



IN THE HIGH COURT OF SOUTH AFRICA,
FREE STATE DIVISION, BLOEMFONTEIN

Reportable:	YES/NO
Of Interest to other Judges:	YES/NO
Circulate to Magistrates:	YES/NO

Case number: 5900/2008

In the matter between:

B H

Plaintiff

and

PRELLER PLAIN APTEEK

Defendant

HEARD ON: 1 & 2 NOVEMBER 2016,
16, 17 & 18 OCTOBER 2017,
24 JANUARY 2018

JUDGMENT BY: MATHEBULA, J

DELIVERED ON: 29 JUNE 2018

- [1] The plaintiff instituted an action for damages against the defendant arising out of the alleged negligent administration of the injection into a sacral nerve in or emerging from or having emerged from one of the paramedian sacral foraminae, two hand widths above the gluteal fold in the vicinity of the sacrum. It is common cause that the injection was administered on 26 August 2006 by an employee of the defendant at its premises.
- [2] The parties handed in a draft order agreeing to separate the merits and quantum. I made it an Order of Court and this Court is seized only with the determination of the merits at this stage.

The grounds of negligence alleged by the plaintiff

- [3] On paragraph 8 of the amended particulars of claim the plaintiff is alleging that the defendant breached the legal duty of care in the following respects viz:-

- “8.1 the said employee was not qualified at all, alternatively adequately qualified to administer injections of this nature; and/or**
- 8.2 the said employee failed to refer the administration of the injection to a suitably qualified person; and/or**
- 8.3 the said employee administered the injection incorrectly by the administering it into a sacral nerve in one of the paramedian sacral foraminae or in the sacral canal via the midline sacral hiatus; and/or**
- 8.4 the said employee failed to administer the injection in accordance with accepted medical protocol to wit in the upper outer quadrant of the buttock.”**

The grounds of denial of negligence by the defendant

- [4] The defendant denied liability. The allegations in the plea are couched in the following manner:-

“Behalwe om te ontken dat die betrokke werknemer van Verweerder nie oor die standard mediese- en/of verpleegkundige vaardigheid in die toediening van inspuitings beskik het nie en paragraaf 5.2 te ontken, word die res van die beweringe in hierdie paragraaf erken.”

“6.2 Verweerder pleit dat die betrokke inspuiting toegedien is in die boonste buite kwadrant van die Eiseres se regter boud en pleit verder dat die inspuiting toegedien is met 12.7 mm kort G26 naald met 0.45 mm deursnee (algemeen bekend as ‘n subkutane naald) welke ook nie die sakrale senuwee kan bereik of die paramediane sakrale foraminae of die sakrale kanaal kan bereik en/of raak nie, en/of kan bereik en/of raak op die wyse soos deur die Eiseres beweer nie.”

“7.2 Verweerder pleit dat medies, anatomies en fisiologies gesproke die kanse uiters skraal en/of bykans onmoontlik is dat die beweerde diskus besering na die inspuiting kousaal kon plaasvind en/of plaasgevind het soos deur die Eiseres beweer”

“8.1.1 Verweerder pleit verder dat die betrokke inspuiting inderdaad in die boonste buite kwadrant van die Eiseres se regter boud toegedien is”

Plaintiff's evidence

- [5] The facts are briefly as follows.

- [6] Prior to 12 August 2006 the plaintiff had urinary tract infection causing her kidney and lower back pain. She consulted Dr Bosman a chiropractor who eased the pain a bit. However, she felt a bit overweight and decided to start a well talked about diet programme offered by the defendant.
- [7] On 16 August 2006 at the business premises of the plaintiff she met Mareli Gscabai who explained the details of the diet plan. She was given some pink tablets meant to obliterate sugar cravings. In addition an injection containing a fat burner and Vitamin B was administered on her by Christanet Gousaard (now Janse van Vuuren). Before an injection was administered on her she kept a close interest to ensure that it was safe. Incidentally she remarked about the size of the needle that it was really big. In her estimation it was approximately five (5) centimetres long. She noticed that the needle holder was green in colour.
- [8] She was in a standing position when she opened her pants for her to inject her buttocks. She was expecting to be injected on the right buttock. Christanet told her that “nee, ek moet jou bo jou naat inspuit.” In that case she exposed her sacrum area without exposing her buttocks for the injection to be administered on her.
- [9] Christanet cleaned her with a swab soaked with alcohol and she could feel its coldness thereof. She then proceeded to inject her. Although she could not see the exact area of the injection, it was almost in the middle of her body more or less near the gluteal cleft at the top. Everything went according to the plan and she left.

- [10] On 23 August 2006 she returned a urine sample holder and to receive another injection. While in conversation with Mareli, Christanet hurriedly entered. She was evidently late for their appointment and she politely apologised. They exchanged pleasantries and plaintiff was pleased that she had lost three (3) kilograms in the past week.
- [11] Christanet removed the green coded needle in preparation to administer an injection. Customarily she observed her every movement to satisfy herself that she was adhering to the required safety standards. She stood up in front of the desk she was sitting next to. She had one hand on the desk, pulled her pants down and leaned forward. This position was in contrast to the first injection which was administered while she was standing upright.
- [12] Like the first time she felt the coldness of the swab on the same area as the previous week. She felt the prick more or less to her left side. In split seconds she felt an excruciating shooting pain at the back of her left leg into her foot. This was followed by hot flushes all over her body and she heard ringing noises in her ears. It was the first time she experienced such a feeling. She knew that she was going to faint and she told Christanet. Both Mareli and Christanet put her on the chair. The latter said that she must put her head between her legs. She remembers seeing Mareli running out of the room probably to summon help and shortly thereafter she blacked out. She suffered excruciating headache with stiff muscles all over her arms, legs and back.
- {13} When she regained her consciousness she was surrounded by a number of people but still feeling the excruciating headache and

back pain. Mareli asked her if she had epilepsy and she responded in the negative. She told her she had properly had grand epileptic fit because she had convulsions and her eyes rolled back. She knew about this because her husband suffers from epileptic fits.

- [14] Christanet rubbed her arm and apologised for injecting her. Embarrassingly she discovered that she had wet herself. An ambulance was called and she was taken to hospital. She was attended to by a medical practitioner and later discharged. Before discharging her, the medical practitioner advised her to consult a neurosurgeon if the back pain persists.
- [15] The pain persisted and she secured an appointment with Dr Relling(neurosurgeon) on 29 August 2006 who operated on her back on 30 August 2006. The explanation that he gave her was that her disk was totally shattered in the same fashion as a glass of wine that is dropped down. The pain did not dissipate and she consulted and sought a second opinion from Dr Hugo (neurosurgeon) who performed another laminectomy in 2008 because pieces of her disk were left behind.
- [16] As a result she is presently suffering constant back pains and had to leave her employment as a manager at Columbus Cleaning and Hygiene. Prior to 23 August 2006 she did not take medication for epilepsy. She experienced another epileptic fit on 3 June 2007. Different epilepsy medication was prescribed for her and eventually she was taken off the medication in January 2013.

- [17] Under intense cross-examination she testified that she was admitted to Bloem Care for depression in 2007. That was after the incident in question. A medical practitioner who treated her there Dr Jordaan erroneously identified her as another patient who had family members with epilepsy. This aspect was rectified about a week later while receiving treatment there.
- [18] She confirmed that the urinary tract infection had caused her a lower back pain. The decision to consult Dr Bosman was motivated by the fact that he had helped her husband in the past. Although the pain progressed from around 10 August 2006 she continued reporting for duty. It was only after she returned from sick leave that she virtually handed everything to her employees.
- [19] She was taken through the reports of Dr Repko and Edeling and pertinently that they did not make mention of the needle that was allegedly used on her. Her response was that she had repeated her version to every medical practitioner and she cannot give a response why that aspect was not properly recorded by them. She remained resolute that the injection was administered in the middle above her gluteal cleft. At the time she was injected her pants were still covering her buttocks otherwise she was only able to inject her through her pants.
- [20] She denied telling Christanet that she was suffering from a severe back pain. Her response was that she was not in the room while she was in conversation with Mareli. Furthermore she did not recall informing her that she was working at a place where she was required to carry heavy boxes. Lastly, she did not say she experienced back pains the previous weekend.

- [21] Once more she confirmed how she felt after the injection. She could not remember what transpired while sitting on the chair because she had blacked out.
- [22] Dr Herman Jacobus Edeling a neurosurgeon registered with the Health Professional Council of South Africa who qualified in 1992 gave evidence on behalf of the plaintiff in the field of neurosurgery. He explained that his field concerns primarily conditions affecting the nervous system which includes the central and peripheral nervous system. The central nervous system is the brain and spinal cord. The peripheral nervous system pertains to the nerves that emanate from the brain and spinal cord and travel to supply various parts of the body.
- [23] He explained referring to the model of the lower end of the spinal column that it is a bony column. At the end of it is the coccyx which has a triangular shape. Directly above it is another triangular shaped bone called the sacrum consisting of five fused sacral vertebrae with holes and gaps between them.
- [24] The twelve bones that are stuck together are connected by joints and in the spine part of the joint is the intervertebral disc. The function of the vertebral disc is to carry and support the weight of the whole top part of the body ie to provide a measure of flexibility or pliability to a weight bearing structure.
- [25] According to him a disc prolapse is when a back part of the disc is injured and the ligament containing the disk raptures resulting in the disc material extruding backwards from the space into the

spinal canal. The nerves are emanating from the spinal cord. As soon as they exit they divide into two branches labelled the ventral ramus and the dorsal ramus. The ventral rami come out the sacral foraminae. The dorsal rami emerge from the sacral foraminae at the back and lay on the surface of the muscle penetrating all soft tissues that overly the bone. These nerves are all connected to the brain and that any sensation will be transferred to the brain.

- [26] He further explained that the midline is a vertical line from the middle of the head at the back down the middle between the left and the right side at the back. The term para median means alongside the midline although it does not give an indication of how many millimetres from the midline.
- [27] He pointed out the gluteal cleft of the plaintiff as shown in photo 15 on page 41 of the defendant's bundle. He confirmed that on top is the skin part where the nerves will lie. He stated that if a needle was to penetrate the skin, it will first go through the skin itself. Thereafter it will go through the subcutaneous tissue which is basically fat and some fibrous tissue. Then it will go through the muscle fascia which is a layer of white tissue lying on the surface of the muscle. Lastly it will hit the bone. However, if the needle was inserted closer to the midline, then it will be a shorter path to the bone.
- [28] The gluteal cleft can have a different length depending on the height, weight of different people. Infra gluteal fold refer to the fold below the buttocks.

- [29] He compiled the first report before consulting with the plaintiff after being given her injury diagnoses. These were given to him as complications of sacral intra neural injection, meaning injection into a nerve. This was followed by epileptic seizures and the L5-S1 disc prolapse with cauda equina radiculopathy. As a result she underwent two operations by Drs Relling and Hugo.
- [30] On 11 October 2013 he had an initial consultation with the plaintiff. This necessitated the amendment of the previous report hence he compiled an addendum to the previous medico-legal report. His previous conclusion was wrong because from the documents at his disposal he concluded that she was more in a horizontal position when the injection was administered. This was contrary to her explanation as to how the second injection was administered. On this occasion she was standing next to the table with her feet closer to each other. Although there was an incline, she was not horizontal.
- [31] Regarding the needle that was used, he formed his opinion on the 26G which was handed in as exhibit 1. He did not canvass this issue with the plaintiff because she told him that she did not see the needle. He explained the difference between subcutaneous intermuscular and intravenous injections. Together with the defendant's expert, Dr Wilkinson, they agreed that the injection site was two hand widths above the gluteal fold.
- [32] However he was critical of the method and described it as an inaccurate description because people have different hands and sizes thereof. In order to be correct in that approximation, a patient has to be undressed, lying horizontal so that the gluteal fold can be

clearly noticeable. The easy reasoning on why the method is not preferable is because patient's buttocks differ in size and shapes depending on their bone structure and size. The difficulty was apparent in the deficiency of this method because Dr Wagner could not indicate where it was along the line.

- [33] Both of them looked at the plaintiff's photographs indicating the site of the injection. They accept that the horizontal orientation of the injection was in or close to the posterior midline between her buttocks. This means that it was in the midline or close to the midline. This was consistent with what the plaintiff had indicated with the circle. However, they were unable to agree or specify how far or close to the midline. Accordingly closer to the midline means that it was in the sacral area which covers the area indicated with the circle by the plaintiff.
- [34] They could not agree on the capacity of a 26G subcutaneous needle with a length of 12.7 millimetres to penetrate a sacral nerve. According to him such a needle will be able to penetrate the sacral nerve. The basis of his conclusion is that the only tissue between the nerve and the outside is the skin and subcutaneous tissue. So, if a needle measuring 12.7 millimetres is injected through the skin directly inwards, it can easily hit the nerve. This can also happen where the needle is pushed on the softer part of the body because there is no resistance there. In that case that needle will get to a depth some distance beyond the 12.7 millimetres assumed depth of injection.
- [35] He concluded that the acute symptoms and their intensity could only have been caused by an injection into the nerve. In his view

there is no other mechanism he could contemplate that can cause that kind of acute symptom. The pain that she felt on her left leg down to the foot is consistent with an injection that was administered on the left side.

[36] In her case she experienced a vasovagal attack which occurs when the brain is bombarded by a very potent sensory stimulus. In this matter it was an unusual sensory input from a nerve into the brain. This is commonly referred to as a faint. The two EEG reports showed a brain focus. The plaintiff did not suffer from any head injury or stroke. The conclusion is that the brain focus was probably present all the time in a latent or symptomatic manner. The plaintiff suffered a grand mal seizure which is described as a bad and obvious kind of epilepsy. This is the case where there is incontinence, all four limbs shake and loss consciousness.

[37] Further the MRI scan taken by Dr Relling six days after the event showed that she had a severe sequestered disc prolapse. When she regained her consciousness she was aware of the back pain. This did not happen at a later stage. The conclusion is that the disc prolapse occurred at the same time as the epileptic fit. In this matter the plaintiff had a longstanding chronic degeneration of her L5-S1 disc.

[38] Under cross-examination, he testified that people faint for a severe emotional reaction. In this matter, the plaintiff felt a sharp intense pain on the second injection. This did not occur the first time she was injected. The difference between the two injections is that the second one went into her sacral nerve.

- [39] He vehemently denied the proposition that she could have fainted from a number of actual issues. The basis of his assertion was that a medical diagnosis is based on the scientific probability of being right. In casu there is the immediate proximate temporal relationship between the injection, the pain and the vasovagal attack. This means that the diagnosis of a vasovagal attack precipitated by an injection into a nerve is a high probability. To think otherwise will amount to an absurdity.
- [40] He conceded that the subcutaneous nerves are linked with the nerves. He pointed out that corporal punishment on the buttocks does not cause one to have a shooting pain down the leg. It is not the same with injection going into a nerve and injecting an irritating substance into it. The outcome will be different.
- [41] He gave a detailed explanation of how an injection into a small peripheral cutaneous nerve lead to a person experiencing pain down the leg. In essence when a strong sensory impulse enters the nervous system through a nerve irrespective of what nerve is, the impulse is carried proximally towards the brain. The pain may feel as if it's coming from a nerve in the leg whereas the impulse went from the sacral nerve in the conus medularis of the spinal cord. That he explained as the pain phenomena. The brain cannot decipher whether it is for example a thorn in the leg or a burning in the leg. He confirmed that he stood by this conclusion that the injury diagnosis is complications of sacral intramural injection. The pain and the sensory overload associated with the injection into the sacral nerve were too insurmountable. According to him the injection precipitated epilepsy from a latent focus. He differed with other experts who held a contrasting view.

Defendant's evidence

- [42] Christanet Janse van Vuuren was the pharmacy assistant employed by the plaintiff at the relevant time. She had completed a pharmacy assistant course obtaining a certificate thereof. She was in charge of the diet programme together with Mareli Gscabai. She was the one who was administering injections.
- [43] In 2003 in Bloemfontein she received training for one (1) day from Josef and Gert Coetzee regarding the diet. It was based on the overall programme, how to test urine and administer injections. The injections were administered weekly and the substance in the syringe remain the same. She was taught to administer the injection on the shoulder and buttocks. The technique she was taught was to divide the buttock into four quarts and inject on the outer corner of the top quarter. The decision of the location of the injection lied with the patient. On the day in question she administered the injection on the plaintiff using a needle commonly referred to as 26G. She vehemently denied using a needle with a green tip.
- [44] Prior to injecting the plaintiff she had already performed almost eight hundred (800) injections on others. She had injected the plaintiff prior to 23 August 2006 although she could not remember on which part of the body. However what she vividly remembers is that she did not inject her as shown on photo 12 on page 42. This refers to the circled area over the sacrum

- [45] On that day she came into the room and found the plaintiff standing and complaining about a very bad back pain. She was explaining that she was carrying heavy boxes and one of her friends had injected her with Voltaren over the weekend. The pain had subsequently subsided. Thereafter the plaintiff dropped her pants a little bit and she proceeds to inject her.
- [46] After injecting her, the plaintiff expressed not feeling well and she advised her to sit down, put her hands in front of her and rest on her arms. She asked Mareli to fetch water. All of a sudden the plaintiff made unusual noise and started sliding down the chair. Her eyes rolled. She summoned help and they made her lie on a mattress. A colleague Marisa Beukmann mentioned that it was an epileptic attack and assisted her that she must not swallow her tongue. They called for an ambulance.
- [47] She confirmed that there was incontinence because the blue chair was wet. The plaintiff suffered convulsions but not at the time she was lying on the floor. The entire episode from the injection to her regaining her consciousness took less than ten (10) minutes.
- [48] She accepted that when the person is injected, there is the depression of the skin although it will differ from one person to the other. Most of the incidents on the day she could not remember because everything happened a long time ago. Indeed she apologised to the plaintiff after injecting her.
- [49] She denied injecting the plaintiff as she alleged. Although she initially said she injected her on the bottom quarter, she retracted that it was a mistake as she meant to say the corner of the top left

outer quarter. She consulted with Dr Wagner and told him that the injection was to be administered two hand widths from the gluteal fold.

[50] Briefly Mareli Gscabai testified that she was employed by the defendant as a diet clinic consultant and worked with Christanet for a period of approximately a year. She received training and she was trained by the Pharmacist to administer injections. The needle that was used was a small brown needle. Although initially she did not give injections at some stage she did.

[51] She observed many times that Christanet administered injections because the programme was very popular. She doubted strongly that Christanet could have used a 21G needle. They were very specific about the size of the needle and that Christanet was a careful person.

[52] She conducted the initial interview with the plaintiff. All the information was obtained from the plaintiff. This includes the fact that she had a back pain. She remembered vaguely the incident on 23 August 2006. She denied that her husband suffers from epileptic fits and at no stage did she say so. Further, words like grand mal are unknown in her vocabulary.

[53] Dr Elizna van Aswegen was stationed at Mediclinic Emergency Unit when the plaintiff was brought to her. She took the history of the patient in order to examine her. In addition a straight leg raising test was performed to see if the sciatic nerve might be pinched and if the patient has any pain. It was negative. She was aware that the plaintiff had a severe back pain after an injection

followed by a fall. She agreed that the disk prolapse result in a tearing of a ligament containing disk materials. If it leaks it goes somewhere and it take some time before reaching the spinal column and a patient getting an impingement on a nerve.

[54] Dr Leon Wagner a forensic pathologist with impeccable curriculum vitae previously attached to the Faculty of Medicine at the University of the Free State gave evidence on behalf of the defendant. In February 2010 he took the photographs of the plaintiff indicating where the needle was inserted on her. However he did not consult with her regarding the history and what led to this particular matter.

[55] He confirmed that Christanet Janse van Vuuren had told him that she was trained to give injections two (2) hand widths from the gluteal fold. This was the correct place to administer an injection whether subcutaneous or intramuscular. It be unusual for any complications to follow if the patient is injected in the right upper quadrant. He contradicted the report by Dr Repko that the injection after administered it moved upwards. Further that the subcutaneous needle was too short and frail to be inserted through the ligaments. The ligaments are very hard, thick and sturdy to be penetrated by such a needle. He concluded that the injection could not have contributed to causing an epileptic fit.

[56] He fortified his argument by stating that a drug that is injected in a slightly obese person will be confined to the fatty not the muscular tissue. The drug will simply lie there and take time to dissolve before being absorbed into the vascular system and have any

systemic effect. In this matter the drug given was harmless to have any effect on the brain.

- [57] He differed with Dr Edeling that the needle was small and that even if it was injected on the midline it could not have penetrated to the extent of perforating the nerve and depositing the drug injected. In addition the fact that the test performed by Dr van Aswegen was negative indicates that there was no protrusion or inflammation present of the sciatic or the sacral nerves. The absence of pain means there is no injury.
- [58] He conceded that he is not a clinician but was expressing an opinion on clinical issues not falling within the ambit of his speciality. He differed with the testimony of Dr Edeling that the plunger must be pressed with force to get into the body.
- [59] Briefly the evidence of Henda Pretorius corroborated that of Dr van Aswegen that she did the general assessment on the plaintiff when she arrived at the emergency unit. She obtained the history from the patient and recorded the vital signs.
- [60] Professor Coert de Vries a registered Radiologist and head of the Department of Clinical Imaging and Sciences also took to the stand. He explained the latest developments in his field and new methods called minimum invasive therapy. He explained epilepsy differently although substantially confirming what Dr Edeling had already touched on.
- [61] He testified that the epileptogenic focus is in the brain and an injection is nowhere near the brain. According to him the

conclusion of Dr Edeling that the small nerves that lies on top of the muscle as peripheral nerves over the sacrum can easily be hit by a needle was wrong. The basis of his reasoning is that those dorsal rami are not motorically connected to the leg. Especially an injection that touches or penetrates such a peripheral nerve, would not cause a shooting pain down the leg. This is impossible simply because there is no direct link between the dorsal, sensory and motoric system to get that direct pain.

- [62] Cross-examination elicited that he had not seen any clinical notes why the plaintiff was admitted at Mediclinic on 23 October 2006. These were not taken into account when he compiled his report. He was also not aware whether the plaintiff suffered any epilepsy or not prior to 23 August 2006 and thereafter. Neither was he aware that he was put on medication called Tegretol. Although he steadfastly maintained that a needle cannot cause an epileptic fit or seizure, he could not tell what caused the plaintiff to experience the epileptic fit.
- [63] The last witness Dr Dewald Gouws a Radiologist and former partner of Van Dyk and Associates practised his profession for twenty three (23) years prior to his retirement in 2016. On 25 February 2011 he compiled a report on pages 146 to 147. The plaintiff showed the area where the injection was administered. The photographs are on page 148 of the bundle. He measured the distance between the skin to the spinal column was measured at 87.2 millimetres.
- [64] He concluded that there was no possibility that a small needle can approach the canal. It is equally impossible to do with a big

needle. In essence, the needle is impossible to puncture the nerve. Accordingly a sacrum can be penetrated at oblique not horizontal angle. Of the two needles mentioned in the matter it was impossible.

Applicable legal principles

[65] The plaintiff bears the onus in proving that the employee of the defendant failed to adhere to the requisite standard of care when she injected her on 23 August 2006. Further that through her actions she suffered a seizure that resulted in prolapse of the L5-S1 disc.

[66] In order to establish liability conduct of the defendant must have been wrongful.¹ It is trite that in a delictual claim a plaintiff is duty bound to prove negligence, causation and harm. The test for culpa was laid in **Kruger v Coetzee**. Holmes JA expressed himself in the following manner:-

“For the purposes of liability culpa arises if –

(a) a diligens paterfamilias in the position of the defendant –

- (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and**
- (ii) would take reasonable steps to guard against such occurrence; and**

(b) the defendant failed to take such steps.

This has been constantly stated by this Court for some 50 years. Requirement (a) (ii) is sometimes overlooked. Whether a diligens paterfamilias in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend upon the particular circumstances of each case. No hard and fast basis can be laid down. Hence the futility, in general, of seeking guidance from the facts and results of other cases”.²

¹ Indac Electronics (pty) Ltd v Volkskas Bank Ltd 1992 (1) SA 783 (A) at 797

² 1966 (2) SA 428 (A) at 430 E-G

- [67] The formula for determining negligence is not a “one size fit all” solution appropriate in every case. This was also stated in **Sea Harvest (Pty) Ltd and another v Duncan Dock Cold Storage (Pty) Ltd and another** as follows:-

“Having said this, it should not be overlooked that in the ultimate analysis the true criterion for determining negligence is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person. Dividing the inquiry into various stages, however useful, is no more than an aid or guideline for resolving this issue.”³

This is the correct approach that has been endorsed and adopted by the Constitutional Court as the applicable test.⁴

- [68] The aggrieved party must prove causation on a balance of probabilities. The court has repeatedly held that the “but for” test requires flexibility and common sense approach. In **Minister of Safety and Security v Duivenboden** the court eloquently said the following:-

“A plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.”⁵

³ 2000 (1) SA 826 (SCA) at 839

⁴ *Oppelt v Head: Department of Health, Western Cape* 2016 (1) SA 325 (CC) para 69

⁵ 2002 (6) SA 431 (SCA) para 25

[69] In this matter the parties adduced evidence of eminently qualified experts in their respective fields. Evidently they expressed conflicting opinions on the matter at hand. In evaluating the evidence of expert witnesses, it must be determined whether and to what extent their opinions are based on logical reasoning. This was emphasized by the Supreme Court of Appeal as follows:

“That being so, what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning.”⁶

This has been held to be the only way the court is able to determine which one of the conflicting opinions should be preferred.⁷

[70] The primary function of an expert is to assist the court in matters that the court does not have the necessary knowledge to decide the issue. The court must be “satisfied that because of his special skill, training or experience the reasons for the opinion which he expresses are acceptable”.⁸ The cogency of the underlying reasoning which led the experts to their conflicting opinions must be determined.⁹

Evaluation of the evidence

[71] It is common cause that Christanet injected the plaintiff on 23 August 2006. The dispute between the two (2) is the area of injection and the type of needle she used to administer the

⁶ Michael and another v Linksfield Park Clinic (Pty) Ltd and another 2001 (3) SA 1188 (SCA) para 36

⁷ Medi-Clinic v Vermeulen 2015 (1) SA 241 (SCA) para 5

⁸ Menday v Protea Assurance Co Ltd 1976 (1) SA 565 at 569 B

⁹ Buthelezi v Ndaba 2013 (5) SA 937 (SCA) at 442 G

injection. According to the plaintiff it was on the encircled area covering the sacrum. This is clearly illustrated by her on the diagram on page 1 of the plaintiff's bundle. She testified that on both occasions the injection was administered in the middle of her body more or less to the top part of her gluteal cleft. The site of the administration of the injection is also recorded as more to the midline as conveyed by the plaintiff to Dr Relling.¹⁰ Further both neurosurgeons namely Drs Edeling and Wilkinson are in agreement that the injection was either in the midline or close to the midline. This is consistent with the evidence of the plaintiff.

[72] Christanet testified that she had administered hundreds of these injections. She had only received extremely limited training of one (1) day. She was taught to administer an injection by dividing the buttocks into four quarters. Then on the bottom quarter on the outer right hand is the appropriate place to inject. However, she retracted this and replaced the bottom quarter with the outer corner of the top right.

[73] In consultation with Dr Wagner, she had apparently told him that she was taught to administer the injection two (2) hand widths from the gluteal fold. The difficulty with this can mean the measurement upwards which will cover the area of the sacrum. This practice was also discarded as inaccurate by Dr Edeling because patients present with different shapes and sizes.

[74] The inconsistencies in her evidence pale into are palpable in the face of the overwhelming evidence of the plaintiff and the experts.

¹⁰ Volume 2 page 7 of the Clinical notes – “ Sy het egter onlang ‘n inspuiting by ‘n apteek gehad, waarskynlik met ‘n B Vitamin as deel van ‘n dieetplan. Volgens die pasient was die inspuiting redelik medial toegedien en het sy acute pyn in die boud ervaar tesame met skwakheid in die been.

Her imprudent manner of administering the injection and ambiguous explanation to Dr Wagner is not supported by the objective facts. Obviously her limited training in administering injections contributed to her actions. She acted negligently and below the standard required of a person in her position. The version that it was administered on the outer upper quadrant of the right buttock is rejected. The conclusion is that the injection was administered in the area of the sacrum with a needle green in colour as the plaintiff testified.

[75] The next issue is whether the injection caused the plaintiff to suffer the seizure that result in the prolapse of the L5-S1 disc. It is on this aspect that there are divergent and conflicting views. Dr Edeling is of the view that the epileptic fit and disc prolapse were precipitated by the injection. Both Dr Wagner and Prof.de Vries are in unison that such a small needle of 12.7 millimetres could not have punctured or perforated the nerve. This view is also shared by Dr Gouws.

[76] It is common cause that the plaintiff was injected and almost immediately had an epileptic fit. She was rushed to the hospital where certain tests were run in particular the "straight leg raising test" which was negative. However it appears that the pain progressed and she consulted Dr Relling six (6) days later who informed her that her disc was shattered. Her case was such an emergency that a day later he operated on her.

[77] During his testimony Dr Edeling reached the following conclusion:-

“What would your comment be with regard to that condition? --- My Lord, the first thing, is that the acute immediate symptoms that she described and the intensity of those symptoms are such that it can only have been an injection into a nerve. There is no other mechanism that I can contemplate that can cause that kind of acute symptom.

COURT: Injection to the nerve? --- Into a nerve.

Into a nerve? --- Yes.”¹¹

[78] This irritation of the nerve by the injection was followed by a group of symptoms known as vasovagal attack. The effect of it is that the blood pressure drops and too low to circulate the blood from the heart to the brain while a person is standing. As the blood flow become insufficient in the brain then the person collapses. In the case of the applicant the EEG report had revealed that she had a brain focus. Her history is that she had not suffered any attack in her life prior to the day in question. She could have easily lived her whole life without suffering an epileptic fit. This was triggered by the injection into the nerve. This is the uncontested evidence tendered based on sound reasoning by the expert.

[79] He sharply differed with the report by Dr Jacques du Plessis (neurosurgeon) who concluded that the injection could not have caused the pain in her leg. There is no justification for this conclusion. In addition, it was reached given a certain set of facts different from those narrated by the plaintiff.

[80] Dr Wagner is also a forensic pathologist who expressed views on this matter outside his field of expertise. He started off by disputing that such a needle can hit the nerve. Under cross-examination it

¹¹ Volume 2 page 153 line 15 -22 of the Record

was pointed out to him that Dr Edeling's evidence was not disputed that a needle can cause the indentation of the nerve. He change tack and stated that he disputed the extent of the indentation. In the end he conceded that Dr Edeling gave the most probable explanation of what happened to the plaintiff. Given this concession I reject his evidence and accept that of Dr Edeling.

- [81] The essence of the conflicting opinions between Dr Edeling and Prof. de Vries is whether an injection into a buttock over the sacrum can cause a person to suffer an epileptic fit. Prof. de Vries testified that there is no direct link between the dorsal, sensory system and the motoric system to get that direct pain. This is contradicted by Dr Edeling in the following manner:-

“When a very strong sensory impulse enters the nerves system, through any nerves, the impulse is carried proximately toward the brain. When the impulse gets into the spinal cord, the place where it gets in is right alongside where nerves from adjacent areas are coming in. That bottom area of the spinal cord which is called a conus medullaris, is a very short segment of spinal cord in which all of the lumbar and sacral vertebrae emerge. They are very close to one another. Now, when the very strong sensory signal hits the spinal nerve it spreads in the spinal cord and then it goes up, not only the pathway linked to that nerve, but also it goes towards the brain in pathways linked to other adjacent nerves. ... So it has got nothing to do with motoric innervation. ... So, the pain spread from the distribution of the sacral percutaneous nerve into the distribution of adjacent nerves giving the experience of pain in the leg.”

- [82] Professor de Vries was expressing an opinion outside his field of expertise. It would appear that he was briefed on limited facts and

was unaware that prior to 23 August 2006, the plaintiff had not suffered any epileptic fit. Under cross-examination his theory fell apart dismally.

[83] This is illustrated clearly in the record as follows:-

“Did this patient have an epileptogenic foci? --- I have not had imaging and no imaging was provided to me to exclude that. No ECG or EEG findings.

Professor, if you ever testify in a court again, please ask the people who brief you in the matter, to provide you with all the facts. Two ECG’s had been performed on her subsequent to this procedure, showing that there were abnormal ECGs. Are you aware thereof? - -- No.

Are you aware thereof that prior to this injection she had not suffered from epilepsy? --- No.

Are you aware thereof that since this incident she was put on epilepsy medicine, Tegretol I think it was, yes. --- No

Are you aware thereof that subsequent to that incident of the injection, she again suffered a seizure? --- No.

Ann they call you as an expert to come and give us an academic lesson of this case that should be applicable, but they fail to provide you with the facts. Do you agree with me? --- It seems to me that I have got a poor ...

Brief. --- No, not a poor brief, I think that my memory is not that good.

What do you say was the cause of the pain in the leg then? --- I cannot explain that.

Cannot explain that. But I will tell you what professor. Dr Edeling gave an exposé of this matter for hours and hours, dealing right from the start to the end on the logical way, because he had all the facts; he took all the facts into consideration and his evidence is the most probable in this matter. You cannot give an explanation. What caused the epileptic attack then, the seizure? She had a

seizure; what caused it? --- What was the cause of that epileptic attack?

Yes. --- The, the needle injection in my opinion, it is not possible to provoke an epileptic focus.

What caused the epileptic fit or the seizure in this case? --- I do not know”¹²

[84] Given this exchange and his concession of the limited exposure to the facts I place no reliance on his opinions as they are not supported by any logical reasoning.

[85] Indeed the plaintiff had a pre-existing condition. However, she could have lived her whole life without suffering epilepsy. This was precipitated by the injection as testified by Dr Edeling. In this regard the necessary causal link has been established. It is trite that you take your victim as you found him. In my view, that the plaintiff has discharged the necessary onus of proving that the conduct of the employees of the defendant was negligent in administering the injection on her in the sacral area. This resulted in her suffering an epileptic fit that resulted in the prolapse of the L5-S1 disc.

[86] There is no reason why the costs should not follow the event. This was an involved and matter of considerable complexity which justifies the employment of two (2) counsel. It will be appropriate to make such an order.

[87] In the result the following order is made:-

¹² Volume 3 page 211 line 14 – 25 to page 212 line 1 - 24

87.1 The defendant is liable to compensate the plaintiff in respect of any such damages as the plaintiff is able to prove in due course.

87.2 The defendant is ordered to pay the costs of suit, as taxed or agreed upon on a party and party scale including the costs of employment of two (2) counsel and the reasonable and necessary travelling, accommodation and qualifying expenses of Dr Willem Edeling (neurosurgeon).

MATHEBULA, J

On behalf of applicant:	Adv. S Joubert SC
Assisted by:	Adv. H Botha
Instructed by:	Rooth & Wessels c/o Bezuidenhout Inc.

On behalf of respondents:	Adv. H Benadè
Instructed by:	Symington & De Kok

/roosthuizen