

REPUBLIC OF SOUTH AFRICA



IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

CASE NUMBER A5005/20
CASE NUMBER A QUO 24339/2017

(1) REPORTABLE: ~~YES~~/NO
(2) OF INTEREST TO OTHER JUDGES: ~~YES~~/NO
(3) REVISED: ~~YES~~/NO

SIGNATURE

...02/09/2024.....
DATE

In the matter between:

MEMBER OF THE EXECUTIVE COUNCIL FOR
GAUTENG DEPARTMENT OF HEALTH

Appellant

and

MAKGADI LETTAH RAPOO

Respondent

ORDER

1. The appeal is dismissed.
2. The plaintiff is awarded costs including costs of one counsel on Scale C.

JUDGMENT

Manoim J, (Makume and Senyatsi JJ concurring):

[1] This appeal relates to alleged malpractice by nurses at the George Mukhari Hospital (“GMH”), a public hospital that falls under the jurisdiction of the appellant, the MEC for Health Gauteng.¹ The plaintiff, Makgadi Rapoo, alleges that the nurses at the hospital were responsible for causing her to experience a severe bedsore on her sacrum whilst she was being treated at GMH.² The plaintiff alleges that her bedsores were caused whilst she was being treated at the hospital for a stroke, which if she was competently treated could have been avoided. In the alternative she argues that even if the cause of the bedsore had preceded her admission to GMH, its nursing staff were negligent in managing the pre-existing condition.

[2] In the court a quo, Adams J found against the defendant. His order which is the subject of this appeal states:

- *The employees of the George Mukhari Hospital are hereby declared to have been negligent in relation to the injury sustained by the plaintiff in the form of a bedsore (“the plaintiffs injury”) on or about the 10th of November 2015.*

¹ GMH is located in Ga-rankuwa which is in the jurisdiction of this court.

² According to Medlin- Plus Medical dictionary: “*The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis.*”

- *Such negligence be and is hereby declared to have been a cause of the plaintiff's injury.*

[3] The defendant appeals against this order. Since Adams J had separated the merits from the quantum in terms of Uniform Court Rule 33(4) the only issue on appeal is whether the court erred in finding in favour of the plaintiff on the issue of liability. For ease of reference I refer to the parties on appeal as they were in the court a quo as the plaintiff and the defendant.

[4] Most of the factual issues in this case are common cause. On appeal the issues have narrowed even further. There are two issues in dispute. The first is over causation – how and where did the plaintiff's bedsores form? The plaintiff's principle contention is that her bedsores were caused by sub-standard treatment whilst she was being treated at the GMH.

[5] The second is over the duty of care. Even if the plaintiff could not establish that her treatment at GMH was the cause of her bedsores, was her subsequent treatment, and here the focus is on nursing, substandard and a breach of the hospital's staff duty of care to her as a patient.

The medical issue

[6] Bedsores are also known as pressure ulcers. According to a widely cited definition:

“A pressure ulcer is an area of localised damage to the skin and underlying tissue caused by pressure, shear, friction and/ or a combination of these.”³

[7] In the same article the author goes on to explain that:

“Recent acute illnesses or uncontrolled chronic diseases may cause lethargy leading to immobility and increasing the risk of pressure ulcers. For example, the patient who had a stroke (Cvi) may have significantly altered mobility and sensation leading to an increased risk. Every patient has to be seen at risk for pressure ulcer development especially if surgery was involved. A pressure ulcer can start on the theatre bed in prolonged surgery and this should be a clear indication to reassess the patient’s skin status.”⁴

[8] In the present case two of the risk factors referred to in this article are relevant. The plaintiff had suffered a stroke and spent a long period of time in an emergency section.

Facts

[9] On 9 November 2015, the plaintiff suffered a stroke. It is not clear when this occurred. She was living on her own aged 74 at the time. She was found by a woman who is identified as a companion or a helper although this identity is not

³ According to the European Pressure Ulcer Advisory Panel (1999) quoted in ‘*The prevention and treatment of pressure ulcers*’ by Sister Liesel Naude, published in the journal ‘*Professional nursing today*’, Volume 11 number 6 November/ December 2007.

⁴ Ibid.

material. I will refer to her as the helper. Between 21h30 and 22h00 on the evening of 9 November, the helper phoned the plaintiff's daughter Desia Dhlomo to say that her mother had collapsed and was lying on the floor unconscious. Ms Dhlomo immediately left home in Johannesburg and travelled to Rustenburg to her mother's home. She arrived at around midnight and found her still lying on the floor. An ambulance was arranged and arrived shortly thereafter and took her to Ferndale, a private hospital in Rustenburg.

[10] It is not known how long the plaintiff had been lying on her floor before the helper had phoned Ms Dhlomo to call for help. The plaintiff was unable to take this further as she still suffers from the effects of the stroke that she experienced that day. Nor was the helper. She was not called as a witness as the plaintiff's legal team could not locate her. (According to Ms Dhlomo the helper was no longer resident in Rustenburg and had gone to another province and they were not able to contact her.)

[11] Ms Dhlomo told the plaintiff's expert that the helper had reported to her that the plaintiff had suffered her stroke shortly after having her bath that evening. This would put the timing of the stroke closer to 20h00 that evening. But as the defendant has argued, this is hearsay and there is no certainty that she might not have been lying on the floor for much longer. The reason why this may be relevant from the defendants' point of view is that if she had been lying on a hard surface for many hours before she was eventually discovered and then taken to hospital, then it is possible that she may have developed bed sore by then.

- [12] The plaintiff was brought to Ferncrest hospital at approximately 2h40 on 10 November 2015. Ferncrest is a private hospital. Since the plaintiff was not on medical aid her family could not afford to have her treated there and so she was moved again by ambulance to a state hospital in Rustenburg the Job Shimankana Tabane Hospital. She arrived there at 08h10 and was then taken to a resuscitation room where she was intubated, described as restless, and given a dormicum infusion. But that hospital did not have the facilities to treat a stroke patient, so she left there at 11h30 that same day and was taken by ambulance to GMH. Records show she arrived there at 12h10 still on 10 November.
- [13] Her treating doctor there was Dr Anyikwa who testified during the trial and who first saw her at 13h00. She was intubated, had a catheter inserted and put on a dormicum drip. The records show that Dr Anyikwa saw her again at 20h10. The record states that at this time she was still awaiting theatre. Again at 02h10 the record shows she was still awaiting theatre. It was now 11 November. At 4h10 the record states she was seen by Dr Anyikwa who says he will attempt to obtain an ICU bed and take the plaintiff to theatre. By 9h00 the records state that she was still awaiting theatre. In the meantime, the night staff had gone off duty and been replaced by the day staff.
- [14] At 11h30 that day a Dr Tau saw the plaintiff, requested an ECG, and had the plaintiff admitted to a ward. This is a significant event in the chronology of her treatment at GMH because up until then she was in an emergency section and not in a ward. This was a period of approximately twenty-four hours. What makes this time period significant on the plaintiff's case are two issues. The first

is that according to one report called the pre-operation report, done shortly after her admission to GMH, she was examined and there is no report of her having bedsores. The second is that she did not receive any treatment according to the hospital's own protocols in relation to the possibility of bedsores whilst in the emergency section.

- [15] At 12h10 when the plaintiff had now been admitted to a ward the following entry was made. It is headed bed sore report:

“Patient was found with an old bed sore 7 by 4 cm, black and peeling off skin. Opsite was put on the bedsores.”

- [16] Then at 12h51 her bed sore was assessed using a technique known as the Waterlow scale.⁵ This technique is explained in medical website in the following way:

“The Waterlow Score calculates the risk of pressure ulcers developing on an individual basis through a simple points-based system.

The Score Card ...includes the build / weight of the resident, their height, skin condition, sex / age, continence, mobility and special risk factors like tissue malnutrition, medication, major surgeries, trauma, and neurological deficit.

.... Each choice has a set value of points, which when tallied up at the end of the assessment will give you the risk score. If the

⁵ It is named after Helen Waterlow who developed the system.

resident scored between 10 – 14 they are considered at risk, 15 – 19 is high risk and if they exceeded 20+ the risk is classed as very high.”⁶

- [17] The nurse who did this assessment recorded that the plaintiff had a Waterlow score of 18. This would put her into the high-risk category.
- [18] This entry was the first mention of the presence of a bedsore in any of the plaintiff’s medical records. Once she was in the ward the hospital staff kept what is known as a Pressure Care chart. The purpose of this chart is to record what is done to relieve pressure on the patient and the time when it is done. According to this chart once the plaintiff was admitted to the ward, she was given pressure care at two intervals of four hours each (from 14h00 until 22h00) and thereafter at four intervals of two hours each (from 22h00 until 06h00 the following day). She was discharged from GMH at 10h20 on 12 November and handed over to the paramedics. The plaintiff’s family had requested she be transferred to a private hospital. The GMH notes record that the family was concerned about the treatment she was receiving at GMH. However, since none of these concerns related to the presence of the bedsores this decision is not relevant to this matter.
- [19] From GMH the plaintiff was sent to a private hospital, Akasia. She was at Akasia for a month until she was sent to a special rehabilitation hospital where she was for a week or two, and thereafter was discharged to go home. Whilst at home

⁶ <https://www.caredocs.co.uk/what-is-the-waterlow-score-and-how-can-it-help-assess-risk-of-pressure-injuries>

she was seen by a wound specialist who advised the family that they see an attorney given the state of the plaintiff's bedsores which they duly did, and hence the present matter. After her return home her daughter photographed her bedsore. The bedsore wound appears large, open, and deep to the lay observer. However, since this photograph, whilst visually disturbing, was taken several weeks after the plaintiff's discharge from GMH, it has no evidential value for the current liability determination.

Evidence of the experts

- [20] Each side called an expert to testify. The plaintiff called Professor Nel a professor of nursing. The defendant called Sister Smit a practising nursing sister. They agreed on several issues in the joint minute. Both agreed that the plaintiff had co-morbidities that made it more likely that she would be susceptible to bed sores. These were her age, hypertension and because she had been lying in the same position for some time.
- [21] The key difference between the two experts was when the bedsore could have occurred. According to Professor Nel whilst research on the topic is 'scanty' a pressure sore can develop in six to twelve hours after sustaining long term pressure. Sister Smit said that a bedsore would take a week or so of lying in the same place. She also was of the view that "... it gets serious after several weeks or months of being bound." Sister Smit therefore considered that a bedsore of the size documented on 11 November at GMH could not have developed in that short time from her admission to GMH till the bedsore was detected the following day. To summarise – whilst Professor Nel posited that

the bedsore could have been formed during the plaintiff's first twenty-four hours at GMH, Sister Smit considered this not possible in such a short period of time.

- [22] Professor Nel also queried the nurses entry describing the bedsore made at 1210 when she was admitted to the ward. The nurse had described the wound as black and 'old.' Professor Nel said the fact that the sore was black did not mean it was old. Rather, what had happened was a process know as necrosis. The pressure placed on small arteries leads to a loss of oxygen and nutrition which is why tissues and cells die. This explains the black colour. In short on her evidence the black colour of the wound is not a function of it being old, rather the onset of necrosis.

Analysis

- [23] The defendant's appeal is premised on two findings by the court a quo. First that it erred in respect of causation in finding that the plaintiff's bedsore was caused in the first 24 hours of her treatment at GMH, or if pre-existing, on her admission that the hospital staff should have discovered this on her arrival or shortly thereafter.
- [24] The issue of causation in this case is difficult. First it is possible that the plaintiff could have developed her bedsore if she had been lying on the floor of her home for some time before she was discovered by her helper. Since the plaintiff could not testify about this period and the helper was not called, it is possible that this period may have been several hours before Ms Dhlomo was contacted. Professor Nel had relied on a report made to her by Dhlomo about what the latter had been told by the helper which suggests that the stroke occurred

around 20h00. But Dhlomo was never led on this during the trial and in any event, it would be hearsay.

[25] So too is Dhlomo's report that the staff at Ferncrest told her that they had bathed the plaintiff because she had been incontinent.

[26] However, the plaintiff's counsel also relies on Dhlomo's direct evidence that she was given the plaintiff's clothes by the hospital staff.

[27] The plaintiff's counsel seeks to derive two inferences from this. First that if she had been changed into new clothes by the hospital staff given that the plaintiff was semi-conscious, it is likely that the staff would have observed her sacral area. If this was the case, then if she had a bedsore at the time, it would have been noted in the records. Since it was not it must not have been in existence at that time.

[28] The next piece of evidence about the plaintiff's condition prior to her admission to GMH comes from GMH's pre-operation list. The plaintiff seeks to rely on the list as it was completed at the time of the plaintiff's admission to GMH. The list shows that the plaintiff was given some form of examination on her arrival yet there is no mention of any bed ulcer. Counsel for the plaintiff argues that if the bedsore was then in existence, it would have been observed, and noted on the form. Since it was not, the bedsore must have developed later. It is common cause that the bedsores were observed whilst she was at GMH, so it is not in dispute that the bedsore occurred before she was discharged from that hospital.

[29] The defendant advanced two arguments around the chain of causation. The first is that without the evidence of the helper it is impossible to know whether the plaintiff was lying on the floor for several hours before the call made to Dhlomo at around 22h00 on 9 November. Given that the plaintiff was found lying on a hard floor it is possible that the pressure on her sacrum developed then. The defendant also argues that the evidence of the return of the clothes at Ferncrest and the absence of any observation on the pre-operative list at GMH, are too speculative to suggest that the plaintiff had no bedsore prior to her admission to GMH.

[30] These two pieces of evidence that the plaintiff relies on to establish that the bedsores were probably caused after her admission to GMH require a court to draw inferences based on facts that are not dispositive. They rely on the absence of entries in hospital records and not direct witness testimony. It is also possible given that the plaintiff had suffered a stroke and had to be intubated urgently, that the staff were not focussed on examining her body for bedsores and this may have been missed. Our courts have held that a litigant will not have discharged the onus of proof if an inference in favour of both parties is equally possible.⁷

[31] But the defendant has no alternative explanation for how the bedsore developed. Even if I accept that the plaintiffs' evidence for causation happening at GMH is too speculative, the trial court did not err in this respect. Rather, it is

⁷ See *Cooper and Another NNO v Merchant Trade Finance Ltd* 2000 (3) SA 1009 (SCA) at 1027 to 1028.

clear that the court allowed for both possibilities as this passage from the judgment indicates:

“If the bedsore was already there when the plaintiff arrived at the hospital, then, had they applied proper bedsore management, they would have discovered it on the plaintiff’s arrival or shortly thereafter. This would have enabled them to do damage control. If the bedsore developed during her short stay of twenty-four hours up to the time the sore was discovered, the hospital staff would have discovered the sore (busy developing) had they applied bedsore management.”

[32] Thus, on the question of causation, the court a quo held correctly, in my view, that even if the bedsore had been brought into existence prior to the plaintiff’s admission to GMH, this did not exonerate the defendant.

[33] On either scenario, the question is what did GMH do about bedsore management once the plaintiff had been admitted. The crucial period was the twenty-four hours from when the plaintiff was admitted to GMH on 10 November until the bedsore was first recorded at 12h10 on the 11 November.

[34] The test for causation is not dependant on proof of commission. It can also arise where there has been omission. In dealing with the question of causation in a medical malpractice case, the Constitutional court in *Oppelt* held that:

“While it may be more difficult to prove a causal link in the context of a negligent omission than of a commission, Lee explains that the 'but-for' test is not always the be-all and end-all of the causation enquiry when dealing with negligent omissions. The starting point, in terms of the 'but-for' test, is to introduce into the facts a hypothetical non-negligent conduct of the defendant and then ask the question whether the harm would have nonetheless ensued. If, but for the negligent omission, the harm would not have ensued, the requisite causal link would have been established. The rule is not inflexible. Ultimately, it is a matter of common sense whether the facts establish a sufficiently close link between the harm and the unreasonable omission.”⁸

[35] The hospital had an ongoing duty of care to the plaintiff from the time of her admission to prevent the bed sore deteriorating or developing. Given the plaintiff's condition at the time of admission, the fact she was a stroke patient who had been moved to GMH from two prior facilities, her age at the time, (she was 72) the history given by the family of how she had been found, the length of time spent in the emergency ward without being moved, the close link between the harm and the unreasonable omission can be established on these facts.

[36] The plaintiff's case on negligence was that the hospital owed her a duty of care the test being that of the “reasonable skill and care” of the professional in question. In this case the professionals in question are not doctors but nurses.

⁸ *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC) paragraph 48

It is common cause that the responsibility for preventing the occurrence of bedsores rests on the nursing staff who are trained to deal with it. It is notable that the academic articles the court was referred to have as their authors persons with a nursing background. Also, both sides called nurses as their expert witnesses.

[37] Against that background the question the court must ask, to apply the customary test in *Kruger v Coetzee* is: (i) was the harm foreseeable and; (ii) would that person have taken reasonable steps to guard against it.⁹

[38] There is not much in dispute about the first point. The defendant's own protocols cautions nurses about the dangers of the occurrence of bedsores for patients. The more contentious point is whether GMH's staff, in particular its nursing staff, took reasonable steps to guard against the harm.

[39] Here we can divide the steps taken into two periods. What was done before the plaintiff was admitted to the ward and what was done after she was admitted to the ward. I will deal with the second period first because it is simpler.

[40] Once the plaintiff was admitted to the ordinary ward from the emergency ward a nurse checked her for the presence of bedsores. This is evident from the note I referred to earlier made at 12h10. The fact that the nurse made the wrong assumption – that the wound was an old one not a new one, does not detract from the fact that she made the note, moved the plaintiff to another position and applied a dressing. Professor Nel testified that this was the wrong type of

⁹ 1966(2) SA 428 (A) at 430.

dressings, but this point was not pursued in argument before us as constituting negligence, so I do not take this aspect any further.

[41] Then the question is what happened with the plaintiff's treatment thereafter until she was discharged early the following day. The pressure chart readings show the plaintiff was moved twice in four-hour intervals and thereafter in two hourly intervals. Whilst Professor Nel suggested a two-hour window was more appropriate this does not give rise to a conclusion of negligence. The literature she referred the court too, also speaks of a two-to-four-hour period for turning patients whilst the hospital's protocol does as well. Plaintiff's counsel correctly did not press this point on appeal. A distinction needs to be drawn between what is expected of the reasonable professional and one that is especially diligent. The fact that one falls short of what the latter may have done does not amount to negligence. As Cameron J held in *Oppelt*:

*"This means that we must not ask: what would exceptionally competent and exceptionally knowledgeable doctors have done? We must ask: 'what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible.'"*¹⁰

¹⁰ See *Oppelt* supra paragraph 108.

- [42] I thus find that the hospital staff were not negligent in their treatment of the plaintiff whilst she was admitted to the ward.
- [43] The focus then is what happened in the first period post admission and prior to the plaintiff being admitted to the ward a period of approximately twenty-four hours. Here the plaintiff's evidence is uncontradicted. She was not given any pressure sore care for this entire period. By this is meant that she was not turned or put onto some other form of support.
- [44] The defendant has raised several defences to this. In the first place the defendant argues, and this is common cause, she was kept at a 30° angle in the bed. This is one of the accepted treatments for bedsores in the literature although by no means the only one. Professor Nel whilst acknowledging this, had two responses. The first is that the reason for her being kept at the 30° angle was part of the stroke prevention treatment not to combat bedsores. But even if this is the case, if this treatment also helped to prevent bedsores the fact that it might be motivated for another reason is irrelevant.
- [45] But the better answer was that keeping the plaintiff at this angle given where her bedsore was located - on the sacrum - may have exacerbated the condition rather than mitigated it because it transferred more weight to this sensitive area. Given that a serious bedsore was observed after twenty-four hours this suggests that Professor Nel is correct. In the case of the plaintiff this was not an optimal treatment.
- [46] The next defence was that the plaintiff could not be turned given that she was in a life-threatening situation awaiting possible surgery during this period. Dr

Anyikwa who was the neurosurgeon who first treated the plaintiff at GMH, testified that when she came in, she was seriously ill and based on a standard known as the ICH, she had only a 28% chance of survival. The defendant also sought to argue that if the plaintiff had been moved during this initial period this may have been harmful given her precarious condition.

[47] But Dr Anyikwa who had been called as a witness by the defendant rebutted both these defences. First, he testified that any unconscious patient irrespective of whether they are in acute emergency must be treated in accordance with the standard that they must be moved every two to four hours. He then denied having ever instructed the nursing staff not to move the patient. Moreover, he testified that the fact that the plaintiff had to be kept at a 30-degree angle nor the fact that she was intubated, did not prevent her from being turned.

[48] Thus, there was no medical reason why the plaintiff could not have been treated in terms of the protocol and been turned in intervals of two to four hours.

[49] Then the defendant argued that because the plaintiff had not been admitted to a ward during these 24 hours it was not possible to treat her for bedsores according to the protocol. But there is no evidence from the treating doctors that her treatment prevented her from being turned. Nor is it a defence that emergency nurses do not treat patients for bedsores only ward nurses do. When a patient is in the emergency section for as long as the plaintiff was there normal protocols for bedsore treatment must be adhered to. The fact that she was not in a ward does not mean that the possibility of bedsores was any less foreseeable than if she had been in a ward.

[50] Finally in argument defendant's counsel contended that public hospitals have much greater constraints imposed on them to serve the public and fewer resources to do so than might a private hospital. This argument has been mooted in cases before. Cameron J refers to what was said by Chaskalson J in *Soobramoney* where in the context of the right to health care he remarked

*"In assessing the availability of remedial treatment, the majority judgment places insufficient weight on the circumstances in which the doctors and medical personnel worked on the critical day. Soobramoney acknowledges that the obligations s 27 places on the state depend on the resources available. Chaskalson P, for the majority, expressly noted that lack of resources may limit the rights the provision confers"*¹¹.

[51] But whatever resource constraints GMH has as a public hospital this was not an issue relevant to the treatment required by the protocols. Had this been the case no doubt Dr Anyikwa would have said so. All that was required of them to meet the standard was to turn the plaintiff every two to four hours. They did not do so in the first twenty-four hours and this fact is not in dispute.

Conclusion

[52] The defendant's hospital staff failed in their duty of care to the plaintiff to prevent the onset or spread of the bedsore she sustained. In doing so in the first twenty-

¹¹ *Oppelt* supra paragraph 100.

four hours of treatment at the hospital the nursing staff failed to adhere to the reasonable standard required of them for the prevention and management of bedsores. This was a standard the hospital itself had adopted and it can be expected that its nursing staff would have been trained in it. Gravely ill as the plaintiff was on admission Dr Anyikwa testified that this was not impediment to the protocol being observed. He gave no instruction to the contrary.

[53] I therefor conclude that the court a quo correctly decided the matter and the appeal must be dismissed. The court a quo reserved costs of the case for the second part of the case which concerns quantum. But regardless of the final outcome the plaintiff has still had to incur the costs of this appeal which are independent of any outcome on quantum. The plaintiff should get her costs. Both counsel considered that scale C of the new scale of costs should apply.

ORDER:-

[54] In the result the following order is made:

1. The appeal is dismissed.
2. The plaintiff is awarded costs including costs of one counsel on Scale C.



N. MANOIM
JUDGE OF THE HIGH COURT
GAUTENG DIVISION
JOHANNESBURG

I concur

pp.  _____

**M. MAKUME
JUDGE OF THE HIGH COURT
GAUTENG DIVISION
JOHANNESBURG**

I concur

pp.  _____

**M. SENYATSI
JUDGE OF THE HIGH COURT
GAUTENG DIVISION
JOHANNESBURG**

This judgment was prepared by Judge Manoim. It is handed down electronically by circulation to the parties or their legal representatives by email, by uploading to the electronic file of this matter on Caselines, and by publication of the judgment to the South African Legal Information Institute. The date for hand-down is deemed to be 02 September 2024.

Date of hearing: 14 August 2024

Date of Judgment: 02 September 2024

Appearances:

For the Appellant: M.W. Dlamini S.C

Instructed by: Office of the State Attorney

For the Respondent: P. Uys

Instructed by: Malcolm Lyons & Brivik Inc