was done and MMG. Symblepharon lids, MMG left lid and medication – symblepharon.

The evidence of the expert witnesses

[79] Dr A P J Botha, a specialist physician, provided a report and testified. Dr Botha and Dr G Promnitz , also a physician, agreed on a joint report. I only find it necessary to set out their joint findings. But I shall deal with aspects of the Dr Botha's evidence later. I stress that the findings of these specialist rest upon the data supplied to them. The joint report reads:

> "Dr Botha and Dr Promnitz held a telephonic discussion with regard to the above patient and we concur on the following points:
>
> - The patient developed Toxic Epidermal Necrolysis because of receiving epileptic medication, Phenobarbitone or Epanutin. This skin reaction is an allergic reaction to this medication and is one of the most severe dermatological complications seen.
> - There was no indication for her to have received the above medication because she does not suffer from epilepsy or any other condition that would require the use of the above medication.
> - Her stay in hospital was a direct result of having been given this medication and the delay in the diagnosis of this condition.
> - There was a delay in the diagnosis and treatment of this condition.
> - The patient should have been under the care of an ophthalmologist at time of her admission to the Mafikeng Hospital and this would have prevented the disastrous eye complication that occurred. The patient only saw an ophthalmologist when she was referred to the Klerksdorp Hospital and was subsequently referred to the St John's Eye Hospital.
> - The patient has lost all function in her left eye because of the failure to treat the eye complications of the above skin condition timeously. She is blind in that eye and has cosmetic disfigurement in the left eye.

- Because of her disability she has been left with a psychological disturbance and she will need psychological therapy and treatment. We defer an opinion of the costs to that of a psychiatrist.
- And ophthalmological assessment must be made and an opinion obtained with regard to the monetary loss incurred of losing an eye."

[80] I must record that their joint finding that there was a delay in diagnosis and treatment of this condition was challenged by the defendant during the cross-examination of Dr Botha.

[81] Dr Botha went on to say that:

(a) It is important to note that prior to the visit to the clinic for a "Road-to-Health card" the child has also received treatment with Phenobarbitone given for epilepsy at a local clinic without any investigations done and without a clear history of epilepsy.

(b) The skin reaction that followed was diagnosed immediately as SJS and treated aggressively in the intensive care unit. She was referred to the Klerksdorp Hospital and also the St John's Eye Hospital in Johannesburg because of the eye complications. She underwent several procedures on the eyes which are described in the records. These included release of symblepharon and other procedures to improve the effects of inflammation and scarring of the eyes.

(c) She was discharged on 2 May 2003. When discharged the skin lesions had healed, there were residual oral ulcers and the vision was then considered as normal. She has, however, not recovered fully from the vision and it is now reported that there is no vision on the left with normal or near normal vision in the right eye. The left eye pains from time to time and continues to discharge. She apparently also has oral ulceration from time to time. The child had been in good health before this episode.

(d) She has never had any attacks that would be reminiscent of epileptic seizures. The current clinical examination reveals a generally healthy 17-year-old girl without systemic signs of illness but with chronic inflammatory change in the right eyelid and entropion, conjunctivitis and a deviated pupil on the left. There were faint scars on the skin not considered disfiguring.

[82] Dr Botha concluded that SJS is a life threatening condition involving skin, mucous membranes and eyes caused by a severe often fatal allergic reaction to drugs of which Phenobarbitone is one of the leading causes.

[83] Dr Botha said:

> "After having considered all the available clinical facts I have very little doubt that the direct cause the Stevens-Johnson syndrome was the unwise prescription of Phenobarbitone for symptoms that did not remotely resemble epilepsy.
>
> ...
>
> Because of this ill-judged prescription the child suffered a life threatening systemic illness and has been left with eye damage and also emotional scarring."

[84] Dr Botha and Dr Promnitz are agreed that the plaintiff's stay in hospital was a direct result of having been given epileptic medication, Phenobarbitone or Epanutin and the delay in the diagnosis of this condition. The patient should have been under the care of an ophthalmologist at the time of her admission to the Mafikeng Hospital. This would have prevented the disastrous eye complication that occurred. The patient only saw an ophthalmologist when she was referred to the Klerksdorp Hospital and was subsequently referred to the St John's Eye Hospital.

[85] Dr C M Kgokolo, a dermatologist, provided a report and gave evidence. Her evidence reflects her report. In Dr Kgokolo's view a patient diagnosed with

SJS should be managed by hospitalization, IV fluids and evaluation of possible systemic involvement. Systemic corticosteroids should be administered at an early stage (after exclusion or treatment of underlying infection). Early ophthalmologist and dermatologist consultation is important. SJS treatment requires routine topical care: disinfectant mouth washes, antiseptic topical ointment and dressings (treatment in burns unit can be invaluable). SJS also involves the genital mucous. Gynaecological care is required to avoid vaginal stenosis and dyspareunia. SJS and TEN are dermatological conditions and therefore should be managed by or with a dermatologist.

[86] Dr Kgokolo outlined the complications which may occur. As far as the skin is concerned it may lead to scarring (hence the need for dermatological involvement in the management). There can be scarring of the eyes and blindness (hence the need for early monitoring by an ophthalmologist whenever there's ocular involvement). Vaginal stenosis and dyspareunia and so gynaecological assessment is important.

[87] Dr Kgokolo concluded that the plaintiff suffered from SJS/TEN. This was most probably caused by Phenobarbitone. The plaintiff recovered from the systemic disease. However, she is left with the following complications:

(a) Atrophic scarring of the cheeks on the face.
(b) Eye complications (see Ophthalmologist report).
(c) Emotional torture (Post traumatic stress disorder).
(d) Genital complications (this may be revealed once she becomes sexually active).
(e) Poor Performance at school (may be related to her low self-esteem).

[88] Ophthalmologists, Drs Williams and Kunzmann, compiled a joint report. The essential part reads:

> "Ophthalmological examination:
>
> Miss Kgosiemang's best corrected visual acuity is 6/6 in the right eye with a refractive error of - 3.251-1.75 x 5. Her best corrected visual acuity in the left eye is hand movements. The right eye has a lower eyelid symblepharon on the lateral aspect with the inferior and superior punctums totally occluded, causing constantly epiphora of the right eye. Corneal epithelium defects are present secondary to the trichiasis that is present on the upper eyelid.
>
> In the left eye the superior nasal aspect of the cornea there is also an area of thinning but it looks like an old scar that has stabilized. The lower eyelid of the left eye has external de- pigmentations on the eyelid margin. The punctums are open but everted. The inferior fornix had a mucosal membrane transplant. Thickening and abnormal red appearance of the conjunctiva is present in this area.
>
> In the left eye there is also symblepharon present in the lower eyelid. Significant cornea scarring is present with pannus formation and scar formation in the cornea. The upper eyelid has significant trichiasis. The anterior chamber is formed. Signs of old perforation in the cornea were present on the lateral aspect of the eyelids with an iris plug. A partial lateral tarsorraphy was done to protect the eye. The superior limbar part of the cornea looks healthy. No epiphoria is experienced in the left eye. The intra-ocular pressure in the right eye was 17mmHg. It was difficult to measure the intra-ocular pressure in the left eye.
>
> Ophthalmological opinion:
>
> This 18 year old patient has a Steven Johnson's Syndrome, probably induced by Phenobarbitone which is anti-convulsive medication. She developed eye complications when she was 9 years of age. There is no mention of her eyes being treated with regular eye swabbing with a glass rod while she was admitted in ICU or in General Ward. If this was the case, the symblepharon complications could have been prevented to a minimum. The symblepharon is not the only complication of the Steven Johnson's Syndrome. The loss of limbal stem cells which is unrelated to regular eye swabbing was caused by the immune reaction due to the Steven Johnson's Syndrome.
>
> The entropion repair could have been prevented by regular swabbing, but the corneal transplant and glaucoma surgery and stem cell transplant would probably occurred even with eye swabbing.
>
> Ophthalmological treatment:

> Miss Kgosiemang will need multiple surgeries to make her eyes comfortable and to retain her visual acuity."

[89] Dr Carman, a dermatologist, examined the plaintiff on 18 April 2012. She noted that the plaintiff was now 18 years old. She was withdrawn and was unable to open her eyes easily or to look upwards. She has severe photophobia and is apparently blind in her left eye. She is still and looks miserable.

[90] The plaintiff's skin has recovered fully. She does not complain of any problem with her urine or periods. She has mild post inflammatory pigmentation on her face and no scarring. No treatment is indicated. She should use sun blocks only.

[91] Dr Carman is of the view that the overwhelming probability is that her SJS was caused by Phenobarbitone. This allergy is not dependant on the dosage of the drug. The plaintiff was given a low dose (1 tablet daily for 30 days).

[92] It is impossible to establish on what basis she was given Phenobarbitone in the first place. The clinic notes relating to the plaintiff were not available to her. Phenobarbitone is not indicated for petit mal seizures only grand mal epilepsy. Her mother claims that she suffered from dizziness and headache and had never had any sort of fit.

[93] However, the prescribing doctor could not have anticipated that this child would develop this rash. It is a rare condition.

[94] From the scanty medical records she seems to have had 2 admissions (on 11 April and then again on 14 May 2003) Dr Carman queries whether the plaintiff actually had two attacks of the disease. Thus the possibility exists that she took Phenobarbitone again after she was told to stop the drug by the ward

sister on Saturday 13 April. It was prescribed again on 14 May 2003 but was stopped before there is any record of her actually taking it.

[95] Dr Carman does not prescribe Phenobarbitone but she does prescribe a drug which can cause SJS in certain of her patients. She does not advise them of the range of side effects but advises them to consult her should they experience side effects.

[96] Dr Flemming, a neurologist, interviewed the plaintiff and her mother. They were accompanied by a driver who testified in the trial that he interpreted from Afrikaans for Mrs Kgosiemang and her daughter. Dr Flemming said he spoke to Mrs Kgosiemang in Afrikaans.

[97] Dr Flemming, testified that Phenobarbitone is appropriate for epilepsy. He sometimes prescribes it for his patients and, when he does so, he does not advise them of the rare reaction; it is too rare. He conducted an EEC test on the plaintiff. He was surprised to find that the plaintiff showed some epileptiform. It may confirm epilepsy if there is other evidence of this condition.

[98] Dr Kunzmann confirmed that he wrote a joint report with Dr Willemse. He is of the view that nothing can be done for the eyes of a patient suffering from SJS during acute period of SJS except to lubricate the eye and apply antibiotics. He does not think that swabbing eyes with a glass rod prevents the consequences of the disease in the end. An ophthalmologist is required once the acute phase has ended. Essentially the ophthalmologist's task is to repair the damage which has been done.

[99] He is of the view that the treatment of the plaintiff at the Mafikeng Hospital was appropriate and that she was probably fit to be discharged when this was done on 2 May 2003. He thinks that the plaintiff should have been seen

by an eye nurse while she was in the Mafikeng Hospital although she was probably still in the acute stage.

[100] The plaintiff should definitely have been referred to an ophthalmologist after her discharge on 2 May 2003. Eyes nurses are not, in his opinion, able to deal with issues of urgency. Dr J Musonda should have liaised with an ophthalmologist. He, tentatively, thinks that the acute pain experienced by the plaintiff on 23 May 2003 May have been caused by a corneal ulcer. Those treating her should have acted expeditiously and contacted an ophthalmic surgeon.

[101] Dr Kunzmann says that the plaintiff was probably experiencing acute pain due to a corneal ulcer. It was imperative for Dr Musonda to have acted expeditiously and to have contacted an ophthalmic surgeon. Prof McLaren endorses this approach but would have acted with a lesser degree of urgency.

[102] Prof McClaren is the head of the St John's Eye Hospital in Johannesburg. He has vast experience. He contextualised the treatment of the illness in the light of the health system prevailing in the rural and semi-rural areas. He saw the plaintiff in August 2003.

[103] His view is that swabbing of the eyes using a glass rod may cause bleeding and increase the risks of infection which must be prevented in the acute stage of SJS. The use of steroids in the treatment of eyes of patients with SJS is controversial. The consequences of SJS on the plaintiff's eyes could not be prevented because SJS is a capricious disease.

[104] He says the treatment of the plaintiff at the Mafikeng Hospital was appropriate. The plaintiff was not discharged prematurely. Prof McClaren does not accept that the diagnosis of SJS was made too late. Rather, for surgical

purposes a delay was beneficial because it enabled the ophthalmologist to harvest membrane which would grow in the meantime.

[105] He thinks that Mrs Kgosiemang delayed in bringing the plaintiff to Thusong hospital. He does not think there was an ulcer in the eyes as the pain would not have abated. The symblepharon would have protected the eyes. It is uncomfortable but not painful. He thinks the pain was caused by a sterile perforation which healed itself.

[106] He regards eye nurses as well trained and competent. He did not tell Mrs Kgosiemang that there had been a delay which had an adverse effect on the treatment of the plaintiff.

The case on the pleadings

[107] The plaintiff's case as in respect of the alleged acts of negligence set out in the pleadings, as amended, are the following:

> "At the time when the said Dr. Theart prescribed Phenobarb to the Plaintiff Dr. Theart acted wrongfully and recklessly, alternatively grossly negligently further alternatively negligently in one or more or all of the following respects:
>
> 7.1 She failed to examine the Plaintiff properly;
> 7.2 She failed to establish, alternatively establish properly, whether Plaintiff was then suffering from any illness, allergy, disease or other medical condition which required that Phenobarb be prescribed to the Plaintiff:
> 7.3 She failed to establish, alternatively establish properly, whether Plaintiff was then suffering from any illness, allergy, disease or other medical condition which demanded that Phenobarb should not be prescribed to the Plaintiff:
> 7.4 She failed to establish, alternatively establish properly, whether it was safe to prescribe Phenobarb to the Plaintiif;
> 7.5 She prescribed Phenobarb to the Plaintilf in too large quantities and/or for too long a period of time.
> 7.6 She failed to adhere to the standard of practice of a reasonable medical practitioner in her position who would have concluded:
> (a) That Phenobarb should only be prescribed as a last resort medication in cases of epilepsy;

(b) That Phenobarb could cause death or serious injury to the Plaintiff;
(c) That Plaintiff did not suffer from any illness, allergy, disease or other medical condition which required that Phenobarb should be prescribed to the Plaintiff.

7A. Alternatively, the person who provided Plaintiff with Phenobarb as stated in paragraph 3.14 above acted wrongfully and recklessly, alternatively grossly negligently further alternatively negligently in that he failed to provide to the Plaintiff the correct medication as prescribed by the said Dr Theart.

At the time when the said Sister Jantjie injected the Plaintiff with the unknown substance as stated herein above, the said sister Jantjie acted, wrongfully and recklessly, alternatively grossly negligently further alternatively negligently in one or more or all of the following respects:

8.1 She failed to examine the Plaintiff properly;
8.2 She failed to establish, alternatively establish properly, whether Plaintiff was then suffering from any illness, allergy, disease or other medical condition which required that she be injected with such a substance;
8.3 She failed to establish, alternatively establish properly, whether Plaintiff was then suffering from any illness, allergy, disease or other medical condition which demanded that the Plaintiff should not be injected with such a substance;
8.4 She failed to establish, alternatively establish properly, whether it was safe to inject the Plaintiff with such a substance;
8.5 She injected the Plaintiff with too large a quantity of the said substance.
8.6 She failed to adhere to the standard of practice of a reasonable medical sister in her position who would have concluded.
(a) That the substance should not be administered to a patient who at the time was taking Phenobarb as a medication;
(b) That the substance could cause death or serious injury to the Plaintiff;
(c) That Plaintiff did not suffer from any illness, allergy, disease or other medical condition which required that the said substance should be administered to the Plaintiff.

8.5. The relevant medical doctors and/or staff in the said hospitals acted wrongfully and recklessly, alternatively grossly negligently further alternatively negligently in that they failed to provide to the Plaintiff the required medical treatment and care whilst they could and should have done so.

9.1 As a result of the said actions of Dr. Theart, of the said person who provided Plaintiff with the medication as stated herein before, of the said medical doctors and/or hospital staff and of Sister Jantjie, Plaintiff.

(a) suffered pain, discomfort and loss of amenities of life;
(b) experienced rash and disfigurement over almost the whole of her body and in her mouth;
(c) lost the sight in her left eye totally;
(d) lost the sight in her right eye partly;
(e) runs a real risk of loosing the sight in her right eye totally in the future;
(f) had to undergo various operations in an attempt to save her eyes;
(g) will have to undergo various operations in the future.

(h) will suffer pain, discomfort and loss of amenities of life in the future
(i) has been admitted to various hospitals, has undergone various operations and had incurred hospital expenses which were paid on her behalf by her said guardian alternatively for which her guardian acting on Plaintiff's behalf is liable.
(j) is expected to attend hospitals in the future.
(k) is suffering permanently from a loss of earning capacity and is expected to suffer damages in this regard."

The Law

[108] In deciding this matter I must have regard to the caution sounded in **Broude v McIntosh and Others** 1998 (3) SA 60 (SCA), where Marais JA said:

> "There is of course another consideration to be borne in mind in cases of this kind. When a patient has suffered greatly because of something that has occurred during an operation a court must guard against its understandable sympathy for the blameless patient tempting it to infer negligence more readily than the evidence objectively justifies, and more readily than it would have done in a case not involving personal injury. Any such approach to the matter would be subversive of the undoubted incidence of the onus of proof of negligence in our law in an action such as this."

[109] The onus of proving negligence rests on the plaintiff.

[110] The inquiry as regards professional negligence is whether a reasonable practitioner in the circumstances would have foreseen the likelihood of harm and would have taken steps to guard against its occurrence, and whether the practitioner concerned failed to take such steps to guard against its occurrence.

[111] A medical practitioner is expected to exercise the degree of skill and care of a reasonably skilled practitioner in his or her field. See **Mitchell v Dixon** 1914 AD at 525. In deciding reasonableness the court will have regard to the general level of skill and diligence possessed and exercised by members of the branch of the profession to which the practitioner belongs. A greater degree

of skill is expected of a specialist than a general practitioner and if a general practitioner undertakes work that requires specialist skill, which the practitioner concerned does not have, he or she would be negligent. See **LAWSA** Vol 17(2) at para 44.

[112] In the case of an expert, the test for negligence in regard to the exercise of the expert's area of activity, is the test of the reasonable expert. See **Hoffman v Member of the Executive Council Department of Health, Eastern Cape** (unreported 2011, case no 1037/2007) at para 66 and **Lourens v Oldwage** 2006 (2) SA 161 (SCA) at 171C.

[113] **Van Wyk v Lewis** 1924 AD 438 at 444 requires that in determining reasonableness:

> "[T]he Court will have 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".

[114] The standard of excellence expected of the medical practitioner cannot be beyond the financial resources of the hospital authority or the medical facility concerned. See **Collins v Administrator, Cape** 1995 (4) SA 73 (C).

[115] In determining whether there has been a breach of a duty of care by a medical practitioner, the court is required to evaluate to what extent the experts' opinions are founded on logical reasoning.

[116] In **Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another** 2001 (3) SA 1188 (SCA) the court made the following finding:

> "[36] That being so, what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical

reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of **Bolitho v City and Hackney Health Authority** [1998] AC 232 (HL (E)). With the relevant dicta in the speech of Lord Browne-Wilkinson we respectfully agree. Summarised, they are to the following effect.

[37] The Court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The Court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached 'a defensible conclusion' (at 241G - 242B).

[38] If a body of professional opinion overlooks an obvious risk which could have been guarded against it will not be reasonable, even if almost universally held (at 242H).

[39] A defendant can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be right to conclude that views genuinely held by a competent expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide 'the benchmark by reference to which the defendant's conduct falls to be assessed' (at 243A - E).

[40] Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an event's occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty per cent chance and so on. This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of **Dingley v The Chief Constable, Strathclyde Police** 200 SC (HL) 77 and the warning given at 89D - E that:

> '(O)ne cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a Judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved - instead of assessing, as a Judge must do, where the balance of probabilities lies on a review of the whole of the evidence'."

The issues

[117] The main issue is whether any employee of the North West Health Department, for whom the defendant is vicariously liable, was negligent in the treatment of the plaintiff and did such negligence cause her harm? To answer this, a number of sub-issues need to be decided. They are:

(a) Was the plaintiff given Phenobarbitone?
(b) If so was the prescription of Phenobarbitone negligent (eg it was not indicated for the plaintiff's condition)?
(c) Was Phenobarbitone dispensed? (further sub-issues: was Phenotion administered? Was vaccination a cause? Was an unknown substance administered?)
(d) Was there an undue delay in diagnosing SJS?
(e) Was plaintiff treated appropriately at the Mafikeng Hospital?
(f) Was the plaintiff discharged from the Mafikeng Hospital prematurely?
(g) Was the plaintiff given a discharge certificate and directed to attend at Thusong Hospital and if she did not what are the consequences?
(h) Was it in accordance with reasonable medical practice to refer the plaintiff, suffering from SJS, to an eye nurse?
(i) Was plaintiff treated appropriately at Thusong on her second admission?
(j) Did the acts or omissions of the medical staff cause the plaintiff harm?

[118] I pause to record that there is no complaint about the treatment the plaintiff received as from the date of her appointment in Klerksdorp on 24 June 2003. This relates to what may be called the repair stage of the disease.

Was the plaintiff given Phenobarbitone?

Exclusion of other drugs

[119] Before dealing with the question whether Phenobarbitone was given or administrated, it is important to consider whether any other drug (which could cause SJS) was administered to the plaintiff during the crucial period.

[120] The plaintiff and her mother say no more than that the plaintiff was given an extra injection at the Clinic at the time the "catch-up" injections were administered on 8 April 2003. It was supposedly as punishment for queue-jumping on the previous Sunday. The Sisters at the Clinic deny this allegation. However, Sister Jantjie, who allegedly injected the plaintiff, was not called as a witness. The Sisters at the Clinic deny that Sister Jantjie injected or vaccinated the plaintiff and say that she was vaccinated by Sister Kaitsane.

[121] The name of the drug, if one was injected, was not known to the plaintiff and her mother. It is unlikely that the plaintiff would have been given the container to carry away.

[122] There is only a suspicion that the plaintiff may have been given an injection at the Clinic (which the sisters deny) and that this may have been Phenotion. But there is insufficient evidence to make a finding that Phenotion was administered on 8 April 2003.

Vaccination

[123] Dr Botha testified that although vaccination has been anecdotally reported as a cause of SJS he would rule it out as being too rare. Dr Flemming seems to share this opinion.

An unknown substance?

[124] The plaintiff's particulars of claim, aver in the alternative, that if the prescription was not Phenobarbitone, then the person in the clinic responsible for providing the medication to the plaintiff supplied Phenobarbitone to the plaintiff instead of the medication prescribed by the Dr Theart. All the persons on duty in the Clinic save Sister Jantjie have testified. This hypothesis was not vigorously investigated.

[125] I am satisfied that the plaintiff did not receive any of the drugs mentioned in this section.

Phenobarbitone

[127] It is the plaintiff's case that she saw Dr Theart in March 2003, some 9 years ago. Dr Theart does not recall the plaintiff. This is completely understandable. The records of the Clinic are missing and Dr Theart has no medical notes for that period. Dr Theart's evidence that she has no recollection of the case warrants no negative inference of any kind. Dr Theart conducted a session at Bodibe Clinic during the time period in question although not on the day alleged by Mrs Kgosiemang.

[128] Dr Theart said she would not administer Phenobarbitone without having a detailed and reliable history indicating that the plaintiff suffered from a form of epilepsy. She also said that if the drug had been prescribed it would be dispensed by the Thusong Hospital dispensary and be sent to the Clinic after a week or two.

[129] There are no documents i.e. prescriptions, files or patient cards (patient cards, when full, are given to the patient), nurse's registers, files for treatment/medicine to be collected or appointment books available. The transfer note which would have accompanied the plaintiff to Thusong Hospital on her first admission is missing. The records at Thusong Hospital are incomplete.

The defendant's submissions

[130] The defendant disputes that Dr Theart prescribed Phenobarbitone. Mr Senatle, who appeared for the defendant, submitted that:

(a) The plaintiff's mother said she visited the clinic with the plaintiff on a Monday towards the end of March 2003. She was advised to return with the plaintiff two days thereafter, i.e. on Wednesday. She did so and met Dr Theart. She was examined and referred to the next room where she was given the tablets which were Phenobarbitone.
(b) Dr Theart was not at the Clinic on that Wednesday. Dr Theart did not work at the Clinic on any Wednesday in March 2003.
(c) Mrs Kgosiemang is not to be believed. She was insistent, that it was Sister Jantjie who, injected the plaintiff. This was despite the fact that she was informed that it was not Sister Jantjie but Sister Kaitsane. Dr Botha, ruled out any other injection in view of the plaintiff's condition.

(d) Mrs Kgosiemang pretended that she does not know Afrikaans. She was also evasive when asked whether she read the name of the medication given to her at the clinic. Mrs Kgosiemang denied that she ever consulted a private medical practitioner in 2003. She swore that she would give the plaintiff the medication to the letter whenever asked by the medical practitioners to do so. But when confronted with Epilim prescribed for the plaintiff on 10 July 2003 she said that the plaintiff refused to take the medication. It will be noted from the plaintiff's answers that she could not remember anything. Yet she remembered, in spite of so many medicines given to her, that she refused to take the Epilim prescribed for her by Dr J Mosunda.

(e) Mrs Kgosiemang described the condition of the plaintiff on her discharge on 2 May 2003. According to her she could not complain when the plaintiff was discharged. However, during the course of her evidence she changed her version and said that the plaintiff had a yellowish discharge from her eyes and that she was bleeding from her lips on 2 May 2003. She lied when she said that she was only given eye ointment on this date.

Evaluation

[131] I accept that the plaintiff saw Dr Theart at the new Bodibe Clinic in March 2003. The plaintiff returned to the Clinic on 11 April. The plaintiff was referred to and transferred by ambulance to Thusong Hospital. It is standard practice for a transfer note to accompany a patient. The transfer note for this date is missing. The Thusong Hospital records are incomplete. But the "Application for a Transfer of a patient" to Mafikeng Hospital dated 13 April signed by Dr Musonda (not Dr J Musonda), the Superintendent of Thusong Hospital. He was not called as a witness. The clinical history noted on the form reads:

> "Please assess and man[a]ge this girl with severe allergic reaction (SJS and TEN). The airway is still patent but she is having difficulty swallowing food, Recatuion is to Phytone, Phenobarb + unknown injection. She is currently on Predisone, 50 mg daily, Cr??? and panado."

[132] It is hardly possible that the 9 year old plaintiff communicated to the Thusong Hospital staff that Phenobarbitone had been prescribed. It is most unlikely that the plaintiff's mother would orally be able to provide the name of the drug. I say this having seen Mrs Kgosiemang in the witness stand and because counsel and I wrestled with the pronunciation of Phenobarbitone.

[133] I find it highly probable that the name of the drug "Phenobarbitone" appeared in writing on the transfer note from the Clinic, or on a container, pouch or envelope containing Phenobarbitone. The Phenobarbitone, if prescribed by Dr Theart, would have been dispensed by the Thusong Hospital Dispensary. The prescriptions for the period have not been discovered. No explanation has been proffered for this failure or the failure to discover other documentation which must have existed at one time or another.

[134] Phenotone is administered intravenously and its name would probably not have been disclosed to plaintiff or her mother. A stock is kept in a locked cabinet at the Clinic and is administered in emergencies by, *inter alia*, the sisters on duty. It is not probable that the name of this drug appeared in the transfer note.

[135] I have difficulty in accepting Mrs Kgosiemang's evidence that the drug was dispensed the same day. But all this happened a long time ago and memories fade. There is no evidence that there was a sub-pharmacy at the

Clinic but drugs were delivered there. The sisters were inconsistent about what drugs were kept at the Clinic.

[136] I may add that there is some substance in Mr Senatle's criticism of Mrs Kgosiemang's evidence but most of this, as regards this date, can be attributed to the length of time that has passed as well as to the fact that some matters were more important to her than others and some events were closer in proximity to the appearance of the side effects than others. She made no notes and her evidence would therefore not be as accurate as those of some other witnesses who have records and notes to assist them.

[137] I conclude that Dr Theart prescribed a month's supply of Phenobarbitone, 30 mg per day, for the plaintiff and that this drug was dispensed wholly or in part to plaintiff and that she ingested at least some of the medication.

Was Phenobarbitone indicated for the plaintiff's condition ie was the plaintiff epileptic?

[138] The medical evidence is beyond question that Phenobarbitone should only be prescribed for epilepsy which has been properly diagnosed. The following summary of the evidence of Dr Botha describes how and on what basis a diagnosis may be made:

(a) To prescribe Phenobarbitone for the possibility of epilepsy in a child requires a very strong index of suspicion that this was epilepsy, and even more than a strong level of suspicion, and some evidence. The way to prove it would be with a clear history of epileptic seizures. Is there a history that the child had seizures, or fits? This information would be

extracted from the patient or from the family or other persons that have witnessed such an attack. A description of exactly what the attack consisted of. Were there features of shaking and convulsing that would be compatible with the diagnosis of epilepsy? Was there was a loss of consciousness or fitting or convulsing? And then the diagnosis should be confirmed by an Electrencephalogram (EEC) showing the typical features of epileptic seizures.

(b) There are different sub-forms of epilepsy. The main forms are Grand Mal seizures which are the major attacks where the whole person convulses or their body contracts. And then, in children, there is a different form which is also known as Petit Mal, or what is called small attacks. It is also referred to as Absence Attacks, or Absence Epilepsy where the child just has a momentarily period of absence. He just does not focus and he just disappears and he is not connected for a short period. And if one looks at these records, maybe that could have been a consideration. Dr Botha is not sure.

(c) The Petit Mal or Absence Epilepsy form is not less severe; it is just a different form of epilepsy. Phenobarbitone would not be appropriate medication for that. Phenobarbitone is traditionally associated and used in what is known as the Grand Mal, the major attacks. But again it could be depending on where one practices and the availability of other drugs. Dr Botha believes that say in rural areas and rural clinics, Phenobarbitone is still widely used and still readily available. So it would be appropriate medication for established epilepsy.

[139] Mrs Kgosiemang says that the plaintiff complained only of headaches and dizziness from time to time. The plaintiff had not suffered any fits or convulsions. The plaintiff's limited recollection was essentially to the same effect.

[140] Dr Theart does not have any medical notes available to her. She does not recall the plaintiff nor does she recall the plaintiff's mother. She cannot say that she prescribed Phenobarbitone for the plaintiff or that she did not do so. She explained how she would diagnose epilepsy.

[141] Dr Islam, a principal Medical Officer at the Mafikeng Hospital, who saw the plaintiff in 2003 while he was working with Dr Kekesi in Paediatrics, went through his notes. He found a reference to epilepsy but he was satisfied that plaintiff was not epileptic.

[142] The Mafikeng Hospital records show, and a note confirms, that the plaintiff suffered no seizures during her stay in that hospital (13 April until 2 May 2003).

[143] On the plaintiff's second admission to Thusong Hospital Dr Piyaienes (Name not legible) notes a history of petit mal.

[144] Dr J Musonda prescribed Epilim in July 2003, a drug indicated for petit mal epilepsy. She too has no notes available to her.

[145] Dr Botha, a specialist physician, testified that the direct cause the Stevens-Johnson syndrome was the unwise prescription of Phenobarbitone for symptoms that did not resemble epilepsy.

[146] In a joint report Dr Botha and Dr Promnitz concur on, inter alia, the following points:

- The patient developed Toxic Epidermal Necrolysis because of receiving epileptic medication, Phenobarbitone or Epanutin. This skin reaction is an allergic reaction to this medication and is one of the most severe dermatological complications seen.
- There was no indication for her to have received the above medication because she does not suffer from epilepsy or any other condition that would require the use of the above medication.

[147] Dr Botha, however, said in his oral evidence that the record showed that the plaintiff had momentary absences which could be a symptom of epilepsy.

[148] Dr Flemming, a neurologist, testified that Phenobarbitone is appropriate for epilepsy. He prescribes it when indicated for his patients. He does not advise his patients of the possible rare reaction.

[149] Dr Flemming conducted the first EEC which the plaintiff had on 26 October 2011. He was surprised to find that the plaintiff showed some epileptiform. This alone is not sufficient for him to find that she suffered from epilepsy. It may, however, confirm other evidence of epilepsy.

Submissions on behalf of the plaintiff

[150] Mr Pistor SC, who appeared on behalf of the plaintiff, submitted the plaintiff was not epileptic and that Phenobarbitone should not have been prescribed. In developing this he submitted:

(a) The fact that the medical staff at the Clinic was fully aware of the risks attached to a prescription for Phenobarbitone, is clear from the defendant's own plea in, inter alia, paragraph 2.4. This paragraph reads as follows:

"No Bodibe health personnel would have prescribed Phenobarb to a child of the Plaintiff's age except if the Plaintiff suffered from epilepsy".

(b) Dr Theart's evidence makes it clear that she would have prescribed Phenobarbitone only in cases of epilepsy.

(c) With reference to the internet description of Phenobarbitone (by MIMS) Dr Botha testified that Phenobarbitone should only be prescribed in clear cases of epilepsy.

(d) None of the experts really contradicted the approach of Dr Botha.

(e) Phenobarbitone was prescribed to the plaintiff whilst it must have been foreseeable to the medical staff that the drug could cause harm to the plaintiff and in particular that it could cause SJS or TEN.

(f) The medical evidence is that Phenobarbitone should only be given to a patient after it has been clearly established:

(i) that the patient has epilepsy; and

(ii) that the epilepsy is of a more serious type (Grand Mal).

(g) There is no evidence at all that the plaintiff had epilepsy in whatever form.

(h) The records of the Mafikeng Hospital state that "no convulsions were noted" during the plaintiff's stay in that Hospital.

(i) Dr Flemming's evidence that he conducted an EEG some eight years after the plaintiff had taken Phenobarbitone and found some support of a diagnosis that the plaintiff could have had epilepsy, cannot be accepted as indicating that the plaintiff had epilepsy at the relevant time.

(j) Furthermore, the plaintiff's condition did not require a prescription of Phenobarbitone for the duration of a period of 30 days. Dr Botha in this regard testified that it looks like an attempt to start chronic medication or

maintenance medication of some sort and that the plaintiff was "put on chronic maintenance epileptic treatment".

(k) In the premises the prescription of Phenobarbitone for the plaintiff was grossly negligent alternatively negligent.

Evaluation

[151] Epilepsy is diagnosed by observation eg convulsions in the presence of the physician, by having a good case history of the symptoms of epilepsy eg convulsions, momentary absence, and, if possible, confirmation by studying an EEC of the patient's brain activity.

[152] The opinion of Dr Botha and Dr Promintz are based on the medical records which were made available to them. I assume that these records are records which were filed at the commencement of the trial. It is common cause that the records are incomplete and that there are no record of Dr Theart's examination of the plaintiff at the Clinic.

[153] The absence of medical records at the Clinic therefore does not mean that Dr Theart was not satisfied that the patient suffered from epilepsy. However, Dr Theart cannot confirm that the plaintiff did suffer from epilepsy. The long time lapse, absence of records and number of patients seen in this period accounts for this.

[154] However, Dr Theart had already had 10 years' experience in private practice by the time she saw the plaintiff. Dr Theart says that she would not have prescribed Phenobarbitone, which she does not recall doing, without good evidence of a history of epilepsy. Phenobarbitone was one of the anti-

convulsion mediation available in the provincial health service. No neurologist or EEC apparatus was available in Lichtenburg or Mafikeng.

[155] There is no evidence which causes me to doubt that Dr Theart would not have acted as she says she would have done or to doubt her competency. The plaintiff's mother confirms that Dr Theart conducted a physical examination on her daughter.

[156] There is no evidence that Dr Theart spoke to the plaintiff or her mother. Dr Theart would use a Sister as an interpreter if she could not communicate with her patients. I mention this because of the strange conflicting evidence about the plaintiff's mother's ability to converse in Afrikaans.

[157] There is some evidence which probably would support a finding that the plaintiff, at some time prior to her examination by Dr Flemming suffered some illness resembling epilepsy. The results of the EEG conducted by Dr Flemming reveal that the plaintiff's brain showed signs of an epileptic form. This alone is not sufficient for him to find that she suffered from epilepsy. All the neurologists were agreed that there must also be good evidence or a good history of convulsions.

[158] There is no evidence that the epileptiform was present when Dr Theart examined the plaintiff some 8 years earlier. Nor can it be said that it was not present. In view of the onus resting upon the plaintiff to prove negligence she bears the burden of showing that the epileptiform was not present in March 2003. She has not shown this to be the case.

[159] There is a note by Dr Dr Piyaienes, who was not called as a witness, on the medical case sheet of 14 May 2003 that the "p/h f petit mal

convulsions". I cannot take this into account. Dr Krug a paediatrician, who was not called, also made a note of convulsions for six months. But this too may have been an inference from the prescription of Phenobarbitone. The note constitutes hearsay I cannot rely on it. But it is probable that the note was made while Dr J Musonda was present and in attendance.

[160] I find that it would not have been negligent for Dr Theart to have concluded in March 2003 that the plaintiff suffered from some form of epilepsy and that anti-convulsant medication was indicated.

Prescribing Phenobarbitone

[161] The plaintiff's case was not constructed on a failure to advise the plaintiff or her mother about the side effects of Phenobarbitone.

[162] I note that the state hospital system utilises the drug **Phenobarbitone**. The drug is also used in private practice. There were also other anti-convulsants available in state hospital pharmacies. Dr Flemming prescribes the drug but does not advise his patients of the possible side effects. Dr Carman prescribes a drug which can cause SJS to her patients. She does not advise them of the side effects but advises them to consult her should they experience side effects. I would have found that the very rareness of the occurrence of SJS, in spite of its extremely serious manifestation, does not require the treating medical practitioner to disclose this side effect to patients.

Was the plaintiff's condition treated negligently?

[163] It is convenient to set out Mr Pistor SC submissions that the defendant is liable for damages suffered by the plaintiff by virtue of the negligence of the relevant members of the Hospitals.

[164] Mr Pistor SC submitted that:

(a) The overwhelmingly strong evidence indicates that in the vast majority of cases, SJS and TEN affect the eyes in one or other form.
(b) The evidence shows that it is necessary to enlist the services or at least to obtain the advice of an eye specialist right from the onset of SJS. Dr. Willemse explained this in detail. Dr. Kunzman tried to justify the actions of the doctors at Mafikeng Hospital but his evidence in this regard does not have the required logical approach. His evidence must be considered in the light of the fact that he was referring to the "acute phase". This criticism is also applicable to the "wait and see" approach of Prof McLaren.
(c) The plaintiff had already been diagnosed with SJS by the time of her transfer to the Mafikeng Hospital on 13 April 2003.
(d) Dr Willemse described the effect, the treatment of treatment of SJS and indicated how SJS initially starts as an apparently innocent condition with limited effect on the eyes and how devastating the consequences can be if not identified early and treated properly from the start.
(e) The medical staff at the Mafikeng hospital should therefore have been on the lookout also for complications to the eyes. The view of some of the experts (Prof McLaren) seems to be to treat a patient conservatively and to wait and see what happens does not satisfy the legal requirements.

(f) Dr. Willemse on the other hand suggested that active treatment (with, inter alia, a glass rod) could have avoided at least some of the consequences of SJS that the plaintiff had experienced. Her evidence represents a practical and logical approach to the matter that satisfies legal requirements. Dr Willemse is supported by Sister Molusi who testified that by the time that she saw the plaintiff it was too late to treat the plaintiff with a glass rod. Dr Kunzmann also agreed that eye swabbing would have reduced the formation of symblepharon. He also agreed that in the case of SJS an eye specialist should be contacted.

(g) According to Dr Botha it is "almost universal that the eyes are affected" by SJS. Dr Willemse testified that the eyes are affected in 70% of SJS cases. Bearing this in mind, the staff at the Mafikeng Hospital were clearly negligent in their treatment of the plaintiff because:

- There was an eye clinic there yet the plaintiff was not referred to that clinic.
- An eye specialist could have been contacted telephonically for advice. This was not done. Instead the relevant doctors relied on their own expertise. The evidence of Dr Rauf and the other practitioners in the Mafikeng Hospital justifies only one inference namely that they have under estimated the seriousness of the plaintiff's condition.
- On discharge of the plaintiff on 2 May 2003 no program was put in place to ensure proper monitoring of the plaintiff's condition. This was a requirement on the evidence of even Prof McLaren.
- The entry in the Hospital records on the date of the plaintiff's discharge "to come back if any signs/symptoms of illness (seizures)", relates to seizures and not to plaintiff's eyes.

- The note on the discharge summary "Review own hospital ophthalmology. Review to exclude corneal ulcers" was meaningless and without any effect since there was no ophthalmologist at the Thusong Hospital. More importantly the plaintiff had been in the Mafikeng Hospital for almost three weeks and the doctors, during that period, did not deem it necessary to refer her to an ophthalmologist. The decision to do so on her discharge is merely pays lip service to the doctors' responsibilities.
- Dr. Willemse testified that corneal ulcers had indeed been formed. Dr. Kunzmann also assumed that on 13, 14 and 15 May 2003 the plaintiff might have contracted a corneal ulcer in which event she needed urgent admission and hourly antibiotics in the eye. With regard to this aspect Prof McLaren testified that such ulcers "do not last long without causing serious damage." Dr Willemse described the eyes as a "disaster" and she stated that even if the vision was normal, proper examination and treatment still had to take place.
- The later negative effects of SJS are important in view of the fact that Dr Kekesi foresaw further negative developments in respect of the eyes since she advised the plaintiff to contact an ophthalmologist.
- Dr Kekesi herself testified that the plaintiff needed to be examined by an eye specialist. Dr Carman also testified that an ophthalmologist should have been involved or contacted.

[165] Objectively speaking it is therefore clear that plaintiff's discharge from Mafikeng Hospital was premature more particularly since there was no monitoring system or program put in place. This conclusion is supported by:

(a) The evidence of plaintiff's mother who testified that at the time of plaintiff's discharge from Mafikeng Hospital there was a discharge from plaintiff's eyes and blood from her mouth. Dr Kunzmann was of the view that the discharge in the plaintiff's eye after her discharge from the Mafikeng Hospital was a sequel of the SJS.

(b) The fact that a day or two after her discharge the plaintiff was sent home from school because of her condition.

(c) The latter situation occurred whilst the plaintiff was using the eye ointment given to her by the doctors.

(d) Some eleven days after her discharge the plaintiff was back in the Thusong Hospital in a seriously ill condition and in pain.

(e) Dr Kekesi herself testified that the medical staff were not ready to discharge the plaintiff but that they have consented to do so because her mother request her discharge (which averment the mother denies).

(f) According to Dr Willemse the patient must have had the symptoms that she had presented with on 13 May 2003 already at the day of her discharge, 2 May 2003.

Evaluation

A short answer

[166] There is a longer and a short answer to the complaint about the hospital treatment of the plaintiff. Both lead to the same result. The short answer is that SJS cannot be cured and or prevented. It must run its course and then an attempt must be made to repair the damage caused by this calamitous disease. There is no evidence that any act or omission in the course of treating the plaintiff caused the damage or increased the damage only that the treatment

as from 16 May 2003 caused the plaintiff to suffer pain and discomfort unnecessarily.

The longer answer

[167] What follows is the long answer. This part of the inquiry is primarily directed at whether the treatment of the plaintiff or any omission constitutes negligence on the part of the hospital staff involved and also concerns causation.

Referral by Clinic to Thusong Hospital (first admission)

[168] The medical staff at Bodibe Clinic acted promptly and correctly according to the information at their disposal by referring and transferring the plaintiff to the Thusong Hospital.

Thusong Hospital (first admission)

[169] The medical staff at Thusong Hospital also acted professionally by diagnosing the plaintiff and referring her and quickly transferring her to the Mafikeng Hospital which has better facilities than Thusong Hospital.

[170] The referral note set out, inter alia, a diagnosis of SJS.

[171] There can be no complaint about the plaintiff's treatment at Thusong Hospital on her first admission there.

Treatment at Mafikeng Hospital (also known as Bophelong Hospital)

An undue delay in diagnosing SJS?

[173] The plaintiff was admitted to Mafikeng Hospital on 13 April 2003 and discharged on 2 May 2003. When the plaintiff arrived at the Mafikeng Hospital she was accompanied by a referral note which stated that the treating doctors at Thusong hospital were of the opinion that she was suffering from SJS. There is no evidence that this diagnosis was disputed and I am satisfied that the plaintiff was treated at the Mafikeng Hospital as suffering from SJS. I do not know on what basis it is alleged that there was an undue delay in diagnosing SJS but the evidence is overwhelming that there was no such delay.

[174] I am satisfied that, the plaintiff was correctly diagnosed as suffering from SJS. Because the disease was a life threatening one, the ICU unit placed the emphasis on preserving the life of the plaintiff. I accept Dr Rauf's evidence as regards this aspect.

[175] Counsel for the plaintiff did not, in his closing argument, submit that the medical staff were negligent in not invoking the assistance of a dermatologist or gynaecologist while the plaintiff was hospitalised in the Mafikeng Hospital. Dr Carman did not think that the treatment was at all inappropriate. I did not understand Dr Kgokolo to have any serious complaints about the sufficiency of the actual treatment of the plaintiff. I accept that it was not essential for Dr Kekesi to have called in the assistance of a dermatologist while the plaintiff was under her care. I accept the evidence of Dr Carman which is to the same effect. I find that the medical staff did not act negligently as far as this is concerned. I make the same finding as regards the non-intervention of a gynaecologist.

[176] I am satisfied on the basis of the opinions of Prof McLaren, Dr Kunzmann, Dr Kekesi, Dr Rauf and Dr Islam that the treatment which was administered in the hospital was appropriate for her condition. Dr Kekesi was alive to the problem that the eyes were affected and could have serious consequences. The eyes were treated appropriately with antibiotic and other ointment.

[177] Dr Keksesi was aware that after the acute stage had passed the eyes were still vulnerable. On the discharge of the plaintiff from that hospital she directed the plaintiff and her mother, in the discharge summary, to refer back to the ophthalmology section of the referring hospital eg Thusong Hospital. I find that the explanation for the discrepancy between copies to be on account of the use or misplaced use of carbon paper.

[178] Dr Kunzmann says that it would have been advisable to call in or to refer the plaintiff to the eye clinic at the Mafikeng Hospital. This was not done. But the plaintiff was still in the acute stage and a referral to the clinic at this stage does not seem to have been indicated.

[179] I accept the evidence of Dr Willemse that swabbing the eyes with a glass rod would have assisted as regards symblepharon. Dr Kunzmann does not challenge this except to say that in the end the result would be the same. Prof McLaren, however, prefers to take a conservative approach. But Dr Willemse's suggested treatment must be weighed up against the condition of the plaintiff while she was at the Mafikeng Hospital and the imperative to concentrate on saving her life and as against the possibility that the use of a glass rod may have aided an infection in the eyes.

[180] The insistence that an ophthalmologist be consulted is clearly a good one. But in the acute stage, Dr Kekesi was able to do what was medically necessary for the proper treatment of the plaintiff's condition bearing in mind that:

(a) SJS is an idiosyncratic disease;

(b) The course of the disease as regards eyes cannot be prevented.

[181] It would constitute negligence on the part of Dr Kekesi if she did not, as regards the eyes, display the same skills and insight which an ophthalmologist would have done. The criticism levelled against Dr Kekesi that she should have consulted an ophthalmologist has little value unless it is shown that such a specialist would have prevented the damage to the eyes or have minimized the damage or have prepared the condition for rehabilitation or spared the plaintiff pain and suffering. The onus of showing this rests upon the plaintiff.

[182] This brings me to the crucial question. What would an ophthalmologist have done differently in the acute stage which ended about 2 May 2003?

[183] The most that can be said is that the formation of the plaintiff's symblepharon might have been reduced by eye swabbing. There is no evidence that the plaintiff would not have developed symblepharon thereafter had the plaintiff's eyes been swabbed. On the other hand the suggested eye swabbing may have lead to infection in the eye. I find that the medical staff at Mafikeng Hospital concentrated on the life threatening possibility of SJS without neglecting to treat the plaintiff's eyes.

Discharge from the Mafikeng Hospital

[184] Both Dr Kunzmann and Dr Carman were of the opinion that the plaintiff was not prematurely discharged from the Mafikeng Hospital on 2 May 2003. I prefer to accept for reason outlined elsewhere in this judgment the evidence of Dr Kekesi and Dr Islam concerning the condition of the plaintiff on her discharge to that of Mrs Kgosiemang.

Appropriate referral to Ophthalmologist

[185] The question to be answered in the present case is whether a reasonable paediatrician in a public hospital would have foreseen that failure to refer the plaintiff to an ophthalmologist will lead to the damages suffered by the plaintiff taking into account the following circumstances:

(i) that the plaintiff suffered from SJS;
(ii) that in 70-90% cases of SJS an ophthalmological complications are involved;
(iii) that the plaintiff was a child patient who was responding very well to treatment and had not exhibited any problems with her eyes and had not mentioned any problems regarding her eyes;
(iv) that the patient had a condition which was very difficult to manage; and
(v) that the mother requested that the plaintiff be discharged.

[186] Dr Kekesi's evidence is that she was aware of the condition SJS and she could have and would have consulted and involved an ophthalmologist or other specialist if the plaintiff developed complications which she could not treat. I accept this and I find that complications did not develop while the plaintiff was treated in the Mafikeng Hospital.

[187] Dr Kekesi was aware that at the discharge of the plaintiff, when the acute phase of SJS was ending, that she was vulnerable to certain sequelae which might affect or have affected the eyes. Dr Kekesi envisaged the referral of the plaintiff to an ophthalmologist by following the normal channels. This is why she required Mrs Kgosiemang to take the plaintiff and the discharge summary to the ophthalmology department at the Thusong Hospital for an examination of the plaintiff's eyes for corneal ulcers.

[188] I have considered whether this is sufficient in the light of the fact that 70 – 90% of the cases involving SJS affect the eyes and whether Dr Kekesi or another member of staff should have ensured a direct referral to an ophthalmologist.

[189] The discharge summary did not refer the plaintiff to an ophthalmologist. It referred her to the ophthalmology department of the referring hospital ie Thusong Hospital. Dr Kekesi knew that as there was no ophthalmologist at this hospital. I can safely assume that, if there was no slit lamp at the Mafikeng Hospital, that there would not be one at Thusong Hospital. An ophthalmoscope was available to the staff at both hospitals.

[190] On 2 May 2003 the plaintiff was discharged from the care of Dr Kekesi in circumstances where it was probable that SJS, which had run its course, had damaged the eyes and the sequelae needed to be identified and, if present, be treated by an ophthalmologist. Instead the plaintiff was referred to an eye nurse who certainly has skills but an eye nurse is not a specialist.

[191] It may have been prudent for the Mafikeng Hospital to have referred the plaintiff to an ophthalmologist. This is particularly so in hindsight

but this insight must not influence the question whether the omission was unreasonable or negligent. Was it negligent not to have done so?

[192] Dr Willemse insisted that it be done from the outset. I have not accepted this standard. It is too high where a patient is treated by a paediatrician who is aware of the nature of SJS. Of all the experts I prefer the evidence of Prof McLaren. However, I am faced with the situation that he was misled (as were others including myself) at the trial about the date that the appointment for the plaintiff to see an ophthalmologist was made. He had the advantage of seeing the plaintiff in August 2003 and seeing the initial consequences of the SJS.

[193] Neither Prof McLaren nor Dr Kunzmann thought such a referral was essential. Prof McLaren expressed confidence in the training and ability of an eye nurse as the first port of call. Dr Kunzmann is not so confident about the competency of an eye nurse. He doubts whether an eye nurse is able to judge that a case is urgent sufficiently or to convey the urgency correctly to the ophthalmologist. Prof McLaren's views should prevail. St John's Hospital trains eye nurse.

[194] Was Dr Kekesi at fault in following the established system of referring patients, and in particular one with SJS, to an eye nurse who would not necessarily act as a conduit to facilitate a referral to an ophthalmologist. But who may act as a sort of gate keeper; treating those she can and distinguishing between cases for urgent and ordinary referral to a specialist. The eye nurse may not always act autonomously but be subordinate to the instructions of other generalist medical doctors. Furthermore the decision about whether a case was urgent or not would be made a by nurse at the specialist's centre.

[195] I am doubtful whether it was negligent for Dr Kekesi or her staff to employ the method of referral that she did. I will deal at a later stage with the actions of Mrs Kgosiemang. What is persuasive is the answer to the question what was the consequence of this omission ie what loss was caused? What would an ophthalmologist have done which would have curbed the disastrous sequelae? The ophthalmologist would have been equipped with a slit lamp. The eye nurse was not equipped with one. This instrument would have enable the observer to see the condition of the eye which could not been seen with any less sophisticated device. But if both eyes were open the eye nurse could have diagnose corneal ulcer if they were present at that stage ie days after the discharge of the plaintiff.

Plaintiff's failure to attend eye clinic with discharge summary

[196] The plaintiff's mother testified that she was not given the discharge note which required the plaintiff to attend at the Thusong Hospital eye clinic. She was also not orally told to do so.

Evaluation

[197] I have said I prefer the testimony of Dr Kekesi and Dr Islam to that of the plaintiff's mother on this aspect. There are features of Mrs Kgosiemang's evidence which are problematic and disturbing. The Sisters at the Bodibe Clinic, Sister van Wyk, Dr Theart, Dr Kekesi, Dr Islam, Dr Flemming, Prof McLaren have all been said to have done something, according to Mrs Kgosiemang which they deny. There is no evidence to suggest that such a wide range of persons, who would not be in contact with each other, would conspire against the plaintiff or her mother or even that so many persons could be mistaken. It is not probable and its improbability leads me to be cautious about

Mrs Kgosiemang's evidence to the extent that I disbelieve her on certain aspects.

[198] There is a mention in the notes relating to the second admission of the plaintiff at Thusong Hospital of a "letter from Bophelong". Mrs Kgosiemang or her daughter, are the probable sources of this information. The fact that the discharge summary is described as a "letter", points to a communication by a layperson; either plaintiff or her mother but more probably her mother.

[199] I find that Mrs Kgosiemang received the note and that she was aware that she must take the plaintiff to the eye clinic at Thusong Hospital and that she did not comply with the instruction. She finds it expedient to deny that she was given the summary and that she was informed of her obligation to take the plaintiff to the eye clinic at the Thusong Hospital.

[200] It is not difficult to predict what would have happened had the plaintiff presented herself at the Thusong eye clinic within days of her discharge. It is probable that there may not have been signs of symblepharon and that no corneal ulcer would have been observed. But later the symptoms, which have been recorded, would have manifested themselves and caused further medical assistance to be sought. I am inclined to the view that the eye nurse would not, had she seen the plaintiff as early as postulated, have referred the plaintiff to an ophthalmologist. But, on the other hand, had the discharge certificate been presented to her she may well have viewed SJS as serious enough to have taken the precautionary step of referring the plaintiff to an ophthalmologist even in the absence of visible complications. At least she would have been able to examine both eyes and decide whether there was a corneal ulcer present. She would also have informed the plaintiff and her

mother of the complications of SJS and have invited them to return should any complication develop.

A continuation of SJS or a fresh episode?

[201] Was the SJS with which the plaintiff presented at Thusong Hospital on her second admission a continuation of her SJS or a fresh or new episode? If it was a new episode ie freshly caused, it may have been a *novus actus interveniens* breaking the link of causation and liability. So too the plaintiff's mother did not take the plaintiff to the eye clinic at Thusong Hospital in accordance with the directions recorded in the discharge summary. But even if the SJS was a fresh bout it is not relevant. Even the failure to follow instructions is unfortunate but they do not affect the issue because of my finding that the medical staff of the Mafikeng Hospital were not negligent.

[202] In any event I do not accept Dr Flemming's suggestion that the plaintiff was suffering from a Herpes infection as the infection was of a bilateral nature. This is indicative of SJS. No other expert shared Dr Flemming's opinion. Dr Kekesi thought that it was a spontaneous reoccurrence of SJS. Although Dr Kekesi is undoubtedly an expert in her field she had not been qualified as an expert for the purpose of opinion evidence. I accept that the symptoms which manifested themselves were a continuation of the SJS with which the plaintiff had been admitted. It is likely that application of the medicine, which was given on discharge, was not administered as strictly as would have been the case had the plaintiff remained in hospital. The symblepharon was an unfortunate development of the disease.

Period 2 May to 24 June 2003

Bodibe Clinic

[203] It is known that after her discharge plaintiff attended school but was sent home. The plaintiff suffered from sore eyes and had sores on her mouth. The plaintiff did not consult the eye clinic at Thusong Hospital as directed by Dr Kekesi and Dr Islam. The plaintiff attended the Bodibe Clinic on 13 May 2003 and was transferred to the Thusong Hospital (the second admission).

[204] I find that there was no negligence on the part of the staff of the Bodibe Clinic.

Treatment at Thusong Hospital (second admission)

[205] When the plaintiff was admitted to the Thusong Hospital on 13 May 2003 she was in the following condition: She had severe photophobia of the left eye. She had severe lip ulceration. She had dermatitis patches on the abdomen. This was recorded by. Dr Piyaienes on the medical case sheet of 14 May 2003.

Plaintiff's submissions

[206] Mr Pistor SC submitted that the relevant medical personnel at the Thusong Hospital failed to properly manage the plaintiff's condition and that they were grossly negligent in this regard because:

(a) When the plaintiff was admitted to the Thusong Hospital on the second occasion (13 May 2003) she was clearly ill and in pain.

(b) Sister Molusi's description of the plaintiff's condition on 15 May 2003 paints a picture of a patient who had serious eye problems with symblepharon, conjunctivitis and photophobia.

(c) With regard to the entry in the records of that hospital, Dr Willemse testified that it should have been very alarming to the doctor to have seen SJS on the document and the patient with a photophobic left eye. This condition needed to be examined by an eye-specialist and needed eye swabbing daily.

(d) The evidence makes it clear that symblepharon takes a long time to heal. Yet, the very next day (16 May 2003) Dr J Musonda sent the plaintiff home with a recommendation that the plaintiff should re-visit the hospital on 23 May 2003.

(e) Dr J Musonda's evidence is a clear revelation of the fact that she was fully aware of the pain and discomfort of the plaintiff on 13 to 16 May 2003 and again on 23 May 2003. She, on her own evidence, did not know how to treat the patient. There was, on her own evidence, nothing preventing her from contacting an eye specialist for help. In this regard Dr Kunzmann supported the evidence of Dr Willemse to the effect that the appropriate literature would have warned the relevant doctors of the possibility of eye complications in the case of SJS and that they could have at all relevant times phoned for help. Yet, Dr J Musonda did not seek help and did not even liaise with Sister Molusi (the only sister trained in the treatment of eyes in that hospital). On the contrary Dr J Musonda sent the plaintiff home with pain killers. Dr. Kunzmann also expressed the opinion that the plaintiff was discharged from Thusong Hospital without proper medication. This was also the view of Prof McLaren. Dr Kunzmann further testified that he would have on that

occasion referred the plaintiff to an eye specialist within hours, although Prof McLaren was not prepared to say "within hours". He also said that he would have referred the plaintiff to a specialist within a day. The delay in treating the plaintiff properly caused an extension of her pain and discomfort.

(f) When the plaintiff again reported to Dr J Musonda some 7 days later (on 23 May 2003) the doctor noted that the plaintiff was still complaining of "painful left eye" and that the plaintiff was unable to attend school due to pain. Yet Dr Musonda again discharged the plaintiff stating that she could attend clinic visits. To aggravate matters, Dr J Musonda subsequently (10 July 2003) prescribed Epilim to the plaintiff. In respect of Epilim Prof McLaren was of the view that it can precipitate SJS. Dr J Musonda also conceded that she would now treat a patient like the plaintiff in a different way.

(g) Sister Molusi testified that she could not properly assess the plaintiff's condition and that the plaintiff had to be seen by an eye specialist. However, she did not make the arrangements because (so she testified) she believed that the plaintiff had been examined by an eye specialist at the Mafikeng Hospital.

(h) Both Dr Kunzmann and Prof McLaren were of the view that the plaintiff should at this stage have been referred as a matter of urgency to an eye specialist. However, this was not done. Instead an appointment for the plaintiff was not requested for Klerksdorp until 11 June 2003. The examination was for 24 June 2003.

(i) The plaintiff therefore saw an eye specialist for the first time in respect of her eyes in about June 2003 which is some 2 months after she had been diagnosed with SJS being a condition which in the majority of cases affects the eyes and requires the attention of an eye specialist from the onset of the condition.

(j) To suggest (as Prof McLaren has suggested) that the delay had no effect on the end result is not in line with legal requirements and in particular with a logical approach that the law requires.

(k) Even if the plaintiff would still have to undergo operations and treatment irrespective of the delay, the delay in her treatment clearly caused unnecessary extension of the duration of her pain, suffering and discomfort which could and on probabilities would have been avoided (alternatively reduced) had it not been for such delay.

Defendant's submission

[207] The following are the submissions of Mr Senatle which relate to the post discharge period:

(a) Dr Kunzmann agreed with Dr Willemse, although insignificant and irrelevant, that the plaintiff should have been referred to an ophthalmologist within hours on 15 May 2003.

(b) Prof McLaren's testimony corroborated the evidence of Dr Kunzmann. The professor has also corroborated the evidence given by Dr J Musonda and Sister Molusi. According to the professor both Dr J Musonda and Sister Molusi did their best and they gave the plaintiff the necessary medication.

(c) Prof McLaren confirmed that there was no delay either at Thusong or Mafikeng Hospitals. According to the professor the more the delay the better for this type of condition.

(d) There was no urgent need to refer the plaintiff to an ophthalmologist. According to him wherever there is symblepharon ophthalmologists will either tend not to interfere or to interfere as little as possible until the symptoms are clear. If one intervenes too soon the response to the surgery

would be traumatic. He further said that one can make things worse rather than better. They will tend to delay with surgical intervention until they are forced to do so.

(e) According to the professor all the cells that are responsible for the health of the eye surface have been damaged or destroyed. As a result it is advisable to play a wait and see game. Prof McLaren corroborated Sister Molusi, *inter alia*, that there was no urgent need to involve an ophthalmologist. The professor said that Sister Molusi was more experienced than an average general practitioner.

(f) Prof McLaren commented on the symblepharon condition as at 15 May 2003. He said that the symblepharon does not normally get better. They just stay scarred until one does something surgical about them. Symblepharon is not painful.

(g) Prof McLaren was referred to an article in Wikipedia handed in by one of the plaintiff's expert. The professor said that Wikipedia is not reliable. He commended the work done by, *inter alia*, the paediatricians at both hospitals.

(h) The monitoring programmes at both hospitals were criticized by counsel for the plaintiff. But there were indeed monitoring mechanisms of the plaintiff in place. There was an ongoing treatment in that the plaintiff was required to continue applying the treatment she was given at the hospitals.

(i) Prof McLaren said that this involved the issue of compliance. He questioned whether the plaintiff complied with the instructions given to her after the discharge on 2 May 2003. He said that it was incumbent on anyone with symptoms like those of the plaintiff, to come back sooner rather than delaying until 13 May 2003. He would advise the patient that if there were symptoms of the eyes getting worse then the patient must come back.

(k) Prof McLaren said that all that was done on the plaintiff was in accordance with what an ophthalmologist would have done. The treatment given on 16 and 23 May 2003 at Thusong was extremely adequate. This corroborated the mother's evidence that during the plaintiff's second admission, between 14 and 16 May 2003, the plaintiff's eyes became better. The medical staff were able to stabilise the plaintiff and according to him the treatment was most effective.

(l) Prof McLaren and Dr Kunzmann testified that there is generally a shortage of ophthalmologists. The professor further said that the general treatment afforded to the plaintiff was appropriate and adequate.

(m) The plaintiff has criticised Dr J Musonda for sending the plaintiff home on 16 and 23 May 2003. According to the professor the monitoring mechanisms were put in place to assess the plaintiff's conditions on these dates. Further, the professor has indicated that there was nothing wrong in that there was on-going treatment.

(n) Dr Kunzmann as well as Prof. McLaren confirmed that there was nothing which could have been done either on the 15, 16 or 23 of May 2003 in that an appointment was already made at Klerksdorp eye clinic to see the plaintiff. They further indicated that as long as the necessary medication was given to the plaintiff there was no hurry because the only thing to be done was surgery, but surgery could not be done on urgent basis.

[208] In terms of the section (1)(1)(a) of the Apportionment of Damages 34 of 1956 Act:

> "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 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."

[209] It was submitted that should this court rule that the defendant was negligent the mother and/or the plaintiff herself was contributory negligent. The plaintiff was returned from school a day after her discharge on 2 May 2003 due to pain, but failed to return to the hospital or her mother failed to take her back there. The plaintiff and her mother were advised to take the plaintiff to the ophthalmology clinic but did not do so. The plaintiff was given a chronic medication, Epilim, but failed to heed the instructions.

Evaluation

[210] The expert witnesses who testified after Dr J Musonda namely Dr Carman, Dr Kunzmann and Prof McLaren, were examined and cross examined on a set of facts about which Dr J Musonda had testified.

[211] In their viva voce evidence Prof McLaren and Dr Kunzmann testified that the plaintiff should have been referred to an ophthalmologist when she was transferred to Thusong Hospital (the second admission). They differed as to whether it should have been immediately or after a day or two.

[212] Dr J Musonda has seriously erred in stating that that on or about 15 May an appointment was made for the plaintiff to see an Ophthalmologist at Klerksdorp on 11 June 2003. Although Dr J Musonda says she sent the plaintiff home on 23 May to wait for her appointment with an ophthalmologist at Klerksdorp. This appointment had not yet been made. It was only requested on 11 June when Sister Molusi saw the plaintiff at Bodibe Clinic.

[213] The result of this error by Dr J Musonda is that it misled counsel and this court and in consequence the expert witness who testified after Dr J Musonda. The evidence of these experts must be approached with care as regards their evaluation of Dr J Musonda's actions concerning her involvement with the plaintiff as from the second admission at Thusong up to and including the consultation on 23 May 2003. These experts testified on the basis that on 15 May 2003 an appointment had been secured for the plaintiff to see an ophthalmologist.

[214] An appointment may have been requested on 15 May had Dr J Musonda not discharged the plaintiff before Sister Molusi could attend to making an appointment for the non-urgent eye surgery.

[215] The result is that Dr J Musonda sent the plaintiff away while she had pain in her eyes without diagnosing what was causing the pain. Although she knew about the effect of SJS on the eyes, she did not refer the plaintiff to a specialist or even wait for the eye nurse at Thusong to follow up the matter. She did not contact a specialist for advice notwithstanding that the consultation on 23 May was a follow up consultation. I may add she provided no review plan even for the non-urgent surgery required to deal with the symblepharon.

[216] It is necessary to consider what an ophthalmologist, would have done and to compare it with Dr J Musonda's conduct. According to Dr Kunzmann an ophthalmologist would be able to conduct an examination using a slit lamp which was not available to Dr J Musonda or the eye nurse. The ophthalmologist would have been able to determine whether there was an infection other than a SJS problem eg a bacterial infection of the cornea or corneal ulcer and to treat it appropriately. Dr Kunzmann assumes that there was a corneal ulcer present as SJS patients are more prone to this. Prof McLaren,

who was at a later stage involved in the repair stage, confirms that there was evidence of an ulcer and a sterile perforation of the cornea. Neither Dr Musonda nor Sister Molusi observed this in the eye which was accessible. This emphasises Dr Kunzmann's opinion that at this post acute stage the disease could not be managed by an eye nurse and that a specialist was indicated.

[217] I should mention that there is hearsay evidence provided by Mrs Kgosimang that the delay in referring the plaintiff to the ophthalmologist in Klerksdorp meant that the specialist was unable to operate on the plaintiff's eyes and she was returned from the theatre without any being operated on. The specialist was not called and I cannot rely on this hearsay evidence.

[218] Dr J Musonda showed a lack of compassion in a serious situation. She did not have the knowledge to treat the plaintiff. She did not seek assistance from Dr Kekesi or an ophthalmologist. She did not make an appointment with such a specialist for the child on the second admission or on 23 May. She discharged the plaintiff before the eye nurse could make an appointment which Dr J Musonda knew was necessary to address at least the symblepharon. She did not have the equipment to examine the plaintiff's eyes. She sent the plaintiff to a clinic where fortunately Sister Molusi saw her.

[219] Dr J Musonda was negligent. She failed to prevent unnecessary suffering when she could and should have done so.

Apportionment of damages

[220] It is permissible to argue that the damages should be apportioned without pleading this defence. This defence is only applicable if the plaintiff is a joint wrongdoer. It has not been suggested that this is the position. Clearly she

did not commit a delict. In any event the capacity of the plaintiff to commit a delict was not investigated. The plaintiff would have been about 9 years old at the time and entirely dependent on her mother for guidance and the means to seek medical attention and as regards the intake of medicine and application of ointment. I am unable to find on the evidence presented in this trial that she had the necessary capacity to commit such an act. There is no merit in this defence.

[221] It seems to me that what was intended was a submission, not that the plaintiff was contributory negligent, but that she failed to mitigate her damages. The issue of mitigation of damages belongs properly to the second stage of the trial.

Costs

[222] The plaintiff has succeeded in part. It would not be fair to award her the entire costs of the trial. Taking into account, roughly, the portion of the trial time consumed by the events after the discharge on 2 May 2003, I am inclined to award her 30% of her general costs. But I would award her the entire costs related to the involvement of Dr V Williams and the costs related to the plaintiff's consultation with the defendant's ophthalmologists.

Order

1. The defendant is found to be liable for payment of such damages as relate to the failure of the medical staff at the Thusong Hospital to refer the plaintiff to an ophthalmologist as the plaintiff might be able to prove.

2 The defendant shall pay one third of the plaintiff's taxed or agreed party and party costs of this action up to the moment of this order including one third of the fees of senior counsel on the High Court scale.

3 The reasonable taxable costs of obtaining an expert medico legal report from Dr V Williams which were served on the defendant in terms of Rule 36(9)(a) and (b).

4 The reasonable taxable preparation and reservation fees of Dr V Williams, including consultations with defendant’s ophthalmology experts, Prof McLaren and Dr Kunzmann, and the preparation of a joint minute.

5 The reasonable taxable transportation costs incurred by the plaintiff in attending medico legal consultation with Dr Willemse and defendant’s ophthalmology experts, Prof McLaren and Dr Kunzmann, inclusive of the reasonable travelling and accommodation costs in attending the trial proceedings, subject to the discretion of the Taxing Master;

6 The above costs must be paid into the following trust account:

Mothlabani Attorneys Trust Account
Account number 62125956857
First National Bank
Branch & Code : Batho-Pele, 260849

7 The following provisions will apply with regards to the determination of the aforementioned taxed or agreed costs:

(a) The plaintiff shall serve the Notice of Taxation on the defendant's attorneys of record;

(b) The plaintiff shall allow the defendant 7(SEVEN) court days to make payment of the taxed or agreed costs from date of the settlement or taxation (whichever might be applicable);

(c) Should payment not be effected timeously, the plaintiff will be entitled to recover interest at the rate of 15.5% on the taxed or agreed costs from date of allocator or the date of the agreement (whichever might be applicable) to date of final payment.

8 The plaintiff is declared to have been a necessary witness.

A A LANDMAN

JUDGE OF THE HIGH COURT

APPEARANCES:

DATE OF HEARING	: 21 – 25 MAY 2012
	: 25 – 26 JUNE 2012
	: 27 – 31 AUGUST 2012
	: 01 OCTOBER 2012
	: 03 DECEMBER 2012
DATE OF JUDGMENT	: 14 FEBRUARY 2013
COUNSEL FOR PLAINTIFF	: ADV J H F PISTOR SC
COUNSEL FOR RESPONDENT	: DR S J SENATLE
ATTORNEYS FOR PLAINTIFF	: MOTLHABANI ATTORNEYS
ATTORNEYS FOR RESPONDENT	: STATE ATTORNEY