IN THE HIGH COURT OF SOUTH AFRICA **REPORTABLE**

(EASTERN CAPE DIVISION, GQEBERHA)

Case No: 2958/2016

In the matter between:

JEANINE CARLA WILLIAMS	**PLAINTIFF**
and	
THE MEMBER OF THE EXECUTIVE COUNCIL, DEPARTMENT OF HEALTH, EASTERN CAPE	**FIRST DEFENDANT**
THE MEDICAL SUPERINTENDENT, LIVINGSTONE HOSPITAL, GQEBERHA	**SECOND DEFENDANT**

JUDGMENT

BANDS AJ:

[1] The plaintiff claims compensation against the provincial health department and the medical superintendent arising out of the tragic and untimely death of

her husband, George Williams ("*the deceased*"). It is not in dispute that the deceased died as a consequence of injuries sustained by him following a fall from the fifth floor of the Livingstone Hospital.

[2] Prior to the commencement of the matter on the first day of trial, the defendants' filed their amended plea in response to the plaintiff's amended particulars of claim.[1] Notwithstanding the inclusion of a special plea of non-compliance with section 3 of Act 40 of 2002 in the defendants' amended plea, this was no longer a live issue between the parties, same having been withdrawn by the defendants, as recorded in a minute of a pretrial, dated 26 January 2022. Accordingly, I need not say more in respect thereof.

[3] At the commencement of the proceedings, and at the request of the parties, I issued an order in accordance with Uniform Rule 33(4) separating the issue of the defendants' liability from the remaining issues in dispute.[2] The effect of such order is that the issues of negligence and causality would be tried separately from, and prior to, the remaining issues in the action. Implicit therein, particularly in light of the defendants' admission that the treating medical personnel were bound to employ reasonable skill and care in the

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[1] Which had been filed once week prior.

[2] "*1. The issues of merits (liability) as defined in paragraphs 1 to 10 of the plaintiff's further amended particulars of claim, read together with the corresponding paragraphs thereto in the defendants' further amended plea to the plaintiff's further amended particulars of claim is hereby separated from the remaining issues.*

2. The remaining issues are hereby postponed sine die for the separate adjudication in due course, if necessary."

treatment of the deceased,[3] is that should I find causal negligence on behalf of the treating medical personnel, wrongfulness would be established and liability on behalf of the Defendants would follow.

[4] Accordingly, this judgment is confined to a determination of the aforesaid issues.

[5] The parties further handed up a minute of a pre-trial,[4] same having been conducted on the morning of the first day of trial, in which the following admissions were recorded: (i) that the deceased died as a result of injuries sustained by falling from the fifth floor of Livingstone Hospital; (ii) that the hospital records were compiled by the defendants' employees acting in the course and scope of their employment with the defendants at the Livingstone Hospital; and (iii) that the hospital records are what they purport to be, without admitting the correctness thereof. I return to the latter aspect and the impact thereof in the context of the present matter, if any, later.

[6] The plaintiff pleads that on or about 3 October 2013, the deceased presented himself to the first and/or second defendant's employees at the Livingstone Hospital, there and then acting within the course and scope of their employment, for treatment associated with his apparent psychosis; visual disturbances; confusion; hallucinations; sleeplessness and restlessness.

[3] See paragraph 12 of the defendants' plea "*The Defendants only admit that the deceased was entitled to treatment by its functionaries in the exercise of reasonable skill and care in their field of expertise."*

[4] Entitled "*Further rule 37 minute dated 7 February 2022*" and dated 7 February 2022.

During the course of 3 and 4 October 2013, it was established by the employees that the deceased, who had a history of alcohol abuse, displayed irrational behaviour and that he suffered from chronic alcoholic liver disease and demonstrated clear signs of severe alcohol withdrawal, a condition known as delirium tremens, and secondary schizophrenia. On a careful analysis of the defendants' plea, the aforesaid was by and large admitted by the defendants. I interpose at this point to mention that delirium tremens is a severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes.

[7] The legal duty on the treating medical and nursing personnel, as contended for by the plaintiff, is that the said personnel were under a legal duty to provide the deceased with adequate and timeous medical treatment with such professional skill and care as may reasonably be expected of reasonable medical and nursing personnel in similar circumstances, failing which, it was reasonably foreseeable that the deceased would wander around the hospital in a state of psychosis and confusion, whilst having visual and auditory hallucinations and alcohol withdrawal delirium. The plaintiff further pleads that (i) in the event of a breach of such legal duty, it was reasonably foreseeable that the deceased would sustain an injury or injuries, with resultant harm; and (ii) a *diligence paterfamilias* in the position of the treating medical personnel would have taken reasonable steps to guard against any possible harm to the deceased, which they wrongfully and negligently failed to do.

[8] The plaintiff, in alleging the treating medical and nursing personnel's wrongful and negligent breach of the said legal duty, placed reliance on various alleged omissions to found negligence, which were pleaded at paragraph 7 of the plaintiff's further amended particulars of claim, as follows:

"7.1. By failing to secure the deceased to a bed or accommodating him in a specialised room close to a nursing station in order to restrict his movements and in order to carefully monitor his condition;

7.2. By failing to properly sedate the deceased in order to restrict his movements and adequately treat his condition;

7.3. By failing to properly monitor the movements of the deceased after admission;

7.4. By failing to allocate the staff to take all reasonable measures to ensure that the deceased does not injure others and/or himself;

7.5. By allowing the deceased to wander around the premises and supervised;

7.6. By failing to provide a safe environment to the deceased, especially in the light of his inadequate response to drugs administered to him;

7.7. By failing to treat his condition properly and with the necessary skill required under the circumstances;

7.8. By failing to consult a psychiatrist to urgently treat the deceased and control the sequelae of his condition;

7.9. By failing to exercise the necessary care, skill and diligence that could be expected of reasonable medical and nursing practitioners in the position of the employees."

[9] The defendants plead, *inter alia* that following the deceased's admission to the ward from casualty and diagnosis of a first episode of psychosis; delirium

tremens associated with severe alcohol withdrawal symptoms; Wernicke-Korsakoff syndrome; schizophrenia; or substance abuse, he: (i) was treated with sedatives, such as Valium, Haloperidol and Revotril; (ii) was close to a nursing station, in an enclosed locked ward, and his condition was monitored; (iii) was properly sedated; and (iv) had shown no violent inclinations or suicidal ideations.

[10] The defendants further plead that the treating medical and nursing personnel had taken reasonable steps at all material times, and accordingly deny any such failures as pleaded by the plaintiff. Insofar as the plaintiff places reliance on the failure to consult a psychiatrist to urgently treat the deceased, the defendants plead that patients are usually seen by physicians first, in order to exclude organic causes for confusion, prior to arranging for psychiatrist.

[11] The only oral evidence tendered at trial was that of the parties' respective expert witnesses. Dr Candice Harris "(*Dr Harris*"), a qualified professional nurse and general practitioner, testified on behalf of the plaintiff. Dr Michelle Walsh ("*Dr Walsh*"), a general surgeon, was in turn called to give evidence on behalf of the defendants. Only the expert report of Dr Harris was placed into evidence. The expertise of Dr Harris and Dr Walsh in their respective fields was not placed in dispute.

[12] The evidence on behalf of both experts proceeded from the premise that the entries contained in the medical records, upon which their respective opinions were based, and which to a large extent were transcribed and formed part of

Dr Harris' report, were admitted and constituted a factual recordal of *inter alia* (i) the observations made by the treating medical personnel; (ii) the treatment received by the plaintiff; and (iii) the events as they unfolded from the time of the deceased's admission to that of his death. Moreover, the correctness of the content of the medical records was not placed in dispute by either party in their respective pleadings nor during the evidence at trial, such content having been put to the respective witnesses as fact.

[13] At this juncture, it is apposite to record that, save for the defendants' refusal to admit the correctness of the content of the medical records in the minute of the pretrial, dated 7 February 2022, the parties during the conduct of the proceedings were *ad idem* in respect of the correctness thereof. The record is replete with evidence of the aforesaid, inclusive of concessions in this regard, on behalf of the defendants, as follows:

MR DALA: Now doctor, the plaintiff was admitted on the evening of 3 October 2013 to casualty; that seems to be common cause between the parties.
DR HARRIS: Yes.
MR DALA: And it was found that he had auditory and visual hallucinations; is that correct?
DR HARRIS: That is correct.
MR DALA: And that the plaintiff reported or when we say the plaintiff, I apologise, Mr. Williams, the deceased; he reported that his visual and auditory hallucinations have been going on for about six months.
DR HARRIS: That appears to be what is indicated in the records.
MR DALA: Yes. Notwithstanding that, prior to being admitted he suffered from hallucinations and sleeplessness as this has become more pronounced over four days before he was admitted."[5]

[5] Record of proceedings p 44 at lines 2 to 18.

[14] In respect of the correctness of the recordal of the treatment received by the plaintiff, the following is of import:

"MR DALA: In the execution of their duty, as we know, I am not going to repeat it because you gave the evidence and that evidence seems to be common cause of the treatment that he was given…"[6]

[15] With reference to the records, it is *inter alia* recorded:

"MR DALA: Yes, also from the records, it says that he was monitored, he was walking around but he was monitored by the nurses and they followed him as well."[7]

[16] The following exchange appears later in the record:

"MR DALA: And then let's take it further; it is at that stage that a note is also made that when they were call it watching him that their fear that they had of him was to be assaulted; is that correct?
DR HARRIS: They were afraid that they would be assaulted.
MR DALA: Yes.
DR HARRIS: Well, they wrote that they were afraid to be assaulted.
MR DALA: Yes, yes, yes, yes, yes, there is no dispute about that, let us just deal with it now. Patients who suffer like this, they are prone to be aggressive."[8]

[17] It was further recorded as follows:

"*MR DALA: And that was at the nurses' station where he went through. And I would like to also further deal with you that notwithstanding that there are many common cause facts in the case regarding the treatment and when Mr. Williams came to the hospital and all those procedural aspects that I'm going to argue before this honorable*

[6] Record of proceedings p 49 at lines 7 to 10.

[7] Record of proceedings p 51 at lines 12 to 14.

[8] Record of proceedings p 52 at lines 3 to 13.

court that notwithstanding your opinion, your opinion should not be accepted on the facts of this matter and that the court should prefer the opinion of Dr Walsh in this matter."[9]

[18] It is trite that it is the court's task to determine issues of fact and not the task of an expert witness,[10] whose function cannot usurp that of the judicial officer.[11] The key function of an expert witness is to guide the court in its decision-making process on questions, which fall within the ambit of the expert's specialised field of knowledge.[12]

[19] Van Zyl DJP (Schoeman J and Noncembu concurring) in *The Member of the Executive Council for Health, Eastern Cape v MM obo ELM* recently had an occasion to consider and restate the distinction between opinion evidence and the evidence of fact, upon which such opinion is based, same being relevant to the present proceedings. The court, at paragraphs [12] and [13] stated as follows:

"[12] … Expert evidence is by its nature an opinion premised on the drawing of an inference from established facts. In the present context it amounts in essence to a statement that established medical opinion, as the expert witness interprets it, dictates a particular result under an assumed set of facts. Accordingly, by reason of its very nature, expert opinion must have a factual basis. The facts, which are usually found in the primary evidence, provide the necessary link with the opinion, which in

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[9] *The Member of the Executive Council for Health, Eastern Cape v MM obo ELM*, judgment of the full bench, Eastern Cape Local Division, Bhisho, case number CA&R 8/2021, by Van Zyl DJP (Schoeman J and Noncembu AJ concurring), at para 10.

[10] Record of proceedings p 52 at lines 3 to 13.

[11] *Twine and Another v Naidoo and Another* [2018] 1 All SA 297 (GJ) at para 18k.

[12] *The Member of the Executive Council for Health, Eastern Cape v MM obo ELM* (*supra*) at para11; *Van Wyk v Lewis* 1924 AD 438 at 477; S v Gouws 1967 (4) SA 527 € at 528D-F.

turn cannot be reached without the application of expertise. If the expert witness is unable to give direct evidence with regard to the existence of a fact, the opinion is based on a fact assumed to be true for the purpose of giving the opinion, and it must be proved at the trial to give the opinion any probative value. ***"In the law of evidence "opinion" means any inference from observed facts, and the law on the subject derives from a general rule that witnesses must speak only to that which was directly observed by them."***[13] *and* ***"An expert's opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some other competent witness."***[14]

[13] It follows that, unless the facts on which an expert witness expresses an opinion on are not in dispute, they are nothing more than factual assumptions which is inadmissible hearsay unless proved by admissible evidence.[15] *Subject to the qualification that in any given matter, all or some of the facts may be common cause, in that its existence was pertinently agreed upon by the litigants, or it was not placed in issue on the pleadings, it is the duty of the court as the final arbiter of fact, to decide if the factual basis for an opinion had been established.* ***"expert assistance does not extend to supplanting the court as the decision-maker. The fact finding judge cannot delegate the decision-making role to the expert."***[16]

[Own underlining].

[20] In light of what I have stated herein above, I am satisfied that the factual basis upon which the respective expert witnesses expressed their opinions, is not in dispute between the parties. As stated, not only was the trial presented on this basis on behalf of both parties, but in addition, the respective counsel

[13] Cross on Evidence 7th ed at page 489. See also Cross on Evidence 7th Ed at page 489. See also Schmidt and Rademeyer Law of Evidence at page 17 – 4 and *McGregor and Another v MEC for Health Western Cape* (1258/2018) [2020] ZASCA 89 (31 July 2020) (McGregor) at para [21].

[14] *Menday v Protea Assurance Co Ltd* 1976 (1) SA 565 (E) at 569 and *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft Für Schädlingsbekämpfung Mbh* 1976 (3) SA 352 (A) (Coopers) at 370 F – G.

[15] *Price Waterhouse Coopers Inc v National Potato Co-op Ltd* [2015] 2 All SA 403 (SCA) at para [99].

[16] *Kennedy v Cordia (Services) LLP* [2016] 1 WLR 597 (SC) at para 49.

adopted this approach in argument, following the finalisation of the evidence. The submission, belatedly raised in the final stages of argument on behalf of the defendants, that the content of the hospital records had not been admitted was not only at odds with the stance adopted in the conduct of the trial and earlier during argument but was no doubt due to the shortcomings in the evidence on behalf of the defendants and cannot hold water. I return to these shortcomings in due course.

[21] Several types of conflicts in expert evidence may present themselves at trial, *inter alia* such as: (i) a conflict in the assumed facts upon which the respective expert witnesses base their opinions; (ii) competing theories of a scientific nature; (iii) a conflict in the analysis of the established and/or common cause facts; and (iv) a conflict in the accepted standard of care/treatment of a medical practitioner in certain circumstances. On an analysis of the evidence, the conflict arising in the present instance, falls within the latter two categories.

[22] In this regard, Van Zyl DJP (Majiki J and Malusi J concurring) in *JA obo DMA v The Member of Executive Council for Health, Eastern Cape*,[17] stated as follows:

"*[12] …, a conflict in the expert opinion may lie in the analysis of the established facts and the inferences drawn therefrom by opposing expert witnesses. A proper evaluation of the evidence in this context focuses primarily on "**the process of reasoning which led to the conclusion, including the premise from which the reasoning proceeds…"** The reason for interrogating the underlying premise of expert opinion lies in its nature. In essence it amounts, as in the present context, to*

[17] [2022] 2 All SA 112 (ECB); 2022 (3) SA 475 (ECB).

*a statement that established medical opinion, as the expert witness interprets it, dictates a particular result under an assumed set of facts. This requires an assessment of the rationality and internal consistency of the evidence of each of the expert witnesses. "**The cogency of an expert opinion depends on its consistency with proven facts and on the reasoning by which the conclusion is reached."** The source for the evaluation of this evidence for its cogency and reliability are (i) the reasons that have been provided by the expert for the position adopted by him/her; (ii) whether that reasoning has a logical basis when measured against the established facts; and (iii) the probabilities raised on the facts of the matter. It means that the opinion must be logical in its own context, that is, it must accord with, and be consistent with all the established facts, and must not postulate facts which have not been proved.*

[13] The inferences drawn from the facts must be sound. The internal logic of the opinion must be consistent, and the reasoning adopted in arriving at the conclusion in question must accord with what the accepted standards of methodology are in the relevant discipline. The reasoning will be illogical or irrational and consequently unreliable, if (i) it is based on a misinterpretation of the facts; (ii) it is speculative, or internally contradictory or inconsistent to be unreliable; (iii) if the opinion is based on a standard of conduct that is higher or lower than what has been found to be the acceptable standard; (iv) if the methodology employed by the expert witness is flawed…

*[14] Other considerations relevant in this context are (i) the qualifications and the experience of the expert witnesses with regard to the issue he or she is asked to express an opinion on; (ii) support by authoritative, peer-reviewed literature; (iii) the measure of equivocality with which the opinion is expressed; (iv) the quality of the investigation done by the expert; (v) and the presence or absence of impartiality or a lack of objectivity. What is ultimately required is a critical evaluation of the reasoning on which the opinion is based, rather than considerations of credibility. Should it not be possible to resolve a conflict in the expert opinion presented to the court in this manner, that is, when the two opposing opinions are both found to be sound and reasonable, the position of the overall burden of proof will inevitably determine which party must fail. It is worth emphasising that the onus as a determining factor "**can only arise if the tribunal finds the evidence pro and con so evenly balanced that it can come to no such conclusion. Then the onus will determine the matter. But if the tribunal, after hearing and weighing the evidence, comes to a***

determinate conclusion, the onus has nothing to do with it, and need not be further considered."

[15] …

[16] … a conflict may also arise in the context of what the accepted standard of conduct of a medical professional is in certain circumstances. Typically medical negligence cases deal with the situation where an injury is alleged to be in complete discord with the recognised therapeutic objective and techniques of the operation or treatment involved. Expert opinion, in this context, is aimed at determining whether the conduct of a professional person in a particular field accords with what is regarded as sound practice in that field. Again, the method adopted is to evaluate opinion evidence with the view of establishing the extent to which the opinions advanced are founded on logical reasoning."

[23] Put simply, the opinion advanced by an expert witness must be properly motivated. Where the court is presented with competing opinions, it is incumbent upon it to carefully consider the underlying reasoning of the respective experts to enable it to choose which of the opinions to adopt, if any, and to what extent. In doing so, the court, after a careful evaluation of the expert testimony, is required to justify its preference for one opinion over the other.

[24] I now turn to the salient common cause facts emerging from the evidence advanced at trial.

[25] The deceased, a known alcoholic, with his last alcohol use being approximately 4 days prior to admission, was admitted to casualty at the Livingstone Hospital on 3 October 2013 at 20h50. He complained of visual

disturbance; dizziness; hallucinations and sleeplessness. The deceased was ultimately admitted for further management of what appeared to be acute psychosis and possible delirium tremens.

[26] On 4 October 2013, the deceased was administered 5mg of Diazepam (more commonly known as Valium), an anxiolytic, at 12h45 by intravenous injection, with no effect. By 15h10 on 4 October 2013, the deceased appeared confused; was up and about; and was still restless. Notwithstanding the aforesaid, the nursing staff failed to inform the doctor on duty that the Diazepam, administered at 12h45, had not taken effect. At approximately 17h30, the deceased was taken up to the ward, still restless and confused. The records note that the deceased was walking up and down the ward. He was thereafter administered a further 5mg of oral Diazepam at 18h00, with no effect. 2.5mg of oral Haloperidol, an anti-psychotic agent, was administered at 18h00, once again with no effect. The deceased remained confused; disorientated; and was seen to be pacing in the ward. A further dose of 2.5mg of oral Haloperidol was administered at 22h00. An entry in the nursing progress report, made at 22h30, records as follows:

"*Patient was so (illegible word) in ward hearing people that are talking at the back door. He first took the drip off, going up and down in ward (illegible word) was given Haloperidol ½ tablet orally and Valium 5mg with no effect. He went to nurses station, we followed him but we were so scared to be assaulted by him (illegible) we heard breaking of the door where he (illegible) door in nurses tea broke it and he went through that door and he fell down to ground floor. Securities (sic) informed, responded very quick and also (illegible) where they send (sic) patient to ICU.*"

[27] It is common cause that the deceased broke the outside entrance glass door of the nurse's tearoom and fell from the fifth floor to the ground floor. As a consequence of the deceased's fall, he suffered polytrauma with hypovolemic shock, and ultimately died at 00h15 on 5 October 2013.

[28] Whilst 1mg of intravenous Rivitrol was prescribed, same was never administered. It is not clear from the records as to what time the said prescription was written out, and why it was not administered. It would appear, however, that it was prescribed at some point after the nurses' shift change on 4 October 2013. An incident report of professional nurse LN Ntlangwini reflects that she contacted the doctor on duty, Dr Groves, and explained the deceased's condition to her. Dr Groves advised that she was unable to attend upon the ward but ordered Rivotril 1mg injection be given to the deceased intravenously.

[29] Dr Harris testified that the delirium tremens is a medical emergency and that immediate management of the condition is necessary. She further testified that given that the deceased, on admission was said to have delirium tremens, it was reasonable to expect the medical staff to know that the deceased would have been experiencing *inter alia* tremors; anxiety; insomnia; visual and auditory hallucinations; confusion; and disorientation.

[30] The published medical guidelines for the management of delirium tremens, on a patient's admission, according to Dr Harris, requires a patient being admitted for inpatient assessment and treatment. A patient suffering from delirium

tremens would not be allowed to do so within the community or a community health clinic. Once admitted, any medical conditions would need to be ruled out by way of vital sign monitoring, blood tests, and general assessments. The next step of care would be to provide supportive care by the monitoring of vital signs frequently. This is important as the condition of a patient undergoing delirium tremens can change and deteriorate fairly quickly. She further stressed the importance of reorientation as to time, place and person, of a patient with delirium tremens as they can suffer from hallucinations; be delusional; confused; and disoriented. A nurse's role with regard to orientation as to time, place and person would be to say to the patient, approximately every 15 to 30 minutes "*hello Mr. Williams, I am sister Harris, I am here to take care of you. You are at Livingstone hospital casualty. It is now 22h00. I'm here to assist you; check your vital signs; and check in on you.*" Such reorientation process needs to occur recurrently to orientate the patient so that he or she knows where he or she is; who is attending to him or her; and what the person attending to him or her is doing; and why he or she is in the hospital.

[31] Dr Harris testified that the deceased was a complicated patient in that not only did he have delirium tremens, which would have caused confusion and disorientation, but he also had a longstanding history of what seemed to be progressively developing psychosis with insomnia; common confusion; and hallucinations. Accordingly, his problem regarding orientation as to who he is; where he is; and what was going on around him was all that more profound. In the event of him becoming disoriented, Dr Harris testified that he might panic; become afraid; become aggressive; might fight; may hear voices, not

knowing whether they are real or not; might be a threat to the medical and nursing staff, to other patients and/or to himself. It is for this reason, she opined, that orientation was critical in the deceased's case. There is no evidence that orientation as to time, place and person ever took place in the deceased's case. Dr Walsh testified that patients suffering from delirium tremens can be unpredictable, and accordingly patients presenting with a confused state need to be managed with caution for the sake of the medical personnel; for the sake of the other patients; and the sake of the patient themselves.

[32] Doctor Harris further stressed the need to administer medication to control agitation and promote sleep in patients undergoing delirium tremens. This was more so, in the case of the deceased, in that not only did he have delirium tremens but he had a tentative diagnosis of schizophrenia, and accordingly he had two factors that would have made him agitated and restless. She further testified that the medication is prescribed primarily to control the agitation; restlessness; pacing; and disorientation and would hopefully have the result of calming the patient down enough to lie down or sleep. The role of the nurse would be to check the prescription; administer the medication as prescribed; and monitor the patient's response to the medication to ensure that the patient had the expected response thereto. In the event of the patient not responding, as in the case of the deceased, it is the duty of the nurse to inform the doctor of this fact.

[33] Doctor Harris, once again referring to the published guidelines, testified that the medication given for a patient with delirium tremens should be adequate enough to control agitation and promote sleep. Primary pharmacology would be utilised, such as the administering of an anxiolytic such as Valium. The prescribed dose should be high enough to achieve a light dozing but still awake, arousable state, while monitoring the patient's vital signs until the delirium tremens abates, in approximately three days. Dr Walsh on the other hand, with no reference to the published guidelines, testified that the sedation prescribed, is usually based on what the assessing doctor thinks will have the desired effect, which would be to calm the patient (to the extent that they would sit calmly in a chair), based on their assessment of the patient in question. It is common cause that neither such desired state was ever reached in the case of the deceased.

[34] Insofar as treatment is concerned, Dr Harris explained that on day one, the dosage amount needed to be sufficient to control the target symptoms, same being Diazepam at a dose of 15 milligrams. An example of the accepted, published, treatment regimens include on the one hand, the administration of 10 to 20mgs, intravenously or orally, every one to four hours, as needed. A further example would be to begin treatment with 5mg intravenously. If needed, repeat the same dose 5 minutes later. If needed thereafter, administer 10mg intravenously, 10 minutes later. If needed, administer 10mg again, 10 minutes later. This dosage can then be increased to 20mgs, 10 minutes later, should same be needed. Doses of 5 to 20mg are thereafter administered as needed.

[35] What is clear from the aforesaid regimens is that it involves a continuous titration of medication to ensure that the target symptoms are controlled. The treatment regimen administered to the deceased, in no way mirrored that of the acceptable regimens as per the published guidelines and fell woefully short thereof. In dealing with the aspect of titration in her evidence in chief, Dr Walsh testified that being in hospital allows a patient to be monitored to enable further interventions to be made, in that the dosage and its frequency can be increased. During cross-examination, she at first conceded that it was fair to say that the deceased *could* have received more sedation, administered at shorter intervals, such as every thirty minutes; and thereafter conceded that the deceased's state *required* stronger sedation in the circumstances. Lastly, and more significantly, Dr Walsh conceded that the medical records contain no evidence that a proper titration process in respect of the deceased's medication took place.

[36] In the case of the deceased, Dr Harris testified that the Diazepam administered at 12h45, ought to have taken effect within 10 to 30 minutes, in that it ought to have calmed the deceased within such timeframe. In the event that it did not, the nursing staff ought to have contacted the doctor on duty in order for the doctor to prescribe a higher dosage or change the treatment regime, which was not done in this instance. Not only was the deceased under-sedated, but there is no evidence that the initial dose, which had no effect, was ever increased as per the published guidelines, despite multiple entries in the hospital records that the deceased remained confused; disoriented; restless; and was walking up and down the passages, such

symptoms worsening over time, to the extent that he had become so agitated that the nursing staff feared that he would assault them by the time that the deceased fell from the fifth floor. Dr Walsh's evidence, was consistent with the fact that the desired effect ought to be reached within 30 minutes of dozing and that the treatment administered to the deceased, did not appear to have the desired effect in that he remained restless and continued to pace up and down the ward. Having said that, in one instance, Dr Walsh testified the initial dose of Diazepam, administered to the deceased at 12h45, perhaps had some sort of effect, which was thereafter wearing off around 15h00/16h00, this being in conflict with the accepted facts.

[37] Dr Harris opined that the doctors failed to recognise the seriousness of the deceased's condition. She testified that he had severe alcohol withdrawal; delirium tremens; and a new onset of psychosis. The medical personnel failed to recognise the existence of a medical emergency and to act with the urgency that was required of them in the circumstances. Moreover, the nurses failed to communicate with the doctors to inform them of how serious the deceased's condition was thereby ensuring that they obtained the correct prescriptions and treatment. She opined that there was no evidence to suggest that the deceased was properly sedated in order to control his psychotic symptoms.

[38] The vast majority of the issues dealt with under cross-examination of Dr Harris pertained to the need for the running of tests to exclude various medical conditions. Whilst this was readily conceded by Dr Harris, it in no way accounted for the fact that running parallel thereto, the deceased, having

being diagnosed with possible delirium tremens, already on admission on 3 October 2013, ought to have been receiving adequate treatment therefor. Significantly, Dr Harris' evidence regarding the accepted treatment regimens, and how the treatment of the deceased fell short thereof, was not challenged during cross-examination.

[39] The evidence advanced by Dr Walsh merely touched on the material issues at hand insofar as her view departed from that of Dr Harris, with time spent on other ancillary issues such as the tests administered to rule out other possible conditions and whether or not she was of the opinion that the deceased ought to have been taken to the ICU ward. In short, it consisted of little more than a restatement of a number of the common cause facts; the general principles in respect of delirium tremens (which supported the plaintiff's case); and the treatment regime administered to the deceased. The highwater mark of her evidence insofar as the treatment regimen of the deceased is concerned was that it was not that the hospital was doing nothing, they were doing something, reference being made to the documented treatment which was received by the deceased. This of course is not the test for negligence.

[40] Negligence will be established if a reasonable person would foresee the reasonable possibility of his or her conduct injuring another and causing him or her patrimonial loss, and if so, whether the reasonable person would have taken reasonable steps to guard against the occurrence of harm. The test,

which has often been restated, was formulated as follows by Holmes JA in *Kruger v Coetzee*:[18]

" For the purposes of liability culpa arises if –

(a) a diligens paterfamilias in the position of the defendant –

(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and

(ii) would take reasonable steps to guard against such occurrence; and patrimonial loss; and

(b) the defendant failed to take such steps."

[41] It is trite that the specific qualities of the defendant in any given matter, which he or she possessed at the relevant time, must of necessity be considered in the assessment of his or her conduct against the requirements for negligence. Whilst a person possessed of specialised skills is not required to display the highest possible degree of professional skill, he or she will be held to the general level of skill and diligence possessed and exercised at the time by the members of the profession to which the person belongs.[19] Accordingly, in the present instance, negligence will follow in the event of a finding that the deceased's persistent condition and state, which was inadequately treated, resulted in his injury and subsequent death, was reasonably foreseeable; and that the medical and nursing personnel failed to provide the reasonable level of skill and care as could be expected to be provided by reasonable medical and nursing personnel in similar circumstances.

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[18] 1966 (2) SA 428 (A) at 430 E-G.

[19] Van Wyk v Lewis 1924 AD 438 at 444.

[42] I am mindful of the fact that in cases such as the present, one must guard against the "*insidious subconscious influence of ex post facto knowledge*", and bear in mind that negligence is not established by merely showing that the occurrence happened, or on the other hand, showing how it could have been prevented, once it has occurred.[20]

[43] In the present instance, the onus rests on the plaintiff to establish the presence of negligence, as pleaded.

[44] If regard is had to the conflicting views of the expert witnesses herein, I am satisfied that the opinion evidence of Dr Harris was well reasoned; logical; and consistent with the common cause facts of the present matter. Not only was she sufficiently qualified with regards to the issues which she was asked to determine, but her opinion in respect of the treatment which ought to have been advanced to the deceased, was clear and definite and is supported by the published guidelines in respect thereof.

[45] The conclusion drawn by Dr Walsh that the steps taken by the medical and nursing personnel were sufficient in the circumstances, is not only illogical, but in no way accords with the accepted and published guidelines for the treatment of deliriums tremens; the accepted facts of the present matter; and the numerous concessions made by her, all of which accords with the plaintiff's case.

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[20] S v Bochris Investments (Pty) Ltd and Another 1988 (1) SA 861 (A) at 866I-867B.
Meyers v MEC, Department of Health, Eastern Cape (1010/2019) [2020] ZASCA 3 (4 March 2020).

[46] The evidence on behalf of Dr Harris must be accepted over that of Dr Walsh. In light of the acceptance of Dr Harris' evidence, the conduct of the medical and nursing personnel in the present instance, fell far short of what is regarded as sound practice in these respective fields.

[47] I am accordingly satisfied that the plaintiff has proven negligence on behalf of the medical and nursing personnel in that they failed to properly sedate the deceased in order to restrict his movements and adequately treat his condition; by failing to treat his condition properly and with the necessary skill required under the circumstances; and by failing to exercise the necessary care, skill and diligence that could be expected of reasonable medical and nursing personnel in the position of the employees.

[48] As set out in *NTH v MEC for Health, Gauteng Province*:[21]

"[15] A successful delictual claim entails proof of a causal link between the Defendant's actions or omissions, on the one hand, and the harm suffered on the other hand (Oppelt (supra) at paragraph 35). This is in accord with the well-established and accepted "but for" test for factual causality (International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA 680 (AD) at 700F-I; Simon & Co (Pty) Ltd v Barclays National Bank Ltd 1984 (2) SA 888 (AD) at 915B-H; Minister of Police v Skosana 1977 (1) SA 31 (AD) at 35C-F).

[16] In the matter of Chapelkin & Another v Mini (103/2015) [2016] ZASCA 105 (14 July 2016), at paragraph 49, the Supreme Court of Appeal cited, with approval, an earlier decision of that court, namely ZA v Smith 2015 (4) SA 574 (SCA),where, at paragraph 30, it was held:-

[21] (57301/15) [2021] ZAGPPHC 208 (8 February 2021)

> *"What [the but-for test] essentially lays down is the enquiry – in the case of an omission – as to whether, but for the defendant's wrongful and negligent failure to take reasonable steps, the plaintiff's loss would not have ensued. In this regard this court has said on more than one occasion that the application of the "but-for test" 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. In applying this common sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish the causal link with certainty (see eg Minister of Safety and Security v Van Duivenboden (SCA)2002 (6)SA431(SCA);([2002] 3 All SA 741; [2002] ZASCA 79) para 25; Minister of Finance & others v Gore NO 2007 (1) SA 111 (SCA) ([2007] 1 All SA 309; [2006] ZASCA 98) para 33. See also Lee v Minister of Correctional Services 2013 (2) SA 144 (CC) (2013 (2) BCLR 129; [2012] ZACC 30) para 41.)"*

[49] Accordingly, what remains to be determined is would the deceased have died, but for the negligence on behalf of the medical and nursing personnel. Had the deceased's medication been titrated as aforesaid, it cannot be gainsaid that he would have been reduced to a calm and lightly dozing state. This would have enabled the medical and nursing personnel to monitor his vital signs and his condition appropriately until such time that the delirium tremens had abated. He would not have been pacing up and down the ward in a confused; restless; and disoriented state. Had this state of affairs been subverted, the deceased, on a balance of probabilities, would not have fallen from the fifth floor of the Livingstone Hospital, resulting in his untimely death.

[50] In the premises, the following order shall issue:

1. It is declared that the first and second defendants are liable, jointly and severally, for such damages as might be agreed upon or proved in consequence of the event that is the subject of this claim.

2. The first and second defendants are ordered to pay the costs, jointly and severally, of the hearing of the issues already determined in this judgment, such costs to include the qualifying fees of Dr Candice Harris.

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I BANDS

ACTING JUDGE OF THE HIGH COURT

Heard:	7 and 8 February 2022
Delivered:	1 September 2022
Appearances:	
For the Plaintiff:	Adv Le Roux
Instructed by:	Lessing, Heyns & Van Der Bank Attorneys Inc.
	7 Bird Street, Central.
For the Defendant	Adv Dala
Instructed by:	State Attorney
	29 Western Road, Central