

SOUTH AFRICA / JUDGMENT

B.J v Member of the Executive Council For Health, Gauteng (33179/2017) [2024] ZAGPPHC 217 (26 February 2024) [2024] ZAGPPHC 217

COURT

North Gauteng High Court, Pretoria

BEFORE

Bam

CASE / FILE NUMBER

33179/2017

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REPUBLIC OF SOUTH
AFRICAIN THE HIGH COURT OF
SOUTH AFRICA
GAUTENG DIVISION,
PRETORIA

CASE NO: 33179/2017

DOH: 14 – 17 &

25 August 2023

1.

REPORTABLE: NO/YES

2.

OF INTEREST TO OTHER JUDGES: NO/YES

3.

REVISED.

DATE: 26 February 2024

SIGNATURE

In the matter of: B[...]
 J[...]
 Plaintiff
 AND
 MEMBER
 OF THE EXECUTIVE COUNCIL
 Defendant
 FOR
 HEALTH, GAUTENG

JUDGMENT

THIS JUDGMENT HAS BEEN HANDED DOWN REMOTELY AND SHALL BE CIRCULATED TO THE PARTIES BY WAY OF E-MAIL AND UPLOADING ON CASELINES. THE DATE OF HAND DOWN IS DEEMED TO BE 26 FEBRUARY 2024

Bam J

1. This is a claim for delictual damages arising out of poor management of a perineal injury. The injury is described in the papers as a third degree tear[1]. The plaintiff, Ms B[...] J[...], sustained the tear during a traumatic birth at Tshwane District Hospital, TDH. She and her baby

were discharged a day following the birth. Four days after discharge, the plaintiff returned to hospital complaining of faecal incontinence and infection in her vaginal area. She was referred to Steve Biko Academic Hospital (SBAH) where she was informed that the tear had not been properly sutured, that her internal and external sphincter[2] muscles had suffered damage, and that she had a recto-vaginal fistula[3]. The remedial work was done by specialist surgeons at SBAH. In a joint note compiled by the surgeons appointed as expert witnesses by the parties, the surgeons could not fault the work done at SBAH. However, they underscored the delay from the date of diagnosis of 27 July 2014, to the start of the definitive diagnosis, on 15 September 2014.

2. The specialist nurses, the doctors specialising in gynaecology and obstetrics, and the surgeons, all being expert witnesses appointed by the parties, were in agreement that the treatment the plaintiff received pre-birth, during, and post birth at TDH was substandard and thus negligent. The experts further agreed on the sequelae[4] arising from the defendant's negligent conduct, excluding the issue of epilepsy which is dealt with by the neurosurgeons. Flowing from the joint positions of the previously mentioned experts, and despite initially refuting liability and contesting it throughout the trial, the defendant in their heads of argument finally conceded that they were negligent in their treatment and care of the plaintiff at TDH[5].
3. With negligence having been conceded, including the sequelae as set out in the expert joint minutes, the only issue that remains for determination is whether the epilepsy complained of by the plaintiff was caused by the defendant's negligent conduct. At the start of the trial,

with leave of this court, the parties agreed that only liability would be determined while the quantification of the plaintiff's damages would stand over for later determination. Following the agreement, the court granted the order separating liability from quantum. The plaintiff's case was led through the testimony of six witnesses. They are, the plaintiff herself, Dr Sevenster, a specialist in gynaecology and obstetrics; Professor du Plessis, a specialist nurse; Dr Goosen, a general surgeon; Dr JA Smuts, a neurologist; and Dr Fine, a psychiatrist. The defendant called Dr Koll and Professor Ballot. Dr Ballot could not comment on the question of negligence as she had not been provided with the relevant records. Given the concession made by the defendant, the only evidence that remains for discussion is that related to the question of epilepsy.

A. The Parties

4. The plaintiff is an adult female. She resides in Silverton Pretoria.
5. The defendant is a Member of the Executive Council for Health, Gauteng. They are cited in this judgment in terms of the provisions of section 2(2) of the State Liability Act[6]. The defendant's elected address is the Office of the State Attorneys, 3[...] T[...] S[...] Street, Pretoria.

B. Background

6. The following emerged from the plaintiff's testimony and is common cause: On the evening of 22 July 2014, at about 18h00, the plaintiff, already at term, presented at the maternity section of TDH with contractions occurring at 10 minutes apart. She decided to walk up and down the waiting area as she was experiencing pain. At about 18h30, at her request, the sister confirmed that she was 4 cm dilated and that the birth would start after 21h00. There was some issue about the plaintiff's request to the midwife that the latter rupture her membranes to hasten the birth but the midwife refused. Apparently the doctor who was present also asked the midwife to rupture the membranes but the midwife refused. Nothing turns on the issue. While standing next to a bed the plaintiff felt immense pressure in her abdomen and lower back, followed by a spontaneous rupture of her waters[7]. She tried to lift her leg to get to the bed but she could not as the birth had already started, with the baby's head already out. The baby was born at 19h00.
7. It is not in dispute that the plaintiff experienced what is known as rapid or precipitate labour. The doctor who was assisting her

informed her she had suffered a bad perineum tear. She was wheeled to the delivery room where the midwife sutured the tear, in

contravention of the existing nursing regulations[8] and guidelines[9]. The plaintiff and the baby were discharged the following day. On 27 July, four days later, the plaintiff returned to TDH complaining

about faecal incontinence and infection in her vaginal area. After some preliminary investigations, she was referred to SBAH where she was informed that her internal and external sphincter muscles were damaged and that she had a recto-vaginal fistula[10].

8. In the same month, she was informed that she had to undergo a sigmoid colostomy. The actual remedial work of the anal sphincter was eventually carried out on 17 November 2014. The colostomy was reversed in April 2015. After the colostomy was reversed, the

plaintiff was admitted to hospital for, inter alia, post operative bowel obstruction and sepsis. These complaints were attended to at SBAH. The closure of the colostomy was complicated by recurrent wound infections because, according to the experts, the procedure is contaminated by bowel content. In September 2017, the plaintiff had a thyroidectomy performed at Dihlabeng Regional Hospital (DRH[11]), in the Free State. By then she had moved to the Free State on account of her husband's work. There was no suggestion that the thyroidectomy had anything to do with the defendant's negligent conduct during evidence. The record suggests that the plaintiff complained of, inter alia, blackouts, mood swings, headaches and dizziness. In August 2019 the plaintiff was diagnosed with uncontrolled epilepsy, described in the record as temporal lobe epilepsy.

Dr Johannes Albertus Smuts - neurologist

9. Dr Smuts provided an impressive CV. He began lecturing in neurology in 1994 and as from 2017 to 2019 he was senior lecturer in neurology at the University of Pretoria. He has ran a private neurology practice. He has participated in over 70 clinical trials as principal and sub-investigator. He has written extensively on the subject and has delivered numerous papers and presentations on the subject of neurology. Although the defendant had indicated its intention to call Professor Kakaza, also a neurologist, she could not attend court. Dr Smuts and Professor Kakaza had signed a joint minute which records areas of agreement and disagreement.
10. Dr Smuts had consulted with the plaintiff on 25 March 2021. His report is dated 30 March 2021[12]. He testified that he had noted that the plaintiff had no history of epilepsy. He mentioned the multiple surgeries as a possible source of risk of epilepsy because there was no history of septicaemia. Aside from the doctor's brief testimony, he had provided a summary of his evidence to which I now turn: When explaining the nexus between epilepsy and the primary obstetric problems experienced by the plaintiff, the doctor said:

'The most important link of the epilepsy and the long hospitalisation, is the fact that the epilepsy started very soon after the other illness with no alternative etiological causes for such condition.'

He went on on:

'The primary reason why it would be difficult to establish a link is that a detailed review of the course of events in each operation regarding the 'potential hypoxemia and or hypovolemia and or hypotension' would need to be tract and it is doubtful that such documentation is available.'

He further added:

'It is an open question whether many operations and anaesthetic procedures potentially could lead to epilepsy. It is also documented that hospital onset seizures are different from that (sic) of the general population.'

In closing the doctor noted:

'Finally, regarding he link to the original problem, is that she developed her epilepsy problems in a temporally linked fashion and that there are circumstantial evidence that link the epilepsy to the prolonged illness.'

11. I will in a moment turn to the established principles pertaining to the evaluation of expert evidence. For now, I record what I find challenging about the doctor's report, which was not explained at all during his brief testimony. I start by recording that the doctor refers to many operations but does not mention anywhere what he means by many operations. The record shows that the plaintiff went through a number of procedures. At no point was there a statement that each of those procedures account for an

operation. The second difficulty is that the doctor refers to long hospitalisation in his report. The record suggests numerous visits and admissions and not necessarily prolonged hospital stay. For example, would the seven days for which the plaintiff was admitted to do the re-work of the third degree tear be considered a long stay? These were also not clarified during the doctor's oral evidence.

12. The main challenge with the doctor's opinion is that in the first instance the link between epilepsy and the obstetric problems is the fact that the epilepsy developed soon after the 'other illness'. Without context to understand what the doctor was referring to by the 'other illness', it is difficult for anyone to understand what the doctor was referring to. In his conclusion, the doctor states that the epilepsy problem developed in a temporally linked fashion and 'there are circumstantial evidence that link the epilepsy to the prolonged illness'. The question arises, what exactly did the doctor mean by the 'circumstantial evidence'? Again, no care was taken to ensure that the doctor explains this area of his report during his testimony. It is noted however, that the doctor made the point that it would be difficult to draw a link between the epilepsy and the many operations. Likewise, he says it is an open question whether many operations and anaesthesia may lead to epilepsy.

The joint minute signed by Professor Kakaza and Dr Smuts

13. I now consider the doctors' joint minutes. The doctors agree that the patient suffers from epilepsy and that its history is complex. They confirmed that the hospital records note that epilepsy began in 2019. I shall from now on concentrate on Dr Smut's views in the joint

opinion since Professor Kakaza was not called to explain her views to the court. Dr Smuts records that the link between the 'epilepsy and the long hospitalisation is the fact that the epilepsy started in temporal association with multiple hospitalisation and repetitive anaesthesia and surgery. He further recorded that many factors such as respiratory problems lead to epilepsy and that hospital onset seizures are different from that of the general population. Finally, he notes that the likelihood of a link between surgery and the epilepsy is possible.

Legal Principles relevant to expert evidence

14. The court is duty-bound to assess and evaluate expert evidence together with all the evidence adduced by the parties and it must be satisfied that the expert's opinion is based on fact and is underpinned by proper reasoning[14]. What is required in the evaluation of such evidence is establishing whether and the extent to which the expert's opinion is founded on logical reasoning[15]. This is particularly so where medical certainty is virtually impossible, the court must be satisfied that the expert has considered comparative risks and benefits and has reached a defensible conclusion[16]. An opinion expressed without logical foundation can be rejected[17].
15. Secondly, experts draw inferences from established facts. The inferences must be reasonably capable of being drawn, for, in the event the inferences are tenuous or far-fetched they cannot be foundation for the court to make a finding of fact[18]. Thirdly an expert's opinion does not bind a court. Such opinion does no more than help the court to itself arrive at a conclusion in an area that the court knows little or nothing about based on the specialised knowledge bearing on the issue[19]. It is also necessary to bear in mind the words of the Constitutional Court in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape*, that logical theories put forwards by experts and not gainsaid by other experts should not be scoffed at without a basis[20]. Finally, this court is mindful that the standard of proof is not scientific but proof on a preponderance of probabilities, as set out in *Michael and Another v Linksfield*[21].

Legal principles on causation

16. An enquiry into causation commences with the 'but for test' to determine whether a postulated cause is the *causa sine qua non* for the damage complained of, *International Shipping Company (Pty) Ltd. v Bentley* (138/89) [1989] ZASCA 138; [1990] 1 All SA 498 (A) (10 October 1989). The question that must be answered in these proceedings is whether the epilepsy, the onset of which, according to the joint minute between Professor Kakaza and Dr Smuts can be traced back to 2019, can be causally be linked to the obstetrics problems experienced by the plaintiff in 2014? From reading Dr Smuts' views as expressed in his report and in the joint minute, and based on his testimony, there is no way of telling whether there is a link between the obstetric problems experienced by the plaintiff and the epilepsy.

17. The manner in which counsel for the plaintiff approached this aspect of the plaintiff's case was by pressing the fact that Dr Smuts' evidence stands uncontested. He further relied on the statement made by Dr Smuts in the joint opinion that, 'The likelihood of a link between surgery and the epilepsy is possible' and suggested that the link between the obstetric problems and epilepsy had been established. In so doing, counsel ignored various parts of Dr Smut's evidence which confirm Professor Kakaza's opinion that: These are:
- (a) It would be difficult to establish a link [between the obstetric problems and the epilepsy] because to do so, one would need to analyse what occurred in each of the operations;
 - (b) It is an open question whether many operations and anaesthesia can lead to epilepsy.
 - (c) And, in the joint minute, the doctor says epilepsy can be caused by many factors such as respiratory problems.
18. Professor Kakaza in the joint opinion expresses similar views. She notes:
- (i) Epilepsy is a problem that has multiple causes;
 - (ii) There is no evidence of direct or indirect trauma;
 - (iii) The temporal relationship of the onset of epilepsy and the history of surgery is accepted by this is an indirect association.
 - (iv) Lastly, she says, it is not possible at the present stage to draw a link between the epilepsy and the obstetric problems experience by the plaintiff in 2014.
19. I have already mentioned my difficulty with the use of the word many with reference to the operations, when no care had been taken to state what the doctor Smuts regards as many. The fact that Prof Kakaza did not testify simply means the court only has the benefit of Dr Smuts' evidence but that too must still be weighed. This is so because the court does not have the benefit of Prof Kakaza's explanation for her reasoning as expressed in the joint note. The court is duty bound to assess Dr Smuts' evidence to understand to what extent it is founded on logic and whether the conclusions reached are defensible. The defendant was emphatic in their response that the evidence on this issue lacks logic. Having earlier expressed my difficulties with Dr Smuts' evidence on this issue, all that need be said is that the plaintiff has failed to draw a link between the obstetric problems of 2014 and the epilepsy diagnosed in 2019.
20. Were I to adopt a charitable view and conclude that factual causation had been established, would the plaintiff succeed in establishing legal causation? Legal causation is concerned with remoteness. Justice Theron explains the function of legal causation in *De Klerk v Minister of Police* thus:
- [26] The function of legal causation is to ensure that liability on the part of the wrongdoer does not extend indeterminately....The

question of legal causation is whether that further harm is too remote from the initial conduct for liability to be imputed to the defendant.

[27] In this way, remoteness operates along with wrongfulness as a measure of judicial control regarding the imposition of delictual liability and as a 'longstop' where most right-minded people will regard the imposition of liability in a particular case as untenable, despite the presence of all other elements of delictual liability.

[28] Legal causation is resolved with reference to public policy. As held by the Supreme Court of Appeal in *Fourway Haulage SA*, although this implies that the elements of legal causation and wrongfulness will overlap to a certain degree as both are determined with reference to considerations of public policy, they remain conceptually distinct...[22]

21. The court in *Premier of the Western Cape Province and Another v Loots* NO[23] further explained legal causation thus:

'...[I]t has been held by this court that the criterion in our law for determining remoteness is a flexible test, also referred to as a supple test. In accordance with the flexible test, issues of remoteness are ultimately determined by broad policy considerations

as to whether right-minded people, including judges, would regard the imposition of liability on the defendant for the consequences

concerned as reasonable and fair.

[18] But, as also appears from the authorities to which the flexible approach owes its origin and development, its adoption did not result in a total discard of the variety of tests, such as foreseeability, adequate causation or direct consequences that were applied in the past. These tests still operate as subsidiary tests or pointers to what is indicated by legal policy. Stated somewhat differently, according to the flexible test, the existing criteria of foreseeability, directness and so forth should still be applied, but in a flexible manner so as to avoid a result which most right-minded people will regard as unjust and unfair.

22. In *Premier Western Cape v Loots*[24], the claimant, Ms Erasmus, or more accurately, her curator, had brought a delictual claim arising from an unsuccessful sterilisation. The claim, as the court noted was not for child raising expenses from an unwanted conception but for the harm suffered by Ms Erasmus in a subsequent birth which left her in a vegetative state. It was common cause that Ms Erasmus had suffered what is known as amniotic fluid embolism, AFE, which is caused when the foetal antigens enter the maternal circulation. AFE, it was accepted by all the experts, was a very rare condition which flows from pregnancy. The pregnancy which flowed directly from the defendant's negligent conduct of performing an occlusion of the patient's ligaments as opposed to the fallopian tubes. The point about *Loots* is that at no point did the court of appeal question whether causation had been established, based on the expert evidence or rather the lack thereof, accepted by the trial court. In fact, as the court found, the evidence of the defendant's (appellants')

expert witness who, for some reason had not testified, was congruent with that of Loots' expert.

Conclusion

23. Bearing in mind that the question whether legal causation has been established calls for judicial determination based on policy considerations as informed by our constitutional values whilst not discarding the traditional factors such as, foreseeability, adequate causation or direct consequences, I cannot say that the theory presented by Dr Smuts helps this court to reach the conclusion that legal causation has been established. Epilepsy as the doctors conceded can be caused by many factors and, it is not possible to make the connection between the plaintiff's obstetric problems and the epilepsy. Even taking the surgical history, Dr Smuts conceded that it is an open question whether surgical history or has he put it, many operations and anaesthesia, can cause epilepsy. As I had earlier said, the theory presented by Dr Smuts does not even assist in finding factual causation. I conclude

that the plaintiff has failed to establish that the defendant's negligent conduct at TDH — which occasioned the obstetric

problems — caused the epilepsy complained of. Thus, this part of the plaintiff's case fails.

Costs

24. The plaintiff seeks punitive costs. The basis as explained by counsel is this, after the joint minutes of the various experts were filed, the defendant had no more room to wiggle out of the merits. The defendant, so the argument goes, should have conceded liability.

Whilst the plaintiff argues that the defendant wasted public funds by engaging in a longdrawn trial, that charge may easily be undermined by the need for transparency and accountability in matters involving public finances. I do not accept these assertions as being a sound basis for punitive costs. As was said in *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others*[25], the award of costs is in the discretion of the court.

Order

25. The defendant is liable to compensate the plaintiff for her proven or agreed damages, excluding liability for epilepsy which the plaintiff failed to prove.
26. The defendant must pay the plaintiff's costs.

NN BAM (Ms)

JUDGE OF THE HIGH COURT, PRETORIA

Date of Hearing:

14 – 17 & 25 August 2023

Date of Judgment:

26 February 2024

Appearances:

For the Plaintiff: Adv J De Beer Instructed by Surita Marais Attorneys Arcadia, Pretoria
For the Defendant: Adv M.S Phaswane Instructed by: State Attorneys Pretoria

- [1] There was disagreement as to whether the plaintiff had suffered a third or fourth degree of tear. The defendant eventually agreed that the plaintiff suffered a third degree tear and the plaintiff accepted. All the evidence led during the trial dealt with a third degree tear. The plaintiff likewise accepts that she suffered a third degree tear. See Plaintiff's particulars of claim: Caselines 037-2, paragraph 6.
- [2] The anal sphincter is made up of two sets of muscles called the internal and external sphincters. The muscles form a ring around the anus. When the muscles are working normally, they squeeze the anus shut so that gas and bowel movements cannot leak out. Definition simplified from extracts taken from www.ncbi.nlm.nih.gov.
- [3] A rectovaginal fistula is an abnormal connection between the lower part of the large intestine — the rectum or anus— and the vagina. General definition from National Library of medicine: www.ncbi.nlm.nih.gov : accessed on 27 December 2023.
- [4] These include, inter alia, post-traumatic stress disorder (PTSD), major depressive disorder, dyspareunia (pain during sexual intercourse), and depression
- [5] The defendant conceded that third degree tear was missed (not properly categorised) Caselines 036-20 paragraphs 25 - 28; The midwife, as opposed to an experienced senior doctor or specialist, sutured the tear: Caselines paragraphs 30-32, and 63 - 64; The tear was sutured in the labour ward not in theatre, with adequate lighting, in clear contravention of the prevailing regulations and guidelines. It is also common cause that: The plaintiff was discharged the following day, which was not acceptable, with no factual record of clear instructions regarding

the management of the sutured area.

- [5] The defendant conceded that third degree tear was missed (not properly categorised) Caselines 036-20 paragraphs 25 - 28;

The midwife, as opposed to an experienced senior doctor or specialist, sutured the tear: Caselines paragraphs 30-32, and 63 - 64;

The tear was sutured in the labour ward not in theatre, with adequate lighting, in clear contravention of the prevailing regulations and guidelines.

It is also common cause that:

The plaintiff was discharged the following day, which was not acceptable, with no factual record of clear instructions regarding

the management of the sutured area.

[6] Act 20 of 1957.

[7] At times, I refer to the rapture of membranes in this judgement, which means the same thing.

[8] In terms of the Regulations to the Nursing Act of 1974, which set out the conditions under which registered and enrolled midwives may carry on their profession, in particular, regulation 2488, Chapter 2, Clause 10: in the event of a third degree perineal tear, the midwife, shall, subject to the consent of the mother, call in a medical practitioner or refer the patient to a medical practitioner.

[9] The gynaecologist and surgeon who testified were in agreement that a third degree tear may be sutured only by an experienced senior

doctor or specialist, in theatre, under general anaesthetic. They also testified that it was a contravention of the guidelines that the plaintiff was discharged the next day.

[10] An abnormal connection between the rectum and perineum causing significant physical discomfort for patients with the chief complaint being the uncontrollable passage of gas and faeces from the vagina, ncbi.nlm.nih.gov; date accessed 2024/01/04.

[11] Caselines 007 - 156 - 161.

[12] Caselines 004:244

[13] Caselines 04-253

[14] NSS obo AS v MEC for Health, Eastern Cape Province (017/22) [2023] ZASCA 41; 2023 (6) SA 408 (SCA) (31 March 2023), paragraph 16; M and Another v MEC Health, Western Cape (1258/2018) [2020] ZASCA 89 (31 July 2020), paragraph 17.

[15] Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another

(1) (361/98) [2001] ZASCA 12; [2002] 1 All SA 384 (A) (13 March 2001), paragraph 36.

[16] HAL obo MML v MEC for Health, Free State (Case no 1021/2019) [2021] ZASCA 149 (22 October 2021), paragraph 53.

[17] Ditto.

[18] Van Zyl N.O obo A.M v MEC for Health, Western Cape Provincial Department of Health (A138/2021) [2022] ZAWCHC 133; [2023] 1 All SA 501 (WCC) (4 July 2022), paragraph 21.

[19] MEC for Health and Social Development, Gauteng v MM on behalf of OM (Case no 697/2020) [2021] ZASCA 128 (30 September 2021), paragraph 17.

[20] (CCT185/14)

[2015] ZACC 33; 2016 (1) SA 325 (CC); 2015 (12) BCLR 1471 (CC) (14 October 2015), paragraph 44

[21] Note 15, paragraph 39.

[22] (CCT 95/18) [2019] ZACC 32; 2019 (12) BCLR 1425 (CC); 2020 (1) SACR 1 (CC); 2021 (4) SA 585 (CC) (22 August 2019), paragraph 26-28.

[23] (214/2010)

[2011] ZASCA 32 (25 March 2011), paragraphs 17-18.

[24] Note 23.

[25] (CT5/95)

[1996] ZACC 27; 1996 (2) SA 621 (CC); 1996 (4) BCLR 441 (CC) (19 March 1996), paragraph 3.

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