

Drunk driving: Bring back the breathalyser – experts

Although mortuaries and trauma units around the country dealt with fewer dead and injured motorists this Easter (46% fewer fatalities than last year), a leading trauma surgeon and a high-profile forensic pathologist emerged to call for a return to legally competent breathalysers.

Abandoned as a substandard primary prosecution tool after a precedent-setting drunk-driving case heard in the Cape Town High Court 3 years ago, the locally inaccurate and badly calibrated breathalyser had previously been the utilitarian weapon of choice. By this Easter there was no sign of its return. Prof. Ken Boffard, Trauma Director at Netcare Milpark Hospital in Gauteng, a level 1-accredited trauma unit, sees 120 major trauma patients a month, half of whom are car occupants and 60% of whom are over the legal alcohol limit (0.05 g/dL). This equals the annual percentage of people over the legal alcohol limit whose bodies are brought to the State mortuary in Salt River, Cape Town – which sees the largest number of unnatural deaths in the country, according to Prof. Lorna Martin, Head of Forensic Medicine at the University of Cape Town and clinical department Head of Forensic Services for the Western Cape. Boffard, citing the average of 1 300 deaths per month on the road, said that the alternative to the breathalyser of securing convictions for alcohol abuse – blood alcohol tests – was ‘too much trouble’ for most police officers. ‘You have to find an appropriately registered doctor, then it takes days to get the tests back, and then you have to spend about 4 days, or more, in court. I’d venture to suggest that you could count on your hand the number of blood alcohols they take in one road block, let alone those drawn by a district surgeon. How do you deal with the problem when the bulk of law enforcers refuse to accept the effort required to deal with it?’ he asked.

Widespread incompetence and lack of skills

Dr David Klatzow, independent forensic pathologist and pivotal expert witness in the case that brought about the breathalyser’s demise, said that ‘pure incompetence’ – from the roadside to the eventual laboratory testing of blood samples – was responsible for multiple court cases being thrown out. ‘Blood sampling is the gold standard when done properly by somebody qualified, but they seem incapable of maintaining the chain of evidence,’ he said. He explained that blood first had to drawn



Prof. Ken Boffard, Trauma Director at Milpark Hospital in Johannesburg.

from a suspect by a registered nurse or a doctor, then put into a labelled bag and then into a ‘vacutainer’ (to keep it sterile), then handed to a policeman, who signed for it, and then transported to a laboratory, where it was again signed for. ‘There are usually four to five links in the chain which they seem incapable of getting right – and then it sits in the lab for weeks, if not several months.’ His contention is that the poor skills and low qualifications of staff at the national health department’s chemical laboratories are then responsible for wide variations in test results and delays – so much so that the bulk of samples are unreliable in court. Samples were supposed to be tested in duplicate at the same lab, with readings varying more by not more than 10%. His most recent experience in consulting for an insurer revealed that a client’s blood alcohol level read 0.08 and 0.16 g/dL in two tests at a state laboratory – which he said was ‘par for the course.’ ‘I’d say that most of the samples they do are 134% apart,’ he added. Boffard says he can remember only one instance of a traffic officer requesting a legal blood alcohol sample from a patient in over 20 years at Milpark Hospital. The only record-breaking exception to the average (of illegally high) blood alcohol levels in 60% of his patients (0.171 g/dL) was a reading of 0.27 – the morning after the person concerned was admitted. ‘Last Christmas period we had three very high blood alcohols – and they were all police officers,’ he chuckled.

Klatzow’s claims on lack of capacity and skills seem strongly backed by figures released

this year that show the direly needed drastic improvements in the backlog for drunk driving samples at state forensic labs across provinces to be patchy. In Pretoria, drunk driving test backlogs, after spiking from 11 890 on 31 January 2014 to 19 841 by 31 January 2015, dropped back in January this year to 6 074, a reduction of 49%. Cape Town’s drunk driving test backlog was 25 933 on 31 January 2014, 12 856 on 31 January 2015, and 2 360 in January 2016 – an impressive reduction of 90%. In Johannesburg, the backlog was 29 589 on 31 January 2014, down to 26 117 on 31 January 2015, and up again to 30 376 on mid-February, an increase of 3%.

Authorities turn down expert help

Klatzow says that he has repeatedly offered his expertise to state, provincial and municipal authorities to help address the breathlyser shortcomings, but has been sullenly turned down. The state, however, reluctantly took his advice to use vacutainers to increase the integrity of blood samples. Turning to drug abuse, he said that the toxicology arm of state pathology services was ‘even worse, if that’s possible. You can wait 5 years for results – the other day a magistrate told me he’d waited 10 years – it’s the laughing stock of the professions.’ He accused government authorities of ‘never admitting that they could possibly be wrong – you cannot make science right by using smoke and mirrors.’

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An *Izindaba* check on trauma patient capacity in and around Bloemfontein, through which one of South Africa (SA)’s main highway routes passes, was somewhat less alarming, although Bloemfontein, Johannesburg and Pietermaritzburg emerged as isolated ‘islands of trauma care’ through which holiday travellers pass. Pelonomi Academic Hospital principal

trauma surgeon Dr Andrew Laubser said that prehospital and in-hospital treatment in both the public and private sectors in and within 150 km of Bloemfontein were 'pretty good', with the private sector 'well above average.' A patient with severe complications in his trauma unit would be resuscitated and be in 'good hands'. However, the problems began when they needed to be moved out of his trauma unit. Radiographers were either unavailable or not appointed, theatre support was often non-existent and computed tomography scanners stood for months in disrepair, while intensive care units were severely understaffed. 'Sometimes we have two sisters attending to 80 patients during the night,' he added. Both Pelonomi and Universitas hospitals had private healthcare hospitals physically attached to them, with patient care collaboration at Pelonomi more efficient. He said that both interpersonal violence and car crash admissions increased by

about 30% over the festive seasons, with alcohol playing a major overall role. Boffard said that 88% of his severely injured Milpark patients had been involved in interpersonal violence.

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Boffard explained that the reason patients had both blood alcohol and toxicology testing on admission was because these affected how shock presented (and thus treatment), and could also be responsible for a reduced level of consciousness. He emphasised that unless a legally requested sample was taken, neither medical measurement could be used by police

or insurance companies. All those interviewed for this article agreed that until SA society began viewing it as culturally unacceptable to drink and drive – and enforcement was backed up with legal accountability – the horrific death and injury statistics would remain. Transport-related injuries account for more than one-third of all external causes of death (33.8%) in SA. Road traffic age-specific mortality rates are about double the global rate in both sexes, peaking at 2.5 times the global rate in adult women aged 30 - 44.^[1]

Chris Bateman

chrisb@hmpg.co.za

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1. Norman R, Matzopoulos R, Groenewald P, Bradshaw D. The high burden of injuries in South Africa. *Bull World Health Organ* 2007;85(9):649-732. DOI:10.2471/BLT.06.037184