THE SUPREME COURT OF APPEAL
OF SOUTH AFRICA

1.1 Case no: 116/02
1.2 REPORTABLE

In the matter between:

Eugene Mabhuti TEMBANI **Appellant**

and

The STATE **Respondent**

Before: Cameron JA, Heher JA, Combrinck AJA, Malan AJA and Theron AJA
Heard: Wednesday 1 November 2006
Judgment: Thursday 30 November 2006

Criminal law – causation – appellant inflicting wound which without medical treatment would be fatal – later medical treatment negligent and possibly even grossly negligent – does not exempt assailant from responsibility for death – murder conviction confirmed

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Neutral citation: This judgment may be cited as S v Tembani [2006] SCA 151 (RSA)

JUDGMENT

CAMERON JA:

[1] The appellant was convicted of murder in the High Court in Johannesburg and sentenced to 18 years' imprisonment.[1] This is an appeal with the leave of the trial judge, against his conviction. The appeal turns on whether an assailant who inflicts a wound which without treatment would be fatal, but which is readily treatable, can escape liability for the victim's death because the medical treatment in fact received is sub-standard and negligent.

[2] The murder conviction arose from an incident late on Friday night 14 December 1996 at the Ivory Park informal settlement near Kempton Park in which the appellant shot his 28 year old girlfriend, Ms Thandi Lamani, at least twice. One bullet entered her chest between the fifth and sixth ribs. It penetrated her right lung, diaphragm and abdomen, perforating the duodenum. The other entered her calf, fracturing her tibia and fibula. At his trial, the appellant pleaded not guilty, reserved his defence and chose

[1] 1999 (1) SACR 192 (W).

not to testify; but the trial court (Hellens AJ with two assessors) rightly accepted the first-hand accounts of the deceased's two sisters, Ms Ntombixolo Lamani and Ms Zodwa Lamani. The former witnessed the appellant shoot the deceased a number of times at point-blank range in the one-roomed shack they shared, while the latter hastened to the scene from close by while the accused was still there, armed and uttering murderous imprecations against the injured woman.

[3] She was admitted to Tembisa Hospital on the night of her shooting, and died there fourteen days later. The evidence established beyond doubt that the appellant intended to kill, and the sole issue on appeal is whether he is responsible for her death. If he is, the conviction of murder stands. If not, it must yield to attempted murder, and his 18-year sentence must be reconsidered.[2]

[4] The cause of death was officially recorded, and proved at the trial, to be septicaemia in consequence of a gunshot wound through the chest and abdomen. On appeal the appellant's main submission was that the hospital staff and doctors were grossly

[2] The delay in the appeal (which we condoned at the hearing) was due, we were informed from the Bar, to the change-over from the old pro deo system to the new system administered by the Legal Aid Board.

negligent and that this broke the chain of causation between his attack on 14 December and her death on 28 December, thus exempting him from liability for murder.

[5] On the night of the deceased's admission, the medical personnel at Tembisa cleaned the wound, inserted an intercostal drain and put her on antibiotic medication; but then – even though the next day she vomited and complained of abdominal pains, sure signs of peril – she was left insufficiently attended in the ward until Tuesday. By that time, four long days later, peritonitis (infection of the abdominal lining) had set in. Only then was a laparotomy (a surgical incision opening the abdominal cavity) performed, and the gunshot wound properly tracked and sutured, though the sufficiency of what was done even then is doubtful. Though she was belatedly transferred to the intensive care unit on 23 December, and a second laparotomy performed on 24 December, it was all too little, far too late. In the graphic words of the district surgeon who performed the post mortem, Dr Peters, by then 'everything had gone septic' (*alles het septies geraak*), and Thandi Lamani died in what must have been acute pain and discomfort on 28 December.

[6] The medical evidence makes pitiful reading, and the conclusion is unavoidable that the deceased received inadequate and negligent care at Tembisa Hospital. The trial court sympathetically observed that the doctor in charge, Dr Jovanovic – who attempted on the one hand to justify his interventions and the hospital's standard of care, while on the other apologising for inadequate treatment and facilities – was 'on a cleft stick'.[3] Despite his anguished explanations of the arduous conditions under which medical personnel are obliged to work at Tembisa, the judge found that it had been prima facie established that the nursing staff and doctors were negligent. His findings may be summarised thus:[4]

a) If the gunshot wound had not been treated at all, the deceased would have died from the injury the appellant inflicted.
b) The gunshot wound was an indispensable pre-condition (a *sine qua non*) of the death of the deceased.
c) Proper, timeous and adequate medical treatment would with a high degree of probability have been effective to render it non-fatal.
d) On admission to Tembisa, the penetrating injury of the abdomen (haemothorax) was adequately treated by an inter-costal drain.
e) But appropriate care on admission should have included close observation for at least the first 12 hours, as well as a laparotomy, very soon after admission, in order to trace the path of the gunshot wound and to establish what damage it

[3] 1999 (1) SACR 192 (W) 202d.
[4] 1999 (1) SACR 192 (W) 200-201.

had caused. [The defence expert, Dr du Toit, testified that a laparotomy, promptly performed with proper attendant treatment, would have ensured a 95% chance of survival.]

f) The mere insertion of the inter-costal drain was inadequate and was short of the normal standard of medical care that one is entitled to expect of a reasonably competent hospital and of reasonably competent doctors.

g) The deceased was left in an ordinary ward for four days after her admission with nothing but basic care being given to her and without being properly attended on by a medical practitioner.

h) The first occasion on which she was properly examined was on Tuesday 18 December, four days after she was admitted.

i) By this time significant peritonitis had set in – probably throughout the abdomen.

j) The operative procedure a reasonably proficient surgeon should have employed was either an anastomosis (excising the damaged [necrotic] tissue and joining the duodenum) at a very early stage, or a gastro-jujunostomy (bypass).

k) A simple repair of the entry and exit duodenal wounds (as performed on 18 December) was not appropriate because the tissue would already have been necrotic, and suturing at that stage was therefore ineffective.

l) A bypass procedure on 18 December would have given the deceased a significantly higher chance of survival.

m) The major fault in the deceased's care lay with (i) the admitting doctors in not performing a laparotomy as soon as possible; and (ii) the hospital and doctors in allowing her to lie in an ordinary ward over four days – during which peritonitis set in.

n) The totality of the treatment by the hospital and medical staff was substantially short of the standard of practice that a member of the public is entitled to expect from a reasonably proficient hospital and reasonably proficient doctors.

o) The failure to perform timeous and appropriate surgery was a contributing cause to the death in that with proper care peritonitis and septicaemia could have been avoided.

[7] The judge noted that the hospital was under-staffed, especially over weekends, and that the doctor/patient and nurse/patient

ratios were woefully inadequate. The medical records were deficient and no proper discipline was enforced in keeping them. The standard of nursing care was evidently poor. Even though these shortcomings resulted partly from budgetary constraints and lack of resources, with consequent enforced prioritisation, the judge did not consider he could find the standard excusably low. It was indeed –

> 'a sad experience for me to realise that many of our citizens and members of our society critically injured or wounded might find themselves by dint of their financial circumstances exposed to so woefully inadequate [a] system of medical care'.[5]

[8] These careful findings have rightly not been challenged on appeal and they must form the basis of our decision. The question is whether the pitiable record of medical neglect and malmanagement they reveal exculpates the deceased's assailant from guilt of murder. The trial court held that it did not. Hellens AJ found that it was of overriding importance that the original wound remained an operating and substantial cause of death even though the poor medical treatment was also an operating cause:

[5] 1999 (1) SACR 192 (W) 202g-h.

'It seems to me not practical to say that a hospital which is overworked and understaffed and which by virtue of those factors delivers sub-standard medical treatment to a patient can be held in the circumstances of this case to have been the juridical or legal cause of the death of the deceased. The deceased died in the same manner and from the same wound with the same cause as she would have died from had she not been taken to hospital. It seems to me not logical nor practical to say that the original wounding was merely the setting in which another cause operated and that the death did not result from the wound'[6]

[9] The judge accordingly found that the hospital's and doctors' negligence was not in the circumstances 'so overwhelming as to make the original wound merely part of the history behind the patient's presence in the hospital so that it could be said that death did not flow from the wound'. Applying a 'flexible approach to causation' – one that was 'practical' rather than 'over-theoretical' – he considered it in accord with justice to hold that in the juridical sense the medical negligence did not oust the causal connection between the shooting and the deceased's death.[7] The appellant was accordingly convicted of murder.

[6] 1999 (1) SACR 192 (W) 203a-b.
[7] 1999 (1) SACR 192 (W) 203c-e.

Causation, medical negligence and responsibility for murder

[10] It is now well established that a two-stage process is employed in our law to determine whether a preceding act gives rise to criminal responsibility for a subsequent condition. The first involves ascertaining the facts; the second imputing legal liability. First it must be established whether the perpetrator as a matter of fact caused the victim's death. The inquiry here is whether, without the act, the victim would have died (that is, whether the act was a *conditio sine qua non* of the death).[8] But the perpetrator cannot be held responsible for all consequences of which his act is an indispensable pre-condition. So the inquiry must go on to determine whether the act is linked to the death sufficiently closely for it to be right to impose legal liability. This is a question of law, which raises considerations of legal policy.[9]

[11] In most cases of murder, the first stage of the causation inquiry presents no problem. There can be no doubt that without the appellant's murderous attack Thandi Lamani would not have died. Questioned by the judge, the pathologist for the defence, Dr Du Toit, confirmed that had there been no medical intervention at all,

[8] *Sv Daniëls* 1983 (3) SA 275 (A) 331B (statement in minority judgment of Jansen JA, adopted in *S v Mokgethi* 1990 (1) SA 32 (A) 39G-H).
[9] *Minister of Police v Skosana* 1977 (1) SA 31 (A) 34G-H per Corbett JA ('This is basically a juridical problem, in which considerations of legal policy may play a part').

the gunshot wound would have proved fatal, with ensuing septicaemia and peritonitis. The wound the appellant inflicted was thus intrinsically fatal.[10] What is in issue is legal responsibility for the death in the manner in which it in fact ensued; and in the form this case presents, the problem is novel in this court.[11]

[12] This court has given consideration to the broader problem whether a subsequent intervening act or omission can exculpate an earlier fatal attacker from liability for death. To the question whether a later deliberate fatal wounding can exempt a previous fatal assailant from responsibility, it has given no conclusive answer. In *S v Mbambo*[12] the court expressed the view that, where two assailants independently inflict injuries on a victim, if it is uncertain whether death ensued as a result of the combined effect of both injuries or as a result of only one or other of them (it

[10] The wound was in other words 'mortal per se' in the sense identified by Beadle J in *R v Mubila* 1956 (1) SA 31 (SR) 33E-F ('an intrinsically dangerous wound from which the injured person is likely to die if he receives no medical attention'). HLA Hart and Tony Honoré *Causation in the Law* (2 ed, 1985) pp 241-242 and 353 identify three other senses of 'mortal wound': (i) sufficient to cause the death of a person of average constitution under normal circumstances; (ii) highly likely to cause the death of a particular victim, given his constitution and the likelihood of medical assistance; (iii) in fact causing death even though not mortal in senses (i) and (ii) (eg a scratch the victim neglected).

[11] In *S v Mini* 1963 (1) SA 188 (A) 189D-G the appellant stabbed the deceased who died of a pulmonary embolism ten days later, after receiving medical treatment. It was argued that the deceased would have had a better chance of recovery had he been treated earlier, but the court dismissed the argument on the basis that the evidence showed not that the medical treatment caused the death, but merely that other treatment might have prevented the death.

[12] 1965 (2) SA 845 (A).

being uncertain which injury in fact caused death), neither perpetrator can be held responsible for the death, even though it is medically established that either injury could have caused death.[13] The court also considered that even where the first injury would inevitably have resulted in death, a second independent injury that operates with decisive and fatal effect before the first injury could result in death, operates as a *nova causa* (thus breaking the causal chain and exempting the first assailant from responsibility for the death).[14] On the medical evidence, however, the court in *Mbambo* found that the first injury (a stone to the head fracturing the skull) was not in fact a cause of death, while the second (a four-inch stab wound penetrating the left lung) was. The stone-thrower was therefore not responsible for the killing, but the stabber was.

[13] In *S v Daniëls*[15] the first accused shot the deceased in the chest. Without emergency medical treatment (which was inaccessible), the chest wounds would have resulted in death within half an hour; but the victim then received a second gunshot to the head. This caused instant death. Since it was reasonably

[13] at 855B-C, per Wessels JA, Steyn CJ concurring.
[14] at 857E-F, Rumpff JA at 846H expressing no apparent disagreement on these issues.
[15] 1983 (3) SA 275 (A).

possible that it was not the first accused, but the second, who inflicted the head injury, the question was whether the first accused bore responsibility for the death. The court split. Nicholas AJA and Botha JA considered that the perpetrators acted with common purpose; since their joint conduct caused the death the first accused was guilty of murder; but without the common purpose the reasoning in *Mbambo* applied, with the result that he could not have been found guilty of murder.[16] Van Winsen AJA and Jansen JA disagreed. They treated the views expressed in *Mbambo* as obiter,[17] but in any event dissented from them: they considered that, as a matter of policy, a perpetrator who inflicts a wound that will in the circumstances cause death should not escape liability for the death merely because a subsequently inflicted mortal wound hastens death.[18] Trengove JA however agreed with Nicholas AJA that the first wound could not be

[16] at 303-304.

[17] at 313-314, per van Winsen AJA; 333B-H, per Jansen JA.

[18] at 314B-C. Van Winsen AJA said:
'I find it, with respect, difficult to reconcile myself with a proposition the effect of which is such that where one person deliberately inflicts wounds on another which inevitably would cause the death of such person [the former] can only be found guilty of assault or attempted murder because someone other than that person thereafter also inflicts a fatal wound which must then be considered a *nova causa interveniens*.'
Jansen JA endorsed this approach at 330H-331A and 332H-333A ('In the specific circumstances of this case it seems to me that no policy reasons exist to exempt the first appellant from responsibility for the consequence, which did ensue in accordance with his intention, but that it would be just and desirable to hold him responsible and find him guilty of murder'). (My translations.)

considered a cause of death because of the supervention of the second; but finding no common purpose he held that a conviction only of attempted murder was competent.[19]

[14] Because of the findings on the medical evidence in *Mbambo*, the views expressed on the criminal liability of the first attacker were in my view indeed not necessary for that decision; nor, in the light of the finding of Nicholas AJA and Botha JA in *Daniëls* that the perpetrators in that case acted with a common purpose, was it pivotal to their decision whether the first or the second wound was the cause of death: the views of those judges on the binding status of *Mbambo* were accordingly not indispensable to their decision.[20]

[15] As a result, the question whether an assailant who inflicts a fatal wound is exempted from liability for death where a second wound thereafter causes immediate death remains undecided. This leaves open also the broader question, which this case presents, whether any culpable later intervention (or omission) can be held to exculpate the earlier actor from liability, and, if so,

[19] at 324-326.

[20] This accords with the analysis of *Daniëls* by JM Burchell in *South African Criminal Law and Procedure* vol 1 *General Principles of the Criminal Law* (3 ed, 1997) pp 60-61.

on what basis.[21]

[16] In *S v Mokgethi*[22] it was held that the negligent and unreasonable conduct of the victim himself interrupted the chain of causation. A gunshot rendered the deceased a paraplegic confined to a wheelchair. Despite the injury he recovered well, and received instruction on the dangers of pressure sores and their prevention. But he unreasonably failed to apply proper self-care, and pressure sores developed that led to septicaemia from which he died six months later. The court held that the assailants could not be held responsible for his death. Though initially the wound was mortally dangerous in that without medical intervention the deceased would probably have died because of it, the threat to his life was eliminated by the proper medical care and instruction he received. The eventually fatal septicaemia was caused not by the original wound, but by the deceased's own unreasonable failure to follow instructions. Even though the gunshot wound was an indispensable pre-condition of the death, the trial court's conviction of murder was changed to attempted

[21] CR Snyman *Criminal Law* (4 ed, 2002) pp 88-90 treats the problem in *Daniëls* (subsequent deliberate conduct) and in the present case (later negligent conduct) as raising in principle similar issues for the prior actor's criminal responsibility, whereas other writers deal with 'medical negligence' as a separate head.

[22] 1990 (1) SA 32 (A).

murder.[23] The outcome may be contrasted with the case where the perpetrator's own actions impel the victim to take self-injuring action: the perpetrator remains liable.[24]

[17] *Mokgethi* concerned the victim's own unreasonable and negligent failure to take self-care, after he had recovered from the fatal attack, which could therefore not be considered the immediate cause of death.[25] Although the factual setting differs, *Mokgethi's* approach to the determination of legal liability applies, since the court adopted what Van Heerden JA called a 'supple' or 'elastic yardstick' for determining whether policy considerations require that legal responsibility should be imputed. The ultimate question is whether there is a sufficiently close link between the act and the consequence.[26]

[18] Among South African writers there have long been divergent views as to whether negligent medical care can be regarded as a

[23] at 47C-I.

[24] See HLA Hart and Tony Honoré *Causation in the Law* (2 ed, 1985) pp 144-145; *Royall v The Queen* (1991) 172 CLR 378 (HC) (an act by a person in the interests of self-preservation, in the face of violence or threats of violence by another, which results in his/her death, does not negative a causal connection between the violence or threats of violence and the death: where the perpetrator induces in the victim a well-founded apprehension of physical harm so as to make it a natural consequence (or reasonable) that the victim would take measures to escape, and is then injured in the course of escaping, that injury is caused by the accused's conduct – see the judgment of Mason CJ at 389-390).

[25] See 1990 (1) SA 32 (A) 41B-C.

[26] at 40-41 and 45G-H, approved in *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) 701, and applied in *S v Counter* 2003 (1) SACR 143 (SCA) para 29.

supervening cause exempting the original assailant from liability. JRL Milton, adopting the approach of PMA Hunt, suggests that in general an event (including a natural event and voluntary human conduct on the part of the victim himself or a third person) is likely to be held to interrupt causation if it is abnormal – that is, 'unlikely, in the light of human experience, to follow an act such as that committed by [the perpetrator]'.[27] Regarding medical treatment, he starts from the express premise that 'in modern times medical proficiency is normal and that negligent, improper procedures are abnormal'. On this basis he proposes that the rule should be that –

> 'medical treatment which is carried out bona fide is a novus actus only if: (i) it is negligent [in a footnote the author adds 'or perhaps "grossly negligent"']; and (ii) but for that medical negligence (and supposing proper, careful treatment) [the victim] would not have died when he did'.[28]

[19] If this were accepted, the appellant must be acquitted of murder, since it is plain that the medical treatment the deceased received at Tembisa was negligent (and perhaps 'grossly negligent'). The trial judge however expressly rejected Milton's

[27] *South African Criminal Law and Procedure* vol II *Common-law Crimes* (3 ed, 1996) (for whose first edition PMA Hunt was responsible) p 331, following Hart & Honoré *Causation in the Law* (2 ed, 1985) pp 240 and following.

[28] Work cited above p 345.

approach as 'too broad and sweeping', holding that factually the premise that medical proficiency in South Africa is normal, and negligent improper procedures abnormal, was wrong.[29]

[20] CR Snyman approves the trial court's reasoning and decision. Where the injuries were serious and the victim's life could have been saved by correct medical treatment, but the treatment was in fact negligent or improper, he considers that the perpetrator's liability for the ensuing death depends on 'whether, at this time, and in this country, one can expect medical treatment always to be proper and proficient'. Since the answer must be No, he considers the trial court's decision to be correct and realistic. Quite apart from the possibility of future additional strains on the country's health care infrastructure,

> 'it seems unjust to allow X, who has intentionally inflicted a lethal or at least very serious injury to Y, to argue afterwards that the subsequent improper medical care should redound to his benefit and absolve him from full responsibility for his deed'.[30]

Snyman suggests however that the outcome might be different if the medical treatment is not merely negligent, but grossly negligent.

[21] In his thesis, writing before the decisions of this court that established the two-stage process for the determination of legal

[29] 1999 (1) SACR 192 (W) 199g-i.

[30] *Criminal Law* (4 ed, 2002) p 89.

liability, FFW van Oosten presciently drew attention to the distinction between the purely factual aspect of determining causation and the question of responsibility, of which the decisions on medical negligence did not always take account.[31]

[22] Hart and Honoré observe that 'some doubt surrounds the effect of improper medical treatment on the responsibility of the accused person'.[32] They note that 'improper medical treatment is unfortunately too frequent in human experience for it to be considered abnormal in the sense of extraordinary'.[33] After surveying mainly the United States and English cases, they summarise thus:

> 'Where, as in England, the distinction between mortal wounds and others is not insisted on, subsequent negligent treatment if lacking in "common knowledge or skill" may relieve accused of further liability even if it is not of a character sufficient without the wound to cause death and a fortiori if it is. Where the distinction is drawn, if the original wound is mortal no subsequent negligence relieves accused of responsibility for homicide. If it is not mortal, though "dangerous" some authorities allow subsequent negligence to relieve only if it is of a character sufficient to have killed the victim independently of

[31] *Oorsaaklikheid by Moord en Strafbare Manslag* (LLD thesis, University of Pretoria, 1981) p 459-460.
[32] *Causation in the Law* (2 ed, 1985) p 354.
[33] Work cited above pp 355-356.

the wound.'

[23] The authors refer with apparent approval to the decision of the English military appeal court in *R v Smith*,[34] which Hellens AJ applied in deciding the present case,[35] and which bears out their proposition that 'if the original wound is mortal no subsequent negligence relieves accused of responsibility for homicide'. In *Smith*, the accused stabbed the victim in the lung. The medical treatment administered was inappropriate and harmful; if he had received immediate and different treatment, he might not have died; and with a blood transfusion (which was unavailable) his chances of recovery might have been 75%. Despite this, the court of appeal held the assailant responsible for the death. Lord Parker CJ rejected the argument that if something happened that impeded the chance of the deceased recovering then the death did not result from the original wound:

'It seems to the court that, if at the time of death the original wound is still an operating and substantial cause, then the death can properly be said to be the result of the wound, albeit that some other cause of death is also operating. Only if it can be said that the original wounding is merely the setting in which another cause operates can it be said that the death does

[34] [1959] 2 All ER 193 (Courts-Martial Appeal Court).
[35] 1999 (1) SACR 192 (W) 198d-f.

not result from the wound. Putting it another way, only if the second cause is so overwhelming as to make the original wound merely part of the history can it be said that the death does not flow from the wound.'[36]

[24] In a broader context, Hart and Honoré comment that 'it is clear that the idea that one who deliberately wounds another takes on himself the risk of death from that wound, whatever the reason for the failure to treat it properly, has an attraction which may be only partly penal in origin':

'It seems to draw, in addition, on the primitive idea that an omission to treat or to cure, like the failure to turn off a tap, cannot be called a cause of death or flooding in the same sense as the infliction of the wound or the original turning on of the tap.'[37]

[25] 'Primitive', in the sense the word shares with 'prime' or 'primal', merely denotes 'the earliest times in history or stages in evolution or development',[38] and I do not understand the authors to disclaim the idea they describe. On the contrary, it seems to me to illuminate well the basis for imputing liability both in *Smith* and in present case. The deliberate infliction of an intrinsically dangerous wound, from which the victim is likely to die without medical intervention, must in my view generally lead to liability for

[36] [1959] 2 All ER 193 at 198D-F.
[37] *Causation in the Law* (2 ed, 1985) p 362.
[38] *Concise Oxford Dictionary*.

an ensuing death, whether or not the wound is readily treatable, and even if the medical treatment later given is sub-standard or negligent, unless the victim so recovers that at the time of the negligent treatment the original injury no longer poses a danger to life. In the latter event, as was found in *Smith*, the original wounding merely provides a setting in which a further cause takes substantial effect. In the present case, the trial court rightly found that at the time of the deficient treatment, the original wound was still an operating and substantial cause of death, and that it could not be said that it merely provided the 'setting' within which the negligent conduct of the hospital staff operated.

[26] In my view, the justification for this approach may be found in two interconnecting considerations of policy. The first relates to the culpability of the assailant; the second to the context in which he harms his victim. First, an assailant who deliberately inflicts an intrinsically fatal wound embraces, through his conscious conduct, the risk that death may ensue.[39] The fact that others may fail to intervene to save the injured person does not, while the wound remains mortal, diminish the moral culpability of the perpetrator, and should not in my view diminish his legal

[39] See the views of Hart and Honoré set out in para 24* above.

culpability. That is so even where those others fail culpably in breach of a duty they independently owe to the victim. It would offend justice to allow such an assailant to escape the consequences of his conduct because of the subsequent failings of others, who owe no duty to him, whose interventions he has no right to demand, and on whose proficiency he has no entitlement to rely. Their failings in relation to the victim cannot diminish the burden of moral and legal guilt he must bear.

[27] The second consideration reinforces the first. In a country where medical resources are not only sparse but grievously maldistributed, it seems to me quite wrong to impute legal liability on the supposition that efficient and reliable medical attention will be accessible to a victim, or to hold that its absence should exculpate a fatal assailant from responsibility for death. Such an approach would misrepresent reality, for it presumes levels of service and access to facilities that do not reflect the living conditions of a considerable part, perhaps the majority, of the country's population. To assume the uniform availability of sound medical intervention would impute legal liability in its absence on the basis of a fiction and this cannot serve the creation of a sound

system of criminal liability.

[28] I therefore endorse the views of those writers[40] who regard improper medical treatment as neither abnormal nor extraordinary and hold that the supervention of negligent treatment does not constitute an intervening cause that exculpates an assailant while the wound is still intrinsically fatal.

[29] In view of the allusion to it by some of the authorities, I should add that I do not consider that even gross negligence in the administration of medical treatment should be sufficient to relieve the original perpetrator of criminal liability for an ensuing death. The trial judge in the present case did not make a finding that the hospital was 'grossly' negligent: indeed he pointed out that neither the hospital nor the medical personnel were on trial or represented by counsel who could defend them.[41] He did however find, with full justification, that the total treatment the deceased received was 'substantially' short of the standard of practice that a member of the public is entitled to expect from a reasonably proficient hospital and reasonably proficient doctors.[42] It is not necessary to determine whether 'substantial' absence of

[40] See the views of Snyman set out in para 21*, and those of Hart & Honoré in para 22* above.
[41] 1999 (1) SACR 192 (W) 200a-c.
[42] 1999 (1) SACR 192 (W) 201h.

reasonable proficiency connotes the presence of gross negligence, since I am prepared to assume in favour of the appellant that a finding of gross negligence may be warranted. Even so, while the wound remains intrinsically fatal, even gross negligence should not permit escape from legal liability for its consequences.[43]

[30] In this regard, for purposes of causation, I would adopt subject to one change the statement in *R v Mabole*,[44] that an assailant 'must have regard to the social environment as well as the physical, and the reasonably predictable consequences of any act of his in the former field':

> 'In this case the reasonably predictable consequences of the accused's attack on the deceased were that he would require medical attention; and in the state of present knowledge mistakes in diagnosis and treatment are a commonplace. Provided, then, that medical attention is given with goodwill and reasonable efficiency, in my view the accused cannot complain of mistakes in diagnosis and treatment.'

I would erase 'and reasonable efficiency'. In my view an assailant is entitled always to expect that medical attention will be

[43] It follows that I do not endorse the criticism of the approach of Hellens AJ expressed by Jordaan AJ in *S v Counter* 2000 (2) SACR 241 (T) [affirmed by this court without comment on this point: 2003 (1) SACR 143 (SCA)] at 249-250; and in *S v Ramosunya* 2000 (2) SACR 257 (T) 264-265 (Bertelsmann J concurring).

[44] 1968 (4) SA 811 (R) 816D-E, per Young J.

given in good faith, and to hope that it will be given also with reasonable efficiency; but where the latter is lacking and death ensues it does not entitle him to exculpation. I would apply this standard also in the case of 'gross negligence', so long as 'gross' is not taken to imply absence of good faith.

[31] Existing first-instance authority preponderantly,[45] though not universally,[46] tends to support the imposition of liability in the present case, as does the decision of this court in *S v Counter*.[47]

[32] The appeal is dismissed.

E CAMERON
JUDGE OF APPEAL

CONCUR:
HEHER JA
COMBRINCK AJA
MALAN AJA

[45] *R v Mouton* 1944 CPD 399; *R v Loubser* 1953 (2) PH H190; *R v Mubila* 1956 (1) SA 31 (SR); *R v du Plessis* 1960 (2) SA 642 (T); *S v Norman* 1961 (2) PH H262 (GW); *R v Formani* 1962 PH H252 (SR); *S v Mabole* 1968 (4) SA 811 (R); *S v Dawood* 1972 (3) SA 825 (N); . The decisions then available were surveyed by FFW van Oosten, *Oorsaaklikheid by Moord en Strafbare Manslag* (LLD thesis, University of Pretoria, 1981) pp 448 and following. In *S v Ramosunya* 2000 (2) SACR 257 (T) the victim of a stabbing died the day after her discharge from hospital, of sepsis of the lungs, but there was no proof that the original stab wounds (near the left collar bone) had caused the death: on appeal the accused was acquitted of murder, but convicted of attempted murder instead.

[46] The odd one out is the decision in *S v Motomane* 1961 (4) SA 569 (W) (medical practitioner taking prudent, but not necessary, decision in treating stab wound held to have broken causal chain).

[47] 2003 (1) SACR 143 (SCA).

THERON AJA