Reportable:	*Yes/No*
Circulate to Judges:	*Yes/No*
Circulate to Magistrates:	*Yes/No*

IN THE HIGH COURT OF SOUTH AFRICA
(NORTHERN CAPE HIGH COURT, KIMBERLEY)

CASE NO.: 1744/2010
Date heard: 09-09-2016
Date delivered: 10-02-2017

In the matter between:

DALEEN ELS **Plaintiff**

And

MEC: DEPARTMENT OF HEALTH, NORTHERN CAPE **Defendant**

CORAM: WILLIAMS J:

J U D G M E N T

WILLIAMS J:

1. The plaintiff, Ms Daleen Els, instituted action against the defendant, the MEC: Department of Health, Northern Cape for damages resulting from the negligence of the employees of the Department of Health in the performance of their duties at the Kimberley Hospital. It is alleged that during the performance of an operation on the right breast of the plaintiff the tip of a needle/alternatively a foreign object had been left behind,

causing a continuous draining sinus which resulted in severe pain and led to numerous visits to doctors hospitals for medical treatment during the period September 2001 until 2009.

2. The defendant denies any negligence and pleads that plaintiff suffered from a pre-existing condition. Alternatively, should it be found that there was a foreign object in the right breast of the plaintiff, that such was not caused by the negligence of the defendant or any of its employees.

3. The parties agreed that the merits and quantum be separated and that the quantum stand over for later adjudication.

4. The plaintiff's problems started during 2001 when she felt a burning sensation in her right breast and discovered a lump. She was referred to the Kimberley Hospital by her general practioner during August 2001 where a fine needle aspiration was done which revealed the presence of inflammatory cells.

5. She was then booked for an open biopsy on 18 September 2001. The plaintiff testified that she had been hospitalised for five days after the open biopsy was performed but the hospital records indicate that she was discharged the following day on 19 September 2001. Be that as it may, the plaintiff says that she experienced terrible pain whilst recuperating at home and noticed that the wound was inflamed with a pussy discharge. During that time her GP attended to the wound and prescribed a different antibiotic – to no avail.

6. On 26 September 2001 the plaintiff returned to the Kimberley Hospital where the sutures were removed and she was given another course of antibiotics.
According to the plaintiff the wound on her right breast would improve for a while but then it would once again became inflamed, open up and become pussy.

7. During May 2002 she was admitted for the excision of subareolar ectatic ducts. After three days she was discharged and sent home with antibiotics. A week later the area became infected again and had a smelly discharge. She visited the GP, Dr Van Niekerk, again who helped to clean and treat the wound. She explained that the skin would eventually grow over the wound but that it would later again become inflamed and burst open.

8. During September 2002 she was back at the Kimberley Hospital with recurrent sepsis and was booked for a wedge excision of stitch sinus. About a week after her discharge the problem of inflammation and sepsis started up again. This time she visited a certain Dr Fischer in her home town of Jan Kempdorp who prescribed a strong antibiotic and cleaned the wound for her every day for about a week. Thereafter the situation improved for a while, but she never recovered fully.

9. At some stage thereafter the plaintiff moved to Bloemfontein. Whilst in Bloemfontein the problem with her right breast recurred. She was advised at the Bayswater Clinic in

Bloemfontein to make an appointment for a mammogram at the Universitas Hospital, Bloemfontein. She however moved back to Jan Kempdorp before she could arrange for a mammogram to be done.

10. Back in Jan Kempdorp the plaintiff developed an unrelated kidney problem for which she was referred to the Kimberley Hospital. At the time the right breast had developed sepsis again and she requested the doctors to attend to the breast as well. A certain Prof Theron was consulted and he then advised that she go for a mammogram.

11. A local diagnostic radiologist performed a bilateral digital mammography and the relevant portions of the report dated 5 November 2008 read as follows.

"There is a tiny metallic density foreign body in the right breast deep to the areola. ?Needle tip." and

Comment:
Benign breast changes. There is a small foreign body in the breast deep to the right areola. ? Significance in relation to the patient's symptoms."

12. Upon receipt of the mammography report the doctors at the Kimberley Hospital concluded that an excision of the foreign body be performed at the Kimberley Hospital. Due to a long waiting period before the operation could be performed and whilst experiencing constant pain, the plaintiff was eventually admitted to the Universitas Hospital in Bloemfontein where an

excision biopsy was performed on 31 July 2009. She was discharged on 3 August 2009 whereafter she experienced no further problems with her right breast.

13. The breast tissue containing the foreign body was preserved and handed to the plaintiff. It is common cause that a dissection of the excised tissue was later performed by Dr Blanco of the Kimberley Hospital in the presence of Dr Reynecke who attended on behalf of the plaintiff. It is also common cause that the foreign body was lost on the dissecting table, never to be recovered.

14. Both parties called expert witnesses as to the probable cause of the repeated abscess formation within the right breast of the plaintiff. On behalf of the plaintiff the testimony of Dr BH Pienaar, principal specialist and senior lecturer at the Department of Surgery, University of Pretoria, Steve Biko Academic Hospital was presented. The defendant called as an expert Dr I Boeddinghaus, a general practitioner whose practice specialises in both benign and malignant diseases of the breast. The defendant also called Dr R Blanco, who in terms of an expert notice and summary under Rule 36 (9)(a) and (b) was to give evidence as an expert witness in his capacity as a general surgeon. Mr Motloung who appeared for the defendant indicated however, that his evidence was not presented as that of an expert but merely related to the period that he treated the plaintiff at the Kimberley Hospital. I allowed the evidence to be led on this basis.

15. It is convenient to deal with the evidence of Dr Blanco first. Initially during examination-in-chief Dr Blanco testified that he had seen the plaintiff in the consultation department on her second visit to the hospital when the cytology report (following upon the fine needle aspiration procedure) was still outstanding. At that time, according to Dr Blanco, she presented with a painful breast. The impression was created that he had personal knowledge of the plaintiff's condition and had in fact been involved in the treatment of the plaintiff. It must be remembered that this trial took place 15 years after the plaintiff's initial visit to the hospital and 7 years after her last, with the result – which is completely understandable – that she could not testify as to the exact dates of her hospital visits or procedures or which doctors had treated her there, with the exception of Prof Theron, whom she mentioned by name.

16. Dr Blanco proceeded to give evidence *inter alia* on the various procedures performed on the plaintiff at the hospital, the high quality of the needles used during such procedures, the unlikelihood of a needle breaking off during such procedures and that it was in any event not probable that a minute object of metallic origin as described in the mammogram report would cause the problems experienced by the plaintiff. He in any event disputes the existence of a metallic object, contrary to his summary.

17. During cross-examination however Dr Blanco, most astoundingly and of his own accord, stated that he had never

treated or seen the plaintiff before performing the dissection of the preserved breast tissue. The basis on which his evidence was introduced was thus at the very least misleading. His evidence was of an expert nature without having qualified himself as such. The question is then – what value can be attached to his evidence? The simple answer is – none. The notices in terms of Rule 36 (9) (a) and (b) make no mention of Dr Blanco's qualifications (even if it did, it has no evidential value) and he has not testified to his qualifications at all. This failure is fatal and his evidence relating to the matter at hand therefore remains mere opinion evidence which is irrelevant. See *Mkhize vs Lourens* 2003(3) SA 292 (T) at 299 C-G. In my view the issue of the probable cause of the plaintiff's complaint can and should be adjudicated without having recourse to the evidence of Dr Blanco at all.

18. This then brings me back to the expert evidence properly before court. Dr Pienaar and Dr Boeddinghaus hold divergent views of the cause of the plaintiff's continuous draining abscess. Dr Pienaar is of the view that the condition was caused by the tip of a surgical needle left behind after an operation, while Dr Boeddinghaus holds the view that the plaintiff presents with a case of periductal mastitis caused by her smoking habit. (Plaintiff admits to smoking a packet of cigarettes a day since she left school)

19. The two experts do however agree *"that a foreign body that is left behind during a surgical procedure by the operating team*

constitutes negligent action on their part" and that the antibiotics given at the Kimberley Hospital were not good enough to manage the infection which had set in. These points of agreement are contained in a joint minute of the experts. During their evidence it also became clear that they agreed that it is improbable that a tip of a needle would have broken off during the fine needle aspiration procedure, which was initially performed on the plaintiff to draw cells from the right breast for cytology (essentially the testing of cells).

20. I deal firstly with the evidence of Dr Pienaar who, in addition to his regular duties, sits on a procurement committee which regularly inspects and assesses the quality of medical materials imported to South Africa. His evidence was that with cost constraints and other prohibitions the quality of surgical material used by the various Health Departments are often found to be inferior and that breakages occur. Breakages also occur due to improper handling of needles since surgical needles also naturally have certain weaker points. Be that as it may, breakages of surgical needles are not uncommon, but it is imperative once a breakage has occurred during a procedure to first attempt to visually establish the location of the broken piece and remove it. If not possible, there are other methods to extract a metallic object, such as an electro-magnet or a screening x-ray machine could be used to locate the missing object. Should a foreign body be left behind in the tissue of a patient it may delay healing since infection could set in.

21. Dr Pienaar's evidence was further that the surgeon will usually know when the tip of a surgical needle has broken since it would be difficult to proceed with a blunt needle. The broken needle would normally be put aside and a new one used. In any event there is an absolute protocol to be followed to guard against any mistakes. All instruments and swabs need to be counted before a surgery, during the procedure (depending on the length of the operation) and at the end of the procedure. All needles should be accounted for and be intact. Should an instrument break during a procedure a note has to be made of it. What was particularly disturbing to him was the fact that none of the theatre notes relating to the surgeries performed on the plaintiff at the Kimberley Hospital reflected that an instrument and swab count had been done. In fact there was no theatre report relating to the open biopsy of 18 September 2001. According to Dr Pienaar, in the medical world it can be accepted that if something is not written down it was not done. In sharp contrast hereto the theatre report for the excision of the foreign body done at the Universitas Hospital on 31 July 2009, records that instrument, needle and swab counts were done before, during and after the operation and was signed by the theatre sisters in attendance.

22. According to Dr Pienaar the reasons for developing a mass in the breast are numerous, but for a woman aged 25 years the most likely cause would be fibrocystic disease (due to hormonal changes) which could then develop into duct ectasia or periductal mastitis. The course of treatment would firstly be to

send the patient for a sonar (a mammogram not being advisable in a patient so young), thereafter a fine needle aspiration and depending on the result thereof, a biopsy.

23. The open biopsy performed on the plaintiff on 18 September 2001 involved only part of the mass being removed, ie an incision biopsy as opposed to an excision biopsy where the whole mass is removed. Because tissue is cut during the procedure it would be standard practice to use sutures in that area to contain bleeding. Sutures would also be used in the subsequent excision operations performed at the Kimberley Hospital.

24. It is Dr Pienaar's evidence that sepsis after an operation is an accepted and recognised complication. However should the problem persist as happened *in casu,* a further meticulous work-up should be instituted, looking for other causes *inter alia* diabetes, cancer, tuberculosis and HIV. A microscopic examination of the discharge fluid to identify the organisms contained in it, in order to prescribe the correct antibiotic, should also be done. X-rays, sonars and finaly a mammogram should also be done in order to identify the cause of the problem. In Dr Pienaar's view the fact that a mammogram was only ordered during 2008 speaks of a lack of care.

25. According to Dr Pienaar, the x-ray taken at Universitas Hospital on 31 July 2009, prior to the excision of the foreign object, shows what looks exactly like the tip of a surgical needle

broken off about 1 mm from where the tapering of the needle stops. He estimates the tip of the needle on the x-ray to be between ½mm to 1mm thick and 2 mm to 4 mm in length, depending on the size of the surgical needle used. Since there is no evidence of any other surgery performed on the right breast of the plaintiff (except for the removal of the foreign body) other than that done at the Kimberley Hospital, Dr Pienaar is of the opinion that the needle tip left behind in the breast of the plaintiff originated from the Kimberly Hospital and most likely occurred during the open biopsy of 18 September 2001.

26. He explains that it is a well known surgical fact that the presence of a foreign body will prevent the resolution of a septic process and especially so where there is a sinus or fistula present. A foreign body in either of these could be a major factor in the healing process. Bacteria could hide in the crevices of a foreign body and particularly so in the irregular, uneven surface where the break in the needle occurred. The size of the foreign body does not matter since even one or two microbes could cause an infection. Dr Pienaar explains that the foreign object and microbes could at times become encapsulated by the surrounding tissue, but sudden movement or a bump against the affected area could release the microbes which would then result in the sepsis experienced by the plaintiff. This phenomenon would also explain the periods of healing and rupture experienced by the plaintiff.

27. As stated above Dr Pienaar is of the view that the needle tip was most likely left in the breast of the plaintiff during the open biopsy of 18 September 2001 since the sepsis and continuous draining of the breast started occurring after this operation. Had a sonar been done when the sepsis recurred, it is extremely likely that the sonar would have shown the foreign object long before the mammogram was ordered.

28. Commenting on the opinion of Dr Boeddinghaus, that the ongoing breast problem of the plaintiff was as a result of periductal mastitis due to smoking, Dr Pienaar is of the opinion that; (i) it is extremely rare that periductal mastitis will cause a continuous sinus; (ii) the left breast would also have been affected had that been the case and (iii) the excision of the foreign body would not have resulted in the healing of the breast since the plaintiff has continued to smoke even after the excision of the foreign body.

29. Dr Boeddinghaus states that periductal mastitis is often incorrectly referred to as duct ectasia as is reflected in the hospital notes/records pertaining to the plaintiff. According to Dr Boeddinghaus periductal mastitis is characterised by inflammation around the areola which often leads to abscess formation. The abscess bursts and leads to a continued leakage of puss which then forms a fistula. Periductal mastitis is a condition which flares up and recovers with no underlying cancer or malignancy. It is classically seen in younger women and is strongly associated with smoking. In fact Dr

Boeddinghaus' testimony is that in her practice she's only seen the condition in smokers. I hasten to add that Dr Boeddinghaus testified that she does not see the condition frequently and over the 15 to 16 years that she has dealt with diseases of the breast she has seen about 20 to 30 cases of periductal mastitis.

30. With periductal mastitis there are loads of inflammatory cells and bacterial pathogens – specifically gram negative bacteria, which can only be treated with an antibiotic specifically targeting gram negative bacteria. The treatment for periductal mastitis would be surgery to excise the affected tissue and/or treatment with gram negative antibiotics. Even with such treatment however there is a high chance of recurrence should the patient continue smoking.

31. Duct ectasia on the other hand is a condition which occurs in older women, and although outwardly it would appear to have similar symptoms to periductal mastitis, for example a cheesy discharge from the nipple and retracted nipples, excision of the offending area and antibiotic treatment would normally suffice. What should be done in cases of periductal mastitis is that the patient be counselled against smoking, which leads to recurrence and which the Kimberley Hospital apparently failed to do.

32. Dr Boeddinghaus' view of the treatment received by the plaintiff at the Kimberley Hospital can be summed up as follows: (i)it is not uncommon for periductal mastitis to be referred to as duct

ectasia; (ii)the operations performed were in accordance with sound medical practise even though sepsis recurred, since recurrence is in keeping with the plaintiff's continued smoking; iii) the antibiotics prescribed by the Kimberley Hospital, even though ineffective against periductal mastitis (it being gram positive antibiotics) are not necessarily a sign of negligent treatment since the correct antibiotics would also not necessarily lead to the resolution of the condition; and (iv) she would also not have done a mammogram on the plaintiff sooner since it is painful, does not give much information in the case of young women since their breasts have denser tissue, and should therefore be used with caution.

33. As to the effect of a foreign body left behind in the breast of the plaintiff, the opinion of Dr Boeddinghaus is that the foreign body would not have altered the course of the periductal mastitis. That she had inserted even larger metal foreign bodies into women's breasts (during the course of treatment) without any problems. The fact that the plaintiff's condition cleared up after the excision of the foreign body is, according to Dr Boeddinghaus, merely coincidental. The fact that a large portion of tissue was removed on that occasion, coupled with the correct gram negative antibiotic treatment is what according to Dr Boeddinghaus led to the plaintiff being free of sepsis for the last seven years. The condition may however recur in future if the plaintiff does not stop smoking.

34. I have no hesitation in accepting the plaintiff's version of the pain and suffering she had to endure over the years. Her lapse in memory as to the specific dates, duration of hospital stays and physicians who attended to her is completely understandable and is in any event clarified by the hospital records and notes pertaining to her treatment. What she has to prove in order to be successful in her claim is two-fold. Firstly, whether the foreign body was left behind by the employees of the Kimberley Hospital during one of the procedures performed by them and secondly, whether the ongoing problems with her right breast were caused by the foreign body.

35. According to the plaintiff the problems of inflammation, abscesses and continuous draining of the right breast started after the open biopsy procedure of 18 September 2001 and continued with periods of flare-ups and recovery until the excision of the foreign body in July 2009. Before this operation, no other person beside the employees of the Kimberley Hospital performed any procedure or worked inside her right breast. She herself did not insert any foreign object into her right breast.

36. A foreign body of *"metallic density"* was found to be present in the right breast of the plaintiff *"deep to the areola"* according to the mammography report of 2008. The radiologist queried the possibility of it being a needle tip. Dr Pienaar, with his years of experience as a surgeon and knowledge of the different types of needles used, expressed no doubt that what he saw on the

x-ray of the plaintiff's right breast was a surgical needle tip, even describing it as having broken off about I mm from where the tapering of the needle stops. According to Dr Pienaar, sutures are used when an open biopsy is performed, requiring the use of a surgical needle. A theatre report would have to be filled out. Since no theatre report could be found in the Kimberley Hospital records the result is that none of the Kimberley Hospital employees involved would be able to assert positively that a needle tip had not been left behind.

37. Mr Motloung argued that since the foreign body disappeared on the dissecting table and the nature thereof could not be confirmed the plaintiff has failed to make out a case that the foreign body emanated from the Kimberley Hospital. I cannot agree with this contention. The mammography report which indicates an object of metallic density has never been disputed. No other plausible way of introduction of such an object into the breast of the plaintiff has been suggested by the defendant. The evidence presented by the plaintiff and Dr Pienaar and pure logic dictates that the foreign object on a balance of probabilities was the tip of a surgical needle left behind by the employees of the Kimberley Hospital during an operation on the right breast of the plaintiff.

38. What falls to be determined next is whether plaintiff has succeeded in proving that the needle tip left behind in her breast was the cause of all her problems. In this regard there are two divergent expert opinions. In such a case it is helpful to

look at the approach adopted in *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001(3) SA 1188 SCA, where the court held that:

". . . it is perhaps as well to re-emphasise that the question of reasonableness and negligence is one for the court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court's reaching its own conclusion on the issues raised."

*". . . what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of Bolitho v City and Hackney Health Authority **[1997] UKHL 46**; **[1998] AC 232** (H.L.(E.)). With the relevant dicta in the speech of Lord Browne-Wilkinson we respectfully agree. Summarised, they are to the following effect.*

***[37]** The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached "a defensible conclusion" (at 241 G - 242 B).*

***[38]** If a body of professional opinion overlooks an obvious risk which could have been guarded against it will not be reasonable, even if almost universally held (at 242 H).*

***[39]** A defendant can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of withstanding logical analysis and is therefore not*

reasonable. However, it will very seldom be right to conclude that views genuinely held by a competent expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide "the benchmark by reference to which the defendant's conduct falls to be assessed" (at 243 A-E)."

39. The opinion of an expert should also be based on the accepted facts otherwise it would amount to no more than unsubstantiated speculation. It is here that the problem with Dr Boeddinghaus' opinion starts. She bases her diagnosis of the plaintiff's condition on the fact that she was a young smoker who presented at her first visit to the Kimberley Hospital with a lump in the breast, an inverted nipple and nipple discharge. The fact is though that the plaintiff did not have a nipple discharge. The relevant hospital note of 8 August 2001 states *"no discharge"*. The following hospital note dated 22 August 2001 also states *"no nipple discharge"*. The discharge from the right breast started up only after the open biopsy of 18 September 2001 and drained through the sub-areolar area. The only reference to a nipple discharge is to be found in the out-patient notes of 5 March 2002 which reads. *"Bly dreineer by regter tepel uit - bloederig, etterig. ? Buis ektasie. Vra Prof Theron om te sien"* However Prof Theron's note, on 16 May 2002 reads *"Recurrent sepsis/abscess of rt subareolar ectatic ducts"*. There is no mention of a discharge through the nipple.

40. The further problem is that Dr Boeddinghaus describes periductal mastitis as a condition distinguishable from duct ectasia or other abscess formation in that it is characterised by the presence in the breast tissue of large amounts of inflammatory cells and a variety of different bacterial pathogens not seen in duct ectasia or a straightforward abscessed infection. These inflammation cells and bacteria present in cases of perdicutal mastitis would be visible under a microscope. The cytological examination done after the fine needle aspiration procedure on the plaintiff showed only inflammation cells. Whether or not such an examination would reveal the presence of bacteria of the type testified to by Dr Boeddinghaus has not been traversed with either of the experts. However after the open biopsy performed on the plaintiff, a histology report was called for in order to get a more comprehensive analysis of the excised breast tissue. This report, and it appears to be the only histology done, from the South African Institute for Medical Research, Kimberley Laboratory, states that the histological sections show breast tissue with florid duct ectasia. The diagnosis reads *"Breast biopsy – Florid duct ectasia with signs of duct rupture, no tumour found"*. Dr Boeddinghaus' explanation of the diagnosis being duct ectasia and not periductal mastitis was once again that these terms are often incorrectly used interchangeably and that a diagnosis of periductal mastitis is not purely histological. That the histological finding of duct ectasia and inflammation plus the clinical symptoms of the plaintiff point to periductal mastitis.

41. This explanation by Dr Boeddinghaus is in my view not satisfactory, firstly since one of the symptoms (nipple discharge) on which her clinical finding is made did not exist, at the very least not as a pre-existing condition and secondly, it is difficult to conceive of the notion that the compiler of the histology report, which I think it fairly safe to assume was a professional, qualified in his/her field (the name at the bottom of the report is given as Prof Beukes) would misdiagnose the condition of periductal mastitis, a condition so markedly different in its cellular composition and treatment, as duct ectasia.

42. In fact none of the medical practioners who attended to the plaintiff over the years have made the diagnosis of periductal mastitis. This diagnosis came to light for the first time in Dr Boeddinghaus' report dated 28 April 2015, which opportunistically, in my view, prompted a defence which was never medically indicated at the relevant time of treatment.

43. Equally unconvincing is Dr Boeddinghaus' explanation for the clearing up of the condition after the operation for the removal of the foreign body. One of her reasons given was that a large chunk of tissue had been removed at that stage – and therefore by inference that a complete excision of the affected area could have ensued. There is however nothing in the notes of the Universitas Hospital to indicate that a large chunk of tissue had been removed. The operation was in fact done with the help of a stereotactic marker which was used to pin-point the exact

location of the foreign body. There would in my view be no need, the purpose of the operation being to remove the foreign body, to excise any more tissue than what was necessary to remove the foreign body.

44. I have in the circumstances no hesitation in accepting the evidence of Dr Pienaar above that of Dr Boeddinghaus. Dr Pienaar is a vastly experience medical specialist and lecturer with more than 20 years experience in private surgical practice. He has seen and treated patients with breast problems for the last 30 years. His evidence was clear, well-balanced, took into account all the relevant considerations and is founded on logical reasoning. Dr Boeddinghaus on the other hand admitted to seeing relatively few cases of periductal mastitis over the course of her career. She could not explain how smoking contributed to the condition except for her statement that there is a strong correlation between smoking and periductal mastitis. Her diagnosis stands unsupported by any of the practitioners involved in the treatment of the plaintiff, or the hospital records of the plaintiff. Dr Boeddinghaus' refusal to acknowledge any possible detrimental effect that a foreign body left behind in the breast of the plaintiff could have had, is to my mind a clear indication of the fact that she is not an independent witness. The view I hold of the lack of independence of Dr Boeddinghaus, is confirmed by her reluctance to concede, on the basis of her diagnosis, that the employees of the Kimberley Hospital had misdiagnosed the

condition as duct ectasia and had as a result prescribed the wrong antibiotics.

45. In the circumstances I am of the view that the plaintiff has succeeded in proving on a balance of probabilities that the recurring problem of the right breast suffered by her from September 2001 until July 2009 was caused by the presence of the foreign body, which in all likelihood was a needle tip, left behind during the open biopsy of 18 September 2001.

46. That brings be to the issue of costs. There is no reason why costs should not follow the result, however there were two prior postponements of this matter which counsel could not meaningfully address me on. I directed that the attorneys file affidavits in this regard. What can be gleaned from these affidavits follows.

47. The trial was initially set down for 11, 12 and 13 September 2012. Prior thereto and on 15 August 2012, the plaintiff served on the defendant a notice in terms of Rule 36(10) informing that she intends to tender the needle tip which was removed from her breast in evidence, offering inspection thereof and requiring the defendant to admit same within ten days of the notice. No response was forthcoming from the defendant and the parties proceeded to trial where on 11 September 2012 the defendant's legal representatives requested that Dr Blanco inspect the needle point before the evidence of the plaintiff's expert Dr Reynecke, be presented in this regard. What

transpired then was that the plaintiff produced not just the needle tip, but the preserved excised breast tissue in which the needle tip was encased. Defendant's attorney explains that they were taken by surprise since the notice only mentioned a needle tip and not that it was still encased in tissue. Defendant objected to the production in evidence of the tissue without first establishing the presence of a needle tip therein and insisted on a dissection of the tissue. This in turn required arrangements to be made for the use of proper facilities at the Kimberley Hospital, which could not be done on that day, which apparently was the only day that Dr Reynecke was available. In the end the trial was postponed to 25, 26 and 27 March 2013 with the issue of costs to stand over for later determination.

48. The plaintiff is of the view that the postponement was caused by the defendant in that there was no objection to the Rule 36(10) notice and had the defendant called for an inspection of the needle tip timeously, the postponement would not have been necessary. The defendant is of the view on the other hand that the plaintiff has attempted a trial by ambush, that they were led to believe that the plaintiff was to present the needle tip in evidence, which they had no objection to, and that they were entitled when presented with the piece of tissue, to establish whether the tissue contained the alleged needle tip.

49. In my view the blame for the postponement on 11 September 2012 lies squarely at the door of the plaintiff. The Rule 36(10) notice states that *"die Eiseres van voorneme is om die*

naaldpunt wat van haar bors verwyder is as getuienis aan te bied en die naaldpunt ter insae aanbied by die kantore van die Eiseres se prokureur." It does not at all mention that the needle tip was still encased in tissue. Defendant was entitled to assume that what was to be presented in evidence was the needle tip. Defendant was also entitled to object to the presentation of the tissue as being the needle tip removed from the breast of the plaintiff.

In my view the plaintiff should bear the wasted costs occasioned by the postponement on 11 September 2012.

50. The dissection of the breast tissue took place on 27 February 2013. Thereafter on 1 March 2013 the defendant delivered a notice of intention to amend the plea. The plaintiff's attorney maintains that the proposed amendments would have effected substantial changes to the defence and that it would not have been possible for the plaintiff, in the time remaining before the trial, to prepare to meet the new allegations therein contained or oppose the proposed amendment or deal otherwise with the proposed amendment within the time limits prescribed by the Rules. To further complicate matters the defendant had filed a request for further particulars in terms of Rule 21 on 25 February 2013, two days late. The upshot was that the parties agreed that the trial enrolled for 25, 26 and 27 March 2013 be removed from the roll on 14 March 2013 and that the costs relating to such removal be argued later.

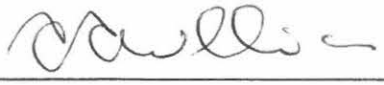
51. It is clear from the above that the removal from the roll of this matter on 14 March 2013 was caused by the defendant's late filing of notices for which there can be no excuse since the trial was by agreement postponed to the specific dates during March 2013. Whatever costs have been occasioned by the removal from the roll should therefore be borne by the defendant.

In the circumstances the following orders are made:

a) Judgment is granted in favour of the plaintiff on the merits.

b) The defendant is ordered to pay the plaintiff such damages as either agreed upon or the plaintiff may prove.

c) The defendant is ordered to pay the plaintiff's costs for proving her case on the merits, inclusive of the qualifying fees of Dr B Pienaar and the costs relating to the removal of this matter from the roll on 14 March 2013, but excluding the costs occasioned by the postponement on 11 September 2012, for which costs the plaintiff is liable.



CC WILLIAMS

JUDGE

For Plaintiff :	Adv.C Botha
	Elliot, Maris Wilmans & Hay
For Defendant:	Adv. S Motloung
	Office of the State Attorney