THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Not Reportable

Case no: 580/2022

In the matter between:

M M **APPELLANT**

(obo E L M)

and

MEMBER OF THE EXECUTIVE

COUNCIL FOR HEALTH: EASTERN CAPE **RESPONDENT**

Neutral citation: *M M v MEC for Health; Eastern Cape* (580/2022) [2023] ZASCA 130 (11 October 2023)

Coram: SALDULKER, MOCUMIE, HUGHES and GOOSEN JJA and MALI AJA

Heard: 16 August 2023

Delivered: This judgment was handed down electronically by circulation to the parties' legal representatives via e-mail, publication on the Supreme Court of Appeal website and released to SAFLII. The date and time for hand-down are deemed to be delivered on 12 October 2023.

Summary: Delict – medical negligence – damages – claim for damages arising out of alleged medical negligence of hospital staff- whether the hospital should be held liable for the damages suffered by the minor child-negligence and causation not established.

ORDER

On appeal from: Eastern Cape Division of the High Court, Bisho (Van Zyl DJP, Schoeman J and Noncembu AJ, sitting as court of appeal).

1. The appeal is dismissed with no order as to costs.

JUDGMENT

Saldulker JA (Mocumie, Hughes, and Goosen JJA and Mali AJA concurring):

[1] The appellant, Mrs MM, instituted an action against the respondent, the Member of the Executive Council for Health (MEC) of the Eastern Cape Government in the Eastern Cape Division of the High Court, Bhisho (high court), for damages arising from a brain injury sustained by her minor child (referred to herein as ELM), after his birth at Frere hospital, East London. The appellant's case was based on the breach of a duty of care and negligence towards her and ELM by the hospital staff. The matter came before Tokota J, who found in favour of the appellant, and ordered that the respondent pay such damages as may be proved by the appellant. The respondent was granted leave to appeal to the full bench of the division on a limited issue, and on petition to this court, it was granted leave against the whole judgment. The full court (Van Zyl DJP, Schoeman J and Noncembu AJ), upheld the appeal of the MEC, set aside the high court's order, and replaced it with an order dismissing the appellant's claim with costs. This appeal is with the special leave of this court.

[2] The salient facts are as follows. On 18 October 2010, the appellant was admitted to Frere hospital and gave birth at 18h25 to ELM by way of an emergency caesarean section.

[3] After his delivery, ELM was transferred to the nursery ward with mild respiratory distress, and on the following day, he was placed with the appellant in the maternity

ward. A day later, on 20 October 2010, it was observed that ELM may have jaundice, and this diagnosis was confirmed by a laboratory report during the morning of the same day, which showed that the total serum bilirubin level (TSB) of ELM was 506 micromol/L. This was registered at 07h41, approximately 37 hours post ELM's delivery. ELM was then transferred to the nursery ward where Dr Harper, a paediatrician, was consulted, and supportive treatment commenced with ELM receiving intravenous haemoglobin and intensive phototherapy. Further tests were performed on 20 October 2010, and during the morning of the 21st. These results indicated no significant drop in ELM's TSB levels, in that the TSB level reduced to 498 micromol/L, and on the morning of 21 October 2010, at 08h24 the TSB level was 493 micromol/L. An entry in the hospital records on 21 October was to the following effect: 'No significant drop in total serum bilirubin overnight despite triple phototherapy and polygam. Blood for exchange transfusion ordered from PE. At this stage neonatal is neurologically sound with no signs of kernicterus and no seizure'.

[4] Blood was ordered from the National Blood Services (the blood bank) for a blood exchange transfusion to be performed. Before the arrival of the blood, and approximately at midday on 21 October 2010, the appellant requested that ELM be transferred from Frere Hospital to Life Beacon Bay Hospital, a private facility in East London. The transfer was preceded by the drafting of a referral letter to the attending paediatrician at the private hospital, Dr Paul, the relevant paragraph reading as follows: 'Baby requires exchange transfusion blood ordered from PE (560mls whole blood) as none available in East London. Estimated time of arrival at blood bank is 17h00.' ELM was admitted to Life Beacon Hospital at 14h50. At 20h00 the blood transfusion was commenced. Throughout the time that ELM was at Frere Hospital, and until the blood transfusion, he did not show any symptoms of neurological complications.

[5] It is not disputed that ELM was diagnosed with dystonic cerebral palsy and profound developmental delay complicated by epilepsy, intellectual disability, and a hearing defect. The cause of the cerebral palsy was hyperbilirubinemia, which was the result of very high levels of TSB in ELM''s blood during the neonatal period. The hyperbilirubinemia occurred as a result of the incompatibility between the appellant's blood group (O+) and that of ELM (B+) which caused haemolysis - the destruction of

ELM's red blood cells resulting in an increase in his TSB levels. The hyperbilirubinemia in turn caused bilirubin encephalopathy and subsequent brain dysfunction known as kernicterus.

[6] The question is whether the negligence of the hospital staff caused or contributed to the injury suffered by ELM. In the high court, the matter came before Tokota J. The parties agreed to an order for a separation of the issues of merits and quantum in terms of Rule 34, and the matter proceeded on the merits and causation. During the trial, the appellant led the evidence of Dr Lombard, whilst the respondent presented the evidence of Dr Harper, the paediatrician who attended to ELM at Frere Hospital.

[7] At the trial the parties agreed that a joint minute drawn up by two expert paediatricians, Drs Lombard and Mzizana, be filed which recorded *inter alia* the following:

'1. [ELM] has been diagnosed with dystonic cerebral palsy and profound developmental delay complicated by epilepsy, intellectual disability and a hearing defect.

It is agreed that the cause of [ELM's] cerebral palsy was hyperbilirubinemia in the neonatal period which caused bilirubin encephalopathy and subsequently kernicterus. The hyperbilirubinemia occurred due to an incompatibility between Ms [MM]'s blood group (O+) and that of [ELM] (B+) which caused hemolysis (destruction of red blood cells) resulting in an increase in the total serum bilirubin (TSB).

. . .

2. ABO blood group determination is not done routinely as an antenatal test. It is, however, possible that first-born infants can be affected.

. . .

3. Bilirubin encephalopathy is a preventable condition.

. . .

4. The MRI findings of abnormal signal intensities in the globus pallidi reported by Dr Zikalala and Prof Lotz are usually seen in kernicterus, due to deposition of bilirubin.

. . .

5. The supportive treatment that [ELM] received at the Frere Hospital was appropriate, but the ordering of the blood for an exchange transfusion was delayed for an unacceptable period.

Published guidelines recommend that an immediate exchange transfusion should be done if

the baby's TSB is more than 85 micromol/L above the threshold for exchange.
[ELM] had a TSB that was 141 micromol/L above the recommended threshold for an exchange transfusion at approximately 37 hours of life on 20-10-2010. Published guidelines further recommend that infants who present with TSB above the threshold should have an immediate exchange transfusion done if the TSB is not expected to be below the threshold after 6 hours of intensive phototherapy, but in [ELM's] case the TSB was only repeated 11 hours later and at that stage it was still 103 micromol/L above the threshold.

Dr Mzizana agreed, but also note that he still remained neurologically sound at that stage.
. . .
6. Blood was only ordered for an exchange transfusion at least 21 hours after [ELM] presented with a TSB that was high enough to qualify for an immediate exchange transfusion. It is of note that the baby was described as neurologically sound at that stage.
. . .
7. The arrival of blood for the exchange transfusion from the blood bank was delayed, but it was still possible to commence the procedure approximately 10 hours after the blood was ordered. If the blood had been ordered on the morning of the 20-10-2010 the transfusion could have been done that same evening. That was the best opportunity to prevent the development of bilirubin encephalopathy.

[Dr Mzizana agreed that] it is also noteworthy that the exact duration of exposure to hyperbilirubinemia to cause bilirubin encephalopathy is unknown and timing of when encephalopathy will occur cannot be predicted; and the parents' request to transfer to private hospital caused further delay.

[Dr Lombard agreed] and is of the opinion that if the blood had been ordered immediately on the morning of 20-10-2010 the procedure could have been done before the transfer was requested.'

[8] Later, Dr Mzizana attempted to retract the agreement in the foregoing para 6 of the joint minute, that blood was only ordered for an exchange transfusion at least 21 hours after ELM presented with a TSB level that was high enough to qualify for an immediate exchange transfusion. This, she explained, was because there was no factual evidence to support this assertion.

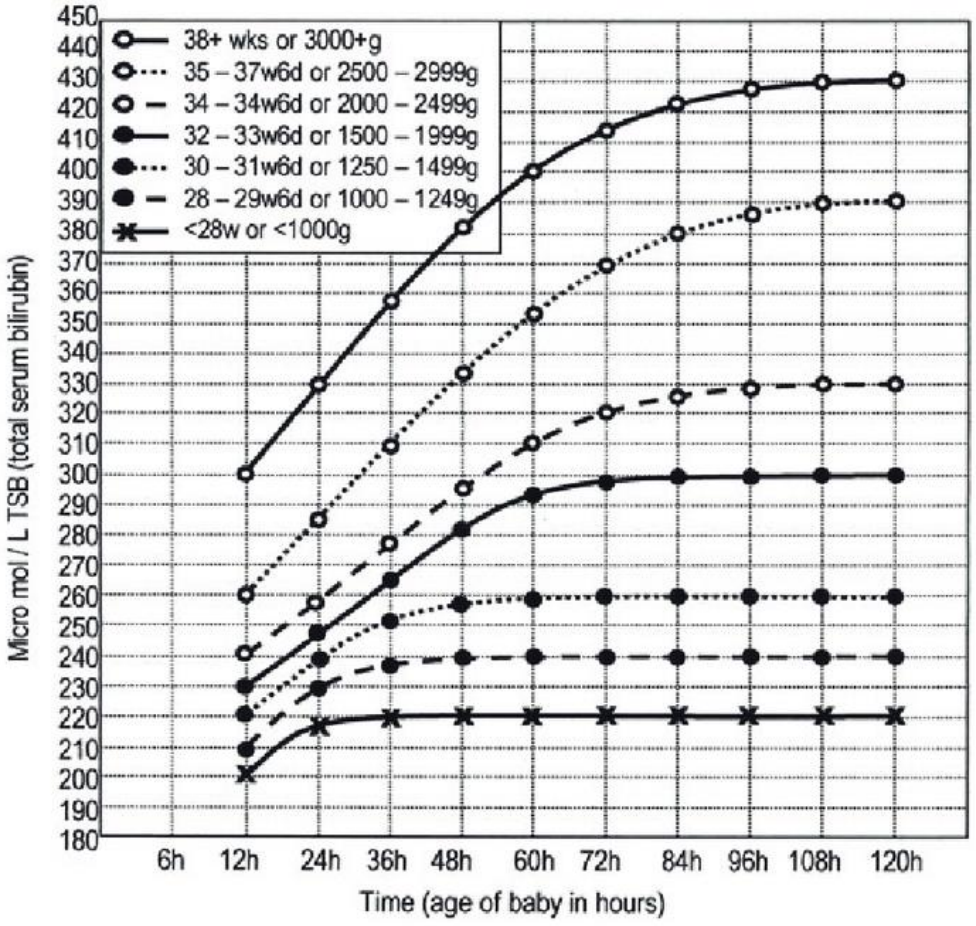
[9] According to both the paediatricians the published medical guidelines recommend an immediate exchange blood transfusion should an infant's TSB be more than 85 micromol/L above the threshold level. The TSB for ELM was 141 micromol/L above the recommended threshold at approximately 37 hours of life on 20 October 2010.

EXCHANGE TRANSFUSION

South African Neonatal Academic Hospital Guidelines: 2006

In presence of sepsis, haemolysis, acidosis, or asphyxia,
use one line lower (gestation below) until <1000g
If gestational age is accurate, rather use gestational age (weeks) than body weight

Note: 1. Infants who present with TSB above threshold should have Exchange done if the TSB is not expected to be below the threshold after 6 hrs of intensive phototherapy.
2. Immediate Exchange is recommended if signs of bilirubin encephalopathy and usually also if TSB is >85 µmol/L above threshold at presentation
3. Exchange if TSB continues to rise >17 µmol/L/hour with intensive phototherapy



[10] Thus, in terms of the foregoing published medical guidelines, infants who present with TSB levels above the threshold should have an immediate exchange transfusion if the TSB is not expected to be below the threshold after 6 hours of intensive phototherapy. In the case of ELM, after 11 hours of treatment, his TSB was still above the threshold. The foregoing chart below indicates when, how, and in which circumstances and at what age of the baby in hours, blood transfusions are required for infants with high TSB levels.

[11] The appellant's case on the pleadings, was that the hospital staff at Frere hospital had allowed ELM to develop kernicterus in that they failed to prevent bilirubin encephalopathy from developing when they had ample opportunity to do so. It was further alleged that the hospital staff failed to initiate a blood exchange transfusion when signs of bilirubin encephalopathy were present. I quote excerpts from para 7 of the plaintiff's particulars of claim wherein it was alleged *inter alia* that the hospital:

'7.6 They failed to act generally as would be expected of medical practitioners when complications arose;

. . .

7.9 They failed to take heed of the fact that [ELM] was at high risk for developing kernicterus due to *inter alia* maternal blood incompatibility, and failed to act accordingly;

7.10 They allowed [ELM] to develop kernicterus;

7.11 They failed to prevent bilirubin encephalopathy from developing when they had sufficient opportunity to do so;

7.12 They failed to initiate exchange transfusion when signs of bilirubin encephalopathy were present;'

[12] The main focus of the appellant's case, although not pertinently pleaded, was that the hospital staff were negligent for not immediately ordering the blood for a transfusion for ELM, when in fact the laboratory test results on 20 October 2010 showed that ELM's TSB levels placed him at a high risk of hyperbilirubinemia. Instead, so the appellant contended, they waited until the following day, 21 October 2010 to order the blood for the transfusion. The case for the appellant, however, as appears from para 7.12 above, was that the respondent failed to initiate an exchange transfusion when signs of bilirubin encephalopathy were present, and not that the blood was not ordered. The focus of the appellant's case, which was advanced at the

trial was that there was a delay of some 21 hours in the ordering of the blood after finding that ELM's TSB level was above the threshold level for exchange.

[13] In contrast, the respondent's case was that fresh whole blood was ordered on 20 October 2010, and the delay in receiving the blood necessary for an immediate exchange transfusion, was not attributable to negligence on the part of the hospital, but rather on the non-availability of fresh whole blood in East London. Frere hospital does not supply blood and it was out of the hospital's control that no blood was available. ELM had no signs of neurological compromise or problems at 19h30 on 21 October 2010 after his transfer to Life Beacon Bay hospital. The neurological symptoms manifested during the exchange procedure which commenced at approximately 21h00 at the private facility. In order to properly transfuse ELM, Life Beacon Bay would have had to transfuse a total blood volume of 576 millilitres, whereas it was common cause that only 390 millilitres was transfused to ELM.

[14] On the issues of negligence and causation, the high court found that the hospital staff at Frere Hospital were negligent, in that, once ELM had been diagnosed with jaundice, the hospital staff at Frere hospital should have ordered blood immediately. The failure to act immediately contributed and caused the harm suffered by the appellant. Furthermore, the hospital staff treated ELM by other measures to reduce the bilirubin levels. Only when such measures were no longer viable, was the decision made, the following day, to order the blood transfusion. The high court found, as a fact, that the blood was only ordered on 21 October 2010. Consequently, it held that bilirubin encephalopathy developed, resulting in ELM developing cerebral palsy. The high court rejected the respondent's evidence that the blood was ordered on 20 October 2010. It held that it was incumbent upon the respondent to have pleaded that blood was ordered on 20 October 2010 for ELM.

[15] On appeal, the full court (Van Zyl DJP, Schoeman J and Noncembu AJ) dismissed the appellant's case and held that there was no evidence to support a conclusion that the blood would have been received on the same day, 20 October 2010. It held that in the absence of evidence of the availability of blood at the blood bank, and the time it would have taken for it to be dispatched and taken to East London, it was nothing more than speculation that it would have been received on the

20th and not on the 21st especially since the order was made on the 20th. The full court reasoned that the opinion expressed by the two paediatricians Drs Lombard and Mzizana in their joint statement that the ordering of the blood was unduly delayed, was based on the assumption that the blood was only ordered on 21 October 2010. The opinion postulated by the two paediatricians was qualified by a further agreement in the joint minutes that the exact duration of the exposure to bilirubinaemia to cause bilirubin encephalopathy was unknown. This then begged the question as to what was reasonably foreseeable, in the circumstances, in deciding the issue of negligence, and whether the negligent conduct of the hospital staff at Frere hospital caused or contributed to the injury suffered by ELM. Pertinently the full court reasoned as follows:

'[19] Turning then to deal with the issues raised at the trial, the first question is whether the hospital staff were negligent in the manner advanced by the respondent at the trial. Negligence is established if a reasonable person would foresee the reasonable possibility of his or her conduct injuring another person and causing that person to suffer patrimonial loss, and would take steps to guard against such occurrence.[1] The requirements for negligence are applied to a reasonable person in the position of a defendant. This means that the specific qualities of a defendant, such as specialised skill and knowledge, which he or she possessed at the time, must be considered in assessing his or her conduct against the requirements for negligence.[2]

[20] The relationship between a plaintiff and a defendant that possess specialised skill and knowledge may consequently require a standard of care from the defendant that is different to what that standard would otherwise be. It is however not expected of such a defendant to exercise the highest possible degree of professional skill.[3] What is expected is the general level of skill and diligence which is possessed and would ordinarily be exercised by a reasonable member of the branch of the profession to which he or she belongs under similar circumstances. Applied to the facts of the present matter, liability will only be imposed if it is found that the injury sustained by ELM was reasonably foreseeable, and that the hospital staff had failed to provide the level of skill and competence that could otherwise expected to be provided by a reasonable health care worker in similar circumstances.'

[16] I turn to consider the issues of negligence and causation. It is trite that negligence is established if a reasonable person would foresee the reasonable possibility that his/her conduct would injure another person causing that person to

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[1] *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430 E.
[2] *Van Wyk v Lewis* 1924 AD 438 at 444.
[3] *Mitchell v Dixon* 1914 AD 519 at 525.

suffer patrimonial loss, and would take reasonable steps to guard against such occurrence.

[17] Dr Harper testified that after ELM was diagnosed with jaundice he was moved to the nursery. The results from the laboratory revealed that ELM's TSB levels were very high, and according to the 'chart' in the nursery, the recommended treatment for an infant matching ELM's profile was an exchange blood transfusion. The blood bank was contacted as that was the first line of treatment according to the published medical guidelines. Dr Harper then instructed a hospital staff member in the nursery during the morning of 20 October 2010 to order the blood in order to do an exchange blood transfusion for ELM. They were informed that 'whole fresh blood' was not available at the East London blood bank, and that blood had to be ordered from Gqeberha. ELM, in the interim, was treated with phototherapy. Further tests were conducted, but during the course of the day, when it became clear that the appellant and ELM's blood group were incompatible, and that there was no blood available, treatment commenced by way of intravenous haemoglobin. Phototherapy continued while they waited the arrival of the blood from Gqeberha, which was scheduled to arrive at 17h00 on 21 October 2010. There was no indication that ELM's condition was deteriorating, and there was no sign of acute bilirubin encephalopathy present.

[18] However, during midday on 20 October 2010, ELM's parents requested that ELM be transferred to a private facility, the Life Beacon Bay Hospital. Dr Harper instructed Dr Evans, another doctor in the nursery to prepare a referral letter, recording at the end of the referral letter that the blood had been ordered from Gqeberha. This was, according to Dr Harper to prevent the private hospital from initiating the same process to order the blood. At 14h50 ELM was transferred to the private facility. Up until the time of the transfusion at the private hospital there were no indications that ELM had been neurologically compromised. The volume of blood required for an exchange transfusion was 576 millilitres. Ultimately, only 390 millilitres was transfused to ELM.

[19] Dr Lombard's testimony was that the blood was ordered on the 21st and not on the 20th. However, it must be borne in mind that this evidence of Dr Lombard did not stem from his personal knowledge, but from his interpretation of the clinical notes

which were kept by the hospital staff in the nursery at Frere hospital. The entries on the 21st record that 'blood exchange transfusion ordered from PE, and the estimated time of arrival at blood bank was 17h00 of the blood ordered'. The high court held that it was on the basis of this assumed fact that both Drs Lombard and Mzizana expressed the view in their joint minutes, that there was an undue delay, and that had the blood been ordered on the morning of the 20th the transfusion could have been done that same evening. This inference that the experts sought to draw, however, was clearly wrong and has no evidential value.

[20] The high court thus erred in concluding that the blood was only ordered on 21 October 2010. The high court appears to have disregarded Dr Harper's evidence that the order for the blood was made on 20 October 2010. Dr Harper was the paediatrician in charge of the nursery who treated ELM. He had a clear recollection of the case and his testimony with regard to the referral letter to the private facility is critical in the assessment of the burden of proof. He testified that he informed Dr Evans that it was important to state in the letter to the private facility that the blood had been ordered 'Because the private facility [uses] the same blood bank that we do and we did not want them to go through the same process of trying to order fresh whole blood when we had ordered it. So, [he] instructed the junior doctor to write very clearly at the bottom of the letter that the blood had been ordered from Port Elizabeth. This letter is not a day-by-day notes account of doctors writing notes on each day. It is a summary of the case. The fact that the note "blood for exchange transfusion" is at the end is because I instructed them to make it very clear that the blood had been ordered.'

[21] This testimony clearly indicates that Dr Harper, as the treating doctor, took ELM's case seriously and was alive to what was expected of him as a medical practitioner. He was aware that ELM required emergency treatment and took steps to bring it to the attention of the hospital staff at Frere hospital, including those at the private facility. He took steps to secure an alternative blood supply when the blood was not available in East London. He was aware that a blood exchange transfusion was required for ELM.

[22] This evidence established, on the probabilities, that an order for blood was indeed placed on 20 October 2010. There appears to have been no cogent reason to

reject Dr Harper's evidence that he instructed the hospital staff to order the blood. Furthermore, Dr Harper took reasonable and supportive measures to treat ELM, whilst the blood was awaited to prevent harm to ELM. On the facts, until the commencement of the blood transfusion, there were no indications. that ELM was neurologically compromised. The consequence is that whilst he was under the care of the hospital staff ELM received proper and reasonable care and was neurologically sound. Therefore, in our view the full court was correct in holding that on the available evidence, the staff at Frere hospital were not negligent.

[23] Additionally, Dr Lombard's evidence was that if the blood was ordered on the morning of 20 October 2010, the transfusion could have been done that same evening. In the absence of any factual evidence, as to the time it would have taken between placing an order for the blood in Gqeberha and its delivery at the blood bank in East London, this evidence has no factual basis, and must remain in the realms of speculation. Consequently, there exists no factual basis for Dr Lombard's assumption that an exchange blood transfusion could have been done on 20 October 2010. The full court was correct in finding that the high court erred in its rejection of the respondent's evidence that the blood was ordered on 20 October 2010. There exists no reason to reject this finding.

[24] In the absence of established negligent conduct the issue of causation does not arise. However, for the reasons that follow, the appeal must fail also on this aspect. In *Lee v Minister of Correctional Service*[4] the Constitutional Court said causation as an element of liability gives rise to two distinct enquiries. The first is the factual enquiry into whether the negligent act or omission caused the harm giving rise to the claim. If it did, then the second enquiry, referred to as the legal causation, arises namely when the negligent act is sufficiently closely or directly linked to the loss for liability to ensure, or whether the loss is too remote. In this matter the conduct in question is the failure to timeously order the blood in order for an exchange blood transfusion to be performed on 20 October 2010 to prevent harm to ELM. This supposes that the blood would have arrived on the 20th. In this regard there was no evidence raising this as a

[4] *Lee v Minister of Correctional Services* [2012] ZACC 30; 2013 (2) BCLR 129 (CC); 2013 (2) SA 144 (CC); 2013 (1) SACR 213 (CC).

probability. Whole fresh blood was simply not available. The blood had to be ordered and dispatched from another city. No evidence was led as to whether it was readily and immediately available at the blood bank in Gqeberha, and at what time it would arrive in East London for ELM to receive the exchange blood transfusion, so as to prevent ELM from developing bilirubin encephalopathy. There are no facts to confirm that the blood would have been received on the 20th.

[25] Regrettably, no evidence was produced as to when the order for blood was in fact placed with the blood bank. It was open to the appellant to have obtained evidence to that effect from the blood bank, which was an entity distinct from the respondent. The question of onus is important in the assessment of the evidence and the onus was on the appellant to establish the elements of delictual liability. The appellant could have, and should have, subpoenaed an official from the blood bank to establish when the blood was actually ordered, but she chose not to do so. This was a factual issue. Simply put, evidence on this point would have put paid to speculation on this important point in the assessment of delictual liability.

[26] There was some debate in the high court, the full court and before this Court, with regard to the manner in which the appellant had formulated the foregoing particulars of claim and the respondent's plea which was filed in response to the appellant's particulars of claim, that it had no knowledge of the allegations constituting negligence on the part of the hospital staff. At the heart of the aforementioned para 7 is the allegation of the respondent's negligent causation of ELM's condition, and that the respondent, through the hospital staff, failed to exercise reasonable care and skill.

[27] The high court found that it was incumbent upon the respondent to have pleaded that the blood was ordered on 20 October 2010, this in circumstances, where the appellant did not plead that the blood was ordered late by the respondent as a ground of negligence. In this regard, the trial court erred.

[28] The effect of this finding by the high court was that the trial court expected the respondent to adduce evidence to eliminate a factual inference drawn by the expert witness, Dr Lombard. Furthermore, the appellant did not adduce any evidence in support of the allegation that the blood was only ordered by the respondent on 21

October 2010, when it was possible for the appellant to have led evidence in this regard. Had the appellant called an official from the blood bank, all the speculation as to the question when or whether blood was ordered would have been settled. Moreover, if the appellant wished to narrow the issues to the failure to order the blood timeously, the particulars of claim should have been amended, thus affording the respondent an opportunity to properly understand the case that had to be met. It is clear that the purpose of pleadings is as stated by Innes CJ in *Robinson v Randfontein Estates GM Co Ltd:*[5]

'The object of pleadings to define the issues; and parties will be kept strictly to their pleas where the departure would cause prejudice or would prevent full inquiry. But within those limits the court has wide discretion. For pleadings are made for the Court, not the Court for pleadings. And where a party has had every facility to place all the facts before the trial Court and the investigation into all the circumstances has been as thorough and as patient as in this instance, there is no justification for interference by an appellate tribunal, merely because of the opponent has not been as explicit as it might have been.'[6]

It is pertinent to note that this position has remained unchanged for decades.

[29] This court cannot rule out the possibility that other factors may have contributed to the factual cause of ELM's injury. It cannot only be said that the blood in East London did not arrive timeously. The decision of the parents of ELM to transfer him to a private hospital, and the conduct of the staff at the private facility in performing the blood transfusion are other factors. It may also have been the fact that the staff at the private hospital had failed to transfuse sufficient blood, and they should have done a further transfusion. It is not known whether this may have had a detrimental effect on ELM. But again this is also a matter of speculation, which regrettably has never been explored.

[30] There is no factual or casual connection between the conduct of the staff at Frere Hospital and the harm suffered by ELM. Had Frere hospital become aware of ELM's serious TSB levels on 20 October 2010, and done nothing, such a delay would clearly and obviously have been negligent. However, as soon as the laboratory result indicated ELM's TSB level were above the threshold, Dr Harper ordered a range of

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[5] *Robinson v Randfontein Estates GM Co Ltd* 1925 AD 173.
[6] Ibid at 198.

treatments on the same day, 20 October 2010, to lessen the severity of the TSB level. From the record the following clearly emanates: '[the treatment was provided] whilst you were still waiting for the order of fresh blood?' to which the answer was 'This [was] while we were waiting for fresh blood to arrive from Port Elizabeth . . . if we needed to do that.' Dr Harper understood the gravity of the situation, commenced treatment using methods readily available, as soon as jaundice was diagnosed and additionally ordered the blood, in the event that the treatments readily available were unsuccessful. This conduct is indicative of a doctor that acted with skill and care and who did not wait for confirmation that the conventional treatments had failed, before ordering the blood; it is clear that the blood had been ordered even when the treatments were being performed. The record indicates that the instruction to order blood was given the moment the severe TSB levels were confirmed, albeit per instruction to another junior doctor.

[31] In addition, there is also nothing in the papers that indicates that Dr Harper was anything other than a reasonable medical practitioner and that the care provided to ELM was anything other than the standard of care that could be expected. The reason why Dr Mzizana's retraction is important is because it casts credence on the assumption that Dr Harper was, in fact performing his duties as could be expected of a reasonable medical practitioner.

[32] A medical professional is expected to act with the reasonable care and skill required, and that it can be expected of a medical practitioner to act knowledgeably in light of the information a medical professional ought to know. A reasonable medical professional would know that the levels of TSB presented in ELM were so severe that blood was immediately required, and from the record, Dr Harper was well-aware of this fact as ELM was treated in order to mitigate the consequences of the high TSB levels during the time that the blood was awaited.

[33] The level of care exhibited by the hospital staff complies with the requirements of a *diligens paterfamilias* expressed in *Kruger v Coetzee*:[7]

'For the purposes of liability *culpa* arises if-

(*a*)

[7] *Kruger v Coetzee* 1966 (2) SA 428 (A).

> a *diligens paterfamilias* in the position of the defendant-
> (i)
> would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
> (ii)
> would take reasonable steps to guard against such occurrence; and
> (*b*)
> the defendant failed to take such steps.'[8]

[34] It does not appear that the staff of the hospital did anything other than what was reasonably expected of them at the time. In view of the foregoing, the appellant was unable to establish negligence or causation on the part of the respondent pertaining to the treatment that ELM received at Frere hospital. The appeal must fail. As regards costs, counsel for the respondent accepted that given the circumstances of this matter, no order as to the costs in respect of the appeal be made.

[35] In the result, the following order is made:

The appeal is dismissed with no order as to costs.

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H K SALDULKER

JUDGE OF APPEAL

[8] Ibid at 430E-F.

Appearances

For the appellant:	G W Austin
Instructed by:	Gary Austin Inc, Benoni
	Honey Attorneys, Bloemfontein
For the respondent:	B Dyke SC
Instructed by:	State Attorney, East London
	State Attorney, Bloemfontein