

IN THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

DELETE WHICHEVER IS NOT APPLICABLE	
(1) REPORTABLE: YES / NO.	
(2) OF INTEREST TO OTHER JUDGES: YES / NO.	
(3) REVISED. ✓	
26/2/2015.	
<u>DATE</u>	<u>SIGNATURE</u>

26/2/15
Case Number: 30083/12

In the matter between:

MR PR VENTER

Plaintiff

and

THE MEC FOR HEALTH GAUTENG PROVINCIAL
GOVERNMENT

Defendant

JUDGMENT

POTTERILL J

Cause of action

- [1] The plaintiff issued a claim for loss of support she suffered as a result of the death of her husband whom was admitted to the Steve Biko Hospital for an operation. It is common cause that the plaintiff and the deceased was married and that the deceased supported the plaintiff. It was also conceded that the deceased was employed and earned a salary. It is also common cause that the amount of the loss of support was correctly calculated by Robert J. Koch, an actuary, in the amount of R451 609.99. It is further common cause that the medical staff were specifically during or about the period 29 August 2011 up to and including 14 September 2011 during the treatment of the deceased, in the employment of the defendant, and were acting within the cause and scope of such employment.

Common cause facts

- [2] The following common cause facts and chronology serve as background to the claim:

- 2.1 The deceased had a squamous carcinoma on his tongue and on the floor of his mouth. This cancer at the clinical stage was classified as a T3 N1. The hospital's multi-disciplinary team decided to operate on the deceased to remove the cancer despite a history of smoking for 30 years, drinking two

glasses of wine and experiencing weight loss due to this disease. The deceased body mass index was good and the smoking was the cause of the mouth cancer;

- 2.2 After the operation the deceased would receive combination therapy resulting in reasonable results with international standards being a 45-65 % survival of the deceased for five years;
- 2.3 On 7 September 2011 the operation took 13 hours to complete and therefore the deceased was hospitalized in the surgical ICU and was ventilated overnight;
- 2.4 The deceased had to be artificially fed. The option chosen was to insert a nasogastric tube into the stomach of the deceased. In layman's terms the deceased was fed through a tube through the nose to the stomach. The medical staff inserting this tube does so "blindly" in the sense that they cannot see if the tip of the tube is in fact in the stomach. The staff is therefore required to test whether the tube was indeed inserted in the stomach. Three tests can be utilised. The most unreliable of the three is to with a stethoscope listen for gurgling noises in the stomach after air is injected into the tube. This is the quickest and easiest test. The second test is to aspirate on the tube to see if greenish fluid appears. This greenish fluid

can only come from the stomach. From this test a clinical conclusion can be drawn that the tube is in the stomach. The best and absolute reliable test is to take an x-ray after the insertion;

2.5 On the 11th of September 2011 the deceased was transferred from the ICU to High Care because his recovery was good;

2.6 Despite his good recovery the notes continuously reflect that there was an abnormal amount of secretions described as *"creamish loose"*. This is recorded on the 11th of September 2011 at 08h00, again at 11h00 on the same day. Again at 15h00 as *"still has a lot of lung secretions"*. At 18h00 the same day *"still has a lot of loose cream secretions"*. At 19h00 the following is recorded *"has a lot of thick secretions coughing productively"*. At 21h00 *inter alia* the following is recorded *"Patient having severe thick and creamy secretion"*. The continued note at 21h00 reads as follows *"Patient at risk for respiratory distress manifested by formation of mucous plug as evidenced by severe secretions"*. On the 12th of August 2011 03h50 it is once again recorded *"Suctioned patient loose creamy secretions"*.

2.7 On the 12th of September 2011 at 14:00 Dr. Fourie inserted a new flexi-flow tube (a nasogastric tube). A note was made that read as follows: *"Another flexi-flow reinserted by Dr. Fourie: tube tested by syringe and stethoscope"*

2E – tested flexi-flow tube by aspirating stomach-like contents. Dr. Fourie reported that the tube was in situ. Feed restarted as prescribed.” At that stage the deceased was fed 75 ml per hour;

- 2.8 On 12 September 2011 at 14:00 a note was made that the deceased was *“given inhalations and suctioned creamy secretions. He was placed in a high fowler’s position encouraged to cough out”;*
- 2.9 On 12 September 2011 at 18:00 the notes *inter alia* reflect the following: *“Hourly excessive loose secretions creamy in colour. Inhalations given and suctioned regularly with chest physio. Placed in high fowler’s position”;*
- 2.10 On the 12th of September 2011 between 19:00 and 20:00 *inter alia* the following is reported: *“Patient suctioned secretions a lot but loose and white in colour”;*
- 2.11 On 12 September 2011 at 23:00 the following is recorded: *“The patient started to become restless ... Patient suctioned to improve saturation, secretes a lot and were feeds from the stomach. Feeds stopped. Dr. Bezuidenhout and Dr. Coetzee informed. Patient put on CPAP Peep 5. Patient did not improve”;*

- 2.12 At 14:00 a chest X-ray was ordered by Dr. Bezuidenhout *"when they viewed the X-ray they found that the flexi-flow was in the lungs. It was taken out and the patient made to lie on side for discomfort"*;
- 2.13 Dr. Bezuidenhout provided retrospective notes on the 13th of September 2011 from memory which reads as follows: *"I was called to High care at approximately 01h00 by the sister in charge, Sr Coetzee, to see mr Venter who had decompensated in the unit. This was an acute decompensation according to the sisters. Apon my arrival in the unit minutes later the patient was on facemask oxygen and was saturating at 85%. He was suctioned repeatedly to remove what seemed to be enteral feeds from his tracheostomy. He indicated that he felt better after doing this a few times. Because the fluid that was suctioned from his trachy looked like feeds I looked at his previous CXR to see whether the tube position had been confirmed to be in the stomach and it had been. I however repeated the CXR and it revealed that the feeding tube was now in the right main bronchus. There was also consolidation of the right lower/middle lobe ... I continued to phone the consultant on call, prof Pretorius, whom was unavailable via cellular telephone. I then phoned Dr Vosloo, another consultant, and discussed the patient with her and the treatment instituted so far. The patient continued to improve. Dr Vosloo concurred with the current*

plan of action and added that a bronchoscopy should be done in the morning”;

2.14 The patient died on the 14th of September 2011 at 22:30;

2.15 The forensic pathologist, Ryan Blumenthal, provided a medic-legal post mortem examination. In paragraph (iv) he concluded the following:

“That the chief post mortem findings made by me on this body were the following: An adult white male with features of having undergone recent maxillo-facial surgery. The right lung weighed 2180 g and section showed signs of grey hepatisation. The left lung weighed 964 kg. Signs of multiple organ failure were present. Histology confirmed right lung pneumonia together with Adult Respiratory Distress Syndrome. According to the available history, a feeding tube was incorrectly placed down the right bronchus with complications.

(iv) that, as a result of my observations a schedule of which follows, I concluded that the cause of death was the following:

PROCEDURE-RELATED DEATH:

INCORRECT PLACEMENT OF FEEDING TUBE WITH

COMPLICATIONS

(IN A PATIENT WITH RECENT MAXILLO-FACIAL SURGERY)";

Expert evidence of the plaintiff

- [3] Dr. Botha, a specialist physician, testified on behalf of the plaintiff. His expertise and his experience of 40 years standing was not in dispute. He testified that he based his opinions on the records of the hospital and his experience.
- [4] It was his opinion that feeding the patient through the nose and down the mouth was not the best option. The best option would have been to feed the patient with a gastronomy placement i.e. a tube directly into the stomach. Besides the discomfort and pain in the mouth after the surgery it would be the best option in a patient with oral cancer with clearly far less complications.
- [5] He testified that the records reflected that even before the changing of the tube it was repeatedly recorded that there was excessive secretions from the lungs described as bloody thick secretions associated with persistent coughing. The restlessness was ascribed to nicotine withdrawal symptoms. Despite these symptoms no X-rays from the lungs were obtained. This is negligent because the deceased had infection, but an X-ray would have determined any form of pneumonia. An X-ray would also have explained the restlessness. The staff would then not have assumed that his restlessness was due to a withdrawal state which

was inappropriately treated with Serenace and other drugs used for alcohol withdrawal symptoms. The recorded evidence in fact shows that his breathing was compromised after the surgery. The defendant was thus negligent in not having an X-ray taken.

[6] The breathing distress and the nature and extent of secretions returned from suctioning of the lungs already indicated a degree of aspiration passed the tracheostomy tube before the major event of aspiration which occurred on 12 September 2011 and there is no indication that aspiration prevention strategies were in place. A small amount of food secretions is normal but the amount indicated on the records required aspiration prevention strategies. A simply X-ray would have determined the extent and reason for the breathing distress; not taking an X-ray constituted negligence on behalf of the defendant.

[7] The reinsertion of the nasogastric tube on 12 September was not followed by assessment of the position of the nasogastric tube. The tube was in the right main bronchus and this was the main reason for the rapid decline in his status and the irreversible shock that caused his death the next day. The expert was quite certain that the tube was put into the lung and did not dislodge. An X-ray was not taken rendering the defendant negligent.

- [8] Dr. Bezuidenhout was advised by Dr. Vosloo telephonically to do a bronchoscopy the next morning. In Dr. Botha's opinion acute management of aspiration involves an emergency rigid bronchoscopy. This is so because after 9 hours the lung would have solidified and the procedure would not achieve any required results. It was thus negligent to wait for 9 hours to do a bronchoscopy.
- [9] The defendant was also negligent in the lack of senior consultant availability when needed in that Dr. Bezuidenhout was desperately seeking help.
- [10] When confronted with Dr. Luvehego's opinion Dr. Botha persisted that the deceased did not die from progressive sepsis, but from terminal sepsis that set in after the aspiration. He was persistent that not only 8 hours after the reinsertion of the feeding tube was there cause for concern. He testified that already two hours after the insertion there was cause for concern because the deceased was encouraged to cough out stomach feed that should not be there. Furthermore, the deceased's PO2 was low for a person on a ventilator. The nurses kept on recording that too many creamy secretions were prevalent and therefore regularly suctioned the deceased. They also put him in an upright position. Although the nurses wrote "*parameters acceptable*" this was not the case. The patient was heavily sedated and only communicated with sign language. "*Parameters acceptable*" is just somebody's impression and no opinion can be based thereon.

- [11] Dr. Botha persisted that the deceased died as a result of the feeds in the lung and the laboratory reports proved that.
- [12] Dr. Botha admitted that tubes can dislodge, but found it unacceptable that it would migrate to a completely different location i.e. the lung. This is supported by the fact that two hours after the insertion the deceased showed worrying signs.
- [13] Dr. Botha accepted that there are three tests that can be utilised to check that the tube was inserted in the stomach. He persisted that he would not advise, and does not practise, by testing with inflating air through the tube because it is wholly unreliable. He also found the method of aspirating on the tube, archaic and very unreliable. The only reliable test is an X-ray.
- [14] He concluded that the major event of aspiration or infusion into the right lung resulted directly from the malpositioning of the feeding tube. This event triggered Mr. Venter's rapid deterioration into a state of irreversible systemic sepsis and organ failure and death. Had it not been for this episode he would on a balance of probabilities have survived the surgery albeit that his long term prognosis was not good.
- [15] Dr. Botha denied that Mr. Venter was severely mal-nutritious and had active infection which resulted in progressive sepsis which led to multiple organ dysfunction.

The body mass index of Mr. Venter was within prescribed parameters. There would be infection after an operation but there was no pre-operational sepsis.

- [16] He agreed that the lung could not hold 670 ml of feed but in this instance it did because the post mortem report clearly shows the discrepancy between the weight of the two lungs. The tube was in the lung and the feeds went into the lung. The weight of the lung cannot be ascribed to inflammation of a lung alone.

Defendant's expert evidence

- [17] On behalf of the defendant Dr. Luvhengo was called. He is a principal surgeon and a senior lecturer and also on the examination board. He is an endocrine surgeon and not a specialist physician. He based his opinion on the reports provided to him. He did not have the forensic officer's medico-legal post mortem report when he compiled his report.
- [18] On the information supplied to him he found that pre-operation the deceased was significantly undernourished and anemic. The deceased's haemoglobin reflected chronic illness. His white cell count was raised showing he had active infections, probably of the lungs. Mr. Venter was severely albuminaemic which alone had put him at risk of at least 40 % 30 day post-operative mortality mainly from pulmonary.

The deceased's prognosis was less than 50 % of surviving for 5 years due to the above.

[19] It was his opinion that the deceased became progressively more septic. The progressive sepsis is in fact what caused the death of the deceased. The dislodgement of the feeding tube leading to infusion of the interal feeds into his lung just expedited his death.

[20] It was his opinion that there was no negligence on the part of the defendant. Dr. Fourie had performed the necessary tests to check if the tube was positioned in the stomach. He testified that it was highly unlikely that the feeding tube had all along been in the right mainstream bronchus from reinsertion at 14:00 and that interal feeds were being infused into his lung, without him showing signs until his sudden decompensation. The tube dislodged and was not inserted in the lung. Throughout the deceased stay in ICU and High Care Mr. Venter was monitored closely reviewed by treating health care teams at most on a two hourly basis.

[21] Dr. Luvhengo could not explain why he referred in his report to the deceased as the deceased's wife. He was however certain that it was just a mistake and that the report pertained to the deceased. He persisted that as an endocrine specialist, not a specialist physician, he could give an opinion on post-operative care in the ICU and High Care. He knew the patient had died but did not ask for the post mortem

report because he did not want to furnish a "biased report". He admitted that the medico-legal report was exceedingly thorough but rejected the finding that the deceased died due to a procedure related death, because that was not based on the forensic expert's own knowledge. He persisted that there were infections and because of this thus the deceased had sepsis. He persisted that the test performed by Dr. Fourie was protocol because a patient can't be exposed to too much radiology. He did agree that an X-ray is the most reliable test pertaining to where the placement of the tube was. It was his opinion that the patient was "up and down" the whole time indicative thereof that his lungs were not functioning well. The deceased had to be suctioned on multiple occasions on each day from the 8th to the 14th of September 2011.

[22] There was no negligence in not immediately performing a bronchoscopy because the deceased's oxygen saturation improved after suctioning.

[23] The defendant also called Professor Pretorius. He was the surgeon that performed the surgery and is the Head of Critical Care of the Steve Biko Hospital. Unfortunately the professor could not favour the court with his opinion because there was no expert notice filed. At best the court could take cognisance of the fact that he performed the operation and that in his opinion the operation was a success. The deceased had oral cancer due to his smoking and had weight loss due to

cancer. The multi-disciplinary team was sure that the prognosis of the deceased was 45-65 % for 5 years.

[24] Post-surgery the deceased did well in the ICU, but he had to contend with restlessness and the airway secretions. They decided to feed artificially with a nasal tube. He could not explain how the tube got into the lung and expressly stated that in his career he had never seen a dislodgement from the stomach into a lung. He conceded that was the tube not in the lung the deceased would have progressively improved. He accepted the finding of the medico-legal report, but he thought the lung size was due to inflammation and not due to tube feeding. He agreed that an X-ray is the best test to see whether the tube is in the stomach but it costs more money and he was satisfied with aspiration because only stomach feeds aspirate green. This was an unfortunate incident and he had put in place corrective measures to prevent any such reoccurrence.

Argument on behalf of the plaintiff

[25] On behalf of the plaintiff it was argued that it was common cause that the tube was in the lung where it should not be. The defendant could not explain it. The evidence of Dr. Botha was not in cross-examination criticised or contradicted and it was thus untested and must be accepted. Contrary to this Dr. Luvhengo was not an expert in critical care post-operative. He disagreed with the results in the post

mortem report whereas Dr. Pretorius agreed with the report. If one then analyses the expert evidence with reference to *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA) the opinion of Dr. Luvhengo is not reliable. It is clear from Professor Pretorius' evidence that it was accepted that something like this should not happen again and therefore that the hospital was negligent. The plaintiff had thus proved her claim.

Argument on behalf of the defendant

[26] On behalf of the defendant it was argued that there was no negligence on the part of the defendant because Dr. Fourie tested where the tube was. The test was done in terms of the respondent's practice and protocol. The mere fact that the test was not fool-proof does not render the defendant negligent *per se* – *Blyth v Van den Heever* 1980 (1) SA 191 (AD) at p221A-C. The court was urged to disregard the finding of the medico-legal report pertaining to what caused the death because no lung could absorb so much feed and that its size was due to inflammation. The lung was accordingly inflamed, but not by the feeds. Absent an act and fault there was no liability and the plaintiff's claim should be dismissed with costs. Dr. Fourie was not called because she is living in the Free State. There was no expert notice filed for Professor Pretorius because he was just called to testify pertaining to the post-operative care of the person as a doctor, not as an expert.

The issue to be decided

- [27] It is not in dispute that there was a contract between the deceased and the defendant that the medical practitioners would undertake the treatment of the deceased with the reasonable skill and care of the practitioners in their field. What the court must thus decide is the negligent breach of the contract and the causation of the death.
- [28] On behalf of the defendant it was also argued that the plaintiff had not proven any act on behalf of the defendant and must therefore fail in her claim. I do not understand this argument. It is common cause the tube was inserted into the lung instead of the stomach. Dr. Botha testified that the personnel of the defendant should have observed same due to the worrying signs observed within two hours after the insertion. Furthermore the acts of not taking an X-ray, not performing a bronchoscopy and the lack of a senior consultant available to Dr. Bezuidenhout all constitute negligent breach of the contract; i.e. not exercising reasonable skill and care.
- [29] If the defendant's argument is that the mere fact that the tube was in the lung does not render the defendant negligent, then I am well aware of the *dictum* in ***Van Wyk v Lewis* 1924 AD 438** at 462 as confirmed in ***Buthlezi v Ndaba* 2013 (5) SA 432 (SCA)** at paragraph 16 that the "*maxim res ipsa loquitur could rarely, if ever, find*

application based on alleged medical negligence. The human body and its reaction to surgical intervention are far too complex for it to be said that, because there was a complication, the surgeon must have been negligent in some respect." Res ipsa loquitur refers to delictual claims but, where it is common cause that the tube should have been inserted in the stomach, but was found in the lung, such action clearly cannot constitute exercise of reasonable skill and care of the medical practitioners unless the defendant can provide reasons sustaining that the medical practitioners were not negligent in so-doing.

- [30] The plaintiff had proven that the tube was in the lung. The medico-legal report confirms as the cause of death that the death was procedure related due to the incorrect placement of feeding tube with complications. For this court to accept that this constituted breach of contract this evidence the court must make an election between the opposing views of the expert witnesses. This must be done "*on an analysis of the cogency of the underlying reasoning which led the experts to their conflicting opinions*" – ***Buthelezi v Ndaba* 2013 (5) SA 437 (SCA)** paragraph 14.

- [31] Dr. Botha has been a specialist in post-operative special and high care for 40 years. Dr. Luvhengo is not such a specialist and although he could give aftercare as a surgeon he is not a specialist physician. Dr. Botha expressed the view that putting a tube in a mouth down the throat after a 13 hour operation to the throat and

mouth and tongue of a patient is not according to practise. It would have been advisable to feed the patient through a tube directly into the stomach. It must be remembered that the deceased also had to remove some of his teeth before the operation. Professor Pretorius testified that they did not put a tube in the stomach because the artificial feeding was not going to be for a long period. On analysis of this reasoning Dr. Botha's reasoning is logical and preferred above that of the professor, but this does not require further comment as the foundation of the plaintiff's claim does not lie herein. It does however reflect that Dr. Botha's testimony from the outset was logical and based on sound reasoning.

- [32] It is common cause that even before the replacement of the tube on the 12th of September 2014 the deceased had breathing distress and creamy secretions coming from the lungs. Dr. Botha testified that not taking X-rays to ascertain as to what was causing the restlessness i.e. if there was a form of pneumonia present was negligent. It would also have disclosed if there was infection in the lungs or just in the upper part where the operation was performed. On the other hand Dr. Luvhengo testified that the deceased had active infection pre-operation which he thought was most probably in the lungs. In his report he however set out a further opinion that the single most probable cause was respiratory tract infection. Dr. Luvhengo further set out that there were excessive secretions which were initially bloody and thick, later brownish and finally loose and creamy and continued to drain

from the deceased's airways. He repeatedly had to be suctioned on multiple occasions on each day from the 8th to the 14th of September 2011. Upon logical reasoning the opinion of Dr. Botha must be accepted. The deceased was restless and struggling to breathe and an unusual amount of secretions were coming from the lungs. The amount of the creamy secretions and the prevalence thereof was unusual and once again a simple X-ray would have ascertained what is causing this. On the common cause fact that the deceased had to be suctioned on multiple occasions every day from the 8th to the 14th of September 2011 it is illogical to dismiss the taking of an X-ray because the patient was "up and down" the whole time indicative thereof that his lungs were from the beginning not functioning well. It is common cause that the patient's lungs were not functioning well, yet no X-ray was taken to ascertain why. This is a simple task clearly not exercising reasonable skill and care.

- [33] On the 12th of September 2011 the tube is reinserted. Dr. Fourie who performed this task is not called because her notes are accepted and she is in the Free State. The essence of this matter is the reinsertion of the tube by Dr. Fourie; living in the Free State is not a good enough excuse not to testify. Even if the notes pertaining to her actions by the medical staff are accepted then I find the evidence of Dr. Botha that an X-ray must be taken to ascertain if the tip of the tube is in the stomach as being logical and sound practice. The mere fact that two other tests were performed

is insufficient. It is in fact common cause that listening to the stomach after air was injected in the tube is unreliable. Dr. Luvhengo testified that the aspiration of the tube to see if a greenish fluid appears is a commonly used reliable test. Dr. Botha found it to be archaic and not to be practised. In *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA) at paragraph 30 is found that even if certain tests are universally held as being proper a court will not find it to be reasonable if an obvious risk could have been guarded against by utilising another test. Where a doctor executes a medical treatment “blindly” eyes are needed to confirm that the treatment was correctly performed. It would be logical to ascertain from a simple X-ray test whether the tip of the tube is in fact in the stomach; the X-ray will be the eyes of the doctor. I find the evidence of Dr. Botha that an X-ray is a necessary requirement the benchmark for such procedure. The defendant’s conduct by not taking an X-ray thus cannot be logically supported especially in view of the deceased’s continued secretions and breathing problems.

[34] Dr. Botha and Professor Pretorius agreed with the conclusion of the medico-legal report. Dr. Luvhengo could give no good reason as to why when forming his opinion he did not take cognisance of the medico-legal report. Stating as a reason that he did not want to provide the court with a biased opinion already leaves the court with a question mark pertaining to what would influence this doctor in coming to his conclusions. It is common cause that the artificial feeds were entering into the

lung due to the tube being in the lung. It was Dr. Luvhengo's opinion that a lung could not absorb so much feeds and that the reason for the lung being so inflated was in fact inflammation of the lung. The reason for this is his conclusion that the deceased did not show any signs until his sudden decompensation at 23h00. This is simply not logical as excessive secretions were noted creamy in colour, and the deceased had to be repeatedly suctioned on multiple occasions there certainly were signs upon which the defendant had to act.

[35] Dr. Botha conceded that tubes can dislodge but he found it improbable that a tube would dislodge and then reinsert itself in a lung. He was adamant that in fact the tube had been inserted into the lung. Dr. Luvhengo testified that the tube probably dislodged and based this on the fact that Dr. Fourie had tested where the tube was inserted. He also based it once again on the fact that the deceased did not show any signs that interal feeds were being infused into his lung until his sudden decompensation at 23h00. Professor Pretorius on the other hand testified that he had never seen a dislodgment of a tube from the stomach into a lung. I once again find the opinion of Dr. Botha to be a defensible conclusion because although tubes can dislodge it is unacceptable to then insert in a completely different location i.e. from the stomach to the lung. Even if I should be wrong in this finding then the signs showed by Mr. Venter even two hours after the reinsertion should have alerted

the respondent to at the very least take an X-ray to explain the excessive secretions and breathing problems of the deceased.

[36] Dr. Botha's evidence that a bronchoscopy 9 hours later would serve no purpose as the lung would have solidified and the procedure would not have achieved any results was uncontested. Acute management of the deceased's aspiration was necessary and it most certainly required an emergency rigid bronchoscopy. The defendant was thus clearly negligent in not exercising reasonable skill and care by waiting until the next morning to perform any bronchoscopy.

[37] Dr. Luvhengo testified that the deceased in fact died from progressive sepsis which led to multiple organ dysfunction. This is in direct contradiction to the finding of the medico-legal report. There is no logical basis on which Dr. Luvhengo can contest the evidence of the medico-legal report. On the other hand Dr. Botha clearly sets out why there was not progressive sepsis but terminal sepsis after the aspiration of the lung.

[38] I am accordingly satisfied that on the preferred evidence of Dr. Botha the defendant and its medical practitioners and staff were negligent in not exercising the

reasonable care and skill of practitioners in that field in the treatment of the deceased in that:

- 38.1 The defendant failed to take an X-ray to ascertain what the reasons for the deceased breathlessness and secretions were;
- 38.2 After the reinsertion of the tube an X-ray should have been taken to satisfy that the tip of the tube was in fact in the stomach;
- 38.3 At the very least two hours after the reinsertion of the tube another X-ray should have been taken to ascertain why the creamy secretions were in such amounts and so prevalent;
- 38.4 The tube was incorrectly inserted in the lung;
- 38.5 An emergency bronchoscopy should have been performed.

[39] I accordingly make the following order:

- 39.1 The plaintiff is to pay to the defendant the amount of R451 609.99 as damages for breach of contract plus the costs of the action;
- 39.2 Interest on the above amount at the rate of 15,5 % per annum and 9 % from 1 August 2014 as set out in the Prescribed Rate of Interest Act 55 of 1975 to date of payment;

39.3 In the event that the defendant fails to effect payment of the plaintiff's taxed costs of suit within 7 days of the defendant's receipt of the signed allocatur to the plaintiff's taxed bill of costs then such costs will bear interests at the rate of 15,5 % per annum calculated from and including the date of signature to the allocatur to the plaintiff's taxed bill of costs including the date of final payment.



S. POTTERILL
JUDGE OF THE HIGH COURT

CASE NO: 30083/12

HEARD ON: 11 and 12 February 2015

FOR THE PLAINTIFF: ADV. T.P. KRÜGER

INSTRUCTED BY: Marais Basson Inc.

FOR THE DEFENDANT: ADV. A.M. JOZANA

INSTRUCTED BY: State Attorney

DATE OF JUDGMENT: 26 February 2015