IN THE HIGH COURT OF SOUTH AFRICA

(EASTERN CAPE DIVISION, EAST LONDON)

CASE NO. 875/2019

REPORTABLE

In the matter between:

THINGAZA NGCOBONDWANA PLAINTIFF

and

MEC FOR HEALTH, EASTERN CAPE DEFENDANT

JUDGMENT

Noncembu J

[1] The plaintiff's husband died at Frere Hospital on 18 June 2019 after having undergone surgery to rectify abdominal distension and bowel obstruction (laparotomy), which was performed on 17 June 2019. Consequent upon his passing, the plaintiff instituted the current action, where she claims damages for loss of support and general damages against the defendant. The claim is lodged on behalf of her two minor children and herself.

[2] By agreement between the parties, the issues were separated, and the matter proceeded on the issue of liability only, with quantum postponed sine die.

[3] At the outset, I deem it convenient to set out the particulars of claim which crystallise the plaintiff's claim. They are formulated as follows:

(a) The defendant, duly represented by his employees who were acting within the course and scope of their employ to the defendant, entered into an oral alternatively, tacit agreement with the deceased, in terms of which he undertook to provide medical and surgical services, care, advice and supervision to the deceased who was suffering from a gastro-related illness complicated by severe abdominal pains;

(b) Alternatively, by accepting the deceased as a patient, the defendant was under a duty of care to administer the aforementioned services with the professional care and diligence as can be reasonably expected of a medical facility;

(c) In breach of the agreement, alternatively, the duty of care owed; on 17 June 2019 and at Frere Hospital, the deceased, who was a known epileptic and on treatment, was denied proper medical care when he needed it, and the defendant was negligent in that –

(i) his employees failed to attend to the deceased as a special case in need of special attention because of his condition when he presented himself for treatment;

(ii) they failed to screen the deceased for pre-existing conditions;

(iii) as a result, the deceased's pre-existing epilepsy was missed, he underwent a surgical procedure after which he was placed in a high bed with no side bars, when it was inappropriate for him in such circumstances;

(iv) shortly after surgery, the deceased had an epileptic fit and fell from the bed on which he was sleeping, and he died;

(v) the healthcare professionals who attended to the deceased during admission failed to properly screen and manage his epilepsy adequately;

(vi) they failed to conduct resuscitation on him when he subsequently fell from his bed and passed out;

(vii) they failed to conduct proper monitoring post-operatively;

(viii) they failed to provide the requisite medical and surgical service with due professional skill and diligence as can be expected of health care professionals; and

(ix) as a result of the defendant's negligence, the deceased passed away in circumstances that could have been avoided.

[4] In reply to the particulars of claim, the defendant, in his amended plea, conceded that he had a legal duty to provide medical care and advice to the deceased with professional skill and diligence as required, but denied that he had entered into any agreement with the deceased as alleged. He also denied that his employees failed to administer medical care and treatment to the deceased with the

requisite professional skill, care, and diligence, alleging that the deceased died of natural causes and therefore his death could not be avoided. In amplification of the plea, the defendant pleaded the following facts:

(a) The deceased was transferred from Cala Hospital, where he received treatment, to Frere Hospital on 16 June 2019 for further treatment and care due to medical complications;

(b) Prior to his transfer, he had complained of abdominal distension and had been diagnosed with intestinal obstruction, which required urgent surgery at Frere Hospital;

(c) On his admission at Frere Hospital on 17 June 2019, the deceased's medical history was investigated, and it was found that apart from his epileptic condition, he had previously undergone an abdominal laparotomy following a gunshot wound in 1996;

(d) The deceased signed a consent form for another laparotomy to be performed in order to rectify the abdominal distension and bowel obstruction he presented, and he was accordingly prepared for theater for the procedure to be performed.

(e) On 18 June 2019, a laparotomy was successfully performed on the deceased commencing at 01h25 to 02h25;

(f) The deceased was removed from theater in a satisfactory condition on the same day at 03h00 and was transferred to the hospital ward, placed on a bed with the raised safety rails, and continuously monitored for postoperative care by a duty nurse;

(g) On 19 June 2019, at about 18h00 and at about 23h00, the deceased complained about pain, and 2 separate doses of morphine were administered;

(h) Later during the morning on the same day at 02h25, the deceased suddenly and unexpectedly jumped out of bed and over the bed safety rails in the presence of the duty nurse, who could not restrain him from this sudden and unexpected action. A doctor was immediately summoned to attend to the situation.

(i) No bleeding was observed on the deceased, and he was placed back on the bed with the assistance of the nurses.

(j) 5 minutes later at 02h30, the deceased started vomiting, gasping and groaning;

(k) After a further 5 minutes, the doctor arrived, and resuscitation was immediately commenced involving chest compressions, and breaths, with a cardiac monitor attached. The deceased was breathing at six breaths per minute, and his abdomen appeared tense and distended.

(l) After 10 minutes of continuous resuscitation, it was observed that the deceased no longer had dull eye reflexes, and his pupil no longer reacted to light; resuscitation was stopped as the deceased had, in fact, died.

(m) It is denied that the defendant suffered an epileptic fit as a result of which he fell from the bed and consequently died as alleged;

(n) A post mortem report performed on the deceased on 22 June 2019 concludes that the deceased died of septicaemia due to small bowel obstruction, caused by bowel adhesion, all of which have not been assigned to the surgery performed on the deceased;
(o) It is denied that the deceased suffered an epileptic fit as a result f which he fell and died as alleged;
(p) It is further denied that the medical staff who attended to the deceased at Frere hospital were negligent, or that they failed to properly screen the deceased on admission and to properly manage his epilepsy adequately;
(q) It is also denied that the medical and nursing staff at Frere Hospital failed to conduct proper monitoring of the deceased post-operatively.[5] The plaintiff filed a replication to the defendant's plea, where she disavowed any knowledge of the deceased's previous surgical history. She contended that if such history is found to have existed by this court, the defendant's employees failed to manage the diagnosis thereof properly and in terms of accepted standards and guidelines in cases of patients with previous laparotomy and or intestinal obstruction.

[6] She also denied that septicaemia was the cause of the deceased's death as pleaded by the defendant, alleging that if it is found to have been the cause, the development thereof was caused by the defendant's employees in that they did not properly monitor and screen the deceased for the existence of such pre- and post-operatively.

[7] The allegation by the plaintiff was that the failure to investigate the source of the deceased's pain post-operatively, which could have led to the discovery that septicaemia was the cause thereof, amounted to negligence on the part of the defendant's employees. In the alternative, it was contended that in the event this court should find that septicaemia, and not falling from a bed as alleged by the plaintiff, was the cause of death, such was due to the failure of the defendant's employees to properly investigate the plaintiff's condition on admission, and therefore missing the diagnosis of septicaemia when by exercise of reasonable care and skill they ought not to have missed it.

Factual background

[8] It is common cause that the plaintiff's husband (the deceased) was attended at Cala Hospital on 16 June 2019, where it was established that he needed urgent surgical treatment to rectify intestinal obstruction and abdominal distension. As such, he was transferred to Frere Hospital, where he was admitted for the said procedure to be performed.

[9] The plaintiff gave evidence that the deceased had complained of pain, and she asked his sister, Zoliswa Ngcobondwana, to take him to Cala Hospital as she (plaintiff) was looking after a baby. She later followed and found the deceased in the hospital, vomiting, saying that he was going to be taken to Frere Hospital. The deceased was indeed taken by ambulance to Frere Hospital, and his sister went along with him. Whilst at Frere Hospital, the deceased told the plaintiff via telephone that he was to be taken for surgery on the following day (17 June 2019).

[10] On the following day, the plaintiff could not get hold of the deceased when she tried calling him, until around 22h00, when he told her that the surgery had been successful. They conversed over the phone for about an hour.

[11] The next day, 18 June 2019, she received a telephone call from her in-laws very early in the morning, and she was taken to their place, where she was informed that her husband had passed away. When she enquired how that had happened, she was told that he had fallen from his bed around 3 in the morning.

[12] On making enquiries at the hospital, she was told that the body of the deceased had been taken to forensics. Beyond that, she could not get any answers as to what had happened. When she could not get answers from the hospital, she thought that perhaps her husband had suffered an epileptic seizure and fallen, as a person who suffered from epilepsy. The family then conducted a funeral for the deceased.

[13] She is seeking compensation as the deceased was the sole breadwinner at their home. She is now struggling to support her two children; one of whom is doing her third year at Walter Sisulu University (WSU), whilst the youngest is doing grade

1. She told the court that before his passing, the deceased had been employed by Red Guard as a security officer. She, however, did not know how much he earned, nor could she produce any pay slip or other documentation confirming his employment.

[14] The plaintiff denied that her husband suffered from dementia, as was recorded in his medical files, but admitted that he was a smoker and partook in alcohol.

[15] Zoliswa Ngcobondwana, who is the sister of the deceased, confirmed that she received a call from the plaintiff on 16 June 2019 informing her that the deceased was not well. On arrival at their home, she found the deceased bending down, vomiting, and having hiccups. She organised a vehicle and took him to Cala Hospital. At the hospital, the deceased was examined by a doctor who took X-rays and said that there was a problem with his bowel, something about his intestines being intertwined. The doctor called Frere Hospital and said that the deceased was going to be transferred there, as there was a doctor there who was going to help him.

[16] She went together with the deceased in the ambulance to Frere Hospital, where the deceased was admitted. At Frere Hospital, she was busy with the paperwork at the reception whilst the deceased was being admitted into the ward. She therefore never went inside the ward. A day after the deceased was admitted, they received the news that he had passed away. They went to the hospital, where they were assisted at the helpdesk and then referred to the mortuary. They never entered the ward where the deceased had been admitted.

[17] She could not explain why the deceased was recorded as having been unemployed on one of the defendant's documents (page 14 of the defendant's trial bundle), which document was purportedly completed by her. According to her evidence in court, the deceased was employed as a security officer at the time of his demise.

[18] Ebenezer Nyarko is a relative of the deceased, an attorney by profession, who lives in Berea, East London. He visited the deceased at Frere Hospital after he had undergone his surgery on the morning of 18 June 2019. The deceased was in high spirits, saying that the operation was a success and he would be able to go home in the next two days or so. He observed that the deceased's bed was too high and commented to one of the nurses there, who responded by saying that they knew what they were doing.

[19] Very early on the following morning, they received a call from the hospital, informing them that the deceased had passed away. They proceeded to the hospital, where they found that the deceased had already been removed from his ward and taken to Woodbrook, presumably for a post-mortem examination. On enquiring, they were given conflicting stories about what had happened. One nurse, whom he believed had not been present before, said that the deceased had died on the operating table. They told her that they had seen the deceased after his operation, and he was okay. This made Mr Nyarko suspect foul play.

[20] Professor (Prof) Franco Plani is a trauma surgeon and critical care practitioner at Chris Hani Baragwanath Hospital. His expertise as a trauma surgeon was not placed in issue. According to Prof Plani, the deceased had received sub-standard care at Frere Hospital, which probably led to his untimely demise. He based this on a number of factors, which are summarised below.

[21] Based on the information he had gleaned from the deceased's hospital records, he testified that the deceased patient was an epileptic defaulter who clearly needed to be placed on anti-seizure medication from the time he was admitted at Frere Hospital for further care and treatment (which included the laparotomy surgery to rectify his abdominal distention and bowel obstruction). His evidence was that, given that the patient's history of epilepsy was recorded in his referral letter from Cala Hospital, the epileptic drug (Epanutin) should have been administered to him intravenously from the morning of 15 June 2019 to control possible seizures. He considered the failure to do so to have amounted to sub-standard care.

[22] He also criticized the fact that no epilepsy was mentioned in the assessment notes of the patient on 16 June 2019, despite the referral letter making it clear that the deceased was an epileptic patient. According to him, in medical practice, if something has not been recorded, it means that it did not happen. He joined issue with the fact that after the surgery was completed, the patient appeared to have been in a satisfactory condition, and yet again, no mention was made about his epilepsy or treatment.

[23] He criticised the administering of the drugs propofol and isoflurane to the patient by the anaesthetist before the surgery, claiming that both drugs were associated with the possibility of triggering epileptic fits. Also, he questioned the fact that no records existed of any anti-seizure medication having been administered by the anaesthetic team to the deceased.

[24] He acknowledged that the surgery performed on the deceased was an uncomplicated procedure consisting of a resection and stapled anastomosis, but he questioned the fact that no mention was made of any perforation of the small bowel or peritonitis in the surgical notes. He noted that the patient was discharged from the theatre in a satisfactory condition, that the nasogastric tube and catheter were removed, and he was introduced to a fluid diet, alert and responsive, mobilising independently out of bed and awaiting referral to commence physiotherapy, but he questioned that no further notes were available to corroborate explanations around his last hours and resuscitation phase.

[25] In his opinion, the post-operative care and emergency response to the deceased's alleged fall were profoundly inadequate. There were no records documenting the critical events surrounding his deterioration, including the absence of a proper resuscitation record, the failure to secure the airway through intubation, and an unclear timeline of medical intervention.

[26] He disputed Dr Zondi and Dr Promnitz's opinions (defendant's experts) that the patient died from complications arising from sepsis and peritonitis. This was based on the fact that no blood culture or blood specimen was done as evidence to prove the said findings. He opined that the patient may have felt like vomiting after

being given morphine and that, possibly having been started on fluids very early after the surgery, may have aspirated, since it was mentioned that he was given chest compressions and breaths, presumably with a face mask on, given that there was no mention of intubation having been attempted.

[27] He also criticised the findings and conclusions of the post-mortem report performed by Dr Zondi on the deceased, stating that no reasons were provided as to why a limited post-mortem was conducted, why the deceased's skull was not opened, and his brain was not examined. According to him, a traumatic brain injury could have been the cause of the deceased's death after he fell from the bed.

[28] He also took issue with the classification of the deceased's death as having been due to natural causes, stating that, in terms of regulations, death resulting from complications in surgery or after surgery cannot be classified as natural causes.

[29] Dr Gregory Paul Promnitz testified on behalf of the defendant. He is an expert physician specialising in the management of complex internal medicine in respect of both acute and chronic conditions. He told the court that he had been involved in intensive care unit complications following surgery in private practice for many years. He also told the court that specialist physicians are often referred to as 'doctors of doctors', as they are consulted by general practitioners, trauma surgeons, and general surgeons in cases where patients present with multiple unclear diagnoses.

[30] He said that as a physician, he has the expertise to give an opinion on the management of epilepsy. He is often consulted intra- and post-operatively, where no neurologist physician takes over the function of chronic treatment. In his view, a trauma surgeon is not qualified to give an expert opinion on the management of epilepsy.

[31] With regards to the cause of death, Dr Promnitz opined, after seeing the findings of the post-mortem report, that the deceased died from peritonitis secondary to a small bowel perforation, which could have occurred postoperatively or been

present at the time of surgery. He noted in his supplementary report that the peritonitis and resultant infection would have caused the development of acute pulmonary oedema, as documented in the post-mortem report, most likely secondary to the Adult Respiratory Distress Syndrome, resulting in hypoxia and the cardiorespiratory arrest.

[32] He said that following surgery, the deceased initially appeared to be recovering well. However, the subsequent ground vomiting was indicative of a gastrointestinal bleed, and gasping was more likely due to hypoxia (low oxygen levels). By the time a clinician attempted resuscitation, the deceased was already in cardiac arrest with no measurable blood pressure. According to him, with 6 breaths per minute, as was the position during the resuscitation, he was unlikely to survive.

[33] With regard to the recorded incident of the deceased jumping out of his hospital bed, he testified that such behaviour was consistent with confusion, likely arising from dementia or alcohol withdrawal, both of which were noted in the deceased's medical history from Cala Hospital. He told the court that the patient was described as having a background of epilepsy, alcohol use, and possible dementia, all of which are consistent with cognitive decline and personality changes.

[32] Regarding the management of the deceased's epilepsy, he testified that it was not clinically appropriate to administer the patient's chronic anti-epileptic medication (Epanutin 300mg) orally due to the patient's vomiting, bowel obstruction, and abdominal distention at the time of admission to Free Hospital. He stated that the only safe route of administering same would have been intravenously, but that would have required prior serum level testing (blood test) to avoid the risk of toxicity or sub-therapeutic dosing. Such test results, he continued, would take 24 to 48 hours to return, and thus would not have been available prior to the deceased being taken to emergency surgery.

[33] In his opinion, any person who has not had a virgin operation has a high chance of bowel infection. He opined that, given the fact that the deceased had undergone a laparotomy for a gunshot wound in 1996, the wound could have perforated and resulted in adhesions, thus making the surgery complicated. He said that complications under those circumstances are unpredictable and therefore could not be prevented.

[34] On the question of resuscitation, he pointed out that the clinical records clearly reflect a 10-minute period of resuscitation with a doctor present, during which no seizure or epileptic activity was recorded. He testified that the success rate of resuscitation in such clinical settings was very low, ranging between 20% and 40 %, and even lower in public hospitals. According to him, the decision whether to intubate and continue with resuscitation is at the discretion of the attending medical practitioner. In his view, there was no basis for suggesting that the deceased's life could have been saved by different resuscitation methods.

[35] In his report, he also referred to the histology report of the specimens submitted at the time of the surgery, which stated that there was small bowel tissue, of which the area of stricture showed transmural infarction and necrosis. Recording that the serosal surface showed dense acute inflammatory exudate. This, according to him, was suggestive of peritonitis being present. He did underscore, however, that this result would only have become available several days after the death of the deceased.

[36] The post-mortem report compiled by the late Dr Zondi, a Chief Medical Officer based at Forensic Pathology Services in Woodbrook, was admitted as part of the defendant's evidence in line with the parties' pre-trial minute dated 29 March 2021. Dr Zondi passed away in 2024 and was therefore not available to testify in court. An opposed application to have the said report admitted was later withdrawn by consent, when it became apparent that the parties had in fact agreed in the pre-trial minute that same would be admitted as evidence in court without further proof, on

the basis that it was what it purported to be, without admission of the truth of the contents thereof.

[37] Dr Zondi worked as a district surgeon for the Eastern Cape Department of Health, trained in conducting post-mortem examinations to determine the cause and manner of death through autopsy. Following the passing of the deceased on 19 June 2019, he conducted a post-mortem examination on the cause of the deceased's death on 23 June 2019, after which he compiled the post-mortem report.

[38] In the report, he made the following chief post-mortem findings: 'History of bowel obstruction due to bowel adhesions, ischaemic bowel, dilated small bowel, perforated small bowel, pale kidneys, pale liver, acute peritoneal.' He thereafter recorded the cause of death as 'Sepsis due to perforated small bowel due to small bowel obstruction due to adhesion.'

The issues

[39] Broadly summarised, the issues for determination by this court are: whether the defendant's employees (medical staff at Frere Hospital) breached their duty of care and were negligent in their execution of duties in providing treatment to the deceased pre-, intra-, and post-operation; and whether such negligence was the cause of the death of the deceased (causation).

The applicable legal principles

[40] It is trite law that the plaintiff bears the onus of proving his/ her case on a balance of probabilities in civil matters. In the present matter, the plaintiff is required to prove not only that the defendant's employees provided substandard care to the deceased and therefore acted negligently, but also that their conduct caused the death of the deceased.

[41] The lay witnesses who testified on behalf of the plaintiff mainly served to give a factual background to the circumstances leading to the admission of the deceased in Frere Hospital, and what transpired after he had undergone the laparotomy. More than that, they could not assist much in respect of what happened and/or how the deceased died. Other than formulating suspicions based on what they were told, they did not know how the deceased died or what caused his death. The only key witness on whose testimony the plaintiff's case rested, therefore, is their expert. Prof Plani. On this score, it must be noted that, like Dr Promnitz, Prof Plani did not see the deceased. His evidence and formulated opinions were based on the deceased's clinical records and documents, which were provided to him.

[42] The defendant, on the other hand, relied on the post-mortem report compiled by Dr Zondi, as well as Dr Promnitz, their expert, who also relied on the clinical records and documents provided to him.

[43] It is therefore not surprising that there were no joint expert minutes filed in respect of this matter, given that the litigants engaged different experts who belong to different fields of expertise. Invariably, this anomaly complicates the assessment of the evidence of the respective experts in the matter. This gets compounded by the fact that none of the medical officials who treated or attended to the deceased at Frere Hospital were called by either of the parties to testify in these proceedings.

[44] The guiding principles under these circumstances were laid down by the Supreme Court of Appeal (SCA) in *Lourens v Oldwage,*[1] where the court, with reference to *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another*,[2] stated the following:

'What was required of the trial judge was to determine to what extent the opinions advanced by the experts were founded on logical reasoning and how the competing sets of evidence stood in relation to one another, viewed in light of probabilities.'

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[1] *Lourens v Oldwage* 2006 (2) SA 161 (SCA)(21 September 2005) at 175H.
[2] *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA) (13March 2001) (*Linksfield Park Clinic).*

[45] In *Linksfield Park Clinic*[3] the SCA cautioned as follows:

'It would be wrong to decide a case by simple preference where there are conflicting views on either side capable of logical support. Only where the expert opinion cannot be logically supported at all, will it fail to provide "the benchmark" by reference to which the defendant's conduct fails to be assessed.'

[46] This matter, therefore, turns on the expert evidence that was presented by both parties. The guiding principle in this regard is that the function of an expert is not to decide the case or advocate for a party, but to assist the court by providing specialised knowledge and opinion on matters beyond the court's ordinary experience. This entails explaining technical or scientific matters and providing reasoned opinions so that the court can evaluate them independently.

[47] In *AM v MEC for Health,*[4] this function was described in the following terms by Wallis JA:

'The functions of an expert witness are threefold. First, where they have themselves observed relevant facts, that evidence will be evidence of fact and admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.' (Footnotes omitted.)

[48] The Learned Judge of Appeal stated further: 'The need for clarity as to the facts on which an expert's opinion is based has been stressed in a number of cases.

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[3] At para 39.
[4] *AM and Another v MEC for Health, Western Cape* 2021 (3) SA 337 (SCA)(31 July 2020) at para 17.

In *Price Waterhouse Coopers v National Potato Co-operative Ltd,* the following passage from a Canadian judgment[5] was cited with approval:

"Before any weight can be given to an expert's opinion, the facts upon which the opinion is based must be found to exist. As long as there is some admissible evidence on which the expert's testimony is based, it cannot be ignored; **but it follows that the more an expert relies on facts not in evidence, the weight given to his opinion will diminish. An opinion based on facts not in evidence has no value for the Court**." (Emphasis intended)

[47 The learned Judge of appeal continued:

'The opinions of expert witnesses involve the drawing of inferences from facts. The inferences must be reasonably capable of being drawn from those facts. If they are tenuous or far-fetched, they cannot form the foundation for the court to make any finding of fact. Furthermore, in any process of reasoning, the drawing of inferences from the facts must be based on admitted or proven facts and not matters of speculation. As Lord Wright said in his speech in *Caswell* v *Powell Duffryn Associated Collieries Ltd*:

> "Inference must be carefully distinguished from conjecture or speculation. There can be no inference unless there are objective facts from which to infer the other facts which it is sought to establish. . .. But if there are no positive proved facts from which the inference can be made, the method of inference fails, and what is left is mere speculation or conjecture." [6] (Footnotes omitted)

[48] The Learned Judge continued further:

> 'Where the facts are central to the opinions of the experts, **courts should require that those facts be led in evidence before the experts express their opinions**. Primarily, that is for the benefit of the court, which is thereby placed in a position where the expert's opinion can be assessed, and, if need be, queried or elucidated, in the light of the factual material before it. It is also conducive to fairness in cross-examination of the experts on behalf of the defendants. Where the case comes on appeal, it facilitates a reading of the record. Lastly, if this principle is borne in mind

[5] A*iddrington (Estate of) c. Wightman*, 2011 QCCS 1788 (CanLII) paras 326-328.
[6] Ibid paras.20-21; *HAL obo MML v MEC for Health*, *FS* 2022 (3) SA 571 (SCA) ([2021] ZASCA 149) paras.212-213.

and objections are upheld to leading the expert evidence without a proper factual foundation being laid, that should avoid situations, such as that in *Madikane,* where the case was conducted entirely on the basis of expert evidence without any factual foundation at all for the opinions being expressed.' [7] (Emphasis intended)

Discussion

[49] As stated earlier, the court in this matter is faced with not only opposing expert opinions but also the fact that the evidence tendered is from experts who come from different fields of expertise. In this regard, counsel for the defendant criticised the evidence of Prof Plani on the basis that he failed to defer when questioned on aspects that do not pertain to his field of expertise.

[50] This was premised on the fact that, according to Prof Plani, the deceased could have died as a result of a traumatic brain injury caused by having fallen from his bed, which fall he attributed to a possible epileptic fit, given that he was a known epileptic. The criticism in this regard was that he is not an expert in the management of epilepsy, a field in which a specialist physician, in this instance Dr Promnitz, was more qualified.

[51] Of course, one cannot make light of the fact that Prof Plani is a specialist surgeon and therefore an expert in surgical procedures. However, the difficulty with his proposition, as proffered in the above regard, is that no clinical evidence was presented before the court to suggest that the deceased suffered an epileptic seizure at any stage before, during, or after his surgery. In the absence of any factual evidence in that regard, anything else becomes speculation.

[52] In short, Prof Plani's hypothesis of sub-standard care on the part of the hospital

[7] At para 215

staff at Free Hospital was premised on three main factors: (a) the failure to properly manage the deceased's chronic condition of epilepsy, which presupposes that the deceased fell as a result of an epileptic seizure, causing injuries that led to his ultimate demise; (b) the failure to intubate the deceased at the critical moment, including the failure to call for assistance; and (c) the failure to open the deceased's skull and thus offering limited post mortem findings by Dr Zondi.

[53] Concerning (a), his main cause of concern emanated from the fact that no record of epilepsy was made in the deceased's clinical notes in Frere Hospital; the anaesthetist team used seizure-inducing drugs on the deceased; and the deceased was not given any anti-seizure medication before his surgery. In my view, the pertinence of these factors, however, diminishes when one takes into account that a referral letter from Cala Hospital specifically mentioned that the deceased was a known epileptic defaulter. According to Dr Promnitz, at times they receive transfers of unresponsive patients, and therefore, the referral letter is very important and is intended for the receiving and treating doctors so that they know what they are dealing with. According to him, therefore, the treating doctor would have been aware of the deceased's epilepsy condition as the letter would have formed part of his file.

[54] Furthermore, Dr Promnitz, provided logical reasons why the deceased's epileptic drug, Epinatum, could not be administered, both orally and intravenously, prior to his surgery. Lastly, and most importantly in this regard, Prof Plani also conceded under cross-examination that there was no clinical evidence to suggest that the deceased had suffered an epileptic seizure, which could have been the cause of his fall. The proposition, therefore, that the deceased suffered an epileptic seizure is not based on any factual evidence, other than mere speculation and conjecture.

[55] As to (b), the evidence of Dr Promnitz was that on the clinical records, it is recorded that a doctor was called within 5 minutes, and the deceased was resuscitated for about 10 minutes. In his opinion, there is no evidence to suggest that a different form of resuscitation would have resulted in a different outcome, as the important thing was to provide some sort of ventilation by creating an airway, which

was done in this case. According to Dr Promnitz, intubation was not always the only way of going about that process.

[56] Prof Plani also criticised the fact that senior medical officers were not called to assist during the resuscitation. This, in my view, cannot be said to have amounted to sub-standard care, given that the necessary resuscitation was done, and the short period within which the deceased passed on.

[57] As to (c), it is significant to note that the post-mortem examination has no bearing on the treatment of the patient/ deceased, prior to his passing, because, as the term itself indicates, it is done post-mortem. Therefore, the inadequacy or otherwise thereof cannot be said to have a bearing on the quality and standard of care that was afforded to the patient while he was still alive.

[58] In this regard, Prof Plani indicated, correctly so in my view, that the pathologist sees the organs (that is what is recorded in the postmortem report and forms the basis of the recorded findings in the current matter) without seeing or knowing the ins and outs of what was involved. He has a non-speaking patient, and he can see the consequences without knowing whether it could have been prevented or not.

[59] It is indeed regrettable that Dr Zondi's evidence could not be tested through cross-examination due to his earlier demise. However, from what I can understand of Prof Plani's criticisms of his report, it is not that he denies the findings based on the observations made (the organs observed) and the consequences thereof; his major criticism is of the fact that more was not done. In fact, he acknowledged that a pathologist does not have the clinical records when he examines a body. It follows therefrom that he cannot be influenced by the findings contained in those records, as his findings are based on his own observations.

[60] I also find it compelling in this regard that Dr Promnitz, in his earlier report before he had sight of the post-mortem report, hypothesized that the cause of the death of the deceased was complications relating to the recent surgery resulting in intra-abdominal sepsis. Notably, the post-mortem report, which was received much

later, confirmed the cause of death to be sepsis due to perforated small bowel due to small bowel obstruction due to adhesion.

[61] I find the following remarks by the SCA in *AM v MEC for Heath,*[8] with reference to *Mitchell v Dixon,*[9] to be apposite in this regard:

'The relationship between a plaintiff and a defendant that possesses specialised skill and knowledge may consequently require a standard of care from the defendant that is different from what that standard would otherwise be. It is, however, not expected of such a defendant to exercise the highest possible degree of professional skill.[10] What is expected is the general level of skill and diligence which is possessed and would ordinarily be exercised by a reasonable member of the branch of the profession to which he or she belongs under similar circumstances.'

[62] Applied to the facts of the present matter, liability will only be imposed if it is found that the death of the deceased was reasonably foreseeable and that the hospital staff had failed to provide the level of skill and competence that could otherwise be expected to be provided by a reasonable health care worker in similar circumstances.

[63] Put differently, the version of the plaintiff is that the deceased died from possible head injuries sustained when he fell from a high hospital bed due to a possible epileptic seizure while he was unattended, and a failure to resuscitate him after his fall (premised on the fact that he was not intubated), all of which could have been prevented had he been provided the requisite standard of skill and care expected of the calibre of medical professionals in Frere Hospital.

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[8] *AM and Another v MEC for Health, Western Cape* 2021 (3) SA 337 (SCA).
[9] *Mitchell v Dixon* 1914 AD 519 at 525.
[10] *Mitchell v Dixon* 1914 AD 519 at 525

[64] This version, in my view, falls short for a number of reasons, some of which I deal with later in the judgment. I have already dealt with the allegation of poor management pre-operation, which mainly stems from the failure to record the epilepsy condition of the deceased in his clinical records, and the consequences allegedly flowing therefrom (giving the patient epilepsy inducing drugs for anaesthetic purposes, the failure to administer anti-epilepsy drugs prior to the surgery, and the alleged seizure suffered post-operation as a consequence thereof).

[65] There was no evidence tendered before the court to support the proposition that the deceased was not monitored/ attended to after his surgery. In fact, the evidence of Mr Nyarko, who visited the deceased after his surgery, was that when he had concerns about the height of the deceased's bed when he was with him, he voiced his concerns to the nurse who was in attendance there. This, in my view, supports the defendant's version that the defendant was attended to by a duty nurse at all relevant times after his surgery.

[66] Counsel for the plaintiff made much of the fact that, besides not being intubated, there was no intervention of a senior staff member during the resuscitation of the deceased. In my view, this aspect was adequately dealt with in the evidence of Dr Promnitz, who testified that whether or not the patient was intubated was not the issue, as the important thing was the creation of an airway, ensuring that the patient was ventilated, something which was done in the present matter. The evidence before the court was that a doctor was called within 5 minutes, who began resuscitating the patient for 10 minutes, at which point the patient passed away. The question in my view then becomes, did the attending doctor display the highest possible degree of professional skill? Maybe not, but there is nothing before me to suggest that he lacked the general level of skill and diligence that is possessed and would ordinarily be exercised by a reasonable doctor under similar circumstances.[11]

[67] Delictual liability can only arise if it is established on a balance of probabilities that the defendant's employees were negligent. Once negligence has been

[11] *AM v MEC for Health*, fn 8 *supra*.

established, the element of causation must still be proved. The test for negligence was set out in *Kruger v Coetzee*[12] where the following was stated*:*

'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.'[13]

[68] In establishing negligence in the current matter, the plaintiff essentially relied on the evidence of Prof Plani. What became apparent in his testimony was that he was highly concerned with the fact that there were limited post-mortem findings. He stated that peritonitis takes a day or two to develop. According to him, it did not make sense that the day following the surgery, there was a perforation, expressing a concern with the fact that the post-mortem report does not state if the perforation was on the suture line or somewhere else.

[69] He did concede under cross-examination, however, that it was not impossible for peritonitis to develop immediately after surgery, stating that, depending on the immune system of the patient, it could occur in under 24 hours. He expressed a concern, though, that absent a full post-mortem report, one would not know if the perforation was new or old.

[70] He also acknowledged that multiple adhesions are frequently found in post-operative abdomen, especially after gunshot wounds, which often cause extensive peritoneal contamination. He noted a concern that there was no mention of any other areas of concern, or whether or not the rest of the bowel was mobilised.

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[12] *Kruger v Coetzee* 1966 (2) SA 428 (A).
[13] Ibid at 430E-F.

[71] Although the two experts disagree on the cause of death of the deceased, their evidence does bear certain similarities with respect to some of their opinions and conclusions. In regard to the perforation, Dr Promnitz testified that it could have occurred post-operatively or could have been present at the time of surgery. Like Prof Plani, he told the court that he was unable to establish exactly when the perforation had occurred.

[72] In the opinion of Dr Promnitz, the original cause of the bowel obstruction was most likely the gunshot wound to the abdomen, which the deceased had sustained previously. The said wound would have caused intra-abdominal adhesions, which in turn caused the obstruction. According to him, this presented a high chance of bowel infection, as the gunshot wound would have perforated, resulting in adhesions, making the surgery complicated and unpredictable.

[73] He further opined that where there is a previous surgery, surgeons are often reluctant to enter, given the risk of perforation, which risks become much higher post-operatively. According to him, the deceased probably had complications arising from the gunshot wound. When asked as to why this was not picked up at the time of the surgery, his response was that it was difficult for a surgeon to get into the other parts of the abdomen, besides the area they are working on.

[74] From the above, what crystallises is that it was common cause between the experts that adhesions post-operative abdomen, especially after a gunshot wound, causing peritoneal contamination (peritonitis), was not an uncommon phenomenon. Furthermore, both experts could not deny that there was bowel perforation, although they both could not say whether this had occurred pre- or post-operatively, or where it was located. Dr Promnitz proposed to give an explanation why it was not possible or easy to establish the location of the perforation during the surgery, which proposition I have no reason not to accept.

[75] With the above in place, I find that a compelling case has been made for the defendant, that the cause of death of the deceased was sepsis due to perforated small bowel due to small bowel obstruction due to adhesion, and that such could not have been prevented under the circumstances. Notably, a similar proposition was made by Dr Promnitz in this regard even before he had sight of the post-mortem report. In the opinion of Dr Promnitz, the fact that the intracranial contents were not examined during the post-mortem examination was unlikely to have changed Dr Zondi's report to any great extent because, on the documentation that was provided, there was no history of any head trauma.

[76] Having considered all of the above factors, I am unable to find that the plaintiff has established negligence on the part of the medical staff at Frere Hospital on a balance of probabilities. Absent such negligence, it follows, therefore, that there can be no nexus between the death of the deceased and the conduct of the medical staff at Free Hospital.

[77] In the result, the plaintiff's claim cannot succeed.

Costs

[78] The general rule in respect of costs is that they follow the result and they are at the discretion of the court. I can find no reason why the general rule should not apply in the present matter.

Order

[79] Consequently, the following order shall issue:

The plaintiff's claim is dismissed with costs.

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V P NONCEMBU

JUDGE OF THE HIGH COURT

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