REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
(WESTERN CAPE HIGH COURT, CAPE TOWN)

Case No. 2094/07

In the matter between:

CHARLES OPPELT	Plaintiff
and	
THE HEAD: HEALTH, DEPARTMENT OF HEALTH, PROVINCIAL ADMINISTRATION: WESTERN CAPE	First Defendant
SOUTH AFRICAN RUGBY UNION	Second Defendant
BOLAND RUGBY UNION	Third Defendant
MAMRE RUGBY FOOTBALL CLUB	Fourth Defendant

Coram: **Van Staden AJ**

Heard **11 April 2011 to 30 March 2012**

Delivered: **21 November 2012**

JUDGMENT

INTRODUCTION

1. Plaintiff's claim against the defendants, for payment of damages in excess of R 9 million, is based on the consequences of a spinal cord injury and

the subsequent medical treatment that he received in various hospitals under the control of the first defendant. He was injured while playing hooker in a rugby match played on 23 March 2002 at Mamre.

2. The claims against the second defendant, South African Rugby Union ('SARU'), third defendant, Boland Rugby Union ('Boland') and fourth defendant, Mamre Rugby Football Club ('Mamre') relate to the control by these three parties over rugby generally and the specific match referred to above, in particular. Of significance is the fact that plaintiff, a slightly built seventeen year old school boy, was chosen to play hooker for Mamre at senior level. In respect of the claims, against these rugby bodies ('the rugby claims'), reliance is furthermore placed on the fact that, although helicopter transport, alternatively ambulance transport was available for the transport of the plaintiff to Conradie Hospital where the plaintiff would have received appropriate treatment, these services were not utilised.

3. The claim against the first defendant, the Provincial Department of Health of the Western Cape Province ('the Health Department') relates to the treatment received by plaintiff at Atlantis Wesfleur Hospital ('Wesfleur') as well as Groote Schuur Hospital ('Groote Schuur'). The plaintiff was admitted as a patient to these hospitals subsequent to suffering the injury. In essence the claim against the health department ('the medical claim') is based on the failure of the health department to timeously transfer the plaintiff to the specialised spinal cord injury unit at Conradie Hospital ('Conradie').

4. When the trial commenced the applicant applied in terms of Rule 33(4) of the Uniform Rules of Court for the issues in respect of the medical claim to be separated from the issues in respect of the rugby claim. I concluded that the intial separate hearing of the issues in respect of the medical claim would not facilitate the convenient and expeditious disposal of the litigation. It is relevant to note that some of the defendants filed notices

citing the other defendants as third parties[1]. In my view the issues of the rugby claim and the medical claim are inextricably linked to such an extent that the separation is not appropriate[2]. On 12 April 2011 this application in terms of Rule 33(4) was therefore refused.

5. By agreement between the parties, it was furthermore specifically ordered, that the quantification of damages stand over for later adjudication and that the issues of wrongfulness, negligence, and causation be determined *in limine.*

6. Mamre was originally represented by its chairman, Mr Japhta, but on 12 April 2011, Mr Schreuder, counsel for Boland, indicated that he had been instructed to also act on behalf of Mamre. At a later stage a conflict arose between Boland and Mamre. As a result Mr Schreuder withdrew as counsel for Mamre. Thereafter Mamre was represented by a member of the club, Mr April. No evidence or argument was presented on behalf of Mamre.

7. At the comment of the trial, certain bundles of the documents were placed before the Court by agreement. These documents were later on referred to in evidence. The status of these documents were recorded in a pre-trial minute dated 25 February 2011, to the effect that they are what they purport to be. The correctness of the contents thereof were however not admitted.

8. The parties reached agreement concerning the contents of certain ambulance records relating to the transportation by ambulance of the plaintiff on 23 and 24 March 2002. A pre-trail minute dealing with this agreement was handed into court on 20 March 2012.

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[1] Minister of Safety and Security and Another v Rudman and Another 2005 (2) SA 16 (SCA) at para 76 at page 43B to para 88 at page 45G and Wright v Medi-Clinic Ltd 2007 (4) SA 327 (CPD), para 132 at page 369H to para 151 at page 373H.

[2] Denel (Edms) Bpk v Vorster 2004 (4) SA 481 (SCA) at 285.

UNDISPUTED BACKGROUND INFORMATION

9. The plaintiff was chosen to play hooker in the front row in a rugby football match, played on 23 March 2002, as a member of the third senior team of Mamre. He was born on 2 March 1995 and therefore turned seventeen years of age three weeks prior to this match taking place. At that time he was a grade 10 scholar at a school in Atlantis. He was selected to play for Mamre as hooker not withstanding the fact that he was slightly built, at a height of 1.65cm and with a mass of 60kg. During the previous rugby season of 2001 he played hooker for an under-nineteen club team.

10. The rugby match in question was a pre-season friendly club match in the third league, played on a Saturday afternoon against a club from a union other than Boland at Mamre's rugby grounds. The match started at about 14h00. Mamre is a small rural town, where a previously disadvantaged community resides. The biggest business in this town is a Seven Eleven supermarket. Rugby is very popular in Mamre and two clubs utilise the rugby grounds consisting of two rugby fields and change rooms without any clubhouse. None of the officials or players of Mamre received any remuneration for their services.

11. At the first scrum engagement of the match, at about 14h15, the plaintiff was seriously injured. The top of his head struck his opponent's shoulder. He immediately collapsed. He was aware that he was unable to move. It later turned out that he suffered a bilateral facet dislocation at C5 and C6, between the fifth and the sixth cervical vertebrae. This was accompanied by a superior end plate wedge compression fracture at the same level. The plaintiff's evidence shows that he sustained a vertex impact, which is a known cause of bifacet dislocation of the cervical spine. It is not in dispute that it takes relatively little force for a vertex impact to cause a serious neck injury.

12. In his evidence in chief the plaintiff stated that he was selected for the match in question by his coach. Under cross-examination he stated that the selection committee of Mamre selected him.

13. The plaintiff was not able to specifically remember the comparative sizes of his team members as opposed to that of their opponents. He stated that the Mamre front rank was a little smaller than the opposing front-row. He could however not recall the identity of the two props who represented his Mamre team on the day in question.

14. At the time of the injury a service called Spineline had already been in operation for more than a year. Spineline is a dedicated service to assist healthcare practitioners in the Western Cape to assess services and advice related to suspected spinal cord injuries. This service was launched on 15 September 2001 by SARU and the Chris Burger/Pedro Jackson Fund, a fund established to assist rugby players with spinal cord injuries. Spineline was primarily intended to address some of the delays in the emergency medical and healthcare system and to expedite appropriate treatment of spinal injuries to rugby players. A toll free Spineline telephone number was linked to an emergency services control room, the Emergency Medical Services ('EMS') coordination centre of the Health Department.

15. Ms April, was in attendances at the Mamre rugby field on 23 March 2002 as first aid official. She was a volunteer and was not paid for her services. She underwent a course in first aid presented by Boland. She established the condition of the plaintiff on the field where he was injured, stabilised his neck with a neck brace and thereafter instructed that an ambulance should be called. There was no stretcher available at the Mamre rugby grounds on that day. Ms April was not in possession of the Spineline number.

16. The plaintiff's mother, Ms Oppelt, who arrived at the rugby field shortly after the plaintiff's injury, was aware of Spineline but could not explain why she did not attempt to phone Spineline from the rugby grounds.

17. The minute of an agreement between the parties in respect of the ambulance records received into evidence on 20 March 2012, discloses that a call was made to the relevant call centre on 23 March 2002 at 14h41. A neck injury was reported and a request was made to transfer the injured player from Mamre rugby field to Wesfleur. The call was marked highest priority. The ambulance arrived at the scene at 14h52 and at Wesfleur, with the plaintiff on a stretcher, at 15h15.

18. At Wesfleur the plaintiff was seen by a nurse and a doctor. His blood pressure was taken, a catheter was installed and an intravenous drip was administered. The Wesfleur records, handed in by agreement[3], discloses that a certain Dr Venter examined the patient. The Wesfleur records disclose that there were no working X-ray and that Dr Venter diagnosed the injury of the plaintiff as T2 complete. Ms Oppelt, was told by a doctor that a helicopter had been called but that it could not be utilised because of weather conditions. Ms Oppelt and the plaintiff could not understand this report since the weather conditions were favourable on that day. Ms Oppelt could also not explain why she did not phone Spineline when informed about the unfavourable weather conditions.

19. A Spineline helicopter was available to airlift the plaintiff on that day, but only up until the time that this helicopter responded to another emergency and departed from Cape Town International to Robertson at about 15h40. Spineline was however not approached in respect of the plaintiff's accident. The Mamre rugby grounds were located about 5 minutes drive from Wesfleur in Atllantis. Wesfleur was located about 45 minutes drive

[3] Paragraph 7 above.

from both Groote Schuur in Mowbray and Conradie in Pinelands. Conradie is located about 6 – 8 kilometres form Groote Schuur. Helicopter flying time from Cape Town International to Mamre and from Mamre to Conradie was 12 minutes in either direction.

20. Dr Rothemeyer, a neurosurgical registrar at Groote Schuur, accepted Dr Venter's referral of the plaintiff to Groote Schuur. Earlier, at 16h00, a call was made by Dr Venter to Groote Schuur and Dr Rothemeyer recommended helicopter transfer of the plaintiff. The ambulance records, more particularly the forms completed by the call centre and ambulance crew dispatched to Wesfleur, discloses that the ambulance arrived at Wesfleur at 16h30, it departed at 16h55 and arrived at Groote Schuur at 17h40.

21. The plaintiff was still on the same stretcher that he was placed on at the rugby field, when he arrived at Groote Schuur. The Groote Schuur Trauma Unit record reflected that the triage management code for the plaintiff was red, meaning that he was to be dealt with as an emergency, contrary to the statement put on behalf of the Health Department to plaintiff. The plaintiff was seen and the spinal injury evaluated by Dr Rothemeyer, at about 20h00, two hours after arrival. Thereafter, at about 21h00, some three hours after arrival at Groote Schuur, he was examined by an orthopaedic surgeon and urgently referred to Conradie.

22. At that time Conradie was a secondary hospital with a specialised spinal cord injury unit, this unit was primarily dedicated to the treatment and rehabilitation of spinal cord injured patients. Dr Newton, who was called by plaintiff as an expert medical witness, was head of this unit at that time. At Conradie spinal cord injuries were treated by means of closed or open reduction procedures. The preferred method of treatment in early stages after injury was rapid closed reductions with skull traction. The reasons

for this preference was the fact that it takes no more than a few minutes to start the process of closed reduction.

23. The minute of agreement in respect of the ambulance records discloses that an ambulance transported the plaintiff from Groote Schuur to Conradie at 01h08, arriving at 01h23. The plaintiff's spinal injury was reduced under traction at Conradie at about 04h00 on 24 March 2007. Plaintiff improved form a Frankel Grade A to Frankel Grade E level of functioning after his reduction and fusion, but has been left permanently paralysed with only reduced function in his arms.

24. SARU is affiliated to the International Rugby Board and is the controlling and coordinating body of rugby in South Africa. The fourteen provincial rugby unions, including Boland, are members of SARU. The South African Union Referees Association acts as national coordinating body of refereeing in South Africa. There are also fourteen provincial refereeing associations. With the exception of four professional referees, no referee in South Africa is an employee of SARU or the provincial unions. In 2002 there were 2 410 rugby clubs in South Africa and 145 000 players registered with the various unions.

25. In terms of the constitution of Boland in force at the time when the match was played on 23 March 2002:

    25.1. The four general annual meetings of Boland and any special meeting had to be attended by one representative of every club.

    25.2. A club was not allowed to play any match against any other club, affiliated to SARU, without the consent of Boland, and only if Boland was convinced that the union of the club visited had consented to the game.

25.3. No player, who was entitled to take part in a competition under the control of the schools ruby union of Boland, was allowed to take part in any of the competitions of Boland, without the written consent of the principal of the relevant school and the parents of that player.

26. Due to the enormous following of rugby and the media exposure given to rugby in South Africa a huge amount of pressure had been placed on SARU to make the game safer. A partnership between SARU and the Chirs Burger/Pedro Jackson Fund conceptualised the BokSmart programme in 2005 and it was finally introduced in January 2008. The primary aim of BokSmart is to equip rugby coaches, referees, players and administrators with the correct knowledge, skills and leadership abilities. It furthermore aims to ensure safety and reducing the number of serious and/or catastrophic head, neck or spine injuries in rugby. The RugbySmart programme, the forerunner of BokSmart was made compulsory for all coaches and referees in 2001 and was in operation in 2002.

THE RUGBY CLAIMS: THE DISPUTES

27. In their heads of argument Mr Duminy SC, who appeared with Mr van der Merwe for the plaintiff, submitted that the plaintiff relies on various omissions in relation to SARU and Boland and on a combination of wrongful acts and omissions in respect of Mamre.

28. There was no evidence that the referee on the day in question, Mr Luke, applied the rules of the game incorrectly or committed any other actionable wrong. This is not surprising since the injury occurred during the first scrum of the match and the plaintiff's evidence indicated that no foul play was involved. Mr Luke was furthermore not joined as a

defendant in the action. Any cause of action based on the actions or omissions of the referee must therefore fall away[4].

29. The evidence showed that Ms April, the first aid official who was on duty at that match, was an unpaid volunteer, who had received first aid training and had passed a first aid course. The plaintiff's mother, Ms Oppelt, gave evidence to the effect that Ms April was not at all certain about the appropriate treatment for the plaintiff's injury. The plaintiff however called Ms April as a witness and her evidence disclosed that the on-field treatment of the plaintiff was appropriate. There was also no evidence that her first aid training was inadequate or deficient.

30. The remaining allegation against SARU, Boland and Mamre as supplemented by further particulars and argument, can be summarised as follows.

    30.1. Sports regulatory bodies such as SARU Boland, should be held liable in this case, because not enough had been done prior to 2002 to promote awareness and to prevent risk and injury in rugby. In this respect it was suggested that BokSmart programme should have been introduced earlier than 2007 and prior to 2002. SARU and Boland should, more particularly, have disseminated information and actively promoted awareness of the risks involved in playing in the front row and the appropriate training and approach to playing in the front row, as expounded in the BokSmart programme, to all participants in the game of rugby in South Africa at that time.

    30.2. SARU and Boland, should be held liable because they failed to impose rule changes that would have rendered the game safer more particularly:

[4] Compare Vowles v Evans (2003) 1 WLR 1607

30.2.1. Rules prohibiting under eighteen players from competing in senior matches.

30.2.2. Rules providing for uncontested scrums especially when young or small players are selected to play in the front row.

30.2.3. Rules providing that the crouch-touch-pause-engage sequence, which only became part of the rules in 2007, were introduced at an earlier stage, more particularly before 2002.

30.3. SARU, Boland and Mamre were under a duty to make officials and first aid workers aware of the existence of Spineline and the Spineline helicopter service.

30.4. Mamre should not have selected a too young, small or improperly trained player, such as the plaintiff, to play in the front row in a senior game.

30.5. Mamre should have equipped their first aid officials, doing duty at Mamre Club and more particularly also Ms April, with the required first aid equipment.

THE RUGBY CLAIMS: UNLAWFULNESS

31. I have been referred to numerous cases dealing with the elements of

delictual liability more particularly wrongfulness and negligence[5]. The recent judgment of Brand JA in Alex Roux NO v Ryand Karel Hatting[6], specifically dealing with an injury in a rugby match was especially instructive for a restatement of the following principles concerning unlawfulness:

31.1. Not every act or omission resulting in harm is actionable.

31.2. Where the loss resulted from a positive act that gives rise to physical damage to the person of the plaintiff, the defendant's conduct is regarded as *prima facie* wrongful and the onus is on the defendant to rebut the inference of wrongfulness[7].

31.3. By contrast, negligent conduct in the form of an omission is not regarded as *prima facie* wrongful. Its wrongfulness depends on the existence of a legal duty;

31.4. The imposition of this legal duty is a matter of judicial determination involving criteria of public and legal policy, consistent with constitutional norms, and will only be regarded as wrongful and actionable if public or legal policy considerations require that such omission, if negligent, should attract legal liability[8].

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[5] These cases include the following: Natal Fresh Produce Grower's Association and Others v Agroserve (Pty) Ltd and Others 1990 (4) SA 749 (N) at 753 I-754 B; Administrateur, Transvaal v Van der Merwe 1994 (4) SA 347 (A) at 361; E G Knop v Johannseburg City Council 1995 (2) SA 1 (A) at 27B – G; Graham v Cape Metropolitan Counsel 1999 (3) SA 356 (CPD), more particularly at page 369I – 370D; Cape Town Municipality and Another v Bakkerud 2000 (3) 1049 (SCA) at 1055B-D; SM Goldstein and Company (Pty) Ltd v Cathkin Park Hotel (Pty) Ltd and Another 2000 (4) SA 1019 (SCA) at para 7; BOE Bank v Ries 2002 (2) SA 39 (SCA) paras 12 and 13; Minister of Safety and Security v Van Duivenboden 2002 (6) SA 431 (SCA) at 442; Van Eeden v Minister of Safety and Security 2003 (1) SA 389 (SCA) para 9; Saaiman & Others v Minister of Safety and Security & Another 2003 (3) SA 496 (O);Minister of Safety and Security and Others v Rudman and Others 2005 (2) SA 16 (SCA) at 36G-37B; ; Gouda Boerdery CC v Transnet 2005 (5) SA 490 (SCA) paras 10 – 13; Telematrics v Advertising Standards Authority SA 2006 (1) SA 461 (SCA) para 13; The Trustees, Two Oceans Aquarium Trust v Kantey & Templer 2006 (3) SA 138 (SCA) (para 12); Shabalala v Metrorail 2008 (3) SA 142 (SCA) para 7 and 8 at 144J – 145 G; Stewart v Botha 2008 (6) SA 310 (SCA) (paras 5 – 6); Four Haulage SA v SA National Roads Agency 2009 (2) SA 150 (SCA) para 12 and Delphisur Insurance Brokers v Dippenaar 2010 (5) SA 499 (SCA) at 509 A – E.

[6] (636)(11/2012) ZASCA 132 (27 September 2012).

[7] Alex Roux NO v Ryand Karel Hatting para 32

[8] Hawekwa Youth Camp and Another v Byrne 2010 (6) SA 83 (SCA) para 21.

31.5. The legal convictions of the community, or '*boni mores is an objective test based on the criterion of reasonableness. This requires the court to weigh the conflicting interests of the parties in the light of all the relevant circumstances and in view of all pertinent factors in order to decide whether the infringement of the victims interest were reasonable or unreasonable*'[9].

31.6. Amongst the considerations that may influence this policy decision whether or not to impose liability is the nature of the fault that is proved, as well as other fault-related factors. The element of wrongfulness introduces a measure of control to exclude liability in situations where most right-minded people, including judges, will regard the imposition of liability as untenable, despite the presence of all the other elements of delictual liability[10].

31.7. Public policy regards the game of rugby as socially acceptable, despite the likelihood of serious injury inherent in the very nature of the game. Causing even serious injury cannot be regarded as wrongful if it falls within the rules of the game. It matters not whether the conduct was negligent or intentional[11].

31.8. Reasonableness in the context of wrongfulness has nothing to do with the reasonableness of the defendant's conduct, which is part of the element of negligence. It concerns the reasonableness of imposing liability on the defendant for the harm resulting form the conduct[12].

31.9. '*The role of foreseeability in the context of wrongfulness must be seen in its correct perspective. It might, depending on the*

[9] Hattingh v Roux NO and Others 2011 (5) SA 135 (WCC) para 16.
[10] Alex Roux NO v Ryand Karel Hatting para 36.
[11] Alex Roux NO v Ryand Karel Hatting para 42 and 43.
[12] Le Roux v Dey 2011 (3) SA 274 (CC) referred to in para 33 of Roux v Hattingh.

circumstances, be a factor that can be taken into account but it is not a requirement of wrongfulness and it can never be decisive of this issue. Otherwise there would not have been any reason to distinguish between wrongfulness and negligence and since foreseeability also plays a role in determining legal causation, it would lead to the temptation to make liability dependent on the foreseeability of harm without anything more, which would be undesirable.[13],

31.10. A presumption of wrongfulness can be rebutted by establishing one of the well-settled defences which have become known as grounds of justification, such as private defence, necessity, statutory authority or *volenti non fit injuria.* In the assumption of risk situations it is generally accepted that a participant to a rugby game assented to the risks inherent in that particular activity. The difficulty lies in deciding whether or not the harm that actually eventuated can be said to fall within the ambit of the inherent risk associated with the activity[14].

31.11. In novel or borderline cases, where the presumption of wrongfulness has not been rebutted by a *volenti non fit injuria* defence, the fact that a plaintiff accepted the risk of injury by partaking in a dangerous sport activity should not be ignored. The fundamental approach to the determination of wrongfulness explained above will still find application, but the dangers involved with the specific sporting activity should be one of the considerations to determine the legal convictions of the community in respect of unlawfulness[15].

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[13] Steenkamp v Provincial Tender Board, Eastern Cape 2006 (3) SA 151 (SCA), para 18 at page 160A – B.
[14] Alex Roux NO v Ryand Karel Hatting para 41.
[15] Alex Roux NO v Ryand Karel Hatting para 36 and 37 and see Agar and Others v Hyde; Worsley v Australian Football Union Ltd 2001CLR 552, para 14 and 18; Green v Country Rugby Football League of MSW Inc (2008) NSWSC 26.

THE RUGBY CLAIMS: NEGLIGENCE

32. The criterion adopted by our law for negligence is the objective standard of the reasonable person. A defendant is negligent if a reasonable person would have acted differently in a situation where the unlawful causing of damage was reasonably foreseeable and preventable. Whether a diligence paterfamilias in the position of the defendant would have taken any guarding steps at all and if so what steps would be reasonable, must always depend upon the particular circumstance of each case. [16]

33. Foreseeability of harm will depend on the degree of probability of the manifestation of the harm[17]. The second leg of the test for negligence, namely preventability, requires the determination of the question whether, in an instance of reasonably foreseeable damage, the defendant took adequate reasonable steps to prevent the materialisation of that damage. Four factors are particularly relevant to the preventability leg of the test for negligence, more particularly the following:

33.1. The nature and extent of the risk inherent in the wrongdoer's conduct.

33.2. The seriousness of the damage if the risk materialises and damage follows.

33.3. The relative importance and object of the wrongdoer's conduct.

33.4. The cost and difficulty of taking precautionary measures[18].

34. In Pretoria City Council v De Jager[19] the SCA stated that the council in question was obliged to take more than reasonable steps to guard against

[16] Kruger v Coetzee 1966 (2) SA 428A at 430E – H and Law of Delict (5th Edition) Neetling, Potgieter and Visser para 4.1 at 116 – 118.
[17] Neethling, Potgieter and Visser, Law of Delict (5th Edition), page 129.

foreseeable harm to the public. All facts and circumstances must be taken into consideration to determine reasonableness. The fact that the harm which was foreseeable did eventuate, does not mean that the steps taken were necessarily unreasonable. The inquiry ultimately involves a value judgement.

THE RUGBY CLAIMS: CAUSATION

35. It is trite that in order to establish delictual liability, it is not enough to prove a wrongful and negligent act or omission by a defendant. No liability will arise unless a plaintiff can show that his loss is causally connected to the defendant's negligent conduct. Our courts have adopted a flexible or subtle test in respect of causation[20]. The question of whether there is a causal nexus in a particular case is a question of fact which must always be answered in the light of the available evidence[21].

36. In Muller v Mutual and Federal Insurance Co Ltd[22] the court observed that causation in delict involves two distinct enquiries:

36.1. Whether the defendant's wrongful act was the cause of the plaintiff's loss ('factual causation');

36.2. Whether the defendant's wrongful act is linked sufficiently closely to the loss for legal liability to ensue ('legal causation' or 'remoteness').[23]

37. The test for factual causation was stated as follows in International Shipping Co (Pty) Ltd v Bentley supra:

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[18] Neethling, Potgieter and Visser op.cit page 130 – 133.
[19] 1997 (2) SA 46 (AD) at 55H – 56C and Tsogo Sun Holdings (Pty) Ltd v Qing-He Shan and Another 2006 (6) SA 537 (SCA), para 11 - 14 at 540H – 541F.
[20] mCubed International (Pty) Ltd v Singer NNO 2009 (4) SA 471(SCA), para 22 – 36 at 479E to 483G.
[21] Neethling Law of Delict (5th Edition) Neetling Potgieter and Visser para 3.1 on page 171 – 174.
[22] 1994 (2) SA 425 (C).
[23] See also International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA 680 (A).

'The enquiry as to factual causation is generally conducted by applying the so-called "but-for" test, which is designed to determine whether a postulated causa can be identified as a cause sine qua non of the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the loss; aliter, if it would not have ensued'

THE RUGBY CLAIMS: DISCUSSION

38. In respect of the rugby claims I do not find it necessary to deal with the evidence of the witnesses in any detail. All the witnesses struck me as credible witnesses. The contradictions in their evidence are not really relevant to any of the material disputes between the parties.

39. I find it convenient to first consider the element of causation, more particularly whether the alleged wrongful and negligent acts and omissions of SARU, Boland and Mamre are causally connected to the catastrophic injury of the plaintiff. In analysing the principles in respect of causation referred to in paragraph 34 – 36 above, and applying them to the facts of the case the following relevant aspects are important in my opinion:

    39.1. The plaintiff's spinal cord injury occurred as a result of a vertex impact as the players engaged in the first scrum.

    39.2. The plaintiff's injuries did not occur as a result of any transgression of the rules. There is no suggestion of deliberate

scrum collapsing, of plaintiff's front row being pushed out of the scrum or of any other form of unlawful or illegal play, nor is it suggested that the referee did not discharge his duties adequately. As stated above the referee was not joined as a defendant in the action.

39.3. The injury occurred in spite of the fact that the plaintiff was aware that he should keep his head uplifted prior to engagement of the players forming the scrum.

39.4. Prof Noakes, a professor of Exercise and Sports Science and the Head of the Sports Science Institute at the University of Cape Town, called by the plaintiff as an expert witness, conceded that the rule relating to scrums as it stood at the time of plaintiff's injury, if correctly applied by the referee and adhered to by the players, was sufficient to avoid a spinal cord injury.

39.5. The plaintiff's evidence of his weight and the weight of his two props, as opposed to that of their opponents was tentative. The high-water mark of his evidence was that the opposing front row was a little heavier than theirs.

39.6. Mr Adonis Manager of Coaching of SARU testified that rugby is game for all shapes and sizes and that one can therefore not be prescriptive about weigh and length.

39.7. Prof Noakes furthermore testified that there are disparities in size at club level along socio-economic grounds. Under privileged players for previously disadvantaged communities are generally smaller by a substantial weight, at prop level the disparity will be less between players of different ages. He recommended that schoolboys should play in mass categories against each other, he

conceded that there was not necessarily a causal link between the mass of a schoolboy in relation to spinal cord injuries.

39.8. Prof Noakes conceded that a serious or catastrophic injury might be caused by a number of variables that present in any match because predictably, if it was a single factor, such injury would occur much more frequently

39.9. It is only in a very small percentage of the thousands of scrums which take place each year that players are injured. There are many variables that separate such scrums from the thousands of scrums which take place without incident. It is impossible to accurately pinpoint the factors or combination of factors which are present in situations where injuries ensue. I agree with the submission of counsel for SARU that it is therefore speculative to assume that the introduction of age-based restrictions would avoid scrum injuries.

40. I am also not at all convinced that the failure to contact Spineline, contributed to the delay in transferring the plaintiff to Conradie. The fact of the matter is that the first aid official, Ms April, immediately instructed that an ambulance should be called. The plaintiff arrived at Wesfleur shortly thereafter at 15h15. There was sufficient time left for the timeous transfer of the plaintiff to Conradie by either helicopter or ambulance. In the circumstances I conclude that the failure of SARU, Boland and Mamre to inform others about Spineline and to contact Spineline, did not cause the plaintiff's late arrival at Conradie.

41. The injury obviously would not have occurred if the plaintiff was not selected to play for the Mamre third team on the day in question. The accident probably would also not have occurred had he been selected to play in another position and not in the front row, or if contested scrums

were not allowed. To determine legal causation or remoteness, these questions are, in my opinion, not the only relevant questions. The more relevant question is whether the plaintiff would have been injured if he was two years older at that time and/or of the same weight as the opposing hooker. The evidence shows that he was injured at the first scrum engagement when the top of his head hit his opponent's shoulder. There is no evidence whatsoever that his young age, lack of weight or alleged inexperience contributed in any way whatsoever to this injury. A conclusion that SARU, Boland or Mamre was negligent would, in my view, clearly be a finding of negligence in the air'.

42. I therefore find that the plaintiff has failed to establish the requirement of causation in respect of SARU, Boland or Mamre.

43. In respect of SARU, Boland and Mamre, I in any event conclude that the plaintiff has not succeeded in proving wrongfulness and in respect of SARU and Boland any negligence. Relevant evidence disclosing factors which, I believe, should play a role in determining whether SARU, Boland or Mamre acted wrongfully and negligently are the following.

43.1. During 2001 the plaintiff played school and club rugby. At club level he played for an under 19A club-team as hooker. This entailed practicing twice a week and playing matches on weekends, during the season which ran from April to September. During 2002 he began training with the Mamre third team in early February, practicing with them twice a week. As a player he had familiarised himself with the rules of the game.

43.2. Plaintiff thus had considerable experience in the game of rugby, and had played a number of matches as hooker. Many of the phases in a rugby match including the scrum, the ruck and the tackle involve physical contact of a robust nature. Such contact

obviously involves the risk of injury to players, even where there is no transgression of the rules of the game. It was clear from the Plaintiff's evidence that he was well aware of these dangers. He was moreover aware that a scrum is a phase exerting great pressure on the two packs of forwards, and that there was a risk of players incurring serious injury during the scrum. He nonetheless freely and voluntarily participated in the match on 23 March 2002. He expressly acknowledged that prior to the match in question he did not at any stage express any unwillingness to play at hooker.

43.3. One hundred and seventy thousand rugby matches, mostly at amateur and club level, are played in South Africa annually. It will be very difficult if not impossible for SARU to exercise any effective control over all these matches. In 2002 there were a hundred and twenty clubs in the Boland area and control over all matches played in the Boland area would also have been very difficult to effectively control;

43.4. Referees, first aid officials, club officials and coaches, who play a vital role in preparing teams for matches in South Africa are, for the most part, unpaid volunteers;

43.5. SARU, Boland and Mamre are non-profit organizations operating on limited budgets, with limited funds available for first aid training equipment and personnel;

43.6. Efforts were taking place on an on-going basis prior to and during 2002, to improve safety standards and the treatment of on-field injuries. RugbySmart was in operation in 2002 and Spineline was introduced in 2001.

43.7. Dr Newton and Prof Noakes testified that the majority of neck and spinal injuries occurred in the tackle and scrum phases of the game, but both of them also conceded that one could not do away with tackles and scrums without fundamentally changing the nature of the game of rugby;

43.8. The opportunity to participate in a sport such as rugby confers a wide range of benefits on thousands of people, and the functioning and future viability of rugby clubs and regulatory bodies would undoubtedly be jeopardised if they were to be saddled with liability for injuries suffered by athletes voluntarily taking part in that sport[24];

43.9. The type of liability which Plaintiff contends should be imposed in this instance, cannot be restricted to spinal or neck injuries. If the duty which Plaintiff alleges does indeed exist in law, it would render clubs and regulatory bodies liable in all cases where injuries are suffered because of dangerous aspects of the game. The argument, throughout, would be that the regulatory bodies could have avoided the harm by prohibiting that particular aspect of the game. Such liability, if accepted by our courts, would extend to a participant who suffers a broken arm or leg, as much as to a participant suffering a severe neck or spinal injury.

44. The evidence of two employees of SARU, Mr Watson, manager of referees in South Africa and Mr Adonis, manager of coaching as well as Mr Berg, the chief executive of Boland and also the evidence of Prof Noakes demonstrated the following:

[24] Agar and Ohters v Hyde (supra).

44.1. Courses for coaches and referees on the correct scrum formations were regularly presented by SARU. Aspects of safety in relation to scrums, as well as the injuries that can eventuate in scrums were explained to coaches and players. Boland presented courses to coaches on a more regular basis than other rugby unions. Boland furthermore complemented the education of coaches by presenting seminars, workshops and clinics.

44.2. Information about Spineline and the telephone numbers of Spineline was distributed to clubs in the Boland area. Documentation on safety measures was made available to Boland and was brought to the attention of players during courses, prior to and during 2002. All information received from SARU at that time concerning coaching, first aid and safety measures as well as referees, were conveyed to players, coaches and referees,

44.3. Mamre was playing in the super league competition and had direct representation to meetings of Boland. On the day in question, Mamre was playing against a club not affiliated to Boland and they should have applied for consent to play such a match. Mamre failed to do so. Mamre also did not apply for a referee to be appointed for the match in question;

44.4. Socio-economic realities dictate that some clubs are financially far better off than others. The coaching and first aid facilities available to the poorer clubs will therefore invariably be inferior to those available to the clubs that are financially well-off.

44.5. A sport such as rugby is in a continual state of change and flux. Changes to rules are effected on an on-going basis, methods of playing and coaching change over time, styles of play undergo an ebb and flow dictated by a wide variety of circumstances, the

resources which the sport has to invest in a particular activity or aspect of its overall functioning increase or decrease depending on economic factors and the knowledge and skill levels of players vary from year to year.

44.6. Many steps were taken by SARU before 2002 to increase awareness of rugby injuries and to improve the quality of care available to players who were injured. These steps include the following:

44.6.1. In the mid-1990's SARU established the Rugby Medic Club, in order to increase knowledge and understanding of injuries, so that these could be prevented. Its efforts were aimed at referees, coaches and all other role-players.

44.6.2. In 1993 Dr Jakoet was appointed as chief medical officer of South African Rugby. Dr Jakoet and Prof Noakes travelled throughout the country to give talks about safety to rugby players and referees.

44.6.3. Various training manuals and protocols were published and disseminated among role-players. Prof Noakes and Dr Jakoet assisted in the compilation of these and tried to make the publications as helpful and meaningful as possible.

44.6.4. A publication known as Injury Time, the official medical newsletter of SARU, was also published and distributed among role-players.

44.6.5. Various workshops dealing with medical aspects and injury prevention were held by SARU in several regions.

44.6.6. Another body, the SARFU Medical Committee, also played a role although that role is not clearly described in the evidence.

44.6.7. Annual medical conferences were held to advise those involved in rugby in advances in the field of sports medicine and sport science. These were addressed by eminent practitioners in the field. SARU has also for some years followed a system of grading and evaluating referees, and has regularly held workshops and seminars among the referees in the country, at which rugby safety aspects were prominently highlighted.

44.6.8. SARU also offered training and seminars to coaches, on a continuous basis. Various facets of the game including scrums and scrum safety formed an integral part of what was taught on these occasions.

45. I agree with counsel for SARU and Boland that one should guard against applying the wisdom of hindsight to the circumstances of plaintiff's injury and using that as a reason for saddling the SARU, Boland or Mamre with liability. Their conduct falls to be evaluated according to the circumstances prevailing in 2002. The fact that at a later stage, as a result of further research and discussion, a more formalised rugby safety programme was introduced under the Boksmart banner, does not mean that SARU, Boland or Mamre were remiss in safeguarding the safety of players in 2002.

46. There was no suggestion in the evidence in chief or in cross-examination of Mr Watson, Adonis and Berg that any of the information furnished by SARU and Boland regarding the on-going training and education of all role-players was incorrect, nor was it demonstrated, in cross-examination, that these training and education initiatives were inadequate, inefficient or that there were glaring deficiencies in what was offered. Dr Noakes conceded that by 2002 SARU and the rugby authorities had initiated number of projects to increase knowledge of injuries and injury prevention,

47. Having regard to the various factors and the evidence referred to above, as well as the authorities discussed, I conclude that plaintiff has not established any unlawful or negligent conduct on the part of SARU or Boland. Mamre can perhaps be regarded as negligent in that the constitution of Boland was disregarded and plaintiff, who was a schoolboy at that time, was selected to play for a senior team. Mamre also did not obtain the consent of Boland to play a game against a team form another union. This is also in conflict with the Boland constitution. In my view however, even if negligent, the conduct of Mamre can for all the reasons referred to above not be regarded as unlawful[25].

48. In respect of the liability of Mamre, who was not legally represented in the later stages of the trial and on behalf of whom no heads of argument was filed, no evidence was presented to show that Mamre is a legal persona. In the plaintiff's particulars of claim, SARU, Boland and Mamre were cited as firms as defined in Rule 14 of the Uniform Rules of Court. Both SARU and Boland pleaded that they were associations rather than firms as defined in Rule 14 and admitted that they have the power to sue and be sued. The constitutions of both SARU and Boland was handed in during the trial. The constitution of Mamre was however not handed in and no evidence whatsoever was presented as to the personality of Mamre.

[25] See Green v Country Rugby Football League of MSW Inc (2008) NSWSC 26, para 141 – 226.

Whether Mamre was a universitas or an association of individuals has therefore not been established[26].

49. In all the circumstances the plaintiff's claims against SARU, Boland and Mamre fall to be dismissed.

THE MEDICAL CLAIM: THE DISPUTES

50. The plaintiff's case against the Health Department concerns the tardiness with which the plaintiff was treated and the accumulation of the delays that were caused or permitted to occur between the time that he first arrived at Wesfleur In Atlantis, and when he was eventually taken to the Conradie spinal unit in Pinelands.

51. The plaintiff's medical claim also involves that the Health Department had acted unlawfully and negligently in the following respects:

51.1. The failure to inform the hospital personnel, particularly those working at Wesfleur, that low velocity spinal cord injuries should be treated with the greatest urgency, and where possible at Conradie Spinal Unit, within 4 hours of the injury;

51.2. The failure to instruct such hospital personnel that in the case of low velocity neck and/or spinal injures they were to seek advice and guidance from the Conradie Spinal Unit urgently;

51.3. The failure to ensure that such patients were transferred to Conradie in time for them to be treated within 4 hours of the injury, by helicopter, alternatively by ambulance;

[26] See the Law of Partnership and Voluntary Association in South Africa (3rd Edition) Bamford, page 126.

51.4. The failure to inform such hospital personnel of the SA Rugby Spine Line service and number;

51.5. The failure to sufficiently treat plaintiff as medical urgency at Wesfleur.

52. The Health Department admitted in its plea that it owed plaintiff a legal duty to dispense reasonable medical care and plaintiff's case was contested on the following grounds:

52.1. Dr Newton's theory that the rapid closed reduction treatment of low velocity spinal cord injuries within four hours would probably lead to a substantially improved outcome for patients, is incorrect.

52.2. There were no unreasonable delays in the management of the plaintiff.

52.3. The plaintiff has not proved that there is a causal link between the Health Department's actions and omissions on the one had and the plaintiff's damage on the other.

THE MEDICAL CLAIM: THE LAW

53. The law in respect of the elements of wrongfulness, negligence and causation referred to above[27], also find application to the medial claim. The following further aspects appear to be relevant:

[27] See para's 31 – 37.

53.1. The causing of damage by means of conduct in breach of a statutory duty is *prima facie* wrongful[28]. Constitutional rights are most certainly rights deemed worthy of legal protection. In this case it not only is a question of the right to life, bodily integrity and bodily security of a person as provided for in Section 11 of the Constitution[29] that are relevant in respect of the rugby claims, but also Section 27(3) of the Constitution, which is of particular importance[30]. Section 27(3) provides that no-one may be refused emergency medical treatment.

53.2. In Soobramoney v Minister of Health: Kwazulu-Natal[31], it was held that there were several reasons against extending the phrase 'emergency medical treatment' to include ongoing treatment for chronic illnesses for the purposes of prolonging life. The Court furthermore specifically held that, since Section 27(3) is coached in negative terms, '*The purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention…should not be refused ambulance other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment. What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm[32].*' Soobramoney was decided largely on the basis of the scarcity of the resources[33]. As far as reasonableness is concerned,

[28] Van der Walt para 5.3 at page 69 and 70.
[29] The Constitution of the Republic of South Africa at Act 108 of 1996.
[30] Minister of Safety and Security v Hamilton 2004 (2) SA 216 (SCA) in para 19 and 20 at 230H – 231C.
[31] 1988 (1) SA 765 (CC)
[32] Soobramoney para 19 and 20 at 773H – 774D and Constitutional Law of South Africa (2nd Edition) Volume 4, Woolman and Others page 56A-17 to page 56A-19.
[33] Woolman loc.cit para bb on page 56A-8 to 56A-10.

a court would interfere with State decisions relating to budgets only where they are irrational[34].

53.3. In Olitzki Property Holdings v State Tender Board and Another[35], the following appears:

'*Where the legal duty the plaintiff invokes derives from breach of a statutory provision, the jurisprudance of this Court has developed a supple test. The focal question remains one of statutory interpretation…To these considerations may be added that in determining whether a delictual claim arises from breach of a statute the fact that the provision is embodied in the Constitution, may (depending on the nature of the provision) attract a duty more readily than if it had been in an ordinary statue[36].*'

53.4. In respect of medical negligence the question is how a reasonable healthcare practitioner would have acted in the applicable circumstances. Negligence refers to the blameworthy conduct of a person who has acted unlawfully and is located in the fact that on account of carelessness or imprudence the person failed to adhere to the standard of a reasonable healthcare practitioner. Negligence must be evaluated in light of all the relevant circumstances of a case. A plaintiff must prove on a preponderance of probabilities that the defendant was negligent. The maxim *res ipsa loquiture* may find an application '*where the only known facts relating to negligence consist of the occurrence itself.*'[37]

[34] Woolman loc.cit page 56A-11.
[35] 2001 (3) SA 1247 para 12 – 14 at page 1257C – 1258E.
[36] Also see LAWSA (2nd Edition) Volume 8 Part I para 65(D) on page 104.
[37] Neethling, Potgieter and Visser op.cit para 4.7 at page 133 – 136.

THE MEDICAL CLAIM: DR NEWTON'S EVIDENCE

54. Dr Newton, an orthopaedic surgeon, who was the specialist in charge of the Conradie Spinal Cord Injury Unit, as an employee of the Department of Health form 1988 to 2002, was called to give evidence by the plaintiff. He testified as follows:

54.1. A bilateral dislocation occurs when the whole vertebrae shifts forward and both facet joints slide forward and slip off. That causes an occlusion of the spinal canal and compression of the spinal cord;

54.2. Cervical spinal dislocation in rugby causes spinal cord compression and ischemia. The latter is probably the main cause of the spinal cord damage in these cases. If the ischemia is reversed within 4 hours then the spinal cord will recover to a greater degree than with later decompression. After 4 hours the ischemic spinal cord injury is probably largely irreversible;

54.3. In common with other central nervous systemic injuries where ischemia determines outcome, the time from injury to reduction, and thus reperfusion, is probably important. If blood supply is interrupted or impeded to living tissue for too long the cells will eventually die;

54.4. The fact that the deprivation of blood supply from neurological tissue for four hours will result in irreversible damage to the tissue is known to any general medical practitioner. The general practitioner at Wesfleur who received plaintiff on 23 March 2002 should have known that irreversible damage would result after four hours;

54.5. Reductions need not be performed only according to the closed reduction technique, but may also be done surgically. Such reductions are termed open reductions;

54.6. Dr Newton had a special interest in practising the rapid closed reduction technique on spinal cord injury patients. Rapid incremental traction on an awake patient was the preferred method of closed reduction and the duration of traction is no more than ten minutes. The procedure is performed whilst the patient is awake, strapped to a bed and weights are used to stretch the neck and pull the vertebrae back into position. In 2002 the procedure was monitored by communicating with the patient by X-ray.

54.7. The injury to plaintiff was a low velocity trauma caused by a forced flexion and/or rotation and the plaintiff's spinal cord was not transected. All rugby spinal cord injuries are low velocity injuries. The plaintiff was therefore a candidate for closed reduction. Decompression of the spinal cord by a reduction procedure can only benefit a patient whose spinal cord is compressed rather than transected. Typically in facet dislocations as a result of low velocity injuries the cord is not transected. If in such an instance the cord is decompressed by reduction before infraction takes place, recovery is spectacular. In his experience reduction must however take place within four hours. As he puts it,' *what is required is a forceful escort bulldozing through the red tape and lethargy in the accident and emergency department*';

54.8. During his tenure 113 patients with spinal injuries from playing rugby were treated at Conradie. Of them 57 patients had facet joint dislocations which were amenable to closed reduction. Of this 57 patients, 32 were completely paralysed at the time of reduction. Fourteen of them received closed reductions within

four hours and nine of those patients (64%) recovered fully, from Frankel Grade A to Frankel Grade E. In all cases the patients were in various degrees of tetraplaegia on admission and would have been permanent paraplegics if their cervical dislocation had not been rapidly reduced. Of those patients who did not receive closed reductions within four hours, only two made full recoveries;

54.9. In his capacity as head of Conradie, Dr Newton was '*evangelical*' in his attitude concerning early reduction. He was spreading the gospel wherever he went at numerous South African orthopaedic association congresses and to schoolteachers, referees and rugby officials. This included medical personnel at hospital structures in the Western Cape. He also trained medical students at the University of Stellenbosch and Cape Town, ambulance personnel, general practitioners, nurses and rugby referees who might be involved in the process. The message was: '*Do it without delay*';

54.10. He was involved in the establishment of Spineline and was present at its launch. As a result of Spineline there was a protocol in place whereby, if the number was phoned the message would be passed rapidly as an emergency to the appropriate Metro Control centre and an ambulance or a helicopter could be sent out for patients to be reduced within four hours;

54.11. Medical personnel were always available at Conradie on Saturday afternoons to do closed reductions. Conradie had helicopter landing facilities available for transport of patients with rugby injuries. From the moment of notification it would take staff at Conradie five minutes to be ready to receive a patient;

54.12. It was put to Dr Newton in cross-examination that Dr Godwana, who is the head of Wesfleur, will testify that very serious patients

should go to Groote Schuur, that there was no protocol or procedure to send a patient straight to Conradie and that less serious patients should go to Somerset Hospital. Dr Gondwana's evidence would further be that Conradie was a step-down facility, and that referrals could only happen through Groote Schuur. Dr Newton's response was that Conradie was a tertiary centre in a secondary hospital. The spinal unit was a highly specialised unit and not a step-down facility. He described any system that determined that patients could not go directly to Conradie as '*a shocking decision*'. He said that it was known at that time that spinal cord injured patients must be referred to Conradie directly.

THE MEDICAL CLAIM: THE HEALTH DEPARTMENT'S WITNESSES

55. Dr Welsh, a consultant in the division of neurosurgery at Groote Schuur qualified as a neurosurgeon in 2000. He is also a lecturer in neurosurgery at UCT, with a private practice at Vincent Pallotti Hospital. His evidence in essence entailed that:

55.1. Dr Newton's theory of a 64% recovery rate in instances where closed reductions are done within four hours is incorrect.

55.2. The referral path of the plaintiff to Groote Schuur, rather than to Conradie, was appropriate.

56. In respect of Dr Newton's theory the gist of Dr Welsh's evidence was the following:

56.1. He referred to a medical article by a certain Fehlings for the conclusion that there are insufficient data to support overall treatments standards or guidelines on the topic under discussion. Class I data has the least scientific bias and is collected under

very stringent conditions. Class III data is the least reliable, since the way it is collected allows for scientific bias. He furthermore stated that there is Class II data indicating that early surgery may be done safely after acute spinal cord injuries and Class III data to suggest a role for urgent decompression in the setting of bilateral facet dislocation and incomplete spinal cord injury with a neurologically deteriorating patient. Early decompression in patients with spinal cord injuries however is only supported by Class III and limited Class II evidence and can be considered only a practice option. There is a strong rationale to undertake prospective control trials to evaluate the role and timing of decompression in acute spinal cord injury. He therefore attacked Dr Newton's theory on the basis that there is insufficient Class I and Class II data to support it.

56.2. He furthermore referred to a survey of American spinal surgeons in 2012 that discloses, that 75% of 900 surgeons would in the situations under discussion prefer to operate within six hours and that the other 25% didn't think it was important. Dr Welsh relied on the fact that this survey done in a litigation conscious environment still shows a lack of consensus.

56.3. Dr Welsh suggested in cross-examination that Dr Newton's paper may be rejected and will not be published. He had been informed that Dr Newton's work is unpublishable. He could however not dispute the statement that the article had in fact been accepted for publication.

56.4. He did not agree with Dr Newton's evidence that all rugby injuries of the spine are low velocity injuries. He submitted that one cannot assume that all rugby injuries of the spine are low velocity injuries. This is so because some rugby players with such injuries

never recover, despite whatever treatment they may receive. He conceded that the most likely form of an injury incurred in a scrum at engagement is a bifacet dislocation. That is top of the list, but Dr Welsh did not wish to comment further. He said that he is not sure whether this information is readily available. He said that the presumption that it is easy to diagnose a cervical bifacet dislocation because it happened to a rugby player in the front row and he cannot move his legs, in the heat of the battle is a little more grey.

56.5. He disputed Dr Newton's evidence that the deprivation of blood supply from neurological tissue for four hours will result in irreversible damage to tissue. He testified that it is no black and white situation and that it is difficult to be categorical. He did however agree that if you interrupted the blood supply to central nervous system tissue for a period of four hours, you would expect to find a substantial deterioration in function.

56.6. In the summary of the expert opinion filed on behalf of Dr Welsh, the following is stated:

'*Bilateral cervical facet dislocation is the one pathological entity whereby there seems to be some support for urgent early reduction. The current literature supports the guideline based on Class II evidence that this should be pursued in the setting of incomplete spinal cord injury*'.

56.7. In his evidence he testified that both the conditions, bilateral facet dislocation, and incomplete spinal cord injury, must be present for rapid reduction to have a reasonable chance of success. According to him most modern spinal surgeons prefer to decompress such patients as soon possible. He said that

whatever various literature or surveys show, there probably is a general opinion that early is better than late. There however has been an ongoing inability to determine what exactly can be classified as early. The only point on which there is ongoing debate is the four hour cut-off time and how soon reduction should be done. Dr Welsh agreed that as a doctor one would want to intervene quickly to transfer patients urgently and decompress them as soon as possible.

56.8. Dr Welsh conceded that in 2002 spinal cord injuries in the acute phase were treated at Conradie, where all the necessary equipment was available for the management of such patients, as opposed to Groote Schuur. This was known throughout the provincial hospital set-up. He also agreed that closed reduction has the advantage of speed and takes only a few minutes to do.

56.9. Dr Welsh testified that in the 1990's the gospel preached by Dr Newton was that six hours was the cut-off limit. Dr Newton changed his viewpoint from a six hour to a four hour cut-off point. When it was demonstrated to him in cross-examination, that Dr Newton advanced the four hour cut-off theory in the early 1990's, he conceded that he may be wrong in this respect.

57. In relation to the referral path of the plaintiff to Groote Schuur rather than to Conradie, Dr Welsh's evidence can be summarised as follows:

57.1. Given the assessment of T2-complete made by Dr Venter at Wesfleur, the fact that X-rays could not be taken at Wesfleur and the protocol for admission to Conradie, requiring a letter of referral and X-rays, the referral to Groote Schuur was reasonable. Dr Welsh relied on the medical records of Groote Schuur for the conclusion that the X-ray at Wesfleur was not working at that time

and for the assessment of the injury of the plaintiff by Dr Venter as complete paralyses at T2 (the thoracic spine). According to Dr Welsh, at the time of an initial assessment of a spinal cord injury one of the crucial factors to determine is whether one is dealing with complete or incomplete spinal cord injury.

57.2. Dr Welsh furthermore referred to the fact that the protocol dealing with admission to Conradie at that time, specifically required a referral letter and X-rays to accompany a patient with a spinal cord injury to Conradie for admission. He specifically said that it is difficult to make a statement regarding the particular case, but that in his experience of that time it would have been difficult to make a referral directly from Wesfleur to Conradie.

57.3. In the expert summary filed in respect of Dr Welsh, a distinction was drawn between complete and incomplete spinal cord injuries. The submission was made that '*In the setting a complete spinal cord injury and the circumstances prevailing at the time*' the reduction after thirteen hours reflects '*an acceptable and reasonable level of medical care*'.

57.4. He testified that at times there is a lack of consensus as to whether injuries are complete or not. It appears that there is some changeability over time. The fact that a spinal cord injury is complete certainly does not preclude recovery, by and large, it means the prognoses is poor in most cases. Dr Welsh conceded that a clinical assessment of a complete neurological loss of function does not indicate that the cord has been transected or physically damaged in an irreversible way. He admitted that his scepticism about the cut-off time preached by Dr Newton is no justification for not treating spinal cord injured patients urgently.

57.5. He submitted that it is difficult to make a statement, but his experience was that at that time in 2002, it would have been difficult to make a referral directly from Wesfleur to Conradie. He also submitted that the plaintiff was assessed and treated by Dr Venter in more than a reasonable space of time[38].

57.6. He testified that the referral to Wesfleur, the closest hospital from Mamre rugby grounds for stabilisation and further assessment, was the correct decision. Given the assessment made at Wesfleur of T2 complete and the fact that the X-rays were not working at Wesfleur the referral pathway to Groote Schuur was appropriate.

57.7. Dr Welsh said that a request for referral to Conradie at that time was often met with the reply that there were no beds available. He however stated that he agrees that if you feel that a spinal cord injury is best managed urgently and you need rapid decompression, the best place to send such a patient would be the place where you would get that treatment and that was Conradie. In the end he agreed that because the plaintiff's injury occurred in a rugby game, plaintiff's chances of being accepted at Conradie immediately and directly were very good.

57.8. When he was referred to the document '*Protocol for Admission to Conradie Spinal Unit*', he testified that this protocol would have been agreed upon by the Conradie Spinal Unit, in conjunction with Metro Control. According to him it would have been the framework for management of acute spinal cord injuries in the province. In cross-examination Dr Welsh was confronted with paragraph 13 of this Protocol stating that all such admissions to

[38] Dr Venter was not available to testify. He was a junior doctor on duty at Wesfleur at the time.

Conradie require a letter of referral, relevant x-rays, consent for surgery if a minor, shoes and clothes and a social worker/ physiotherapist/occupational therapist report. He suggested that, although the other requirements would not relate to an acute injury referral, but rather to a more chronic one, the requirement of a letter of referral and relevant x-rays are of importance in urgent cases. He said that although the protocol was the standard framework of referral, there would be adaptations in practice.

57.9. According to Dr Welsh, whatever you see in television dramas or whatever you read in terms of how people feel about how medical care should unfold, appropriate steps takes time to be done properly. He stated that the process of referring patients to Groot Schuur is not red-tape or bureaucracy. He said that the healthcare system does not only cater for rugby players but for every sick or injured person in the whole of the Western Cape. There must therefore be a logistic framework. Resources furthermore were limited in 2002.

57.10. According to Dr Welsh protocol and so-called red-tape are there to run a complete health system, rather than necessarily to deal with an individual case. Protocols are in place to arrange for an orderly transfer of patients from where they are injured to the place where they are best going to be looked after. Unfortunately those protocols need to take everybody's requirements into account and also the available resources.

57.11. In respect of a complete lesion in the clinical sense and the question whether you can then take your foot form the gas, he said that if you look at a broad spectrum of patients who suffered neck injuries diagnosed as complete, their prognoses in general is very poor. In such instances it is the practice to seek treatment on

a less urgent basis. Dr Welsh however said that he does not advocate a non-urgent approach simply because there is a clinical diagnosis of a complete lesion.

57.12. On the question as to why Dr Venter could not have contacted Conradie directly, Dr Welsh replied that he could have, but that Prof Wallis the metro expert may be able to comment on that more accurately, in that there are referral systems and referral patterns and protocols. Dr Welsh also testified that he does not know whether a referral by Dr Venter would have been successful or not.

57.13. He explained that the Spineline initiative, is an attempt to involve a very senior person to direct the traffic from the beginning. It is not a provincial initiative. Dr Welsh testified that one cannot say or know whether Dr Venter was familiar with that facility or not. He was in any event bound by his standing orders and referral protocols.

58. Dr Wallis, is an emergency physician, a professor and head of the Division Emergency Medicine at the University of Cape Town and Stellenbosch University. He is also the Chief Specialist and head of EMS for the Western Cape Government. He came to South Africa in 2002, but was only appointed to work for the Health Department in 2006. Previously he was involved with Metro EMS and the Red Cross Children's Hospital. He has no qualification in neurosurgery or orthopaedics. He gave evidence about whether the plaintiff should have been transported sooner. Important aspects of his evidence is the following:

58.1. The resources of EMS were limited in 2002.

58.2. If everybody with a suspected spinal injury went to the spinal unit at Conradie, the medical staff at Conradie would spend all their time assessing patients. There is a need for patients to go through a filter, like a gate otherwise very highly specialised resources, such as Conradie will deal all the time with patients that do not actually need their service.

58.3. It was not the practice to directly refer a patient from Wesfleur to Conradie in 2002.

58.4. The referral pathway from Wesfleur to Groote Schuur rather than to Conradie was appropriate. He sought to characterise the delay in transferring plaintiff to Conradie as reasonable on the basis that other cases might have had a higher priority.

58.5. He expressed reservation about helicopter transportation of spinal cord injured patients. He conceded that it was possible to convey plaintiff to Conradie within four hours, even if the referral path from Wesfleur to Groote Schuur was followed.

58.6. He testified that of the available fleet of ambulances in the Western Cape, only about one third were, at any given time, available to convey patients.

59. Dr Rothemeyer, who was on duty at Groote Schuur on 23 March 2002 as a registrar training to become a neurosurgeon, testified that at the time nursing staff in the trauma unit were incredibly busy. There were usually at least six to ten acutely ill patient to cope with. As neurosurgeon at that time, she was serving both Groote Schuur and Red Cross for 24-hour shifts at a time. From time to time she was driving between the two hospitals, but there was no time to waste. In respect of her recommendation of helicopter transfer for plaintiff, she testified that she

probably decided that the patient should be brought to Groote Schuur as soon as possible for further management and that, with her '*somewhat simplified understanding of the logistics of patient transfer*' she obviously decided that a helicopter would be faster than an ambulance. She specifically stated that she is not a logistic expert at all.

THE MEDICAL CLAIM: DISCUSSION

60. Dr Newton and Dr Rothemeyer made a good impression on me and I accept their evidence.

61. Dr Rothemeyer's evidence about the very heavy workload at Groote Schuur on 23 March 2002, when the plaintiff arrived there, must be accepted. The plaintiff in any event only arrived at Groote Schuur at the earliest at 17h45. There is therefore no basis for a finding that the Health Department is liable for any delay at Groote Schuur causing the plaintiff not to be treated within the four hour cut-off point.

62. Mr Potgieter SC, who appeared with Mr Salie for the Health Department, emphasised that Dr Newton was adamant that a closed reduction has to be completed within four hours of injury to make a difference and that there is no urgency after four hours. It was furthermore submitted that that the closed reduction procedure itself takes at least half an hour. It was also pointed out that Dr Newton expressly agreed that the implication of this, in the context of the existing transport facilities at that time, meant that unless there was a direct link arranged between the rugby field and Conradie, like Spineline, the four hour cut-off would be missed. The plaintiff also submitted that the fact that Spineline did not form part of the Health Departments health service framework, but was an initiative of SARU, should be taken into consideration.

63. In respect of Dr Newton's theory it was submitted that this theory is not based on research. Dr Newton simply wrote up a series of rugby cases, at best Class III data which is the least reliable way of assessing scientific processes. Counsel for the Health Department further submitted that Dr Newton's theory is little more than his own personal opinion, based on a sample of patients with broadly similar injuries that he treated over a certain period many years ago. Dr Newton did not quote any research or individuals supporting his thesis. The fact that his re-worked and co-authored article was eventually published is, according to counsel for the Health Department, neither here nor there.

64. Despite the criticism of Dr Newton's four hour cut-off point theory, no acceptable evidence gainsaying this theory was, in my opinion, presented by the Health Department. Dr Welsh conceded that some of Dr Newton's conclusions were correct. This theory, although not based on Class I data and only on Class III and limited Class II data, comes across to me as well-reasoned and logical. I accept Dr Newton's evidence that the plaintiff would have had a 64% chance of full recovery had he been treated within four hours.

65. In relation to referral pathways the status of the Wesfleur records that were placed before the court and referred to in evidence was recorded in the pre-trial minute dated 25 February 2011. In this minute it was sated that the documents are what they purport to be. The correctness of the content has however not been admitted. By contrast the correctness of the content of the ambulance records (which were dealt with on that basis by agreement between the parties) has been admitted, as recorded in the pre-trial minute dated of 16 March 2012. The Health Department relied on the fact that plaintiff did not question the authenticity of the correctness of the Wesfleur records and that plaintiff in fact referred to these records as part of the factual background, more particularly for Dr Newton to confirm

that there were no working X-ray facilities to treat spinal cord injuries at Wesfleur.

66. At the closing of the case for the Health Department it was placed on record that Dr Venter could not be traced and would therefore not be called as a witness. In cross-examination it was furthermore put to Dr Newton that Dr Gondwana who is the Registrar of Wesfleur would testify. He was however not called as a witness. Not one of the medical staff or any other person who was present at Wesfleur at the time when the plaintiff arrived there on 23 March 2002 was called as a witness and no explanation was forwarded why they were not called.

67. The mere handing in of documents in terms of Rule 35(10) does not make its contents admissible in evidence against a defendant. It is hearsay evidence and will only be admissible as evidence if it can be brought under one of the exceptions to the hearsay rule[39]. No application was made to allow this hearsay evidence. I would in any event not have granted such an application in terms of Section 3 of the Law of Evidence Amendment Act 45 of 1988, since no acceptable reasons were furnished why this evidence was not given by a person upon whose credibility the probative value depends.

68. I therefore conclude that no admissible evidence was presented in respect of the question whether the X-ray at Wesfleur was working, or whether Dr Venter made a diagnoses of T2 complete. I must add however that, should this evidence have been allowed as admissible, I still would have concluded that the delay to refer the plaintiff to Conradie was not properly explained by the Health Department.

[39] Zungu NO v Minster of Safety and Security 2003 (4) SA 87 (D) at 90; Weintraub v Oxford Brick Works (Pty) Ltd 1948 (1) SA 1090 (T) 1093; Selero (Pty) Ltd And Another v Chauvier and Another 1982 (2) SA 208 (T) at 215 – 216 and Knouwds v Administrateur, Kaap 1981 (1) SA 544 (CPD) at 551H – 552B.

69. As stated above the Health Department sought to make out a case that the referral path of plaintiff to Groote Schuur was reasonable in the circumstances. In relation to the evidence that the Health Department rely upon in this respect it must be stated that both Prof Welsh and Prof Wallis struck me as highly educated and dedicated professional experts. The criticism that Dr Wallis was not involved with the Health Department in 2002, cannot however be ignored. I agree with counsel for the plaintiff that his evidence were speculation in many respects. The same applies to the evidence of Dr Welsh. As was stated in Micheal and Another v Linksfield Park (Pty) Ltd[40], the question of reasonableness and negligence is one for Court itself to determine on the basis of conflict expert opinions and not of the experts. '*As a rule that determination will not involve considerations of credibility but rather the examination of opinions and the analyses of their essential reasoning, preparatory to the Court's reaching its own conclusion on the issues raised*'.

70. The Health Department submitted that the delays that occurred, was reasonable on the basis of fist defendant's protocol. Both Prof Welsh and Dr Wallis regarded protocol as vital for the functioning of a proper emergency health system. The Health Department's reliance on protocol is misplaced. Dr Newton made the point forcefully in his evidence that it is not reasonable or acceptable that protocols or referral paths deprive a patient of medial treatment if the treatment is urgently required. Dr Welsh furthermore agreed that the Conradie protocol could be ignored in the case of urgent referrals. Protocols should not trump Section 27(3) of the Constitution and the blind adherence is no excuse for emergency treatment not being administered timorously.

71. The Health Department's reliance on a one page Conradie Hospital admission protocol (namely, the absence of an X-ray) is completely

[40] 2001 (3) SA 1188 (SCA), para 34 at 1200C – E; Mutual and Federal Insurance v SMD Telecommunications 2011 (1) SA 94, para 17 at 99I – 100G.

unconvincing. This is especially so since there were no admissible evidence that X-ray at Wesfleur was not in a working condition. It is even more so in view of the evidence of Mrs Oppelt and Plaintiff referred to above, and Dr Rothemeyer's own observations on the need for a helicopter to convey Plaintiff. There is no evidence from First Defendant explaining that delay.

72. Much emphasis was placed by the Health Department on limited resources. With reference to McIntosh v Premier Kwazulu-Natal and Another[41], counsel for the Health Department referred to the finding that where a public authority is involved a further consideration arises. In McIntosh the following was stated: '*a court when determining the reasonableness or otherwise of a authorities conduct will in principle recognise the autonomy of the authority to make decisions with regard to the exercise of its power. Typically, a court will not likely find a public authority to have failed to act reasonably because it elected to prioritise one demand on its possible limited resources above another. Just where the line is to be drawn is no easy matter and the question has been the subject of much judicial debate…*' In the matter under consideration there is no question of extra resources being utilised if a patient is referred directly to Conradie. Conradie at that time was established as a specialised spinal unit and the evidence is that the plaintiff would have been accepted at Conradie. All that was required was for the medical staff at Wesfleur to have been properly informed, and to have made the necessary telephone calls to arrange transport.

73. I agree with counsel for the plaintiff that a loading time of plaintiff into the ambulance at Wesfleur Hospital of 15 minutes is a very conservative estimate, compared to the actual loading time of plaintiff at the sports fields at Mamre which was 8 minutes. The evidence is that plaintiff

[41] 2008 (6) SA 1 (SCA) and more particularly para 14 at 9F – 10B

required stabilising at Mamre, and the loading time can be expected to have been considerably longer than elsewhere.

74. The ambulance records show that plaintiff arrived at Wesfleur Hospital at 15h15, 25 minutes before the dispatch of the emergency air services helicopter on an alternative mission. Counsel for the Health Department's submission that the alternative helicopter mission would have been arranged and agreed upon some time prior to 15h40, apparently the take-off time, is probably correct. This aspect was however not explored in the evidence in chief or cross-examination of Mr McCormick, who testified about the availability of helicopter transport. I am prepared to accept that the request for the alternative mission was first made prior to take-off time, at about 15h30. The fact of the matter is that the plaintiff arrived at Wesfleur fifteen minutes earlier. The transfer of plaintiff to Conradie by helicopter would at most have been preceded by a few phone calls to for example Conradie, Spineline and the ambulance service. That could have been achieved in less than 10 minutes if there were no other priorities to attend to. There is however no evidence about the situation at Wesfleur on 23 March 2002. We do not know what the staff position was and whether there were any other emergency patients being treated. In the end, the delays in the management of plaintiff at Wesfleur Hospital were simply not explained by any evidence. There was, in my view, an evidential burden on the Health Department in this Respet.

75. Professor Wallis sought to characterise the delay in transferring plaintiff to Groote Schuur as reasonable on a completely speculative basis that other cases might have had a higher priority. His evidence is obviously in direct conflict with that of Dr Newton in this respect. Prof Wallis' evidence about availability of ambulances, conditions that prevailed at the various hospitals and referral "*pathways*" for spinal cord injured patients in 2002, was mere speculation. The same applies to the evidence of Dr Welsh concerning referral pathways. Neither of them had direct knowledge of

the conditions that prevailed at Wesfleur on the day in question. The ambulance records and Professor Newton's direct evidence show that their speculation about these conditions were incorrect. .

76. The ambulance records show that it took approximately one hour and 10 minutes from Plaintiff's arrival at Wesfleur, until an ambulance was dispatched to collect Plaintiff at Wesfleur and a further half hour before the ambulance eventually departed. The delay in calling for an ambulance, as is the case with the helicopter, is not explained.

77. Dr Newton was the Health Department's employee at that time and the person most authoritatively concerned with the treatment of spinal cord injured patients under the Health Department's care in the Western Cape. The need to treat those patients urgently and to transfer them directly to Conradie was not only Dr Newton's opinion, it was shared by all the personnel and staff employed at Conradie. Dr Rothemeyer also appears not to have been ignorant of the need for urgent intervention when she suggested helicopter transfer. The information was also widely disseminated according to Dr Newton, amongst *inter alia*, hospital personnel in hospitals in the Western Cape. To the extent that it was not, the Health Department's failure to do so was, in my opinion, also wrongful and culpable.

78. Not only Dr Newton, but all the personnel employed at Conradie Spinal Unit at the time, was aware of the importance of early closed reduction and within the timeframe of four hours. Some of those doctors are still in First Defendant's employment at present Dr Stander is currently the head of the Spinal Cord Unit at Groote Schuur. Dr Baalbergen is also at Groote Schuur. Dr Newton explained that the delay in reducing the plaintiff's injury at Conradie in the early hours of 24 March 2002 can probably be explained by the decision of Dr Stander that it was already to late and that

no necessity for urgent intervention existed. Dr Stander was not called to contest this conclusion.

79. In my opinion there is no question that the plaintiff would have been taken to Conradie timeously, within four hours, if the ambulance had been directed to go directly to Conradie. Despite the unexplained delays, the ambulance with the plaintiff as a passenger, departed from Wesfleur at 16h55. It should therefore, despite those delays have arrived at Conradie at 17h40. In light of the evidence of Dr Newton and also that of Dr Welsh, I do not agree with counsel for the Health Department that it would have taken half an hour to prepare the plaintiff for and to do the closed reduction. On my interpretation of the evidence it rather would have been fifteen minutes. Be that as it may there was sufficient time to do the reduction within the four hour cut-off point.

80. The acceptance of Dr Newton's theory as valid and the finding that the Health Department acted unreasonably in not taking him to Conradie earlier, justify the conclusion that the Health Department refused emergency medical treatment to the applicant as provided for in Section 27(3) of the Constitution[42]. The inference that the Health Department acted unlawfully and negligently is unavoidable.

81. The inference is inevitable that plaintiff was not treated with the reasonable skill and expertise required of the Health Department's staff at Wesfleur at the time. The unexplained delays called for an explanation. The statements attributed to Dr Godwana by First Defendant's Counsel in cross-examination of Plaintiff's witnesses was an attempt to set up such an explanation. The failure to call Dr Godwana (or any other witness) means that the explanation was not given in evidence, and there is

[42] See also Woolman and Others, Constitutional Law of South Africa (2nd Edition) Volume 3 para 39.8 at page 39-17 to 39-21.

accordingly no evidence from of the Health Department to explain the delays.

82. In the present case I agree with counsel for the plaintiff that it was incumbent on the Health Department to heed the gospel of the head of their Spinal Unit and to inform all hospital personnel of:

82.1. The need to transfer low velocity spinal cord injury patient, especially those injured in rugby matches, urgently to Conradie for treatment within four hours.

82.2. That existing protocols or referral paths should not be adhered to and in an emergency such as arose in plaintiff's case.

83. A 64% chance of recovery in my view constitutes causation on a preponderance of the evidence[43]. Whereas causation requires establishment on a balance of probabilities of a causal link between the negligence and the loss, quantification of damages, where it depends on future uncertain events is based on the assessment of the chances of the risk eventuating[44]. The fact that the plaintiff only had a 64% chance of recovery as shown by Dr Newton's evidence will therefore probably play a role in the determination of damages due that will take place at a later stage.

84. In all the circumstances I therefore find that the plaintiffs claim against the Health Department must succeed.

[43] The Application of the Doctrine of a Loss of Chance to Recover in Medical Law, Pat van der Heever para 5.4 on page 62and 63; Foundational Principles of South African medical negligence of Pieter Caarstens para 96, 14.9.6.14.2.1 on page 834 and 835. In respect of causation in medical cases, see the Premier of the Western Province and Another v JH Loots NO (214/2010) (2011) ZADSCA 32 (25 March 2011). para 16 – 25.
[44] Van der Heever loc.cit para 5.6 at page 65 and 66.

COSTS

85. In respect of costs, it must be taken into account that the plaintiff as a young boy of 17 years suffered a catastrophic injury while playing rugby, a sport under the control of SARU, Boland and Mamre. Although I have decided that his claim against SARU, Boland and Mare must fail, I believe that these associations have at least a moral obligation to assist the plaintiff.

86. In issuing the summons the plaintiff was attempting to enforce his constitutional right in terms of Section 11 of the Constitution. In the circumstances I have decided to exercise the discretion in respect of costs and to order that each party must pay its own costs[45].

87. I estimate that about 50% of the plaintiff's costs was expended in respect of the rugby claims and 50% in respect of the medial claim. I do however believe that it will be fair for plaintiff to be reimbursed for the qualifying charges in respect of the expert witness Dr Newton.

CONCLUSION

In the result the following order is made:

1. Plaintiff's claim against second-, third- and fourth defendant is dismissed. Each of the parties is ordered to pay its own costs.

2. Plaintiff's claim against the first defendant succeeds and the first defendant is declared to be liable to the plaintiff to pay such damages as plaintiff may prove that he has suffered as a consequence of the neck injury sustained in the rugby match played at Mamre on 23 March 2002.

[45] Minister of Correctional Services v Lee (supra) para 68 and 69 at 632C – D.

3. The Registrar is requested to set the matter down for hearing, in consultation with plaintiff, first defendant and the Judge President, in order for the parties to lead evidence pertaining to the quantum of the plaintiff's damages, the sequelae thereof, as well as the portion of such damages for which the first defendant is liable.

4. First defendant is ordered to pay 50% of plaintiff's total costs of suit, including the costs of two counsel. In respect of the qualifying charges of the expert witness, Dr Newton, first defendant is ordered to pay all such costs.

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W H VAN STADEN,
Acting Judge of the High Court