- *Sampson v MEC for Health, Western Cape* 2025

- The Western Cape High Court held the defendant negligent for failing to perform timely follow-up diagnostic imaging after a gunshot wound, which led to the delayed diagnosis of a severe renal injury and the eventual removal of the plaintiff's kidney.

Case Overview

- **Parties:** LA Sampson (Plaintiff) v The MEC for Health, Western Cape Provincial Department of Health (Defendant).
- **Date of Incident:** 1 January 2020.
- **Judgment Date:** 6 February 2025 (with a subsequent leave to appeal dismissed on 11 April 2025).
- **Forum:** Western Cape High Court, Cape Town (Before Van den Berg AJ)

Key Facts - The Injury:

- Mr LA Sampson, a 55-year-old resident of Mitchells Plain, attended a New Year's Eve party to celebrate the beginning of 2020.
- As he was leaving the celebration, he was shot in the back by an unknown assailant.
- The bullet entered his lower back on the left-hand side and exited through his upper abdomen.
- He was admitted to the emergency unit at MPH, where he underwent emergency, life-saving surgery performed by Dr Moodley, addressing life-threatening injuries from bleeding mesenteric vessels and contamination from the perforated bowel.
- There was a non-expanding retroperitoneal haematoma (left kidney) not explored at that stage.

- On 3 January 2020, the plaintiff discharged himself from MPH because he was not satisfied with the treatment he received.
- He tried to obtain treatment at a private hospital in Rondebosch but was unable to afford the fees, so he returned to MPH sometime during the 4th of January 2020.
- On 4 January 2020, blood tests showed a slight drop in haemoglobin and slightly decreased renal function.
- Blood cultures showed no growth.
- On 5 January 2020 the plaintiff was in pain and had a tachycardia with a spiking temperature.
- His abdomen was distended, and serous fluid was draining from the wound.

- On 6 January 2020, a diagnosis of acute kidney injury (“AKI”) was made.
- On 9 January 2020, the plaintiff returned to the MPH and complained of abdominal tightness.
- The plaintiff was given pain medication and instructed to return two weeks later.

- On 10 January 2020, the plaintiff returned to the MPH and was seen by Dr Moodley and readmitted.
- The plaintiff was tachycardic and had a slightly lowered haemoglobin and abdominal distention.
- Fluid was still draining from the wound site.
- The plaintiff was placed on antibiotic medication.
- The plaintiff was referred for a contrast CT scan, which showed a large collection of fluid.
- Hereafter, the plaintiff was referred to Groote Schuur Hospital for a percutaneous drainage of the collection of fluid.

- On 12 January 2020, the plaintiff underwent the percutaneous drainage procedure at GSH.
- CT scan confirmed that there was active extravasation from the renal collecting system with a collection of fluid around the left kidney. The fluid was sent for testing.
- On 16 January, the plaintiff underwent a further procedure at GSH to insert a stent in the left kidney in the form of a cystoscopy, a left retrograde pyelogram, and insertion of a stent.
- The plaintiff was transferred back to the MPH.

- On 16 January 2020, the plaintiff was readmitted to the Urology Department at GSH.
- On 21 January 2020, the plaintiff was taken back to theatre and underwent the surgical removal of his left kidney, as it could not be saved, due to the extensive damage to it.
- On 28 January 2020, the plaintiff was discharged with instructions to attend follow-ups at the urology outpatient department and the day hospital.

Key Facts - The Omission:

- The surgeon noted a non-expanding renal haematoma (blood clot in or around the kidney) but failed to order or carry out timely follow-up CT imaging by 6 January 2020.

Key Facts - The Complication:

- The failure to diagnose a grade-4 renal pelvis injury caused a severe infection and necessitated the surgical removal (nephrectomy) of the plaintiff's left kidney on 21 January 2020.

Conflicting Expert Opinions

- Dr Plani and Prof Bosman differed in their opinions regarding the treatment of the non-expanding renal haematoma due to GSW.
- Dr Plani (expert for the plaintiff) testified that the hospital breached its duty of care by failing to conduct timely follow-up diagnostic imaging by 6 January 2020.
- Prof Bosman (expert for the defence) differed and was of the opinion that initial conservative management of the haematoma was in line with standard care and acceptable medical practices, and the later complications were in any case unavoidable.

The Judge's opinion

- A conflict in the expert opinion may lie in the analysis of the established facts and the inferences drawn therefrom by opposing expert witnesses.
- This requires an assessment of the rationality and internal consistency of the evidence of each of the expert witnesses.
- "The cogency of an expert opinion depends on its consistency with proven facts and on the reasoning by which the conclusion is reached."

- It is ultimately the task of a Court to determine the probated value of expert evidence placed before it and to make its own finding with regard to the issues raised.
- Faced with a conflict in the expert testimony, the Court is required to justify its preference for one opinion over another by a careful and critical evaluation thereof.

Evaluation, Reasons and Judgment

- The following three issues had to be decided:
- The factual cause of the injury being the removal of the plaintiff's kidney;
- Negligence, and
- Causation

Ruling and Outcome

- **Negligence and Causation:** The court found the medical staff negligent for the delay in diagnostic imaging, which directly caused the delayed treatment and loss of the kidney.
- **Liability:** The defendant was held 100% liable for the plaintiff's proven damages, alongside legal costs.
- **Appeal Dismissal:** The MEC's subsequent application for leave to appeal was dismissed with costs on scale C on 11 April 2025, the court finding no reasonable prospects of success on appeal.

Medicolegal Lessons

Recognizing a Risk Demands an Actionable Plan

- The court emphasized that identifying a potential complication during surgery creates a proactive duty of care to investigate it.
- The operating doctor documented a "non-expanding retroperitoneal haematoma".
- While not exploring it surgically at that exact moment was standard practice, leaving it completely unmonitored without scheduling targeted, timeous follow-up imaging constituted actionable negligence.
- **If a clinical risk is recognized, a concrete timeline to investigate or address it must be instituted.**

Emergency Interventions Do Not Terminate the Duty of Care

- A successful life-saving operation does not absolve healthcare professionals from subsequent postoperative vigilance.
- Courts scrutinize the continuity of care and postoperative decision-making just as stringently as they do the emergency procedure itself.
- Diagnostic protocols must be followed to completion until the patient is fully stabilized or appropriately transferred.

Clear Communication on Diagnostic Timelines is Vital

- The hospital contended that the patient left the hospital against medical advice (or failed to return), complicating the continuity of care.
- However, the legal chain of causation remains intact if the medical facility fails to properly inform the patient of the critical necessity and strict urgency of diagnostic tests like a CT scan.
- Medical staff must clearly communicate, document, and schedule vital follow-up investigations so patients understand the direct risks of non-compliance.

Objective Scrutiny of Expert Witness Logic

- Reaffirming established legal precedents like *Michael v Linksfield Park Clinic*, the court highlighted that a defendant cannot avoid liability simply because an expert claims a practice was "acceptable".
- The judge must evaluate whether the expert's reasoning withstands logical analysis.
- In this case, trying to justify the omission of definitive imaging in a high-risk trauma case failed to satisfy the legal test for reasonable care.

