**IN THE HIGH COURT OF SOUTH AFRICA**

**(WESTERN CAPE DIVISION, CAPE TOWN)**

CASE NO: **20388 /2011**

In the matter between:

**C. B.** First Plaintiff

**R. B.** Second Plaintiff

v

**DAWN KATHRYN DOUGLAS MOORE** First Defendant

**PROVINCIAL GOVERNMENT OF THE WESTERN CAPE: DEPARTMENT OF SOCIAL DEVELOPMENT** Second Defendant

*Coram:* ***Dlodlo J***

Date of Hearing: **27 March 2017**

Date of Judgment: **30 June 2017**

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**JUDGMENT**

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***DLODLO, J***

[1] On 14 October 2010, a dark cloud enveloped the B. family when their precious child named A. rolled from the bed at Aunty Dawns Daycare Centre and met her death. The plaintiffs are the biological parents of the late A. B with identity number […], born on 2 May 2010. A. and her older sister Chloe were both enrolled at the first defendants Day-Care Centre in Pinelands (known as Aunty Dawns Day-care and Playgroup). This Day-Care Centre ('ECD') was situated as 5 Verbena Way, Pinelands, Cape Town. On the date mentioned above the first defendant took A. to her own bedroom and placed her on her bed. She left the room and closed the door behind her. When she returned later that morning (at approximately 10h30) she found A. on the floor next to the bed on which she had been put. A. was not breathing and she was already dead.

[2] The plaintiffs aver that whilst A. was left unattended on the bed she probably rolled off the bed and fell onto the floor and became wedged between the bed and a bedside table. She was then unable to breath due to the position of her body and asphyxiated and died. This form of death is described as positional asphyxia or postural asphyxia. Experts explain that positional asphyxia occurs in an infant when the infant's position prevents her from breathing adequately either because her nose or mouth is blocked and/or her chest is unable to fully expand and/or her airway is kinked. The infant is unable to get sufficient air and asphyxiates and dies. Accordingly, positional asphyxia can occur when an infant is put to sleep or falls asleep in an unsafe sleeping environment or in an unsafe position. An unsafe environment would be an adult's bed. It is common cause that A. was 5½ months old at the time of her death.

**THE CAUSE OF ACTION AGAINST**

**FIRST AND SECOND DEFENDANTS.**

[3] The plaintiffs aver that the first defendant was under a legal duty to ensure that safety and security of A.'s person whilst she was in her (first defendant's) custody and care. The plaintiffs further aver that the death of A. was as a direct result of the first defendant's wrongful and negligent breach of her legal duty, *inter alia*, in that she left A. alone and unattended on a bed and failed to place her in a cot or some other safe resting area.

[4] The Department admits that:

(a) in terms of the Constitution of the Republic of South Africa as read with the Children's Act (and the Regulations promulgated thereunder) as well as the Department of Social Development's Guidelines to ECD Services, the Department had a constitutional and legislative mandate to regulate, manage and control the provision of ECD services within the Western Cape; (b) in terms of SS 7 and 8 of the Constitution of the Republic of South Africa, the Department was under an obligation to respect, protect, promote A.'s right to life as entrenched in S 1 of the said Act; (c) in terms of the Constitution of the Republic of South Africa Act, as read with the Children's Act (and the Regulations promulgated thereunder) as well as the Guidelines to ECD services, the Department was responsible to protect the rights of all children, including A., within the Western Cape,

[5] The Department admits that the provincial head of the Department was obliged to consider, and having duly considered, reject or grant an application for registration of partial care facilities and early childhood development programmes in the province. The Department admits that in terms of S 82 (1) (a) of the Children's Act, the head of the Department had to within 6 months of receiving an application for registration consider the said application for registration or conditional registration and either reject the application or, having regard to Subsection (2), grant the registration with or without conditions.

[6] The Department admits that in terms of S 82 (2) of the Children's Act, when considering an application for registration the head of the Department was obliged to take into account all relevant factors, including whether: (a) The ECD facility complied with the prescribed national norms and standards contemplated in S 79 and such other requirements as may be prescribed; (b) the applicant was a fit and proper person to operate a partial care facility; (c) the applicant had the necessary funds and resources available to provide the partial care services of the type applied for; (d) each person employed at or engaged in the partial care facility was a fit and proper person to assist in operating a partial care facility; and (e) each person employed at or engaged in the partial care facility had the prescribed skills and training to assist in operating the partial care facility.

[7] The plaintiffs aver that the Department was under a legal duty to ensure, *inter alia*, that first defendant's ECD facility constituted a safe environment for A. to be kept and to ensure that her facility was either registered or closed down. The plaintiffs further aver that the death of A. was a direct result of the Department's wrongful and negligent breach of its legal duty in the respects set out in paragraphs 14.1 to 14.15 of their Particulars of Claim, which include that: (a) t he Department failed to process the First Defendant's application for the registration of her ECD facility timeously or at all; (b) the Department failed to inspect the first defendant's ECD facility; The Department failed to regulate, manage and monitor

the provision of ECD services at First Defendant's facility; (c) the Department failed to advise the first defendant that she was operating an unsafe ECD facility; (d) the Department failed to advise the first defendant that her ECD facility did not comply with the prescribed norms and standards and minimum requirements for ECD services; (e) The Department failed to facilitate processes and put into place mechanisms that assisted ECD centres to comply with their obligations and with the requirements of the Children's Act; (f) the Department failed to advise the first defendant that she was operating an unregistered and illegal ECD centre; (g) the Department failed to instruct the first defendant to cease operating the ECD facility until such time as it was safe and registered; (h) the Department allowed the first defendant's ECD facility to continue operating notwithstanding that the first defendant's ECD facility was unsafe for A. to be kept there; (i) the Department allowed the first defendant's ECD facility centre to continue operating notwithstanding that the ECD facility had insufficient personnel and/or personnel who were not properly qualified or trained; (j) the Department failed to prevent the unlawful death of A. in circumstances where it could and should reasonably have done so.

[8] The Department's defence to the plaintiffs' claim against it is essentially: (a) a bald denial that it had any positive legal duty as alleged by the plaintiffs; and (b) a bald denial that it wrongfully and/or negligently breached its legal duty in any respects.

**THE PLAINTIFFS' EVIDENCE**

[9] Dr Yolande Van Der Heyde holds the degrees MBChB (UCT) BSc (Micro) DipForMed (SA) M Med Path (Foren). She is a Specialist in Forensic Pathology and is in the service of the Province of the Western Cape and stationed at the Medical Faculty of the University of Cape Town. On 18 October 2010 at 12h00 she examined the dead body of A., whose body was certified as dead on 14 October 2010. She conducted a post-mortem examination on the said body and recorded her findings which facts she ascertained by means of an examination requiring skill in anatomy and pathology. The chief post-mortem findings made by her on the body were: (a) The body was of a female infant. There was a peri-mortal abrasion just below the right temple and a bruise in the left parietal region of the head; (b) there was evidence of anoxia[1] as indicated by subcapsular thymic petechial haemorrhages, subpleural petechial haemorrhages and intra-pulmonary haemorrhage. (Anoxia is defined to mean a lack of oxygen to the brain but Hypoxia is a reduced supply of oxygen to the brain). As a result of her observations she concluded that the cause / causes of death was / were undetermined at autopsy alone, pending results of histological and toxicological examination of tissue, ancillary investigative procedures and circumstantial evidence.

[10] On 21 October 2010 at 12h45 Dr Van Der Heyde visited Aunty Dawn's Day-care facility at 5 Verbena Road, Pinelands. She met the first defendant who escorted Van Der Heyde to the bedroom where baby A. had been put to sleep, on a double bed. There were pillows present on the bed. According to Dr Van Der Heyde there was another child who was in what appeared to be a playpen on the floor, to the left of the bed (when viewed from its foot end). In her evidence, when viewing the photographs, Dr Van Der Heyde confirmed that what appeared to be a playpen was a cot. To the right of the double bed, (when viewed from its foot end) there was a solid looking rectangular bedside table on which stood a bedside lamp. First defendant said that she had found baby B. between the bed and bedside table, on the floor, but was unable to say *"how far in",* nor in what position the baby was found. First defendant took the baby to the kitchen and placed her on the table, which was clear of objects, and she performed CPR there. Dr Van Der Heyde studied the contents of the police docket and made the following findings: (a) the deceased baby, A. B., was a 5 month old girl who was at the time of her death in a day care centre in Pinelands. (b) the first plaintiff noted that on 14 October 2010, before going to the day care, the baby was well; he and his wife played with her prior to taking her to the day care centre.

[11] At the day care centre, first defendant on 14 October 2010 at 09h45, left the baby who was asleep on a bed between pillows while she prepared a bottle. At 10h30 she found the baby on the floor between the bed and the bedside table, the latter

being a solid wooden structure. The first plaintiff indicated that she could not recall the position the baby was in nor how far between the bed and the table, the body of the baby was. The first defendant removed the baby from the floor and placed her on a wooden kitchen table and commenced resuscitation. The paramedics were summoned and resuscitation was continued but to no A.il. Baby A. was declared dead on the scene. Dr Van Heyde noted that A.'s Apgars at birth were normal. The child having been born on 02 May 2010 was 5 months and 2 weeks old at the time of her death. On examination of the body organs, the main finding was in the lungs and thymus which showed petechial haemorrhages as seen in cases of an asphyxia death; The lungs showed haemorrhage in the lung septae, and alveolar spaces and in an airway. This is considered to be asphyxia related. The upper cervical cord showed rarerifaction / swelling which is considered to be acute (recent) in nature.

[12] Dr Van Der Heyde concluded that the mechanism of death in this case is considered to be an asphyxial mechanism. The child having been found between the bed and bedside table suggests positional asphyxiation. The exact position could not be inferred from the autopsy findings conclusively. Based on the histological and toxicological tissue results and ancillary investigative procedures and circumstantial evidence Dr Van Der Heyde was able to conclusively exclude all other possible causes of death. According to Dr Van Der Heyde a possible scenario as to how A. died, given the autopsy findings, is as follows: (a) the

injuries on the child's head are in keeping with the child being alive when she had fallen off the bed; (b) there was an injury on both sides of the head; (c) the abrasion on the right temple suggests the head was turned to the right, possibly caused by the carpet on the floor on which the bed side table stood; (d) The bruise on the left hand side of the head superiorly could have been sustained when the child attempted to lift her head in order to breathe in air and bumped her head against the side of the bed, which is a wooden structure; (e) the swelling of the upper cervical spinal cord noted histologically, also suggests abnormal head and neck position; (f) the autopsy photographs show vomit present on the chin on the left hand side, and on the dorsal surface of the left wrist; (g) the first defendant noted that vomit was present on the baby blanket; (h) it is possible that the baby's wrist came into contact with her mouth as she lay on the floor, and contributed to the obstruction of the mouth and nose. According to Dr Van Der Heyde, how baby A. ended up on the floor remains unascertained.

[13] Dr Heidi Van der Watt, a qualified paediatrician, with the degrees MBChB FCP DCH testified on behalf of the plaintiffs. Dr van der Watt testified that she attended A. B.'s birth on 02 May 2011. According to her A. was healthy when she was born. Dr van der Watt testified also testified on the neurodevelopmental milestones of a 5 month old infant. According to her, a 5 month old infant can roll from prone to supine and supine to prone, learns to sit with support, starts to grab objects and put them in the mouth and babbles and coos. Taking the

development and mobility of a 5 month old infant into consideration, Dr van der Watt testified that such infant should never be left unattended on a raised surface, as the infant can roll off the surface and sustain injuries. Dr van der Watt further stated that a 5 month old infant should therefore never be left unattended on a bed or raised surface as the infant can easily roll off the surface and thereby sustain severe or even fatal injuries. Furthermore, according to the AAP guidelines (American Academy of Paediatrics), loose bedding which includes pillows, blankets and bumper pads should be kept out of sleeping environments. Dr van der Watt testified that if a 5 month old infant is left unattended in a room, the infant should be placed in a secure cot or on the floor if a secure cot is not available. She also testified that if a 5 month old infant rolls off a bed and becomes wedged between a bed and a side-table, as occurred in this case, then the infant would not have had sufficient muscle strength to extricate herself. A 5 month old infant who is lying face down and who is unable to breath would asphyxiate within a very short time, estimated to be approximately 5 minutes.

[14] Terrance Athean November testified as an expert called by the plaintiffs. He holds the degree of BA Social Science III. He studied a course in Fundraising and Resource Mobilisation at Oxford University. His previous work experience was *inter alia*, at the Annie Starke Village (as a Social Work Assistant for emotionally deprived children; he worked at the Grassroots Adult Education and Training Trust as a Community Developer in the Early Childhood Development (ECD)

Sector; he was the operations manager at the ECD in Claremont. Because Mr. November's evidence is very long I will set out *infra* the summary thereof. In his opinion, the Department had an obligation to monitor the provision of the ECD services being offered by the first defendant. The Department was also under an obligation to ensure (by inspecting, assessing, reviewing, monitoring and by providing guidance and support) that first defendant's ECD facility complied with the legal requirements necessary to operate an ECD facility and to ensure that it became registered. It is apparent that first defendant's ECD facility remained unregistered for over 2½ years before A.'s death. The Department sent first defendant an acknowledgement letter, dated 27 February 2008, acknowledging receipt of her application. They also sent a letter to the City of Cape Town requiring a health clearance certificate. Thereafter nothing further was done by the Department. The Department failed to process the first defendant's application for registration within 6 months of receipt of the application. The application was only considered after A.'s death on 14 October 2010. The Department was aware that the facility was being run as an unregistered facility. The Department was also aware that the first defendant intended to have up to 20 children at the facility. The officials from the Department would have been aware that more than 6 children were enrolled at the facility. In 2009 there were 8 children attending the facility.

[15] At the time of A.'s death in 2010 it appeared that there were 15 children below three years and 1 four year old. It is also evident from the first defendant's applications for registration (one in 2008 and the second in 2010) that she had no qualifications or formal training to look after infants or toddlers. Furthermore, the first defendant was being assisted by her housekeeper who also supervised and looked after the infants or toddlers. Furthermore, the first defendant was being assisted by her wo also supervised and looked after the infants and toddlers. The housekeeper, likewise, did not have any qualifications or formal training to look after infants or toddlers. There was no staff register or children's register or daily attendance register. The first defendant and the housekeeper were not aware of the National Norms and Standards. No formal application was made to the Municipality for rezoning from residential to business. Mr November is of the view that the first defendant's facility did not comply with the CCA or the CA, nor did it comply with the Regulations or the National Norms and Standards or the Guidelines. In particular, the facility did not constitute a safe environment for A. to be in. She was not kept under constant supervision at all times. She was placed on a bed and left alone in the room with the bedroom door closed, for an extended period of time. According to the plaintiffs, this was not the first time that A. had been left unsupervised by the first defendant. If the first defendant was unable to supervise A. at all times, then she should have placed her in a cot with a baby monitor in the room, or if there were insufficient cots, then she should have been placed on a sleeping mat on the floor. The Department failed to

comply with its obligations in terms of the CCA and the CA, its obligations under the Regulations and in terms of the National Norms and Standards and as stipulated by the Guidelines. Had the Department properly discharged its statutory functions prior to A.'s death, by *inter alia*, visiting and monitoring and evaluating the facility, and either closing it down, or by providing support and guidance to ensure that it became registered and that it remained compliant with the law, then the death of A. could and would have been prevented. The Department thus failed to protect A. from the risk of harm in the First Defendant's ECD facility, under circumstances where it was obliged to.

[16] The Department did not take any steps to assist the first defendant to become compliant with the necessary requirements for registration. Once the application was received, the Department should have ensured that there were regular visits and assessments done by the Department's social workers. The Department also failed to obtain a report by a social service professional on the viability of the application. The Department's officials did not visit the premises (pursuant to the application for registration) nor did the Department take any steps whatsoever to inspect or monitor the first defendant's ECD facility and the safety of the children that were there. The Department was aware that the first defendant was operating an unregistered ECD facility. The Department also allowed the first defendant to operate her ECD facility in contravention of the Acts and Regulations and the National Norms and Standards and Guidelines. The

Department took no steps to close down the first defendant's ECD facility, even though it was unregistered and unsafe. Had the Department monitored and assessed the first defendant's ECD facility, then it would have realised that there were severe health and safety risks for A.. Placing a 5½ month old infant on a bed and leaving her unattended and alone in a room, exposes her to physical danger and constitutes a clear non-adherence to basic safety standards on how to care for an infant. Had the Department visited the premises, it would have noted that a number of infants and small toddlers were being kept there. It would have noted that there were infants and numerous young toddlers, but only three cots Available which was insufficient. Had the Department assessed the staff, as it should have, then it would have realised that they were not qualified or trained to look after toddlers. The Department would then presumably, at the very least have advised the First Defendant and her staff, to keep an eye on the toddlers at all times, not to leave them alone and never to leave them on a changing table or on a bed or countertop unattended.

[17] If the Department had visited the premises and observed (or been told) that small toddlers and infants were also left to sleep unattended on the beds, then they would presumably have advised First Defendant that this was an unsafe and unacceptable practice. In his view, despite its statutory duties, the Department failed to take all proper and reasonable measures in order to ensure the safety of

A.. Had the Department complied with its obligations and ensured that the ECD practitioners were properly qualified and trained and that the necessary health and safety requirements at first defendant's ECD facility were implemented and maintained, then the incident would have been avoided. It was only after the incident that the Department visited and inspected the premises. It was only after the incident that the Department undertook to ensure that the minimum Norms and Standards would be adhered to by the facility. It is upon conducting this assessment that the relevant social worker discovered that the first defendant is not properly trained. It was therefore only after the incident that the Department undertook to assist the facility with registration and to become compliant. According to Mr November, he is aware of at least two deaths of infants at unregistered crèches during or about 2010. He is aware of numerous other reported incidents of abuse and injuries at unregistered facilities. He testified about the Department's response to A.'s death and about the current situation regarding unregistered ECD facilities in the Western Cape.

[18] Following A.'s death in 2010, the then Social Development MEC Patricia de Lille ordered a departmental investigation into A.'s death, which she was obliged to do in terms of section 89(1) of the Children's Act. She also made numerous statements in the press regarding the incident (which reports have been discovered by Plaintiffs). In one of the press reports she was quoted as saying

that: *"The owner applied in January 2008 for the registration of the facility. This application was received by the Department of Social Development, which also sent an acknowledgement letter to the owner. The Department requested the Environmental Health Inspector from the City of Cape Town to provide the department with a clearance certificate for the number of children Aunty Dawn's Daycare and Playgroup wanted to accommodate"*. She also said that: *"The Social Development Department failed to follow up on whether the letter had been received by the Environmental Health Practitioner"* and further that *"This means that over two years the situation with this day care centre has remained unchanged".* De Lille was further quoted as saying that: *"Unregistered partial care facilities must understand that they are not allowed to operate unless they have a valid registration certificate from the department of Social Development".* She also confirmed that there were more than 2000 unregistered day care centres in the Western Cape. The Department then declared that an amnesty period would be given to unregistered day care facilities in the Cape Town, from 1 February 2011 until 31 July 2011 (which only applied to crèches in existence before the end of January 2011). In her official press statement, dated 01 February 2011, De Lille said that: *"The amnesty Period represents an opportunity for all of us, Government, crèche owners and operators, and parents alike, to start complying with the Children's Act, which is there to protect and nurture our children'.*

[19] According to Mr November despite numerous promises from the Department (made after A.'s death) that it would enforce start complying with its obligations to register all ECD facilities in the Province and enforce the law, there are still a large number of ECD facilities which are being operated on an unregistered basis in the Province. The situation remains that the Department does not process the applications for registration within 6 months. Applications take years to be processed. He is aware of cases where people have been waiting for up to 5 years for their applications to be processed by the Department. According to Mr November the Department should offer better training and access to information for ECD practitioners and officials on legislation governing ECD provision and registration application processes for ECD Centres to become compliant and in order to prevent the death of more young children. In conclusion Mr November feels strongly that the mandate recognised by the CCA and CA was not properly executed or *"enforced"* by the Department and they had failed to protect and act in the best interest of A..

**THE SECOND DEFENDANT'S EVIDENCE**

[20] Dr Badronessa Govender testified that she holds the four year Bachelor's degree in social work as well as a Master's degree and a PhD in early childhood development from the University of the Western Cape. She is a registered social worker in the employ of the Second Defendant and has been so employed for

several years. She was employed at the Bellville Regional Office of second defendant from 1 April 2009 to November 2011, whereafter she took up a position at Second Defendant's Head Office in Cape Town. In 2010 she was responsible *inter alia* for the registration of partial care facilities under the Children's Act and Pinelands – where Aunty Dawn's Day Care Centre was situated – fell within her geographic area of responsibility. The Children's Act which had already been passed into law in 2006, was to come into effect on 1 April 2010. It was to replace the Child Care Act that was operative in the preceding period. The Children's Act required the registration of all partial care facilities at which more than six children were accommodated. The Children's Act also provided for the registration of early childhood development programmes at all registered partial care facilities. All registered places of care under the Child Care Act would be deemed to be registered as partial care facilities under the Children's Act and would be required to apply for the registration of early childhood development programmes.

[21] The national government made limited funds Available to promote registration of places of care prior to the implementation of the Children's Act. Dr Govender had no staff to engage in such promotion and was provided with two persons employed under the Extended Public Works Programme to assist her. The said persons had to be specifically trained for the purpose. As there was insufficient capacity to attend to all unregistered places of care, she was instructed to attend

to the registration of facilities in poorer and less capacitated areas. The programme to encourage and assist with registration was conducted in 2009 and she focussed on areas such as Delft. The programme was not conducted in the Pinelands area where Aunty Dawn's was situated, as it was considered that facilities in that area would likely know of the requirements for registration. She testified that, at the time of little A.'s death, she was on leave and that another social worker, Ms Charmaine Brown, had conducted the investigation into the death of A., in accordance with the second defendant's obligations under section 89 of the Child Care Act. Mrs Brown had compiled a report of which she later became aware. Upon her return to work she had been requested by her Head Office to conduct a further investigation for the purpose of determining whether Aunty Dawn's Day Care Centre should be closed down. Essentially she was asked to assess Aunty Dawn's Day Care Centre for compliance with the minimum norms and standards and readiness for registration. She did her assessment on 25 October 2010. She found that first defendant had applied for registration of a place of care under the Child Care Act, which application had been received on 6 February 2008, when Dr Govender had not yet been employed by the second defendant. The application form was acknowledged by letter dated 27 February 2008 and it was stated that a further communication would follow. In accordance with established procedure a letter dated 28 February 2008 was addressed to the City of Cape Town for the clearance certificate that was required before the

application for registration could be processed further. No correspondence was received from the City of Cape Town in response to that letter.

[22] When Dr Govender took up her employment at the second defendant's Bellville Regional Office, in April 2009, one of the first things that she did was to compile a data base of registered and unregistered partial care facilities that were known in the area for which she was responsible. From that data base, she established that there had been an application for registration of Aunty Dawn's Day Care Centre in February 2008. From the application form she determined that at the time of application the facility had less than six children. In terms of the Child Car Act that would imply that registration of the facility as a place of care was not necessary. However, the owner had made application as she intended expanding the facility to accommodate 15 children. During her assessment, she found that there were several respects in which the Guidelines and National Norms and Standards were not being complied with at the facility. However, she found the premises at the facility were clean and safe for children and there were three cots Available at the facility and adequate mattresses for the other children.

[23] She formed the opinion that the facility could be assisted to become registered through a capacity building process. However, she found no reason to shut the facility down and recommended that the facility scale down the number of

children accommodated there to less than the required number for registration – six – until all outstanding documentation had been received within a period of six months. In her oral testimony she indicated that, had she found the conditions which pertained during her visit on 25 October 2010 if she had visited the facility prior to little A.'s death, she likewise would not have shut it down as there were no dangers to the well-being of the children. Under cross-examination she denied that she knew that the facility was operating as a facility that accommodated more than six children. She indicated that she had not visited the facility as the practice was that that would only be done once the City of Cape Town had certified that it met the requirements of the City's Department of Health, its Fire Department and the City's zoning requirements.

**LEGAL AND POLICY FRAMEWORK**

[24] In terms of the Child Care Act, a 'place of care' meant any building or premises maintained or used, whether for profit or otherwise, for the reception, protection and temporary or partial care of more than 6 children apart from their parents. Under the Child Care Act the Department was responsible for regulating the provision of places of care in the Western Cape. In terms of section 30(2) of the Child Care Act, all ECD facilities (referred to as *"places of care")* in the Western Cape were obliged to be registered. The section stipulates that no child may be received in any place of care (other than a place of care maintained and controlled by the State) unless that place of care has been registered under that

section, or otherwise than in accordance with the conditions on which that place of care has been so registered. Section 30(3)(b) stipulates that the Director-General must be satisfied that the place of care (1) complies with the prescribed requirements and (2) that it will be so managed and conducted that it will be suitable for the care and of children in order to grant an application for registration of a place of care.

[25] In terms of section 30(1)(a) a social worker, a nurse or any other person, authorized thereto by the Director-General, or any commissioner, may enter any place of care in order to inspect that place of care and the books and documents appertaining thereto. In terms of section 31(4) the social worker, nurse or other person so authorized, or the commissioner, shall submit a report to the Director-General after having inspected a place of care. In terms of Regulation 34A, on receipt of a report referred to in section 31 (4) of the Act indicating that a requirement for registration of a place of care, in terms of Regulation 30 or 31 has not been met, the Director-General shall inform the places of care, in writing, of the contents of the report and where necessary, require the management to respond to the report, in writing, within 14 days of receipt of such report and provide a developmental programme, guidance and support to enable the place of care to meet the requirements within a specified period being not less than 2 months and not more than 6 months of receipt of such report. In terms of Regulation 30a.(1) no place of care shall be registered

unless the Director-General is satisfied that certain behaviour management practices are expressly forbidden. In particular, the Director-General could only register a place of care if he or she was satisfied, inter alia, that the children were not being isolated from other children at the place of care, other than for the immediate safety of such children, only after all other possibilities had been exhausted, and then under strict adherence to policy, procedure, monitoring and documentation. Regulation 30.(2)(a) stipulated that all children in a place of care had the right to a plan and programme of care and development and the right to expect that their plan and programme was based on an appropriate and competent assessment of their developmental needs. It also stipulated that they had the right to a regular review of their placement and care or development programme. Section 30(6) of the Child Care Act stated that any person who contravened or failed to comply with any provision of section 30 shall be guilty of an offence.

**THE CONSTITUTION OF THE**

**REPUBLIC OF SOUTH AFRICA**

[26] Section 1 of the Constitution confirms that the Republic of South Africa is founded on the values of, *inter alia,* (1) human dignity and (2) the advancement of human rights and freedoms and (3) supremacy of the constitution and the rule of law. Section 2 of the Constitution states that the Constitution is the supreme law of the Republic; that law or conduct inconsistent with it is invalid, and that the

obligations imposed by it must be fulfilled. Section 7(2) stipulates that the State must respect, protect, promote and fulfil the rights in the Bill of Rights. According to section 8(1) of the Constitution, the Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state. Section 8(3)(a) of the Constitution stipulates that when applying a provision of the Bill of Rights a Court, in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right.

[27] According to section 10, everyone has inherent dignity and the right to have their dignity respected and protected, which includes the right to bodily and psychological integrity (recognised in section 12). According to section 11, everyone has the right to life. Section 28 of the Constitution deals specifically with the rights of children. It states, inter alia, that every child has the right to social services and to be protected from neglect and abuse. According to section 28(2), a child's best interests are of paramount importance in every matter concerning the child. Section 39(1) stipulates that when interpreting the Bill of Rights, a Court must promote the values that underlie an open and democratic society based on human dignity. Section 39(2) stipulates that when interpreting any legislation, and when developing the common law, every Court must promote the spirit, purport and objects of the Bill of Rights. Section 173 states that the High Court has the inherent power to develop the common law, taking into account the interests of

justice. Section 195(1)(f) states that public administration must be accountable. Section 237 stipulates that all constitutional obligations must be performed diligently and without delay.

**THE GUIDELINES FOR EARLY CHILDHOOD**

**DEVELOPMENT SERVICED (MAY 2006)**

[28] The Guidelines aim to explain the most important facets of ECD service delivery and were developed to facilitate the Department of Social Development's mandate towards ECD in South Africa. They also refer to important core aspects in the early childhood phase of life, such as health and safety. The Guidelines explain that an *'ECD Centre'* and a *'Place of Care'* are defined as any building or premises maintained or used, whether or not for gain, for the admission, protection and temporary or partial care of more than 6 children away from their parents. Depending on registration, an ECD centre or Place of Care can admit babies, toddlers and/or pre-school aged children. The term ECD centre can refer to crèche, day care centre for young children, a playgroup, a pre-school, after school care etc. ECD centres are sometimes referred to as ECD sites. The guiding principles which form the basis for the Guidelines include the following, namely: (a) That the needs and rights of children are central to all services and provisions; (b) That the rights of young children must be protected; (c) That everyone who intervenes in the lives of young children should be held

accountable for the delivery of an appropriate, effective and efficient service. (underlined to stress importance).

The Introduction section to the Guidelines recognises that young children have rights in South Africa which are well protected by the Constitution and laws and further that it is, inter alia, the Department's responsibility to know what these rights are and to make sure young children are properly cared for.

The Introduction goes on to state that "*We want children to enjoy life and live in a safe and healthy environment"*. The Introduction also recognises that the "*The Department of Social Development is one of the government departments* ***that*** *have to ensure that young children are taken care of in the best way".*

[29] Part One, Chapter 1, of the Guidelines acknowledges that: "*The Department of Social Development has a responsibility to ensure that conditions are created for the optimum development of all children and their families through the provision and support of appropriate services*." Chapter 1 of the Guidelines deals with the rights of children and acknowledges that: "*children need special protection and care".* It also acknowledges that "*The laws of the State are needed to protect children before and after they are born.*" The Guidelines further recognise that children in South Africa are protected by the Constitution and the Child Care Act of 1983. Some of the rights of children which the Guidelines aim to protect and enhance are as follows: (a) All organisations concerned with children should work towards what is best for each child; (b) All children have the right to life. Governments should ensure that children survive and develop healthily; (c)

Governments should ensure that children are properly cared for, and protect them from violence, abuse and neglect by their parents, or anyone else who looks after them; (d) Children should be protected from any activities that could harm their development.

[30] The Guidelines recognise that inter-sectoral collaboration and integrated service delivery requires commitment from various government departments. They recognise that it is important for each service provider to seek practical ways to facilitate inter-sectoral collaboration and integration in service provision to young children. They should know what each department is doing and determine ways to work with other service providers. In collaboration, they must keep the rights of the young child CENTRAL to discussions, strategies and agreements.

Chapter 3 of the Guidelines sets out and defines the roles and responsibilities of the Department, as, *inter alia*: (a) To promote the importance of early childhood development services in the province (in this case, the Western Cape); (b) To establish mechanisms and programmes to facilitate capacity development in early childhood development service delivery in the province; (c) To provide support and guidance to early childhood development service providers in the province; (d) To ensure that national policies, legislation, strategies and priorities are implemented within the means of the provincial department; (e) To register early childhood development centres (which includes Places of Care in terms of section 30 of the CCA and the Regulations thereunder); (f) To put mechanisms in place

to facilitate the registration of early childhood development centres (places of care) in an empowering and developmental way; (g) To keep a provincial register of all registered early childhood development services. (h) To monitor the provision of registered and non-registered early childhood development services (with specific reference to section 31 of the CCA); (i) To cancel the registration certificate of a Day Care Centre (place of care) in terms of section 32 of the CCA. (j) Chapter 4 of the Guidelines deals with the legislative framework for ECD Centres (Places of Care). It explains that in terms of the Act, section 30(2), a place of care must be registered. No child may be kept in an unregistered place of care. The Guidelines also states that there is a particular obligation on the Department of Social Development in terms of section 30(3)(a) to obtain information with regard to an application for registration.

[31] According to the Guidelines, Regulation 30(2) indicates that certain additional information should accompany the application form, which includes a certificate from the Director-General i.e. the Department of Social Development in the province indicating that a needs assessment was done. The Guidelines state further that Regulation 30(2) and (3) are clear on the importance of adhering to, and implementing minimum standards. The Guidelines refer to Regulation 34 which stipulates that a specific register that needs to be kept by a place of care and describes the information which it must contain. Managers of places of care have to ensure that they adhere to this and keep such a register updated. The

Guidelines note that the Child Care Act makes provision for the *"inspection"* of places of care, which refers to a system of monitoring and evaluation, whereas the Regulations refer to a quality assurance process. As the methodology for quality assurance has significantly changed in the past 20 years, the Guidelines state further that it is understandable that the Act and the Regulations might differ. Regulation 34A refers to a report which must be submitted to the Director-General indicating that a requirement for registration of a place of care has not been met and the steps which must then be taken by the Department. The Guidelines state further that within the context of the Department of Social Development, monitoring and evaluation should be seen as a developmental and empowering process, with the best interest of the child being more important than anything else.

[32] The guidelines deal with the circumstances that can lead to the closure of a Place of Care, which includes, *inter alia:*

(a) Jeopardizing the health of children; (b) Insufficient personnel (c) Incapable personnel; (d) A non-functioning or dysfunctional management committee with maladministration.

The Guidelines also refer to the procedure for dealing with centres which contravene the stipulated requirements (see the Child Care Act for the detailed procedure). When, after monitoring or reviewing the facility or if a complaint is received, and it is found that the requirements of the Act are not met, the social

worker must, *inter alia* compile an assessment report; provide guidance and support to the facility; and review the facility and compile a report. Chapter 5 of the Guidelines sets out the minimum standards for the registration of ECD services. The Guidelines stress that ECD Centres must meet minimum standards of care in order to be registered. If minimum standards are kept and improved on, then parents and families will know that their children are being cared for in a safe place. In this regard, the Guidelines point out that children must be protected from physical harm or threat of harm from themselves or others. All reasonable precautions must be taken to protect children from the risk of fire, accidents and or other hazards. All furniture and equipment must be safe and in good repair.

[33] This means that beds, mattresses or mats for sleeping and resting on must be safe and clean. Practitioners should have at least the minimum qualification and work towards improving their qualifications. The minimum qualification of practitioners is the registered Basic Certificate in ECD NQF Level 1 of the South African Qualifications Authority. This qualification entails basic knowledge and skills about child development from birth to six year old. ECD centre supervisors should have a minimum qualification of the National Certificate in ECD at NQF Level 4 by the South African Qualifications Authority. They should have a general understanding of early childhood development from birth to six year old. ECD programme supervisors should demonstrate a theoretical and practical knowledge and experience in managing ECD centres. All ECD practitioners must

have appropriate training in ECD. They must receive ongoing training in early childhood development and the management of programmes and facilities for young children. ECD Practitioners should be physically and mentally capable of meeting all the demands made of caring for children. Practitioners should show that they know and understand how children develop (and be familiar with the development milestones at each stage of development). The Guidelines explain what must be done to register an ECD centre. According to the Guidelines, the Minister will consider the registration or re-registration of a centre when a report and a recommendation by the Department of Social Development have been received. A certificate from the local authority stating that the centre complies with all the structural and health requirements of the local authority must accompany the report of the Department of Social Development. An ECD centre is subject to quality assurance review or inspection by the Department of Social Development at least once a year. The Guidelines also set out the 6 steps involved in registering an ECD facility.

[34] If the necessary requirements for registration have not been met then the social worker or other official employed and authorised by the provincial Department of Social Development will continue to consult, advise, empower, build capacity and review the facility. The Guidelines also deal with the quality assurance review. In terms of the Child Care Act, the Director-General, or a person authorised by him or her, is entitled, at all times, to evaluate the place of care, its books, documents

and registers and its developmental programmes, and to examine the health, nutrition and general well-being of the children in the place of care. The quality assurance review is important as it helps improve the way the centre is run. Good practice must be noted and praise given where appropriate. Where there are improvements to be made, these should be discussed with the responsible staff member and guidance offered so that changes can be made. Where there are unacceptable practices, these must also be discussed and agreement reached on changes to be made immediately to ensure the safety and well-being of the children at the centre.

**THE CHILDREN'S ACT (38 OF 2005)**

[35] The Children's Act was aimed at expanding the range of social services provided to children, which was lacking under the Childcare Act, and providing clarity on what services need to be delivered, by whom and to whom. The Act recognises that children have a constitutional right to social services and that the State bears the primary duty to ensure that these services are delivered. The Children's Act accordingly brings South Africa's child care and protection law in line with the Bill of Rights and International law. The Children's Act was assented to on 08 June 2006 and came into operation on 01 April 2010. It repealed the whole of the Child Care Act 74 of 1983. As from 01 April 2010, the First Defendant and the Department were accordingly subject to the provisions of the Children's Act and

the Regulations promulgated thereunder. The guiding principles as set out in the Guidelines would have continued to be operative. The Foreword to the Act states that it is intended*, inter alia*, to give effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children; to provide for partial care of children and to provide for early childhood development. The Pre-amble of the Act recognises that the Constitution establishes a society based on democratic values, social justice and fundamental human rights and seeks to improve the quality of life of all citizens; that every child has the rights set out in section 28 of the Constitution; that the State must respect, protect, promote and fulfil those rights; It further recognises that children are entitled to special care and assistance and that it is necessary to effect changes to existing laws relating to children in order to afford them the necessary protection. Section 2 of the Act states that the objects of the Act are, inter alia, to give effect to the constitutional rights of children, including the right to be protected from neglect; to ensure that the best interests of a child are of paramount importance in every matter concerning the child; to protect children from physical harm and hazards; and generally, to promote the protection, development and well-being of children.

[36] The overarching objective of the Children's Act, in relation to ECD services, is to increase the number of children that have access to registered ECD facilities, which are compliant with various health and safety requirements, and which can

meet the educational and development needs of a child. It is clear that the Children's Act places an obligation on the Department to regulate the provision of ECD facilities and services in the Western Cape. Section 4(1) deals with the implementation of the Act and states that the Act must be implemented by organs of state in the national, provincial and, where applicable, local spheres of government subject to any specific section of this Act and regulations allocating roles and responsibilities, in an integrated, co-ordinated and uniform manner. Section 4(2) recognises that competing social and economic needs exist, and directs that organs of state in the national, provincial and where applicable, local spheres of government must, in the implementation of this Act, take reasonable measures to the maximum extent of their Available resources to achieve the realisation of the objects of this Act.

[37] Section 6(1) of the Act states that the general principles set out in the section guide the implementation of all legislation applicable to children, including this Act and all proceedings, actions and decisions by any organ of state in any matter concerning a child or children in general. According to section 6(4)(b) in any matter concerning a child a delay in any action or decision to be taken must be avoided as far as possible. In terms of section 8(1), the rights which a child has in terms of this Act supplement the rights which a child has in terms of the Bill of Rights. In terms of section 8(2), all organs of state in any sphere of government and all officials, employees and representatives of an organ of state must

respect, protect and promote the rights of children contained in the Act. Section 9 stipulates that, in all matters concerning the care, protection and well-being of a child the standard that the child's best interest is of paramount importance, must be applied. Section 15 of the Children's Act deals with the enforcement of rights and states that anyone listed in that section has the right to approach a competent Court, alleging that a right in the Bill of Rights or the Children's Act has been infringed or threatened, and the Court may grant appropriate relief. Plaintiffs would clearly fall within the class of persons listed in section 15 of the Children's Act.

[38] Chapter five of the Act deals with Partial Care. Section 76 states that partial care is provided when a person, whether for or without reward, takes care of more than 6 children on behalf of their parents or care-givers during specific hours of the day or night, or for a temporary period, by agreement between the parents or care-givers and the provider of the service. In terms of section 78(1), a partial care facility must be managed and maintained in accordance with this Act and must comply with the prescribed national norms and standards contemplated in section 79 and such other requirements as may be prescribed. Section 79 of the Children's Act sets out what the national norms and standards must relate to, which includes, a safe environment for children. The Children's Act also makes it illegal for anyone to run an unregistered ECD centre with more than 6 children. Section 80 stipulates that all partial care facilities: (a) must be registered with the

provincial government of the province where that facility is situated; (b) must be managed and maintained in accordance with any conditions subject to which the facility is registered; and (c) must comply with the prescribed national norms and standards contemplated in section 79 and such other requirements as may be prescribed.

[39] In terms of Section 81, an application for registration must be lodged with the provincial head of social development of the province where the facility is situated in accordance with a prescribed procedure. It states further that the application must contain the prescribed particulars and must be accompanied by a report by a social service professional on the viability of the application. This presupposes a visit of the facility from a social service professional. Section 82(1)(a) stipulates that the provincial head of social development must within 6 months of receiving the application consider an application for registration or conditional registration and either reject the application or, having regard to subsection (2), grant the registration with or without conditions. According to section 82(2) of the Act, when considering an application for registration the provincial head of social development must take into account all relevant factors, including whether: (a) the facility complies with the prescribed national norms and standards contemplated in section 79 and such other requirements as may be prescribed; (b) the applicant is a fit and proper person to operate a partial care facility; (c) each person employed at or engaged in the partial care facility is a fit

and proper person to assist in operating a partial care facility; and (d) each person employed at or engaged in the partial care facility has the prescribed skills and training to assist in operating that partial care facility. Section 85 permits the Director-General or the head of the Department to apply to the High Court for an order to instruct a partial care facility, whether registered or not, to stop operating that facility.

[40] Section 87(1)(a) obliges the provincial head of the Department to maintain a record of all partial care facilities in the province, the types of partial care facility and the number of each type of facility. Section 87(1)(c) also states that the provincial head of the Department must conduct inspections at the prescribed intervals of partial care facilities in the province to enforce the provisions of this Act. Chapters 6 of the Act deals with ECD programmes which stipulates that: (a) every a partial care facility providing partial care services for any children up to school-going age must provide an ECD programme; (b) that a person or organisation providing an ECD programme must register the programme with the provincial head of social development of the province; and (c) that the ECD programme must be provided in accordance with the Act and must comply with the prescribed national norms and standards contemplated in section 94 and such other requirements as may be prescribed.

[41] Chapter 20 deals with the Enforcement of the Act. In particular, it allows a person authorised by the Director-General, a provincial head of social development or a municipality may enter any partial care facility which on reasonable suspicion is being used as an unregistered partial care facility, in order to inspect that facility and its management. The person conducting the inspection may determine whether the ECD facility complies with: (a) the prescribed national norms and standards; (b) other national norms and standards as may be prescribed by regulation; (c) any structural, safety, health and other requirements as may be required by any law; and (d) the provisions of this Act; A person who has conducted an inspection must submit a report to the Director-General, the provincial head of social development or a municipality, as may be appropriate, on the inspection carried out by that person. According to section 305(1) a person is guilty of an offence if that person operates an unregistered ECD facility or fails to stop operating an unregistered ECD facility after that person has been instructed by way of a notice of enforcement.

**THE REGULATIONS PROMULGATED**

**UNDER THE CHILDREN'S ACT**

[42] Certain Regulations were also promulgated under the Children's Act. In particular, the General Regulations Regarding Children, 2010 are relevant. Chapter 4 of the Regulations deals with Partial Care and Chapter 5 deals with Early Childhood Development. Part I of Annexure B to the Regulations sets out

the National Norms and Standards for Partial Care. The Regulations stipulate what documents must accompany the application and what files and registers must be kept by the ECD facility. Regulation 19 deals with the employment of staff at a partial care facility and states that any person employed at a partial care facility in a managerial or supervisory capacity or who is directly involved in the partial care of a child must possess a number of skills, which includes, inter alia, the ability to implement an ECD programme for ECD; the ability to write reports and notes and the ability to assess age related developmental milestones. Very importantly, Regulation 21(1) stipulates that all partial care facilities must be subjected to inspection and monitoring to determine compliance with the Regulations and Part I of Annexure B. According to the Regulation, the inspection and monitoring of all partial care facilities must be executed by a person designated by the provincial head of the Department. All inspections and monitoring visits must be followed by a report that must be submitted to the head of the Department and the management of the partial care facility. Inspection of a partial care facility must take place every 5 years or may take place at shorter intervals if inspection is a condition for registration. Regulation 28(1) likewise stipulates that all early childhood development programmes must be subjected to assessment and monitoring to determine compliance with the National Norms and Standards for ECD, contained in Part II of Annexure B. The National Norms and Standards for Partial Care (Part I of Annexure B) include, inter alia, the following requirements: (a) Children must experience safety and feel cared for

whilst at the partial care facility; (b) Premises must be safe, clean and well-maintained; (c) Equipment used must be safe, clean and well-maintained; (d) There must be adult supervision at all times; (e) All reasonable precautions must be taken to protect children and staff from the risk of fire, accidents or other hazards.

**DISCUSSION ANND APPLICATION**
**OF LEGAL PRINCIPLES TO THE**
**FACTUAL MATRIX OF THIS CASE.**

[43] Before I start discussing the merits of this case it is necessary to note that the trial readiness of this matter was declared on 13 July 2016 by my brother, Bozalek J. At that stage the first defendant was still represented by Gerhard Kotze of attorneys Buchanan Boyes whose offices are in Cape Town. Subsequent to the matter being declared trial ready the first defendant's attorneys reportedly attempted to make contact with the first defendant in order to advise her that a trial date had been allocated for 18 October 2016. This was to no A.il resulting in the first defendant's attorneys withdrawing as her attorneys of record.

[44] The correspondence reveals that the first defendant's attorney received an e-mail from an acquaintance of the first defendant advising him that the first defendant had gone overseas for an undisclosed period of time. The first defendant's erstwhile attorney also attended the first defendant's place of residence in

Pinelands (Cape Town) to hand deliver a letter to her advising and enclosing the notice of set down for 18 October 2016. The visit reveals that the Aunt Dawns Day care and Playground had closed down. Apparently an unknown gentleman (of foreign nationality) opened the front door and advised the attorney that the first defendant no longer resided in the house. The gentleman advised the property had been sold and transferred. An attempt was then made (reportedly) by the erstwhile first defendant's attorney to advise her of the trial date via e-mail address ashblonde@telkomsa.net and this bounced back. The plaintiff's attorneys also sent an e-mail to the first defendant using the same e-mail address but it similarly bounced back. The subsequently appointed tracing agents confirmed that the first defendant emigrated to England where her son resided.

[45] After all attempts proved fruitless contact was made with one Grant Moore (a son of the first defendant). An e-mail enclosing notice of set down was e-mailed to the latter with a request that he hands same over to the first defendant. Mr Grant Moore advised that he had no contact with the first defendant because '*she has left SA for good*'. It is common cause that the trial scheduled for 18 October 2016 was postponed to afford plaintiffs an opportunity of notifying the first defendant of the new trial date. A formal application was made for leave to serve the Court Order on the first defendant by way of substituted service. The latter application was granted. The order made provision that the first defendant must be served in England. Seeing that it was anticipated that she would attempt to evade personal

service, a provision was made, *inter alia*, that service was also to be effected on the first defendant's son, Craig Moore (who resided at 18A Station Parade, Willesden Greens, London) requesting him to bring the order to the first defendant's attention. The first defendant had already been traced to be residing at 18A Station Parade, Willesden Green, London, England together with her son Craig Moore. The plaintiffs' attorneys instructed Cesar Augusto Sepulveda (a process server in London) who interviewed the letting manager of the property, who confirmed the first defendant and her son Craig were indeed resident in the property. On 8 March 2017, Mr Sepulveda attended to the property and served the order on the first defendant and her son, Craig Moore. Because no reply could be obtained from the occupants inside the building Mr Sepulveda effected service by posting two copies of the order through the letterbox of the property and by fixing two further copies of the order (in transparent envelopes), to the front door of the property.

[46] Mr Sepulveda then deposed to an affidavit wherein he confirms the aforesaid service. He also annexed two colour copies of photographs depicting the two time copies of the court order which he had affixed to the front door of the abovementioned London property. I fully agree with Mr Coughlan that there was proper service of the court order and that it must have come to the attention of the first defendant and her son, Craig Moore. The plaintiffs are entitled to be granted default judgment seeing at the date of hearing mentioned in the order

served the first defendant did not appear before court. So much as to the service on the first defendant. I now return to the discussion of the merits of this matter.

[47] I have fully summarised the evidence tendered in this matter above. I state categorically that the most likely conclusion to be drawn from the Available evidence is that A. rolled off the first defendant's bed onto the floor and that her positioning on the floor led to a lack of oxygen and a death by asphyxia (suffocation). The totality of the evidence led concerning the first defendant leads me to an inescapable conclusion that the latter's actions in placing baby A. on her bed to sleep and then leaving A. unattended on that bed, were indeed clearly wrongful and negligent. See **Hawekwa Youth Camp and Another v Byrne** 2010 (6) SA 83 (SCA) at [25] where the Supreme Court of Appeal, *inter alia*, observed as follows:

*'…..On the assumption that the teachers in charge of the group could have prevented the harm that Michael suffered and that they had negligently failed to do so, should they – and by vicarious extention, the Minister – as a matter of public and legal policy, be held liable for the loss resulting from such harm? But for the confusion between wrongfulness and negligence which transpires from the Minister's heads of argument, it appears to me that wrongfulness had in fact been conceded. What is in effect disputed is negligence. However, be that as it may, I am satisfied that wrongfulness had been established.* In this regard I am in full

agreement with the following statement by Desai J in **Minister of Education and Another v Wynkwart** NO 2004 (3) SA 577 (C) at 580A-C:

*"It was not in dispute that [the respondent's minor son] R was injured at school while under the control and care of the appellant's employees and it was fairly and properly conceded that teachers owe young children in their care a legal duty to act positively to prevent physical harm being sustained by them through misadventure. It was submitted that in this instance, as many other delict cases, the real issue is 'negligence and causation and not wrongfulness".*

[48] Mr Oliver prefixed his submissions by pointing out that the first defendant was not an employee or agent of the second defendant. He contended that the second defendant could not incur vicarious liability for any negligence or wrongful deeds or omissions of the first defendant. He submitted that there is no evidence indicating that any of the second defendant's employees committed an act that caused or causally contributed to the death of A.. Mr Oliver referred this Court to the test as succinctly stated by the Constitutional Court in a dictum in **Le Roux v Dey** (Freedom of Expression Institute and Restorative Justice Centre as Amici Curiae 2011 (3) SA 274 (CC) where the following appears:

"*In the more recent past our courts have come to recognise, however, that in the context of the law of delict: (a) the criterion of wrongfulness ultimately depends on a judicial determination of whether – assuming all the other elements of delictual liability to be present – it would be reasonable to impose liability on a defendant for the damages flowing from specific conduct; and (b) that the judicial determination of that reasonableness would in turn depend on considerations of public and legal policy in accordance with constitutional norms. Incidentally, to avoid confusion it should be borne in mind that what is meant by reasonableness in the context of wrongfulness has nothing to do with the reasonableness of the defendant's conduct, but it concerns the reasonableness of imposing liability on the defendant for the harm resulting from that conduct."*

See also **F v Minister of Safety and Security and Others** 2012 (1) SA 536 (CC); **Country Cloud Trading CC v MEC, Department of Infrastructure Development** 2014 (2) SA 214 (SCA). I fully accept the aforegoing line of reasoning. In fact the **Supreme Court of Appeal in Olitzki Property Holdings v State Tender Board and Another** 2001 (3) SA 1247 (SCA) held as follows:

*'Where the legal duty the plaintiff invokes, derives from breach of a statutory provision, the jurisprudence of this Court has developed a supple test. The focal question remains one of statutory interpretation, since the statute may on a proper construction by implication itself confer a right of action, or alternatively provide the basis for inferring that a legal duty exists at common law. The process in either case requires a consideration of the statute as a whole, its objects and provisions, the circumstances in which it was enacted, and the kind of mischief it was designed to prevent. … The conduct is wrongful, not because of the breach of a statutory duty per se, but because it is reasonable in the circumstances to compensate the plaintiff for the infringement of his* [or her] *legal right. The determination of reasonableness here in turn depends on whether affording the plaintiff a remedy is congruent with the court's appreciation of the sense of justice of the community. This application must unavoidably include the application of broad considerations of public policy determined also in the light of the Constitution and the impact upon them that the grant or refusal of the remedy the plaintiff seeks will entail.'*

[49] In Mr Oliver's submission all the duties of care alleged by the plaintiffs derive from the Guidelines and the norms and standards provided in the Guidelines. Mr Oliver contended that the Guidelines are not mandatory or peremptory but they are rather directory or permissive. In his view, to the extent that the second defendant has not adhered to the Guidelines and Norms and Standards contained in them, the second defendant cannot be held to have breached any statutory duties such as to entail liability to plaintiffs for the death of A.. In this regard Mr Oliver is of the

view that the statutory requirements that the second defendant is obliged to keep a register of unregistered partial care facilities must similarly be seen as a permissive rather than a peremptory requirement. He concluded by stating that the practice of visiting facilities that had applied for registration only after the required documentation had been received from the City of Cape Town was not unreasonable given the limited resources and manpower Available to the second defendant to conduct such visits. I do not agree with Mr Oliver and I shall deal with his submissions *infra.*

[50] From the summary of the legal and policy framework given above, it is clear that one of the Department's primary responsibilities is to promote the care of children and the protection of their rights within ECD facilities. It is of importance to mention that the Department's admission that the responsibility for ensuring that ECD facilities are registered and for monitoring compliance with the Children's Act and Regulations thereunder is to protect children from the risk of harm in ECD facilities. That is one of the reasons why the Department is vested with the power to shut down ECD facilities which are unsafe. It is the Department's obligations to facilitate the protection and promotion of the rights of children in line with S 28 of the Constitution of this Country and the UN Convention on the rights of the child. It is subject to no dispute that the Department has to ensure that ECD facilities, services and programmes are well managed, equipped, staffed and maintained. There is a duty on the Department to monitor the quality of ECD facilities,

services and programmes in order to ensure adherence to safety standards. It is of importance that the Department recognises that the registration of partial care facilities in accordance with the Children's Act 38 of 2005 is a necessary safeguard for young children and their facilities to ensure that basic and adequate health and safety standards have been met.

[51] The Department's officials are required to support persons who wish to register their ECD facilities. The Department must support such persons in taking the steps needed to make sure that their facility is registered and compliant with the national norms and standards in the manner set out hereunder. The applicant wishing to register his or her ECD facility should contact the Department to advise them that he or she wishes to register the facility. It then becomes an obligation for the Department to assist the applicant to navigate the registration process. There should then be an initial interview at the Regional Office where the Department's official advises the applicant on the process and what needs to be done. The interview would cover the registration requirements, legislative mandates, registration procedure, norms and standards, registration documents and monitoring processes. Of course the Department provides the applicant with an application form and a list of required documents. An interview is necessary because of the cumbersome and unclear registration process and requirements. An interview allows for face to face interaction with the applicant so that the

Department can apply a step by step approach to provide guidance on the application process.

[52] The Department also requests the Environmental Health Officer to provide a certificate. This is a local government responsibility, and is limited to a physical inspection of the facility conducted by a Health Inspector to assess how many children can be accommodation at the facility. Once the Department receives an application, and as part of the application process, it must send an official to visit the facility. Site visits must be done in order to assess compliance with conditions for registration and norms and standards. A site visit forms an essential part of the evaluation of an application for registration as it allows an official from the Department to inspect and monitor the ECD Services being rendered and to assess the competency of the staff and the general care of children, as well as the administrative systems and financial systems and compliance with national norms and standards.

[53] After the assessment of the facility has been conducted the official will complete an inspection form and then contact the applicant to let him or her know if the ECD facility and/ ECD programme meets the necessary requirements or not. Therefore, part of the Department's ECD registration service is to provide updates to the applicant on the status of the application. If the facility or programme does not meet the necessary requirements then the Department must advise the

applicant thereof and explain the shortcomings to the applicant. The Department must then assist and mentor the applicant and conduct follow up visits in order to re-assess whether the applicant meets the requirements for registration. This accords with the official media release of the then MEC Patricia de Lille, dated 15 October 2010, which states that *'our policy is to help unregistered facilities get registered.'*

**THE ACTIONS OF THE DEPARTMENT**

[54] It is common cause that the first defendant submitted an application to the Department for registration of her ECD facility on or about 6 February 2008. The Department acknowledged receipt of the application on 27 February 2008 and advised the first defendant that further communication would follow soon. A letter was then drafted by Charmaine Brown (dated 28 February 2008), which was sent to the Environmental Health Inspector. Charmaine Brown was the social worker at the Bellville District Office at the time. The Department is unable to prove that the letter to the Environmental Health Officer was ever sent. That perhaps, would explain why no response was ever received from the Environmental Health Inspector. According to the handwritten note following the Department's visit of the facility on 15 October 2010 it states that: '*Health did not do an inspection. There (sic) didn't know of it'.*

[55] The Department concedes that between 28 February 2008 and 14 October 2010, no official (or unofficial visit) was done by the district office. The Department essentially put up three justifications for failing to process the first defendant's application for registration. The first excuse was that (according to Dr Govender), the first defendant's application form indicated that there were less than 6 children at the facility and therefore registration was not applicable. It is strange because the application form does not state this. I am of the view that this is an incorrect assumption which was made by Dr Govender and the Department. I find no basis for such an unwarranted assumption given that the first defendant expressly stated on her application that she had established her ECD facility centre 2 years ago (2006) with 5 children and that her needs had increased very much since then. I point out that the Department's assumption is also not borne out by the handwritten notes from the Departmental visit of the first defendant's facility on 15 October 2010. This indicates that the first defendant had 8 children enrolled in her facility in 2008. Of course it was wrong of the Department to assume that applicants would limit the number of children at their facilities to less than 6 children until such time as they were registered (which can take years). In my view it should have been obvious to the Department that many of the applicants who were applying for registration were doing so because of the fact that they had more than 6 children enrolled at their facility. I hasten to add that the Department's excuse for not processing the application because there were less than 6 children at the first defendant's facility is contradicted by the very fact that

the Department intended to send a letter to the Environmental Health Officer at the City of Cape Town to inspect the first defendant's facility (along with 8 other ECD facilities). This fact alone indicates that there was an intention on the part of the Department to process the application for registration.

[56] The second excuse offered by the Department is that, according to Dr Govender, she was unable to visit all of the unregistered facilities in the Goodwood Magisterial District because of the fact that she had an extensive workload in 2009. According to Dr Govender, it was only herself and 3 ECD assistants who were responsible for visiting approximately 294 unregistered facilities that fell within the Goodwood Magisterial District. This evidence by itself does not prove that there was a lack of resources on the part of the Department to deal with applications for registration. No evidence was presented by the Department regarding its annual budgets and how such budgets were allocated. In any event, Dr Govender was only employed at the Bellville Regional Office from April 2009. She ordinarily would be unable to comment on the workings of the office before that time. According to Dr Govender at some stage her office had no ECD assistants. There was no explanation why this was the case. The Doctor did not testify that she ever requested the Department to allocate additional staff to assist her with processing the backlog of applications for registration. There is no evidence to indicate that such additional staff were not Available had such a request been made. It cannot thus be said that the Department lacked the

necessary resources to process the first defendant's application for registration. It would appear that before the incident (the death of A.) application for registration were simply not prioritised by the Department. But as soon as the incident occurred the Department realised that it was at fault. An emergency Departmental meeting was called to look at how the Department could fast track application for registration. According to the Department's press release dated 1 February 2001:

*'The amnesty period represents an opportunity for us all Government, crèche owners, and operators and parents alike to start complying with the Children's Act, which is there to protect and nurture our children.'*

[57] Mr Coughlan submitted that the excuse of the office being understaffed is a convenient afterthought by the Department to try an cover up the fact that it neglected to process applications for registration timeously and to cover up the fact that it omitted to process the first defendant's application timeously or at all. I am in full agreement with Mr Coughlan in this regard. In any event this excuse was raised by the Department for the first time during the hearing of the trial in April 2017. Dr Govender testified that she did not visit any of the unregistered facilities in Pinelands because she elected to prioritise the more marginalised and disadvantaged areas, such as, those unregistered ECD facilities in Elsies River, Bishop Lavis and Delft. According to the official media release dated 15 October 2010, the Department's district offices have regular information drives to educate facility owners about their legal obligation to get registered. The truth is though whilst the Department can be commended for their information drives and for

visiting unregistered ECD facilities in poor communities which had not yet applied for registration, this does not constitute a legitimate excuse for ignoring those applications for registration which had already been submitted to the Department and which were already on file. This I say especially because there was a statutory obligation on the Department to process the said applications within a 6 month period. In a failed attempt to bolster her excuse for not having processed the first defendant's application for registration, Dr Govender testified that the Bellville District office was also responsible for 3 other programmes (namely, older persons, youth and substance abuse). I should express my view that this excuse does not constitute a rational or legitimate ground for ignoring applications for registration which had already been submitted to the Department and which was already pending. Needless to again mention that there was a statutory obligation on the Department to process the said application within 6 months.

[58] The third excuse offered for failure to process the first defendant's application for registration is that during Dr Govender's audit of ECD facilities in September or October 2009, she noted that the first defendant's application had been on file for 2½ years, but that there were certain documents outstanding for registration (such as an Environmental Health report and a fire clearance). According to Dr Govender, she required all the relevant documents from the other departments before she would visit and assess the ECD facility. She stated, because all the documents were not on file she therefore did not conduct any assessment of the

ECD Services at the first defendant's facility. Of course this is not at all a valid excuse. The relevant documents were not on file because the Department's letter to the Environmental Health Officer was probably never sent. Notably, the Department at no stage made any effort whatsoever to contact the first defendant in order to advise her that her application was deficient and to assist her in that regard. It is not logical to state that the application for registration can simply be ignored (where certain documents from other departments are outstanding). One must bear in mind that the purpose of the visit of the facility is to assess the health and safety of the children at the facility and to assess whether the facility meets the registration requirements under the Children's Act and to assess whether the facility concerned should be registered, conditionally registered or shut down. This would determine which assessment can and should be undertaken, regardless of any other outstanding requirements from any other departments. Mr Coughlan was constrained to submit as follows in the above regard:

*'It is accordingly submitted that even if the application for registration cannot be finalised until certain other legal requirements have been met, this does not justify the Department's failure to consider the application, given the clear intention of the Guidelines and the wording of section 82(1)(a) of the Children's Act which states that the provincial head of social development must within 6 months of receiving the application consider an application for registration or conditional registration and either reject the application or grant the registration, with or without conditions.'*

In fact the above submission finds support from the recommendation made by the same Dr Govender in her Quality Assurance Report (dated 2 November 2010)

wherein she makes it clear that compliance with various legislation and government policies (i.e re-zoning, health clearances) is not a pre-requisite for granting registration. She states that such compliance would assist the Department in recommending registration of the facility.

[59] Dr Govender in her testimony stated that she had attempted to follow up with Mr Johannes Gerber (the Environmental Health Officer) on 2 occasions to enquire why he had not submitted his Health and Safety report to the Department. She alleges that she sent 2 e-mails to Mr Gerber and received no response. It is strange though that the said e-mails are not on record. I hold the view that it is highly unlikely that she would have ever followed up with Mr Gerber given her earlier excuse that she did not attend to the first defendant's application for registration because she was prioritising registration in disadvantaged areas. The official Departmental report on the incident does not state when the letter was actually sent to the Environmental Health Officer or whether it was ever received by him. It also does not mention that Dr Govender followed up with Mr Gerber by sending e-mails. Importantly, the report also does not indicate that the lack of an official visit from the Department was due to the fact that the response from the Environmental Health Officer was outstanding. There is a handwritten note on file from Dr Govender regarding a meeting that she had on 3 December 2010 with representatives from the Minister's Office where she wrote *'I had to answer*

*questions with regard to why no follow-up was done on the file'*. It is strange that Dr Govender's own note indicates that there was no follow-up done on the file.

[60] This contradicts her later evidence in court that she did follow-up. The note also suggests that there should have been a follow-up done on the file. One must ordinarily reason as follows: if it was the Department's policy not to follow-up on the applications (until all the outstanding documents were on file), then it is unlikely that Dr Govender would have been called to a meeting to explain this shortcoming on her part to the Department (in circumstances where the Department already knew that no response had been received from the Environmental Health Officer). In any event, the then MEC's official press release contradicts Dr Govender's evidence. In this regard the MEC wrote:

*"Even though the applicant had fewer than six children at the time, on the application form she indicated that she wished to register for 18 to 20 children."*

*"As a matter of course, the department therefore requested the Environmental Health Inspector of the City of Cape Town, to provide the department with a Health Clearance Certificate for the number of children the facility wanted to accommodate," De Lille says.*

*"What the department failed to do was follow up on whether the letter it sent to the Environmental Health Officer was actually received. This means that for over two years the situation with this day care centre has remained unchanged."*

[61] The fact is the first defendant's application was not processed and her premises was not visited after she lodged her application for registration in 2008. The

Department took no further steps after acknowledging receipt of the first defendant's head of the Department was obliged to do so within a 6 month period. The Department was accordingly obliged to devise and implement a comprehensive and workable plan to meet its obligations in terms of the sub-section. It did not do so. The Department failed to implement a strategy aimed at a properly resourced, co-ordinated and managed ECD system in the Western Cape. It was only after A.'s death, at a meeting which was held on 20 October 2010, between Environmental Health and the other relevant role players in Pinelands, where it was realised that (1) the different departments had different policies regarding partial care facilities and (2) that there was a lack of effective communication between the different departments (3) and that what was needed was an integrated approach to applications for registration. It was also stressed at that meeting that once an application for registration was received the Department and the Environmental Health Officer would need to assess the facility together. It was accordingly decided at the meeting that all (unregistered) partial care facilities would be visited by the Department and Environmental Health during the course of that month.

[62] It is needless to state that quite evidently there were a number of significant shortcomings on the part of the Department. The most obvious example I can think of is that there was no evidence from the Department (nor was there any documentation in its file) to indicate that an interview was ever held with the first defendant. It is abundantly clear that the Department failed to evaluate the first

defendant's application for registration. It also failed to revert to the first defendant on her application as was promised in the acknowledgement letter. I find it completely strange and unacceptable that on 31 January 2013 (some 5 years after first applying for registration) the first defendant's attorneys were still desperately trying to get the Department to register her ECD facility. Her premises were never visited (whilst application was being processed). She was never assisted by the Department to meet the requirements for registration. It was only after the incident (15 October 2010) that the first defendant's facility was visited by the Department's social worker (Ms Nazeera Abrahams and Mr Johan Gerber – the Environmental Officer). The facility was then assessed on 25 October 2010 for compliance by Dr Govender. She compiled a report dated 2 November 2010 referred to earlier in this judgment.

[63] It emerged from the visit and the quality assessment report after A.'s death that the first defendant's facility did not meet most of the necessary requirements for registration. For an example, it appears from the first defendant's second application for registration that she only had one (1) assistant helping her. The latter was actually the domestic cleaner who had no ECD qualification and who had no experience in ECD when she started working for the first defendant in 2008. It is so that during the said Departmental visit the first defendant was provided with the minimum norms and standards as well as the procedures for registration. She supposedly indicated an eagerness to comply with the

Department's regulations and was willing to be trained. The Department undertook to assist the facility with the registration process and assist them with capacity building. This does not appear to have ever happened. It is common cause that the Department further recommended in the quality assessment report that the facility consider scaling down the number of children to less than the required number for registration until all outstanding documentation has been received.

[64] Had the Department processed the first defendant's application and visited the premises (which it was supposed to do as part of the evaluation of the application), then it would, *inter alia*, have realized that the first defendant and her staff were not properly qualified or trained to look after infants and that they were unfamiliar with safe sleep practices which practices were not in fact being implemented. Had the Department officials visited the first defendant's premises prior to the incident under discussion herein, the Department would have noted any unacceptable practices and directed that changes be implemented immediately in order to ensure the safety and well-being of the infants and other children at the facility. Notably, Dr Govender conceded that if the Department had fulfilled its function by visiting the facility, by assessing the ECD Services there, by assessing the experience and qualifications of the staff, by mentoring and training the staff, by advising on safe sleep practices and by ensuring compliance with the prescribed minimum norms and standards, and by registering the facility,

that would significantly reduce the type of incident under review. She further did not hesitate to concede that had the Department's officials visited the facility they would have advised the first defendant on basic health and safety (such as the need to implement safe sleep practices by not leaving infants unattended on her bed).

[65] There are numerous material shortcomings in the ECD Services being provided by the first defendant's ECD facility. Clearly the persons rendering those ECD Services were not suitably qualified or experienced in ECD and were thus not fit and proper. This, the Department would easily unearth if only premises were visited as the law requires. Had the Department processed the application for registration and visited the premises then it would have advised First Defendant that she did not meet necessary requirements for registration in terms of the Act and that she must either close down her facility pending compliance with the statutory requirements or that she must limit the number of children at her facility to less than 6 until such time as she became registered. From the Available evidence having been considered holistically, I hold that the Department's failure to comply with its statutory duties seriously compromised the care and safety of the children at the facility (owned by the first defendant) and that this caused or materially contributed towards the death of A. whilst she was at the first defendant's ECD facility. The death of A. would probably have been prevented had the second defendant intervened as it could have and should have done. It is

trite law that in order to succeed in a delictual claim, a claimant would have to prove the following elements: (i) causation; (ii) wrongfulness; (iii) fault (negligence); and (iv) harm. It shall be helpful to briefly discuss these elements (hereunder) as far as they pertain to the factual scenario of the present case. See **Oppelt v Department of Health, WC** 2016 (1) SA 325 (CC) at para [34].

**FACTUAL CAUSATION**

[66] A mention must be made that the criterion applied to determine factual causation is the well-known but-for test. This is a factual enquiry. The plaintiffs must prove, on a balance of probabilities that, but for the negligent omissions of the Department that A. would not have died. Of course the issue pertaining to factual causation relates to the question whether the negligent act or omission in question caused or materially contributed to the claim. In **Minister of Police v Skosana** 1977 (1) SA 31 (A) at 34F-H and 35A-D, the then Appellate Division guidingly made the following formulation:

'Causation in the law of delict give rise to two rather distinct problems. The first is a factual one and relates to the question as to whether the negligent act or omission in question caused or materially contributed to (see Silva's Fishing Corporation (Pty.) Ltd v Maweza, 1957 (2) S.A. 256 (A.D.) at p. 264; Kakamas Bestuursraad v. Louw, 1960 (2) S.A. 202 (A.D.) at p. 222) the harm giving rise to the claim. If it did not, then no legal liability can rise and cadit quaestio. If it did, then the second problem becomes relevant, viz. whether the negligent act or

omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether, as it is said, the harm is too remote. This is basically a juridical problem in which considerations of legal policy may play a part. The distinction between these two enquiries is well explained by Prof. Fleming, The Law of Torts, 4th ed., p. 169, as follows:

*"The first involves what may broadly be called the 'factual' question whether the relation between the defendant's breach of duty and the plaintiff's injury is one of cause and effect in accordance with 'scientific' or 'objective' notions of physical sequence. If such a causal relation does not exist, that puts an end to the plaintiff's case, because no policy can be strong enough to warrant the imposition of liability for loss to which the defendant's conduct has not in fact contributed.*

*The second problem involves the question whether, or to what extent, the defendant should have to answer for the consequences which his conduct has actually helped to produce. There must be a reasonable connection between the harm threatened and the harm done. As a matter of practical politics, some limitation must be placed upon legal responsibility, because the consequences of an act theoretically stretch into infinity. The task is to select those factors which are of sufficient significance to justify the imposition of liability and to draw a boundary along the line of consequences beyond which the injured party must either shoulder the loss himself or seek reparation from another source."*

*(See also Hart and Honorè, Causation in the Law, p. 104; American Restatement (Torts), 2nd ed., secs. 430-3).*

*The present case turns on the first of these problems, viz. causation in fact, for it could hardly be contended that, if the negligence of Davel and Mahela in fact caused or contributed to the death of the deceased, this was too remote a consequence to give rise to legal liability. Of a "cause" in this sense Prosser, Law of Torts, 4th ed., at p. 237, states:*

*"A cause is a necessary antecedent: in a very real and practical sense, the term embraces all things which have so far contributed to the result that without them it would not have occurred. It covers not only positive acts and active physical forces, but also pre-existing passive conditions which have played a material part in bringing about the event. In particular it covers the defendant's omissions as well as his acts."*

*The test is thus whether but for the negligent act or omission of the defendant the event giving rise to the harm in question would have occurred. This test is otherwise known as that of the causa (conditio) sine qua non and I agree with my brother VILJOEN that generally speaking (there may be exceptions – see Portswood v. Svamvur, 1970 (4) S.A. 8 (R.A.D.) at p. 14) no act, condition or omission can be regarded as a cause in fact unless it passes this test (see Da Silva and Another v. Coutinho, 1971 (3) S.A. 123 (A.D.) at p.147).'*

[67] What it essentially lays down is the enquiry – in the case of an omission – as to whether, but for the defendant's wrongful and negligent failure to take reasonable steps, the plaintiff's loss would not have ensued. The Supreme Court of Appeal has said on more than one occasion that the application of the 'but-for test' is not based on mathematic, pure science or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the background of everyday – life experienced. See **ZA v Smith** 2015 (4) SA 574 (SCA) at para [30]. In applying this common sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this causal link with certainty. See **ZA Smith** *supra* at para [30] and authorities collated therein. In **Minister of Safety and Security v Van Duivenboden** 2002 (6) SA 431 (SCA) the Supreme Court of Appeal held at [24] that:

*'The first enquiry is whether the wrongful conduct was a factual cause of the loss. The second is whether in law it ought to be regarded as* a *cause. Regarding the first enquiry he said the following:*

*'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 cause can be identified as* a *causa*

*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.' ...A plaintiff is not required to establish the causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.'*

[68] In **Lee v Minister for Correctional Services** 2013 (4) SA 144 (CC) at [41], the Constitutional Court said the following about causation in the case of a negligent omission:

*'(I)n the case of an omission the but-for test requires that a hypothetical positive act be inserted in the particular set of facts, the so-called mental removal of the defendant's omission. This means that reasonable conduct of the defendant would be inserted into the set of facts. However, as will be shown in detail later, the rule regarding the application of the test in positive acts and omission cases is not inflexible. There are cases in which the strict application of the rule would result in an injustice, hence a requirement for flexibility*.'

While it may be more difficult to prove a causal link in the context of a negligent omission than a commission, **Lee** explains that the *'but-for'* test is not always the be-all and end-all of the causation enquiry when dealing with negligent omissions. The starting point, in terms of the *'but-for'* test, is to introduce into the facts a hypothetical non-negligent conduct of the defendant and then ask the question whether the harm would have nonetheless ensued. If, but for the negligent omission, the harm would not have ensued, the requisite causal link would have

been established. The rule is not inflexible. Ultimately, it is a matter of common sense whether the facts established a sufficiently close link between the harm and the unreasonable omission. See **Oppelt v Department of Health, WC** 2016 (1) SA 325 (CC).

[69] It is particularly apt where the harm that has ensued is closely connected to an omission of a defendant that carries the duty to prevent the harm. Regard being had to all the facts, the question is whether the harm would nevertheless have ensued, even if the omission had not occurred. See **Mashongwa v Passenger Rail Agency of South Africa** 2016 (3) SA 528 (CC) at [65]. It is also settled that a plaintiff can hold a defendant liable whose negligence has materially contributed to a totality of loss resulting partly also from the acts of other persons or from the forces of nature, even though no precise allocation of portions of the loss to the contributing factors can be made. It is not for the plaintiffs to prove which part of the loss the defendant caused. The harm is presumed to be indivisible, and the plaintiff need prove only that the defendant contributed materially to the totality of it. The onus is then on the defendant to rebut the presumption by proving that the harm is in fact divisible and that he did not cause all of it (which he does by proving which part he did cause). **See Humphrys NO v Barnes 2004 (2) SA 577 (C)** at 581.

[70] Accordingly, in the present instance it is incumbent upon the plaintiffs to prove only a *'material factual link'* between the Department's negligent omission and the death of A.. The plaintiffs are not required to quantify the extent of the Department's causal contribution. Thus applying the ordinary, common-sense standards, it can safely be said that the causal connection between the death of A. and the Department's failure to act, was sufficiently real and close to enable the court to say that the omission of the Department to act and intervene was a factual cause of A.'s death. In other words, it was a *conditio sine qua non* of such loss. I find that the most probable inference is that, if the Department complied with its obligations after they received the first defendant's application for registration, then the risk of the first defendant leaving A. unattended on the bed alone would have been eliminated, with the result that her death would have been avoided.

**WRONGFULLNESS**

[71] The next enquiry is whether the *'negligent omission'* is unlawful. The Department's omission will only be unlawful if it occurred in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm. The wrongfulness enquiry is based on the duty not to cause harm and that (in the case of negligent omissions), the focus is on the reasonableness of imposing liability. An enquiry into wrongfulness is determined by weighing competing norms and interests. The criterion of wrongfulness ultimately depends

on a judicial determination of whether, assuming all other elements of delictual liability are present, it would be reasonable to impose liability on a defendant for the damages flowing from specific conduct. Whether conduct is wrongful is tested against the legal convictions of the community which are *'by necessity underpinned and informed by the norms and values of our society, embodied in the Constitution.'*

See **Oppelt v Department of Health WC** *supra* at [51] (the Constitutional Court judgment).

[72] The fact is that the State is obliged to protect individuals by taking active steps to prevent violations of the constitutional right to freedom and security of person. It is not essential that there be a special relationship between the plaintiff and the defendant for imposing a legal duty to act. See **Van Eeden v Minister of Safety and Security (Women's Legal Centre Trust, as Amicus Curiae)** 2003 (1) SA 389 (SCA). The State is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The State remains obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programs implemented by the Executive. These policies and programs must be reasonable both in their conception and their implementation. Thus the formulation of a program is only the first stage in meeting the State's obligations.

The program must also be reasonably implemented. An otherwise reasonable program that is not implemented reasonably will not constitute compliance with the State's obligations. See **Grootboom,** para [42]. The Supreme Court of Appeal has recognised in a number of cases that where there is no effective way to hold the State to account other than by way of a private law action for damages, and in the absence of any norm or consideration of public policy that outweighs it, a legal duty should be recognised unless there are public considerations which point in the other direction.

[73] Perhaps I need to point out that the wrongfulness enquiry focuses on the conduct of the Department and goes to whether the policy and the legal convictions of the community, constitutionally understood, regard it as acceptable. It is based on the duty not to cause harm-indeed to respect rights – and questions the reasonableness of imposing liability. Negligence, on the other hand, tests the defendant's conduct against that of a reasonable person in the same situation in order to determine fault. See **Loureiro and Others v Imvula Quality Protection (Pty) Ltd** 2014 (3) SA 394 (CC) at para 53. The proper approach to the question, whether an omission to comply with a statutory obligation gives rise to delictual liability, appears from the following judgment of the Supreme Court of Appeal in **Olitzki Property Holdings v State Tender Board and Another** *supra* at para 12 of the judgment:

'*Where the legal duty the plaintiff invokes derives from breach of a statutory provision, the jurisprudence of this Court has developed a supple test. The focal question remains one of statutory interpretations, since the statute may on a proper construction by implication itself confer a right of action, or alternatively provide the basis for inferring that a legal duty exists at common-law. The process in either case requires a consideration of the statute as a whole. . . . But where a common-law duty is at issue, the answer now depends less on the application of formulaic approaches to statutory construction than on a broad assessment by the court whether it is just and reasonable that a civil claim for damages should be accorded. The conduct is wrongful, not because of the breach of the statutory duty per se, but because it is reasonable in the circumstances to compensate the plaintiff for the infringement of his legal right. The determination of reasonableness here in turn depends on whether affording the plaintiff a remedy is congruent with the court's appreciation of the sense of justice of the community. This appreciation must unavoidably include the application of broad considerations of public policy determined also in the light of the Constitution and the impact upon them that the grant or refusal of the remedy the plaintiff seeks will entail*.'

[74] Wrongfulness is generally uncontentious in cases of positive conduct that harms the person or property of another. Conduct of this kind is *prima facie* wrongful. This principle remains true where one is dealing with negative conduct (omission) where there is a pre-existing duty, such as the failure to protect a vulnerable person from harm. See **Mashongwa v Passenger Rail Agency of South Africa** *supra* at para [19]. The point is where a constitutional duty has been breached the value of accountability assumes a prominent role in the determination of the appropriateness of transposing that breach into a private-law breach leading to an award of damages. That transposition will, however, become an option only if there are no other appropriate non-judicial remedies Available to enforce accountability. The prospects of recognising a private-law remedy following upon

a breach of a public-law duty would be enhanced where no other effective remedy exists. See **Mashongwa** *supra* para [24].

[75] In the case of **Mashongwa v Passenger Rail Agency of South Africa** *supra* at [25] the following guiding observation appears:

*'The state and its organs exist to give practical expression to the constitutional rights of citizens. They bear the obligation to ensure that the aspirations held out by the Bill of Rights are realised. That is an immense responsibility that must be matched by the seriousness with which endeavours to discharge it are undertaken. To this end, the state, its organs and functionaries cannot be allowed to adopt a lackadaisical attitude, at the expense of the interests of the public, without consequences. For this reason, exceptions are at times made to the general rule that a breach of public-law obligations will not necessarily give rise to a delictual claim for damages. Absent that flexibility, public authorities and functionaries might be tempted and emboldened to disregard their duties to the public. And that could create fertile ground for a culture of impunity. These obligations cannot therefore be ignored without any repercussions, particularly where there is no other effective remedy.*

*Safeguarding the physical wellbeing of passengers must be a central obligation of Prasa. It reflects the ordinary duty resting on public carriers and is reinforced by the specific constitutional obligation to protect passengers' bodily integrity that rests on Prasa, as an organ of state. The norms and values derived from the Constitution demand that a negligent breach of those duties, even by way of omission, should, absent a suitable non-judicial remedy, attract liability to compensate injured persons in damages. When account is taken of these factors, including the absence of effective relief for individual commuters who are victims of violence on Prasa's trains, one is driven to the conclusion that the breach of public duty by Prasa must be transposed into a private-law breach in delict. Consequently, the breach would amount to wrongfulness.'*

[76] It is of importance that I mention that our common law employs the element of wrongfulness (in addition to the requirements of fault, causation and harm) in

order to determine liability for delictual damages caused by an omission. The appropriate test for determining wrongfulness has been settled in a long line of decisions of the Supreme Court of Appeal. An omission is wrongful if the defendant is under a legal duty to act positively to prevent the harm suffered by the plaintiff. The test is one of reasonableness. A defendant is under a legal duty to act positively to prevent harm to the plaintiff if it is reasonable to expect of the defendant to have taken positive measures to prevent harm. The court determines whether it is reasonable to have expected of the defendant to have done so by making a value judgment based, *inter alia*, upon its perception of the legal convictions of the community and on a consideration of policy. The question whether a legal duty exists in a particular case is thus a conclusion of law depending on a consideration of all the circumstances of the case and on the interplay of the many factors which have to be considered, See **Van Eeden v Minister of Safety and Security (Women's Legal Centre Trust, as Amicus Curiae)** 2003 (1) SA 389 (SCA) at para [9].

[77] In applying the concept of the legal convictions of the community of the court is not concerned with what the community regards, as so socially, morally ethically or religiously right or wrong, but whether or not the community regards a particular act or form of conduct as delictually wrongful. The legal convictions of the community must further be seen as the legal policy makers of the community, such as the Legislature and Judges. The approach of our courts to the question

whether a particular omission to act should be regarded as unlawful has always been an open-ended and flexible one. See **Van Eeden** *supra.* Most certainly the concept of the legal convictions of the community must necessarily incorporate the norms, value and principles contained in the Constitution. The Constitution is the Supreme Law of the country, and no law, conduct, norms or values that are inconsistent with it can have legal validity, which has the effect of making the Constitution a system of objective, normative values for legal purposes.

[78] The entrenchment of fundamental rights and values in the Bill of Rights, enhances their protection and affords them a higher status. State actions, court decisions and even the conduct of natural and juristic persons may be tested against them. All private law rules, principles or norms (including those regulating the law of delict) are subjected to and given content in the light of the basic values in the Bill of Rights. See **Van Eeden** judgment where the following appears.

*'Section 7(2) of the Constitution imposes an affirmative duty on the State to 'respect, protect, promote and fulfil the rights in the Bill of Rights'. Section 8(1) of the Constitution provides that the Bill of Rights applies to all law, and binds the Legislature, the Executive, the Judiciary and all organs of State. Under section 11 of the Constitution, the Bill of Rights entrenches the right to life. It follows that there is a duty imposed on the State and all of its organs not to perform any act that infringes these rights. In some circumstances there would also be a positive component which obliges the State and its organs to provide appropriate protection to everyone through laws and structures designed to afford such protection.*

[79] In **Minister of Safety and Security v Van Duivenboden** 2002 (6) SA 431 (SCA), the Supreme Court of Appeal concluded that while private citizens might be entitled to remain passive when the constitutional rights of other citizens are under threat and while there might be no similar constitutional imperatives in other jurisdictions, in this country the State has a positive constitutional duty to act in the protection of the rights in the Bill of Rights. The Supreme Court of Appeal held as follows:

*'Where the conduct of the State, as represented by the persons who perform functions on its behalf, is in conflict with its constitutional duty to protect rights in the Bill of Rights, in my view, the norm of accountability must necessarily assume an important role in determining whether a legal duty ought to be recognised in any particular case.'*

Where the conduct of the State, (as represented by the persons who perform functions on its behalf), is in conflict with its constitutional duty to protect rights in the Bill of Rights, the norm of accountability must necessarily assume an important role in determining whether a legal duty ought to be recognised in any particular case. The norm of accountability, however, need not always translate constitutional duties into private law duties enforceable by an action for damages, for there will be cases in which other appropriate remedies are Available for holding the State to account.'

See **Van Duivenboden** *supra* para [21] and [22].

[80] It is trite that where the State's failure occurs in circumstances that offer no effective remedy other than an action for damages the norm of accountability will, ordinarily demand the recognition of a legal duty unless there are other considerations affecting the public interest that outweigh that norm. The Supreme

Court of Appeal has developed the legal principles governing the State's delictual liability in respect of its constitutional obligations, and particularly, those relating to the rights to dignity, life and freedom and security of the person in a series of cases. See **Minister of Safety and Security v Hamilton** 2004 (2) SA 216 (SCA); **Minister of Safety and Security v Van Duivenboden** 2002 (6) SA 431 (SCA); **Van Eeden v Minister of Safety and Security (Women's Legal Centre Trust, as Amicus Curiae)** 2003 (1) SA 389 (SCA); **Minister of Safety and Security and Another v Carmichele** 2004 (3) SA 305 (SCA); **Rail Commuters Action Group v Transnet Ltd t/a Metrorail** 2005 (2) SA 359 (CC). The Supreme Court of Appeal has explicitly acknowledged that one of the considerations relevant to the question of whether a legal duty for the purposes of the law of delict exists is the constitutional value of accountability, in terms of which Government and those exercising public power should be held accountable to the broader community for the exercise of their powers. There is no effective way to hold the State to account in the present matter other than by way of an action for damages and (in the absence of any norm or consideration of public policy that outweighs it), the constitutional norm of accountability requires that a legal duty be recognised.

[81] Accordingly, where (as in circumstances such as the present), persons in the position of the plaintiffs have no other effective remedy against the State, an action for damages is the norm unless public policy considerations point in the other direction. When considering whether the Department owed a duty to A. the

answer lies in the recognition of the general norm of accountability: the State is liable for the failure to perform the duties imposed upon it by the Constitution unless it can be shown that there is compelling reason to deviate from that norm. See **Minister of Safety and Security v Carmichele** 2004 (3) SA 305 (SCA) at para [43]. Section 36(1) of the Constitution, therefore, requires the State, or any person asserting that a limitation of a right falls within the provisions of section 36(1), to show that the limitation is reasonable and justifiable. It is one of the objects of the Bill of Rights to require those limiting rights to account for the limitations. The process of justifying limitations, therefore, serves the value of accountability in a direct way by requiring those who defend limitations to explain why they are defensible. See **Metrorail**, para [75].

[82] It has also been said that the Court requires the bearer of constitutional obligations to perform them in a manner which is reasonable. What constitutes reasonable measures will depend on the circumstances of each case. Factors that would ordinarily be relevant would include the nature of the duty, the social and economic context in which it arises, the range of factors that are relevant to the performance of the duty, the extent to which the duty is closely related to the core activities of the duty-bearer - the closer they are, the greater the obligation on the duty-bearer, and the extent of any threat to fundamental rights should the duty not be met as well as the intensity of any harm that may result. The more grave is the threat to fundamental rights, the greater is the responsibility on the

duty-bearer. Thus, an obligation to take measures to discourage pickpocketing may not be as intense as an obligation to take measures to provide protection against serious threats to life and limb. See **Metrorail,** para [88]. A final consideration will be the relevant human and financial resource constraints that may hamper the organ of State in meeting its obligation. This last criterion will require careful consideration when raised. In particular, an organ of State will not be held to have reasonably performed a duty simply on the basis of a bald assertion of resource constraints. Details of the precise character of the resource constraints, whether human or financial, in the context of the overall resourcing of the organ of State will need to be provided. See **Metrorail,** para [88].

[83] The Department is and remains the primary agency of the State responsible for the discharge of its constitutional duty to protect the rights of infants in ECD facilities. Indeed it failed to act in accordance with its obligations. It cannot, in my view, evade being held accountable for A.'s death. It is and cannot be disputed that the Department is under a public-law duty to protect children in ECD facilities. Additionally to the public law duty there can be no doubt that that duty, together with constitutional values, has mutated to a private-law duty to process applications for registration in order to prevent harm to children in ECD facilities. Undoubtedly, Section 15 of the Children's Act would confer an action for damages on plaintiffs. It must be pointed out that regardless of section 15, the

norm of accountability would translate the applicable statutory and constitutional duties into private law duties enforceable by an action for damages.

[84] An important consideration in favour of recognising delictual liability for damages on the part of the Department in circumstances such as the present is that there is no other practical and effective remedy Available to the Plaintiffs. Conventional remedies such as review and mandamus or interdict do not afford plaintiffs any relief at all. The only effective remedy for plaintiffs is a private law delictual action for damages. I fully agree with Mr Coughlan that there is no reason (no policy considerations) to depart from the general principle that the Department (as an organ of State), will be liable for its failure to comply with its constitutional and legislative duty to protect A.. On the contrary, A. was pre-eminently a person who required the State's protection. See **Carmichele (SCA**) at para [44]. Thus, in my view, it would be eminently reasonable to impose legal liability on the Department in this matter.

**Legal Causation**:

[85] Indeed demonstration (as done above) that a wrongful act was a *causa sine qua non* of the loss sustained by the plaintiffs herein does not necessarily result in legal liability. See **Hing and Others v Road Accident Fund** 2014 (3) SA 350 (WCC) at [41]. The second leg of the causation enquiry relates to whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to

ensue or whether (as it is said), the loss is too remote. This is sometimes called *'legal causation'*. Legal causation as a requirement serves as a moderating tool to regulate a defendant's liability so as to keep it within bounds which legal policy would consider reasonable.

[86] In our law, the test to be applied in determining legal causation was described by Corbett CJ as *'a flexible one in which factors such as reasonable foreseeability, directness, the absence or presence of a novus actus interveniens, legal policy, reasonability, fairness and justice all play their part'.* See **Standard Chartered Bank of Canada v Nedperm Bank Ltd** 1994 (4) SA 747 (A) at 764 I-765B. In delict, the reasonable foreseeability test does not require that the precise nature or the exact extent of the loss suffered or the precise manner of the harm occurring or details of the injury should have been reasonably foreseeable for liability to result. It is sufficient if the general nature of the harm suffered by the plaintiff and the general manner of the harm occurring was reasonably foreseeable. See **Standard Bank Chartered Bank of Canada v Nedperm Bank Ltd** *supra* at 768; **RAF v Russel** 2001 (2) SA 34 (SCA) at [26]

[87] In essence, therefore, the question of legal causation is not a logical concept concerned with causation but a moral reaction, involving a value judgment and applying common sense, aimed at assessing whether the result can fairly be said to be imputable to the defendant. If the negligence of the Department caused

or contributed to the death of A., then it could never be contended by the Department this was too remote a consequence to give rise to legal liability. I hold that policy considerations based on the norms and values of our constitution and justice point to the reasonableness of imputing liability to the Department. I further hold that failure of the Department to prevent A.'s death is accordingly the kind of conduct that ought to attract liability.

**NEGLIGENCE:**

[88] The test for determining negligence is that enunciated in **Kruger v Coetzee** 1966 (2) SA 428 (A) at 430E - F. The issue of negligence essentially involves a threefold enquiry. The first is whether the harm was reasonably foreseeable. The second is whether the *diligens paterfamilias* would have taken reasonable steps to guard against such occurrence. The third is whether the *diligens paterfamilias* failed to take those steps. Even where the circumstances of an accident are deemed to be *'somewhat unusual'*, the element of foreseeability will be met if the general nature of the harm to the third party was foreseeable; it is not necessary that the precise or exact manner in which the harm occurs be foreseeable.

See **Mcintosh v Premier, KZN** 2008 (6) SA 1 (SCA) at [13]; **Carmichele (SCA)** *supra* at para [45]

[89] The fact is liability in delict is for causing damage, not for causing *'accidents'* or *'events'* leading to damage. Thus the test of negligence is the reasonable foreseeability of damage, harm or injury, not of an accident or event causing the same. As such, it is sufficient if the person sought to be held liable therefor should have foreseen the general nature of the harm that might be caused in consequence of his conduct, that is, it is the harm or damage and not the occurrence or event giving rise thereto that is relevant. See **Vorster v AA Mutual Insurance Assoc. Ltd** 1982 (1) SA 145 (T) at 161. The crucial question, therefore, is the reasonableness or otherwise of the Department's conduct. This is the second leg of the negligence inquiry. Generally speaking, the answer to the inquiry depends on a consideration of all the relevant circumstances and involves a value judgment which is to be made by balancing various competing considerations, including such factors as the degree or extent of the risk created by the actor's conduct, the gravity of the possible consequences and the burden of eliminating the risk of harm. In the ultimate analysis, the true criterion for determining negligence, is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person. Dividing the inquiry into various stages, however useful, is no more than an aid or guideline for resolving this issue. See **Carmichele (SCA)** *supra* at para [44] – [45].

[90] Obviously, it is reasonably foreseeable that infants are going to be injured or even killed if the Department does not fulfil its duties by regulating ECD services

provided at ECD facilities. It is reasonably foreseeable that an infant could be seriously injured or killed if the Department failed to process the First Defendant's application for registration and if the First Defendant's ECD services were not monitored and she was permitted to continue to operate an unsafe ECD facility. I agree with Mr Coughlan's submission that a reasonable person in the Department's position would reasonably have foreseen the possibility of harm befalling someone in A.'s position as a result of a failure to fulfil its constitutional and legislative responsibilities. I am of the view that, given that the harm was foreseeable and given that such harm could result in serious injury or even death to vulnerable persons (infants) such a reasonable person would have taken reasonable steps to prevent harm to A. by processing the application and by visiting the facility to assess the safety of the children. It is common cause that the Department did not take any steps to avert the foreseeable harm that ultimately occurred to A.. The reasons put forward by the Department for its failure to process first defendant's application do not, in my view, constitute valid and excusable reasons. The fact remains that the Department failed to comply with its core responsibilities. Its failure resulted in a breach of A.'s fundamental right to the safety and security of her person. This failure thus infringed A.'s most fundamental right to life. I state categorically that the Department did not present sufficient evidence to demonstrate that there were resource constraints which justified its failure to act. I therefore hold that in conformity with the value of

accountability, the Department's failure to comply with its legal responsibilities amounted to negligence.

**HARM**

[91] Not much time and energy need be spent on this element. The element of harm is not in dispute. The fact is, A. died and the plaintiffs' rights were infringed.

**CONCLUDING REMARKS**

[92] The plaintiffs have proved liability on the part of both defendants on a balance of probabilities. The first and second defendants are thus consecutive wrongdoers in as much as their wrongful omissions follow one another in time. In my finding, the omissions of both defendants constitute substantial factors in bringing about the harm that eventuated in this matter. This is a case where one is dealing with a situation where separate delictual acts (omissions) have combined or coalesced (so to speak) to cause a single indivisible injury. See **Nedcor Bank Ltd t/a Nedbank v Lloyd – Gray Lithographers** (Pty) Ltd 2000 (4) SA 915 (SCA) at 902 where Scott JA pointed out that concurrent wrongdoers are persons whose independent or '*several'* delictual acts (or omissions) combine to produce the same damage. See **Van Der Walt Delict** para 60; McKerron **The Law of Delict** 7th ed at 107-8. See also **Harrington NO v Transnet Ltd** 2007 (2) SA 228

(C). In the circumstances, it is fair and reasonable that each defendant should be held jointly and severally liable for the harm suffered by the plaintiffs.

**ORDER**

[93] In the circumstances this court makes the following order:

(a) The defendants are jointly and severally liable to pay damages to plaintiffs arising from the wrongful death of their daughter A. B., which occurred on 14 October 2010;

(b) The defendants are jointly and severally liable for the party and party costs incurred by the plaintiffs in the action to date.

(c) The remaining issue of quantum is postponed *sine die* for determination.

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**D V DLODLO**

**Judge of the High Court**

**APPEARANCES:**

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|---|---|
| **HEARD:** | 27 March 2017 |
| **DELIVERED:** | 30 June 2017 |
| **COUNSEL FOR PLAINTIFFS:** | Adv. W S Coughlan |
| **ATTORNEY FOR PLAINTIFFS:** | DSC Attorneys<br>Mr C Smit |
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