IN THE HIGH COURT OF SOUTH AFRICA
KWAZULU-NATAL LOCAL DIVISION, DURBAN

Reportable/Not Reportable

Case no: 9605/2016

In the matter between:

B[....]2 M[....]	First Plaintiff
H[....] B[....] M[....]	Second Plaintiff

and

THE MEC FOR HEALTH FOR THE PROVINCE OF KWAZULU-NATAL	Defendant

Coram: ME NKOSI J

Heard: 22, 23, 24 & 26 August 2022, and 14 September 2022

Delivered: 16 September 2022

ORDER

The following order shall issue:

1. The defendant is directed to pay to the first plaintiff in her personal capacity and in her representative capacity as mother and natural guardian of her minor child, G[....] B[....] M[....], a girl born on 25 May 2009 and in her capacity as executrix of her deceased child, Welcome B[....] M[....], who passed away on 1 January 2018 and to the second plaintiff, such damages as may be proved or agreed for their claims for loss of support as a result of the death of M[....]2 C[....] M[....] who died on 19 May 2014.

2. The defendant is directed to make payment of the plaintiffs taxed or agreed party and party costs on the high court scale, which costs shall include all reserved costs, the costs of plaintiffs' counsel, such to include the costs of preparation for trial, preparation of heads of argument and for attending upon any necessary consultations with the undermentioned expert witnesses and the fees and expenses reasonably incurred by the undermentioned expert witnesses for qualifying themselves and reserving themselves for trial and attending at trial (where applicable) and for the preparation of their reports, joint minutes (where applicable), and attending upon any necessary consultations with the plaintiffs' counsel and attorney (with the quantum of their fees, if any, to be determined by the taxing master) namely: -

2.1 Dr G Perumal, Specialist Forensic Pathologist

2.2 Dr E Hodgson, Specialist Anaesthesiologist

2.3 Dr A Osman, Orthopaedic Surgeon

2.4 Dr P Matley, Vascular Surgeon

JUDGMENT

ME Nkosi J

Introduction

[1] This is an action in which the first and second plaintiffs lodged a claim for loss of support against the defendant arising out of the death of M[....]2 C[....] M[....] ("the deceased") after he was admitted to King Edward VIII Hospital ("the hospital") for treatment of a compound fracture of his left femur that he had sustained at his workplace on 14 May 2014 when a stack of pallets fell onto him. The first plaintiff sued in her personal capacity as the wife of the deceased, as well as in her representative capacity as the mother and natural guardian of her two minor children, namely, Welcome B[....] M[....], a boy born on 28 July 2004, and G[....] B[....] M[....], a girl born on 25 May 2009 ("the minor children"). The second plaintiff sues in her personal capacity as a biological child and a dependant of the deceased.

Factual background

[2] By way of background, it is common cause that after the admission of the deceased to the hospital on Wednesday, 14 May 2014, he was taken to theatre on the same date for the wound debridement and a definitive fracture fixation by the insertion of a femoral nail. However, although the debridement of the wound was performed on that date, the femoral nail was not inserted due to the malfunction of the X-ray screening equipment described as the C- arm image intensifier. Instead, he was sent back to the ward and his left leg was placed in a Thomas Splint and a below-knee skin traction in order to stabilise the wound pending his surgery for the insertion of a femoral nail in his left leg.

[3] According to the hospital records submitted in relation to this matter the deceased was next seen by the hospital staff on Thursday, 15 May 2014. It is recorded in their history and progress notes that they attended to the dressing of his wound and re-booked him for the nailing surgery on Saturday, 17 May 2014. However, according to the next entry made on Friday, 16 May 2014, the deceased's booking for the nailing surgery was moved to Monday, 19 May 2014. No other entry was made in the hospital records on that date.

[4] On 19 May 2014, the definitive fracture fixation operation was finally performed on the deceased. The femoral nail was successfully inserted into his left leg during an uneventful operation which lasted for three hours. After the operation, the deceased was sent back to the ward awake and was talking. However, shortly thereafter his condition had suddenly deteriorated. Attempts were made to resuscitate him but without success. He was declared dead at 3.20 pm on 19 May 2014.

[5] According to the post-mortem examination report compiled by Dr G Perumal, who is a Specialist Forensic Pathologist, the cause of the deceased's death was pulmonary thrombo-embolus, which resulted from a large thrombus in the left and right pulmonary arteries. Dr B Pillay, who was one of the experts who testified for the defendant at the trial, relied in his evidence on a number of academic papers which dealt with the subject of thromboembolism, one of which was an article published in *The American Journal of Surgery*[1] in which the authors expressed the following views regarding the condition:

> 'Pulmonary embolism (PE) and deep vein thrombosis (DVT), referred to collectively as venous thromboembolism (VTE), is a life-threatening condition that can arise in patients with acute trauma. The reported prevalence of DVT in trauma patients ranges from 5% to 58%, and patients are frequently asymptomatic until they experience a fatal PE.

[1] Hegsted D, Gritsiouk Y, Schlesinger P, et al. 'Utility of the risk assessment profile for risk stratification of venous thrombotic events for trauma patients' Tlte American Journal of Surgery Volume 205, No 5, May

> Prevention requires a reliable tool for risk stratification for the development of VTE, screening strategies, and effective prophylaxis to significantly reduce mortality in trauma patients. One such tool is the Risk Assessment Profile (RAP) developed by Greenfield et al. The RAP is a risk stratification scoring system that uses easily determined risk factors in a weighted summary to determine the likelihood of DVT developing in acute trauma patients.'

[6] In simpler terms, the term *thromboembolism* is defined in the *Oxford South African Concise Dictionary*[2] as *'obstruction of a blood vessel by a blood clot that has become dislodged from its original site'.* Its effect is to stop the normal blood flow to the lungs, invariably with fatal consequences. The main issue for determination by the court in this matter is whether the defendant's medical personnel at the hospital were negligent in their treatment of the deceased and, if so, whether their negligence was a causative factor of the deceased's death.

The plaintiffs' contention

[7] Against the factual background set out above, the plaintiffs' contention is that the defendant had a contractual obligation to provide the deceased with reasonable medical treatment by virtue of him being a patient at a State Hospital. In the alternative, they pleaded that the defendant owed the deceased a duty of care, that is, to provide him with the necessary medical services and treatment with the reasonable skill and diligence. They further contend that the defendant's breach of his contractual obligation or, alternatively, the negligence of his medical personnel at the hospital was the cause of the deceased' s death.

[8] In particular, the plaintiffs' case is that the defendant's medical personnel at the hospital failed to recognise that the deceased was at an increased risk of developing deep vein thrombosis (DVT) and subsequently

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2013 at 517.

pulmonary embolus. Consequently, they failed to administer the requisite dose of pharmacological prophylaxis to the deceased which could have helped save his life.

The defendant's contention

[9] In essence, the defendant denied that his medical personnel at the hospital had failed to recognise that the deceased was at an increased risk of developing venous thromboembolism (VTE). Based on the views expressed by Dr J P Arnold, who testified as an expert witness on the defendant's behalf, the defendant's contention was that using the Risk Assessment Profile (RAP) that was developed by Greenfield *et al,* the deceased would have been allocated two points for being obese and two points for being over 40 years of age, which would have resulted in him being classified as 'low risk' for the development of VTE because his overall score would have been less than five. A person who scored five or more points would be classified as 'high risk' and, therefore, more likely to develop VTE.

[10] It was further contended by the defendant that even if the deceased had been recognised as 'high risk' by the defendant's medical personnel at the hospital the administration of early prophylaxis (mechanical or pharmacological) to him would have been contraindicated due to his swollen left leg from the injury and the possibility of repeat surgery. This was confirmed by Dr Arnold in his evidence, who testified that it was also possible that the deceased had already developed the DVT within the first 24 to 48 hours of sustaining the injury, during which period the administration of prophylaxis was contraindicated for him due to the risk of excessive bleeding and further surgery.

The evidence

[11] The plaintiffs and the defendant called a total of six witnesses to testify

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[2] 2ed(2010)

on their behalf at the trial. The witnesses who testified for the plaintiffs were the first plaintiff, Ms B[....]2 M[....]; Dr Philip Matley, a Vascular Surgeon; Dr A A Osman, an Orthopaedic Surgeon; and Dr G Perumal. The witnesses who testified for the defendant, on the other hand, were Dr J P Arnold, an Orthopaedic Surgeon; and Dr B Pillay, a Vascular Surgeon. Except for the evidence of the first plaintiff, which was factual, the rest of the

evidence led by the parties in this matter was based on opinions provided by various experts who testified on behalf of the parties.

[12] Starting with the first plaintiff, a brief summary of her evidence was that she and the deceased were married to each other on 6 August 1994 in the Democratic Republic of Congo. They had four children, namely, Nicole M[....], Joseph M[....], Welcome M[....] (who passed away on 1 January 1998) and G[....] M[....]. They moved to the Republic of South Africa in 1994. The deceased was employed by Rand B Timbers in Umhlanga as a yard manager for more than 13 years. He was earning a monthly salary of approximately R7 000 at the time of his death. She was also employed at Spar as a cashier earning a monthly salary of approximately R5 000.

[13] On 14 May 2014, at approximately 1.00 pm, she received a telephone call from the deceased's employer requesting her to come to the deceased's workplace immediately. She informed her manager, who immediately took her to the deceased's workplace in his vehicle. Upon their arrival they found the deceased lying on the ground bleeding, but he was conscious and able to talk. He was taken in an ambulance to the hospital, where they waited for approximately two hours before he was attended to. The deceased shouted at the nurses to attend to him as he was bleeding, but they told him to wait for his tum because there were other patients who came before him.

[14] It was approximately 5.00 pm when they finally attended to him. The duty doctor took him to an X-ray room where he cut his pants in order to take an X-ray of his fractured leg before they could operate on it. However, she was

subsequently informed by the duty doctor that they could not proceed with the operation on the deceased's leg because there was a problem with the operating machine. He told her that they would clean the wound and reschedule his operation for another date. She left the hospital at approximately 7.30 pm that evening and went home. She returned during the visiting hours the next morning and found the deceased lying on his hospital bed with his bandaged left leg suspended and a stone hanging from it.

[15] She continued to visit him daily during visiting hours and observed that he was unable to move because of the pain he experienced every time he attempted to move. He could not even go to the bathroom on his own and had to use a bedpan to relieve himself, unless his brother and his friends were present during visiting hours to carry him to the bathroom. However, he pretended to be in good spirits and would be laughing and joking when she could tell that he was in pain. She also noticed that his stomach and right leg were becoming swollen, and he told her that he had no feeling in his right leg. She informed the duty nurse about this, and requested her to inform the duty doctor. She repeated the same request to another nurse during visiting hours the next day when she was informed by the deceased that he did not get any treatment for the swollen leg and stomach. The second nurse advised her to get the deceased an ENO to treat his swollen stomach, which she did, but it did not help the deceased.

[16] The surgery on the deceased's leg was finally performed on Monday, 19 May 2014. She was not at the hospital when the operation was performed. He called her at approximately 2.30 pm after the surgery and asked her to bring him a yoghurt or mageu as he could not take _solid foods. Shortly thereafter, around 3.30 pm, she received a telephone call from someone at the hospital advising her that her husband had passed away.

[17] Dr Matley's evidence was primarily that amongst the various prophylactic agents used for the treatment of VTE over the years the Low Molecular Weight Heparins (LMWHs) have emerged as one of the most

effective methods of DVT prophylaxis in trauma patients. The most commonly used LMWH in South Africa is enoxaparin (Clexane). The deceased sustained a high risk injury (compound lower limb fracture) which, coupled with his obesity, being over 40 years old, the delayed surgery and an extended period of immobility put him at a high risk of developing VTE. Without contra-indications to the use of anticoagulants (drugs used to reduce the risk of the formation of blood clots), LMWH would normally have been given to him within 12 hours of the injury. The ideal time to commence this would probably have been shortly after the initial debridement.

[18] The fact that no thromboembolism prophylaxis was offered falls short of the actions of a reasonable doctor or clinical team under the circumstances. In his view, the likelihood was that the administration ofLMWH would have meaningfully reduced the risk of a fatal pulmonary embolus, although not to zero as venous thromboembolism has been consistently observed in patients receiving these drugs in the various randomised trials, albeit at a lower rate than in patients who did not receive prophylaxis. He did, however, qualify his views by stating that his recommendations were based on the available evidence which was insufficient to make an absolute level one insistence that such therapy was mandatory for the deceased.

[19] He also pointed out that a further matter for consideration is the observation by the forensic pathologist and the plaintiff that the deceased's right leg was swollen prior to the second operation. He said this should have been observed and investigated by the responsible healthcare workers. In conclusion, he opined that had the DVT been diagnosed pre-operatively there would have been an opportunity to intervene either with a therapeutic dose of anti-coagulant or possibly the placement of a temporary IVC filter.

[20] Dr Osman agreed in his evidence with the views expressed by Dr Matley regarding the risk assessment of the deceased for predisposition to the development of VTE. His evidence, briefly stated, was that the factors which predisposed the deceased to the development of DVT included his femur

fracture (severe compound), obesity, delayed surgery, surgical time of three hours and poor fracture immobilisation prior to surgery. Using the RAP scoring as the risk assessment tool, the deceased would have got two points for being over the age of 40 years, four points for a compound femur fracture and two points for an anaesthetic time of three hours, which should have given him a total of eight points. This should have put him in a high risk category, as compared to the four points that was allocated to him by Dr Arnold who gave expert evidence on behalf of the defendant. In conclusion, he opined that the deceased would have benefited from the pharmacological prophylaxis, which would have prevented a fatal pulmonary embolus.

[21] The evidence of Dr Perumal was focused primarily to his post-mortem examination of the deceased. His chief post-mortem findings from the deceased's body were a fractured femur, which was stabilised by an intra-medulary (IM) rod; swollen right calf with residual thrombus in deep calf vein (DVT); large thrombus in the left and right pulmonary arteries; loops of bowel were distended with gas; and the bladder was distended with urine. Based on his observations, he concluded that the cause of the deceased's death was pulmonary thrombo-embolus.

[22] The first witness who testified for the defendant was Dr Arnold. The salient points of his evidence were that he classified the deceased as low risk in his assessment of his predisposition to the development of VTE using the RAP method. He allocated the deceased a total score of 4 points made up of his obesity (two points) and his age of more than 40 years old (two points) at the time of his death. He then alluded to an argument which could be made to have more points added for femur fracture, which could place the deceased in the high risk group if the isolated femur fracture he sustained was to be regarded as a severe lower limb fracture.

[23] He opined that the management of the deceased was of an appropriate standard of care initially. However, he was critical of the deceased's treatment after his surgery was delayed due to the malfunction of the image intensifier.

Be that as it may, his view was that an early prophylaxis, whether mechanical or pharmacological, would have been contraindicated for the deceased due to his swollen leg from the injury, the risk of bleeding and further surgery. Had he been deemed a candidate for prophylaxis, according to variable risks, it could only have been administered to him around day three as he was initially placed on the emergency board and was only removed from it on day two, which means that he would have missed the daily Cclexane dosage that is administered to patients at 10.00 am.

[24] He further opined that even if the deceased had received prophylaxis, it would have been a maximum of only two doses as it was contraindicated within 48 hours before the surgery. This would not have been sufficient to prevent the deceased from developing a fatal pulmonary thrombo-embolus. Furthermore, he thought there was a high possibility that the deceased had already developed DVT within the first 24 to 48 hours after he sustained the injury, which would fall within the period when prophylaxis was contraindicated.

[25] In conclusion, he conceded that the hospital notes on the treatment administered by its medical personnel to the deceased were sparse and showed a gap between 16 May 2014 and 19 May 2014. No record was made of the deceased's condition and status of his fractured leg over that period, which Dr Arnold regarded as amounting to sub-standard level of care. He commented that notes should have been made and the deceased' s leg should have been examined by the relevant medical personnel at the hospital while the deceased was awaiting surgery.

[26] The second and last witness who testified for the defendant was Dr Pillay. In essence, Dr Pillay's evidence was that pulmonary thrombo-embolus within the context of long bone fractures tends to occur within 48 hours. Whilst he agreed with Dr Arnold on withholding prophylaxis prior to the initial surgery, his view was that some form of thrombo prophylaxis should have been administered to the deceased when considering the bleeding risk, the

fact that surgery was delayed, the long bone fracture, the obesity and immobilisation after an objective evaluation of the deceased's clotting profile. He further opined that had thrombo-embolic prophylaxis been administered to the deceased timeously, it might have reduced the DVT, but not totally eliminated the risk of fatal pulmonary embolus.

Assessment of evidence

[27] The evidence led by the parties during the trial painted a grim picture of a premature death of a 44-year old father and husband who was relatively healthy and strong before that fateful day of his accident at work. The question is whether his untimely death could possibly have been avoided by the exercise of reasonable care by the medical personnel at the hospital. This is the contention made by the plaintiffs in their claim against the defendant, which is denied by the defendant. The defendant's position is that the personnel who were entrusted with the deceased's care at the hospital exercised a reasonable standard of care in his treatment and, therefore, could not be held responsible for causing his death. Either way, the court has to discern the truth from the evidence led.

[28] The first plaintiff testified that when she visited the deceased at the hospital she found him with a swollen right leg and stomach. This was confirmed by Dr Perumal in his post-mortem examination report on the deceased, who attributed the swelling of the deceased' s right calf to residual thrombus in the deep calf vein, and the swelling of his stomach to gas in loops of his bowel. Therefore, if the first plaintiff was right in her observation of the swelling on the deceased's leg and stomach, the question is how did such important observation escape the notice of the trained personnel at the hospital for days prior to the deceased' s second operation.

[29] In my view, the answer to the question posed in the preceding paragraph lies in the hospital records submitted by the defendant containing the treatment notes of the deceased. It was confirmed by Dr Arnold in his evidence that the hospital protocol and, indeed, the good medical practice is

to record every treatment administered to every in-patient at the hospital, as well as any observation that is necessary to keep track of the patient's condition. In the case of the deceased, there is a glaring blank in the hospital records of any attendance or observation of the deceased over the period 16 May 2014 to 19 May 2014. This was noted as a cause for concern even by the defendant's own witness, Dr Arnold, who described it as 'sub-standard level of care'. In the absence of any evidence to the contrary, I can only conclude that no treatment was administered to the deceased from 16 May 2014 until the date of his second operation on 19 May 2014.

[30] Insofar as the risk profile of the deceased to develop VTE was concerned, it is clear from the evidence that the deceased ought to have scored more than 5 points using the RAP method, which would have resulted in him being classified as a high-risk patient to develop VTE. Therefore, taking into account the various factors which ought to have been considered in the risk assessment of the deceased to develop VTE, I am in full agreement with the view expressed in the joint minute prepared by Drs Arnold and Osman that the minimum requirement to save the deceased's life would have been for him to have been administered pharmacological prophylaxis. Of course, there is no guarantee that if this was done it would have prevented his death from pulmonary embolus. However, it was admitted by both witnesses who testified for the defendant that, absent any contraindications after his second surgery, it could have possibly saved his life.

[31] Similarly, a joint minute was prepared by Drs Matley and Pillay in which they agreed that, inter alia, the deceased exhibited several risk factors for the development of DVT, including his age, obesity, severe lower extremity fracture and the need for operation lasting longer than two hours. The risk was further exacerbated by his prolonged immobilisation resulting from several days' delay before his definitive surgery; that given the increased risk of VTE, the deceased should have received pharmacological thrombo prophylaxis, and that a LMWH, such as enoxaparin, would have been a good choice; and, that pharmacological prophylaxis was not required during the period between the initial injury and the

debridement.

[32] Notably, Dr Pillay had disagreed in the joint minute with the statement that the fact that no thromboembolism prophylaxis was offered to the deceased at all fell short of the actions of a reasonable doctor or clinical team under the circumstances. However, he conceded in his evidence that, absent any contraindications after the deceased's first surgery, the administration of adequate doses of thromboembolism prophylaxis would probably have saved the deceased's life, albeit without any guarantees. In the circumstances, the inescapable conclusion I can draw from the collective evidence of all the witnesses is that the failure of the defendant's hospital personnel to administer thromboembolism prophylaxis to the deceased had, indeed, caused his death.

The Law

[33] In deciding on the legal basis of their claim against the defendant, the plaintiffs elected to adopt a dual approach of basing their claim mainly on contract, and alternatively on delict. Of course, nothing hinges on such approach because the evidence led by the plaintiffs at the trial was adequate and sufficient to sustain their claim either in contract or, alternatively, m delict. It was held by the Constitutional Court in the case of *Oppelt v Department of Health, Western Cape*[3] that:

> 'There is no doubt that the legal convictions of the community demand that hospitals and health care practitioners must provide proficient healthcare services to members of the public. These convictions also demand that those who fail to do so must incur liability.'

[34] According to *Oppelt,* the legal test for negligence was said to be essentially a failure to meet the standard of care to be expected from a reasonable doctor having regard to the standards of the medical profession at the time. It was argued by Mr *Pillemer,* who appeared for the plaintiffs, that

the defendant's medical personnel at the hospital fell short of that standard when they failed to recognise the various factors which ought to have been taken into account in the assessment of the deceased for predisposition to the development of VTE. Consequently, they failed to administer to the deceased· the thromboembolism prophylaxis which could have prevented or minimised the development of VTE and saved his life.

[35] Mr *Pillemer* also referred this court to the decision of the Supreme Court of Appeal in *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another,*[4] which was quoted with approval in *Oppelt* as having laid down the correct approach to the evaluation of medical evidence. In essence, the Supreme Court of Appeal held in *Linksfield* that:[5]

3 *Oppelt* v *Department of Health, Western Cape* 2016 (I) SA 325 (CC) para 54..

4 *Michael and Another* v *Links.field Park Clinic (Pty) Ltd and Another* 200 I (3) SA 1188 (SCA). See also *Lee* v *Minister for Correctional Services* 2013 (2) SA 144 (CC); *Mashongwa* v *Passenger Rail Agency of South Africa* 2016 (3) SA 528 (CC).

5 Links.field ibid para 34.

' ... 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.'

[36] It was argued by Ms *Bhagwandeen,* who appeared with Ms *Govender* on behalf of the defendant, that the conduct of the defendant's medical personnel at the hospital was not wrongful as it was not guaranteed whether

the administration of prophylaxis would have prevented the deceased from developing DVT which led to the fatal pulmonary embolus. With respect, I disagree with that proposition. In my view, this is an unconscionable proposition, particularly, as it implies that it is not necessary for the medical personnel at public hospitals to do whatever is in their power to save the lives of patients entrusted in their care unless their efforts are guaranteed to yield positive results. That is definitely not what the public health institutions are intended to do. When it comes to saving lives every effort must count, no matter how minimal the chance of a patient's survival may be.

Finding

[37] In the circumstances, I make an order in the following terms:

1. The defendant is directed to pay to the first plaintiff in her personal capacity and in her representative capacity as mother and natural guardian of her minor child, G[....] B[....] M[....], a girl born on 25 May 2009 and in her capacity as executrix of her deceased child, Welcome B[....] M[....], who passed away on 1 January 2018 and to the second plaintiff, such damages as may be proved or agreed for their claims for loss of support as a result of the death of M[....]2 C[....] M[....] who died on 19 May 2014.

2. The defendant is directed to make payment of the plaintiffs' taxed or agreed party and party costs on the high court scale, which costs shall include all reserved costs, the costs of plaintiffs' counsel, such to include the costs of preparation for trial, preparation of heads of argument and for attending upon any necessary consultations with the undermentioned expert witnesses and the fees and expenses reasonably incurred by the undermentioned expert witnesses for qualifying themselves and reserving themselves for trial and attending at trial (where applicable) and for the preparation of their reports, joint minutes (where applicable), and attending upon any necessary consultations with the plaintiffs' counsel and attorney (with the quantum of their fees, if any, to be determined by the taxing master) namely: -

2.1 Dr G Perumal, Specialist Forensic Pathologist

2.2 Dr E Hodgson, Specialist Anaesthesiologist

2.3 Dr A Osman, Orthopaedic Surgeon

2.4 Dr P Matley, Vascular Surgeon

ME NKOSIJ

Appearances

For the plaintiffs:	Mr R Pillemer
Instructed by:	Du Toit Havemann & Lloyd, Durban
Tel:	031-201-3555
Ref:	ms p gounden/bp/15/M666-0001
For the defendant:	Ms N Bhagwandeen, with Ms S Govender
Instructed by:	State Attorney (KwaZulu-Natal), Durban
Ref:	24/5693/16/M/P24/mmd
Date of Hearing:	22, 23, 24 & 26 August 2022
Date of Judgment:	16 September 2022