

SAFLII Note: Certain personal/private details of parties or witnesses have been redacted from this document in compliance with the law and [SAFLII Policy](#)



**IN THE HIGH COURT OF SOUTH AFRICA
NORTHWEST DIVISION, MAHIKENG**

CASE NO:16/2018

Reportable: **NO**

Circulate to Judges: **NO**

Circulate to Magistrates: **NO**

Circulate to Regional Magistrates: **NO**

In the matter between:-

T[...] M[...]

Plaintiff

and

**THE MEC FOR HEALTH AND SOCIAL DEVELOPMENT:
NORTH WEST PROVINCE**

Defendant

Coram : Mfenyana J

This judgment was handed down electronically by circulation to the parties' representatives *via* email. The date and time for the hand-down of the judgment is deemed to be **22 April 2026**.

ORDER

- a. In accordance with the provisions of Rule 33(4), the issues of liability and quantum are separated.
- b. The defendant is liable for 100% of the plaintiff's proven or agreed damages arising from the injuries sustained by the plaintiff as a result of the negligent conduct of the medical and nursing personnel at the defendant's various clinics and hospitals between 10 March 2015 and 15 May 2015.
- c. The issue of quantum is postponed *sine die*.
- d. Costs shall stand over for later determination on a day to be arranged with the parties.

JUDGMENT

Mfenyana J

Introduction

- [1] The plaintiff instituted proceedings against the defendant for damages she suffered, allegedly arising from injuries she sustained consequent to medical treatment she received at the Phaposane Clinic ("Phaposane"), the Tlaskgameng Community Health Centre and Clinic ("Tlaskgameng"), the Ganyesa Hospital ("Ganyesa") and the Joe Morolong Memorial Hospital ("Joe Morolong") in the province of the North West (collectively referred to as the hospitals and clinics).
- [2] The plaintiff avers that the defendant's employees at the hospitals and clinics falling under the defendant owed her a duty of care to ensure that their

treatment of her was offered with the degree of skill, care and diligence reasonably expected at hospitals and clinics providing antenatal, pre-surgical, surgical and post-surgical care, which they breached, causing her to suffer damages.

[3] The defendant has defended the action and denies liability, asserting that the medical and nursing staff acted appropriately in the specific circumstances of the case. The defendant, consequently, seeks a dismissal of the plaintiff's claim.

[4] The plaintiff called the following witnesses to testify:

- 4.1. Ms T M[...], the plaintiff.
- 4.2. Dr Davis- obstetrician- gynaecologist.
- 4.3. Prof Bizos – specialist surgeon.
- 4.4. Dr Botha- specialist physician.
- 4.5. Dr Webber – specialist pathologist in clinical virology.

[5] The following witnesses testified on behalf of the defendant:

- 5.1. Dr Manthata-Cruywagen- obstetrician- gynaecologist.
- 5.2. Dr Malinga- general surgeon.
- 5.3. Dr Tsela – physician.
- 5.4. Dr Maphoto – virologist.
- 5.5. Dr Brooms – (factual witness)
- 5.6. Dr Fourie – (factual witness).

[6] The expert reports filed in respect of both parties (including addendum reports), as well as the available medical and hospital records, which formed

the basis of the opinions and conclusions reached by the various experts, were admitted into evidence. Joint minutes were prepared by the following experts:

6.1. Dr Davis and Dr Manthata-Cruywagen

6.2. Prof Bizos and Dr Malinga

6.3. Dr Webber and Dr Maphoto

6.4. Dr Botha and Dr Tsela.

Preliminary issues

[7] On 6 February 2020, Hendricks DJP (as he then was) granted an order condoning the plaintiff's late service of the notice contemplated in section 3 of the Institution of Legal Proceedings Against Certain Organs of State Act (the Act)¹.

[8] At a pre-trial conference on 29 June 2020, the parties agreed, in terms of Rule 33(4) and subject to the court's approval, that the issues of liability and quantum would be separated. They further agreed that the documents in the core bundles, including the clinical and hospital records relating to the plaintiff's admission to and treatment at clinics and hospitals between March and July 2015, are what they purport to be and will be admitted into evidence on mere production, without formal proof or originals, and without admitting the correctness of their contents. Any party wishing to object to this agreement must give five days' notice to the other party.

¹ Act 40 of 2002.

- [9] Pursuant to an application by the plaintiff, I delivered a judgment on 11 July 2023 in which I ruled that the medical records contained in the core bundles, being those agreed to by the parties during the pre-trial conference, are admitted into evidence.
- [10] On 23 July 2023, the defendant delivered a notice of repudiation, seeking to repudiate certain portions of the agreements between Prof Bizos and Dr Malinga, the parties' surgical experts.

Relevant factual basis and timeline

- [11] The following timeline of events leading to the plaintiff's claim is central to the present dispute.

11.1. On 2 March 2015, the plaintiff, then 32 years old and pregnant, attended

Phaposane for her first antenatal visit.

11.2. She returned to Phaposane on 10 March 2015, presenting with abdominal pains and a yellowish, non-offensive vaginal discharge.

11.3. On 11 April 2015 at approximately 01h35, the plaintiff attended at Tlakgameng, presenting with severe abdominal pain and vaginal bleeding. She was admitted. She thereafter started to vomit. At approximately 08h14 on the same day, the bleeding had stopped, and the abdominal pains had subsided. She was subsequently discharged

with medication to take home and advised to go to the local clinic the following Monday, 13 April 2015, so she could be referred to Ganyesa and booked for “High Risk Clinic”.

11.4. On 14 April 2015, the plaintiff was admitted to Ganyesa, on referral from

the local health care centre.

11.5. On 15 April 2015, while at Ganyesa, an ultrasound was performed, which

showed that she was 11+ weeks pregnant. She was diagnosed with a normal intrauterine pregnancy with the date of delivery estimated at 4 November 2015. She was scheduled for follow-up at the local clinic on 6 May 2015.

11.6. On 29 April 2015, the plaintiff returned to Tlakgameng with abdominal pains. She was wheeled in on a stretcher. She was later transferred to Ganyesa by ambulance just before midnight.

11.7. Upon admission at Ganyesa on 30 April 2015, she was diagnosed with severe abdominal pains during pregnancy. She was unable to walk. At 10:45, a repeat ultrasound showed no fetal heartbeat.

11.8. On 1 May 2015, the plaintiff was transferred by ambulance to Joe Morolong in Vryburg, with a diagnosis of internal bleeding in pregnancy and abdominal pains since 29 April 2015. She was admitted at approximately 16h30 and diagnosed with a ruptured ectopic

pregnancy. At approximately 17h30 on the same day, she underwent a laparotomy under the care of Drs Mphatsoe, Mvula and Moyo(the first operation). Dr Buabau was the anaesthetist.

11.9. On 4 May 2015, the plaintiff was seen by Dr Mphatsoe and was scheduled for transfer back to Ganyesa despite a tachycardia of 134 bpm. While awaiting an ambulance for transfer to Ganyesa, she developed a fever, worsening tachycardia, and abdominal distension. She remained at Joe Morolong.

11.10. On 5 May 2015, the plaintiff underwent an exploratory laparotomy and hysterectomy (the second operation). During the procedure, it was discovered that she had a 1 cm perforation in her ileum, 25 cm from the ileocecal valve. A total abdominal hysterectomy was performed.

11.11. On 7 May 2015, the plaintiff was transferred back to Ganyesa.

11.12. On 11 May 2015, the plaintiff was transferred back to Joe Morolong for post- hysterectomy complications.

11.13. On 15 May 2015, the plaintiff underwent another exploratory laparotomy,

and it was discovered that she had intra-abdominal abscesses and wound sepsis, which necessitated debridement (the third operation).

[12] The plaintiff contends that the defendant breached its duty of care towards the

plaintiff in various respects in that: (i) it failed to diagnose the cause of her lower abdominal pain and vaginal bleeding between 10 March and 15 April 2015, causing her cornual ectopic pregnancy to remain undiagnosed until rupture; (ii) it failed, on 15 April 2015, to refer her to a facility able to investigate, diagnose and treat her clinical symptoms properly; (iii) it failed, on 29, 30 April and 1 May 2015, to appreciate the seriousness of her persistent lower abdominal pains, to diagnose internal bleeding, and to act timeously and appropriately; (iv) it failed, between 1 and 5 May 2015, to recognise that her small bowel had been perforated and to respond timeously; and (v) prematurely transferred her on 7 May 2015, to a lower-level facility while she was extremely ill, without any referral or clinical notes.

[13] Also linked to these is the allegation that the defendant failed to employ suitably qualified and experienced medical practitioners and nursing staff to timeously and appropriately assess, monitor, and manage the plaintiff, render the necessary nursing services, and ensure that the clinics and hospitals were adequately equipped for that purpose during the antenatal period, the birth process, and before, during, and after the first operation.

[14] The plaintiff further avers that the defendant failed to take the reasonably necessary steps to prevent complications during the pregnancy and laparotomy, including preventing the plaintiff from developing intra-abdominal abscesses and wound sepsis, despite being able to do so through the exercise of reasonable care and diligence.

[15] Consequently, the plaintiff avers that she suffered emotional shock, trauma,

anguish, pain, and discomfort, and will continue to endure such anguish for the remainder of her life. She has severe scarring of the abdominal wall, suffers daily chronic abdominal pain, is unable to bear children, and has been permanently disabled and disfigured. As a result, she has sustained permanent loss and will require future hospitalisation and medical treatment, she adds.

[16] Lastly, the plaintiff avers that she has suffered a permanent loss of her ability, alternatively her capacity, to earn an income, as well as a loss of the enjoyment of the amenities of life.

[17] In opposing the claim, the defendant denies liability and asserts that the medical practitioners and nursing staff at all its medical facilities exercised the requisite skill, care, and diligence reasonably expected of them in the care and treatment of the plaintiff, in accordance with the applicable protocols. The defendant further denies any causal connection between the alleged negligence and the plaintiff's injuries.

[18] In particular, the defendant avers that a sonar conducted on 11 April 2015 revealed a foetal heart rate. The plaintiff was thereafter medicated intravenously and kept under observation overnight. The defendant further avers that the laparotomy performed on 1 May 2015, the plaintiff's subsequent treatment, and the decision to discharge her were all undertaken with the requisite skill and diligence, and that the plaintiff showed no signs of injury.

[19] The defendant further avers that the 1 cm perforation recorded by Dr Brooms

was not caused by any negligence on the part of the medical and nursing staff who treated the plaintiff on 1 May 2015 and thereafter. Following the second operation, the plaintiff was transferred to Ganyesa only once the medical staff were satisfied that she was feeling better and experiencing less pain.

JOINT MINUTES

Joint minutes of the obstetrician-gynaecologists (Dr Davis and Dr Manthata-Cruywagen)

[20] The obstetricians disagree on various aspects of the plaintiff's care and management at the relevant clinics and hospitals, focusing in particular on the obstetrical issues in this case. They note that no abnormalities were observed when the plaintiff first attended Phaposane for her antenatal visit on 2 March 2015.

[21] Dr Davis is of the opinion that when the plaintiff was admitted to Ganyesa on 14 April 2015, she had been complaining of severe abdominal pains since March 2015. On 15 April 2015, an ultrasound was done by a general practitioner with no specialised training in ultrasound to make a diagnosis of a cornual ectopic pregnancy. He opines that at that stage the plaintiff should have been referred to Joe Morolong hospital to an obstetrician, stating that lower abdominal pains in pregnancy are abnormal and failure to refer the plaintiff is substandard antenatal care.

[22] Dr Manthata-Cruywagen, however, states that when an ultrasound is done

with a foetal heart rate present, with no adnexal masses (growth near the uterus), this confirms the diagnosis of intra-uterine pregnancy. However, with the benefit of hindsight, the plaintiff had a cornual pregnancy. She adds that a cornual pregnancy is difficult to diagnose, and the doctors at Ganyesa could not have wilfully delayed her transfer to Joe Morolong. Dr Manthata-Cruywagen further notes that the bleeding and pains spontaneously subsided, and a miscarriage was excluded. Dr Manthata-Cruywagen further notes that most of the common causes of pain in pregnancy were excluded, further noting that the plaintiff was newly diagnosed with HIV.

[23] Dr Davis notes that not referring the plaintiff to a higher centre timeously meant that the pregnancy continued for another two weeks when she was admitted at Tlaskgameng on 29 April 2015, presenting with severe abdominal pains and a tender abdomen. Her haemoglobin dropped from 14.6 g/dl to 9 g/d. The experts agree that she was correctly referred to Ganyesa. Dr Manthata-Cruywagen, however, adds that the pregnancy was allowed to continue as it was diagnosed as a normal intra-uterine pregnancy.

[24] According to Dr Davis, when the plaintiff was found to be pale on examination at Ganyesa, it should have been clear to the medical staff that she was bleeding internally, as she had no vaginal bleeding. The ultrasound done showed no foetal heart rate, but she was kept at Ganyesa until the ectopic pregnancy ruptured. Her haemoglobin reached life-threatening levels at 3.1 g/dl, and she should have been immediately referred for an operation; failure to do so constitutes grossly substandard care.

[25] Dr Manthata-Cruywagen disagrees. She states that the medical staff at Ganyesa did not suspect an ectopic pregnancy and had diagnosed a normal intra-uterine pregnancy with no foetal heart rate. They considered it to be a miscarriage, which can be managed at the district level, and referral was not indicated. She adds that a cornual ectopic pregnancy tends to bleed a lot more, which is confirmed by Dr Davis, hence the drop in haemoglobin.

[26] Dr Manthata-Cruywagen further opines that the plaintiff's resuscitation and subsequent transfer with blood products constituted appropriate management, noting that she could have died in transit had she not been resuscitated so effectively. She added that this made it easy for Joe Morolong to diagnose her with a ruptured ectopic pregnancy.

First operation and the period from 1 May to 5 May 2015

[27] The obstetricians disagree about the timing of the small bowel injury. Dr Davis opines that it occurred during the first operation, while Dr Manthata-Cruywagen is of the view that it did not, as small bowel contents would have leaked if the injury had occurred during the first operation. This is a view also shared by the surgeons. Dr Manthata-Cruywagen, thus opines that the injury occurred during the hysterectomy (second operation) and was identified and repaired. She, however, points out that this is outside of their expertise as obstetricians and defers to the surgical experts.

Second operation and the period from 5 May to 7 May 2015

[28] Regarding the plaintiff's transfer to Ganyesa on 7 May 2015, Dr Manthata-Cruywagen states that the plaintiff was sent to Ganyesa for further care, as there were doctors at Ganyesa who would be able to look after her, post-operation, and such transfers are usually done once a patient stabilises, in order to manage resources. She, however, notes that it is not clear why the plaintiff was transferred back to Ganyesa on day 2 post-reoperation, as she was sent with no notes or care plan. Notably, she states that the transfer itself did not cause the wound sepsis and subphrenic abscesses and that "what caused Ms M[...] to be so ill was HIV as she was immune compromised".

Joint minutes of the surgeons (Prof Bizos and Dr Malinga)

First operation – 1 May 2015

[29] Dr Malinga and Prof Bizos agree that the operation performed on the plaintiff on 1 May 2015 constituted a life-saving operation, given that the plaintiff was haemodynamically unstable and presented with a haemoglobin(Hb) level of 3 g/dl. In this regard, Dr Malinga notes that, in addition, the plaintiff was resuscitated at a district hospital before being transferred to a regional hospital, and that her Hb level increased to 7.2 g/dl after the resuscitation.

[30] They also agree that they are unable to say whether there was any operative misadventure or poor judgment after the first operation.

Second operation- 5 May 2015

[31] The surgeons agree that there was a delay in taking the plaintiff back to the theatre after the first operation and/or investigating her timeously, noting that

the second operation should have occurred at least 24 hours earlier than it was performed. This, they agree, would influence the outcome of such operation in that the patient was more likely to have had a protracted post-operative course and possible septic complications, relook laparotomies and subsequent incisional hernias. Dr Malinga adds that it is not possible to determine the extent of such impact as she was operated on when the operation was warranted.

[32] The surgeons further agree that they cannot comment on the precise time the bowel perforation occurred, with Dr Malinga noting that the fact that there was no peritonitis (inflammation of the peritoneum) suggests that the bowel injury was recent and not longer than 6 hours. Prof Bizos, on the other hand, opines that small bowel content might take approximately 12 hours to induce visible peritonitis.

[33] Because the first operation occurred four days earlier, the surgeons agree it was highly unlikely that the bowel injury arose during that procedure; in such a case, peritonitis would have developed, and the plaintiff would have deteriorated much sooner. Having considered other potential causes, they concluded that the perforation almost certainly did not occur at the first operation but was likely either a delayed perforation or an injury sustained during the second operation on 5 May 2015. They also agree that small bowel injuries of this kind do occur and are not, in themselves, regarded as negligent.

Transfer to Ganyesa on 7 May 2015

[34] Regarding the plaintiff's transfer from Joe Morolong to Ganyesa after the second operation, the surgeons agree that it was too soon to transfer the plaintiff after she had undergone such a major operation, and this may have led to further delay in managing additional complications. They, however, note that this may have been due to circumstances at the time. Dr Malinga further points out that there are various factors to be taken into consideration when a decision to transfer a patient is made, including whether the receiving hospital has the necessary expertise, transfer instructions and hospital resources.

Third operation – 15 May 2015

[35] The surgeons further agree that there was a delay in doing the third operation, partly due to the hasty referral back to Ganyesa on the third day after a major operation with loss of blood, a small bowel injury, and a delay in doing the second operation, all of which may have led to ongoing sepsis, herniation, and almost certainly further wound complications. In this regard, the surgeons agree that the plaintiff has a complex lower abdominal wound with a hernia, which will require extensive surgery to try to repair. They agree that the plaintiff has experienced substantial pain and suffering. Dr Malinga, however, acknowledges that commenting on pain and suffering falls outside the scope of their expertise and the agreement to confine their comments to the general surgery aspects of the case.

[36] The surgeons disagree on whether the unsightly Pfannenstiel incision and incisional hernia could have been avoided if the plaintiff had undergone an uncomplicated repair of the cornual ectopic pregnancy after a relook

laparotomy, as Prof Bizos suggests. Dr Malinga states that post-operative complications after laparotomy are a recognised risk, estimated by some authors at 10% to 15%. He adds that a hernia can occur even after a single operation and notes that the plaintiff had recently been diagnosed with HIV.

- [37] Prof Bizos is of the view that the plaintiff's HIV positive status did not contribute to the complications she suffered. He explains that a CD4 count is of limited value in the setting of acute sepsis and notes that the plaintiff only tested HIV-positive on 29 April 2015, after the first two operations.

Joint minutes of the virologists (Dr Webber and Dr Maphoto)

- [38] In their joint minute, Drs Webber agree that the plaintiff's seroconversion and early-stage HIV infection did not affect the development of the post-operative septic complications.

- [39] In the addendum report, Dr Maphoto states that, in light of the notation of stage III tuberculosis (TB) on 2 May 2018, under the WHO clinical staging system, the plaintiff's diagnosis of stage III disease indicates advanced HIV disease and a likely compromise of her immune system.

- [40] In their second joint minute, the virologists agree that the plaintiff was possibly in the WHO clinical stage 3 disease in 2018, and pulmonary TB is a WHO stage 3 disease.

[41] Dr Webber, however, disagrees with Dr Maphoto that “by virtue of being diagnosed with stage 3 disease”, the plaintiff is in advanced HIV disease and her immune system is likely to be compromised, stating that the plaintiff’s HIV was successfully treated as indicated by the test results showing an undetectable viral load. In this regard, Dr Maphoto notes that her assessment was based purely on clinical staging as provided in the notes, and not on laboratory tests, which were not provided. The experts disagree on whether the plaintiff’s immunity was severely compromised in 2018, with Dr Webber referring to the test results indicating recovery in the CD4 count and that the 2018 results have no bearing on the 2015 events. Dr Maphoto is of the opinion that although she agreed with Dr Webber that the plaintiff’s seroconversion in 2015 had no bearing on the 2015 events, the fact that in 2018, the plaintiff was reclassified as WHO stage 3 cannot be ignored, as her HIV status progressed, with a possible TB diagnosis.

Joint minutes of the physicians (Drs Botha and Tsela)

[42] With reference to the reports and agreements between the virologists, the physicians agree in their first joint minute that the plaintiff’s asymptomatic primary HIV infection had no significant influence on the development of post-operative septic complications.

[43] In a subsequent joint minute, the physicians considered the addendum report of Dr Maphoto that the plaintiff had TB, based on a hospital entry made on 2 May 2018 and additional clinical records.

[44] Both experts agree that before the operation on 1 May 2015, the plaintiff was in haemorrhagic shock. Dr Botha, however, notes that it cannot be taken for granted that the haemorrhagic shock that the plaintiff suffered was the predominant cause of surgical site sepsis and intra-abdominal abscess formation. Dr Tsela, however, notes that haemorrhagic shock can make a patient susceptible to post-operative complications, but agrees that this state of shock may not have been the only contributor to the plaintiff's post-operative septic complications. Both experts defer to the surgical experts on this aspect. This is also the portion of the joint minutes of the surgeons sought to be repudiated by the defendant.

[45] Dr Botha further notes that a diagnosis of pneumonia was not made, and a CT scan of the abdomen and pelvis performed on 15 May 2015 showed abscesses in the pouch of Douglas and the left subphrenic space due to intra-abdominal sepsis. He is of the opinion that the lower lung changes are reactive, secondary to these intra-abdominal collections, and are common in patients with subdiaphragmatic abscesses. They are neither causative of nor contributory to the intra-abdominal septic complications and do not represent pneumonia.

[46] Dr Tsela is, however, of the opinion that a diagnosis of pneumonia cannot be excluded, as the plaintiff had clinical findings in keeping with pneumonia. In her addendum report, she states that the CT scan of 15 May 2015 noted a possible left pleural effusion and left broncho-pneumonic changes (pneumonia), and the plaintiff had "crackles" on her left middle and lower lung

on 12 May 2015 with bronchial-pneumonic changes.

Repudiation

[47] On 12 and 14 July 2023, the defendant delivered a notice and a supplementary notice, respectively, in which it sought to repudiate the agreement reached between the surgeons regarding (a) the delay in returning the plaintiff to theatre for the second operation, (b) the consequences of that delay, and (c) its effect on the outcome of the operation.

[48] The physicians, in their joint minute, defer to the surgeons concerning the effect of haemorrhagic shock on the plaintiff and other causes of post-operative septic complications.

[49] In their joint minute, the surgeons agree that:

“there was a delay in taking the plaintiff back to theatre and/or investigating the patient timeously before taking the patient back to theatre. It is both experts’ opinion that this second operation should have occurred at least 24 hours prior to when it was performed. She was operated on 5 May 2015.

this would influence the outcome of such operation in that the patient was more likely to have had a protracted post-operative course as well as possible septic complications, relook laparotomies and subsequent incisional hernias.

[50] In the affidavit filed in support of the repudiation, the deponent states that he was given instructions on 6 July 2023, *“to repudiate this aspect of the experts’ agreement to allow the evidence in relation to the timing to be led, and for the Court to decide on whether there was indeed a delay in performing the second procedure and whether such delay is causative of the Plaintiff’s*

damages as claimed.”

[51] The defendant cites, as the reason for the repudiation, that the agreement between the surgical experts on this aspect “*has no factual basis or is based on incorrect facts.*” The deponent further states that the deference by the physicians led the defendant to reconsider the surgeons’ joint minute and concluded that it has no factual basis.

[52] In the heads of argument filed on behalf of the defendant, reliance is placed on **Bee**² that a litigant may repudiate the joint minutes, provided the repudiation is clear and timeous. The defendant, thus, avers that it has complied with these requirements, as the notice to repudiate was served before Dr Bizos’ and Dr Malinga’s evidence was led.

[53] The defendant further avers that, according to the available records, the plaintiff was relatively well and exhibited no overt signs of complications during the 24 hours preceding 16h30 on 5 May 2024, when the second operation was performed, and that she was scheduled for transfer back to Ganyesa.

[54] During his testimony, Dr Malinga did not deviate from his views and the agreement reached with Prof Bizos. He testified that he did not, at any stage, contact Prof Bizos to indicate that he no longer wished to be bound by the agreements they had reached, nor did he file any addendum reports in that

² *Bee v Road Accident Fund* [2018] ZASCA 52.

regard. Dr Malinga thus testified that he was not repudiating the agreements stated in the notice of repudiation, as no new facts had come to his knowledge.

[55] The plaintiff also relies on **Bee**³ for the proposition that the agreements reached by the experts in a joint minute are binding on the parties unless due warning is given to the other side. The plaintiff contends that the defendant ought to have given notice before the start of the trial. Besides, Dr Malinga, in cross-examination, stood by the agreement he reached with Prof Bizos.

[56] In *Thomas v SD Sarens (Pty) Ltd*⁴, the court held that where certain facts are agreed between the parties, the court is bound by such agreement, even if it is sceptical about those facts. Where experts meet and agree on those facts, a litigant may not repudiate the agreement unless it does so clearly, and at the very latest, at the outset of the trial.⁵ Thus the facts agreed by the experts enjoy the same status as facts which are common cause on the pleadings or facts agreed in a pre-trial conference or in an exchange of admissions.⁶

[57] The trial commenced on 14 November 2022 with the evidence of the plaintiff. It proceeded for the whole week and another week in March of 2023. During that time, Dr Davis, the plaintiff's obstetrician-gynaecologist, testified. The trial was postponed to 17 July 2023. On 12 July 2023, the defendant served its notice of repudiation, followed by a supplementary notice on 14 July 2023.

³ Id.

⁴ [2012] ZAGPJHC 161; 2012 JDR 1711 GSJ.

⁵ Id para 11.

⁶ Id para 12.

- [58] The defendant avers that the plaintiff can suffer no prejudice because the notice of repudiation, although served after the trial commenced, was served before the surgical experts testified. I disagree. A joint minute records the experts' consensus and narrows the issues in dispute. Parties prepare their cases on that basis, and no evidence need be led on agreed issues.
- [59] A notice of repudiation served after the commencement of the trial, therefore, creates a moving target for the other party and is plainly prejudicial. As Sutherland J (as he then was) observed in *Thomas*⁷, the limitation imposed on litigants is necessary for orderly litigation and to ensure fairness to every litigant by enabling each to know, from the outset of the trial, the case it must meet.
- [60] Even if that were not the case, the irony is that the repudiation itself has no factual basis; alternatively, its factual basis is flawed. As the court further noted in *Thomas*, 'a decision on what constitutes the facts on any issue is a preserve of the court'.⁸ Apart from the defendant's contention (contrary to its own surgical expert), that the plaintiff appeared stable and showed no overt signs of complications in the 24 hours preceding the second surgery, and that there was therefore no reason for an earlier return to the operating theatre, the available records indicate that the plaintiff had tachycardia of 134 bpm at 05h32 and between 06h00 and 10h00 on 4 May 2015. The application for repudiation must therefore fail.

⁷ Id n4.

⁸ Para 9.

PLAINTIFF'S WITNESSES

Ms M[...] (the plaintiff)

[61] The plaintiff testified, with the assistance of an interpreter, that she discovered she was pregnant in February 2015 at Phaposane. She was given tablets and instructed to return the following month, which she did. In March, she was again told to return in April. She also testified regarding her visits to Tlakgameng and her subsequent transfers to Ganyesa and Joe Morolong after complaining of abdominal pain and vaginal bleeding. These are common cause.

[62] Ms M[...] further stated that she did not know the purpose of the operations, although the doctor told her that the baby had died. She further testified that the doctors operated on her again, but she still did not know why. She testified that she could not recall most of the details of the operations because she was in severe pain.

[63] During cross-examination, Ms M[...] was questioned about an apparent inconsistency in her evidence: although she claimed that she could not remember certain details because she was in severe pain, she was nevertheless able to recall specific details when instructing her attorneys in preparation for a condonation application filed on her behalf. In her affidavit, the plaintiff stated that she had been diagnosed with a ruptured ectopic pregnancy. She was unable to explain how this information came to be included in the affidavit and testified that no one had given her that diagnosis. She further testified that her attorney assisted her in preparing the affidavit filed in support of the condonation application.

[64] When referred to the consent form she signed on 1 May 2015, in which she consented to an operation and a blood transfusion, she conceded that she had been told she was going for an operation but said she had not been told what operation it would be. It was put to the plaintiff that the operation was unavoidable and life-saving, and she responded that she did not know.

[65] Ms M[...] was further questioned about her HIV status and her affidavit, in which she stated that nurses refused to provide her with disability forms because they considered her fit to work. She confirmed their refusal. She was then referred to a hospital record dated 2 May 2018, when she collected her HIV treatment, noting that she had no complaints. It was suggested that, having been unable to obtain a state disability grant, she instituted these proceedings instead, which she denied.

Plaintiff's experts

[66] In addition to their joint minutes, the experts testified on various aspects of the plaintiff's care. Their testimony is addressed only to the extent necessary to highlight the disagreements between them, which required clarification.

[67] The main points of contention with regard to the joint minutes of the surgeons relate to their agreement that there was a delay in performing the second operation. During cross-examination, Prof Bizos was questioned about his opinion that the second operation should have been performed 24 to 36 hours earlier. Following agreement on a joint minute with Dr Malinga, this period was

settled at 24 hours. He testified that the plaintiff's pulse rate of 134 was problematic and should have been investigated. He conceded that the plaintiff was ultimately not transferred to Ganyesa on 4 May 2015. He was further questioned about the 24-hour period, as there was no indication for theatre. Although he conceded that at 16h20, there was no indication for theatre, Prof Bizos testified that no investigations had been conducted and that, had they been done, it would have become apparent that theatre was warranted. He further conceded that, on 3 May 2015, there was no indication for an urgent CT scan.

[68] Dr Davis, the obstetrician-gynaecologist who testified on behalf of the plaintiff, testified to various aspects of the plaintiff's obstetric care and related issues, particularly the points of disagreement. His testimony essentially confirmed his views contained in the joint minutes with Dr Manthata- Cruywagen. In particular, Dr Davis testified that the care of the plaintiff at Ganyesa was substandard and their failure to refer her to a higher-level facility amounts to negligence. He added that bleeding in pregnancy is a risk factor, and the plaintiff should have been referred to a higher-level hospital as early as 14/15 April 2015, when the ultrasound was done by a general practitioner with no specialised training in ultrasound.

[69] He questioned the fact that the pregnancy was allowed to continue for a further two weeks. He further stated that when the plaintiff was found to be pale, it should have been clear to the staff at Ganyesa that she had internal bleeding, as she was not bleeding vaginally at the time. He testified that the 1cm perforation occurred during the first operation.

[70] He conceded that limited resources in regional hospitals are a relevant consideration and that patients are sometimes not referred to regional hospitals. He further conceded that a cornual ectopic pregnancy is rare and difficult to diagnose, and the staff at Ganyesa could not be expected to diagnose it.

[71] The essence of Dr Webber's testimony, as contained in the reports and the joint minutes, is that the plaintiff's seroconversion and her early stage of HIV infection had no impact on her immunity. She further testified that the possible tuberculosis diagnosis in 2018 had no bearing on her post- surgery complications and the 2015 events.

[72] Dr Botha testified to the plaintiff's immunity as well as her HIV status. With reference to an article relied on by his counterpart, Dr Tsela, he conceded that even patients with a moderate CD4 count were susceptible to surgical wound sepsis.

DEFENDANT'S WITNESSES

Dr Brooms

[73] Dr Brooms' testimony pertained to his involvement in the events which took place at Joe Morolong when he was there; the relook laparotomy and hysterectomy that Ms M[...] underwent on 5 May 2015, and the operation on 15 May 2015. He testified that he has no recollection of the specific case. He largely relied on the clinical notes and standard medical procedures. He testified that when he was called in to assist in the operation at 18h00 on 5

May 2015, the bowel perforation had already occurred; that was the reason he was called in.

[74] He further testified that, when he arrived, the abdomen had already been cleaned and the perforation exposed. He examined the abdomen and noted no overt bowel contamination in the peritoneum. He said the gynaecology team was performing a hysterectomy when the bowel perforation occurred and that he was called in to assist. He repaired the bowel and left the team to continue the surgery.

[75] He further testified that he was the only surgeon at Joe Morolong at the time. On 11 May 2015, he was contacted with regard to the transfer of the plaintiff from Ganyesa. He then arranged for the transfer of the plaintiff back to Joe Morolong on 12 May 2015.

[76] During cross-examination, Dr Brooms was asked about the plaintiff's transfer from Joe Morolong to Ganyesa without transfer notes and no medication to take with. He stated that he had not transferred the plaintiff, explaining that she was in the maternity ward. He, however, stated that it would not be appropriate care to do that after the plaintiff had such a complicated surgery, but he does not know what motivated the doctors to transfer her back to Ganyesa. He reiterated that he had arranged for the plaintiff to be transferred from Ganyesa to Joe Morolong on 12 May 2015. When the plaintiff arrived, she had sepsis, and Dr Brooms needed to establish the source. He suspected a subphrenic abscess. He ordered a chest and abdomen X-ray, which came

back at approximately 14h05, but he could not establish the source of the sepsis from them.

[77] On 14 May 2015 at 08h55, he ordered a CT scan, which was scheduled for 15 May 2015. He explained that a CT scan could not always be performed immediately for various reasons, including a broken machine or the fact that it was a weekend. However, he conceded that the notes contained no record that the machine was broken, nor did they provide any reason for the delay in obtaining the CT scan.

[78] Dr Brooms testified that, where a patient has sepsis, the patient must first be stabilised and the source removed only once the patient is fit for theatre. He conceded that the longer the source remains undiagnosed, the greater the risk of complications. He added, however, that the plaintiff was started on antibiotics and fluids to mitigate that risk.

[79] Referring to the surgeons' agreement on the cause of the plaintiff's septic complications, Dr Brooms testified that the plaintiff had several risk factors for developing subphrenic abscesses: a massive hemoperitoneum, a later hysterectomy involving a bowel perforation and contaminated surgery, and a new HIV diagnosis.

Dr Fourie

[80] The essence of Dr Fourie's testimony was the resources and infrastructure at Joe Morolong. He testified that he has been the acting clinical manager at Joe Morolong since 2022. He testified that Joe Morolong is classified as a regional

hospital or a Level -2 hospital. He describes it as a developing regional hospital, as it does not meet the requirements for a regional hospital, such as having 200-300 beds, as it is quite small. He testified that Joe Morolong has 120 – 160 beds.

[81] Dr Fourie further testified that Joe Morolong receives referrals from district hospitals and local clinics. In some instances, patients would be transferred back to the district hospital or clinic. He explained the process involved. He testified that Joe Morolong has a combined ICU / high care unit hosting four beds. On some days, there would be high demand for high care beds, and on other days, there would be no patients or one in high care.

[82] He further testified that their units are small, so once a patient is out of immediate danger, they would be sent back to the base hospitals to continue care and monitoring to a point where they are stable enough to go home.

[83] During cross-examination, Dr Fourie testified that it is standard procedure for a patient to have a referral note or some information with them when transferred from Joe Morolong to Ganyesa for continuation of care at Ganyesa. That referral note would also contain information about why the patient was transferred and the treatment the patient received from the referring hospital.

Defendant's experts

[84] Dr Malinga testified predominantly to the surgical aspects of the case, reiterating his agreement with Prof Bizos. Regarding his opinion that the

second operation should have been done approximately 24 hours earlier, he accepted that at 16h20 on 4 May 2015, there was a note made by a nurse (that the plaintiff managed to spend the day well; prescribed medication given; meals served; still awaiting transport) and that based on that note there was no need to summon a doctor.

[85] Dr Tsela explained that multiple factors can predispose a patient to surgical sepsis complications, including pregnancy itself, the fact that the plaintiff had an ascending infection independently of her seroconversion, as well as the fact that she had haemorrhagic shock. She further testified that the plaintiff's state of health was compromised prior to the first operation, which put her at risk of developing post-operative complications, including septic complications. She disagrees with Dr Botha that after resuscitation, the plaintiff recovered, stating that at a cellular level, she may have still been compromised.

[86] Concerning a possible diagnosis of pneumonia, she testified that because the plaintiff had radiological confirmation of changes in the lungs, she would have treated the plaintiff as a patient with pneumonia. With a left-sided pleural effusion, the plaintiff's clinical presentation was suggestive of pneumonia. She further stated that it was reasonable for the plaintiff to first be stabilised before being taken into theatre for the third operation, corroborating Dr Brooms in this regard.

[87] The only contentious issue concerning Dr Maphoto's testimony, as with Dr Webber, is the effect of the plaintiff's reclassification as Stage III (TB) and HIV

in 2018 on the 2015 events. Dr Maphoto testified that this entry, although inserted on 2 May 2018, cannot be ignored as it indicates that the plaintiff's HIV disease progressed.

[88] Dr Manthata-Cruywagen's testimony was that the staff at Ganyesa had to do a process of elimination as they were grappling with the plaintiff's situation. They eventually referred the plaintiff to Joe Morolong. She further testified that the staff did not fail to diagnose the plaintiff as they did an ultrasound which showed an intra-uterine pregnancy.

[89] As regards the plaintiff's referral to Ganyesa after the second operation, she testified that in order to manage resources, patients are prioritised and the plaintiff was transferred once she was stable. She added that the referral itself did not cause the plaintiff to develop wound sepsis and that multiple factors, including her HIV positive status and the vaginal discharge she had, which was suggestive of an ascending infection on 10 March 2015 caused the plaintiff's complications.

[90] She conceded that the plaintiff's heart rate was elevated on 4 May 2015 prior to the decision to transfer her, but it had been fluctuating since the first operation. Dr Manthata-Cruywagen added that it is standard procedure to send patients home on day 3 after an operation. She concluded that the plaintiff was well managed at Ganyesa despite being transferred without notes as she was put on a triple regime of antibiotics.

Discussion

[91] In essence, this case concerns the care and management of the plaintiff by the medical and nursing staff at the various clinics and hospitals operating under the defendant's authority between 10 March and 15 May 2015. The inquiry extends to whether any of the defendants' employees acted negligently and, if so, whether that negligence causally contributed to the plaintiff's eventual outcome. The enquiry also includes determining when the perforation occurred.

[92] It brooks no reiteration that the onus of proving negligence rests with the plaintiff, who must prove on a balance of probabilities that the defendant had a legal duty which it breached. This would satisfy both the requirements of unlawfulness and negligence. As set out by the Appellate Division in *Kruger v Coetzee*⁹, the test for negligence is that:

“ 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;
(b) and the defendant failed to take such steps.”

[93] If sufficient evidence exists, giving rise to an inference of negligence on the part of one or more of the medical and/or nursing staff of the defendant, it is not necessary to prove that the inference is the only reasonable inference. What is required is for the plaintiff to satisfy the court that the inference is the most readily apparent and acceptable inference from a number of possible

⁹ 1966 (2) SA 428 (A).

inferences.¹⁰ In respect of professionals such as doctors and nurses, they are required to adhere to the level of skill and diligence exercised by members of the profession to which they belong, failing which they would be negligent.¹¹

[94] Moreover, the nature of damages that might occur need not be precisely foreseeable, as long as it can be foreseen that the plaintiff will suffer damages¹².

[95] In the heads of argument submitted on behalf of the plaintiff, it is argued that the defendant's employees were negligent in failing to diagnose the cause of the plaintiff's lower abdominal pains and vaginal bleeding and conduct investigations during the period between 10 March 2015 and 15 April 2015. On this score, the plaintiff contends that the staff at Ganyesa only investigated the condition of the foetus and did not investigate the cause of the abdominal pains and bleeding. No investigations were conducted at Phaposane or Tlaskgameng either.

[96] It is further submitted that the defendant's employees were negligent in failing to diagnose the cause of the plaintiff's lower abdominal pains, vaginal bleeding and abdominal distention during the period between 29 April and 1 May 2015. For this period, the plaintiff attributes the negligence to various factors. First, having arrived at Ganyesa at 00h21, the plaintiff was only attended to 3 hours after her arrival. Secondly, the history of lower abdominal pain and vaginal bleeding was only recorded 6 hours after her arrival. Thirdly,

¹⁰ *AA Onderlings Assuransie- Assosiasie Bpk v De Beer* 1982 (2) SA 603 (A).

¹¹ *Van Wyk v Lewis* 1924 AD 438.

¹² *Botes van Deventer* 1966 (3) SA 182 (AD).

her haemoglobin was recorded as 7.5 g/dl and 6.3 g/dl at 09h03 and 10h39, respectively. Fourth, the attending doctor noted that the plaintiff's haemoglobin on 15 April was 14 g/dl, an indication that it was dropping. Fifth, her pulse was 130 bpm, and her blood pressure was 93mmHg, indicating that she was in shock. Sixth, at 13h00 on 1 May 2015, the plaintiff's haemoglobin was 3.1 g/dl and only then was a blood transfusion done.

[97] The plaintiff further argues that the decision to transfer the plaintiff from Joe Morolong to Ganyesa on 4 May 2015 constitutes negligence as the plaintiff's pulse was over 130 and the staff at Joe Morolong did not properly monitor the plaintiff while she was awaiting transport or that her clinical condition was worsening.

[98] The plaintiff further argues that there was a 24-hour delay in performing the second surgery on 5 May 2015, occasioned by the delay in diagnosing the deterioration of the plaintiff's condition, especially with regard to her rising temperature, tachycardia and distended abdomen. Following the second operation, the plaintiff further argues that the plaintiff's transfer on 7 May 2015 to Ganyesa further constitutes negligence as she was not a healthy patient. Moreover, the fact that she was transferred to a lower-level facility without transfer notes was also negligent.

[99] The plaintiff places reliance on the Supreme Court of Appeal (SCA) decision in *Sea Harvest Corporation (Pty) Ltd & Another v Duncan Dock Cold Storage (Pty) Ltd & Another*¹³ for the proposition that negligence is determined by asking whether, in the particular circumstances, the conduct complained of

¹³ 2000 (1) SA 827 (SCA).

falls short of the standard of the reasonable person. It is not necessary that the exact manner in which the harm occurs be foreseeable, so long as the general manner of its occurrence is reasonably foreseeable.

[100] The defendant denies that its employees were negligent in their care and treatment of the plaintiff at any given time during the period between 10 March and 15 May 2015.

[101] In particular, the defendant contends that upon her presentation at Tlakgameng on 11 April 2015, the plaintiff was attended to by the defendant's nursing staff, who conducted a sonar, observed a foetal heart rate, gave the plaintiff medication and kept her overnight for further observations before referring her to Ganyesa.

[102] The defendant further contends that the first operation on 1 May 2015 was performed with the necessary skill, care and diligence until its finalisation, and there was no indication or sign of any injury to the plaintiff. In its amended plea, the defendant denies that the plaintiff was tachycardic on 4 May 2015 and developed a fever and a tender and distended bowel when she was scheduled for transfer back to Ganyesa. The defendant, however, admits that on 5 May 2015, the plaintiff underwent an exploratory laparotomy and hysterectomy by Dr Mphatsoe; Dr Brooms was called in to assist, and that a 1cm perforation was discovered and recorded by Dr Broom; a total abdominal hysterectomy was performed. The defendant avers that the 1cm perforation was not caused by the negligence of the defendant's employees during the first operation or at any time thereafter.

[103] The perforation clearly occurred while the plaintiff was in the care of the defendant's employees. The overwhelming consensus is that it probably occurred during the second operation. The defendant's denial in this regard is without any basis. Besides, both Dr Malinga and Prof Bizos agree that such perforations are a common occurrence and are not regarded as negligence. There is also no complication attributable to the perforation. In my view, that should be the end of the matter on this aspect. No negligence can be attributed to the defendant in this aspect.

[104] The defendant further denies that the plaintiff was tachycardic on 7 May 2015, and had a high temperature when she was transferred back to Ganyesa, stating that the medical staff were satisfied that she was feeling better and had less pain.

[105] Lastly, the defendant admits that the plaintiff developed complications while at Ganyesa and was transferred back to Joe Morolong Hospital on 11 May 2015 for treatment of the post-operative wound. On 15 May 2015, the treatment was rendered with the requisite skill, care, and diligence expected of medical and nursing staff in public hospitals, and that the interventions were intended to provide the plaintiff with the best available medical care.

[106] Reliance is placed on various decisions, including *Goliath*¹⁴, *Kruger v Coetzee*¹⁵, *Van Wyk v Lewis*¹⁶, and many others. The import of these

¹⁴ *Goliath v MEC for Health, Eastern Cape* 2015 (2) SA 90 (SCA).

¹⁵ *Id* n3.

decisions, as cited by the defendant, is that the plaintiff bears the onus to prove that the hospital and clinic personnel were negligent, with specific reference to the standards expected; that the defendant's conduct should be judged against a reasonable standard and only when it falls short of that standard can the defendant be found to be negligent.

[107] Counsel for the defendant argued that the court must place itself as nearly as possible in the exact position the surgeon found himself when conducting a particular operation and determine from all the circumstances, whether he acted with reasonable care or negligently.¹⁷

[108] Counsel further submits that where a medical practitioner, in making a diagnosis, adheres to a degree of skill and care, which a reasonable practitioner would adhere to, but makes an incorrect diagnosis, there will be no fault, and liability will only result if such a diagnosis leads to a misdirected treatment resulting in harm.

[109] These authorities are self-explanatory, and I do not intend to belabour the point. What is clear is that the standard applicable to professional persons is that they should adhere to the skill and diligence exercised by members of their profession, in this case, a reasonable doctor and a reasonable nurse.

[110] Regarding causation, the enquiry centres on two key components: whether, 'but for' the defendant's wrongful conduct, the harm would have occurred, and

¹⁶ 1924 AD 438.

¹⁷ *Id.*

whether the wrongful act is sufficiently, closely, and directly connected to the loss.

[111] Put differently, the plaintiff must prove on a balance of probabilities that the negligence complained of was the cause of the harm suffered. “A plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.”¹⁸

[112] In applying these principles to the facts of this case, regard must be had to the timeline of the plaintiff’s attendance at the hospitals and clinics, as well as to the treatment and management meted out to her by the defendant’s employees. This is largely common cause, and is evidenced by the hospital records and clinical notes filed in this matter. I deal with the specific intervals in so far as they relate to the contentions by the parties.

[113] Regarding the period between 10 March and 30 April 2015, the uncontroverted evidence is that the medical and nursing staff at Tlakgameng and Ganyesa did not investigate the source and cause of the plaintiff’s recurring abdominal pains and vaginal bleeding.

[114] When the plaintiff’s haemoglobin continued to drop, they failed to identify that

¹⁸ *Minister of Safety and Security v van Duivenboden* [2002] ZASCA 79; 2002 (6) SA 431 (SCA) at para 25; See also: *Oppelt v Department of Health* 2016 (1) SA 325 (CC) para 45.

the plaintiff was bleeding internally or to establish why she was deteriorating. In this regard, Dr Manthata- Cruywagen' s evidence is that a cornual ectopic pregnancy tends to bleed a lot more, hence the drop in haemoglobin. The difficulty with this contention is that when the plaintiff was transferred to Joe Morolong on 29 April 2015, the staff at Ganyesa had not diagnosed a cornual ectopic pregnancy. They could therefore not have attributed the plaintiff's low haemoglobin level and her pallor to an ectopic pregnancy.

[115] I accept, as agreed by all the relevant experts that a cornual ectopic pregnancy is difficult to diagnose, as testified by the experts. It was explained that part of the reason this is so, is that it masks itself as an intra-uterine pregnancy. There is however, no suggestion that it is impossible to diagnose.

[116] The facts as they stand are that the plaintiff had been complaining of abdominal pains since 10 March 2015. While the defendant's employees temporarily managed the symptoms, they did not investigate the cause of the pain and the vaginal bleeding. One wonders what it is that they were treating, if at all. When the plaintiff returned to Tlakgameng on 11 April 2015, the cause of the abdominal pain was still not investigated. This time, she also had vaginal bleeding. A mitigating factor is that she was indicated for referral to Ganyesa by the staff at Tlakgameng. This happened the following week on 14 April 2015.

[117] On 14 April 2015, when she was transferred to Ganyesa, she had the same complaints. A sonar was performed the following day and confirmed an intra-uterine pregnancy. Again, no attempt was made to diagnose the cause of her

severe abdominal pains and vaginal bleeding.

[118] I must state firmly that the issue is not whether the staff at Phaposane, Tlakgameng and Ganyesa made an incorrect diagnosis of an intrauterine pregnancy. The issue is whether the source of the plaintiff's abdominal pains and vaginal bleeding was addressed. It was, after all, the reason she had been referred to Ganyesa in the first place. It was clearly not.

[119] The defendant's submission in this regard is that "while the team were still trying to manage her at the district hospital, the CEP ruptured ... she was resuscitated and transferred to JMMH by ambulance and on arrival, she was immediately operated on."

[120] This is not entirely accurate. The fact that in the plaintiff's case, it was not diagnosed until it had ruptured speaks to the failure to investigate the plaintiff's symptoms and the delays in her management. It further speaks to the pain and suffering the plaintiff had to endure, which, according to Dr Davis's testimony, is no mean feat. In this regard, the defendant's employees were negligent. A reasonable nurse/ doctor in the position of the nurses / staff would have investigated the plaintiff's complaint. This would have enabled them to provide the best available care and treatment to her.

[121] Once admitted at Ganyesa on 30 April 2015 until the first operation, the plaintiff's contention is that there were several delays before she was taken into theatre. The evidence has established that the first operation was lifesaving.

[122] Concerning the second operation on 5 May 2015 and the period leading up to it, the surgical experts agree that it was delayed by approximately 24 hours, during which time the plaintiff had a pulse of 134 bpm. The plaintiff places reliance on the evidence of Prof Bizos that there is no indication that the plaintiff was examined after the decision to transfer her was taken at 10h00 on 4 May 2015. Prof Bizos opines that if the plaintiff had been examined at 16h20 when her pulse was over 130bpm and the doctors had been notified, it would have been clear to them that the plaintiff was deteriorating and that transferring or recommending to transfer her was reckless.

[123] By the defendant's own admission, what followed after the first operation "was a cascade of events, each one linked to the next". It was therefore incumbent on the staff at Joe Morolong to be on 'high alert'. In my view, their failure to adequately monitor the plaintiff during this period lends credence to the surgeons' opinion that the second operation could have been performed sooner. That being the case,

[124] Following the second operation on 5 May 2015, the defendant's employees on 7 May 2015 transferred the plaintiff to a lower-level facility. According to the surgeons, this was too soon. The plaintiff had undergone a major operation just two days before she was transferred. Not only that: a few days before that operation, she had undergone another complex operation. The surgeons opine that it was predictable that she was transferred back to Joe Morolong on 11 May 2015, having developed wound complications. This, the surgeons further agree, predisposed her to hernias and a risk of abscesses. The

unsightly scar referred to by the experts is a consequence of the repetitive surgeries the plaintiff underwent.

[125] According to Prof Bizos and Dr Davis, the subsequent surgeries after the first one could have been avoided, had the ectopic pregnancy been diagnosed before it ruptured. There was ample time for the defendant to do this, with due diligence and skill. This, in my view, disposes of the defendant's contention that the second and third surgeries were inevitable or even lifesaving. The plaintiff's issue, as I understand it, is not that she is scarred, but that the scar is unsightly- a direct consequence of the multiple operations she underwent within a period of two weeks.

[126] Although Dr Manthata-Cruywagen is of the opinion that the elevated pulse was consistent with a patient who had undergone major surgery, received multiple blood transfusions, and had anaemia, it should nevertheless have raised concern and prompted investigation by the medical staff. Moreover, the plaintiff's condition deteriorated when she developed a fever and further tachycardia. There was no reason for the medical staff to wait until she had deteriorated when the signs were always there. Contrary to the defendant's assertions, her condition at the time (when she had a pulse of 134 bpm) warranted intervention by the medical staff.

[127] The septic complications and consequently, the third operation could have been avoided had the plaintiff been attended to promptly at Joe Morolong and not transferred to a hospital with a lower standard of care and fewer facilities.

[128] It is immaterial, in my view, as argued by the defendant, that the progressive realisation of the right of access to health care services is subject to the availability and affordability of resources. It is not the defendant's case that the failure to investigate the plaintiff's complaints was occasioned by a lack of resources. It also does not matter that the National Health Act (NHA) provides for a system of triaging and referrals between health care establishments. The purpose of the constitutional provision, and by extension, the NHA, is to provide (access to) adequate health care services to the users of those services and provide the best possible health care for each level of hospital within the available resources. It is not intended to disadvantage users or expose them to danger.

[129] Again, I do not understand the defendant's case to be that the staff at Ganyesa could not timely diagnose the ectopic pregnancy before it ruptured due to a lack of resources. The evidence in this matter demonstrates that the plaintiff was transferred to a lower-level hospital when it was not only inopportune but also harmful to the plaintiff to do so. This conduct went against the defendant's own submissions that patients are prioritised according to their needs. Both Drs Manthata-Cruywagen and Davis note that it is unclear why the plaintiff was transferred at that stage.

[130] It is noteworthy in this regard that Dr Manthata-Cruywagen opines that patients are generally transferred once they have stabilised, in order to manage resources, as there are doctors at Ganyesa to continue with the care. In the peculiar circumstances of this case, this does not ring true. The plaintiff was not in a stable condition when she was transferred to Ganyesa on 7 May

2015. A more probable explanation lies in the evidence of Dr Fourie, who testified that, to manage space resources, patients are transferred once they are out of the immediate danger zone. In my view, such decision should be balanced with the needs of each patient. In this case, it is not clear why the plaintiff was transferred.

[131] The surgeons also agree that the decision to transfer the plaintiff to Ganyesa after the second operation was hasty. The available records do not indicate that there were any factors taken into consideration as suggested by Dr Malinga. He, himself, also does not say what factors were taken into consideration when the plaintiff was transferred on 7 May 2015, as this is not apparent from the record. Dr Malinga's evidence in this regard is speculative and not borne out by the facts.

The plaintiff's HIV status and stage III tuberculosis

[132] There is no rational connection between the plaintiff's reclassification as WHO stage 3 in 2018 and the events of 2015, including her post-operative complications. There is also no conclusive diagnosis of stage III TB. Apart from a single note, the clinical records contain no indication that the plaintiff was diagnosed with TB, nor is there any record of TB treatment having been prescribed for her. Having regard to the WHO clinical staging system to which Dr Maphoto referred, the plaintiff did not present with any of the listed symptoms.

[133] It is improbable that the plaintiff was diagnosed with stage III TB, as

suggested by Dr Maphoto, which would have ‘severely compromised’ her health, yet she was not provided with any treatment in those circumstances. Counsel argued that ‘something was brewing’ even before the first operation. This is speculative and would likewise require the court to speculate. It can therefore not stand.

Failure to testify

[134] The plaintiff avers that an adverse inference should be drawn from the defendant’s failure to call Dr Mphatsoe to testify, despite an indication that he would be called. Relying on *Sampson v Pim*¹⁹, the plaintiff avers that as Dr Mphatsoe is the gynaecologist who attended to the plaintiff from her first arrival at Joe Morolong, performed the first and second operations, including the hysterectomy, when the bowel perforation occurred and was one of the doctors who ordered the plaintiff’s transfer to Ganyesa on 4 May 2015 and 7 May 2015, he could have provided the court with material evidence. The court should therefore draw a negative inference that his evidence would have been unfavourable to the defendant and caused damage to its case.

[135] In response, the defendant approbates and reprobates. On the one hand, it contends that Dr Mphatsoe was not called to testify because the medical records in the core bundles, which the parties agreed to at the pre-trial conference, were admitted into evidence. I understand this submission to mean that the defendant accepts that those medical records, as they stand, are sufficient to prove its case, at least insofar as they relate to Dr Mphatsoe.

¹⁹ 1918 AD 657.

This is misplaced.

[136] The admission of documents into evidence does not negate the need for Dr Mphatsoe to testify as a factual witness. While contemporaneous notes and medical records are generally admitted without authentication, their admission does not establish the truth of their contents. Nor do such records explain the reasoning behind specific decisions made at the time, matters that may be known only to Dr Mphatsoe. The defendant's awareness of this is apparent from its decision to call Dr Brooms to testify despite the admission of the records. In these circumstances, the defendant's stance is misleading.

[137] On the other hand, the defendant suggests, albeit indirectly, that Dr Mphatsoe's evidence was not deliberately withheld and that no adverse inference should be drawn. Yet, alarmingly, rather than call Dr Mphatsoe, as it did Dr Brooms, the defendant resorted to artifice. The inescapable inference is that it chose not to call him for fear that his evidence would be unfavourable.

Conclusion

[138] Save to state that in some instances, already mentioned, the evidence of the experts was not supported by the facts of the matter and the available records, it is not warranted to make credibility findings against any of the expert witnesses. I am acutely aware that the role of experts is to assist the court, with reference to their knowledge and expertise and the facts of the matter. Where there are conflicting expert opinions, "the court must determine which, if any, of the opinions to accept, based on the reasoning and reliability of the expert witnesses. The court must determine whether and to what extent

an opinion is founded on logical reasoning²⁰.

[139] There are no significant disagreements between the experts, save between Dr Manthata-Cruywagen and Prof Bizos, and, to a limited extent, Drs Davis and Tsela and Drs Maphoto and Webber.

[140] Dr Manthata-Cruywagen's suggestion that it may have been reasonable to transfer the plaintiff to Ganyesa on 7 May 2015 is not borne out by the available evidence, as there is no evidence that the doctors and nurses at Ganyesa were apprised of the plaintiff's situation and care plan in the absence of any instructions from the transferring hospital. To the extent that this is in view of managing scarce public hospital resources, it should be balanced with the needs of the patients.

[141] The question is whether any of the negligence by the defendant's employees caused the harm suffered by the plaintiff. Would the multiple operations have been necessary, had the defendant's staff acted with the care, skill and diligence reasonably expected of professionals in their position? In particular, would the plaintiff have had a ruptured ectopic pregnancy had the staff investigated the cause of her abdominal pains and referred her timeously? Would she have had to endure the pain and suffering she endured? Would she have had to undergo a total abdominal hysterectomy. Would she have had septic complications? Probably not. In my view, the prolonged delay in investigating and diagnosing the cause of the plaintiff's pain and vaginal bleeding (which turned out to be the cornual ectopic pregnancy) set

²⁰ *Michael & Another v Linksfield Park Clinic (Pty) Ltd & Another* 2001 (3) SA 1188 (SCA) para 37.

everything in motion.

[142] On a conspectus of all the evidence in this matter, it is evident that the outcome of the plaintiff was caused by the conduct of the defendant, *inter alia*, the failure to investigate the cause of her abdominal pains and vaginal bleeding for over a month and resultantly, the failure to timeously diagnose the ectopic pregnancy before it ruptured; the delay in taking the plaintiff back to theatre after the first operation until her condition had worsened; the plaintiff's premature transfer to a lower level facility after the second operation; failure to provide transfer notes and a care plan to the lower-level hospital for further care and management of the plaintiff which led to her developing septic complications and thus, the third operation.

[143] While the defendant seems to suggest that there was nothing untoward in transferring the plaintiff to a lower-level facility after several post-surgery complications, the plaintiff's return to Joe Morolong belies this. According to Dr Fourie, it is standard procedure to transfer a patient with transfer notes to apprise the receiving hospital of the plaintiff's care in order to continue with the care which was not done. It is therefore improbable, as suggested by Dr Manthata-Cruywagen, that the plaintiff was well managed at Ganyesa without knowing what needed to be managed.

[144] The defendant was, all along, aware of the risks, as it had previously attempted to transfer the plaintiff to Ganyesa two days after the second operation. Surely, the second time around, the staff should have been more diligent and less hasty. All these factors suggest that the defendant ought to

have foreseen the possibility of harm occurring to the plaintiff. It ought to have taken preventative measures to prevent the harm from occurring. In failing to do so, the defendant caused the plaintiff harm.

Costs

[112] As far as costs are concerned, the plaintiff requested that the costs relating to the merits trial be reserved, and the defendant did not oppose this request. According to the plaintiff, this was occasioned by various factors in the conduct of the trial, dating back to the commencement thereof. It was understood that these costs would be argued before this court on a date to be arranged with the presiding judge. I am inclined to agree, as this would enable the parties to address all issues relating to costs comprehensively.

Order

[145] In the result, I make the following order:

- a. In accordance with the provisions of Rule 33(4), the issues of liability and quantum are separated.
- b. The defendant is liable for 100% of the plaintiff's proven or agreed damages arising from the injuries sustained by the plaintiff as a result of the negligent conduct of the medical and nursing personnel at the defendant's various clinics and hospitals between 10 March 2015 and 15 May 2015.
- c. The issue of quantum is postponed *sine die*.
- d. Costs shall stand over for later determination on a day to be arranged with the parties.

S MFENYANA
Judge of the High Court
Northwest Division, Mahikeng

APPEARANCES

For the plaintiff:
Counsel: DS Gianni with DP Viller
Instructed by Savage Jooste & Adams Inc

For the defendant:
Counsel: H Cassim
Instructed by the State Attorney

Date/s heard: 14 – 18 November 2022; 20, 22, 27 March 2023; 17 – 28 July 2023; 22- 26 April 2024; 6 -10 May 2024; 4- 8 November 2024; 6 & 7 February 2025

Date of judgment: 22 April 2026