

SOUTH AFRICA / JUDGMENT

Vallaro NO v MEC for Health and Social Development Gauteng (A5009/16) [2017] ZAGPJHC 474 (30 October 2017) [2017] ZAGPJHC 474

COURT

South Gauteng High Court, Johannesburg

BEFORE

Victor, K Matojane, E Francis

CASE / FILE NUMBER

A5009/16

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REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG LOCAL DIVISION, JOHANNESBURG

APPEAL CASE NO: A5009/16

COURT A QUO CASE NO: 23977/12

In the matter between:

CINZIA VALLARO N.O.

As Curatrix ad Litem to Appellant

BAREND JACOBUS BARNARD Plaintiff court a quo

and

MEC FOR HEALTH & SOCIAL Respondent

DEVELOPMENT GAUTENG

Defendant court a quo

J U D G M E N T

VICTOR, J:

- [1] This matter was referred from the Supreme Court of Appeal on petition. The appellant is the curatrix ad litem for Mr B J Barnard (the patient) who seeks damages as a result of alleged medical negligence following upon treatment received at the Tambo Memorial Hospital in

2011. The respondent is a Member of the Executive for Health and Social Development Gauteng Province responsible for the Tambo Memorial Hospital and the medical personnel who are employed at that hospital.

The Issues

- [2] The issues which arise are whether the failure to perform a craniotomy timeously on the patient led to the consequences which he is now suffering from; inter alia he is wheelchair-bound, suffering from severe aphasia, poor memory and various other complaints. In essence whether the Oliver Tambo Memorial Hospital's failure to take into account the patient's deteriorating clinical condition which left untreated resulted in secondary brain damage. Further whether the omission was wrongful. It is also necessary to determine whether it would be reasonable to impose liability for the damages flowing from the omission. A further consideration is whether the failure to perform a craniotomy by opening the skull and attending to decompression and repairing the ruptured blood vessels timeously was negligent and whether reasonable doctors in the position of the Department's doctors would have foreseen the possibility of the omission causing the harm and whether they would have taken steps to prevent it occurring. It is the patient's case that reasonable doctors would have foreseen the possibility of permanent damage if a craniotomy was not performed after the first brain scan. The legal issue is whether delictual liability has been established. This in turn involves a consideration whether the following elements of delict have been established:
- (i) wrongfulness;
 - (ii) causation; and
 - (iii) negligence.

Common Cause Facts

- [3] Barnard was assaulted on the night of 21 May 2011 and sustained a head injury. On 22 May 2011 he was transported to Tambo Memorial Hospital by ambulance and admitted to the Casualty Department at approximately 11h40. At that stage he had suppressed consciousness with weakness of the left side of his body. During the night of the 21 May 2011 his son had to assist him to go to the toilet. He exhibited lameness on his left side and he was incoherent and aphasic. An overdose of some 70 tablets sleeping tablets was suspected. He was not treated for the overdose. Prior to the trial commencing in the court a quo the defendant conceded negligence in relation to the plaintiff's treatment and this admission was made an order of court. In the pre-trial minute of the two neurosurgeons they agreed that there was a delay in establishing the correct diagnosis which delayed the definitive treatment of a craniotomy for the removal of the intracranial hematomas. They agreed that the delay in diagnosis was not an acceptable standard of medical practice. Dr Karan of the defendant contended that the delay made no difference and Dr De Klerk an expert called by the patient contended the contrary.

[4] This led to the question of whether there was negligence in the delay in performing that craniotomy, this became a central issue in the trial. The court a quo found that the delay in the performance of the craniotomy did not lead to the sequelae that were evident at the time and the sequelae he now suffers from.

[5] After his admission on 22 May 2011 the first CT scan to his brain was done 3 days later on 25 May 2011. These were the findings:

‘CTB (meaning CT scan of the brain). There is a large intro cerebral haemorrhage. C perifocal oedema (pressure) in the left temporal parietal region. There is compression of the left lateral ventricle with 10 mm midline shift to the right. Two fractures can be seen through the right zygomatic arch. No other fractures seen. The paranasal sinuses and orbits appear normal.’

[6] Both the appellant’s expert doctor, Dr De Klerk and Dr Karan agreed that bleeding leads to intracranial pressure and that develops after a few days. If there is such a compression the brain liquid needs to be drained. It was the appellant’s case that by 25 May 2011 the pathology in the patient’s brain was such that he needed urgent surgery to evacuate the compression. This was the evidence of Dr De Klerk and one of the treating doctors

Dr Carrim. Dr Karan, the expert neurologist called by the respondent, agreed that subdural haematomas cause brain damage by increasing

intracranial pressure and shifting of brain structures and that this can be rapidly reversed by surgical evacuation.

Clinical profile

[7] The clinical picture is as follows: On the morning of 25 May 2011 to the afternoon of 25 May 2011 there was a noted deterioration in patient’s condition and this prompted the MRI scan of 25 May

2011. On 27 May 2011 Dr Carrim noted a deterioration in patient’s condition and he was sent for a further MRI scan. Thereafter a series of bureaucratic bungling events occurred and in my view caused a critical delay in the patient’s treatment for his head injury.

He was transported to the Charlotte Maxeke Hospital on 27 May 2011 for neurosurgical assessment. Because the original CT scan films were not available, only the report. The neurosurgeon who was supposed to do the craniotomy was not prepared to do it without seeing the scan films. During the day of 25 May 2011 Dr Carrim noticed a deterioration in the patient and this was the basis of referring him for the scan. That deterioration and the objective referral on that basis for a scan stands in direct contradiction of Dr Karan’s testimony that there was no change in the patient from admission to discharge. Dr Carrim also agreed that the patient’s condition deteriorated even the next day. On 27 May 2011 Dr Mbuyane found that the patient had expressive aphasia.

[8] The Patient was referred to the Radiology Department for the scans to be retaken. The radiologist refused to retake the scans because he said they had already been done. This administrative impasse resulted in the patient being transported back to the Tambo Memorial Hospital. He lay there until Dr Carrim suggested to his family that they discharge him and take him to the Outpatients of the Charlotte Maxeke Hospital where he could be admitted afresh. This happened on 1 June 2011 and the CT scan was done on that day. The results are as follows:

‘There is hyper dense surface collection on the left parietal lobe. Widest diameter measuring 1 cm and ? left. There is attenuation of the surface sulci. There is poor grain white matter differentiation in the left cerebral hemisphere superiorly. Hyper dense flax suggestive of SAH. Cranial contusion in the left temporal parietal lobe with surrounding vasogenic oedema. This measures 4.9 cm x 7.3 cm x 3.6 cm. There is a midline shift measuring 1.6 cm (on 25/5/11 was 10 mm. Attenuation of both anterior and posterior horns of left ventricles.’

[9] Dr De Klerk testified that based on the clinical records he studied, there was a significant deterioration in the pathology of patient’s brain from the first scan on 25 May 2011 to the second scan on 1 June

2011. Dr Karan conceded that the pathology in the brain increased from the earlier scan but regarded it as insignificant. Dr Karan also conceded that the layer of blood between the two hemispheres seen on the scan on 1 June 2011 was not recorded in the scan of 25 May 2011. On the second scan a large contusion was seen which was not reported on the first scan. In heated cross examination Dr Karan accused Counsel of trying to be an expert. Dr Karan’s thesis remained throughout that radiologist describe the results differently and therefore the scan of 1 June 2011 was not to be interpreted as a worsening condition. It is common cause that on 2 June 2011 the craniotomy was performed whereafter the patient’s condition improved.

[10] It is common cause between Dr de Klerk and Dr Karan that there was an increased possibility of epilepsy as a result of the brain pathology. Two years after the event the patient suffered two seizure type attacks and his mobility and cognition decreased. Dr De Klerk did a sophisticated MRI study and he excluded the possibility of a stroke and came to the conclusion that the attacks were epileptic attacks. This was not disputed in cross-examination.

[11] It is the respondent’s case that the primary insult was a result of the assault and this caused the neurological deficits and that the treatment or lack thereof did not lead to any further deterioration. The respondent’s expert Dr Karan stated that it was natural to have aphasia after a primary insult to the brain and that the haematoma suffered from the primary insult would have in any event led to weakness on the right side of the body. It is therefore the respondent’s case that the original insult caused the weakness to his body and problems with his speech. The respondent contends that despite the delay in performing the craniotomy resulting in exposure to raised intracranial pressure which caused poor cerebral

perfusion and ultimately a hypoxic insult to the patient's brain could not be ascribed to any negligence on the part of the medical treatment. This in the face of the concession referred to above prior to the trial.

Glasgow Coma Scale

- [12] The scoring of the Glasgow Coma Scale (GCS) was a point of difference between the doctors on behalf of the patient and the respondent. The Glasgow Coma scale is a neurological scale which aims to give a reliable and objective way of recording the conscious state of a person for initial as well as subsequent assessment. In this context it was used to assess the patients head injury. Elements of the scale include assessing eye responses, verbal responses and motor responses. Dr De Klerk who had spent many thousands of hours in trauma units in Pretoria, Medunsa, Groote Schuur, the University of Zurich and in Edinburgh, placed emphasis on the GCS and concluded based on the hospital notes that it was incorrectly scored. There was no evidence of a GCS score chart. He gave the example that on the morning of 25 May 2011 at 7H40 the patient was not communicating but conscious yet the MRI scan of that day showed pathology over his left hemisphere compressing the speech area. In his view the GCS score was wrong. He also had raised intracranial pressure and doubted the comment about the patient being conscious. The patient also had weakness on the right side. He also doubted the entry that the patient could have had supper in that semi-conscious state. There were several other notations which he noted as being inconsistent with his condition. Dr De Klerk emphasized that from his admission the treating staff knew there was an injury to the head and the GCS should have been recorded.
- [13] The defendants' doctors were of the view that the GCS score is subjectively done. For example, Dr T Mbuyane who saw the patient at the time found that the patient had expressive aphasia but assessed a normal score of 15/15. He refused to concede that there was a mistake in the score and he doubted the validity of the GCS anyway as it was developed many years ago and it is not easy to use on a variety of patients. He also testified that the scoring of the GCS depends on where the doctor is trained. It was

put to him that on 27 May 2011 the patient had right hemiplegia and expressive aphasia but that did not result in a lower GCS score. He testified that one has to 'look at the patient' and even if the patient is paralyzed you can give a full score.

- [14] On 1 June 2011 Dr Mbuyane notes that the patient has dense hemiplegia and is confused but gives him a full score of GCS 15/15. He sees no problem with that. Yet Dr Mbuyane made a concession that the doctor who scored the patient when he returned back from Oliver Tambo Memorial Hospital described the patient as confused but made a mistake when he noted the GCS scale of 15/15.

- [15] Dr Karan opposed every bit of the cross examination of even the simplest concept of the difference between comatose and semi-comatose described in the Youmans neurological surgery work which is the 'Bible' of the neurological field. He was not aware of the difference between comatose and semi-comatose and does not appear to have confidence in the Youmans work.
- [16] Dr Karan did however concede certain principles from the work, for example the fact that subdural hematoma including time from injury to treatment as significant, the proposition of subdural hematomas causes brain damage by shifting brain structures. Other propositions from Youmans he suggests be taken with a pinch of salt. When the results of the scans were put to him having conceded principles from the Youmans text book he agreed that early evacuation was correct and that it has

a major bearing on the final long-term prognosis. He says that this deduction is trite and there is no need to go to the Text Book. Notwithstanding the acceptance of the principle without reservation and saying that it is trite, he nevertheless would not concede that the delayed evacuation in this case affected the outcome. He basis this on the fact that the patients' GCS score remained the same from admission. Dr Karan maintained that the patient's GCS score remained the same from when he was admitted until after the craniotomy. He was wrong on this as when the patient was discharged his score was 14/15. Dr Karan was reluctant to concede that the improved GCS meant that the patient's condition remained the same from admission to discharge but was ultimately forced to concede that the craniotomy improved the patient's condition. He would not concede that if the craniotomy was done earlier the outcome would have been better.

- [17] The very different approaches to the scoring of the GCS by the doctors is a concern, if the score is to be used as a benchmark to assess whether the delayed craniotomy caused secondary damage. The subjective variability in scoring is evident throughout the record even to the extent of how the scoring method is taught at different hospital institutions. It is technical evidence which an appeal court can't resolve. It then becomes necessary to look at other factors. In my view the comparison between the two scans remains an objective comparative standard.

Comparison between the two CT scans of 25 May 2011 and 01 June 2011

- [18] Dr De Klerk's expertise is unchallenged. He testified that there was a difference in the CT scan done on 25 May 2011 and the one done on 1 June 2011. He described an increase in the shift of the brain across the midline. It was indicative of intracranial pressure that caused changes in the grey and white matter of the brain. The flattening of the brain surface also suggested abnormal pressure within the skull. He was clear that the research indicated that by treating intracranial pressure from whatever cause the aim was to get the pressure down before secondary pressure sets in. Dr Karan conceded this as being a trite medical principle and necessary procedure. Dr De Klerk suggested further treatment where there was high intracranial pressure such as increased oxygenation to the brain by manual or mechanical ventilation and to give appropriate medication.

- [19] Dr. De Klerk found that the secondary insult was evident in the brain between the first scan on 25 May to 1 June when the second scan was done. Dr de Klerk found that if the cerebral hemorrhage had been drained earlier, the duration of the pressure would have been shorter and the level of pressure lower and this would have led to less neurological deficits. He would have had 'mild hemiparetic weaknesses and mild decline in 'mentation'. He found that the present neurological deficits were at a micro circulatory level due to the long term raised intracranial pressure.
- [20] Dr De Klerk was of the view that the initial assault amounted to 40% and the delay in evacuation 60%. It was put to him that he did not know the extent of the primary insult and could not opine on this. His opinion was also based the second scan showing severe progression of what was going on in the patient's brain between those two dates. Dr de Klerk's position was that the second haemorrhage and the build-up of pressure would not have occurred if he had been diagnosed earlier and operated on earlier. It was submitted that this failure to do the craniotomy timeously increased the risk of damage. This is relevant to the question of causality.
- [21] Dr Karan tried to undermine the way radiologists report on scans. The pre-existing brain pathology was not reported on the first scan of 25 May 2011. In the first scan intracerebral haemorrhage was described as a large contusion but in the second scan measurements were placed on the contusion. He also criticised the report in Volume 7 at page 501 in the work of Youmans, Neurological Surveys, which refers to subdural intracerebral hematomas. Dr Karan suggested that the reliance on the literature was incorrect as it was referring to deep seated hematomas and not applicable to trauma patients. This was never put to Dr de Klerk and must be assessed in that context. It was also not put to Dr de Klerk that CT scans can be interpreted in variable ways and that perhaps not all the detail was included in the report of the first scan thus undermining the comparison.
- [22] The patient suffered two episodes which his wife described in lay terms as strokes. The patient underwent a highly specialised procedure and Dr De Klerk found that it was not a stroke but epileptic attacks which were sequelae to the brain damage. Thereafter his condition deteriorated. Presently he cannot walk or stand properly and his speech has deteriorated. He is wheel chair bound. The epilepsy was commented on by Dr de Klerk. Dr Karan conceded an increased chance of epilepsy for the patient.
- [23] Ultimately it is clear that a common sense and practical approach is required. Both experts agreed that evacuation of the liquid from the brain is indicated to release intracranial pressure. This must be evaluated in light of Dr Karan's finding that the craniotomy treatment would have made no-difference to the sequelae is puzzling in the circumstances. This must also be juxtaposed to the agreement reached between the parties that the patient's treatment was negligent.

Causation

[23] The question for determination is whether the failure to do a craniotomy earlier was the direct cause of the symptoms referred to. Does that failure amount to negligence? The issue of negligence involves a twofold enquiry. In *McIntosh v Premier, KwaZulu-Natal and Another* 2008

(6) SA 1 (SCA) para 12 Scott JA observed:

'The second inquiry is whether there was fault, in this case negligence. As is apparent from the much-quoted dictum of Holmes JA in *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E – F, the issue of negligence itself involves a twofold inquiry. The first is: was the harm reasonably foreseeable? The second is: would the diligens paterfamilias take reasonable steps to guard against such occurrence and did the defendant fail to take those steps? The answer to the second inquiry is frequently expressed in terms of a duty. The foreseeability requirement is more often than not assumed and the inquiry is said to be simply whether the defendant had a duty to take one or other step, such as drive in a particular way or perform some or other positive act, and, if so, whether the failure on the part of the defendant to do so amounted to a breach of that duty. But the word duty, and sometimes even the expression "legal duty", in this context, must not be confused with the concept of "legal duty" in the context of wrongfulness which, as has been indicated, is distinct from the issue of negligence. I mention this because this confusion was not only apparent in the arguments presented to us in this case but is frequently encountered in reported cases. The use of the expression "duty of care" is similarly a source of confusion. In English law "duty of care" is used to denote both what in South African law would be the second leg of the inquiry into negligence and legal duty in the context of wrongfulness. As Brand JA observed in *Trustees, Two Oceans Aquarium Trust* at 144F, duty of care in English law straddles both elements of wrongfulness and negligence.

At para 14 Scott JA suggests that the court has to address:

'The crucial question, therefore, is the reasonableness or otherwise of the respondents' conduct. This is the second leg of the negligence

inquiry. Generally speaking, the answer to the inquiry depends on a consideration of all the relevant circumstances and involves a value judgment which is to be made by balancing various competing considerations, including such factors as the degree or extent of the risk created by the actor's conduct, the gravity of the possible consequences and the burden of eliminating the risk of harm'

[24] In *ZA v Smith* 2015

(4) SA 574 (SCA) Brand JA at para [30] stated a practical and common sense approach. It is not 'based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the background of everyday-life experiences.'

[25] The appellant relies in the alternative of the dictum of Nkabinde J in *Lee v Minister for Correctional Service* 2013 (2) SA 144 (CC) at para [61]

‘In postulating the hypothetical non-negligent conduct needed for the substitution exercise, the SCOs provide helpful guidance. The minimisation of risk of contagion is largely dependent on the effective screening of incoming prisoners and the isolation of infectious patients. The SCOs provide for screening for medical problems by a registered nurse on admission and for a medical examination within 24 hours by a registered nurse, medical officer or medical practitioner. They also make special provision for the immediate reporting of communicable or contagious diseases and for the isolation of persons with these diseases. There is nothing on record to suggest that this kind of screening, examination and isolation in terms of the SCOs would not have been effective in reducing the risk of infection and contagion of a disease like TB — indeed the case the authorities initially sought to present was that the process was properly followed. It does not require much imagination to postulate that adherence to the SCOs may constitute the non-negligent conduct necessary for the substitution exercise.’

[26] See also the dicta in *Mashongwa v PRASA* 2016 (3) SA CC 528 Mogoeng CJ at para [65]:

‘Lee never sought to replace the pre-existing approach to factual causation.[60] It adopted an approach to causation premised on the flexibility that has always been recognised in the traditional approach. It is particularly apt where the harm that has ensued is closely connected to an omission of a defendant that carries the duty to prevent the harm. Regard being had to all the facts, the question is whether the harm would nevertheless have ensued, even if the omission had not occurred. However, where the traditional but-for test is adequate to establish a causal link it may not be necessary, as in the present case, to resort to the Lee test.’

[27] This practical common sense approach to causality was already applied in *Bonnington Castings Limited v Wardlaw*

[1956] UKHL 1; [1956] 1 All ER 615 the evidence in that case proved the presence of dust in the work environment which could have been reduced if there had been openings in the wall. It would have improved the circulation of air which would have diminished the possibility of contracting pneumoconiosis. In *Wilsher v Essex Health Authority* [1987] UKHL 11; [1988] 1 All ER 871 a case involving medical negligence the ratio was that in difficult cases one must take a broader view on the question of causation. The analysis of the legal concept of causation cannot be a scientific enquiry. A common sense and an overall approach is preferable. The plaintiff has to show a material contribution to his injuries. In *McGhee*

[1973] 1 W.L.R 1 it was found that a judge can infer a causal relationship between a breach of duty and damage even though it is not possible to establish by direct evidence (expert or otherwise) whether the damage would or would not occurred without that breach of duty. It is an unspoken application of common sense. It was the duty of the defendants to do something about it.

Evaluation

[28] The appellant submits that in order to establish factual causation the following applied: The objective evidence demonstrates the difference between the two scans and the deterioration noted, the evidence of the treating doctors regarding clinical presentation of symptoms and the entries in the hospital records.

[29] In this case the joint pre-trial minute shows unequivocally an agreement by both neurologists that the treatment the patient received was not up to standard. Both neurologists agree that an early evacuation would have led to a better result. Only Dr Karan disputed the import of the clinical deterioration. As stated, Dr Carrim ordered the scan because

he noticed a deteriorating medical situation. Once that is coupled with Dr Karan's concession of what he regarded as a trite

proposition there should have been early evacuation. The two scans showed change and I accept that delay led to the secondary brain

damage. The case law suggests that a common sense approach be adopted. There is substantial agreement by the experts that a delay in carrying out a craniotomy is not advisable. The highly technical and contradictory evidence cannot be resolved by an appeal court. The court a quo focused on the GCS readings to support its conclusion. In this regard the subjective variability of the assessor of the scale was clear.

Apportionment of damage

[30] There is the question of the apportionment of the damage between the first insult and the second insult being the negligent medical treatment. In our law divisibility of damage is permissible. See *Wright v MediClinic* 2007(4) SA 327 C at para 114 -123 and 140 – 146. Reference is made to *Jones NO v Santam Bpk* 1965 (2) SA 542 (A),

'the Appellate Division followed, and in one respect clarified, what was said in *South British Insurance Co Ltd v Smit* (supra). See the following passage at 555C/D - D:

'It is on the basis of comparison between the respective degrees of negligence of the two parties (or several parties if there be more than one claimant or defendant) that the Court can determine in how far the fault or negligence of each combined with the other to bring about the damage in issue.'

[31] In the light of the complexities set out by both parties, in my view the assessment of the apportionment cannot be calculated on a technical and mathematical scale. The patient seeks an apportionment of 60% in his favour. In my view an apportionment of 50% is a fairer assessment having regard to the complex issues facing both parties.

[32] I would therefore uphold the appeal and find that the defendant is liable for 50% of the plaintiff's damages.

General damages

[33] It follows that the question of damages requires consideration as the court a quo in the light of its finding did not have to do so. The cost of future medical treatment has been agreed as per the minutes of the experts. The actuarial calculation is R6 883 141. 50% of this is R3 441 570. In regard to future loss of earnings Ms Donaldson's evidence was not successfully challenged. He can no longer work. He was earning R15 000 per month at Jacobs décor. An actuarial calculation on Ms Donaldson's evidence amounted in average to R1 065 409, 25. He was 55 years old at the time and the usual contingency would be ½% per annum. That is 5%. Having regard to the factors in this case I agree with the plaintiff's submission that 10% contingency is appropriate. That equals R517 788.91. Having regard

to the cases cited by the plaintiff where awards of between R750 000 to R1 000 000 were made, an award of R900 000 would be appropriate. 50% would be R450 000 000.

The total claim by the plaintiff having regard to the finding that the defendant is 50% liable for the plaintiff's damages:

Future medical expenses (as per agreement) R3 441 570

Loss of earnings R517 788

General Damages R450 000

TOTAL R4 409 358

The order that I would make is the following

The appeal is upheld

The order is replaced with the following:

'The defendant is liable for 50% of the plaintiff's damages.'

4 The defendant shall pay to the plaintiff the sum of R4 409 358. The defendant shall pay the costs of the reports of the plaintiff's witnesses and/or the appearance of Ms Donaldson and Dr De Klerk.

5 The defendant shall pay costs of suite including the costs of senior counsel

VICTOR, J

1. JUDGE OF THE HIGH COURT OF SOUTH AFRICA GAUTENG LOCAL DIVISION,
JOHANNESBURG

K. MATOJANE

2. JUDGE OF THE HIGH COURT OF SOUTH AFRICA GAUTENG LOCAL DIVISION,
JOHANNESBURG

E FRANCIS

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

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