IN THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

DELETE WHICHEVER IS NOT APPLICABLE

(1) REPORTABLE: ~~YES~~ / NO.

(2) OF INTEREST TO OTHER JUDGES: ~~YES~~ / NO.

(3) REVISED.

31/10/2014
DATE

SIGNATURE

Case Number: 67610/2012

31/10/2014

In the matter between:

KAFA PETRUS MAVUSO Plaintiff

and

MEC FOR THE DEPARTMENT OF HEALTH, MPUMALANGA Defendant

JUDGMENT

POTTERILL J

[1] The parties agreed in terms of Rule 33(4) that the special plea of prescription be separated from the merits of the matter. The only issue before me thus is whether the plaintiff's claim against the defendant has prescribed. The parties agreed, correctly so, that the defendant has the onus to prove that prescription bars the plaintiff to proceed with his claim. The parties did not call any witnesses.

[2] As background to the special plea I set out the common cause facts and chronology of the matter:

2.1 The plaintiff was on 1 May 2008 injured in the collision on the Ermelo/Breyton Road.

2.2 The plaintiff was by ambulance taken to the Ermelo hospital on the same date i.e. 1 May 2008 and admitted.

[3] The hospital records reflected that he was treated with traction. He was all the while hospitalised until he was operated on, on the 22nd of May 2008.

[4] Surgery was performed on the plaintiff's arm and femur. On the arm an open reduction and internal fixation was performed on the fracture of the right forearm. On the fractured femur an intramedullary nail placement was performed.

[5] Control X-rays were requested by the doctor on the 23rd of May 2008. On the same date X-rays were indeed taken of the femur and right arm.

[6] On 24 May 2008 at 11h00 a doctor writes in the clinical doctor's notes that:

"Control X-rays – satisfactory reduction and fixation."

[7] On 26 May 2008 at 09:36 am a doctor wrote with reference to the control X-rays that were taken, the following:

"Control X-rays – position good."

[8] On 26 May 2008 the plaintiff was discharged. A note on the hospital records reflected that the plaintiff was informed that he should see a physiotherapist, the plaintiff is however confident with crutches and can be discharged. The plan was to refer him to a clinic for removal of the stitches and for the plaintiff to do a follow-up at the orthopaedic division on the 19th of June 2008.

[9] On 19 June 2008 the plaintiff attended his follow-up visit. It is recorded on the progress note that the plaintiff had no complaints and that the plaintiff claimed that he is unemployed. On the record it is also stated:

"J88 completed for temporary DG."

[10] On 2 June 2008 the plaintiff consulted with his attorney of record with the instruction to lodge a third party claim against the Road Accident Fund for the damages he suffered as a result of the injuries he sustained in the collision.

[11] On 3 June 2008 the plaintiff's attorney requested the superintendent at the Ermelo hospital to complete the medical section of the RAF Form I.

[12] On 2 July 2008 the plaintiff went for a follow-up visit at the Ermelo hospital.

[13] On 23 July 2008 he went for a further follow-up visit at the Ermelo hospital. On this date the doctor noted that the plaintiff complained of pain. His blood pressure was taken and a J88 was also completed for temporary DG. He was prescribed pain medicine.

[14] On 29 July 2008 the RAF Form I is completed by Dr. G. Ikotia.

[15] On 26 February 2010 the plaintiff's attorney issued summons against the Road Accident Fund.

[16] The plaintiff's attorney obtained a medico-legal report from an orthopaedic surgeon, Dr. F.A. Booyse on 14 August 2012. On the same date the report was forwarded to the plaintiff's attorney and the following paragraphs relevant to this claim reads as follows:

"I must comment on the intramedullary nailing – it's insertion through the proximal fragment, missing the intervening fracture fragment of the proximal third of the femur and then again continue into the intramedullary cavity of the distal femur fragment – this is a surgical mystery how this could possibly be done ...

It is to be noted that the surgical treatment that this claimant has received, needs to be explained and I am of the opinion that the claimant has the right to a legal claim of medical negligence against the treating surgeon."

In essence thus Dr. Booyse reported that the fracture of the proximal ulna was not properly reduced by open reduction and the intramedullary locking nail was inserted into the distal femoral fracture segment during the surgery that was performed on the plaintiff on 23 May 2008 at the Ermelo hospital, totally missing the proximal fractures and femur fragments. This resulted in a complete mal-union of the femur fragments and a 4 centimetre shortening of the right femur.

[17] On 12 September 2012 the plaintiff's attorney gave notice by registered mail to the defendant in terms of section 3(2) of Act 40 of 2002 and issued and served a summons with a cause of action relating to medical negligence. This summons was served on the 4th of December 2012.

[18] The quantum pertaining to the Road Accident Fund matter was settled on 23 July 2013.

[19] The parties also agreed that the particulars of claim of the summons pertaining to the professional negligence as well as the hospital records and other records and reports were correct for the purposes of the argument pertaining to prescription.

[20] In terms of section 11(d) of the Prescription Act 68 of 1969 hereinafter referred to as ("the Act") a claim is subject to a three year prescription period and this period starts to run when the debt is due. Section 12 of the Act reads as follows:

> *"12 When prescription begins to run*
>
> *(1) Subject to the provisions of subsections (2) and (3), prescription shall commence to run as soon as the debt is due.*
>
> *(2) If the debtor wilfully prevents the creditor from coming to know of the existence of the debt, prescription shall not commence to run until the creditor becomes aware of the existence of the debt.*
>
> *(3) A debt shall not be deemed to be due until the creditor has knowledge of the identity of the debtor and of the facts from which the debt arises: Provided that a creditor shall be deemed to have such knowledge if he could have acquired it by exercising reasonable care."*

[21] The defendant argued that the plaintiff had knowledge of the facts on 26 May 2008, the day the plaintiff was discharged from the hospital. The defendant never refused the plaintiff the hospital records and the plaintiff's attorney could have

requested the X-rays that were taken at the hospital. On these records and the X-rays he could have had all the material facts as on that date. It was further argued that the plaintiff experienced pain all along and this should have alerted him to enquire about the operation. It was submitted that the plaintiff cannot rely on the report of Dr. Booyse as to when he became aware of the facts because this is a legal opinion. A legal opinion is not necessary to complete a cause of action and the claim thus prescribed on the 26th of May 2011. In support of this contention reliance was placed on ***Truter and Another v Deysel*** **2006 (4) SA 168 (SCA).** Furthermore in the period after 26 May 2008 he could reasonably have acquired knowledge of the facts from which the debt arose by the exercise of reasonable care.

[22] On behalf of the plaintiff it was argued that the plaintiff only had knowledge of the material facts on the 14th of August 2012 when the plaintiff's attorney received Dr. Booyse's report. The plaintiff as a person with the highest qualification of Grade 3 and a self-employed traditional healer could not have reasonably acquired knowledge of these facts before 14 August 2012 when he received the report.

[23] The defendant's plea that the plaintiff had knowledge of the identity of the defendant and of the facts giving rise to the debt on which his claim was based not later than 26 May 2008 is bad in law. There is simply not a single fact that the defendant can rely on as to why on the date of discharge the plaintiff should have been alerted that he had a cause of action against the defendant. This is so because there can be no conceivable fact on the discharge date as to why the defendant would have had material facts for a cause of action.

[24] In the alternative the defendant pleaded as follows:

> *"(The plaintiff) could, with an exercise of reasonable care, have acquired knowledge of the identity of the defendant and of the facts from which the debt arose by not later than 26-05-2008."*

This is once again a preposterous allegation. The defendant did not provide a single fact as to why the plaintiff had any facts on the date that he was discharged that he had a cause of action against the defendant. It could also not be argued before this court as to why he would have with reasonable care on the date of discharge been alerted that he had a cause of action against the defendant.

[25] Contrary to their plea the defendant argued that after the date of discharge the plaintiff had consistent pain and this should have alerted the plaintiff to his cause of action. The hospital records reflected that on the first two occasions post operation the plaintiff attended the hospital and no mention was made of pain. On 23 July 2008 i.e. 8 weeks after the operation he did complain of pain. He was prescribed pain medication. There is no factual evidence before this court that the plaintiff or any other person would have due to the pain been alerted that something was wrong and he had a cause of action. Firstly this argument is contrary to the plea only referring to the date of discharge. Secondly this court cannot find that any other person would have due to pain 8 weeks after a hospitalisation of 26 days and 2 operations would have thought that pain would be inconceivable and therefore have been alerted that there is a cause of action against the defendant.

[26] It was also argued that if the plaintiff had asked for the hospital X-rays on a later date the plaintiff would have been alerted to his cause of action. It does not appear from the hospital records or any other evidence before the court that the plaintiff had any reason to question the success of his surgery and that there was therefore a duty on him to make further enquiries through which he could then have ascertained certain facts. During the plaintiff's three follow-up visits at the hospital X-rays were not taken and he was not informed or alerted to any facts during these visits that should have alerted him. There was never any suggestion made that anything could have gone wrong with the surgery; in fact the hospital records reflected that the operation was a success.

[27] The reliance on the ***Truter*** matter ***supra*** is misplaced. The court therein found on p175 paragraph 21 as follows:

> *"[21] By contrast, in the present case, it is abundantly clear that Deysel believed and appreciated from as early as 1944 that a wrong had been done to him by Drs Truter and Venter."*

and

> *"[24] According to Deysel's own evidence, from at least the time of his initial complaint to the Council, in July 1994, he knew the details of the operations performed on him by Drs Truter and Venter, and that he had suffered harm. He also knew that the two doctors were required to exercise reasonable care and skill in treating him; indeed,*

his unremitting and oft-repeated complaint was that they had failed to do so, as a result of which he had undergone a multiplicity of medical and surgical procedures and had suffered permanent damage to his remaining eye ..."

and

"[25] As is clear from the sequence of events described above, all the facts and information in respect of the operations performed on Deysel by Drs Truter and Venter in 1993 were known, or readily accessible, to him and his legal representatives as early as 1994 or 1995."

[28] *In casu* there are simply no material facts relating to the cause of action before the report of Dr. Booyse comes to light. The plaintiff could not with an exercise of reasonable care have acquired knowledge of the facts before the report of Dr. Booyse. The report of Dr. Booyse was thus not merely advancing an opinion in the form of a conclusion that there had been negligence, but set out the facts on which a cause of action for medical negligence could be based. The defendant is thus incorrect in its submission that the report of Dr. Booyse is only a legal opinion not necessary to set out a cause of action and the plaintiff can accordingly not rely thereon. The plaintiff is specifically relying thereon not as a legal opinion but as for the first time having knowledge of the facts that could sustain a cause of action against the defendant.

[29] In ***Drennan Maud & Partners v Pennington Town Board*** **1998 (3) SA 200 (SCA)** at 212E-G the test relating to the "facts from which the debt arose" is not a stringent test.

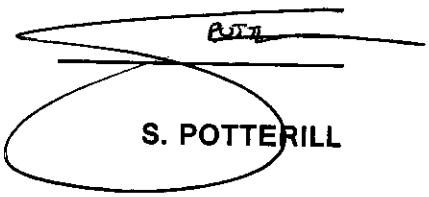
> *"In short, the word 'debt' does not refer to the 'cause of action', but more generally to the 'claim'. There is in my view no reason to give the word another meaning in s 12(3).*
>
> *... In deciding whether a 'debt' has become prescribed, one has to identify the 'debt', or put differently, what the 'claim' was in the broad sense of the meaning of that word."*

In terms thereof the plaintiff most certainly only had the material facts or the claim in the broad sense of the meaning when he received the report from Dr. Booyse on 14 August 2012. The summons was served on the defendant on 4 December 2012; thus within the three year period.

[30] I am thus satisfied that the defendant did not prove that the plaintiff's claim has prescribed.

[31] I accordingly make the following order:

The special plea of the defendant is dismissed with costs.



S. POTTERILL

JUDGE OF THE HIGH COURT

CASE NO: 67610/2012

HEARD ON: 29 October 2014

FOR THE PLAINTIFF: ADV. F. PAUER

INSTRUCTED BY: Gerhard von Wielligh Attorneys

FOR THE DEFENDANT: ADV. M. MALATJI

INSTRUCTED BY: State Attorney

DATE OF JUDGMENT: 31 October 2014