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IN THE HIGH COURT OF SOUTH AFRICA
FREE STATE DIVISION, BLOEMFONTEIN

Case No. 1304/2019

Reportable:	**NO**
Of Interest to other Judges:	**NO**
Circulate to Magistrates:	**NO**

In the matter between:

CLAUDIA ELLIOT **FIRST PLAINTIFF**

NADIA ELLIOT (assisted by first plaintiff) **SECOND PLAINTIFF**

and

THE MEMBER OF THE EXECUTIVE COUNCIL: DEFENDANT

DEPARTMENT OF HEALTH, FREE STATE PROVINCE

CLAUDIA ELLIOT **THIRD PARTY**

CORAM: GUSHA, AJ

HEARD ON: 7, 8 and 10 MARCH 2023, 20-22 JUNE 2023, and 5-6 DECEMBER 2023.

DELIVERED ON: 26 JANUARY 2024

JUDGMENT

"Our greatest regrets in life tend not to be the things we did wrong or failed to achieve; but rather the missed opportunities or things we didn't do that we wish we had. All too often missed opportunities are in plain sight" Germany Kent (Own emphasis).

[1] I use the above quote as a prelude to this judgment as it aptly embodies what this whole case is about.

[2] Mr Norman Elliot Jnr (the deceased)[1] was in life a young man of 26 years, a husband to the first plaintiff and a father to his 4 year old daughter, the second plaintiff.

[3] The common cause facts are concisely that the deceased on the 6th March 2016 presented at the casualty department at Thusanong Hospital, reportedly complaining of severe headaches, loss of weight, vomiting and general lack of appetite. He reportedly, was also on anti-depressant medication. Upon examination by Dr Thompson[2] and as noted in her clinical notes, she observed that he was generally emaciated, sat slouched, was not engaging at all and had a blunted effect. Subsequent to the examination she diagnosed the deceased with acute depressive disorder and admitted him to the hospital ward for further treatment.

[4] Primarily, because Thusanong Hospital had no psychiatric ward and there was no improvement in the condition of the deceased, the latter was on the 22nd March 2016 transferred to Boitumelo Regional Hospital for psychiatric treatment. Thereat the family of the deceased informed a certain Dr Perez that there was a family history of Von Hippel-Lindau Syndrome (VHL syndrome) [3] as the patriarch, Mr Elliot Snr, was diagnosed with VHL syndrome and the family suspected the deceased to suffer from the same fate. Upon this information being imparted to her, Dr Porres immediately arranged for the deceased to be transferred to Universitas Academic Hospital in Bloemfontein for a brain scan and or further

[1]The deceased sadly demised on the 26th March 2016 at Boitumelo Regional Hospital.
[2] Attending Dr at the casualty department.
[3] VHL syndrome is a hereditary condition associated with tumors arising in multiple organs. VHL related tumors include, amongst others, hemangioblastomas, which are blood vessel tumors of the brain, spinal cord and retina. The clinical manifestations thereof in each patient depend on the type of genetic mutation present.

screening.[4] Sadly, before he could be transferred, the deceased demised on the 26th March 2016.

[5] Aggrieved by the death of the deceased, the plaintiffs instituted action against the Member of the Executive Council for Health, Free State Province (the defendant)[5] for pecuniary loss as detailed in their particulars of claim. [6] The nub of their claim is that the servants of the defendant were allegedly negligent and or breached their duty of care in the treatment of the deceased while he was hospitalised at both Thusanong Hospital and Boitumelo Regional Hospital, as a result, the plaintiffs aver that they suffered damages. To bolster their claim, they aver that the defendant's servants were negligent;

5.1. By diagnosing the deceased at Thusanong Hospital as suffering from depression and/or drug abuse;

5.2. By treating the deceased at Thusanong Hospital as suffering only from depressions and/or drug abuse;

5.3. By not diagnosing the deceased at Thusanong Hospital, and treating him, as suffering from Von Hippel-Lindau syndrome;

5.4. By diagnosing the deceased at Boitumelo Regional Hospital as suffering only from drug abuse, depressive mood and aggression;

5.5. By treating the deceased at Boitumelo Regional Hospital as suffering from drug abuse, depressive mood and aggression;

5.6. By not diagnosing the deceased at Boitumelo Regional Hospital, and treating him, as suffering from Von Hippel-Lindau syndrome;

[4] Management and or treatment for VHL syndrome was not available at Boitumelo Regional Hospital, such treatment only being provided at tertiary hospitals.
[5] Based on liability for damages caused by the negligent conduct of the medical personnel.
[6] Amended index to pleadings pages 4-14.

5.7. By not diagnosing and/or detecting cysts in the deceased's body or a large hemangioblastomas in his brain.

[6] It is further the plaintiffs pleaded case that as a result of the aforesaid alleged negligence, the plaintiff was misdiagnosed and was not treated for the VHL syndrome, resulting in his condition deteriorating and culminating into his untimely demise.

[7] The defendant disavowed any negligence as alleged by the plaintiffs, pleading instead, that its servants exhibited the requisite care, skill, expertise and caution when they treated the deceased. Truncated, the plea is that on admission of the deceased at Thusanong hospital, the first plaintiff conveyed naught to the medical personnel regarding the family's history with VHL syndrome. Mentioning instead that he was not keeping any food down for some 4 weeks, suffered from severe headaches, psychiatric problems and depression and was abusing dependence inducing substances (drugs).[7] In the alternative the defendant denied that the deceased's death was caused by any alleged negligence of its servants. Alleging instead that the first plaintiff and or the deceased were negligent in that they failed to disclose to the medical personnel the family's history with VHL syndrome. [8] The defendant further pleads in the alternative that, in the event that the court finds that its servants were negligent in the treatment of the deceased, then the defendant denies that such negligence was the cause of the deceased's death.

[8] At the onset of the hearing the parties in terms of Rule 33(4) of the Uniform Rules of Court agreed to separate the merits from the quantum. In accordance with that agreement, I am called upon to only adjudicate on the merits. Accordingly the issue(s) to be decided by this court is whether the servants of the defendant at

[7] Amended index pleadings at pages 21-31.
[8] *Ibid.*

both hospitals failed to exercise the requisite degree of skill and care in their treatment of the deceased by not diagnosing VHL syndrome and whether such failure and or negligence on their part contributed to the death of the deceased.

[9] As most of the evidence with regards to the deceased's admission at both Thusanong and Boitumelo hospitals is common cause, I shall not traverse those aspects relating to the admission and continued stay of the deceased at the respective hospitals. In my view, either parties' case turns on whether the disclosure relating to the deceased's risk of developing VHL syndrome, in view of the patriarch's history with the disease and its hereditary nature, was made to the personnel at either hospital, either by the deceased or his family. To that end, and for purposes of this judgment I shall focus only on the disputed facts in that regard.

[10] The plaintiffs tendered the evidence of the following witnesses; Mrs. Engela Elliot (Mrs. Elliot) the deceased's mother, Mrs. Engela Roos (Mrs. Roos), the deceased's sister, Dr Muller a pathologist and Dr Scott a general practitioner and also the Elliot's family Doctor.

[11] Mrs. Elliot testified that the deceased became sick and vomited blood. As a result thereof they took him to Boitumelo hospital in Odendaalsrus. At the hospital she informed the attending Dr, who she called Dr. Theron, that her husband was diagnosed with VHL syndrome some 30 years ago and that her son presented with similar symptoms; convulsions and severe headaches.[9] Dr Thompson however informed her that she could not conduct any tests as she was working at casualty she would admit the deceased and the medical personnel at the ward would conduct the necessary tests.

[9] Mrs. Elliot conceded in cross examination that the attending Doctor at casualty was Dr Thompson and not Dr Theron.

[12] She further testified that since the deceased's admission at both hospitals, the family frequently visited him and with each visit found him in a generally worse condition, with no signs that the medical personnel were attending to him. She mentioned that at some of these visits, they would notice that the deceased had not been fed, his bedding was wet and the deceased wore adult diapers, and there were no intravenous drips, to mention but a few incidents of alleged patient neglect. She testified that with each visit she and indeed other members of her family, would not miss an opportunity to inform the medical personnel about the family's history with VHL syndrome, but alas, all fell on deaf ears.

[13] After the deceased's transfer to Boitumelo Regional Hospital she again informed the medical personnel of the family's history with VHL syndrome. Here too, her pleas came to naught. It is only on the 24th of March 2016 when the deceased was seen by a Dr Porres, who immediately upon being informed of the family's history with VHL syndrome, made arrangements to have the deceased transferred to Universitas Academic hospital in Bloemfontein. Sadly 2 days before he could be transferred, the deceased demised.

[14] The germane aspects which emerged during cross examination are that the Elliot family were aware of VHL syndrome and its hereditary nature, dangers and management since at least 2002 when the patriarch of the family was diagnosed. It therefore is puzzling that when Mrs. Elliot was quizzed on why upon noticing the symptoms in the deceased he was not immediately taken for medical treatment and or screening for VHL syndrome, she tried to obfuscate by testifying that she is a lay person and could not be expected to know the intricacies of the syndrome. In view of the patriarch's known diagnosis since 2002 and known management of the disease, I find this explanation less than candid and improbable. The finding of improbability is bolstered by the following; if indeed she was not aware of the dangers and or management associated with VHL syndrome, why, on her own version at least, would she persistently and

frantically inform the medical personnel at both hospitals about VHL syndrome? The inescapable conclusion surely must be that this is so precisely because she was aware of the dangers, management etc. of the disease.

[15] She was further quizzed on the length of time it took to take the deceased to hospital, in view of his condition and numerous visits with his treating Doctors. She retorted that the deceased was an adult who was capable of making his own decisions and as he had just secured a promotional post as his place of employment, the deceased elected to go to work rather than attend to his health.

[16] Mrs. Roos testified that the deceased was her brother. The family has been aware of VHL syndrome since the patriarch's positive diagnosis in 2002. Dr Scott who was their family doctor was also aware of the family's history with VHL syndrome. Despite their father's diagnosis she testified that the family was not offered screening and or surveillance.

[17] Upon the deceased falling ill they took him to Thusanong Hospital. Thereat she and the other members of her family (her mother and the deceased's wife) informed Dr Thompson of the family's history with VHL syndrome and their suspicions regarding the deceased. She also handed to Dr Thompson the medical certificates from both Drs. Scott and Bester. She largely supported her mother's evidence with regards to informing the medical personnel at both hospitals regarding the family's history with VHL syndrome.

[18] Dr Muller performed an autopsy on the body of the deceased on the 1st April 2016. The main findings as contained in his comprehensive report[10] are that the body of the deceased presented with a benign hemangioblastoma in the brain (cerebellum). A clear cell papillary cystadenoma (tumour) was observed on the deceased's left testes. He commented that the simultaneous occurrence of the hemangioblastoma and the clear cell papillary cystadenoma is consistent with

[10] Amended index: expert witnesses pages 97-115.

VHL disease. Further, that although the exact cause of death could not be determined by post mortem examination, it was most likely related to the space occupying effect of the hemangioblastoma. Metabolic disturbances or fatal cardiac arrhythmia cannot be excluded with certainty. I accept the evidence of Dr Muller as it was coherent and logical and stands uncontroverted.

[19] Dr Scott is medical doctor plying his trade as a general practitioner for some 32 years and is also the Elliot's family doctor. He testified that he was aware of the family's history with VHL syndrome as the patriarch was his patient. The deceased was his patient since 2011. In 2015 the deceased presented with chronic lower back pain. As he wanted to rule out any problems with the spine in view of the known history of VHL syndrome, he referred the deceased to Pelonomi Hospital for spinal examination. As per the patient referral letter, Exhibit A, the deceased presented with spontaneous onset of paraesthesia and pain of the whole back, worse over thoracic spine, shoulders and lumbar spine. Further noted on the referral letter was the patriarch's history with VHL syndrome. The findings of the MRI scan performed were noted as "insignificant findings" and the deceased was informed to return for a follow up in 6 weeks. Evidently the deceased did not make the return appointment as no other clinical information is available in this regard either from Dr Scott or any of the family members.

[20] Fast forward a year later. As per the medical certificates admitted into evidence, in 2016 Dr Scott saw and treated the deceased for a range of ailments, ranging from headaches, backache, vertigo and encephalitis.[11] On the 02nd of February 2016 he saw the deceased again, this time he presented with headaches and dizziness, he was referred to Bongani Hospital for CT and or an MRI scan. Reportedly the hospital did not conduct the tests as they did not have CT and or MRI scans, the deceased was reportedly only given medication. He saw the deceased again on the 17th, 22nd and 23rd of February 2016. On the 1st of March

[11] Amended index-pleadings pages 124-127.

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2016 the deceased was seen by a Dr Bester, on a referral from Dr Scott, for a scan on his back and not his brain. Dr Bester reported that on the day of the examination, the deceased was extremely ill such that it was difficult to obtain his medical history. It is noteworthy that none of the medical certificates issued by Dr Scott reference VHL syndrome. Not even the medical certificate issued by Dr Bester dated 01 March 2016 references VHL syndrome.[12]

[21] Dr Scott testified that he saw the deceased again on the 25th of February 2016, he realised that the deceased was not getting better and he then changed his medication. For the remainder of his evidence Dr Scott went on a tangent about what the hospitals ought to have done and did not do and proceeded to give an opinion of the detection, management and or treatment of VHL syndrome. He opined that if the deceased was referred for a CT scan when he was admitted on the 6th of March 2016, the scan would have detected the tumour that was found on the deceased's body post-mortem, and with the known history of VHL syndrome, the hemangioblastoma would equally have been detected.

[22] He conceded during cross examination that he is a general practitioner and not a specialist, was not a geneticist and also not an expert on the detection, treatment and or management of VHL syndrome. He however maintained that in order to diagnose VHL syndrome he did not need to be a specialist as the disease could be detected without testing genes. He testified that in order to diagnose the disease all that was needed was a CT scan to confirm the presence of a tumor, if the results came back with a hemangioblastoma then VHL syndrome would be confirmed without conducting any genetic tests. As will become evident later on, If only it were that simple, we would not be here!

[23] This was the sum total of the plaintiffs case.

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[12] *Ibid at* pages 128-129.

[24] In rebuttal of the claim, the defendant called 2 witnesses, Dr Thompson and Professor Christianson.

[25] Dr Thompson testified that she is a medical practitioner currently in private practice. On 06 March 2016, she was employed at Thusanong Hospital as a community service medical officer (an intern) and posted at casualty. She supported the evidence of the Elliots that the deceased was brought to casualty, examined and or assessed by her and subsequently admitted to the ward. She however pertinently disavowed that either of the Elliots informed her of the family's history with VHL syndrome. She testified that as a relatively inexperienced Doctor at the time, she knew very little, if anything, about VHL syndrome, and had mention thereof been made, she would have looked it up and also noted same in her clinical notes. Furthermore, the medical certificates handed to her by the family also did not reference the disease. She remained steadfast throughout her evidence that neither the deceased nor his family made mention of VHL syndrome in her presence.

[26] During cross examination she was quizzed about the missing family history on the clinical notes. She conceded that same did not appear on the clinical notes but explained that the deceased did not present with life threatening symptoms and as casualty was extremely busy that evening, a fact confirmed by the Elliots, she deemed it necessary to only note what was important for purposes of admitting the deceased. She also testified that once in the ward, the medical personnel would obtain all the relevant information and conduct whatever tests were deemed necessary. This was the sum total of her evidence.

[27] According to his curriculum vitae professor Christianson is a specialist in medical sub-genetics and an academic in the field.[13] His evidence is that VHL syndrome is a complex disorder in which the diagnosis and follow up is a challenge in

[13] Amended index-Expert witnesses pages 38-96. Albeit he has since retired.

clinical practice. An on-going and multi-disciplinary approach involving different specialists is recommended and the facilities required for medical genetic counselling and testing would mostly be available in tertiary and quaternary care facilities. He testified that neither Bongani nor Boitumelo Regional Hospital were classified as tertiary and or quaternary care facilities. In fact he testified that both were primary care facilities staffed by general practitioners and not specialists, and that in his experience doctors at these hospitals possess no expertise to diagnose VHL syndrome. His evidence is further that the clinical presentation of VHL syndrome is variable and may first manifest from 11-20 years of age, with 50% of patients symptomatic at the time of diagnosis with cerebellar hemangioblastoma being the most common presentation of VHL syndrome. Further that the mortality and morbidity are high, with the most frequent cause of death being complications of cerebellar hemangioblastomas and that life expectancy was between 40 and 52 years of age.

[28] The high water mark of his evidence was that the clinical protocol for screening, surveillance, early detection, and or treatment of tumors in patients with the clinical diagnosis of VHL syndrome and their first degree relatives has been in place and available free of charge since the early 1990's. He testified that as VHL is a hereditary disease, the rationale behind the early screening was to offer and or start management of the disease in those family members who inherited the disease as early as possible as the early diagnosis and surveillance with improved imaging resulted in an improved prognosis and diagnostic techniques resulted in an improved prognosis of VHL syndrome. Early screening also served to exclude those first degree family members who did not inherit the disease.

[29] In the preparation for his report, he testified that he went through the plaintiffs' documents that he was furnished with. In those he found nothing to suggest that through the 1990's to the death of the deceased, he and or his wife were placed under a surveillance programme. He testified that it was imperative, as the

deceased had a 50% risk of inheriting the disease from his father. Professor Christianson opined that as the facilities for genetic testing were at that stage already available free of charge at the medical genetics unit in the department of neurology at Universitas Hospital in Bloemfontein, this failure to place the deceased under early surveillance presented a missed opportunity for an early detection and diagnosis of VHL syndrome.

[30] With regards to the standard of care the deceased received whilst at Thusanong hospital, Professor Christianson opined that proper examination and assessment of the deceased was done and a diagnosis of acute depression was made. As the deceased presented with its symptoms at casualty, he opined that there was nothing untoward with said diagnosis as made by Dr Thompson. He further opined that the deceased was previously seen and examined by Doctors Scott and Bester who were both senior to Dr Thompson, and noteworthy, both had the deceased's family history. Furthermore, Dr. Bester's notes were clear in respect of the diagnosis and prognosis. Furthermore, in both the medical certificates handed to Dr Thompson by the family, VHL syndrome was not referenced.

[31] He testified further that from the clinical notes furnished, it appears that someone noted the history of hemangioma in the patriarch. In as much as plaintiffs' counsel tried to get the Professor to concede that whoever noted same actually meant to inscribe hemangioblastoma, he remained steadfast that he interprets what is on the clinical notes and cannot assume what was or was not meant. Professor Christianson testified that a hemangioma, unlike a hemangioblastoma, is a benign birth mark which presented itself on the surface of the skin and was not of medical concern, he was thus not surprised that the mention of the hemangioma appears to not have been acted on at the hospital.

[32] He expressed a different view to that expressed by Dr Scott that on the available clinical information, a diagnosis of VHL syndrome could be made. Professor

Christianson testified that the investigation of the disease was an on-going process until a diagnosis was ultimately made. At the time before the deceased's death no one, Dr Scott included, knew that the deceased had a large hemangioblastoma on one of his testes, this was only revealed post mortem. He was also at variance with the expressed opinion by Dr Scott that the deceased would have survived. Professor Christianson testified that patients with VHL syndrome had a defective gene, the condition was not curable, the proper care of a patient only served to elongate the patient's life. In the final analysis, Professor Christianson opined that, taking into account the grading of the hospital and the expertise and or skill of the personnel available in such institutions, in his expert opinion, proper care was given to the deceased at Thusanong Hospital.

[33] For the same reasons, he arrived at the same conclusion with regards to the degree of care and skill at Boitumelo Regional Hospital. He further opined that as soon mention of VHL syndrome was made by the deceased's family to Dr Porres, she immediately took the necessary steps to refer the deceased to a tertiary hospital, sadly the deceased demised before such transfer could be made.

[34] As early as 2002 when the deceased's father had a positive diagnosis for VHL syndrome, the failure to offer the deceased screening and surveillance was a missed opportunity. According to him the deceased ought to have been screened every 2 years post his father's diagnosis. He further opined that the fact the deceased had been vomiting, not eating and practically emaciated, was an indication that the deceased had been in poor health for some time.

[35] This was the sum total of the defendant's case.

[36] It is settled law that to found delictual liability a plaintiff must allege in detail and prove that the defendant was negligent.[14] If a plaintiff relies on a breach of duty of

[14] *Eversmeyer (Pty) v Walker* 1963 (3) SA 384 (T), *SA Fish Oil Producers' Association (Pty) Ltd v Shipwrights & Engineers Holdings Ltd* 1958 (1) SA 687 (C).

care, he or she must set out the facts that could or should have been foreseen by the defendant. [15] The test for negligence is whether a reasonable person in the defendant's position would have reasonably foreseen harm befalling the plaintiff as a result of his conduct, and would have taken reasonable steps to prevent the harm. If so, the question is whether he took reasonable steps to avert the harm that ultimately occurred. The reasonableness of such conduct is assessed objectively.

[37] Liability for medical negligence is determined by asking whether the failure of a professional person to adhere to the general level of skill and diligence, possessed and exercised by the members of the branch of the profession to which he or she belongs, would normally constitute negligence. What constitutes the general level of skill exercised by members of a particular profession is demonstrated through evidence of experts in that profession. Our courts have in numerous judgments outlined the approach to the evaluation of such evidence. [16]

[38] In **McGregor and another v MEC Health, Western Cape**[17] the court held that

> *"…The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and [be] admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions."*

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[15] *Beurain h/a Toptrans Transport v Regering van die RSA* 2001 (4) SA 921 (O).
Kruger v Carlton Paper of SA (Pty) Ltd 2002 (2) SA 335 (SCA), *Kruger v Coetzee* 1966 (2) SA 428(A) at 430 E-F, *Pitzer v Eskom* [2012] ZASCA 44 (SCA) para 24.
[16] *Goliath v Member of the Executive Council for Health, Eastern Cape* [2014] ZASCA 182; 2015 (2) SA 97 (SCA), *Louw v Patel* (245/2021) [2023] ZASCA 22 (9 March 2023), *JA obo DA v MEC for Health Eastern Cape* 2022 3 SA 475 (ECB).
[17] [2020] ZASCA 89; 2021 (3) SA 337 (SCA) para 17.

[39] Therefore, fundamentally, an expert's primary function is to assist the court to reach a conclusion on matters in which the court itself does not have the necessary expertise to decide. It is accordingly not the mere opinion of a witness which is decisive, but his ability to satisfy the court that because of his or her special expertise, the reasons for the opinion expressed are founded on logical reasoning.

[40] *In casu* the court is faced with 2 divergent opinions. From the onset, I am of the view that the opinion expressed by Dr Scott on the detection, treatment, surveillance of VHL syndrome stands to be rejected. By his own admission he is not an expert in the field of genetics, he is a general practitioner. As his evidence progressed and indeed his cross examination, it became painfully apparent that his knowledge of the diagnosis and management of the disease was at best limited and amounted to conjecture at worse. Therefore whatever opinion he proffered was without any logical reasoning.[18] Furthermore whatever opinion he expressed during the proceedings was not objective- he is after all the deceased's and the Elliot's family doctor.

[41] In view of Professor Christianson's qualifications and expertise in the field of genetics, I am inclined to accept the opinion he proffered. Not only was he a coherent and cogent witness he greatly assisted the court in understanding the syndrome, he was undoubtedly non-partisan, notwithstanding the fact that he was called by the defendant. Proof of his objectivity is found in his criticism of Pelonomi Hospital when the deceased attended thereto for CT scans. Notwithstanding the fact that the referral letter was clearly endorsed with the family history of VHL syndrome, it did not appear that the deceased was referred

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[18] *Mediclinic v Vermeulen* (504/13) [2014] ZASCA 150 (26 September 2014)

for the surveillance and or screening protocol. Professor Christianson called this yet another missed opportunity in the life of the deceased. As what transpired at Pelonomi is not the subject of these proceedings and thus not before me, I shall not take that aspect any further than I have.

[42] In view of the expert opinion expressed by professor Christianson, I hold the view that the medical personnel at Thusanong hospital were not negligent in their treatment of the deceased. They acted on the symptoms he presented with, the letters from Doctors Scott and Bester referencing depression. I further hold the view that the probabilities, when weighed against the available facts, favour the finding that the medical personnel, more especially Dr Thompson, at Thusanong were not informed about the family's history with VHL syndrome. Both Ms Elliot and Roos prevaricated and vacillated when quizzed in cross examination on this aspect. I accept the evidence of Dr Thompson that she was not informed of the presence of VHL syndrome in the family, she struck me as an honest witness and certainly had nothing to gain by coming to court and spinning untruths. Furthermore in view of Dr Thompson's observation of the almost catatonic state the deceased was in at admission, I find it improbable that he too would have said anything to the medical personnel.

[43] Lastly, it needs no restating that a medical practitioner is not expected to bring to bear upon a case entrusted to him / her the highest possible degree of professional skill, but he / she is bound to employ reasonable skill and care. Even if it could be said that the diagnosis by Dr Thompson was incorrect, that does not in itself mean that she was negligent. The test to be applied to determine negligence is whether a reasonable general practitioner at her level and at the hospital she was at would, under the same circumstances and available facts, have made the same diagnosis she did. Considering the level she was at, the type of hospital she was employed at and the services available and rendered there; the available information to her; her own observation and examination of

the deceased, I am satisfied that reasonable care and skill was employed in treatment of the deceased at Thusanong hospital.

[44] I hold the same view when it relates to Boitumelo Regional hospital. Here, too, no negligence can be found. This much is evinced by the plaintiffs' own evidence that they too did not know whether the deceased had VHL syndrome, they harboured only a suspicion, and that upon informing Dr Porres of this, the necessary action was taken. In my view, the fact that it was found post mortem that the deceased had a cerebellum hemangioblastoma does not establish negligence on the part of the defendant's servants. In **Meyers v MEC, Department of Health, Eastern Cape**[19] the court held that;

> *"In assessing a person's conduct in a case such as this, one must guard against the 'insidious subconscious influence of ex post facto knowledge', and bear in mind that '[n]egligence is not established by showing merely that the occurrence happened . . . or by showing after it happened how it could have been prevented' – the reasonable person does not have 'prophetic foresight. (footnotes omitted)..."*

[45] If the version of the plaintiffs is accepted as is, that indeed they were never offered any screening or surveillance protocols, then this would have been the first instance of a missed opportunity in the life of the deceased. Secondly, Dr Scott as the family's doctor is well versed in their history with VHL syndrome, well versed in the deceased's medical condition and prolonged illness, his failure to refer the deceased for screening, and or, surveillance presented the second instance of a missed opportunity. I do not for a second accept his explanation that as a doctor in private practice he could not directly refer the deceased to a public hospital with a request to conduct the necessary tests. He had all the time to refer the deceased since 2011, at least, alternatively when the deceased's symptoms started being more severe and frequent.

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[19] 2020 3 SA 337 (SCA).

[46] The third missed opportunity can be attributed to the deceased himself. In 2015 after his MRI results were inconclusive and he was expected to return after 6 weeks he failed to do so. In 2016 when he ought to have known that his medical condition was becoming dire, instead of attending to his health he elected to assume duty as his new post.

[47] I can go on and on detailing the missed opportunities in the life of the deceased but that would serve no purpose, the few that I have mentioned serve only to highlight that in the life of the deceased, indubitably, the missed opportunities were in plain sight.

[48] Albeit I have already found that no negligence was established, for the sake of completeness and because the aspect of causation was raised in arguments, I find it apposite to very briefly deal therewith. Causation in the law of delict gives rise to two rather distinct problems. The first is a factual one and relates to the question as to whether the negligent act or omission in question caused or materially contributed to the harm giving rise to the claim. If it did not, then no legal liability can arise and cadit quaestio. If it did, then the second problem becomes relevant, viz. whether the negligent act or omission is linked to the harm sufficiently; closely or directly for legal liability to ensue or whether, as it is said, the harm is too remote. This is basically a juridical problem in which considerations of legal policy may play a part. [20]

[49] In **International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA 680 (A)** it was pointed out by Corbett JA that causation involves two distinct enquiries. The first enquiry is whether the wrongful conduct was a factual cause of the loss. The second is whether in law it ought to be regarded as a cause. In this regard the following is apposite;

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[20] *Minister of Police v Skosana* 1977 (1) SA 31 (A) 34D-H.

> *"The enquiry as to factual causation is generally conducted by applying the so-called 'but for' test, which is designed to determine whether a postulated cause can be identified as a causa sine qua non of the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such a hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the loss; aliter, if it would not have ensued.*
>
> *The second enquiry then arises, viz. whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes called "legal causation". (See generally Minister of Police v Skosana 1977 (1) SA 31 (A), at 34 E - 35 A, 43 E - 44 B; Standard Bank of South Africa Ltd v Coetsêe 1981 (1) SA 1131 (A), at 1138 H - 1139 C; S v Daniëls en 'n Ander 1983 (3) SA 275 (A), at 331 B - 332 A; Siman & Co (Pty) Ltd v Barclays National Bank Ltd 1984 (2) SA 888 (A), at 914 F - 915 H; Mokgethi en Andere v Die Staat, a recent and hitherto unreported judgment of this Court, pp 18 - 24)."*

[50] 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 have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.[21]

[51] Accordingly, in order to be successful the plaintiffs bore the onus to show that, but for the negligence, alleged non diagnosis of VHL syndrome, the deceased would have survived. On this score too I hold the view that they would not have passed muster.[22] The post mortem report by Dr Muller is clear and stands uncontroverted that the exact cause of death could not be determined. All that the court knows is that it was considered to be most likely due to the space

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[21] *Minister of safety and security v Van Duivenboden* 2002 (6) SA 431 (SCA) at 25.

[22] In view of the now known fact that the VHL syndrome is an exceedingly difficult disease to diagnose and manage. Its management is an on-going multi-disciplinary process incapable of an on the spot diagnosis and or management.

occupying effect of the hemangioblastoma. No evidence was placed before the court with regards to how, if at all, the treatment of the VHL syndrome in the deceased would have ensued and what the outcome(s) thereof would have been. Furthermore no evidence was placed before the court with regards to when the tumour in the brain developed, no evidence that had the hospitals detected VHL syndrome, the tumour would have been successfully removed and that the deceased would have survived the operation etc.

[52] In final analysis the plaintiffs bore the onus to establish negligence by the servants of the defendant on a preponderance of probabilities, sadly none was established. I have the greatest sympathy for the loss of the first plaintiff's husband and the second plaintiffs' father, however that should not and indeed does not move me to infer blameworthiness where none exists.[23] As sad and final as the circumstances are, on the proven facts the plaintiffs' case stands to be dismissed.

[53] In conclusion, I can do no better than the following remarks by Zondi JA in the Meyers case;

> *"In conclusion, the plaintiff has suffered such terrible consequences that there is a natural feeling that he should be compensated. But, as Denning LJ correctly remarked in* ***Roe v Ministry of Health & others; Woolley v Same [1954] 2 All ER 131 (CA) at 139****: 'But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.'"*

[23] Broude v Mcintosh and others 1998 3 SA 60 (SCA).

[54] This leaves the court with the remaining aspect of the third party procedure as instituted by the defendant. [24] Despite instituting same, the defendant seems to have undergone a Damascene moment and has during arguments, elected to withdraw the third party procedure, as submitted, the wrong party had been cited. Counsel for the plaintiffs did not quibble with the withdrawal save to pray for costs in this regard. In view of the withdrawal of the third party procedure (albeit at such late stage of the proceedings) and in view of the decision reached in this matter, nothing more needs to be said in this regard, save for the issue of costs which I deal with momentarily.

[55] As regards the issue of costs, I see no reason to deviate from the norm that costs should follow the result. In any event no such submissions were made by either party. With regards to the third party procedure however, albeit withdrawn, in view of the late withdrawal and the cost and preparation the plaintiffs no doubt would have embarked on, the dictates of fairness are that they are entitled to the costs related thereto.

[56] Accordingly the following orders are issued:

1. The plaintiffs' claim is dismissed with costs.

2. The defendant to pay the costs occasioned by the third party procedure.

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NG GUSHA, AJ

[24] *Ibid* at pages 32-34.

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