THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Not Reportable

Case no: 1219/2021

In the matter between:

DOCTOR SUDHIR MOHUN **FIRST APPELLANT**

DOCTORS G SANPERSAD,
R MAHARAJ & ASSOCIATES **SECOND APPELLANT**

and

ADVOCATE BRETT KINGSLEY PHILLIPS N O
on behalf of DAVID ROBIN SHEARER **FIRST RESPONDENT**

JUSTINE SHEARER in her personal capacity and
on behalf of DECLAN GRAHAM WILLIAM TINDALE
and KEZIAH RHEEDER **SECOND RESPONDENT**

Neutral citation: *Mohun and Another v Phillips N O obo Shearer and Another* (1219/2021) [2022] ZASCA 186 (22 December 2022)

Coram: VAN DER MERWE, PLASKET and MABINDLA-BOQWANA JJA and CHETTY and MASIPA AJJA

Heard: 16 November 2022

Delivered: This judgment was handed down electronically by circulation to the parties' legal representatives by email, publication on the Supreme Court of Appeal website and release to SAFLII. The date and time for hand-down is deemed to be 11h00 on 22 December 2022.

Summary: Delict – medical negligence – medical practice engaged specialist doctor as *locum tenens* – whether doctor was negligent by failing to appropriately monitor and treat patient in emergency unit of a hospital – patient sustaining hypoxia and eventual brain damage – whether case made out for vicarious liability of practice for actions of independent contractor – whether foundation laid for development of common law to recognise non-delegable duty of care.

ORDER

On appeal from: KwaZulu-Natal Division of the High Court, Pietermaritzburg (Mngadi J, sitting as court of first instance):

1 The appeal of the first appellant is dismissed with costs.

2 The appeal of the second appellant is upheld with costs.

3 The order of the high court is set aside and substituted with the following:

'1. The first defendant is found liable for 65% of whatever damages the patient, Mr Shearer, represented by the first plaintiff, might prove for injuries sustained by him as a result of the cardiac arrest and resultant brain damage which Mr Shearer suffered in the emergency unit of Life Westville Hospital in Durban on 27 December 2014.

2. The first defendant is ordered to pay the first plaintiff's costs of suit, including costs occasioned by the employment of two counsel where so employed. These costs shall include:

(i) the cost of preparation for, and attendance of, all pre-trial conferences that were held and attended by them, as well as the drafting and settling of the pre-trial agendas and minutes; and the plaintiffs' costs of obtaining the medical legal reports of the plaintiffs' experts relating to the issue of liability, including the cost of counsel for drafting the plaintiffs' expert summaries in respect of the issue of liability in which formal notice was given in terms of rule 36(9)*(a)* and *(b)*;

(ii) the cost of preparation, qualifying and reservation of the plaintiffs' experts in respect of the liability trial of whom notice was given in terms of rule 36(9)*(a)* and *(b)*, including the costs of consultations by the plaintiffs'

legal representatives with these experts and the costs of these experts in preparation for and holding joint meetings with their respective counterparts, and preparing joint minutes, if any. These costs are for the following experts: (a) Prof André Coetzee, (b) Prof Lee Wallace, (c) Prof Isabel Coetzee, and (d) Dr Izak A J Loftus; and the fees of Prof André Coetzee for testifying at the liability trial as an expert witness for the plaintiffs.

(iii) the costs of having the proceedings of 28 May, 29 May, 3 June and 5 June 2019 transcribed for purposes of the court and the argument submitted to the court.

3. The claims of the second plaintiff in a personal capacity, and in her representative capacity, on behalf of the minor children, Declan and Keziah, are postponed *sine die* to be determined together with the quantum of the first plaintiff's claim for damages against the first defendant.

4. The action against the second defendant is dismissed with costs.'

JUDGMENT

Mabindla-Boqwana JA (Van der Merwe and Plasket JJA and Chetty and Masipa AJJA concurring):

Introduction

[1] The central issue in this appeal is whether the appellants are liable for the brain injury sustained by Mr David Robin Shearer, who was admitted as a patient in the emergency unit of Life Westville Hospital (the hospital) on 27 December 2014. Mr Shearer, who was 43 years old at the time, was brought to the hospital's

emergency unit by his wife, the second respondent, Mrs Justine Shearer, after he reportedly consumed an unknown quantity of tablets in combination with alcohol. Shortly after his arrival, the first appellant, Dr Sudhir Mohun, examined him. It is common cause that during the course of that evening, Mr Shearer became hypoxic[1] and suffered from cardiac arrest, which led to permanent brain damage.

[2] The first appellant is a specialist physician who was, on the evening in question, engaged as a *locum tenens* by the second appellant, Doctors G Sanpersad, R Maharaj & Associates, a medical practice which provided clinical care in the emergency unit in terms of a memorandum of agreement with the hospital.

[3] The respondents instituted action against the appellants and the hospital in the KwaZulu-Natal Division of the High Court, Pietermaritzburg (the high court), for damages arising from alleged negligent conduct of the appellants and the hospital. The first respondent, Advocate Brett Kingsley Phillips N O, acted as *curator ad litem* on behalf of Mr Shearer, while the second respondent brought the action in her personal capacity and on behalf of her minor children. The action against the hospital was withdrawn before the matter went to trial, as the claim against it became settled. The parties agreed to separate the rest of the issues in the action from the appellants' liability in relation to the first respondent's claim.

[4] The essence of the respondents' pleaded case was that the first appellant acted negligently by failing to properly assess and monitor Mr Shearer's condition so as to timeously render appropriate treatment to him. Had he done so, so it was alleged, Mr Shearer would not have sustained the cardiac arrest and the ultimate brain damage. In respect of the second appellant, it was alleged that a doctor-

[1] Low amount of oxygen in the blood.

patient relationship came into existence upon Mr Shearer's admission into the emergency unit. It was further alleged that, acting through the first appellant and/or the nursing and medical personnel, the second appellant owed the respondents a duty of care and ought to have taken the necessary steps to prevent the harm that was caused to Mr Shearer.

[5] The appellants denied that the second appellant employed any nursing or medical personnel or that the respective personnel were under its control. They pleaded that the second appellant, from time to time, engaged *locum tenentes* as independent practitioners and that the nursing personnel were employed by and worked under the direct control of the hospital. The appellants further alleged that the first appellant timeously and properly examined Mr Shearer, taking into account his history of consuming alcohol with an unknown amount of tablets. According to the appellants, the first appellant had satisfied himself that Mr Shearer was haemodynamically stable[2] before he left him. When he was informed of Mr Shearer's deteriorating condition, he immediately reassessed the situation, treated and resuscitated Mr Shearer and remained with him until his admission to the intensive care unit (ICU).

The background

[6] At the trial, the first respondent called an expert witness, Professor André Retief Coetzee, who is a specialist anaesthetist for cardiac and pulmonary procedures, as well as an intensivist in general adult intensive care. Prof Coetzee gave an opinion primarily based on the hospital records and the relevant clinical notes written by the first appellant and the nursing staff. The appellants, on the other hand, only called the first appellant as a witness.

[2] Stable blood flow.

[7] In the hospital records and clinical notes, it was recorded that on arrival at the emergency unit at 21h30, Mr Shearer was triaged[3] as orange with a discriminator listed as 'overdose'. At that stage, his heart rate was 108 beats/minute; blood pressure 146/82; temperature 36.2°C; and oxygen saturation level 93%. At 21h35, the first appellant examined him. He was given 40% oxygen via a facemask. Upon examination by the first appellant his chest, cardiovascular system and abdomen were clear and normal.

[8] The next entry was made at 21h45, when Mr Shearer's oxygen saturation level was recorded as 82%. Apart from this lowered oxygen saturation, no other observations of Mr Shearer's condition were noted since 21h35, when he was seen by the first appellant. The next noted observations were at 22h00 when Mr Shearer was found to be unresponsive, pale and starting to desaturate.

[9] At approximately 22h05, Mr Shearer suffered a cardiac arrest. His peripheral pulses were absent and he had no heart rate. By that time, Mr Shearer's oxygen saturation level had sunk to 28%, even though 40% oxygen was administered. The first appellant and the nursing staff in the emergency unit undertook resuscitation comprising chest compressions and administration of drugs from 22h05 until 22h30, after which they intubated Mr Shearer with an endotracheal tube. At 22h40, he was taken to the ICU under the care of Dr Insam.

[10] Prof Coetzee's evidence focussed on the dangers presented by alcohol overindulgence combined with medication. He testified that it was common knowledge in the medical field that a person who had consumed such combination

[3] A procedure of assigning degrees of urgency to illnesses to decide the order of treatment of patients.

was at risk of suffering respiratory depression and/or airway obstruction. This was regardless of the fact that such a person might initially appear to be reasonably stable on admission, such as Mr Shearer was. The reason for the stable impression could be that the alcohol and the drugs were still being absorbed into the digestive system. Mr Shearer's condition could therefore gradually change as those were taken up by the system.

[11] This gradual change, according to Prof Coetzee, was evidenced by the fact that when Mr Shearer was admitted, his oxygen saturation level was at 93% according to the clinical notes, or 98% according to the first appellant's evidence. Those levels gradually went down to 82% and then 28%. This, according to Prof Coetzee, necessitated the first appellant to regularly check on Mr Shearer. From the hospital notes evaluated by Prof Coetzee, there was no other crisis that evening in the emergency unit that would have prevented the first appellant from doing so.

[12] Prof Coetzee further testified that an oxygen saturation level of 93%, in the absence of chronic lung disease, should have alerted the medical personnel attending to Mr Shearer that he was already close to the lower limit of acceptable oxygenation. Under these circumstances, it was imperative to continuously monitor Mr Shearer from the time he was admitted in the emergency unit at 21h30.

[13] After the first appellant examined Mr Shearer at 21h35, the first appellant should have ensured that Mr Shearer could maintain his airway, that his respiration was satisfactory and that he was properly oxygenated. This could be done by intubating the trachea, and if Mr Shearer's efforts at spontaneous breathing were insufficient, he would then have had to be placed on a ventilator. Prof Coetzee

concluded that the ensuing cardiac arrest was probably caused by severe and sustained hypoxia, which if prevented or reacted upon timeously would probably not have occurred.

[14] The first appellant's evidence largely conformed to what was in the clinical notes. However, his evidence was that because Mr Shearer's chest examination was clear, he reckoned that the low oxygen saturation of 93% must have been due to a problem with the oxygen probe. He replaced it correctly on Mr Shearer's finger and after doing so, the oxygen saturation level improved to 98%. This improvement reassured him of Mr Shearer's stability. He however did not record this alleged changed level of oxygenation in the clinical notes.

[15] He further testified that when he last saw Mr Shearer at 21h35, his clinical judgment was that he was drunk but stable. His blood pressure was a little bit elevated but not adverse in that situation. A full blood count and further investigations revealed that he had ingested high doses of aspirin. The dextrose saline that Mr Shearer was given was to help counteract low blood sugar that could lead to irreversible brain damage following an acute ingestion of alcohol. Once he finished examining Mr Shearer, he had a conversation with Dr Insam who had known Mr Shearer as a patient from previous admissions. Dr Insam agreed with the medication that the first appellant had used to treat Mr Shearer. He also agreed with the first appellant's decision to admit Mr Shearer to the high care.

[16] The first appellant further testified that a professional and experienced nurse, Sister Phillips, assisted him. He did not stay with Mr Shearer, because apart from Mr Shearer being vitally stable, he had instructed Sister Phillips to monitor the

patient. In addition, Mr Shearer's condition was monitored by a device which would activate an alarm in the event of a deterioration in his condition. No one called him concerning any change in Mr Shearer's condition and he did not hear any alarm going off.

[17] Sister Phillips called him while he was busy with another patient. Apparently, a phlebotomist[4] had discovered that Mr Shearer was unresponsive and raised the alarm with Sister Phillips. When the first appellant got there, he established that Mr Shearer was in cardiac arrest. He resuscitated Mr Shearer with the help of Sister Phillips; they got his heart to beat on its own and his blood pressure to normalise. They then inserted the endotracheal tube and immediately attached a bag valve mask, which pushes the air into the lungs.

[18] The high court found the appellants to be jointly and severally liable. It held that the first appellant was an independent contractor appointed by the second appellant, that the nursing staff at the emergency unit were employed by and worked under the control of the hospital, and that no evidence which established negligence on the part of the second appellant had been adduced. It, however, went on to hold the second appellant liable based on a contractual relationship it found had been entered into with Mr Shearer, upon his admission to the emergency unit.

[19] The high court determined the degree of fault attributed to the appellants as 65% of whatever damages might be proved by the first respondent. It subsequently refused the appellants leave to appeal, which leave was granted by this Court on petition.

[4] A technician who collects blood from patients and prepare the samples for testing.

Issues on appeal

[20] On appeal the appellants contended, firstly, that on the medical evidence presented, the first appellant acted reasonably by leaving a stable patient in the care of an experienced and duly qualified, medically trained nursing sister employed by the hospital. Further, Mr Shearer suffered a cardiac arrest and resultant brain damage in spite of the exercise of reasonable care by the first appellant.

[21] Secondly, it was impossible on the probabilities to find that, had the first appellant regularly checked on Mr Shearer, the cardiac arrest and the resultant brain damage, which he suffered, could have been prevented. The evidence, so it was contended, overwhelmingly supported the appellants' version that Mr Shearer's deterioration was not gradual but sudden.

[22] Thirdly, the first respondent should have called Mrs Shearer as a witness, who would have provided facts regarding the ingestion of drugs as well as Mr Shearer's deteriorating condition. An adverse inference should have been drawn as a result of the first respondent's failure to call her as a witness.

[23] As to the second appellant, the argument was that, in the absence of a duty of care or vicarious liability, it should not have been found liable. Additionally, no doctor/patient relationship existed between Mr Shearer and the second appellant, and consequently no legal duty existed to give rise to any negligence claim.

Negligence and causation in relation to the first appellant

[24] Prof Coetzee's evidence was cogent, clear and founded on logical reasoning. Most importantly, it was undisputed in material respects. The first appellant agreed

with a number of statements and conclusions made by Prof Coetzee. He did not dispute Prof Coetzee's testimony that the detrimental effects of the intake of quantities of alcohol and pharmaceutical drugs on the brain and airways were common knowledge in the medical field. He also agreed with Prof Coetzee's opinion that the probabilities were high that the cardiac arrest that Mr Shearer had suffered was caused by severe and sustained hypoxia.

[25] The first appellant further conceded that if the hypoxia was reacted upon timeously, even up to two minutes before the arrest, the arrest would probably not have occurred and Mr Shearer would not have suffered brain damage. He agreed with the proposition put to him in cross-examination that if he had gone to check on Mr Shearer after 21h35 and up until 22h00, he would have been able to save him from suffering brain damage.

[26] It was clear from Prof Coetzee's evidence that because of the history of the intake of alcohol and drugs, Mr Shearer could not have been stable, as presumed by the first appellant. He explained that Mr Shearer's condition would gradually change as the drugs and alcohol were absorbed into the system.

[27] The first appellant's evidence that he was assured by the improvement in the saturation level that went to 98% after he corrected the oxygen probe on Mr Shearer's finger, does not absolve him. Apart from this not being recorded in the clinical notes, the history of overdose of alcohol with drugs should have caused a reasonable medical practitioner in the first appellant's position to expect a gradual change in Mr Shearer's breathing and oxygenation.

[28] Prof Coetzee testified that it was not sufficient to leave Mr Shearer with the nursing staff, because they would not be able to pick up the subtle changes which could occur. They would (most likely) not appreciate the fact that the oxygen administered to Mr Shearer would not resolve the underlying threat of his breathing deteriorating due to the delayed absorption of the intoxicants into his system. In this regard, the small matters such as the maintenance of the airway, a change in breathing rate and the method of breathing and whether it was deep enough, would be lost on the nursing staff, but not on a medical practitioner. The nursing staff would wait until the saturation went below 90% and the alarm went off. They would also probably not take note of the significance of the fact that Mr Shearer, who was aggressive on admission, was becoming sleepy.

[29] Because of these subtleties, a medical practitioner would have had to write down clear instructions as to what had to be monitored by the nursing staff. In this case, there were no clinical notes which Prof Coetzee could find instructing the nursing staff on these matters. The first appellant conceded that he should have given clear instructions to the nursing staff, in particular Sister Phillips, to constantly remain with Mr Shearer, as well as to what precisely to monitor him for, given that the ingestion of drugs and alcohol could affect his respiratory rate and lead to possible airway obstruction.

[30] According to Prof Coetzee, had all of these processes occurred, the changes would have been noted and timeous ventilation and oxygenation, which could well have included trachea intubation, would have prevented Mr Shearer from desaturating to the point where he became hypoxic and eventually suffered a heart arrest.

[31] With the first appellant having made material concessions, the only issue in dispute was whether the first appellant discharged his duty of care by relying on the nurses. Prof Coetzee's evidence was clearly based on logical reasoning on this issue, as demonstrated above. The high court was correct in accepting it. Prof Coetzee gave his opinion primarily based on the hospital records and the emergency unit's clinical notes, calling Mrs Shearer as a witness would not have taken the case any further. On his own evidence, the first appellant was negligent by leaving the patient in the care of the nursing staff without adequately instructing them.

[32] I am of the view, therefore, that the evidence of negligence and causation is overwhelmingly against the first appellant. There is, accordingly, no reason to interfere with the high court's decision in relation to him.

Liability of the second appellant

[33] The position as regards the second appellant is different. In this Court, the only question in relation to the liability of the second appellant was whether in law it was liable for the negligence of the first appellant. The high court found that the first appellant was an independent contractor in relation to the second appellant. This finding was not challenged before us.

[34] Our law is clear that the principal is not liable for the civil wrongs of an independent contractor, except where the principal was personally at fault.[5] Counsel for the first respondent submitted that, whilst the first appellant was not an

[5] *Chartaprops 16 (Pty) Ltd and Another v Silberman* [2008] ZASCA 115; 2009 (1) SA 265 (SCA); [2009] 1 All SA 197 (SCA) paras 6 and 42; *Langley Fox Building Partnership (Pty) Ltd v De Valence* 1991 (1) SA 1 (A); [1991] 3 All SA 736 (A).

employee of the second appellant, the facts of this case nevertheless call for the application of general principles of vicarious liability. Alternatively, given the facts of this case, it is appropriate to recognise a stricter obligation on the part of the second appellant, described as a non-delegable duty.

[35] In respect of vicarious liability, counsel for the first respondent submitted that the second appellant's appeal should fail on the law as it currently is. However, insofar as a non-delegable duty of care is concerned, he invited this Court to develop the common law, should the first argument fail.

[36] The submission made on behalf of the first respondent was that vicarious liability is not limited to employer and employee relationships. It can attach to situations where the person committing the delict is undertaking an activity which serves the other party's interests. To illustrate this, an owner of a motor vehicle can be held vicariously liable for the delicts committed by the driver thereof in the absence of an employment relationship. In this regard, it is sufficient that the vehicle was driven on behalf of the owner, even if only partly for the purposes of the owner. This is all good and well, but for the reasons that follow, does not avail the first respondent.

[37] The matter must be determined on the basis that as a fact, the first appellant was an independent contractor. In this regard, Nugent JA clearly stated in *Chartaprops 16 (Pty) Ltd and Another v Silberman*[6] that it is well established that the relationships to which vicarious liability applies do not include the relationship of a principal and an independent contractor. The party who appointed the

[6] *Chartaprops 16 (Pty) Ltd and Another v Silberman* [2008] ZASCA 115; 2009 (1) SA 265 (SCA); [2009] 1 All SA 197 (SCA) para 6.

independent contractor could only be liable in delict for its own failure to take reasonable steps to guard against foreseeable harm. The same was said in the majority judgment of Ponnan JA.[7] The first respondent disavowed any intention to attempt to persuade us to develop the law of vicarious liability. It follows that there was simply no legal basis upon which the second appellant could attract vicarious liability for the conduct of the first appellant. Thus, on the evidence before us, no case has been made out for a finding that the second appellant was vicariously liable for the delicts of the first appellant.

[38] This takes me to the alternative argument that we should develop the common law by reconsidering the principle of non-delegable duty of care in circumstances where the victim was especially vulnerable, particularly in places like hospitals and schools. In this regard, a higher standard of care in the sense described by Nugent JA in the minority judgment of *Chartaprops*[8] and English authority to this effect is argued for.[9]

[39] Acceptance of this proposition would entail overturning the majority view in *Chartaprops*. Writing for the majority, Ponnan JA criticised the application of the non-delegable duty of care as being inconsonant with the principles of negligence existing in our law. He said, inter alia, the following when applying the facts of that case to the law:

'. . . [I]t is difficult to see why the general policy of the law that the economic cost of the wrong should be borne by the legal entity immediately responsible for it, should not be enforced in this case. Furthermore, to shift the economic cost of negligent acts and omissions from Advanced

[7] Ibid para 28.
[8] Ibid paras 7-26.
[9] *Woodland v Essex County Council* [2013] UKSC 66; *Hughes v Rattan* [2021] EWHC 2032 (QB).

Cleaning, the independent contractor with primary responsibility, to Chartaprops, because of the legal fiction of non-delegability, appears to me to be undesirable.'[10]

[40] It is established that when circumstances are compelling courts must develop the common law. In doing so, courts are obliged to 'promote the spirit, purport and objects of the Bill of Rights'.[11] As stated in *Dendy v University of the Witwatersrand and Others*:[12]

'. . . This ensures that the common law will evolve, within the framework of the Constitution, consistently with the basic norms of the legal order that it establishes (*Pharmaceutical Manufacturers Association of SA: In re Ex parte President of the Republic of South Africa* 2000 (2) SA 674 (CC) at para 49). The Constitutional Court has already cautioned against overzealous judicial reform. Thus, if the common law is to be developed, it must occur not only in a way that meets the section 39(2) objectives, but also in a way most appropriate for the development of the common law within its own paradigm (*Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) at para 55). (See also *City of Tshwane Metropolitan Municipality v RPM Bricks (Pty) Ltd* [2007] SCA 28 (RSA) para 20.)

A court, faced with such a task, is obliged to undertake a two-stage enquiry. *First, it should ask itself whether, given the objectives of s 39(2), the existing common law should be developed beyond existing precedent.* If the answer to that question is a negative one, that should be the end of the enquiry. If not, the next enquiry should be how the development should occur and which court should embark on that exercise. (See *S v Thebus* at para 26.)' (My emphasis.)

[41] In *Mighty Solutions CC t/a Orlando Service Station v Engen Petroleum Ltd and Another*,[13] the Constitutional Court laid out what factors a court should consider before developing the common law:

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[10] *Chartaprops* fn 6 para 44.
[11] Section 39(2) of the Constitution.
[12] *Dendy v University of the Witwatersrand and Others* [2007] ZASCA 30; [2007] 3 All SA 1 (SCA); 2007 (8) BCLR 910 (SCA) paras 22-23.
[13] *Mighty Solutions CC t/a Orlando Service Station v Engen Petroleum Ltd and Another* [2015] ZACC 34; 2016 (1) SA 621 (CC); 2016 (1) BCLR 28 (CC).

'Before a court proceeds to develop the common law, it must (a) determine exactly what the common law position is; (b) then consider the underlying reasons for it; and (c) enquire whether the rule offends the spirit, purport and object of the Bill of Rights and thus requires development. Furthermore, it must (d) consider precisely how the common law could be amended; and (e) take into account the wider consequences of the proposed change on that area of law.
In *Carmichele* Ackermann J and Goldstone J stated that "where the common law deviates from the spirit, purport and objects of the Bill of Rights the courts have an obligation to develop it by removing that deviation". The Court reminded us though that, when exercising their authority to develop the common law, "[j]udges should be mindful of the fact that the major engine for law reform should be the Legislature and not the Judiciary". The principle of separation of powers should thus be respected.'[14]

[42] Therefore, a duty rests upon a litigant to present these considerations before this Court. It is not sufficient to simply submit that the common law must be developed in a particular way. There must be an assessment of the existing legal position, its underlying reasons and deficiencies, how it deviates from the constitutional values, and how that should be rectified. That should be done taking into account the wider consequences of bringing change to the area of the law concerned. The first respondent has presented none of this.

[43] Apart from alleging a case for the vulnerable, the underlying reasons for the current common law rule and the reasons for its existence have not been canvassed. Neither has the first respondent set out in what way the common law principle is in conflict with the values of the Constitution and the Bill of Rights or offends the spirit, purport and objects of the Bill of Rights, requiring it to be developed. This Court cannot develop the law in a vacuum.

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[14] Ibid paras 38-39. See also *Carmichele v Minister of Safety and Security and Another* [2001] ZACC 22; 2001 (4) SA 938 (CC) paras 40-41.

[44] In addition, a case for the development of the common law must be brought at the earliest opportunity. Ideally, this would mean that the first respondent ought to have raised this issue in the high court 'in order to ensure that our jurisprudence under the Constitution develops as reliably and harmoniously as possible'.[15] It would have been beneficial for this Court to have the views of the high court on this matter. It is so that in appropriate cases, courts will allow these points to be raised on appeal or do so even *mero motu*. This is, however, not a case falling into the category of those compelling or exceptional cases and such argument has not been advanced. *Chartaprops* is a recent precedent. Any reconsideration of the position set out therein, required a clearly set out basis.

[45] Consequentially, both arguments in relation to the liability of the second appellant must fail. This means that the high court's order concerning the second appellant cannot stand.

Conclusion

[46] As indicated earlier, the high court found the appellants to be jointly and severally liable, the one paying the other to be absolved, for 65% of damages that may be proved by the first respondent. It is not clear how the high court determined that apportioned percentage. That issue, however, is not before this Court. The apportionment order in relation to the first appellant will remain undisturbed.

[47] The appeal of the first appellant concerned an uncomplicated factual issue, which did not reasonably warrant the employment of two counsel. I will accordingly not allow such a costs order.

[15] Ibid.

[48] In the result, I make the following order:

1 The appeal of the first appellant is dismissed with costs.

2 The appeal of the second appellant is upheld with costs.

3 The order of the high court is set aside and substituted with the following:

‘1. The first defendant is found liable for 65% of whatever damages the patient, Mr Shearer, represented by the first plaintiff, might prove for injuries sustained by him as a result of the cardiac arrest and resultant brain damage which Mr Shearer suffered in the emergency unit of Life Westville Hospital in Durban on 27 December 2014.

2. The first defendant is ordered to pay the first plaintiff’s costs of suit, including costs occasioned by the employment of two counsel where so employed. These costs shall include:

(i) the cost of preparation for, and attendance of, all pre-trial conferences that were held and attended by them, as well as the drafting and settling of the pre-trial agendas and minutes; and the plaintiffs’ costs of obtaining the medical legal reports of the plaintiffs’ experts relating to the issue of liability, including the cost of counsel for drafting the plaintiffs’ expert summaries in respect of the issue of liability in which formal notice was given in terms of rule 36(9)*(a)* and *(b)*;

(ii) the cost of preparation, qualifying and reservation of the plaintiffs’ experts in respect of the liability trial of whom notice was given in terms of rule 36(9)*(a)* and *(b)*, including the costs of consultations by the plaintiffs’ legal representatives with these experts and the costs of these experts in preparation for and holding joint meetings with their respective counterparts, and preparing joint minutes, if any. These costs are for the following

experts: (a) Prof André Coetzee, (b) Prof Lee Wallace, (c) Prof Isabel Coetzee, and (d) Dr Izak A J Loftus; and the fees of Prof André Coetzee for testifying at the liability trial as an expert witness for the plaintiffs.

(iii) the costs of having the proceedings of 28 May, 29 May, 3 June and 5 June 2019 transcribed for purposes of the court and the argument submitted to the court.

3. The claims of the second plaintiff in a personal capacity, and in her representative capacity, on behalf of the minor children, Declan and Keziah, are postponed *sine die* to be determined together with the quantum of the first plaintiff's claim for damages against the first defendant.

4. The action against the second defendant is dismissed with costs.'

N P MABINDLA-BOQWANA
JUDGE OF APPEAL

APPEARANCES

For the appellants:	N A Janse van Rensburg MacRobert Attorneys, Durban Webbers Attorneys, Bloemfontein
For the first respondent:	S R Mullins SC and J A Ploos van Amstel
Instructed by:	N Kelly Incorporated Attorneys, Illovo Green Attorneys, Bloemfontein