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

(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO
(3) REVISED.

SIGNATURE DATE: 9 May 2023

Case No. 39328/2019

In the matter between:

TLM Plaintiff

and

MEC FOR HEALTH AND SOCIAL DEVELOPMENT, GAUTENG PROVINCE Defendant

Neutral citation: TLM v MEC for Health and Social Development, Gauteng Province (case no. 39328/2019) [2023] ZAGPJHC 442 (9 May 2023)

JUDGMENT

WILSON J:

1 On 10 December 2016, the plaintiff, TM, attended a friend's engagement party in Protea Glen, Soweto. TM was drawn into an altercation at the party. He was pulled from behind, fell back and twisted his knee. TM says that the pain from

this injury was instant and excruciating. He says that he was unable to walk or stand.

2 TM says that a friend took him immediately to the Chiawelo Clinic. Nursing staff at the Clinic attended to TM promptly. They suspected a fractured knee. Shortly after 02h00 on 11 December, TM was taken by ambulance to Chris Hani Baragwanath hospital. He arrived at Baragwanath at around 02h45. A patient record was opened for TM at 03h29, but TM was not examined until around 4h30.

3 It is common cause that the 4h30 examination was conducted by a medical student. The medical student noted a swollen and sensitive right knee. The student could not detect a right pedal pulse (in other words, there was no sign of blood flow to the right foot). But she (TM described the doctor who first saw him as “a lady”) noted that TM still had some sensation in his lower right limb. The medical student recommended that an X-Ray and, possibly, a computerised tomography (“CT”) angiogram be performed. A CT angiogram would have allowed TM’s treating physicians to tell whether and where blood flow to TM’s right foot had been occluded.

4 TM says that he was taken for an X-Ray, which revealed that there was no fracture. At 11h45 TM was seen by an orthopaedic surgeon. Shortly thereafter, TM was referred to Dr. Sechaba Palweni, then a registrar working as a vascular surgeon. Dr. Palweni immediately diagnosed TM with an occluded popliteal artery. In other words, TM’s knee injury had resulted in a blockage to a blood vessel in TM’s knee. That blockage had effectively cut off the blood

supply to TM's right lower limb. By the time Dr. Palweni saw TM, TM's right foot was cold. He still had no pedal pulse.

5 Dr. Palweni classified TM's injury on the Rutherford scale. The Rutherford scale is a typology of vascular limb injuries that helps characterise the degree of risk to a limb from a damaged blood vessel. A type-1 injury refers to a limb that is not immediately threatened, and in which there is still detectable blood flow to the lower extremities. A type-II (a) injury refers to a limb in which no arterial blood flow can be detected, but in which there is little or no muscle weakness. The limb can be saved if prompt action is taken. A type-II (b) injury refers to a limb in which there is no arterial blood flow, and in which mild to moderate muscle weakness has set in. If blood flow to the limb is immediately re-established, then the limb may be saved. A type-III injury refers to a situation in which the blood supply to the limb has been cut off for so long that the tissues starved of oxygen and other nutrients will almost inevitably die, and the limb will have to be amputated.

6 Dr. Palweni classified TM's injury as being of the type-II (b) class. This indicated a real risk that TM would lose his lower right leg. Dr. Palweni then began a sustained effort to save the limb. Several operations ensued in which Dr. Palweni and other surgeons at Baragwanath sought to re-establish blood flow to the limb, and to prevent the necessity of amputation. During the first of these operations, Dr Palweni performed a CT angiogram, identified the occlusion of TM's popliteal artery, and sought to bypass the occlusion by grafting a new blood vessel on to the existing artery.

7 These efforts were both valiant and unsuccessful. TM's right leg was amputated above the knee on 27 December 2016.

The action for damages

8 On 4 December 2019, TM instituted a claim for damages against the defendant, the MEC, arising from the amputation of his leg. The merits of that claim were enrolled for trial before me on 25 April 2023. TM's case at trial was that the MEC's staff at Baragwanath wrongfully and negligently failed to identify the nature of his injury in time to save his right leg. TM says that but for the failure to promptly identify and treat the occlusion of his popliteal artery, he would not have lost his limb. He seeks an order from me declaring the MEC liable for such damages as he may later prove, an order postponing the trial on those damages *sine die*, and an order directing the MEC to pay his costs.

9 There is obviously no dispute that TM has suffered loss. Nor is there any dispute that, if the MEC's employees at the Chiawelo Clinic or at Baragwanath are shown to have been negligent in their care of TM, then that negligence was wrongful. The issues arising for determination at trial were those of negligence and causation. The MEC denied both that TM's care had been negligent and, even if it was negligent, that the negligent care caused TM's loss. Ms. van Heerden, who appeared for the MEC, ultimately submitted that TM's loss was in fact caused by his own delay in seeking treatment after he sustained his injury.

10 It is, accordingly, to an examination of what the evidence reveals about the standard of care TM received, and its effect on the deterioration of his limb, that I now turn.

Negligence

11 The first question is whether TM's medical treatment was negligent. His case that he was treated negligently is of narrow compass. TM accepts that he received prompt and appropriate care at the Chiawelo Clinic, and that he was swiftly and professionally transferred to Baragwanath. Mr. Uys, who appeared for TM, also accepted that Dr. Palweni's assessment and treatment of TM cannot be criticised in any way. Once TM reached Dr. Palweni, Dr. Palweni did everything he could to save the limb. His actions were prompt and appropriate in the circumstances. There was some controversy at trial about whether Dr. Palweni and the nursing staff in charge of TM's case properly informed TM of the nature of and risks attached to each of the surgeries performed on him. But even if fully informed consent had not been obtained, it had nothing to do with the ultimate outcome of TM's case. The evidence on this point was in any event insufficient for me to make any finding, save to say that I am satisfied that Dr. Palweni did everything that could have been expected of a reasonable medical practitioner to explain TM's condition and course of treatment to him.

12 TM's case is rather that, once he had been seen by a medical student at 4h30 on 11 December 2016, the medical staff in charge of TM's case negligently failed to take the prompt action necessary to save TM's limb. It was argued that a reasonable medical practitioner presented with a patient in TM's condition at 4h30 would have foreseen the possibility of muscle death and amputation, would have taken immediate action to confirm a popliteal artery occlusion, and would have operated to restore blood flow to TM's right lower

limb. But that did not happen. Other than the X-Ray that TM said was performed, TM was left substantially untreated for seven hours before he was seen by an orthopaedic surgeon, and referred to Dr. Palweni.

13 The MEC led no direct evidence of what happened during those seven hours. Professor Martin Veller, who gave expert evidence for TM, confirmed that the course of treatment Dr. Palweni implemented after 11h45 was, in his view, the standard of care that ought to have been implemented at or shortly after 04h30. To refer TM for an X-Ray was insufficient, because, whether or not there was a fracture, the absence of a pedal pulse indicated a blood vessel occlusion of some sort, and a limb in real jeopardy. Dr. Palweni accepted under cross-examination, that, had he been faced with the observations of the medical student who originally saw TM at the time those observations were made, he would have taken immediate action of the type he was later to implement. Dr. Palweni also helpfully confirmed that the practice at Baragwanath was for a medical student on duty immediately to report observations of the nature made by the student who saw TM to a more senior physician. The MEC led no evidence to establish that this happened.

14 Faced with this yawning absence in the MEC's case, Ms. van Heerden could do little in argument to resist the obvious inference that those charged with TM's care had been negligent in failing to implement the course of treatment that TM's expert witness and Dr. Palweni himself accepted was both necessary and urgent.

15 Dr. Sabatta Tsotetsi, who gave expert evidence for the MEC, made the bald assertion in his evidence that there had been no negligence in the handling of

TM's case, but that proposition was as unhelpful as it was stark. Dr. Tsotetsi was unable to offer any basis on which a seven hour delay in treating TM could be characterised as anything other than negligent.

16 In any event, the gravamen of Dr. Tsotetsi's evidence was that, by the time TM reached Baragwanath, there was probably nothing to be done that could have saved TM's leg. That proposition is not relevant to the standard of care TM should have received. Nor is there any evidence that this was the view of any of TM's treating physicians at the time. Dr. Tsotetsi's opinion is, however, relevant to whether the failure to treat TM promptly caused the harm he suffered. I shall turn to that issue shortly.

17 In argument, Ms. van Heerden asked me to have regard to the fact that TM was first seen by a medical student, not by a fully qualified medical practitioner. But I do not see what difference that makes. There was no suggestion that the medical student overlooked any critical features of TM's condition. The criticism is rather that the medical student's observations were not acted upon. The suggestion might have been that staff and resources at Baragwanath were overstretched, and there was simply nothing that could have been done to attend to TM earlier than 11h30. But that case was neither pleaded, nor proved, nor argued. Nor would it have done anything to prevent an inference of negligence being drawn. It might have gone to wrongfulness, but that is not something I need to consider, since wrongfulness is conceded in the event that negligence is found.

18 In any event, Dr. Palweni confirmed in his evidence that, had he been called to attend to TM at 04h30, he would likely have been able to assess TM within about 15 minutes. That was his response time at 11h45.

19 It has, in my view, been established on a balance of probabilities, that the failure to take steps to address the occlusion of TM's popliteal artery in the seven and a quarter hours between 04h30 and 11h45 was negligent.

Causation

20 It is, of course, not enough that TM has demonstrated that he was treated negligently. He must also show that the amputation would not have been necessary but for the negligent treatment. I now address that question.

21 Injuries of the type TM sustained carry a 30% risk of amputation, even if they are immediately attended to. By their very nature, popliteal artery occlusions prevent blood flow to the lower limb and ultimately result in muscle death. This is confirmed in the joint minute of experts compiled by Professor Veller and Dr. Tsotetsi. The joint minute also confirms that any chance there was that TM's limb would be saved was progressively eliminated over the hours between the injury and the action Dr. Palweni took after 11h45 on 11 December 2016. The statistical likelihood of an amputation becoming necessary increases, eventually at an exponential rate, the longer it takes to ensure that someone with a popliteal artery occlusion is treated. The joint minute states that "in most circumstances" a "point of no return" beyond which "amputation is required" is reached within "in the region of 6 to 7 hours". This imprecise language is then supplemented by reference to an audit of injuries of this nature conducted at Groote Schuur Hospital in Cape Town. That audit

found that in the popliteal artery injuries which presented at that hospital during the period of the audit, there was a treatment window of around seven hours and forty minutes between injury and appropriate intervention, after which limb loss became more probable than not.

22 The question in this case is whether, on the probabilities, TM's limb would have been saved had appropriate action been taken shortly after 04h30, when TM was first seen at Baragwanath. The joint expert minute ruled out any underlying clinical factor that might have put TM at more or less than a normal risk of amputation. Pre-existing weaknesses in, or illnesses of, the circulatory system, for example, would obviously have heightened TM's risk of amputation. But it was agreed that there was nothing of that nature at work in TM's case.

23 Accordingly, the issue is entirely one of delay, particularly whether the seven-hour delay in treating TM at Baragwanath was likely to blame for the amputation.

24 It was here that the MEC's case was most vigorously pursued. It was argued that TM did not sustain his injury at 01h20, as he claimed. The injury was, Ms. van Heerden argued, most likely sustained at around 22h00 on 10 December 2016. TM did not immediately seek treatment because he was drunk at a party. Rather than seek help, he carried on enjoying himself until the pain became too great to ignore. It was this critical delay that caused the injury, not the delay that later transpired at Baragwanath. Accordingly, so it was argued, TM's negligent treatment made no difference to the ultimate clinical outcome of his case.

25 The strength of this argument boils down to two critical factual issues. The first is exactly when TM sustained his injury. The second is the objective state of TM's leg when he was first seen at Baragwanath.

When did TM sustain his injury?

26 The medical notes generated in the course of TM's treatment record in at least two places that his injury was sustained at 22h00 on 10 December 2016. If that is correct, TM's popliteal artery had already been occluded for six and a half hours by the time he was seen at Baragwanath. On the evidence supplied by the Groote Schuur audit referred to in the joint expert minute, that is within, but close to the end of, the treatment window available for injuries of this nature. On the rougher estimate supplied elsewhere in the joint minute, TM presented at Baragwanath at more or less exactly the point at which amputation became more likely than not.

27 The medical records in which an injury time of 22h00 was recorded were placed before me by agreement between the parties, on the basis that they are authentic. The truth of their contents was not, however, agreed. The first reference to 22h00 appears in the notes made by the paramedics who drove TM from Chiawelo to Baragwanath. There, it is recorded that TM suffered his injury at 22h00. The paramedic who made that note was not called to give evidence, so it was not possible to test its accuracy. The note is accordingly inadmissible to demonstrate the truth of its contents.

28 The second reference to a 22h00 injury time comes in Dr. Palweni's notes, which were made shortly after he first saw TM. Dr. Palweni says that the 22h00 time could only have come from TM himself, but he was unable to say,

categorically, that TM actually told him that the injury happened at 22h00. Entirely understandably, Dr. Palweni's evidence was a blend of unaided direct recollection, memories jogged from his notes, inferences drawn from notes he made at the time, and what he knows to be standard medical practice.

29 I mean no criticism of Dr. Palweni, but I do not think I can accept that TM told him that he sustained the injury at 22h00. Dr. Palweni's version, consistent with the care, frankness and fairness of the rest of his evidence, was too equivocal for that. There is an obvious difference between directly recalling that TM told him that the injury was sustained at 22h00, and inferring from his notes that TM must have done so. I think Dr. Palweni's evidence was of the second kind. If that is so, it is as likely as not that Dr. Palweni simply replicated the earlier note made by the paramedics at Chiawelo.

30 Still, that note may have been accurate, but for its inconsistency with TM's own evidence. Though he himself at times relied on medical records apparently inconsistent with his version, TM was adamant that the injury was sustained at around 01h15 or 01h20. He said that he had not had a drink for four hours by that point, having earlier consumed four "dumpies" (330ml bottles) of Castle Lite beer, between 19h00 and 21h00. This version was not challenged. Nor was it challenged that TM's injury caused him instant and excruciating pain. It is in my view improbable that four bottles of Castle Lite, the last of which was consumed an hour before the MEC claimed TM suffered his injury, could have so anaesthetised TM that he would have been capable of delaying over three hours before seeing a physician. Either TM was a great

deal drunker than he let on (which was not established), or TM's injury was sustained when he said it was.

31 I find, on a balance of probabilities, that TM's injury was sustained at around 01h20 on 11 December 2016.

The state of TM's limb on arrival at Baragwanath

32 Relying on the notes of the medical student who saw TM at Baragwanath, Professor Veller assessed TM's injury as being of the type-II (a) class on the Rutherford scale – a limb under threat, but capable of being saved with prompt treatment. This is an assessment with which Dr. Palweni could not disagree, and which is consistent with both his evidence and the medical student's notes. On arrival at Baragwanath, TM still had some mobility in his foot, and there was no suggestion that his foot had gone cold. By the time Dr, Palweni examined him, TM's foot was cold and TM had no sensation in his right foot.

33 Dr. Tsotetsi offered no meaningful evidence on this issue. He asserted simply that, had the injury been sustained at 22h00 on 11 December 2016, then it was statistically unlikely that the limb could be saved. That missed the point. Whatever the statistical probabilities, the inferences I draw must be based on the facts of this case, albeit informed by the statistical background which informed the expert opinions provided. Dr. Tsotetsi's evidence did not engage with the evidence of TM's condition as recorded at 04h30.

34 Taken together, I think that the evidence as to the time of TM's injury, and the evidence of the state of TM's leg at the point he arrived at Baragwanath, render the probabilities clear: had action been taken at or shortly after 04h30

to treat the popliteal artery occlusion, it is more likely than not that the amputation of TM's limb would have been avoided. In other words, it was negligence at Baragwanath, rather than any delay attributable to TM, that probably caused the loss of TM's limb.

Order

35 It follows from all this that TM has established that the loss of his limb was caused by the wrongful and negligent failure to promptly and appropriately treat his popliteal artery occlusion after his arrival at Baragwanath on 11 December 2016. The MEC is liable for TM's proven losses, to be determined at a later stage.

36 I shall make an order in the following terms –

36.1 The defendant is liable for 100 % of the plaintiff's agreed or proven damages, arising from the treatment and care that the plaintiff received at the Chris Hani Baragwanath Hospital from 11 December 2016 and the above knee amputation of the plaintiff's right leg on 27 December 2016, and the *sequalae* thereof.

36.2 Quantification of the plaintiff's claim for damages is separated from the balance of the issues in terms of Rule 33(4) of the Uniform Rules of Court and postponed *sine die*.

36.3 The defendant shall pay the plaintiff's agreed or taxed High Court costs of suit to date as between party and party, such costs to include –

36.3.1 The travelling costs of the plaintiff to and from all medico-legal appointments and consultations;

36.3.2 The reasonable costs of:

36.3.2.1 obtaining all expert:

36.3.2.1.1 medico-legal reports and any addendums thereto (where applicable),

36.3.2.1.2 joint minutes and any addendums thereto (where applicable),

36.3.2.2 expert reservation and/or qualification and/or preparation costs/fees of Professor Martin Georg Veller (Vascular Surgeon) who gave expert evidence on 26 April 2023;

36.3.3 Costs of counsel, including the consultations and preparation for the trial;

36.3.4 The costs of the preparation and perusal of the trial bundles and the uploading thereof to CaseLines.

36.4 The plaintiff shall, if the costs are not agreed, serve the notice of taxation on the defendant's attorneys of record with no less than 20 days' notice.

36.5 The costs shall be paid in accordance with the provisions of Section 3(3)(a)(i) of the State Liability Act 20 of 1957 as amended, failing which interest will accrue on the amounts payable from the due date (agreement or taxation) at the applicable *morae* interest rate until date of final payment.

S D J WILSON
Judge of the High Court

HEARD ON: 25, 26 and 28 April 2023

DECIDED ON: 9 May 2023

For the Plaintiff:	P Uys Instructed by Logan Naidoo Attorneys, Houghton
For the Defendant:	K van Heerden Instructed by the State Attorney