LEGAL RISKS IN A HIGH-TECH NEONATAL ENVIRONMENT

9TH NATIONAL CONFERENCE AND NEONATAL EXPO
"PURPOSEFUL PASSION" WHAT WE DO TODAY WILL MATTER TOMORROW……

Niki Botes

B Cur I et A, LLB

Failure to follow policies, negligence, not applying evidence and safe practices, and human errors may create legal risks for individuals and institutions.

ICE BREAKER

DEFINITIONS:

RISKS = “the possibility of something bad happening at some time in the future; a situation that could be dangerous or have a bad result.” (oxford dictionary)

Something bad happened → disciplinary hearing / SANC / civil litigation / criminal

Court case relating to civil litigation against one in person/hospital – private or public sector

Civil litigation due to professional medical negligence

* the faulty conduct of a medical practitioner or hospital staff whose conduct was unlawful and or negligent
* the faulty behaviour of the person/s involved lies in the carelessness, unwise or indiscreet behaviour of that Nurse.

- The question asked to establish blame = how a reasonable competent nurse in that specific branch of medicine (NICU) would have acted in the same situation? The answer will depend on the expert medical evidence placed before the court or at a disciplinary hearing.

  The plaintiff has to show on a balance of probabilities that

  - there was negligence
  - he/she (the neonate) has suffered damages
  - damages suffered are causally linked to the nursing staff's negligent conduct

- Test for medical negligence:

- how would a reasonable competent nurse practitioner in the NICU have acted in a similar situation?
- If a reasonable nurse would have foreseen the likelihood of harm, and
- would have taken steps to guard against its occurrence,
- but the nurse whose conduct is under investigation failed to,
- this conduct would fall below the standard of care expected of a nurse in his/her class.

Medical negligence in criminal law

- Culpable homicide
- **Murder**
- Rape
- Indecent assault
- Assault
- Criminal defamation
- Crimen injuria
- **Fraud**

A REPORTER AT LARGE

A BRITISH NURSE WAS FOUND GUILTY OF KILLING SEVEN BABIES. DID SHE DO IT?

Colleagues reportedly called Lucy Letby an "angel of death," and the Prime Minister condemned her. But, in the rush to judgment, serious questions about the evidence were ignored.

By Rachel Aviv

May 13, 2024

SANC

Examples of acts and omissions which are regarded as professional misconduct by the Nursing Council

- Failure to give the required treatment to a patient
- Failure to keep accurate and complete records of all nursing care provided to a patient
- Giving confidential information about a patient to unauthorized persons
- Neglect to or delay in obtaining medical assistance for a patient
- Failure to prevent injury or accident to a patient
- Theft from a patient, or a deceased person)
- Patient assault (physical, sexual or verbal)
- Arson and attempted murder
- Patient left unattended
- Misuse of medication
- Forcing a patient to sign a consent for a surgical procedure

Code of Ethics:

Such ethical principles include, but are not limited to the following:

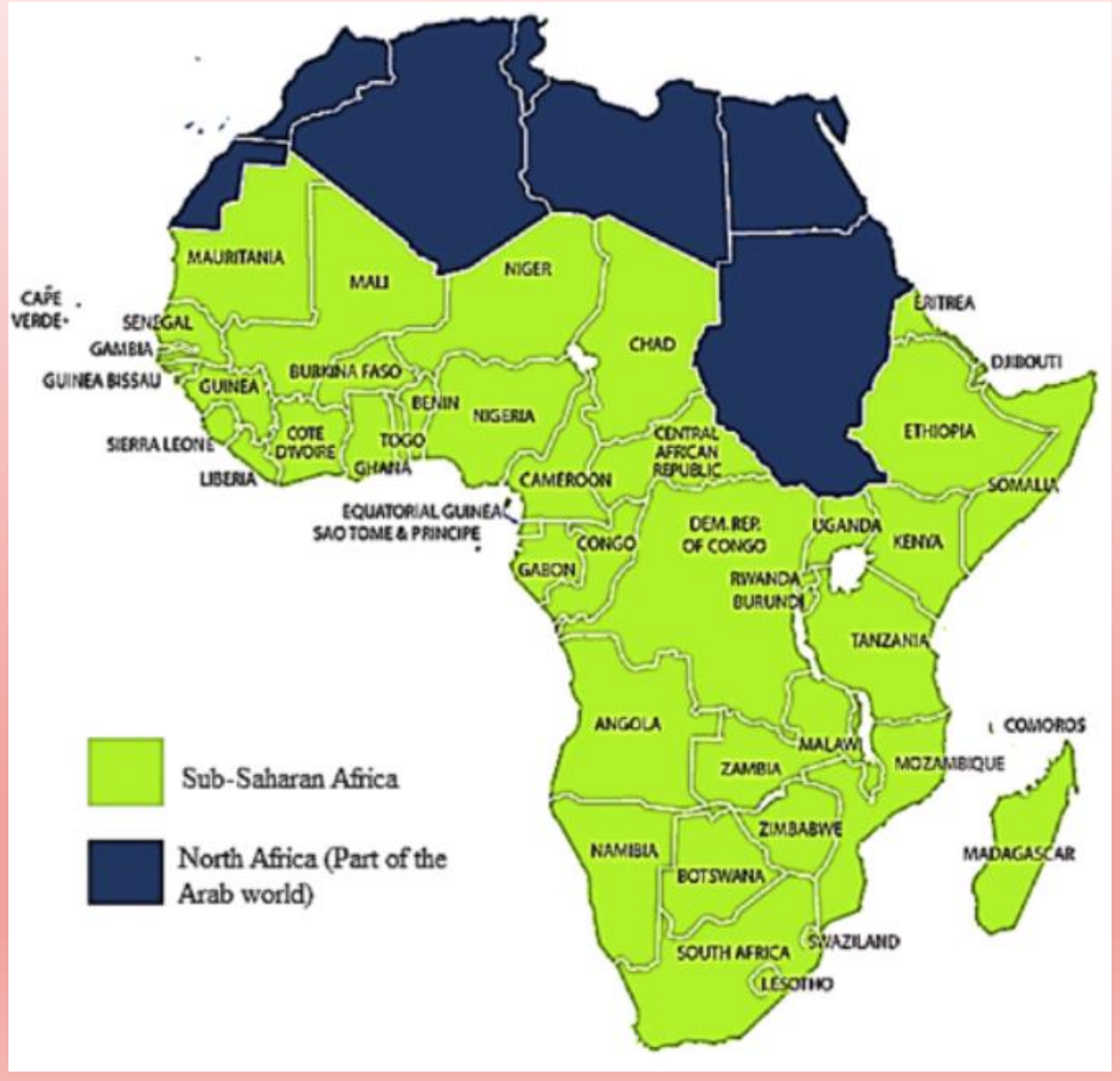
1. (Social) Justice
2. Non-maleficence
3. Beneficence
4. Veracity
5. Fidelity
6. Altruism
7. Autonomy.
8. Caring

WHO 4 March 2024 Newborn mortality

SUB-SAHARAN AFRICA IS THE AREA AND REGIONS OF THE CONTINENT OF AFRICA THAT LIE SOUTH OF THE SAHARA.

- IN 2022, NEARLY HALF (47%) OF ALL DEATHS IN CHILDREN UNDER 5 YEARS OF AGE OCCURRED IN THE NEWBORN PERIOD (THE FIRST 28 DAYS OF LIFE), WHICH IS AMONG THE MOST VULNERABLE PERIODS OF LIFE AND **REQUIRES INTENSIFIED QUALITY** INTRAPARTUM AND **NEWBORN CARE** -- PREMATURE BIRTH, BIRTH COMPLICATIONS (BIRTH ASPHYXIA/TRAUMA)**, NEONATAL INFECTIONS** AND CONGENITAL ANOMALIES REMAIN THE LEADING CAUSES OF NEONATAL DEATHS.

- CHILDREN WHO DIE WITHIN THE FIRST 28 DAYS OF BIRTH SUFFER FROM CONDITIONS AND DISEASES ASSOCIATED WITH LACK OF QUALITY CARE AT BIRTH OR SKILLED CARE AND TREATMENT IMMEDIATELY AFTER BIRTH AND IN THE FIRST DAYS OF LIFE.



PCDC320 PROVINCIAL DISTRIBUTION OF NURSING MANPOWER VERSUS THE POPULATION OF SOUTH AFRICA Stat. 1/2023
2024/12/03 PAGE: 1
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PROVINCE	POPULATION (ESTIMATE) 2023	NURSING MANPOWER AS AT 2023/12/31				STUDENTS IN TRAINING 2023/12/31		
		REGISTERED CATEGORIES	ENROLLED NURSES	NURSING AUXILIARIES	TOTAL ON REGISTER	NURSING / MIDWIFERY	ENROLLED NURSING	NURSING AUXILIARY
PERSONS *******								
Eastern Cape								
- FEMALES	3 827 630	14363	3569	5100	23032	2045	49	185
- MALES	3 348 600	2512	764	962	4238	826	29	54
- TOTAL	7 176 230	16875	4333	6062	27270	2871	78	239
Free State								
- FEMALES	1 609 120	7143	1351	2264	10758	718	47	104
- MALES	1 434 930	1283	339	272	1894	194	11	25
- TOTAL	3 044 050	8426	1690	2536	12652	912	58	129
Gauteng								
- FEMALES	7 865 610	38062	11455	14902	64419	3339	637	612
- MALES	8 066 214	3772	1119	980	5871	803	77	57
- TOTAL	15 931 824	41834	12574	15882	70290	4142	714	669
KwaZulu/Natal								
- FEMALES	6 412 330	31243	16276	10643	58162	1300	330	136
- MALES	5 900 382	4222	1865	1042	7129	612	69	26
- TOTAL	12 312 712	35465	18141	11685	65291	1912	399	162
Limpopo								
- FEMALES	3 338 352	11739	3796	8683	24218	748	40	13
- MALES	3 064 242	1905	436	756	3097	326	12	8
- TOTAL	6 402 594	13644	4232	9439	27315	1074	52	21
Mpumalanga								
- FEMALES	2 556 082	7878	1614	3414	12906	446	27	170
- MALES	2 501 579	1316	186	199	1701	103	6	21
- TOTAL	5 057 661	9194	1800	3613	14607	549	33	191
POPULATION PER QUALIFIED NURSE (IN THE SAME PROVINCE) **********								
Eastern Cape		425:1	1656:1	1184:1	263:1			
Free State		361:1	1801:1	1200:1	241:1			
Gauteng		381:1	1267:1	1003:1	227:1			
KwaZulu/Natal		347:1	679:1	1054:1	189:1			
Limpopo		469:1	1513:1	678:1	234:1			
Mpumalanga		550:1	2810:1	1400:1	346:1			

Note: Population figures - Statistics South Africa.

Professional Conduct Cases March 2023 to November 2023

TYPE	EC	FS	GP	KZN	LP	MP	NC	NW	WC	TOTAL
Infringement of patient's right to privacy										0
Fraud										0
Maternity			9	3						12
Medication related			1							1
Poor nursing care			4	4	5			1		14
Theft			1							1
Total	0	0	15	7	5	0	0	1	0	27

TYPE	RN	RN&M	EN	ENA	TOTAL
Infringement of patient's right to privacy					0
Fraud					0
Maternity	23		1	3	27
Medication related	1				1
SexualAssault					0
Poor nursing care	30		10	12	52
Theft	1				1
TOTAL	54	0	11	15	80

…in 9 months 54 R/N professional conduct cases

RISKS IN NICU

- **Hypoxia (Oxygen Deprivation):**

  Insufficient oxygen supply to the brain before, during, or after birth can cause cerebral palsy and other neurological damage.

- **Retinopathy of Prematurity (ROP):**

  Improper oxygen administration, failure to screen high-risk newborns, or delays in diagnosis and treatment can lead to blindness.

- **Infections:**

  Failure to maintain sterile conditions or adequately treat infections acquired in the neonatal ICU can cause serious illness and even death.

- **Errors in Medication Administration:**

  Incorrect dosages or types of medication can have devastating effects on fragile newborns.

- **Failure to Monitor:**

  Inadequate monitoring of vital signs and other indicators of health can lead to delayed recognition of problems and missed opportunities for intervention.

- **Breach of Duty of Care:**

  Failing to provide the level of care that a reasonably competent healthcare professional would have provided in similar circumstances.

- Hospital-Acquired Infections in Babies

- **Policies and protocol/work procedures not followed / out dated**
- Equipment (faulty/how to operate)
- Emergency trolley
- Infection prevention
- Visitors
- Consent/info to parents
- Initiating CPR
- **Feedings**
- Staff delegation / level of experience

Case law 1

du Preez N.O obo B.R.S v MEC for Health, Gauteng (58051/2018) [2024] ZAGPPHC 109 (12 February 2024)

20. Ms X'S testimony was based on her report and the joint minute she signed with the defendant's specialist nurse, Ms Z. The key aspects of her testimony may be summarised thus: She noted that documentation is an important aspect of nursing. She confirmed a statement that is used in training nurses and relevant to recording as follows: '***If it has not been documented, it has not been done***.' She said that as nurses, they are trained on the importance of record keeping from the early stages. On the question of how one determines the intervals of monitoring a patient, she stated that the process begins by **evaluating** the patient. She referred to various categories of vulnerable patients such as neonates, babies born prematurely, the elderly, and patients in comma. She stated that the needs of the patient determine how often the patient must be monitored. She stated that with this particular baby monitoring on hourly intervals was necessary because of the history of extravasation.

- 21. With reference to the joint minute[19], she confirmed that she and Ms Z agreed that the **lack of care** over a period of ten hours on the night of 20 May through to the morning of 21 May led to the baby's permanent injuries. They further agreed that there is **no record evidencing any evaluation of the patient to determine the baby's needs which would have informed the staff of the necessary intervals** of monitoring. Ms X was cross examined on the source of authority for her assertion that the baby needed to be monitored on hourly intervals. She replied that the needs of the patient determine the frequency of inspection. This issue is not only covered in the defendant's own specialist nurse's report but also by the nurses' joint minute, which was not disputed by the defendant. There was no re-examination for Sister X. The plaintiff closed his case after this witness.

du Preez N.O obo B.R.S v MEC for Health, Gauteng (58051/2018) [2024] ZAGPPHC 109 (12 February 2024)

FLYNOTES: MEDICAL NEGLIGENCE –

– Child injured by intravenous drip

– Drip site left unchecked for ten hours

– Injuries caused by substandard treatment

– Standard of care in ten hours was substandard compared to care baby previously received

– The injuries were caused by defendant's negligence

- No plan to monitor the infant on a hourly basis.

CASE LAW 2

N.T.H v MEC for Health, Gauteng Province (57301/15) [2021] ZAGPPHC 208 (8 February 2021)

The Plaintiff's case

[4] The Plaintiff's case is that the employees of the Defendant were negligent in failing to diagnose and treat the progression of hydrocephalus sustained by N[...] timeously. In addition thereto the Plaintiff avers that the revised ventricular-peritoneal shunt ("VP shunt"), inserted in May 2015, became blocked and was never revised. The aforegoing caused N[...]'s death. In respect of the Plaintiff herself the Plaintiff claims both special and general damages arising from the loss of her child. General damages are also claimed on behalf of N[...].

[55] From the aforegoing, it is clear that the employees of the Defendant were negligent in their diagnosis of N[...]'s true condition and by failing to properly render medical treatment to her. These omissions constituted negligence in that reasonable medical practioners, in the position of the Defendant's employees, would not only have reached an earlier and proper diagnosis of that medical condition but would have taken proper and reasonable steps to treat that condition. In other words, the Defendant's employees failed to render to N[...] the necessary medical treatment with the requisite care and skill which other medical practioners, in the same position, would have done *(Oppelt (supra) at paragraph 71*).

“Case law 3”

Doctor worried after baby reportedly burns in hospital

July 21, 2014

Phillip Bruwer

Doctors are concerned about the burns that four-week-old Juan Venter reportedly suffered at the Bertha Goxwa Hospital in Germiston after one of those wounds became septic.

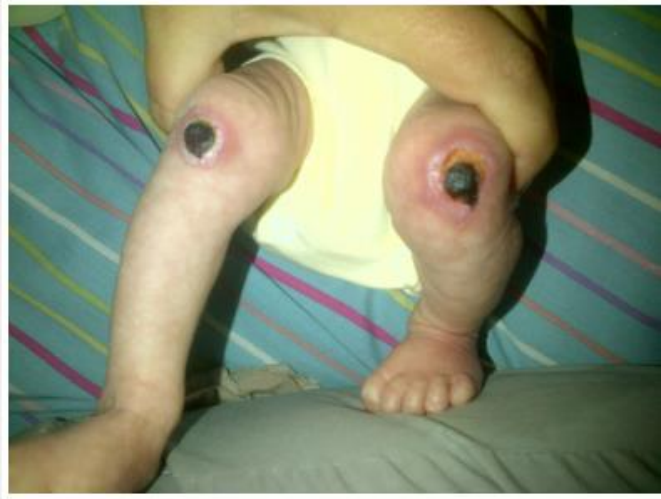
Juan's mother, Mariaan Pienaar (25), told Maroela Media on Monday that the doctor was particularly concerned about the wound on Juan's left knee.

Baby Juan Venter. Photo: Supplied.

"Juan's wounds already look better than they were, but the wound on his left leg is septic," Pienaar said.

Maroela Media reported last week that Pienaar gave birth to her and her fiancé, Riaan Venter's, first child on 18 June. The couple lives in Boksburg.

Juan suffered burns after reportedly burning with an electric blanket in hospital when she was only two days old. Juan's wounds turned black after two weeks after which he and Pienaar were transferred to the Chris Hani Baragwanath Hospital in Soweto.



Juan's wounds on July 21.

MP AND MP OBO JV AND MEC OF HEALTH GAUTNG

Case law 4

N V MEC FOR HEALTH, GAUTENG (44761/2013) [2015] ZAGPPHC 645 (8 SEPTEMBER 2015)

5. The plaintiff was to be anaesthetised by a spinal block which was duly administered but was found to be ineffective when the operation commenced and plaintiff had to be given a second dose which made her very drowsy. After the performance of the operation the plaintiff was told that the baby had been cut on the left arm during the procedure by one dr Mabena.

6. The plaintiff's new-born was removed to a neonatal ward without the plaintiff having been afforded the opportunity to see or hold the baby. She could not ascertain the nature of the injury her little daughter had suffered, nor could she comfort or suckle the child. In spite of repeated requests to be allowed to see her baby plaintiff was only taken to her daughter on the morning of the third day of the new-born's life after she had been informed that the child was screaming with hunger. She found the child in an incubator that had either not been switched on or was dysfunctional. The little baby had not been attended to at all, she had not been fed and her wounds – the mother found two cuts on her left arm – had not been treated or dressed. In spite of not having been fed at all since birth the baby had not been put on a drip. She had simply been neglected.

7. The plaintiff was understandably dismayed and protested against the way her child was dealt with. She fed the little one and demanded medical attention for her. The cuts were some four centimetres long and had penetrated the skin into the muscle. The wounds were dressed and plaintiff was later informed that an operation would have to be performed to suture the wounds. The operation was eventually performed only on the eighth day of the baby girl's life. It was supposed to have been performed two days earlier. The baby was taken off her feeding routine and put on an intravenous drip for two days because other operations had to take precedence, according to the hospital's staff.

8. The wounds became infected and it took three months for the condition to heal. The baby suffered pain and discomfort as a result of the protracted healing process.

Case law 5

PREMIER OF PROVINCE
OF KZN AND
KISHORE SONNY1ST RESPONDENT,
JAYANTHI DEVI SONNY 2ND RESPONDED

THE SUPREME COURT OF APPEAL
REPUBLIC OF SOUTH AFRICA

MEDIA SUMMARY – JUDGMENT DELIVERED IN THE SUPREME COURT OF APPEAL

From: The Registrar, Supreme Court of Appeal

Date: 4 March 2011

Status: Immediate

The SCA said the following about the duty of doctors and medical staff in public health facilities:

'In our country poverty and a lack of literacy abounds. Masses of our people attend public health facilities. Their lack of sophistication and the vulnerability that accompanies poverty are factors that cannot be ignored. They are entitled to be treated in the same way as patients who can afford private medical assistance. That means that they should be fully informed and should be as involved as possible in their own treatment. This does not require a drain on public resources. This case is not about the availability of material resources. It is about a doctor communicating adequately with a patient. What is required is a public health delivery system that recognises the dignity and rights of those who are compelled to use its facilities. It is that basic sensitivity that the Constitution demands.'

OUTCOMES OF THE INVESTIGATION INTO ALLEGATIONS AGAINST RAHIMA MOOSA MOTHER AND CHILD HOSPITAL (OHSC)

c) Whether the health and dignity of patients, and the well-being of healthcare workers is severely compromised.

i. The allegation that the health and dignity of patients and the well-being of healthcare workers is severely compromised was substantiated and confirmed.

ii. The investigation revealed crumbling infrastructure throughout the hospital, free- flowing sewage between buildings, a pervasive foul-smelling environment, filthy ablution facilities, and leaking steam pipes leading to poor heating in the wards, which does not provide a conducive, healthy, and safe environment for the provision of quality care for patients by healthcare workers.

iv. The challenges of overcrowding, staff shortages, and a dire lack of specialised nursing staff compromised the health and well-being of healthcare workers. Significantly, these challenges affect patient safety, by placing patients' lives at risk.

d) Additional findings include issues pertaining to:

i. Human Resources
ii. Infrastructure
iii. Blood Bank (SANBS) and Laboratory (NHLS) Services
iv. Radiology services (CT scan)
v. Hospital Board
vi. Security challenges
vii. Shortage of Nursing Staff
viii. Flouting of Supply Chain Management (SCM) Processes
ix. Infection Prevention and Control
x. Lack of an Intensive Care Unit (ICU) for adults at RMMCH

CONCLUSION

Risks in a high-tech neonatal environment

- System
- Lack of quality of care
- Skilled care
- 1 RN : 381 Human beings in Gauteng.
- Documentation
- Scientific Nursing process
- Failing to diagnose
  - *The human factor*
  - *Situational stupidity*
  - *Cognitive overload*
  - *Emotional overload*

SANC; THE PLEDGE

- On 12 May 1820, Florence Nightingale was born in Florence, Italy. Her legacy in not only the science of nursing, but also the art and value of nursing as an independent and recognised profession, is still visible today and is globally celebrated on International Nurses' Day (12 May) each year. The original **Nightingale Pledge**, composed in 1893 by Lystra Gretta is an adaptation of the Hippocratic Oath taken by physicians and emphasises the following principles:
- Leading by example
- Faithfulness
- Accountability
- Accuracy
- Responsibility
- Confidentiality
- Devotion
- Quality

- **Any questions?**

- **References**

- (PDF) Endsley, M.R.: Toward a Theory of Situation Awareness in Dynamic Systems. Human Factors Journal 37(1), 32-64
- du Preez N.O obo B.R.S v MEC for Health, Gauteng (58051/2018) [2024] ZAGPPHC 109 (12 February 2024)
- www.saflii.org/za/cases/ZAGPPHC/2024/109.html
- https://www.who.int/news-room
- SANC