

Medical negligence as a causative factor in South African criminal law: *novus actus interveniens* or mere misadventure?

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ABSTRACT

The aim of this article is to assess the validity and applicability of medical negligence as a *novus actus interveniens*, with reference to recent South African criminal case law. Such an assessment necessitates an analysis of the most important rules pertaining to causation in South African criminal law. In the context of medical negligence as a new intervening act, reference is made to the influence of medical errors of judgement and the concept of medical misadventure. The judicial 'grading' of criminal medical negligence as 'gross' or 'overwhelming', with reference to relevant case law, is also explored and criticised. It is submitted that the courts should avoid 'grading' medical negligence by way of policy considerations to establish the absence of a *novus actus interveniens*. They should rather make a principled assessment of medical negligence, with due consideration to the concepts of medical misadventure and professional errors of judgement. More often than not, a principled assessment will lead to a finding that there was no medical negligence and consequently no *novus actus interveniens*, even in the face of adverse consequences.

1. Introduction

The judicial assessment of medical negligence as a possible causative factor regarding the materially defined crimes of murder and culpable homicide is a recent revival in South African criminal law.¹ In practice this phenomenon manifests in the following way: X (the perpetrator) unlawfully and intentionally inflicts life-threatening wounds upon Y (the victim). Consequently, Y is hospitalised in a serious condition. It is common cause that Y would die if Y does not receive urgent medical treatment. However, as a result of the hospital being understaffed, ill-equipped or otherwise medically compromised, or alternatively, as a result of medical negligence by the attending physician or nursing staff, Y does not receive either timely, adequate or correct medical treatment and therefore dies.

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¹ The word 'revival' is used as this is not a new development in the case law — compare authority referred to in (n2) and (n23) *infra*.

Later, at the criminal trial when X is charged with the murder of Y, X raises the defence that Y died as a result of medical negligence on the part of the hospital and/or attending physician or nursing staff. X contends that the medical negligence is to be construed as a *novus actus interveniens* (a new intervening act) breaking the chain of causation and that X at most should be convicted of attempted murder or assault with intention to do grievous bodily harm. In contrast, the prosecution usually argues that, due to the infliction of life-threatening wounds, Y would have died in any event. Nevertheless, policy considerations dictate that X is the legal cause of Y's death despite the medical negligence.

The aim of this paper is to assess the validity and applicability of medical negligence as a new intervening act, with reference to recent South African criminal case law. It will be shown that general principles of criminal law governing the element² of causation in the assessment of medical negligence are not always in synergy with the case law. Furthermore, judicial sentiment in this regard is indicative of a certain degree of so-called 'legal or judicial protectionism' slanted in favour of the medical profession. In addition, the courts in these instances tend to 'grade' medical negligence in order to rule that such negligence, on policy considerations, should not be regarded as a *novus actus interveniens*. Specific reference is made to 'errors of professional judgement' or 'medical misadventure' as a possible new intervening cause.

2. The most important rules pertaining to causation in current South African criminal law

An assessment of medical negligence as a possible causative factor necessitates a brief consideration of the most important rules pertaining to causation in the current South African criminal law. Briefly, various rules of causation can be stated. First, to find that an accused's act or omission caused a certain result, such as the death of the victim, the accused's act or omission must be the factual and legal cause of the victim's death.³

² It should be noted that, for purposes of this article, reference is made to the 'element' of causation. Causation is of course not a separate element per se for criminal liability but is rather part of the definitional elements (or proscription) of the crimes of murder and culpable homicide, as correctly observed by CR Snyman *Criminal Law* 4ed (2002) 64ff. See also JC De Wet & HL Swanepoel *Die Suid-Afrikaanse Strafbare Manslag* 4ed (1985) 62ff; J Burchell & J Milton *Principles of Criminal Law* 2ed (1997) 115ff; J Burchell *Principles of Criminal Law* 3ed (2005) 209ff. For a detailed discussion of causation in criminal law see FFW Van Oosten *Oorsaaklikheid by Moord en Strafbare Manslag* LLD (Pretoria) (1981) 224; compare FFW Van Oosten 'Oorsaaklikheid by mediese behandeling as tussenfaktor in die Suid Afrikaanse strafreg' *EM Hamman-Gedenkbundel* (1984) 173.

³ *S v Daniels* 1983 (3) SA 275 (A); *S v Mokgethi* 1990 (1) SA 32 (A); *S v Counter* 2003 (1) SACR 143 (SCA); see also *Minister of Police v Skosana* 1977 (1) SA 31 (A) 34 albeit in the context of causation in the law of delict.

Factual causation in the case of an act is determined with reference to the *conditio sine qua non* test: the accused's act is the factual cause of the death of the victim if the act cannot be 'thought away' without the victim's death also disappearing.⁴ Factual causation in the case of an omission is determined with reference to the *conditio cum qua non* test: a positive act must be imagined in the place of the omission — the question is whether the prohibited result would have ensued if the accused had in fact acted positively.⁵ As a variety of factors or events may qualify as factual causes of a prohibited result, the criterion of legal causation is applied to limit the wide scope of factual causation.⁶

An accused's act or omission is the legal cause of a victim's death if a court is of the opinion that policy considerations require that an accused's act or omission be regarded as the cause of the victim's death. 'Policy considerations' ensure that it is reasonable and fair to regard the accused's act or omission as the cause of the victim's death. In assessing what would be reasonable and fair a court may be guided by one or more specific theories of legal causation, such as the proximate cause criterion,⁷ the theory of adequate causation⁸ or the *novus actus interveniens*.⁹ An event can be a *novus actus interveniens* only if it is an unexpected, abnormal or unusual event.¹⁰

⁴ *S v Van As* 1967 (4) SA 594 (A); *S v Mokoena* 1979 (1) PH H13 (A); *S v Daniels* supra (n3) at 275.

⁵ *S v Van As* supra (n4) at 594; *S v Barnes* 1990 (2) SACR 485 (N) at 491d-e; Snyman op cit (n2) 86.

⁶ *S v Daniels* supra (n3) at 275.

⁷ Compare *R v Mubila* 1956 (1) SA 31 (SR).

⁸ Compare *S v Loubser* 1953 (2) PH H190 (W).

⁹ *S v Grotjahn* 1970 (2) SA 355 (A); *S v Williams* 1986 (4) SA 1188 (A); *S v Tembani* 1999 (1) SACR 192 (W); *S v Ramosunya* 2000 (2) SACR 257 (T); *S v Counter* supra (n3).

¹⁰ See *R v Makali* 1950 (1) SA 340 (N); *S v Ntuli* 1962 (4) SA 238 (W). Compare Snyman op cit (n2) 84: 'In other words [an event] which according to general human experience deviates from the ordinary course of events'. For a further discussion of the scope and ambit of the *novus actus interveniens* see Burchell (2005) op cit (n2) 218ff where the following factors for the determination of a *novus actus interveniens* are stated: (i) An act or event is likely to be regarded as a *novus actus interveniens* if, in the light of human experience, it is abnormal or unlikely that it will follow the accused's act; (ii) the chances of an intervening act or event being regarded as a *novus actus interveniens* are considerably greater where the injury inflicted by the accused is not a mortal one; (iii) the accused need not be the sole cause of the consequence; (iv) conduct which is voluntary is more likely to be regarded as a *novus actus interveniens* than conduct which is not voluntary; (v) an abnormal event which would otherwise rank as a *novus actus interveniens* does not so rank if it was actually foreseen or planned by the accused; (vi) the victim's pre-existing physical susceptibilities never rank as a *novus actus interveniens*; (vii) in determining whether medical intervention can rank as a *novus actus interveniens*, it is important to determine whether the medical conduct was negligent, or in some other way improper.

3. Specific scenarios involving causation according to South African criminal case law

An evaluation of South African criminal case law reveals that three specific factual scenarios to which the general principles of causation find application can be identified.

In the first scenario, X (the perpetrator) inflicts a potentially lethal wound on Y (the victim). Y would die as a result of the lethal wound should Y not receive urgent medical treatment within a very short time. Z, an independent third party, arrives on the scene and inflicts a wound on Y causing the immediate death of Y. It is common cause that Z's act is the *causa causans* of Y's death. Can it, however, be found that X nevertheless legally caused the death of Y? This scenario was dealt with in the case of *Daniels*.¹¹ Here two Judges of Appeal ruled that X, on policy considerations, will also be regarded as the legal cause of Y's death, despite the fact that Z was the immediate or proximate cause of Y's death.

In the second scenario, X inflicts a potentially lethal wound upon Y. Y is taken to hospital for emergency medical treatment. The doctors at the hospital manage to contain the emergency and save Y's life. However, they instruct Y to follow medically indicated procedures (or to refrain from dangerous activities) in order to assist with his/her recuperation. Y does not follow these instructions and consequently dies as a result of foreseeable and preventable medical complications. Can it be found that X is nevertheless the legal cause of Y's death in these circumstances? This scenario was addressed by the Appellate Division in the case of *Mokgethi*.¹² The court held that in these circumstances, on policy considerations,¹³ the act or omission that is the factual cause of Y's death is too remote to be considered as the legal cause of Y's death when: (1) Y's omission to follow the doctors' instructions was the immediate cause of death; (2) the initial lethal wound was no longer life-threatening at the time of Y's omission and; (3) Y's omission was relatively unreasonable with regard to his/her subjective convictions and characteristics.¹⁴

In the third scenario, X inflicts a serious wound on Y and Y is taken to hospital. However, Y does not receive timely medical treatment or receives the incorrect medical treatment (including misdiagnosis). Y dies as result of what is perceived to be medical negligence on the part of the attending health care professionals. Can it nevertheless be found that X is the legal cause of Y's death? This was the legal question in the cases of

¹¹ *S v Daniels* supra (n3).

¹² *S v Mokgethi* supra (n3).

¹³ In reliance on the judgment in *S v Daniels* supra (n3).

¹⁴ As per Van Heerden AJ in *S v Mokgethi* supra (n3). It should be noted that these three principles were enunciated not on the basis that Y's failure or omission was a *novus actus interveniens* but on the basis of policy considerations.

Tem bani,¹⁵ *Ramosunya*¹⁶ and most recently in *Counter*.¹⁷ The discussion that follows will focus on an analysis of this third scenario.

4. Recent South African criminal case law with regard to the legal question stated in the third scenario

4.1 *S v Tem bani*¹⁸

The facts

The accused was charged with murder — it being alleged that he shot the deceased (his girlfriend) after an argument, thereby causing her death. After the incident the victim was admitted to hospital in a serious condition. It appeared that one of the shots fired by the accused had pierced the deceased's duodenum, as a result of which bile and bowel matter spilled into her abdominal cavity, creating the hazard of peritonitis and resultant septicaemia. It was established that, if left unattended, this injury would have proved fatal but that proper, timeous and adequate medical treatment would, with a high degree of probability, have been effective in rendering the injury non-fatal. It was also established that the appropriate treatment upon the deceased's admission to hospital ought to have included close observation for at least the first 12 hours. Furthermore, a laparotomy¹⁹ should have been performed to trace the path of the wound and to establish what damage had been caused. This was not done.

An inter-costal drain was inserted and the deceased was left unattended in an ordinary ward for four days where she received nothing more than basic care. By the time she was properly examined peritonitis of a significant degree had set in around the site of the wound to the duodenum. The wound to the duodenum was simply repaired — a measure which was doomed to failure as the tissue had by that stage already become necrotic. Eventually, the deceased died of peritonitis and resultant septicaemia. It was common cause on the facts that the failure by the attendant health care professionals to administer timeous medical care to the deceased was due to the hospital in question being understaffed and overworked, resulting in substandard medical treatment to patients.

¹⁵ *S v Tem bani* supra (n9); Snyman op cit (n2) 88 discusses this aspect under the heading 'subsequent conduct of a third party'. See also the discussion on this point by Burchell (2005) op cit (n2) 220ff.

¹⁶ *S v Ramosunya* supra (n9).

¹⁷ *S v Counter* supra (n3). This is the judgment of the Supreme Court of Appeal regarding the appeal lodged against the judgment of the court *a quo* of *S v Counter* 2000 (2) SACR 241 (T) — for a recent discussion of this case see M Reddi 'General principles of liability — causation' (2000) *SACJ* 362; see also Burchell (2005) op cit (n2) 220.

¹⁸ *S v Tem bani* supra (n9).

¹⁹ Surgical entry into the abdominal cavity.

The judgment

The accused argued that the apparent medical negligence by the attending health care professionals was a *novus actus interveniens*: the gunshot wound to the duodenum of the deceased was clearly the factual cause of the deceased's death but it could not be construed as the legal cause of the deceased's death therefore the accused could not be guilty of the crime of murder. The court rejected this argument. It found the approach of English law (notably *R v Smith*²⁰) compelling regarding whether the medical negligence could constitute a *novus actus interveniens*. According to this approach, if at the time of death the original wound was still an operating and substantial cause of death then the death could properly be said to have been the result of the wound. Only if the medical negligence was so overwhelming as to make the original wound merely part of the history of the chain of events could it be said that death did not flow from the wound. Similarly, by applying the flexible yardstick of policy considerations, the court ruled that the hospital's negligence was not so overwhelming as to make the original wound merely part of the history behind the patient's presence in the hospital. Upon an application of this flexible approach there was a sufficiently close connection between the act of the accused and the death of the deceased to establish legal causation. It followed that the accused had to be convicted of murder.²¹

4.2 *S v Ramosunya*²²

The facts

The appellant was convicted in a regional court of murder and arson. It appeared that the appellant had stabbed the deceased, his mother-in-law, four times in the region of her left collarbone. The deceased was taken to hospital and treated for six days before being discharged. She died at home on the day after her discharge due to sepsis of the lungs. The doctor who performed the autopsy on the deceased was of the opinion that the sepsis of the lungs could have a number of causes. It was contended on behalf of the appellant that there was gross negligence on the part of the hospital, as the deceased was discharged from the hospital apparently in a stable condition to be sent home. Consequently, it was argued that the gross negligence by the hospital should be construed as a *novus actus interveniens*.

²⁰ *R v Smith* [1959] 2 All ER 193.

²¹ The dictum in *S v Mokgethi* supra (n3) was followed.

²² *S v Ramosunya* supra (n9).

The judgment

This judgment is significant because the court reviewed the case law on causation with regard to finding a *novus actus interveniens* in the context of medical treatment.²³ It held there was a reasonable possibility that there was no nexus between the stab wounds and the death of the deceased and that the act or omission of a third person could have disturbed the chain of causation. The lack of evidence of how the deceased was treated in hospital did not exclude gross medical negligence and the possibility that the sepsis in the lungs could have had a natural cause could also not be excluded. In essence the court ruled that the prosecution could not prove beyond reasonable doubt that there was no *novus actus interveniens*. The appeal therefore succeeded and the conviction of murder was set aside and substituted with a conviction of attempted murder. It should be noted that a review of all the relevant case law by the court was indicative of a judicial reluctance to rule that later emergency medical treatment, or even medical treatment with fatal consequences for the victim, will be construed as a *novus actus interveniens*. In these instances an accused will not be absolved from being the legal cause of death and will consequently be convicted of murder.²⁴

4.3 *S v Counter*²⁵

The facts

The appellant, a man of 31 years, was estranged from his wife, the deceased. One evening after some commotion the appellant fired several shots at the deceased. One of the bullets struck her on the buttock and unbeknown to her and, until a later stage, to the doctors who treated her in hospital, it penetrated the anal canal. This eventually caused virulent septicaemia that led to pneumonia, which caused the deceased's death. The appellant was tried for murder of his wife and elected not to give evidence. The trial court found that he had discharged his firearm at the deceased with the intention of killing her and that he had been the cause of her death. On appeal, counsel for the appellant attacked the conviction on the basis that there was no causal nexus between the wounding of the deceased and her death. It was contended that the hospital staff were negligent in their treatment of the deceased and that this negligence should be construed as a *novus actus interveniens*.²⁶

²³ See *R v Mouton* 1944 CPD 399; *R v Du Plessis* 1960 (2) SA 642 (T); *S v Hostosky* 1961 (1) SA 84 (W); *S v Norman* 1961 (2) PH H262 (GW); *R v Motomane* 1961 (4) SA 569 (W); *R v Formani* (2) 1962 PH H252 (SR); *S v Mini* 1963 (3) SA 188 (A); *S v Mabole* 1986 (4) SA 811 (R); *S v Dawood* 1972 (3) SA 825 (N) and *S v Tembani* supra (n9).

²⁴ As for example in *R v Formani* supra (n23) per Lewis J: 'If ... a victim receives medical attention which was unskilled or negligent, and the victim would in any event have died, there is no *novus actus interveniens*.'

²⁵ *S v Counter* supra (n3).

²⁶ See *S v Counter* supra (n3) at para [4].

For a full comprehension of the facts it is necessary to note that on admission to the hospital the deceased was examined in the casualty ward. The attending doctor found a two centimetre entrance wound on the left thigh but there was no exit wound. The degree of bleeding was not unusual. The doctor was aware that the anal canal may have been injured and he said that he conducted an examination per rectum using his fingers — in itself a difficult task. He could find no wound internally, nor were there warning signs in the nature of acute bleeding or faecal blood. If he had found such signs he would have investigated further. The clinical assistant with the attending doctor was also of the opinion that further exploration was not indicated. They considered that the patient's condition was stable, and absent any warning of an undiscovered injury, the use of a sigmoidoscope under general anaesthetic to look for damage to the anal canal was not considered. In addition, the X-rays of the thigh and pelvis which were taken did not reveal a low anal canal injury.

The attending doctor kept careful clinical notes but he did not record that he examined the patient per rectum. He explained that his examination had been interrupted for several minutes by an outbreak of firing which occurred outside the casualty department. Although his notes were written up after the examination was completed, he thought that the distraction must have led him to overlook the per rectum examination when he came to make them.

By the time that the patient's condition deteriorated,²⁷ and a per rectum examination suggested the presence of anaerobic bacteria in the area of the track and the anus, it was medically clear that a necrotising infection had set in. A sigmoidoscopy²⁸ was done and extensive necrotising fasciitis in the pelvic region was identified. Worried by what he found, the attending doctor ordered a full spectrum of antibiotics. The patient was admitted to the intensive care ward unit in an unstable condition. After 24 hours a further examination was carried out and the patient was put on massive antibiotics. It should be noted that no nursing charts covering the patient's demise could be located. According to the attendant physician's recollection, the patient's condition improved gradually to the extent that support was being withdrawn. Suddenly, however, the patient's condition deteriorated and she died as a result of multiple organ failure, secondary to septicaemia.²⁹

²⁷ Necrotic tissue was observed at the wound entrance.

²⁸ An examination of the rectum and sigmoid colon.

²⁹ Counsel for the accused submitted that the gross medical negligence could be derived from the following acts or omissions of the attending physicians: the failure to conduct a rectal examination timeously; the misplaced reliance on the X-rays, particularly in the absence of a visible wound track; failure to submit the patient to a sigmoidoscopy; negligence of the nursing staff in failing to draw the attention of the doctors to the stench from the wound; the bleeding from her private parts and infection which manifested itself; insufficient supervision by qualified doctors; failure to carry out a debridement or an exploratory operation timeously — see *S v Counter* supra (n3) at 151 para [21].

The judgment

The court ruled on the totality of the evidence, with specific reference to the evidence of medical experts in the context of medical negligence,³⁰ that: there was no evidence that any other body of medical expertise would reasonably have discovered earlier what was not discovered until necrotic tissue was first noticed and; given the information available, the deceased would not have been treated with greater skill or different options. Moreover, whatever treatment was administered to the deceased, even if administered at the earliest stage of her reception in hospital, there was no certainty that she would have survived the onslaught of the bacteria.

The doctor who had been treating her before the necrotic tissue was discovered was an experienced practitioner. Nonetheless, he had found no compelling reason to take steps which, in retrospect, might have saved the life of the patient until two days had passed. The operation was performed on her once sepsis was known to be present. The wound was not opened before that because to do so was to admit infection — good medical/clinical practice dictated conservative treatment first. The court consequently ruled that the attending health care professionals, unable to predict the presence of infection or the extent thereof, chose the less invasive remedy and could not be faulted for this.³¹ The court in essence ruled that the attending medical practitioners were not negligent if regard was had to the ‘reasonable medical practitioner in the same circumstances’.

The court held that the sequence of events from the time of the deceased’s admission until her death had not been interrupted by any causal factor which affected or changed the natural order of events. In particular there had been no intervention or omission by the persons responsible for her care. The gunshot had left germs from the bullet all along the wound track. Fragments had been deposited and infection had progressed surreptitiously. By the time its ravages could no longer be kept secret the infection had been almost unstoppable. The patient’s resistance weakened and she developed other complications, all superimposed on the initial injury, and all adding to her eventual death from pneumonia. It was inconceivable that the appellant should not be held responsible for the consequences of his actions. They led directly to the deceased’s death by stages entirely predictable and in accordance with human experience.³² Consequently, the court ruled that there is nothing unfair in a conclusion which holds the appellant guilty of murder.

³⁰ *S v Counter* supra (n3) at paras [23], [26], [28].

³¹ *S v Counter* supra (n3) at 152h-153b para [28].

³² It should be noted that it appears from this dictum that the court applied the theory of adequate causation in ruling that the appellant was the legal cause of the deceased’s death: see *S v Counter* supra (n3) at 153d-f para [30] where the court apparently emphasised ‘human experience’ as the decisive factor to determine legal causation.

5. The concepts of medical negligence and medical misadventure in the context of causation

Before a critical analysis of the discussed case law is undertaken it is necessary to briefly consider the nature and scope of criminal medical negligence, as well as the concept of 'medical misadventure', in order to assess whether medical negligence should ever be regarded as a *novus actus interveniens*. The question is also posed whether South African criminal law, in principle, recognises degrees of negligence.

5.1 Medical negligence

In the context of the legal question stated in the third scenario above,³³ the argument invoked on behalf of all the respective appellants ultimately came down to this: although it was conceded that their initial wounding of the deceased was the factual cause of the death, it was contended that the medical negligence of the attending health care professionals was the legal cause of the deaths and therefore the medical negligence was a new intervening event that interrupted the chain of causation. In considering this argument, the courts had to determine whether there was in fact medical negligence on the part of the attending health care professionals. If it was found that the alleged medical negligence was a new intervening event, then it follows that the medical negligence in itself should also have been the factual and legal cause of the death of the victims. Consequently it is criminal medical negligence that is in issue in the context of culpable homicide, in that it has to be proven that the medical negligence as a new intervening event caused the death of the victim.³⁴

It is trite law that negligence refers to the blameworthy conduct of a person who has acted unlawfully. The blameworthiness is located in the fact that on account of carelessness or imprudence the person failed to adhere to the standard legally required of him. In the case of a health care practitioner, the question is how a reasonable health care practitioner would have acted in the same circumstances. For the crime of culpable homicide on account of medical negligence the test is whether the reasonable health care practitioner in the same circumstances would have foreseen the possibility that the patient/victim could die and, if he/she had foreseen that possibility, would the reasonable health care practitioner in the same circumstances have taken steps to guard against

³³ See para 3 above.

³⁴ See *Snyman op cit* (n2) 84: 'Furthermore, an event can qualify as a *novus actus* only if it is itself a *conditio sine qua non* of the resultant situation and if X had not foreseen or intended that it should result in the prohibited situation (such as Y's death)'. See *Burchell* (2005) *op cit* (n2) 218.

death ensuing.³⁵ The test for criminal medical negligence is thus in essence a foreseeability and preventability test measured against the normative yardstick of the reasonable and competent health care professional in the same circumstances.

5.2 Degrees of criminal negligence/medical negligence?

An assessment of criminal medical negligence raises the question whether South African criminal law recognises degrees of negligence? In principle it can be stated that South African criminal law, in contrast to English law,³⁶ does not recognise different degrees of negligence to establish criminal negligence on a charge of culpable homicide. It is accepted that an accused 'is either negligent or he is not'.³⁷ Thus even the slightest degree of negligence will suffice, although for a conviction on a charge of culpable homicide South African criminal law confines negligence to reasonable foreseeability of death. It should also be noted that in South African law the degree of negligence on the doctor's part makes no difference to his or her civil or criminal liability. The test for medical negligence in private law and criminal law is also the same, apart from the burden of proof that differs.³⁸ However, it is conceded that the degree of negligence might have a bearing on the gravity of the punishment/sentence imposed by

³⁵ See SA Strauss & MJ Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 268; SA Strauss *Doctor Patient and the Law* 3ed (1991) 243; NJB Claassen & T Verschoor *Medical Negligence in South Africa* (1992) 16; PA Carstens *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesbeër op grond van Nalatigheid* LLD (Pretoria) (1996) 128ff; T Barlow 'Medical Negligence Resulting in Death' (1948) *THRHR* 175; FFW Van Oosten 'Professional Medical Negligence In Southern African Practice' (1986) *Medicine and Law* 18; *R v Van Schoor* 1948 (4) SA 349 (C); *R v Van der Merwe* 1953 (2) PH H124 (W); *S v Mkwetsbana* 1965 (2) SA 493 (N); *S v Mablatela* 1966 (1) SA 226 (A); *S v Kramer* 1987 (1) SA 887 (T); *S v Shivute* 1991 (1) SACR 656 (Nm). For the most recent decisions in South African law on medical negligence see *Michael v Linksfield Park Clinic* (2002) 1 All SA 384 (A); *Oldwage v Louwrens* (2004) 1 All SA 532 (C).

³⁶ In English law manslaughter can be a result of either gross negligence causing death (so-called involuntary manslaughter) or circumstances where the causing of the death was intentional but nevertheless, on account of diminished responsibility or provocation, the charge is reduced to manslaughter (so-called voluntary manslaughter): see A Ashworth *Principles of Criminal Law* 4ed (2003) 293-297. It should be noted that the Appellate Division (as it was then) in *S v Bailey* 1982 (3) SA 772 (A) rejected the partial defence theory whereby a conviction of murder could automatically be reduced to a conviction of culpable homicide. See also *S v Ntuli* 1975 (1) SA 429 (A).

³⁷ *R v Meiring* 1927 AD 41; *R v Van Schoor* supra (n35) at 350. See also FFW Van Oosten 'South African Medical Law' (1996) *International Encyclopaedia of Laws* para 162. Thus what holds true for medical negligence in civil law also holds true for medical negligence in criminal law.

³⁸ Compare Burchell (2005) op cit (n2) 524ff. See also Van Oosten op cit (n37); Carstens op cit (n35) 45.

the court. The notion of 'grading' criminal negligence as 'slight', 'gross' or 'overwhelming' seems to be a distinct principle of English law.³⁹

5.3 Medical misadventure and errors of professional judgement

The concepts of 'medical misadventure' and 'professional errors of judgment' are well known in medical practice. Historically these concepts originated in English medical law⁴⁰ but have since been imported into South African medical law.⁴¹ It is well-known in medical practice that when medical treatment is administered or an operation is performed the treatment/operation will be accompanied by overt or inherent medical risks to the patient. Even when the treatment or operation is executed with the utmost of medical skill there is the risk of serious bodily injury or even death. Not every medical slip, wrong diagnosis or mistake imports negligence. It is necessary to have regard to the peculiar circumstances that may present themselves for urgent attention. These may include: the multiform difficulties presented by the particular circumstances of an operation; the condition of the patient and the set of problems arising out of the risks to which he/she is being exposed and; the difficulty of the attending medical practitioner's choice between risks and the paramount need that this discretion be unfettered if he/she thinks it right to take one risk to avoid a greater one.

Despite good intentions, things sometimes go amiss in surgical operations or medical treatment. A doctor is not negligent simply because

³⁹ As borne out by the case of *R v Smith* supra (n20). See also the English authorities listed in (n46) infra. Compare RA Taylor *Medical Malpractice* (1980) 34: 'Criminal negligence is negligence of so gross a degree as to constitute an offence against the State. One has to go back many years to find a successful prosecution of a doctor in respect of his attendance on a patient. Such attempts as have been made in recent years have largely arisen from the verdicts of the Coroner's Court; and since the Criminal Law Act of 1977 abolished the power of these Court to commit for trial, it is perhaps unlikely that such cases will come before the Criminal Courts in future'. Compare *R v Bateman* (1925) 19 Cr App R 8: 'In order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment'.

⁴⁰ Compare I Kennedy & A Grubb *Principles of Medical Law* (1998) 366. See also Lord Denning *The Discipline of Law* (1979) 243; PS Atiyah 'Contract and Tort' in *Lord Denning: The Judge and the Law* (1984) 61-3; RM Jackson & JL Powell *Professional Negligence* (1987) 308; *Mabon v Osborne* [1939] 2 KB 14; *Hatcher v Black* [1954] Times, 2 July; *Hucks v Cole* [1968] Times, 8 May; *Whitehouse v Jordan* [1981] 1 All ER 267; *Ashcraft v Mersey Regional Health Authority* [1983] 2 All ER 245; cf in international context D Giesen *International Medical Malpractice Law* (1988) 129.

⁴¹ Strauss op cit (n35) 249; Claassen & Verschoor op cit (n35) 19; Carstens op cit (n35) 193; see also *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W) at 385B-D, 395A-F; *Castell v De Greef* 1994 (4) SA 408 (C) at 416l.

something went wrong.⁴² It would be wrong, and bad law, to say that the hospitals or the doctors are liable simply because a misadventure occurred. Indeed, it would be disastrous for the community if it were so, as medical practitioners may be distracted from performing their jobs for fear of potential legal repercussions. A doctor should not be found negligent for example: simply because something goes wrong if one of the risks inherent in an operation actually takes place; because a complication ensues which adversely affects the benefits that were hoped for, or; because as a matter of opinion he made an error of judgement.⁴³

6. Critical analysis of recent criminal case law with regard to whether medical negligence would ever be regarded as a *novus actus interveniens*

A critical analysis of the recent South African criminal case law, discussed above, with regard to the question whether medical negligence would ever be regarded as a *novus actus interveniens*, leads to a number of comparative observations, which follow.

According to the judgment in *Tembani*, if at the time of the death of the victim the original wound inflicted by the perpetrator is still an operating and substantial cause of the death then the death could properly be construed as a result of the wound. Only if the medical negligence was overwhelming can it be said to be a *novus actus interveniens*. When medical negligence will be so overwhelming as to qualify as a new intervening act is an open question. Overwhelming negligence will at least denote a gross deviation from accepted medical practice, for example, possibly where the wrong operation is performed on the wrong patient or an overdose of medication or wrong medication is administered.

Economic realities such as a lack of resources, staff, infrastructure and poor working conditions, will certainly influence a court, on policy considerations, not to find that there is a new intervening act. Medical negligence is not determined 'in the air' but with reference to the particular

⁴² As was observed by Denning MR in *Hucks v Cole* supra (n40). See also *Maynard v West Midlands Health Authority* [1985] 1 All ER 635 at 635: 'There is seldom any one answer exclusively to all the problems of professional judgment. A doctor is unlikely to succeed by saying that he was not negligent because he had made an error of clinical judgment — an error of judgment is not in itself compatible with negligence' (per Lord Scarman).

⁴³ As per Denning LJ in *Hatcher v Black* supra (n40); cf *Whitehouse v Jordan* supra (n40) at 281: 'The true position is that an error of judgment may, or may not, be negligent: it depends on the nature of the error. If it is one that would have been made by a reasonable competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If on the other hand, it is an error that a man, acting with ordinary care might have made, then it is not negligence' (per Lord Fraser). Also compare A McCall Smith 'Criminal or Merely Human?: The Prosecution of Negligent Doctors' (1995) 12 *J. Contemp. Health L. & Pol'y* 135.

circumstances of each case. Economic realities and the circumstances relating to the locality where the medical treatment is administered can thus be seen as justifiable limitations against finding medical negligence to be a new intervening act.⁴⁴ It is clear from the *Tembani* judgment that a court will not easily be swayed, in the face of a serious life-threatening wound which was initially inflicted by the perpetrator, to find that ensuing medical negligence, if not gross, will be a new intervening act.

It is submitted that the subtext in the *Tembani* judgment is one of sympathy for the attending medical staff — they did the best that they could under difficult circumstances and the negligence, although not excusable, is almost inevitable. In addition, the victim was seriously wounded and inevitably 'at death's door', irrespective of whatever medical treatment was administered or not. In these circumstances the accused cannot escape liability on account of a lack of legal causation. It is significant that the court, per Hellens AJ, relied on English precedent.⁴⁵ In so doing, the court affirmed the approach in English law, which is based on policy considerations decidedly slanted against the notion that medical negligence, unless gross, will easily be regarded as a *novus actus interveniens*.⁴⁶ It is also significant that, by relying on English law, Hellens AJ graded criminal medical negligence according to an 'overwhelming' standard.

Whereas medical negligence, albeit not overwhelming, was established in the case of *Tembani*, it is clear that the verdict in the case of *Ramsunya* was reached purely on evidentiary considerations: the prosecution failed to prove beyond reasonable doubt that there was no *novus actus interveniens* and consequently the accused had to get the benefit of the

⁴⁴ This construction would be in accordance with the judgment in *Soobramooney v Minister of Health Kwazulu-Natal* 1998 (1) SA 765 (CC) where it was ruled that the right to access to health care and emergency medical care (in terms of s28 of the Constitution of the Republic of South Africa Act 108 of 1996) could be limited (in terms of s36) on account of economic considerations. This construction would accord with the so-called 'locality rule' in medical law whereby the locality in which a medical intervention takes place can be regarded as a 'particular rule of circumstance' to be taken into the equation when an assessment of medical negligence is made: see PA Carstens 'The locality rule in medical practice' (1990) *De Rebus* 421; Claassen & Verschoor op cit (n35) 18; *Van Wyk v Lewis* 1924 AD 438 at 444. For a comprehensive discussion on the effect of the *Soobramooney* judgment in the context of medical law see DL Pearmain *A Critical Analysis of the Law on Health Service Delivery in South Africa* LLD (Pretoria) (2004) 140ff.

⁴⁵ See *R v Smith* supra (n20). See also McCall Smith op cit (n43) 133.

⁴⁶ As further borne out by the judgments of Lord Denning: see English case law supra (n40); cf *Whitehouse v Jordan* [1980] 1 All ER 650 (CA); see also Denning op cit (n40) 237: 'At one time the Courts held that a professional man was not liable for ordinary negligence but only for gross negligence, *Crassa Negligentia*. Later on it was said that there is no difference between negligence and gross negligence. But there is a tendency today to draw the distinction again. It is done so as to protect a professional man from having his reputation unjustly besmirched.' Compare *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771 (HL).

doubt. More pertinently, the lack of evidence on how the deceased was treated in hospital did not exclude gross negligence.

It is noteworthy that the presiding judge in *Ramosunya*, Jordaan AJ, expressed that his own views on the question of causality do not accord with those expressed by Hellens AJ in *Tembani*.⁴⁷ In particular, the judge stresses that it is clear from the authorities that where there is an intentional or gross negligent intervening event that changes the course of events so that the original act can no longer be regarded as the cause of death, then there is a *novus actus interveniens*. In his view a *novus actus interveniens* can either be a positive act, for example the administering of wrong medication, or an omission, such as failing to perform proper medical treatment. He further states, however, that if a person assaults another person by shooting him with a firearm he foresees that death as a direct result of the bullet could follow or; if the victim does not die, that medical treatment will be administered. It is within the ambit of human experience that medical science is not infallible and that death can result even from an assault not involving a vital organ — this is a common occurrence even after diligent medical treatment. Therefore, in each case the court must decide on the proven facts whether an event changed the course of events⁴⁸. Significantly, Jordaan AJ grades criminal medical negligence according to a standard of ‘gross negligence’.

It is submitted that Jordaan AJ’s judgment in *Ramosunya* affirms that medical interventions/omissions will only be construed as a *novus actus interveniens* if they are intentional or grossly negligent. In this regard his ruling is in line with the decision in *Tembani* — there is only a slight variance in the grading of the negligence: ‘gross’ negligence (*Ramosunya*) as opposed to ‘overwhelming’ negligence (*Tembani*). It is also significant that Jordaan AJ recognises, by implication, ‘medical misadventure’, expressed in the words: ‘... that death can result even from assault not involving a vital organ, even after diligent medical treatment’.⁴⁹ He also employs the test of adequate causation when considering that it is within the ambit of *human experience* that medical science is not infallible — echoing, in my opinion, the reality of medical misadventure. An analysis of the judgment in *Ramosunya* leads one to the inference that, were it not for the lack of evidence, the court would not have easily found the alleged medical negligence a *novus actus interveniens*, as the original stabbing of the victim by the accused was so serious that death could easily have ensued.

The finding of the Supreme Court of Appeal in *Counter* can be summarised as follows: the accused was the legal cause of the death of the deceased and there was no medical negligence on the part of the attending hospital

⁴⁷ Jordaan AJ in the court *a quo* of *S v Counter* supra (n17) as quoted in *S v Ramosunya* supra (n9) at 264-5.

⁴⁸ *S v Ramosunya* supra (n9) at 265.

⁴⁹ As stated in *S v Ramosunya* supra (n9) at 265.

staff and consequently no possibility of the presence of a *novus actus interveniens* on the proven facts. Although the court was referred to the *Ramosunya* judgment during legal argument, it is interesting to note that the case of *Tembani* was not referred to nor considered.⁵⁰ This is regrettable, as the Supreme Court of Appeal had the opportunity to rule conclusively on the reliance that was placed on English law as well as the grading of the criminal medical negligence. The Supreme Court of Appeal, in dismissing the argument that the attending hospital staff was negligent, rightly relied⁵¹ on the evidence of a medical expert who stated that the medical practitioners in question acted reasonably and that 'good [medical] practice requires conservative treatment first'.⁵² In applying the test for medical negligence the court ruled that there was no evidence that any other body of medical expertise would reasonably have discovered the anal wound earlier or would have treated the deceased with greater skill or different options.

The finding by the Supreme Court of Appeal that there was no medical negligence warrants, in hindsight⁵³, further scrutiny: it is significant that when the victim was admitted to hospital with the gunshot wound there was an entrance wound but no exit wound, indicative that the bullet was still lodged somewhere in the victim's body⁵⁴. It was the very fragments

⁵⁰ This can possibly be ascribed to the fact that Jordaan AJ in *Counter* (trial court) (supra (n47)) distanced himself from the views of Hellens AJ in *Tembani* (supra (n9)) and, that the Supreme Court of Appeal, by confirming the judgment of Jordaan AJ, by implication agreed with his views.

⁵¹ As to the criteria for the judicial acceptance for expert medical evidence see *Michael v Linksfeld Park Clinic* supra (n35) –in this case the Supreme Court of Appeal relied exclusively on English law (notably the case of *Bolito* supra (n46)) with regard to an action based on medical negligence. For a critical discussion of this case see Carstens 'Setting the Boundaries for Medical Expert Evidence in Defence or Support of Medical Negligence' (2002) *THRHR* 234; in general with regard to the assessment of expert evidence see also L Meintjies-Van der Walt 'Decision-maker's Dilemma: Evaluating Expert Evidence' 2000 *SACJ* 319.

⁵² *S v Counter* supra (n3) 152-3: 'Whereas some bacteria we can control with antibiotics, these germs are so strong that nothing will hold them back and the only way of curing is to cut away very deeply, like they have done in this lady, to get rid of the dead tissue ... That the responsible persons, unable to predict the presence of infection or its extent, chose the less invasive remedy is hardly to be wondered at'.

⁵³ The term 'in hindsight' is used respectfully here, as it is easy to be wise after the event. One is obviously bound by the reported facts as reflected in the law report and to speculate what the tendered evidence was or ought to have been can amount to conjecture. One is, however, permitted to question the inferences drawn from the proven facts.

⁵⁴ In this regard Burchell (2005) op cit (n2) 221 at (n82), which observes:

'One might be forgiven for wondering whether the fact that there was no exit wound, indicating that the bullet was still in the body of the deceased, that there was evidence of a stench from the wound and that the deceased died some two weeks later after the initial gunshot wound was inflicted, might not have indicated some negligence on the part of the medical personnel involved. One can only assume that the Court did not regard this conduct as constituting a sufficiently severe departure from the norm to warrant being classified as a *novus actus interveniens*'.

of the bullet which were deposited along the wound track that caused the infection to progress surreptitiously. The attending physicians testified that they nevertheless considered the victim to be in a stable condition and that no further exploration was necessary.⁵⁵ Further, a superficial examination of the victim's rectum was apparently performed by one of the physicians, although this was never recorded in the medical records due to an apparent distraction as there was an 'outbreak of firing' outside the casualty ward.⁵⁶ Even more surprising is the evidence of another attending physician who did perform several medical procedures on the victim and who was well aware of the presence of a deep-seated infection and ordered a full spectrum of antibiotics to be administered. Under his care the victim, in an unstable condition, was admitted to the intensive care unit, yet he did not visit the patient the following day. There were also no nursing charts covering that period until the patient's death.

The prosecution could produce no medical records for this period and no witnesses were called to cover this obvious gap.⁵⁷ One cannot help wondering whether the prosecution had discharged its onus of proof beyond reasonable doubt that there was no possibility of medical negligence and therefore no *novus actus interveniens*.⁵⁸ It could be that there was a possibility of medical negligence but that the court was just not prepared to make such a finding on policy considerations. Could it not be said that the version of the events placed before the court by the appellant, as borne out by the reported facts, was reasonably possibly true, in which instance he should have been given the benefit of the doubt as was the accused in *Ramosunya*? *Counter's* case can be seen as a classic example of medical misadventure possibly brought about by reasonable errors of medical judgement.

⁵⁵ *S v Counter* supra (n3) at para [9].

⁵⁶ *S v Counter* supra (n3) at para [10].

⁵⁷ *S v Counter* supra (n3) at paras [13], [14].

⁵⁸ Doubt may even exist as to the criminal capacity of the appellant at the time of the shooting as the record states (according to the case report) that the 'appellant smelled strongly of liquor, his eyes were bloodshot, and he was unsteady on his feet and, at the police station he struggled to furnish his name ... an experienced officer described him as "very drunk"...': *S v Counter* supra (n3) at para [6]. Criminal capacity is, however, not part of the causation enquiry.

It is respectfully submitted that the subtext of the judgment in *Counter* is indicative of what is well-known in comparable English law:⁵⁹ due to policy considerations there is a tendency of 'legal or judicial protectionism' in favour of the medical profession. By the direct or indirect application of legal protectionism the courts recognise that a finding of medical negligence, even in context of a *novus actus interveniens*, causes medical practitioners to practice defensive medicine to cover up their mistakes, and to feel aggrieved when they have been doing their best in stressful and medically compromised circumstances.

Ultimately this is the dilemma for the courts: if they do find that medical negligence was indeed a *novus actus interveniens* the attending health care professionals would then themselves be subject to a possible criminal prosecution on a charge of culpable homicide or a judicial inquest.⁶⁰ Alternatively, they could face a civil suit for damages or a disciplinary hearing for unprofessional conduct before the Health Professions Council of South Africa.⁶¹ In order to overcome this dilemma it appears the courts apply the flexible yardstick of 'policy considerations' to grade medical negligence so that only 'gross' or 'overwhelming' medical negligence would be regarded as a *novus actus interveniens*. This is despite the rule in South African criminal law that there are in principle no degrees of criminal negligence. This is the stance adopted in English law where it has been observed that for policy considerations it is inappropriate to criminally prosecute doctors who act with anything less than subjective recklessness.⁶² Significantly, in the assessment of medical negligence (whether civil or criminal) South African courts tend to rely exclusively on English precedent.⁶³

⁵⁹ See also authorities supra (n40). Also compare *Whitehouse v Jordan* supra (n46) at 658d: 'Take heed of what has happened in the United States. Medical malpractice cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor who is insured ... Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved' (per Lord Denning). See also Atiyah op cit (n40) 63: 'A professional man's reputation is publicly on trial when he is sued for negligence, and the presence of insurance does not alter this fact. So if it is the case that the ordinary law of negligence leans heavily in favour of plaintiffs because sympathy for the injured victim is so strong, ... there is no countervailing sympathy for the defendant [doctor]. In professional negligence cases, the interests of the defendant [doctor] are much more important, and perhaps therefore, they should be allowed to enter the scales against too ready a willingness to find negligence' (own emphasis). Although these pronouncements were made in respect of civil medical negligence, they also hold true for criminal medical negligence.

⁶⁰ In terms of the Inquests Act 58 of 1959, as amended. For a discussion of inquest proceedings in a medical context see Strauss op cit (n35) 436.

⁶¹ In terms of s42 of the Health Professions Act 56 of 1974, as amended in 1997.

⁶² McCall Smith op cit (n43) 135.

⁶³ As illustrated in *S v Tembani* supra (n9) and *Michael v Linksfield Park Clinic* supra (n35).

It is submitted that the judicial grading of medical negligence should be avoided when assessing whether medical negligence can be construed as a *novus actus interveniens*. Grading amounts to an artificial value judgement that is almost impossible to establish. When would medical negligence be gross or overwhelming⁶⁴ and how does a judge determine such judgments, specifically when these judgments are motivated by judicial reluctance to rule that subsequent medical negligence was indeed a *novus actus interveniens*? If an accused who inflicts a life-threatening wound upon a victim who consequently dies as a result of a medically compromised event (albeit not accompanied by gross or overwhelming negligence) will almost never be able to rely on the defence of *novus actus interveniens*, the rejected doctrine of *versari in re illicita*⁶⁵ would be revived under the guise of legal or judicial protectionism.

It is not submitted that an accused in such circumstances should be acquitted on the basis that the medical negligence was indeed a *novus actus interveniens*. The criticism is respectfully levelled at the approach, and in essence the unprincipled approach, courts apply to the rule that medical negligence (unless gross or overwhelming) ought not to be construed as a *novus actus interveniens*. *Tembani* is a prime example of this: faced with the finding that there was, in principle, medical negligence on the proven facts, the court simply ruled that the proven medical negligence was not overwhelming. An assessment whether medical negligence can be construed as a *novus actus interveniens* requires that a proper judicial determination is made of the existence of criminal medical negligence on the proven facts with reference to the relevant principles. This should entail that due consideration is given to the influence of professional errors of judgement and the possibility of medical misadventure on the proven facts.⁶⁶

In this regard there is much to be said for the views of McCall Smith,⁶⁷ who observes that the concept of medical negligence involves the application of an objectively determined standard against which conduct is measured. The way in which this standard is defined may not be related to a model of how doctors typically act or are statistically likely to act. Rather, the standard may be based on a notion of how a doctor should act if adverse consequences are to be avoided. A failure to meet this standard

⁶⁴ Compare *R v Meiring* supra (n37) at 41: 'What amount of negligence can be called "culpable", is a question of degree for the jury, depending on the circumstances. An unsatisfactory position indeed' (per Innes CJ quoting Sir Fitzjames Stephen). In English law adjectives such as 'serious', 'wanton', 'willful' or 'culpable' have also been used by the courts — see McCall Smith op cit (n43) 139.

⁶⁵ See *S v Bernardus* 1965 (3) SA 287 (A). See Burchell (2005) op cit (n2) 544-5: 'Courts must be vigilant in ensuring that the *versari* doctrine does not again surface, even in a disguised form.'

⁶⁶ Compare the discussion in paras 5.1-3 above.

⁶⁷ McCall Smith op cit (n43) 135.

does not necessarily involve moral culpability. Doctors are required daily to make delicate judgements and to exercise a high degree of skill. It is inevitable that even the most skilled and careful doctor will occasionally omit to do something which should have been done. These omissions and mistakes may amount to negligence according to the objective standard of care but do not necessarily reveal a careless attitude towards patients or victims of crime. Such errors are a statistically inevitable concomitant of ordinary human fallibility.

7. Conclusion

It appears that medical mishaps, often termed medical negligence, are really rather cases of medical misadventure or professional error of judgement, and therefore not medical negligence.⁶⁸ It is submitted that recent South African criminal case law,⁶⁹ on the proven facts, strongly suggests the presence of medical misadventure in the context of reasonable errors of professional judgement if regard is given to the medically compromised circumstances. In the assessment of medical negligence as a possible *novus actus interveniens*, instead of grading medical negligence by way of policy considerations, courts should rather make a principled assessment of criminal medical negligence, with due consideration to the concepts of medical misadventure and professional errors of judgement.

A principled assessment would entail that no distinction should be made between various degrees of negligence. More often than not a principled assessment will lead to a finding that there was no medical negligence and consequently no *novus actus interveniens*, even in the face of adverse consequences. Conversely, should a principled assessment on the proven facts be indicative of medical negligence, irrespective of the degree thereof, then a court ought to construe such medical negligence as a *novus actus interveniens*. The assessment of medical negligence as a possible *novus actus interveniens* also requires a strict adherence to the onus of proof in criminal cases. It is for the state to prove beyond reasonable doubt that there is an absence of a possible *novus actus interveniens*.⁷⁰ If it is proven that the medical negligence was indeed a *novus actus interveniens*, it stands to reason that the medical negligence in itself should then be the factual and legal cause of the death of the deceased.

⁶⁸ Could this not be said of the judgments in *Tembani* (supra (n9)) and *Counter* (supra (n3)) (although it was ruled in the latter case that there was no medical negligence)?

⁶⁹ With reference to *S v Tembani* supra (n9) and *S v Counter* supra (n3).

⁷⁰ As was the case in *S v Ramosunya* supra (n9).