

**HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG
REPUBLIC OF SOUTH AFRICA**



CASE NUMBER: 24977/12

DELETE WHICHEVER IS NOT APPLICABLE

- (1) REPORTABLE: NO
- (2) OF INTEREST TO OTHER JUDGES: NO
- (3) REVISED:

In the matter between:

BARNARD, BAREND JACOBUS

Plaintiff

And

**THE MEMBER OF THE EXECUTIVE COUNCIL FOR
HEALTH AND SOCIAL DEVELOPMENT OF THE GAUTENG
PROVINCIAL GOVERNMENT**

Defendant

Coram: WEPENER J

Heard: 27 July to 5 August 2015

Delivered: 28 August 2015

JUDGMENT

WEPENER J:

[1] The Plaintiff, a curatrix at litem for Barend Jacobus Barnard, seeks damages from the defendant as a result of injuries sustained by Barnard in 2011. As is the case with the pleadings, and was the case during evidence and argument, Barnard was referred to as the plaintiff and, for practical reasons, I too do so. The defendant is the Member of the Executive for Health and Social Development Gauteng Province under who's auspices the Tambo Memorial Hospital falls and its the medical personnel are ultimately employed by the defendant.

[2] In this matter there was also another hospital and staff members involved in the treatment of the plaintiff, but liability as a result of actions at that hospital or its status were not canvassed in the pleadings or argued, despite the pleadings alleging that a breach of duty of care occurred at the Tambo Memorial Hospital alternatively, the Johannesburg Hospital (it's proper name being the Charlotte Maxeke Johannesburg Academic Hospital). Whatever the true nature or status of the Charlotte Maxeke Johannesburg Academic Hospital may be, there is nothing to suggest that the defendant can or should be held liable for anything that might have happened at that hospital or that may have an impact on the plaintiff's condition.

[3] The common cause evidence is that during the evening of 21 May 2011, the plaintiff's brother assaulted him, inter alia by 'stomping' down a foot onto the plaintiff's head. This left the plaintiff bleeding from his head and unconscious for approximately fifteen minutes. Thereafter, the plaintiff stood up and despite being dazed, had some tea. A few minutes later the plaintiff drove away in his vehicle but returned home between 22h00 and 23h00. The plaintiff seemed to be confused and after taking a tablet, he went to sleep. During the night the plaintiff woke up a few times and during the first such incident, the plaintiff's son observed that the one side of the plaintiff's body

was half paralysed and the plaintiff did not speak or respond to his son. His son formed the impression that the plaintiff knew what he was doing. On the second such occasion, the son observed that the plaintiff was more paralysed and still did not reply to him. On the third occasion, the plaintiff's son formed the impression that half the plaintiff's body was 90% paralysed and that the plaintiff had no control over the one side of this body. The following morning the son was unable to wake the plaintiff and in conjunction with the other family members it was decided to call an ambulance. Whilst the ambulance staff attended to the plaintiff he opened his eyes but he could not talk.

[4] From this point onwards the plaintiff essentially relied on that which is contained in the hospital records and an interpretation thereof by a neurosurgeon, Dr de Klerk who in his evidence stated that his contrary opinion is a matter of interpretation, at least regarding one of the recorded facts of the plaintiff's condition on 26 May 2011. It became the plaintiff's case that a failure by the Tambo Memorial Hospital staff to identify the need for a craniotomy earlier than the time when they did, caused a delay in the performance of a craniotomy which in turn, caused a deterioration in the plaintiff's brain pathology. This delay, the plaintiff submitted, exacerbated his condition after the initial assault and caused him to suffer additional damage. Medically, it was referred to as a delay in the performance of a craniotomy on the plaintiff, which exposed the plaintiff to raised intracranial pressure for a prolonged and unnecessary period of time. The defendant conceded that there was negligence on the part of the hospital staff in not performing the craniotomy earlier, but denied that the delay in its performance contributed to or caused the plaintiff to suffer any damage.

[5] In interpreting the hospital records Dr de Klerk concluded that it showed deterioration in the condition of the plaintiff prior to the performance of the craniotomy while hospitalised at Tambo Memorial Hospital. This, Dr de Klerk said, caused secondary brain damage. The defendant's witnesses disputed such a deterioration and counsel for the defendant submitted that it was not shown that the plaintiff's condition deteriorated while at the Tambo Memorial Hospital or that any brain pathology during that period had been shown to be causally connected to the plaintiff's current condition.

[6] In support of his contention that his condition deteriorated during the delayed period the plaintiff relied inter alia, on the fact that Dr de Klerk doubted the correctness of certain entries contained in the hospital records. In particular, the recordal of the plaintiff's level of consciousness prior to the craniotomy being performed, was disputed. Dr de Klerk even disputed an entry that the plaintiff had supper on 25 May 2011. The factual basis of such dispute is absent but also indicative of the fact that Dr de Klerk's opinion should be approached with caution. What is important is that whilst disputing some of the factual entries in the hospital records, Dr de Klerk also candidly stated that he might be wrong. Dr de Klerk's point of departure due to his refusal to accept the entries in the hospital records is consequently tainted.

[7] In concluding that a delay in the performance of a craniotomy on the plaintiff, which caused poor cerebral perfusion which, in turn, caused hypoxic insult to the brain, was causally linked to his current deteriorating physical condition, Dr de Klerk relied on several factors. The first of such was his view that the plaintiff's condition deteriorated whilst in the Tambo Memorial Hospital. Indicative of the deterioration was inter alia, the doubtful Glasgow Coma Scale (GCS) scores contained in the hospital records. Dr de Klerk expressed the view that some of the findings by the personnel were wrong and he disputed all of the GCS scores in the hospital records, although not the score recorded by the anaesthetist prior to a craniotomy being performed at the Charlotte Maxeke Hospital. A GCS is a score arrived at out of a possible fifteen points in order to determine the level of consciousness of a patient. It is mainly used in neuro-trauma cases and shows the level of consciousness of a patient and, according to Dr Karan, also a neurosurgeon, a good indication about the general state of a trauma patient. If there is a significant change in the score it can be accepted that there are intra-cranial developments. Dr Ranchod, a specialist physician, testified that the outcome may well be a subjective outcome and that it depends on the observation of the person performing the test. Dr Karan, was of the view that the scores obtained by medical doctors would be of more value than those obtained by junior staff. Nevertheless, I am of the view that the direct evidence of the doctors, who treated the plaintiff, although doubted by the plaintiff during cross-examination of the defendant's witnesses, cannot be faulted and should be accepted above the speculation of Dr de Klerk that the scores

are all wrong. I am of the view, like Dr Karan, that there were no reasons, and none have been indicated, why the hospital personnel would record incorrect findings in a patient's records. Although mistakes can obviously occur, none had been shown to have occurred and the probability of a number of scores being incorrect, from the day of admission to the day of final discharge, based on an ex post facto reading of the records, is in my view, so low that it can be discarded as speculation rather than a probability. This is so even by virtue of the fact that witnesses who testified before the court may have expressed a view that they would have differed with a particular score by one point of a particular reading, taking into account that there was never a score below 12 over 15. A variation between 12 over 15 and 13 over 15 is not significant. Dr de Klerk said in cross-examination that there could be many reasons for these slight variations. But the evidence of Dr Karan that a substantial variation which required intervention was absent was not gain-said.

[8] The significance of this finding lies in the evidence of Dr Karan that the plaintiff's GCS remained stable throughout his stay at the hospital (and even improved at certain stages) and there was never a situation where the scale dropped to a point such as 8 over 15, which would call for immediate or urgent medical intervention. Counsel for the plaintiff cross-examined Dr Karan and submitted that there was indeed a variation and that Dr Karan's evidence was therefore unreliable. That of course, is incorrect. Dr Karan's evidence was that the baseline of the GCS score remained stable throughout. The fact that it improved from time to time, was an additional factor indicating that urgent intervention was not necessary during the plaintiff's hospitalisation at Tambo Memorial Hospital. The anaesthetist scored the plaintiff at 14 over 15 just before the craniotomy. The assessment of the anaesthetist is also significant. It was done at the Charlotte Maxeke Hospital and not the Tambo memorial Hospital. The anaesthetist would be directly affected if there were complications due to a wrong scoring. The latter scoring was not attacked by Dr de Klerk as were the scores recorded at Tambo Memorial Hospital. On the contrary, Dr de Klerk failed to deal with the GCS found by the anaesthetist just prior to the craniotomy being performed. The only logical explanation for a GCS of 14 over 15 is found in the evidence of Dr Karan that the plaintiff's condition did not deteriorate whilst at the Tambo Memorial Hospital to the extent that it required

an earlier craniotomy or that an earlier craniotomy would not have had any different outcome. There was no rapid deterioration in the plaintiff's condition and he remained stable throughout.

[9] When assessing the role of the GCS of the plaintiff during his hospitalisation, I will approach it on the basis that the GCS readings were in all probability recorded correctly. This view is strengthened by the viva voce evidence of Drs Carrim, Ranchod and Mbuyane, who all confirmed their respective records of the plaintiff's GCS as documented in the hospital records. As Dr Mbuyane put it:

'But I have seen the patient. There is no reason to write wrong notes'.

Dr Mbuyane also referred to the similar score (albeit a higher and improved score) found by the anaesthetist just before a craniotomy was performed on the plaintiff. I will refer to this score again.

[10] In considering a matter a court is also to keep in mind that direct evidence of facts are of great value when determining an issue. Although Eksteen J referred to the reconstruction of a collision in *Motor Vehicle Assurance Fund v Kenny*¹, his remarks may well be applied to any factual circumstances. He said²:

'Direct or credible evidence of what happened in a collision, must, to my mind, generally carry greater weight than the opinion of an expert, however experienced he may be, seeking to reconstruct the events from his experience and scientific training. Strange things often happen in a collision and, where two vehicles approaching each other from opposite directions collide, it is practically impossible for anyone involved in the collision to give a minute and detailed description of the combined speed of the vehicles at the moment of impact, the angle of contact or of the subsequent lateral or forward movements of the vehicles. Tompkins' concession, therefore, that there are too many unknown factors in any collision to warrant a dogmatic assertion by an expert as to what must have happened seems to me to have been a very proper one. An expert's view of what might probably have occurred in a collision must, in my view, give way to the

¹ 1984 (4) SA 432 (ECD).

² At 436H-437B.

assertions of the direct and credible evidence of an eyewitness. It is only where such direct evidence is so improbable that its very credibility is impugned, that an expert's opinion as to what may or may not have occurred can persuade the Court to his view (cf *Mapota v Santam Versekeringsmaatskappy Bpk* 1977 (4) SA 515 (A) at 527-8 and *Madumise v Motorvoertuigassuransiefonds* 1983 (4) SA 207 (O) at 209).'

[11] The objective evidence in the form of impartial notes and the evidence of the medical doctors far outweigh the speculative evidence of Dr de Klerk that all the GCS readings contained in the hospital records were wrong or not 'possible'. Once this point of departure is accepted, the evidence of Dr de Klerk that there was a deterioration in the plaintiff's condition whilst at the Tambo Memorial Hospital by relying inter alia, on the fact that the GCS recorded in the hospital records were all wrong, must be approached with extreme caution because the GCS recorded over a period from admission to discharge, remained stable and never dropped below 12 over 15. Dr de Klerk's steadfast refusal to accept the facts in order to justify a conclusion is a matter of concern and places a question mark over his impartiality in this matter.

[12] In so far as reliance was placed on the alleged incorrect recordings of the plaintiff's GCS, I am of the view, that such reliance was misplaced.

[13] Although the evidence and cross-examination of witnesses concentrated to a large extent around the GCS of the plaintiff during his hospitalisation and it being the principle factor relied upon before me, other factors regarding the plaintiff's condition during his stay at the Tambo Memorial Hospital were also canvassed.

[14] Dr Karan expressed the opinion that the condition of a patient is monitored and is dependent on several factors of which the GCS is but one and, although an important factor, it should be seen in context of a patient's clinical condition. This was also the evidence of Dr de Klerk. The clinical condition of the patient is also assessed with reference to other factors or vital signs such as blood pressure, respiratory rate, pulse rate, pupils that remained equal and reactive, urine tests and the absence of vomiting. An example is that if a patient's pupils remain reactive, there is no life-threatening condition. The hospital records in this regard consistently show that the plaintiff's pupils

remained reactive. It reinforces the view that the plaintiff remained in a stable condition at the Tambo Memorial Hospital. There are other examples such as the blood pressure and lack of change in the plaintiff's respiratory rate – the latter which is affected by intracranial haematoma. The plaintiff remained in a stable condition throughout the period that he spent in the Tambo Memorial Hospital. Throughout the plaintiff's stay at the hospital these factors also remained constant. Clinically, the plaintiff presented no symptoms which indicated that he needed an urgent craniotomy.

[15] In addition, Dr Karan testified that if the plaintiff indeed suffered a hypoxic ischaemic insult it would have caused the plaintiff's death within hours. He also testified that in the event of the plaintiff's suffering an additional neurological deficit while hospitalised, his GCS would have decreased substantially. During cross-examination Dr de Klerk gave three answers regarding this aspect: one, that he did not know; two, that he did not have an answer to this proposition and thirdly, that he did not agree. Instead of selecting one of the answers given by Dr de Klerk which were contradictory, I prefer to accept the clear evidence of Dr Karan that the steady GCS indicated no further neurological deficit that required immediate intervention.

16] The background of the plaintiff's hospitalisation is also relevant. The plaintiff's son testified that the plaintiff was 90% paralysed on his one side. The hospital admission form recorded (without detailed particularity) that the plaintiff was admitted with limited movement and that he was semi-conscious. The history supplied was that the plaintiff was assaulted and had an overdose of sleeping tablets. There was a superficial laceration above the left eye. A further record shows that the overdose was approximately 70 Alprazolam tablets, which Dr de Klerk regarded as 'deadly in nature'. Dr de Klerk agreed that the fact that the medical personnel concentrated on that immediate danger would be the responsible thing to do. Dr de Klerk's criticism that no stomach wash or blood test was done is of no consequence as this plays no role in the plaintiff's medical condition. The tenor of the evidence of the defendant's witnesses was that the overdose aspect required careful observation and that the taking of such an overdose would result in symptoms such as the plaintiff's drowsiness which was recorded in the hospital records. Dr de Klerk agreed with this evidence.

[17] During the trial Dr de Klerk also testified that the plaintiff developed hemiplegia on the right side, a further indication that his condition deteriorated. Dr de Klerk stated that the notes on 25 May 2011 gave the first indication that the plaintiff had right sided weakness. This evidence was obviously given to support his contention that the condition of the plaintiff deteriorated during the time that he was hospitalised at Tambo memorial Hospital. This was also put as a fact to Dr Karan in cross-examination. The basis for the stance is lacking. Dr de Klerk's evidence on this point is clearly wrong. The plaintiff's son testified that the plaintiff was 90% paralysed on the one side and the hospital admission record, although cryptically, notes on admission that the plaintiff had limited movement. This supposed indication of further deterioration of the plaintiff whilst at the Tambo Memorial Hospital was not pursued in argument, but it was accepted as a fact that the hemiplegia was present from the outset. It does detract from the veracity of the evidence of Dr de Klerk who relied on this factor to opine that the plaintiff's condition deteriorated whilst in hospital.

[18] Another factor on which the plaintiff relied to conclude that his condition deteriorated was an alleged deterioration of the brain from the time that a first brain scan was done on 25 May 2011 until the second scan was done on 1 June 2011. It is the plaintiff's case that the second brain scan showed deterioration between these two dates and that therefore the delay in the performance of the craniotomy caused damage to the brain. Dr de Klerk expressed his opinion on his experience and certain literature. I had no detailed evidence of the underlying experience but the literature was referred to. According to Dr de Klerk, he relied on *Youmans*³ being an authoritative work on Neurosurgery. He relied on the following passage:

'To further investigate the destructive effect of the haematoma and the optimal timing of each evacuation, Nakayama and Colleagues, studied ICP in surgical treated patients with Putaminal ICH's who presented with severe neurological defects (semi-comatose). Patients with smaller haematomas evacuated before eight hours had lower ICP than those with larger haematomas evacuated after eight hours. In this setting, high ICP correlated with death and poor outcome. In this group, elevated ICP may reflect a secondary effect of the haematoma – induced alterations

³ A 2004 edition.

in microcirculation, because experimentally these effects are more pronounced when larger haematomas are evacuated.'

[19] Dr de Klerk concluded that:

'(E)arly evacuation of large intracranial haematomas, were they sub-dural, extra-dural or intra-cerebral in nature, is of the utmost importance'.

[20] Dr Karan testified that the passage in *Youmans* does not relate to trauma related cases such as was the case of the plaintiff. The passage deals with deep-seated haematoma (Putaminal inter-cranial haemorrhage) which is a result of hyper-tension. Dr Karan testified that a delay in performing a craniotomy may even be deliberate depending on several factors. There is nothing to gainsay this evidence and the reliance on an incorrect passage contained in the authoritative work on neurological surgery would, in my view, be fatal to the conclusions reached by Dr de Klerk.

[21] The plaintiff's case was eventually largely based on an alleged deterioration in his condition due to a delay between the diagnosis of the inter-cranial pathology and the definitive surgery. However, the defendant submitted that the plaintiff failed to show that the plaintiff's condition deteriorated during his hospitalisation. This was so, due to the inability of the plaintiff to show that the initial trauma, as a result of the assault, caused a lesser pathology in the brain than that which was eventually found. That this is so, Dr de Klerk had to concede as there was no evidence of the nature of the injury to the brain as a result of the assault itself. To overcome this, the plaintiff's case was that there was deterioration between the time that the first brain scan was performed to the time that the second scan was performed. This deterioration, it was submitted, indicated that the failure to operate earlier caused additional damage to the plaintiff's brain as an earlier craniotomy could, to some degree, have either prevented or reversed secondary changes in the brain. The question that the defendant posed was, additional damage to what? This question has not been answered in evidence before me. Dr de Klerk highlighted the differences that he thought were apparent between the two brain scans. Dr Karan's evidence was that the differences (if they were difference, save for the midline shift) were illusory. All the conditions were present during the first scan. The shift in the midline could, but did not, contribute to the additional damage and had no

clinical significance in this case as the plaintiff's clinical condition remained stable. Dr de Klerk agreed that the midline shift was 'just' one thing that he noticed but he said that there were much more important things noticeable on the scans. The more important matters included the contusions – which in all probability were a result of the assault - and blood in the lobes of the brain – also most probably as a result of the assault. This conclusion I reach by virtue of the evidence of Dr Karan that application of force to the head causes contusions and bleeding. Due to the fractures in the strong, thick bone of the zygomatic arch of the plaintiff's head, significant force was applied to him. The only known force was at the time of the assault. Dr Karan testified that the force used caused an immediate significant injury to the brain. The result is that the midline shift has not been shown to have contributed to deterioration in the plaintiff's condition whilst at the Tambo Memorial Hospital.

[22] In so far as there was a change in the brain area after the first scan and at the time of the second scan, can it be said that those changes contributed to or caused the plaintiff's current condition? Dr de Klerk had no information regarding the severity as a result of the assault or primary injury. He conceded that he did not know what the pathological deficit occasioned by the primary injury was. He did not take into account the fourteen hour delay from the time of the infliction of the primary injury to the time that the plaintiff presented at the hospital. Without a proper point of departure, Dr de Klerk's evidence lacks a basis for his conclusion that the plaintiff's chances of recovery from his neurological deficit were compromised by the delay. On the other hand, the evidence of Dr Karan is based on accepted empirical data contained in the plaintiff's hospital records.

[23] I am fortified in the above finding by virtue of the following factors. Plaintiff's son testified that after the discharge from the hospital, the plaintiff's speech was just like before, he had trouble with his right leg and his arms were completely normal. When Dr Karan assessed the plaintiff in July 2013, he found that the plaintiff's comprehension and languages functions were normal. Save for decreased vision in his visual fields, his clinical nerves were normal. The upper limbs' power was 5 over 5. Muscle tone was normal. Sensation was intact and reflexes were normal. In the lower limbs, the right leg

power was 5 over 5. The left leg power was 2 over 5. He had a foot drop. His co-ordination was normal. Dr Karan concluded that the delayed treatment did not cause major neurocognitive and neurological defects as Mr Barnard's level of consciousness (the GCS) remained the same. When hospitalised, Mr Barnard had right hemiparesis, which completely resolved and he now had a weakness in the left leg which was not documented during his hospital treatment at the Tambo Memorial Hospital. The cause of the new medical condition as a result of a new neurological deficit is explained if one has regard to the statement of the plaintiff, and his wife, that the plaintiff suffered several strokes during 2013. According to Dr Karan the left sided weaknesses which the plaintiff later developed was unrelated to the initial injury which caused right sided problems. Because fibre threads cross in a person's body, problems in the left side of the brain will cause right sided weakness. The plaintiff's later left sided weakness is non-related to his initial injury.

[24] In addition, the case pleaded by the plaintiff is as follows:

'On 1 June 2011 and at Johannesburg Hospital a repeat CT scan showed much the same condition as was found on 25 May 2011 at the Tambo Memorial Hospital.'

Relying on *Fritz v Minister of Safety and Security*⁴, counsel for the defendant submitted that the case for the plaintiff shifted and was at variance with the case pleaded and that the version of the defendant should be accepted as true. I need not go that far and reject the evidence of the witness (Dr de Klerk), which evidence is at variance with the pleadings. I am satisfied that it was not the case of the plaintiff that there was a marked deterioration between the two brain scans, resulting in damage. The plaintiff's pleadings were first signed on 12 June 2012, a date after Dr de Klerk's first evaluation of the documentation on 24 November 2011. Even after several additional reports by De de Klerk, the pleadings remained as set out above. The case that the plaintiff suffered additional damage due to the delay in the performance of the craniotomy, developed as a last resort. It is at variance with the pleaded case that the second brain scan showed much the same condition as was found with the first scan which is, significantly in line with the evidence of Dr Karan. It also ignores the assertions of the plaintiff and his wife

⁴ 2012 (2) SACR 451 (ECG).

that the plaintiff later suffered strokes. Dr de Klerk reconstructed the plaintiff's condition on what he believes the position to be after interpreting hospital records (and believing parts thereof to be wrong). He is much in the same position as witnesses who reconstruct accident scenes, especially where it is contradicted by the direct evidence of medical doctors.

[25] The plaintiff's condition deteriorated some two years after his discharge from hospital and he is now apparently wheelchair bound. But the evidence before me that the plaintiff suffered some further problems after he was discharged from the Tambo Memorial Hospital is highly relevant having regard to the complete resolution of his right hemiparesis after the craniotomy. The problem with the left leg is not as a direct result of the intracranial problems suffered in 2011. At the outset of the trial, both parties agreed that all the medico-legal reports of the parties' expert witnesses are to be admitted by consent (save for the neurologists' reports). Save for the direct evidence of the plaintiff's recovery as testified to by his son and Dr Karan, an occupational therapist's report filed by the plaintiff, states as follows:

'Mrs and Mrs Barnard reported that his condition has been deteriorating since the writer initially saw him in August 2013.'

(The report was dated 25 July 2014)

They reported that he suffered a stroke at the end of May 2013. He was unable to walk or carry out personal care tasks for a period of time. His wife reported that he suffered a number of light strokes thereafter. Both left and right sides of his body have affected. Neuro-physical and neuro-psychological deterioration was evident'

[26] The plaintiff's neurological assessment done by Mr Mallison records that during late May 2014 the plaintiff suffered an attack that affected his right hand and right side of his face. The plaintiff's wife also advised Mr Mallison that the plaintiff suffered 'a mild stroke on the left side and partially on the right side.' As result of this, Mr Mallison said:

'Just prior to the present assessment he purportedly suffered a further neurological event which does not appear to have been fully investigated or diagnosed. These neurological and neuro-cognitive status, however, appears to have deteriorated further since then and it is not possible

to distinguish on the basis of neuropsychological assessment which difficulties have resulted from which event.’

Despite Mr Mallison continuing to state that it appeared that some of the difficulties were pre-existing and have been exacerbated by the later event, he too was in no position to determine whether the assault or whether a delayed performance of a craniotomy was the cause of the plaintiff’s condition prior to the later neurological events. Indeed, Mr Mallison refers to the severity of the brain injury of the plaintiff without a distinction between the consequences of the assault and the possible consequences of a delayed craniotomy.

[27] The evidence shows that the plaintiff recovered after the craniotomy but suffered further medical events, which events have not been shown to be as a result of delayed medical intervention during 2011 – as the plaintiff’s brain damage sustained as a result of the assault itself has not been shown to be a lesser nature than that which was eventually found in the scans.

[28] The plaintiff further attempted to introduce the fact that he suffered from epilepsy which was as a result of the delayed craniotomy. But such an inference would in direct conflict with the evidence that he and his wife had reported that he suffered several strokes. It would also be in direct conflict with the evidence of Dr de Klerk who testified that he was of the opinion that epilepsy came from whatever happened to the brain right from the very start before the plaintiff was even admitted to hospital and that the injury to the surface of the brain can lead to epilepsy. Dr Karan agreed that the contusion as a result of the assault with consequent haematoma resulted in an increased chance of epilepsy.

[29] The result is that any later epileptic seizures suffered by the plaintiff (if indeed he had such seizures) have not been shown to have had its origin in the delayed craniotomy and cannot be attributed to the medical staff of the Tambo Memorial Hospital as it had its origin in the original assault.

[30] Causation

In *ZA v Smith*⁵, Brand JA said⁶:

[30] The criterion applied by the court a quo for determining factual causation was the well-known but-for test as formulated, eg by Corbett CJ in *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at 700E-H. What it essentially lays down is the enquiry – in the case of an omission – as to whether, but for the defendant's wrongful and negligent failure to take reasonable steps, the plaintiff's loss would not have ensued. In this regard this court has said on more than one occasion that the application of the 'but-for test' is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the background of everyday-life experiences. In applying this common sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this causal link with certainty (see eg *Minister of Safety & Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 25; *Minister of Finance v Gore NO* [2006] ZASCA 98; 2007 (1) SA 111 (SCA) para 33. See also *Lee v Minister of Correctional Services* [2012] ZASCA 30; 2013 (2) SA 144 (CC) para 41.)'

[31] In this matter, I am asked to find that, but for the delay in the performance of the craniotomy, the plaintiff would not have suffered the consequences which he now suffers. Such a finding would be against the preponderance of the evidence which I have referred to. The plaintiff's claim consequently falls to be dismissed with costs.

Wepener J

⁵ 2015 (4) SA 574 (SCA).

⁶ At para 30.

Counsel for Plaintiff: J.J. Wessels SC

Attorneys for the Plaintiff: Munro Flowers & Vermaak Attorneys

Counsel for Defendant: M.W. Dlamini

Attorneys for Defendant: State Attorney Johannesburg