IN THE HIGH COURT OF SOUTH AFRICA
WESTERN CAPE DIVISION, CAPE TOWN

CASE NO: 116612021

In the matter between

A L S[…] **APPLICANT**

And

MEC FOR HEALTH, WESTERN CAPE **RESPONDENT**

Date of hearing: **13 & 14 November 2024 with closing argument being presented on 4 December 2024 and the last set of supplementary heads of argument being filed on 20 December 2024**

Date of judgment: **Judgment delivered electronically on 6 February 2025**

JUDGMENT

[1] In this matter, the plaintiff claims damages arising from the alleged negligent treatment administered to him at the Mitchells Plain District Hospital ("MPH") in and during January 2020. The issues regarding the defendant's liability, including the alleged grounds of negligence and causation, have been separated in terms of Rule 33(4), and the trial proceeded only in respect of the issues of negligence and causality.

INTRODUCTION

[2] '…So if you do the right things and things don't go right, you're still justified in what you've done, but you've done all the right things first, … Know exactly what you're doing, what you're supposed to be doing. You do it. Then medicine is not an exact science; and in particular in trauma it is not an exact science. The type of injuries, particularly in trauma is not an exact science either. You can find injuries that are better or worse. The healing of the patient can be better or worse. There may be lots of other factors. What we are arguing here is whether one should actually have known to do the right thing which was not done in this case, in my opinion.'

[3] This is what the plaintiff's expert witness, the trauma specialist Dr Phani, testified to under cross-examination regarding the appropriate level of medical care. In *NK obo UK v Member of the Executive Council for Department of Health, Eastern Cape*,[1] the Full Court followed the judgment by Corbett JA in Blyth,[2] holding that the determination of the factual cause of the injury, i.e., the medical reason, must be decided before addressing the question of negligence of the medical staff involved. This is not an easy task if confronted with the specialised nature of the subject and the lack of consensus among expert witnesses. Similarly, Brand JA observed in *Buthelezi v Ndaba*:[3]

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1 [2024] 3 All SA 882 (ECB) at 91
2 1918 (1) SA 191 (A) at 196E
3 2013 (5) SA 437 (SCA)

"The human body and its reaction to surgical intervention is far too complex for it to be said that, because there was a complication, the surgeon must have been negligent in some respect."

[4] The aforesaid is an apt observation, and I align this judgment with the statement by the Full Court in *NK obo UK*[4] that:

"It is unnecessary to strive, at one extreme, for absolute clarity and unwavering certainty about the reasons for an injury and whether the medical practitioners involved must be held accountable. The courtroom is not a scientific laboratory. At the other extreme, causation and delictual liability cannot be decided merely on a balance of possibilities. The role of the court, reduced to its essence, is to evaluate the available evidence and to adjudicate the dispute based on whether the plaintiff has on a balance of probabilities proved his or her case… "

NOT JUST ANOTHER NEW YEAR'S DAY

[5] The plaintiff, Mr L[…] A[…] S[…], a 55-year-old resident of Mitchells Plain, attended a New Year's Eve party to celebrate the beginning of 2020. As he was leaving the celebration, he was shot in the back by an unknown assailant. The bullet entered his lower back on the left-hand side and exited through his upper abdomen. He was admitted to the emergency unit at MPH, where he underwent emergency, life-saving surgery performed by Dr Moodley. It is important to emphasise that the plaintiff owes his life to Dr Moodley and the emergency personnel at MPH. In this regard, both experts who testified on behalf of the plaintiff and the defendant agreed in their joint minute that *"... the initial surgery by Dr Moodley saved the patient's life, life-threatening injuries being bleeding from the torn mesenteric vessels and contamination from the multiple perforated bowel."*

And

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4 [2024] 3 All SA 882 (ECB)

"That in view of the retroperitoneal haematoma being nonexpanding, the correct approach presently is not to have explored the left kidney surgically at that stage (referring to the emergency operation performed in the early hours of 1 January 2020)."

[6] This is, however, where the plaintiff and the defendant part ways. There is a dispute between the parties regarding the appropriate level and manner of care that the plaintiff should have received at MPH and if a different treatment plan would have resulted in the plaintiff not having to have been readmitted on 21 January 2020 to theatre, where he underwent the surgical removal of his left kidney.

[7] Resulting from the removal of his left kidney, the plaintiff now sues the defendant for damages arising from the alleged negligent medical treatment administered to him at MPH in January 2020.

THE TRIAL AND WITNESSES

[8] At the commencement of the trial, by agreement between the parties, the issue of the so-called merits and quantum was separated. The trial, therefore, only proceeded in respect of the alleged grounds of negligence and the question of causation. The quantification of the plaintiff's claim was postponed *sine dies*.

[9] Four witnesses testified at the trial. The plaintiff testified in person followed by the plaintiff's expert, Dr Frank Plani, trauma surgeon. The defendant led the evidence of Dr Kaestner, a senior consultant in the Urology Department responsible for reconstructive renal surgery at Groote Schuur Hospital ("GSH"). The defendant also called its expert, Prof. Flip C. Bosman.

CHRONOLOGY

[10] The following events are common cause with reference to the pleadings, the mentioned dates, and the treatment administered to the plaintiff. Essentially, this was uncontroversial at trial because, unlike in many other cases of this nature, the medical records were clear and nearly always complete.

[11] The plaintiff presented at the MPH at approximately 03h00 on 1 January 2020 with a gunshot wound described as paraspinal in the lumbar region and in a subcostal position on the left-hand side. The plaintiff was referred to the surgical department. He underwent surgery at the hands of Dr Moodley, assisted by Dr Parker.

[12] The plaintiff had suffered small bowel injuries and a mesenteric injury. The plaintiff was also found to have a haematoma surrounding the left kidney. The abdomen was washed out and the injuries to the small bowel and mesentery were surgically repaired.

[13] On 3 January 2020, the plaintiff discharged himself from MPH because he was not satisfied with the treatment he received. He tried to obtain treatment at a private hospital in Rondebosch but was unable to afford the fees, so he returned to MPH sometime during the 4th of January 2020.

[14] On 7 January 2020, the plaintiff was discharged from the MPH. Fluid was still draining from the gunshot wound. Upon his discharge on 7 January 2020, he was still in pain and had a fever and elevated heart rate.

[15] On 9 January 2020, the plaintiff returned to the MPH complaining of abdominal tightness. The laparotomy wound appeared to be clean with no signs of infection. Fluid was draining from the wound.

[16] On 10 January 2020, the plaintiff returned to the MPH and was seen by Dr Moodley and readmitted. The plaintiff was tachycardic (an increased heart rate), diaphoretic (excessive sweating), slightly lowered haemoglobin, and there was abdominal distention. Fluid was still draining from the wound site. The plaintiff was placed on antibiotic medication.

[17] The plaintiff was referred for a contrast CT scan, which showed a large collection of fluid. Hereafter, the plaintiff was referred to GSH for a percutaneous drainage of the collection of fluid.

[18] On 12 January 2020, the plaintiff underwent the percutaneous drainage procedure at GSH under local anaesthetic and conscious sedation with the administration of intravenous contrast. The CT scan confirmed that there was active extravasation from the renal collecting system with a collection of fluid around the left kidney. The fluid was sent for testing. On 16 January, the plaintiff underwent a further procedure at GSH to insert a stent in the left kidney in the form of a cystoscopy, a left retrograde pyelogram, and insertion of a stent.

[19] The plaintiff was transferred back to the MPH. On 16 January 2020, the plaintiff was readmitted to the Urology Department at GSH. On 21 January 2020, the plaintiff was taken back to theatre and underwent the surgical removal of his left kidney. On 28 January 2020, the plaintiff was discharged with instructions to attend follow-ups at the urology outpatient department and the day hospital.

PLAINTIFF'S TESTIMONY

[20] The plaintiff is a 55-year-old man from Mitchells Plain. On New Year's Eve 2019, the plaintiff attended New Year's celebrations at an establishment. When he left in the early hours of 1 January 2020, he was accosted and shot in the back by an unknown assailant. He was rushed to the MPH.

[21] He was shot in the left lower back with an exit wound on the front. He was seen at the emergency unit and underwent surgery to repair the injuries to the small bowel. The emergency surgery was performed by the surgeon, Dr Moodley, assisted by Dr Parker.

[22] According to the plaintiff, he suffered a lot of pain and had a raised belly. He describes the pain that he felt after the surgery as excruciating, and he did not believe that "*he would make it*". On 3 January 2020, he discharged himself due to what he described as not being properly taken care of. His complaints to the hospital staff were brushed off and ignored. He decided to leave. His cousin accompanied him to a private hospital in Rondebosch. The plaintiff could not afford the fees demanded by the private hospital, which advised him to return to MPH later that evening.

[23] According to the plaintiff, he was still suffering from a fever, a swollen belly, and an elevated heart rate on 7 January 2020. He suffered severe pain, but did not know that he had a leaking kidney. He was released on 7th of January but returned to the hospital on the 9th of January. He testified that he was in great pain and was crouching on the floor. One of the treating doctors came and asked if he was "*okay*", but the doctor did not attend to him.

[24] On 10 January, he went to the hospital again and was seen by Dr Moodley. He raised complaints of severe pain, fever, and an elevated heart rate. A CT scan was performed, and he was referred to GSH for a drainage procedure. After the drainage procedure was completed, the plaintiff was sent back to MPH. He can vaguely remember the test that was performed using contrast to investigate if there was a leakage.

[25] He later again returned to GSH where a stent was inserted. He testified that his urine was cloudy, and he was still leaking urine. On 21 January, he underwent a necrotomy (the removal of a kidney) because the treating doctors informed him that his kidney could not be saved, due to the extensive damage to it. It was irreparable.

[26] Under cross-examination, he admitted that the emergency treatment he received saved his life after he suffered life-threatening injuries, due to the gunshot. He was hospitalised until he decided to discharge himself on 3 January. He refused medical treatment but had to return on the morning of the 4th of January at approximately 07h15. He was referred to the clinical notes of

the outpatient department that did not record any leaking urine. The plaintiff tried to explain that his recollection of leaking urine was due to the imaging test performed. It was put to him that the contrast test was only performed later at GSH and that he could, therefore, not have known about the leaking urine. He had no knowledge of leaking urine prior to 10 January 2020.

[27] He consented, on 20 January, to undergo surgery for the possible removal of the kidney that was removed on the 21st. The plaintiff lodged a series of complaints with the HPCSA, the Minister of Health, the Public Health Department, and other State organisations. His complaints concerned the surgeon, Dr Moodley and the other doctors who treated him at MPH.

[28] The HPCSA did, however, not take any steps or find Dr Moodley or any other medical personnel guilty of professional misconduct. The plaintiff tried to explain this by stating that the HPCSA's reply to him contained factual inaccuracies and that, as far as he was concerned, they did not consider his complaint properly.

PLAINTIFF'S EXPERT – DR FRANK PLANI, TRAUMA SURGEON

[29] Dr Plani is a retired professor and general surgeon. He testified and confirmed the contents of his CV and previous experience. He was referred to the clinical records regarding the plaintiff's admission and the emergency surgery performed. The plaintiff suffered, in essence, a soft tissue injury of the bowel, causing a mesenteric injury, which indicates damage to the membrane that surrounds all the organs. He explained the emergency surgical procedure that was performed. The haematoma near the left kidney was not getting bigger and the abdomen was washed out. The plaintiff underwent surgery at the hands of Dr C. Moodley, assisted by Dr Parker, which lasted from 04h54 to 06h58. There was 800ml of blood in the peritoneal cavity and a total blood loss of 1,500ml. There was evidence of destructive injuries to the proximal small bowel, which were debrided and re-sected, and a primary anastomosis was performed. Mesenteric injuries were identified and ligated. There was a haematoma surrounding the left kidney. The peritoneal cavity was washed out

with sterile saline. It was felt that the haematoma near the kidney was not expanding and was not explored further, so the wound was closed without drains *in situ*.

[30] The plaintiff appeared to be stable post-operatively. On 4 January 2020, blood tests showed a slight drop in haemoglobin and slightly decreased renal function. Blood cultures showed no growth. On 5 January 2020, a note was made that the plaintiff was in pain and had a tachycardia with a spiking temperature. His abdomen was distended, and serous fluid was draining from the wound.

[31] On 6 January 2020, a note was made of persistent tachycardia, spiking temperature, and a diagnosis of acute kidney injury ("AKI"). The abdomen was distended, and tender, and serous fluid was draining from the gunshot wound site. On 9 January 2020, the plaintiff returned to the MPH and complained of abdominal tightness. The laparotomy wound looked clean with no signs of infection. Bloody fluid, which was getting lighter in colour, was still draining from the gunshot wound. The plaintiff was given pain medication and instructed to return two weeks later.

[32] The plaintiff was sent for a contrast CT scan, which showed the following:

"Large left upper quadrant rim enhancing collection with smaller surrounding collections, with associated mass effect of the left kidney proximal ureter with mild hydronephrosis." Dr Moodley referred the plaintiff to the Radiology Department, GSH, for subcutaneous drainage of the collection of fluid.

[33] On 11 January 2020, the plaintiff underwent a percutaneous "pigtail" drainage procedure at GSH under local anaesthetic and conscious sedation with the administration of intravenous contrast. The fluid was drained and sent for testing. On 13 January 2020, the plaintiff was readmitted to the GSH, and on 14 January 2020, a further 1000ml of fluid was drained. The plaintiff's case was discussed with Dr Oppel of the Urology Department at GSH, who requested a CT scan.

[34] The CT scan confirmed that there was active extravasation from the renal collecting system, with a collection of fluid around the left kidney. On 15 January 2020, Dr Moodley referred the plaintiff back to the Urology Department, GSH, as the draining fluid was acknowledged to be urine. On 16 January 2020, the plaintiff was readmitted to the Urology Department, GSH, and taken to theatre for a cystourethroscopy, a left retrograde pyelogram, and the insertion of a left double J stent. It was recorded that there was a missed left grade-4 renal injury to the collecting system. The plaintiff was placed on antibiotic medication.

[35] On 21 January 2020, the plaintiff was taken back to theatre and underwent a laparotomy and left open nephrectomy and the wound was sutured in layers. During surgery, the findings included *"…large posterior and anterior renal pelvic defect with infected and friable tissue."* A photograph was taken during the procedure showing the double stent. It looked as though a 9mm bullet had caused the injuries.

[36] Dr Plani testified that it is evident from the records that, after his original admission, the plaintiff was operated on by Dr C Moodley, a Medical Officer in the Surgical Department. The haematoma around the left kidney appeared to have been visualised, found not to affect the ureter outside of the Gerota's fascia, and assessed as not expanding and, therefore, not requiring immediate exploration. This approach by Dr Moodley is in line with modern teaching of non-operative management, in order to avoid causing more damage to the kidney, more bleeding, and breaking the tamponade offered by the Gerota's fascia and renal capsule. This line of action was historically only applied in cases of blunt trauma, but it has now become the standard practice in cases of penetrating trauma. However, once the patient is stable, the kidney should be visualised by contrast CT/IVP scan, in order to exclude high injury grades, either due to disruption of the collecting system or the blood supply, which could possibly lead to pseudoaneurysm or stenosis formation. Furthermore, future treatment plans and care ought to be devised by a specialist surgeon in collaboration with the medical officer on duty.

[37] In the opinion of Dr Plani, a contrast CT scan ought to have been performed within a day or two of the laparotomy procedure, in order to grade the severity of the injury to the left kidney. Dr Plani further expressed the opinion that, had the CT scan been done timeously, the nature of the injury to the left kidney would have been observed, and the plaintiff would have been referred to the Urology Department at GSH for the appropriate treatment.

[38] Once the bleeding has been contained, it is imperative to trace the trajectory of the bullet so as to ascertain which organs have been injured. Dr Plani performed kidney reconstruction surgery in the acute trauma setting, which includes the utilisation of double J stents and the reconstruction of the kidney with absorbable mesh. If the patient has a grade-4 renal injury with extravasation and if surgery is not performed early on to insert a double J stent and a drain to minimise the effect of the leak of urine, the outcome will probably not be favourable.

[39] Because of the lengthy delay before the injury to the kidney was diagnosed and treatment was administered, a large abscess had developed, due to sepsis with friable tissue, which made it impossible to repair the defect in the kidney surgically. Dr Plani referred to the clinical notes recording that the plaintiff complained of a raised heartbeat which Dr Plani explained could be as a result of a lowered haemoglobin load in the blood. On 6 January, Dr Moodley again examined the plaintiff and recorded the diagnosis of "*acute kidney*" which does not refer to an injury, but to the functioning of the kidney. The plaintiff's abdomen was very tender, and the plaintiff was not absorbing enough fluids.

[40] On 7 January, the plaintiff was discharged, but he returned on the 9th. On his re-admission, the plaintiff complained, according to the clinical note, about tightness and reference is made to a "*drain in situ*". Dr Plani could not explain if a drain was inserted, and this may only have been a drain bag. The plaintiff was given Augmentin, a general-spectrum antibiotic, since it could have been

possible that he was suffering from or developing sepsis. Blood cultures were again requested to be obtained.

[41] The plaintiff's bowel did not move, distention of the bowel was noted, and the hospital was still awaiting the results of the blood cultures on 10 January 2020. The plaintiff then underwent the CT scan imaging. It became clear that there was an unknown mass in the abdomen, and the plaintiff was referred to GSH for a drainage procedure. A drainage bag was placed over the gunshot wound and approximately 800mm was drained. It is unlikely that the injuries affected the plaintiff's bladder, which led to further investigation into the collecting system by administering contrast fluid. Dr Plani explained that there was a parametric injury, which means that the leakage was in the pouch surrounding the kidney. It can contain quite some fluid before it starts leaking into the greater area. The kidney cellux is the middle of the kidney where the collection system is found.

[42] At GSH, the plaintiff underwent an imaging contrast test and Dr Plani testified that, if the same test had been performed two weeks earlier, it would have been possible to detect the injury. The procedure is performed by inserting a catheter and scope in the urethra. Contrast is inserted under pressure to identify any leakage. A double-jointed stent could have been inserted to stop the leakage if it had been detected earlier and operated on. The double-jointed stent allows for drainage without leakage. Due to the fact that the injury was not detected early, the whole area around the kidney became infected and it would be difficult to insert stitches. Dr Plani referred to an academic article prepared in San Francisco that dealt with kidney injuries as a result of gunshot incidents.

[43] Kidney injuries are graded from 1 to 5, 1 being the least and 5 being the greatest. According to Dr Plani, the injury that the plaintiff suffered is graded as 4. He further testified that the golden standard is that anything done within the first three days would make it possible to perform a reconstruction and renal repair. Damage to the kidney, if detected within the first three days, can

be repaired by stitching or repairing the remainder of the kidney performing what Dr Plani referred to as wrapping it with the Augmentin.

[44] Dr Plani differed from the authors of the article and proposed that invasive surgery should not be performed. He contended that this was the *"old way of thinking"*. If detected and performed within the first three days, surgery can be performed successfully. You do not need to perform the surgery immediately but within a day or two of the patient being stable. A CT scan would have assisted in grading and finding out if there was anything requiring intervention. It would serve to have a treatment plan. A grade-1 injury will heal by itself, but a grade-4 injury requires intervention.

[45] Dr Plani's critique was that, whenever a medical team is confronted by a gunshot wound, they should determine the trajectory of the bullet. This is the only way in which one can for sure determine what organs or structures may have been damaged. Dr Plani further criticised the treatment offered, by explaining that there are usually three consultants on call at provincial hospitals. Dr Moodley, could therefore have obtained assistance from a surgeon or sought advice. The consultant should have been more proactive to ensure that the correct treatment is provided. There is no criticism against the Urology Department at GSH, whose staff, according to Dr Plani, is extremely competent and could have repaired the damage to the kidney if the leak had been detected earlier.

[46] Referring to paragraph 3 of the joint minute, Dr Plani explained that, given the plaintiff's symptoms, the treating doctors should have taken the CT scan much earlier since that would have determined the grade or percentage of the injury, which would have been indicative of the treatment plan. Dr Plani sharply criticised Dr Moodley who, according to him, did not reach out to the consultants or the Urology Department at an earlier stage.

[47] Dr Plani explained, with reference to the trajectory of the bullet, that the bullet did not go through any bone, the back mussels and given its velocity, the wound could not have been bigger than 9mm. If it was picked up early, the

Urology Department may have elected to treat non-operatively, by inserting a drain and double-jointed stent through the apex of the kidney. There would have been a chance of success, and he could have recovered. The drain would remain *in situ* for 3 to 6 weeks, after which a further contra-colour study would be conducted.

[48] Under cross-examination, Dr Plani was questioned on whether he had any experience in a district hospital. He explained that he has worked in an 849-bed hospital in Vosloorus. He conceded, however, that the expertise of a general surgeon is not the same as the experience of a younger consultant. He explained that he has experience in treating many gunshot wounds and providing primary care. A registrar should be trained to provide expert medical care when confronted with injuries such as these on a regular basis in a hospital such as MPH. Dr Plani conceded that different levels of skills and expertise apply to different surgeons.

[49] He further conceded that the plaintiff was treated during one of the busiest times of the year but contended that the medical personnel in charge should have planned for emergencies such as this. He admitted that the letters "*CWR*" on the clinical notes refer to "Consultant Ward Round". It was suggested to Dr Plani that the consultant and registrar decided together on the appropriate treatment plan. Dr Plani disagreed with this. The consultant should have red-flagged the patient, based on the plaintiff's symptoms, and referred to, or at least consulted with GSH. Dr Plani explained that the injury caused by the bullet that went from the back to the front was not diagnosed. He disagreed that Dr Moodley correctly diagnosed the injury as not being a serious kidney injury. She should have been aware of the trajectory and should have thought of what damage could be caused.

[50] Dr Plani was referred to the involvement of the special surgeon, Dr Nabeer, Dr Bertels, and Dr Gani, all of whom saw the patient on different days. Dr Plani replied that four of these consultants should have treated the plaintiff. The blame is not on Dr Moodley, the intern, but on the consultants. It was put to Dr Plani that reasonable care was taken of the plaintiff and that the mere fact that

something was missed, does not *per se* constitute negligence because doctors overlook things but not all issues are regarded as negligence. Dr Plani replied that he never uses the term 'negligence' and that this is still up to the Court to determine but that he testifies as to the level of care. The plaintiff was mis-assessed and undertreated. The bullet went from back to front and this was not investigated. If the medical team suspected a urine leakage, they could have acted on it. They should have done so before 9 or 10 January. The CT scan should have been done by no later than 2 or 3 January because the trajectory was not identified. And if you do not identify the trajectory, in order to determine any damage, the correct level of treatment cannot be provided. The treatment of other grade-4 kidney injuries due to blunt or stab injuries does not differ from gunshot wounds. The critical fact is that the doctor should identify the grade of damage.

[51] Dr Plani again emphasised that the consultant should have consulted a surgeon or the Urology Department at GSH. Dr Plani was further cross-examined on the likelihood of a positive outcome if the injury was detected earlier depending on the grading of the injury. The average age of the patients in the article, upon which Dr Plani relied, was also only 27 years compared to the age of the plaintiff. The outcome is further dependent upon further surgery performed to repair damage to the kidneys and does not account for other injuries caused by the gunshot.

[52] The plaintiff was stable, but his symptoms indicated that greater care was required. Dr Plani testified that GSH and UCT have a very high standard of treatment, are highly rated internationally, and have the skills to provide the necessary treatment with the plaintiff's kidney if diagnosed earlier.

[53] Dr Plani explained that reconstructive surgery refers to the insertion of a drain. You use what is available to repair the kidney. You not only do damage control to save a life, but also all things that could have saved the kidney if done earlier than two weeks after the incident. Despite the size of the renal pelvis, reconstructive surgery would be complicated but manageable by an expert.

[54] Dr Plani then explained the procedure he would have used. He has successfully saved the kidney in one incident where there was more than 50% damage to the kidney. Despite his many years of experience, he only once performed renal pelvis reconstructive surgery. Dr Plani is of the view that he would be surprised if GSH was not able to save the plaintiff's kidney if operated on within 3 to 4 days after the shooting incident.

DR LISA KAESTNER

[55] Dr Kaestner was previously the senior consultant at GHS and led the Blue Firm, the reconstructed urology and renal stone firm at GHS. She was also the programme director of the academic programme. GSH is the primary department to which MPH refers. The plaintiff suffering from a gunshot wound ("GSW") was accordingly referred to GSH. She remembered being called to the theatre on 21 January and consulting with the plaintiff. She testified to her observations of the plaintiff's kidney, based on the two CT scans and the urology ward notes that the plaintiff's left kidney had quite a large leak in the renal pelvis, affecting blood supply and reduced perfusion. According to her, it seemed that the tract had gone snug onto the edges of the renal cortex and had basically gone in and out across just where the edge of the cortex rolled over basically through the area where the rest of the pelvis connects into the kidney. Dr Kaestner testified that "*one could see that it had, it was going through where the renal pelvis should be connecting to the kidney and one could see that the excreted contrast was going down the ureter, ja, so that ...*". The defect she observed in the theatre on 21 January could not be closed, repaired or reconstructed. Her view that the removal of the left kidney was justified is strengthened by the facts that a debridement could not be performed and a watertight closure attained, and that the plaintiff has another healthy kidney and bowel injury.

[56] Dr Kaestner testified that she could not remember repairing and salvaging a single renal pelvis injury resulting from a gunshot wound at GSH. This is because "…*they are rare injuries, they are very rare. The other issues that*

they are often associated with other injuries. So the patients have multiple pathologies which compete for us actually getting the patient to theatre on, you know, in a reasonable amount of time and also because they are very, they are often complex injuries to fix because of where they are and because the renal pelvis is quite small and if it is a gunshot there is – they are more difficult to fix than a kind of a clean incision with a knife or something that has happened from, you know, a planned, clean surgery procedure…".[5]

[57] She testified that the treatment plan was always to repair and save the kidney, if viable and confirmed that, according to the operation notes, the defect could not be closed/reconstructed, because the edges were non-friable and could not be debrided. A watertight, tension-free repair over a stent could not be performed. The reason a surgeon "*…would not perform a repair like this is because you do not do a well-debrided onto good bleeding edge tension-free repair, then the repairs usually will fail and bleed. Also this patient had another kidney and he also had a bowel anastomosis close to the areas. So although it was very…, it did not look repairable in our department, it is often a consideration that if there is a concomitant bowel injury close by that, it does almost make you lean more to nephrectomy in a situation where you think the repair will be precarious*".[6]

[58] Under cross-examination, Dr Kaestner agreed that the treatment plan, when the nephrectomy was performed on 21 January 2020, was a so-called ureteric proximal pelvic repair, meaning that, if the kidney was not repairable, a nephrectomy would be performed. Significantly, she agreed that it was the intention of the surgical team to repair the injury, but this was found not feasible during the procedure.

[59] Mr Corbett SC for the plaintiff put it to Dr Kaestner that the friable tissue was evidence of infection. The doctor replied –

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5 Record, pp 96, line 20 to p 97 line 5
6 Record p98 line 1 to 13

"*They have called it infection. I am not certain that I can – I am a little bit nervous as to how much I can say now.*
MR CORBETT: Alright, if you do not go any further, it is fine.
MS KAESTNER: It is for a number of reasons related to the direct injury, the delay in repair and perhaps infection inflammation, a multifactorial…".[7]

DEFENDANT'S EXPERT – PROF. PHILLIP BORMAN

[60] Prof. Borman is an experienced general surgeon who specialises in sub-speciality trauma. He confirmed the contents of his CV provided to the Court, referencing the important aspects of his qualifications, experience, publications, and role in peer review.

[61] According to Prof. Borman, the entry gunshot wound was fairly high on the left flank and back of the plaintiff. The exit wound was lower. The bullet perforated the lining of the bowel. He explained the procedure followed by the surgeons when performing emergency surgery. The part of the perforated small bowel was removed, approximately 10 cm, and stitched together. There was minimum contamination of bowel content, and the urethra was more mobilised, meaning that the doctor tested that there was peristaltic movement in the urethra, i.e. passing urine. The left kidney appeared to be intact, and she could not feel any injuries. The plaintiff lost 1,500ml of blood which is substantial. Dr Moodley did not visualise the left kidney. I.e., she did not remove it from behind the colon. No other injuries were noted. Prof. Borman confirmed that the kidneys are behind the pericanot note and surrounded by fat. It is quite protected. A kidney is approximately 8cm in size.

[62] Regarding the plaintiff's complaints of pain, Prof. Borman explained that the gunshot entry wound to the back damaged muscle and that, in itself, would have caused severe pain. Post-operatively, the plaintiff was "*fine*" and the extended pelvis is expected post-operative. Prof. Borman was referred to the clinical notes of 3 January/second-day post-op, on which it was recorded that

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7 Record page 101 Line 14 to 24

the plaintiff "*looks well*" and that the blood pressure decreased, although there was a rise in temperature. The abdomen was soft, and the dressing soiled. Prof. Borman states that the soft abdomen is indicative thereof that there was peristaltic movement. It is recorded that the plaintiff's calves are soft, indicating a good blood supply and no risk of thrombosis forming. A wound bag was placed over the gunshot wound.

[63] Prof. Borman commented on Dr Plani's testimony that there was a urine leak. According to Prof. Borman, there was considerable damage along the trajectory of the bullet wound and the bowel. It is to be expected that fluid would drain from the bowel and wound. It is standard practice to monitor the temperature. A rise in temperature could be caused by the partial collapse of the lung, due to the expanded bowel putting pressure on the lung. This is why they would attempt to mobilise the patient as soon as possible.

[64] The patient refused hospital treatment, but returned on the 3rd with nauseous, feverish symptoms and no stool. There was concern about the rise in temperature, although a tender bowel is to be expected. The plaintiff was provided with painkillers, but no systemic infection was found. Reference is made in the clinical notes to the use of dipsticks, but no results are recorded. On 5 January, the plaintiff was still showing symptoms of an increased heart rate and "*air hunger*" (breathing quickly). The clinical note records that the plaintiff was anxious and that he had previously suffered from panic attacks. The plaintiff received an enema because he was not passing stool. He was given morphine for the pain and Prof. Borman says that it remains uncertain what caused the drainage of fluid. The wound could cause a rise in temperature, damage to the muscles, or the plaintiff simply being dehydrated, due to being unable to absorb fluids. A spike in temperature is expected post-operatively.

[65] The treatment plan referred to in Exhibit A on paginated page 441 was the correct one, being imaging, including possibly a CT scan. They continued to test the kidney functions as evident from the electrolyte test reference. According to Prof. Borman, the fact that imaging is considered on day 6 post-

op (7 January) indicates that the treating doctors were concerned about the plaintiff's condition. On 7 January (6 days post-op) the clinical notes record that the plaintiff was not vomiting and eating the ward food. This means he was no longer on a soft diet and eating normally. His temperature was also down to normal.

[66] The collection of 27ml of fluid after the drain was inserted is not significant, since it is measured over a period of 24 hours. There is only one or two references in the clinical notes to the pain suffered by the plaintiff in his left flank. On day 7, it is recorded that there was an ileus, which means that the bowel was not working and there was no peristalsis. This would explain the bowel tenderness and distension. The temperature and pulse rose again, and the haemoglobin dropped, but not significantly. The treating doctors were concerned that there was a break in the repair work performed during the emergency surgery.

[67] Prof. Borman agrees with the clinical picture described in the referring doctor's note to the radiologist. The radiologist notes in his conclusion the finding of an anastomotic leak. Prof. Borman states that he would be concerned about the kidney, due to the further finding by the radiologist that there was "*mass effect of the left kidney*".

[68] Subsequently, the plaintiff was booked for a CT scan at GHS. The scan established that there was leakage of urine and a kidney colyx injury. Prof. Borman states that he is impressed by the standard of the medical notes at MPH. The notes accord with what one would expect to see post-operatively, and the management of the plaintiff was correct. He was not neglected, and he was properly looked after.

[69] With regard to the nursing notes, Prof. Borman stated that he could not find any references to excruciating left flank pain, as alleged by the plaintiff. He was prescribed pain medication, voiced that he was hungry from time to time, and his condition was noted as stable. On 5 January, it was recorded in the

nursing notes that the plaintiff was feeling better, and on the 6th, no complaints were raised. He was mobilised for the toilet.

[70] Regarding the testimony of Dr Plani that the omenment should be used to close the defect in the renal pelvis. Prof. Borman testified that he has not used the omenment to close the renal pelvis, since there is nothing that you can stitch it with. The renal pelvis is 1cm to 2cm in width.

[71] The plaintiff was never unstable during the time he was cared for by the MPH and Dr Moodley's decision not to explore the left kidney was tempered by the finding of no microscopic blood in the urine. The only indicator of an injury would be increased heartrate. If one finds microscopic traces of blood in the urine, one should proceed with a CT scan. Prof. Borman states that he has in all his time as a surgeon since 1974 not come across a case such as this. The criticism by Dr Plani that the surgeons should have given better guidance to the interns is also wrong. The first port of call for any doctor is a clinical picture and the second is the results from tests conducted. In the first 7 days, the plaintiff was at MPH there was hardly anyhting in the clinical picture to indicate that there was anything wrong.

PROF. BORMAN AND DEFENDANT'S APPROACH

[72] The defendant contended that the plaintiff and Dr Plani failed to recognise the distinction between a GSW to the kidney and a GSW to the renal pelvis of the kidney. A repair to the renal pelvis is incredibly rare if not near impossible, never has been seen or done by the defendant's lay witness, Dr Kaestner or the defendant's expert, Prof. Borman.

[73] The defendant disputes that Dr Plani's evidence is correct. The defendant argues that Dr Plani's evidence was to the effect that he had performed surgeries and saved kidneys in multiple instances from GSW but not to the renal pelvis. Accordingly, the defendant argues that the plaintiff bears the onus to prove that the initial missed renal pelvis injury amounted to negligence

and that the failure to detect the injury sooner was the cause of the surgical removal of the kidney instead of the damage caused by the GSW.

[74] In the defendant's supplementary heads Adv. Bawa SC argued that the crux therefore is that, despite both Dr Plani and Prof. Borman having decades of surgical experience between them, neither is specialised in the repair of renal injuries. Neither has extensive experience in repairs to GSW injuries to the renal pelvis of the kidney. While GSW injuries to kidneys are uncommon, it is even more uncommon in terms of renal pelvis. Neither of the experts could attest to having extensively repaired injuries to the renal pelvis from a GSW. Prof. Borman testified at length on what basis he said the injury to the renal pelvis was not repairable by referring to the size of a standard bullet measuring 9mm and the comparable size of the renal pelvis. The bullet having gone through the renal pelvis left a large anterior and posterior defect.

CAUSATION

[75] In *JA obo DMA v The Member of the Executive Council for Health, Eastern Cape*,[8] the Court held that:

"*...it is not the function of the court to develop its own theory or thesis and to introduce on its own accord evidence that is otherwise founded on special knowledge and skill.* Ex hypothesi*, such evidence is outside the learning of the court. The function of the court is restricted to deciding a matter on the evidence placed before it by the parties, and to choose between conflicting expert evidence, or accepting or rejecting the proffered expert evidence.*"

[76] In *AM obo LM v MEC for Health, Eastern Cape*,[9] the Court relied on the judgment in *AM obo LM v MEC for Health, Eastern Cape*, in which Molemela JA held that a plaintiff is not required to establish the causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably

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8 [2022] 2 All SA 112 (ECP) also reported 2022 (3) SA 475 (ECB)
9 [2024 (1) SA 413 (ECB)

have occurred based upon the evidence and what can be expected to occur in the ordinary course of human experience. In *Minister of Finance and others v Gore NO*, this Court aptly held that the application of the "*but for*" test is not based on mathematics, pure science or philosophy. Rather, it is a matter of common sense, based on the practical way in which the ordinary person's mind works against the background of everyday life experiences. The flexible approach reflected in the above judgments was adopted by the Constitutional Court in Lee. The flexible test in Lee does not replace the pre-existing approach to factual causation; rather, it adopted an approach to causation premised on the flexibility that has always been recognised in the traditional approach as reflected in the authorities. In restating the "*but for*" test in Mashongwa, the Constitutional Court settled the law on this aspect. It pointed out that the imputation of liability to the wrongdoer depends on whether the harmful conduct is either too remote or sufficiently closely connected to the harm caused. It emphasised that where the traditional "*but for*" test is adequate to establish a causal link, it may not be necessary to resort to the Lee test.

[77] In *Afrikander on behalf of DMA v Member of the Executive Council of Health, Eastern Cape*,[10] the Full Court of the Eastern Cape Division held, regarding the test for factual causation, the burden of proof and conflicting expert opinion, that expert opinion evidence is received when the issues require special skill and knowledge to draw the right inference from the facts stated by witnesses. Conceptually, different kinds of conflicting expert evidence may present themselves in any given case. Van Zyl DJP continued:

"*The first is a conflict with regard to the assumed facts. By reason of its very nature, expert opinion must have a factual basis. The facts upon which an expert's opinion is based must be proved by admissible evidence. An expert opinion based entirely on inadmissible evidence is itself inadmissible. The facts may be established by asking the expert witness in examination-in-chief what those facts are.*"

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10 [2020] JOL 52016 (ECB)

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...

[12] Secondly, 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 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."[11]

[78] Ultimately, what is required is a critical evaluation of the reasoning on which the opinion of an expert is based rather than considerations of credibility. If it is not possible to resolve a conflict in expert opinion, such as where 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. This will only be the situation where the Court:

"[c]an only rise 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 the weighing of evidence, comes to a determinable conclusion, the onus has nothing to do with it and need not be further considered".[12]

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11 Buthelezi v Ndaba 2013 (5) SA 437 (SCA) at para 14

12 Robins v National Trust Co (4) [1927] AC at 520

[79] In general, it is important to bear in mind that it is ultimately the task of a Court to determine the probated value of expert evidence placed before it and to make its own finding with regard to the issues raised. Faced with a conflict in the expert testimony, the Court is required to justify its preference for one opinion over another by a careful and critical evaluation thereof. The primary function of expert testimony is to guide the Court to a correct decision on questions that fall within the expert's specialised field.[13]

EVALUATION, REASONS AND JUDGMENT

[80] Considering the aforesaid, the following three issues need to be decided:

[80.1] The factual cause of the injury being the removal of the plaintiff's kidney;

[80.2] Negligence, and

[80.3] Causation.

FACTUAL CAUSE OF INJURY

[81] The plaintiff presented at MPH on 1 January 2020 with a gunshot wound described as paraspinal in the lumbar region and in a subcostal position on the left side. He underwent life-saving emergency surgery at the hands of Dr Moodley assisted by Dr Parker.

[82] Dr Kaestner testified that it appeared from the imaging performed at GSH that the contrast seemed to be filling a linear area behind the kidney or at least posterior to the kidney through the pelvis anterior into where the collection was, and that seemed to be a space that was being filled with the contrast which she assumed to be the track of the projectile.[14] She continued to

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13 Afrikander obo DMA v Member of Executive Council for Health, Eastern Cape [2022] JOL 52016 (ECB) at para 17

14 Record, p 96, line 125

explain that one could see that it (the projectile) had gone through the renal pelvis where it should be connecting to the kidney and one could see that the excreted contrast was going down the ureter.[15] During the nephrectomy performed by the surgeon, Dr Salukazana, on 21 January 2020, Dr Kaestner was asked by the surgical team to advise on whether they should attempt a repair. According to Dr Kaestner, it did not appear that one could debride the non-friable edges and do a watertight tension-three repair over the stent that was inserted. There was not enough friable tissue around to be able to do a good-quality tension-three end-to-end repair.[16]

[83] Dr Kaestner listed a number of reasons why the kidney was removed including the trajectory of the projectile that caused a direct injury, the delay in repair, infection, inflammation, and other multifactorial aspects.

[84] I conclude, therefore, that the removal of the plaintiff's kidney was factually caused by the infection and inflammation that occurred as a result of the delay in repair which made reconstructive surgery inappropriate.

NEGLIGENCE

[85] Dr Moodley could not establish, during the emergency life-saving surgery, whether or not there was an injury to the plaintiff's kidney. The only way in which this could be established is with imaging. The trajectory of the bullet was not ascertained during the surgery and Dr Moodley, who observed only a non-expanding haematoma, could not grade the kidney injury and whether or not there was a leakage problem.

[86] It is common cause that, based on the medical studies relied upon by both parties' experts, imaging must be done as a routine procedure after any suspected injury to the kidney. Imaging must be done as soon as possible after the patient is stable.[17] Dr Moodley was alive to the possibility or may

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15 Record, p 96, line 8 to 11
16 Record, p 97, line 24 to p 98, line 9
17 Record, p 113, line 1 to p 115, line 18

have suspected an injury to the left kidney at the time of performing the life-saving emergency surgery as is evidenced by the detailed description of what was done during surgery to identify or exclude an injury to the left kidney.[18]

[87] On a conspectus of the expert testimony, imaging should have been performed during 2 to 6 January 2020. It is impossible to make a finding whether Dr Plani's testimony that it should have been performed on the 2nd or 3rd or the concession of Prof. Bosman that it should have been performed by the 6th of January is correct.

[88] I accept that, at best, for the defendant, imaging should have been performed to exclude or establish and grade the kidney injury by 6 January 2020. The defendant's treating doctors were not concerned about the fluid leaking out of the GSW. They did not order further investigations, regardless of Dr Moodley's suspicion of a possible kidney injury. Already on the 6th of January, the medical notes reflect references to the term "*AKI*", meaning "*Acute Kidney Injury*". The experts disagreed whether this term referred to an actual injury or to the kidney's functioning. I do not believe that it matters. The plaintiff's kidney was not functioning normal and required further medical attention to establish the cause of the problem. This was not done until the plaintiff was referred to GSH on 11 January. Unfortunately, the scan performed on 11 January 2020 showed an intra-abdominal collection but does not seem to determine where the collection of fluid was coming from.[19] A second scan was performed on 14 January 2020, and it showed extravasation of urine in the vicinity of the left kidney. The persistent tachycardia and abdominal distention and the nature of the injury are indicative of factors that should have caused the treating doctors to perform imaging and, in particular, a CT scan during 5 or 6 January 2020. If this treatment plan had been followed, the injury would have been easier to treat because infection would not have set in and caused the sepsis, making the edges of the damaged tissue friable, and the widespread sepsis could have been prevented. Once the tissue became septic, it eventually died and became non-viable, which resulted in the

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18 Record, p 116, line 8 to 18
19 Record, p 132, line 10 to 25

surgeons being confronted, on 21 January 2020, with a kidney that could not be repaired. If a different treatment plan was followed and the presence of the kidney injury was detected by imaging, the surgery would probably have been performed at least 2 weeks or more earlier. This would mean that the plaintiff would have presented with a different clinical picture, given credence to Dr Plani's testimony that it is very likely that reconstructive surgery would likely have been successful.

[89] I conclude, therefore, that the defendant was negligent in not offering the appropriate or timeous treatment reasonably required to diagnose and treat the pelvic renal injury.

CAUSATION

[90] The question of causation is complex. It is common cause between the parties that there is no room of any allegation of negligence against the Urology Department and its staff at GSH. This means that the Head of the Reconstructive Department's testimony, given by Dr Kaestner, is of great importance and I cannot but accept her testimony that she cannot recall since she started working at GSH in 2006 a single reconstructive surgery to have repaired and salvaged a kidney from a gunshot and in particular the renal pelvis. Renal pelvis injuries caused by GSWs are very rare.

[91] Dr Plani for the plaintiff testified that one does not need to operate on all kidneys after a GSW to the bowel. The modern and currently applied trend is to perform a CT contrast scan once the patient is stable. The purpose of the CT scan would be to determine and grade any injury to the kidney requiring intervention. The scan will provide the treating surgeon with a roadmap of the required treatment. Dr Plani testified that he has seen a large number of fresh kidney injuries in which the tissue is good and a clamp can be placed successfully on the bleeding vascular vessel or can be easily observed and that there is no reason to find that there would not be as high a success rate in saving the kidney as indicated in the academic research material relied upon by both parties' experts.

[92] He conceded, however, under cross-examination that an injury to the renal pelvis is a complex injury, but that it is manageable by experts. Regarding the physical damage, Dr Plani testified under cross-examination:

"*So we said specifically that the fact that the patient was shot from the back means that it is probably was and there was very little damage to the kidney per ... we found that that's why we treat non operative well also a lot of gunshot abdomens because the holes are actually a lot smaller than you actually think ...*"

[93] He further supported his reasoning that the hole was actually quite small because the haematoma observed during the life-saving emergency surgery was small and non-pulsating. If there was massive damage, the kidney would have been bleeding. Critically, under cross-examination, the following was asked of Dr Plani:

"*Ms Bawa SC* *When you've done this injury, fixing of injury to the renal pelvis, in your experience, when you've done it, have you had a case of where you'd had more than 50% of the posterior and anterior wall of the structure damaged by a gunshot wound.*

Dr Plani *Yes, in one case I can think of one case.*

Ms Bawa SC *One case.*

Dr Plani *One case, yeah, one case I did myself only one case.*

Ms Bawa SC *And what was and so in all your years you've only had one case of that scenario.*

Dr Plani *Of this particular thing in a lot of cases the situation we have to do in the frequently in other cases put in a couple*

of stitches because of the small hole but you know I have only had one case where everything works exactly as planned and exactly as described because tissues are tissues. If you got the principles. That's what you need to stick too."

[94] Having considered the aforesaid and, in particular, having regard to the fact that Dr Moodley suspected a kidney injury that was not serious, given the non-pulsating haematoma and the defendant's own evidence that there was no clear indication in the absence of imaging by way of a CT scan of renal damage, that the damage to the renal pelvis was most probably not that severe and could be repaired if detected earlier, I find that the plaintiff succeeded in proving that, as a matter of fact, if surgery was performed at an earlier stage, the kidney could have been saved. This finding is supported by the indisputable fact that the treatment plan at GSH was to repair and save the kidney. If the kidney was irreparable, it would not have made sense for the specialist urology department at GSH to have inserted the double stent on 16 January 2020. It would have been clear earlier in January if the damage had been so severe that any efforts to reconstruct and repair were futile. The evidence instead points to a situation becoming progressively worse, probably due to the onset of infection and inflammation. The gunshot wound and associated injuries, apart from the kidney, resolved and healed. No evidence was presented that the gunshot wound per se complicated the clinical picture to such an extent that I can conclude that GSH would never have operated to reconstruct and repair the kidney. The evidence indicates otherwise.

[95] This is, however, a very rare injury requiring the expertise of an experienced surgeon such as Dr Plani, who has only performed surgery of this nature regarding the renal pelvis in one instance. However, it is undisputed that the GSH renal unit and its staff are highly experienced, specialised, and recognised internationally. The injury might have been rare but treatable if diagnosed timely and promptly. I did not understand the defendant's case to be that because it is a rare injury, the surgical team at GSH would not have

performed surgery even if damage to the kidney had been detected earlier before the onset of infection, inflammation and sepsis.

[96] The plaintiff is not required to establish the causal link with certainty but should demonstrate that the wrongful conduct was probably the cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred based upon the evidence and what can be expected to occur in the ordinary course of human experience. I cannot find the harmful conduct too remote from the harm caused. The question is not whether the treating doctors could reasonably have prepared the renal pelvis as it presented during surgery on 21 January 2020, but rather whether the treating doctors, acting reasonably with the necessary skill and diligence expected of medical practitioners in their position, would have followed a different treatment plan that would have resulted in a different clinical picture presenting itself in theatre a week if not two weeks early which could have resulted in the plaintiff's kidney being saved.

[97] In the premises, I grant the following order:

[97.1] The defendant is liable for such damages as the plaintiff may prove to have arisen as a result of the treatment administered to him at MPH in and during January 2020, resulting in the performance of a nephrectomy on 21 January 2020.

[97.2] The defendant is liable for the plaintiff's costs of suit on a party and party scale including, but not limited to:

[97.2.1] Senior Counsel's fees at Scale C and

[97.2.2] The reasonable and necessary qualifying expenses of the plaintiff's expert witness, Dr F. Plani, trauma surgeon.

VAN DEN BERG AJ

FOR THE PLAINTIFF:

P. A. CORBETT SC
MALCOLM LYONS & BRIVIK INC
REF: MR T. BRIVIK

FOR DEFENDANT:

ADV N. BAWA SC
ADV T. M. STEYN (HEADS OF ARGUMENT)
STATE ATTORNEY
CAPE TOWN