Judge Coley

IN THE HIGH COURT OF SOUTH AFRICA
KWAZULU-NATAL LOCAL DIVISION, DURBAN

Case No: D12441/2016

In the matter between:

MKHISHWA CEBEKHULU **PLAINTIFF**

and

THE MINISTER OF CORRECTIONAL SERVICES **DEFENDANT**

ORDER

The following order is granted:

The defendant is found liable for 100 percent of the plaintiff's proved or agreed damages, with costs.

JUDGMENT

ZP Nkosi J

Introduction

[1] This is an action for damages arising out of the amputation of the plaintiff's lower limbs following the medical condition which developed while in the care of the defendant. The plaintiff was a prisoner released from Westville Prison on parole and fitted with an electronic monitoring device ("the device"), initially to his right leg but later removed and attached to his left leg when it seemed to cause a swelling. The left leg suffered the same fate whereafter both legs were amputated – one below the knee while the other above it, after the presence of the gangrene had been discovered in hospital.

Pleadings

[2] The plaintiff alleges that the defendant and its employees owed a common law and statutory duty of care to him to ensure and / or take reasonable measures to ensure that the device did not cause a threat to his health, but failed to do so. As a direct result of the defendant employees' conduct the plaintiff thus suffered general damages for pain and suffering; disability; disfigurement; loss of amenities of life; and special damages in the total amount of R 5,7 million.

[3] The plaintiff's claim is disputed by the defendant. In particular, the defendant pleads that the device did not cause a threat to the plaintiff's health and denies that it is liable to the plaintiff as alleged or at all.

Trial

[4] Before the trial began in earnest and by agreement between the parties the issues of liability and quantum were separated in terms of Uniform rule 33(4). The issue of quantum was to stand over.

[5] The court was also advised that the plaintiff had since suffered a stroke which had rendered him unable to speak and testify. In his stead the evidence of Mr Ndlangisa was adduced.

[6] Mr Ndlangisa, a senior correctional officer of the defendant, testified to a report (marked "Exhibit A") he had compiled for his seniors which encompasses the facts of the case. He was stationed at Durban Community Corrections office in Field Street, Durban. His duties entailed ensuring adherence to parole conditions by parolees and in that regard was overseeing the supervisors of the monitoring officials of the parolees. He said the high-risk parolees, like the plaintiff, have to be monitored four times a month. The monitoring officials' report would be handed over to their supervisors who in turn report to him and he would further report to the head of the correctional services. The report, in this instance was compiled at the behest of the Deputy Commissioner, Tshiamo Badirwang who was advised of the plaintiff's case.

[7] The report contains the medical history of the plaintiff and it includes the tagging process, that is the fitting of the device on the plaintiff; the complications which developed therefrom; and how such complications were attended to. It appears from the records of the defendant's prison hospital that the plaintiff was on high blood pressure medication for his entire stay in prison; had no signs of diabetes mellitus or tuberculosis or prostate cancer up to the time of his release on parole, on 30 April 2015.

[8] According to the report, under the heading 'Policy Procedure on Electronic Monitoring' reference is made to paragraph 2.2.1 of the Policy which states that "the medical condition of offenders must be established prior to tagging, during activation, re-tagging and de-tagging of EM. To this effect a medical certificate must be submitted as a proof thereof". Mr Ndlangisa established that there was no medical certificate filed with the records of the plaintiff in the prison hospital before his tagging was done, on 8 June 2015.

[9] Mr Ndlangisa also refers to paragraph 2.2.5 of the Policy Procedure on Electronic Monitoring which highlights the "circumstances under which the de-tagging can be effected i.e. upon the sentence expiry, revocation of parole, exceptional circumstances in custody or deteriorating health condition". Paragraph 3.1.10.5 highlights "the areas to look for when you are examining the person's skin where the device attached i.e. signs of

allergic reactions such as swelling, inflammation or redness". And it further advises that "if this occurs seek the advice from medical professionals".

[10] Mr Ndlangisa stated in his report and viva voce evidence that although there were two certificates from different medical practitioners advising for the removal of the device from the plaintiff, this was not done immediately, instead and surprisingly without any medical advice or assessment the device was removed from the swollen right leg to the unswollen left leg which seemingly caused the latter also to swell, leading to both legs being eventually amputated.

[11] The next witness for the plaintiff was Dr Vinesh Padayachy ("Dr Padayachy"), a vascular and endovascular surgeon in private practice. He testified to his report (marked exhibit "D") which he confirmed under oath.

[12] The report contains the plaintiff's history after the tagging. The doctor based his opinion on the plaintiff's medical records and noted in his report that from the medical records the plaintiff had chronic or pre-existing peripheral vascular disease (exhibit D page 3). He found it was impossible for him to accurately determine if the device was the cause of the onset of gangrene having not seen the plaintiff at the time of his injury. He surmised, however, that the device did contribute to the plaintiff losing his legs, as he stated, "since both legs were amputated in a patient who had no previous history of similar problems in short succession and the only common factor seems to be the device" (exhibit D, page 4). In this regard, the doctor assumed, since the plaintiff's vascular status was not checked at the time of tagging, that the arterial supply to his legs became compromised due to tagging and that due to delays in de-tagging ischemia developed and eventually led to gangrene onset. That obviously assumes there was constriction of the blood flow caused by the device.

[13] Dr Padayachy's opinion is encapsulated in his evidence (Volume 4, page 100 line 16-page 102 line 9 of the transcribed record) as follows:

'...so obviously the person who fitted the device must have done this 100 times before so he would have fitted a fairly loose device. Mr Cebekhulu was hypertensive and he was on hypertensive medication as well, one of the side effects of hypertensive medications is that it can cause swelling of the legs, and when the device is fitted obviously it is fitted almost optimally, you know, the patient's leg would have been normal, he would have just got up in the morning and come there, once he is sent home his circumstances changes, now he is on his feet, he is walking around and he is then prone to developing swelling, so I am sure many people here as well find by the time they go home their leg is swollen, when they get up in the morning their leg is fine, so if the device was fitted loose at that point in time it was fine, but when he went home with his constant up and down, taking his medication, the leg would have swelled. Now because the device is there the leg would not have come back to normal by the next day...Because the device is now constricting the leg now...there it is going to limit the amount of fluid that is going to go back...It continues to swell up to a point where it is so swollen that it is now constricting the arterial flow and that is when you complain of pain ...so the problem was that it was not checked, once it was fitted that was it, no subsequent check was done, and I think that should be done'.

[14] In his replies under cross-examination, Dr Padayachy was of the opinion that, even with underlying vascular disease, it is highly unlikely to end up with two amputations so close to each other, as it is "usually a slowly progressive thing". He said, if a swelling is on the limb that has got a device that is constrictive and the patient complains of pain and swelling, then the assumption is that he is heading towards a compartmental syndrome – meaning the end scale of it where you are about to lose the leg if it progressively gets worse in the absence of an intervention.

[15] Dr Padayachy also stated that by the time the plaintiff was seen in St Mary's Hospital (exhibit A, page 54) on 21 July 2015 when they noted that the foot was numb and cyanosed (blue), tissue damage was done to that leg. So, when the officials took the device out at that stage it was too late as the damage would not have been reversed. The damage started would have progressed with the tissues slowly dying off, become blue, become black, become dry and then shrivel up, become infected and ultimately develop wet gangrene leading to amputation after demarcation is reached, that is, what level to amputate at.

[16] Dr Padayachy in his evidence noted that the plaintiff had never been diagnosed with diabetes nor any vascular disease (femoropopliteal) until he already had gangrene. He found it difficult to say or accept if the plaintiff had the latter condition before gangrene started (exhibit "C1", page 191).

[17] Dr Padayachy was also of the opinion that one does not go from normal legs to both legs being amputated in the matter of two months bearing in mind that the natural history of peripheral vascular disease is a slow drawn-out process. He reiterated in his evidence that the plaintiff was never documented as suffering from a peripheral vascular disease and that the ischemia developed from that condition.

[18] As to the damage to the left leg, Dr Padayachy stated that an extensive assessment should have been done of the leg before the device was put on, more so if there was a likelihood that there was an underlying peripheral vascular disease. This was obviously not done and the left leg suffered the same fate.

[19] In reference to Dr Rajkissor's medical report (exhibit A, page 29), Dr Padayachy stated that if the plaintiff had cellulitis on the leg, the swelling would have got even worse which means the arterial compromise would have been even worse. He said the problem with its presence (the cellulitis) is that while it can be treated, if you have a constrictive device while you treat it the constriction is still happening and the arterial compromise is still happening. So, the presence of cellulitis would have worsened the entire picture and that is why the doctor suggested the device be removed.

[20] Dr Padayachy was referred to Dr Perumal's report (exhibit D, pages 6-11), at page 10, which states:

'6.3 Had the device been the "culprit" causing the problems in the legs, then there ought to have been some improvement in the condition of the limb once the device was removed, on 24 July 2015. Instead, his condition deteriorated and necessitated amputation of the right leg on 23 September 2015, i.e., two months later. Furthermore, if the device was the cause of the amputation, then the amputation would have been at the level of the ankle and not above the knee, as in this case'.

In response, Dr Padayachy was of the view that Dr Perumal, being a forensic pathologist would not qualify to make the above statement as he does not deal with clinical patients but dead bodies. He added that, ordinarily, doctors do not amputate above the ankle because there is no prosthesis that can reasonably fit above the ankle. Even if the gangrene is just involving the foot, he stated, your amputation is below knee-mid to about two-thirds down.

[21] In the plaintiff's case, he states, gangrene had already progressed to mid-leg when he saw him at King Edward Hospital, in keeping with where the device was probably inserted. By then, he added, the damage was already done. So, he further states, whether you improved blood flow at that stage would have made no difference at all because he was already numb, cold and cyanosed which means he had nerve damage.

[22] With the plaintiff's case closed, the defendant opened its case by calling Mr Mbuso Nelson Buthelezi ("Buthelezi"), followed by Mr Sabatha Mkhize ("Mkhize"), both who were officers in the employ of the defendant as tagging officers and correctional supervision supervisors. On 8 June 2015, and on instruction from his superiors, Buthelezi subjected the plaintiff to electronic monitoring, that is, fitted the device (which he described as light plastic but indestructible) on his right leg above the ankle such that it could move up and down. It was, as he stated, not fitted tight on his leg.

[23] On 24 July 2015 he received a call from Mkhize that the plaintiff was in their offices, in Durban to complain that the leg on which the device was fitted was swelling. He then proceeded to the office and met Mkhize with the plaintiff.

[24] The plaintiff reported that the device has caused his leg to swell, which he also observed (exhibit "C3", pages 262-268). Buthelezi stated he also observed that the protection cloth under the device had since been replaced with the plaintiff's own bandage and it was tight to his mid-shin.

[25] On advice from their head office he removed the device from the plaintiff's right leg and fitted it on the left leg. He said the plaintiff's own bandage was also removed and discarded and that he warned the plaintiff not to remove the new cloth provided for protection. He said the left leg looked normal and unaffected.

[26] Buthelezi further testified that the plaintiff contacted him after the tagging of the left leg to advise him that the device had to be removed, on the doctor's advice. He then promised the plaintiff to make time to meet with the doctor. He said he made an appointment to meet with Dr Govender at RK Khan Hospital and the doctor advised him that it was not the device that was causing the swelling to the plaintiff's leg but his underlying sickness.

[27] Thereafter, he said, the plaintiff would phone and complain that he suffers swelling and pain also in the other leg. He and Mkhize then phoned their head office in Pretoria to report the problem but were advised to call the regional office in Pietermaritzburg, which they did. The regional office advised them to give the plaintiff a visit and check on him, which they did. He said during August 2015 they paid a visit and found the plaintiff sitting on a wheelchair with the left leg damaged – skin peeling under the foot, veins on top of the foot "transparent", as he put it (exhibit C1, pages 42-48).

[28] On this occasion he also noticed that the plaintiff had again put on his own bandage which was sitting tight under the device. On 3 August 2015, the plaintiff visited Drs Rajkissor and Vanmari who diagnosed that he had severe cellulitis in both legs which they believed was likely caused by the device and recommended its removal.

[29] Buthelezi stated that on or about 4 August 2015 his offices received a doctor's note recommending the removal of the device. They then liaised with the regional office in that regard. The device was then removed from the plaintiff's leg on 20 August 2015 by him with the assistance of Mkhize.

[30] Buthelezi stated that after the plaintiff was de-tagged, he breached his parole condition by visiting the area where he had committed the crime for which he had been sentenced. He was re-arrested and admitted back to Westville Correctional Centre for breaking his supervision conditions.

[31] Under cross-examination, Buthelezi explained that the protective cloth under the device can be easily removed, washed and put back on. He said parolees had a duty to do so and also to charge the battery of the device when it goes low. He mentioned that the monitoring officers only visited and checked the high-risk parolees four times a month. Otherwise, every other movement of the parolee would be ordinarily monitored on the "board" centred at the head office. But he added that the parolees are advised to call the supervisors or visit their offices if they encounter a problem relating to the tagging.

[32] Buthelezi stated that he was only carrying out the instructions given to him when he removed the device from the plaintiff's right affected leg to the unaffected left leg without establishing the plaintiff's medical condition. He said although he had undergone training for tagging parolees, he was unaware of the Policy Procedure on Electronic Monitoring referred to in Mr Ndlangisa's report. As he put it, they received instructions from prison, on form D 326, that an offender must be tagged and then they tagged him as per instruction.

[33] Buthelezi, under re-examination, said that the four times a month monitoring would include one occasion where the parolee comes to the office and on the other three occasions the monitoring officials must visit the parolee at home. He added that due to a shortage of members and the monitoring case load, sometimes they do not monitor four times as prescribed.

[34] Mkhize testified that his duties were also to monitor offenders that are under parole. All in all, and without repeating his evidence it should suffice to say he confirmed Buthelezi's evidence in all material aspects.

[35] Dr Pragandaran Moodley ("Dr Moodley") was the last witness for the defendant. He is a specialist vascular surgeon in private practice. He testified to the report he compiled for the defendant (exhibit D, pages 12-21). He confirmed the report and his findings therein.

[36] Dr Moodley opined that had the device been tightly fitted, on 8 June 2015, the swelling would have manifested much sooner than 13 July 2015 when the plaintiff visited Dr SS Meer. According to Dr Moodley the plaintiff developed swelling of his right leg from another cause and the device was "merely a compounding factor rather than the causative agent".

[37] Dr Moodley stated that "when we are looking at perfusion to a leg, there is a grey area normally about six hours, about six to 12 hours when we have compromised flow that, if we restore flow, we save the leg. Once we pass that period then it is – well, there is no point in doing anything because our tissues are already dead, they are non-viable. That is talking in an acute situation which means short onset". (Transcribed record, Volume 5, page 15 lines 3-9).

[38] Dr Moodley believes that had the right leg not been viable between 21 July 2015 (when seen at St Mary's Hospital) and 23 September 2015 (date of amputation) the plaintiff would have presented to a doctor complaining about really bad symptoms of excruciating pain. But because for a two-month period he had no complains relating to the right leg once the device had been removed, Dr Moodley said he was quite certain that it was a viable limb still.

[39] In Dr Moodley's opinion the plaintiff probably did have pre-existing peripheral vascular disease which was the predominant factor resulting in his amputations. He states that the plaintiff has several risks factors for peripheral vascular disease, which included uncontrolled poorly compliant hypertension, being a smoker and a newly diagnosed diabetic. However, he noted in his report that in the absence of documented medical

records confirming his pulse status at his time of incarceration the above conclusion can be brought into question.

[40] In his report (exhibit D, page 19) Dr Moodley found it highly improbable and virtually impossible for an ankle bracelet to have caused or even worsened the plaintiff's peripheral vascular disease which was clearly documented to be at the above knee level. He also found that there may have been some delay in removing and refitting the device when suggested by certain medical practitioners, however such delay was not the causative factor in the plaintiff requiring bilateral amputations.

[41] Dr Moodley believes firmly that had the plaintiff received critical medical care after both devices were removed, on 20 August 2015, his peripheral vascular disease would not have progressed from dry to wet gangrene which in his opinion is probably the most significant factor which resulted in the amputation of both his legs. He said the breaking of his parole condition (by defaulting, on 7 September 2015) was the most likely reason for him not seeking early medical care thus compromising his own health.

Issues

[42] The primary issue for determination is whether the plaintiff has succeeded to show, on a balance of probabilities that:

(a) he suffered damages caused by a wrongful and negligent act or omission of the defendant; and

(b) there is a causal connection between such act and the damage he suffered.

The underlined legal requirements are trite in our law of delict and will be traversed individually below.

[43] In arguments, the defendant has raised a new point in *limine* relating to the plaintiff's capacity to litigate. It is noted that this point has never been specially pleaded before the commencement of the trial nor raised at any other stage during the trial in order for it to be interrogated. I therefore consider that it has not been properly or appropriately raised to be considered in this judgment.

Merits

Act / Omission

[44] The act and / or omission of the defendant is evident in the following facts which are common cause: -

(a) the device was fitted on the plaintiff's right leg, on 8 June 2015, as part of his parole release conditions; and was moved to his left leg, on 24 July 2015, after having complained it was causing pain and swelling and provided a medical certificate to that effect. His right leg was amputated on 23 September 2015;

(b) the device was removed from his left leg, on 20 August 2015, also after experiencing pain and swelling and his left leg was amputated on 15 November 2015; and

(c) the plaintiff was not subjected to a medical assessment before being fitted with the device nor at any stage after its removal to check the extent of damage caused to his leg.

Wrongfulness

[45] In *Hawekwa Youth Camp and Another v Byrne* 2010 (6) SA 83 (SCA) para 22, the court held that:

'...wrongfulness depends on the existence of a legal duty. The imposition of this legal duty is a matter for judicial determination, involving criteria of public and legal policy consistent with constitutional norms. In the result, a negligent omission causing loss will only be regarded as wrongful and therefore actionable if public or legal policy considerations require that such omission, if negligent, should attract legal liability for the resulting damages.'

[46] This principle is cemented in *F v Minister of Safety and Security and Others* 2012 (1) SA 536 (CC) which held, at paragraph 118, as follows:

'Wrongfulness is established where there is a breach of a legal duty not to cause harm to another by one's negligent conduct. If the conduct consists of a positive act causing physical damage to another's person or property, both the existence of the duty not to cause harm and its breach are self-evident. The duty arises because the positive act infringes upon the recognised interests of property and security of the person. It is for that reason that the law recognises these invasions

as prima facie wrongful. In these cases, public and legal policy issues surrounding wrongfulness are already settled and wrongfulness can be avoided only by pleading some form of justification for the breach of the duty or, put differently, for the infringement of the recognised right or interest.' (Footnotes omitted.)

[47] The plaintiff submits that the defendant's act was wrongful in that there was a legal duty of care imposed on it by its own statute, in reg 28(2) of the Correctional Services Regulations, and at common law, to ensure that the device did not cause a threat to the plaintiff's health. Furthermore, the plaintiff adds, the defendant has its own policy and procedure which requires that a parolee be subjected to a medical assessment before being fitted with the device and after de-tagging.

[48] It appears to me from the legal prescripts referred to above that the existence of the legal duty not to cause harm to the plaintiff, as a parolee of the defendant, is self-evident. The defendant had a legal duty to ensure that the device did not threaten the health and safety of the plaintiff.

[49] On the evidence adduced the defendant seems to have failed in its duty and potentially exposed the plaintiff to harm or physical damage when the device was fitted on him. The defendant failed to conduct a medical assessment before fitting the device on the plaintiff and also failed to remove it timeously, upon medical experts' requests, when it appeared to negatively affect or threaten his health.

Fault (Negligence)

[50] The next crucial question is whether any culpability is attributable to the defendant for the physical damage suffered by the plaintiff. It is argued for the plaintiff that the defendant was negligent in fitting the device without due regard to the plaintiff's medical history, by fitting it in a manner that constricted blood flow to his legs and failing timeously to remove the same when advised to by the plaintiff's doctors.

[51] It is a trite principle of our law that liability for negligence arises if a reasonable person in the position of the defendant would foresee the reasonable possibility of his

conduct injuring another in his person or property and causing him patrimonial loss and would take reasonable steps to guard against such occurrence. (See *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E-F). In casu, a reasonable person would refer to someone trained and qualified to fit tracking devices, as the defendant's officials were.

[52] It seems clear that the defendant had foreseen the possibility of harm in fitting the device on a parolee without following the protocols specified in its monitoring regulations and procedures in order to safeguard against the risk to another person's health. In paragraph 2.2.1 of its Policy Procedure on Electronic Monitoring it is stipulated that the medical condition of offenders must be established prior to tagging, during activation, re-tagging and de-tagging. To this effect, a medical certificate must be submitted as proof thereof. Furthermore, in paragraph 2.2.5 it is provided that in circumstances where the health condition of the offender deteriorates, de-tagging can be effected.

[53] Despite being aware or, put differently, with the possibility of harm foreseeable, the defendant went ahead to fit the device on the plaintiff – not once but twice to his legs without first conducting a medical assessment as required and thereafter failed to de-tag him, timeously, when his health condition deteriorated as seen and advised by the medical doctors. The defendant would have been aware that the plaintiff had high blood pressure and was on medication for his entire period in prison. Also, that on occasions he would visit the prison hospital complaining of leg and body pains.

[54] After the tagging, the defendant via its employees, Buthelezi and Mkhize, at the very least became aware, on or about 13 July 2015 that the device was compromising the health of the plaintiff's right leg and that de-tagging was required. The de-tagging was not undertaken until 24 July 2015, apparently when irreversible damage had occurred. Thereafter, no medical assessment or medical opinion was sought in order to determine if it was safe to re-tag to the left leg which, likewise, became compromised.

[55] I believe, a reasonable person in the position of the defendant would have taken reasonable steps to guard against the foreseeable injury to the plaintiff by undertaking a

proper medical assessment of the plaintiff's health prior to tagging and re-tagging to the left leg and to respond timeously to the deteriorating health condition of his legs when medically advised by doctors. The defendant's conduct (breach of legal duty) was therefore negligent.

Causation

[56] The test for causation is laid out, *in Minister of Police v Skosana* 1977 (1) SA 31 (A), 34 E-G per Corbett JA, as follows:

'Causation in the law of delict gives rise to two rather distinct problems. The first is a factual one and relates to the question as to wether the negligent act or omission in question caused or materially contributed to the harm giving rise to the claim. If it did not, then no legal liability can arise and *cadit quaestio*. If it did, then the second problem becomes relevant, viz whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether, as it is said, the harm is too remote'. (Cases cited were omitted).

'The evidential hurdle to be crossed by a plaintiff is not required to be established with certainty – a plaintiff need only establish that the wrongful conduct was probably a cause of the loss'. (*Minister of Safety and Security v Venter and Others* 2011 (2) SACR 67 (SCA) para 28).

[57] It is the plaintiff's argument that the fitting of the device is the factual and legal cause of him losing both legs due to developed gangrene caused by the lack of blood circulation in his legs, with the fitted device gradually becoming tight because of the swelling ostensibly from an underlying health cause.

[58] It seems to be common cause that:

(a) prior to the plaintiff being fitted with the device, he did not have any serious medical issues with both legs; and

(b) subsequent to being fitted with the device, each leg fitted with it gradually developed a swelling accompanied by pain which necessitated de-tagging.

[59] It also appears to be common cause between the vascular and endovascular surgeons that:

(a) the swelling of the plaintiff's legs could not have been caused by the tightness of the device when fitted – otherwise the plaintiff would have presented earlier than 13 July 2015 for medical attention with pain that would have been unbearable;
(b) the device should not have been fitted without the doctor's preliminary examination and approval;
(c) the device contributed to the swelling of the legs; and
(d) the removal of the device as soon as it was discovered that it was compounding his condition was critical to avoid compromise in his blood circulation.

[60] Dr Moodley formed an opinion that the plaintiff possibly had an underlying peripheral vascular disease, undiagnosed earlier, which later led to the amputations when it was not medically attended to on time. He believes that at the time the device was removed, the plaintiff's legs were still viable.

[61] The plaintiff submits that no evidence of prior medical issues with both legs was led by the defendant. He further submits that although it was intimated, by Dr Moodley, that he could have had an underlying peripheral vascular disease, it was never confirmed if indeed he had the disease, and it therefore remained a medical speculation.

[62] It seems too much of a coincidence that each leg fitted with the device became the only one compromised if caused by an underlying peripheral vascular disease. I agree that Dr Moodley's opinion is speculative in that respect.

[63] It is Dr Padayachy's expert opinion that the perfusion of the blood flow to the legs was compromised by the presence of the device when the swelling of the legs from other causes, probably hypertension treatment side-effects occurred. His opinion takes into account the fact that the plaintiff was confirmed hypertensive and taking treatment for it even in prison and had never been diagnosed with an underlying peripheral vascular disease.

[64] In his view, absent the device the blood occlusion would probably not have taken place, certainly not in an accelerated fashion it did on both legs. From 13 July 2015, and

when advised by the doctor that the device might be causing harm to the plaintiff and had to be removed, it took the defendant a further 11 days to remove the device from the right leg and approximately another four weeks from the left leg. Dr Padayachy holds the view that by the time the device was removed the damage had already been done to the legs and the course became unchangeable. The medical report issued at St Mary's Hospital suggests so, as there was already an indication of nerve and muscle damage to the right leg before the device was removed.

[65] It appears to me that the fitting of the device, without a medical assessment, on someone with a condition prone to swelling and failure to intervene immediately or as soon as possible before his health deteriorates to an unchangeable status or to have him immediately assessed to arrest further damage, is the most probable cause of the plaintiff developing ischemia, gangrene and ultimately losing both legs. So, I find that there is a sufficiently close link between the fitting of the device and the plaintiff losing both legs since no illness or medical condition has been shown to be the cause of same. In this regard I consider the bandage used as a skin cushion to be part of the device and less of a dominant factor, if not insignificant, to the damage caused to the plaintiff. Put differently, the device – not the bandage was the catalyst for the harm suffered or occasioned by the plaintiff.

[66] After having caused harm to the plaintiff, the defendant had a duty to medically assess him upon de-tagging and seek treatment for him to arrest and / or reverse the damage already caused in order to restore the blood flow to his limbs, if so medically advised. That should not have been left in the hands of the plaintiff who was still under its care.

[67] In the result, I am satisfied that the defendant is liable to the plaintiff for 100 percent of the damages he has suffered or is able to prove. The costs should follow the result.

Order

[68] The following order shall issue:

The defendant is found liable for 100 percent of the plaintiff's proved or agreed damages, with costs.

ZP Nkosi J

CASE INFORMATION

DATE OF HEARING	:	12 JULY 2022
DATE JUDGMENT	:	24 FEBRUARY 2023
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