IN THE HIGH COURT OF SOUTH AFRICA

(WESTERN CAPE DIVISION)

Case no.: 2026-049305

In the matter between:

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL	**Applicant**
and	
MD	**First respondent**
PD	**Second respondent**
In re:	
AD	**The minor child (patient)**

Coram: Pangarker J

Hearing dates: 10 and 11 March 2026

Order granted: 11 March 2026

Reasons delivered electronically: 27 March 2026

Summary: ***Urgent application by Medical Superintendent of treating hospital in terms of section 129 of Children's Act 38 of 2005*** *– Surgical intervention required for necessary Syme and below knee amputations to minor child's legs – Parents consistently refused to provide consent on the basis of their religious/traditional/cultural beliefs – Hospital engaged with parents to accommodate traditional beliefs – Legislative framework and best interests of minor child standard considered – High Court's intervention as upper guardian of all minor children*

REASONS FOR ORDER

PANGARKER J

Introduction

[1] This application was instituted on an urgent basis. On 11 March 2026, after considering the application and the applicant's counsel's submissions, I granted an order in terms of section 129(9) of the Children's Act 38 of 2005 (the Children's Act/the Act) whereby this Court consents to the surgical intervention for the below knee amputation of the left leg and Syme amputation of the right leg of the minor child, AD (the minor child), and that the further medical treatment to/of the minor child be determined by her treating medical team at the applicant, the Red Cross War Memorial Children's Hospital (the hospital). Further orders were granted as more fully set out below. Due to the urgency of the matter, I deferred the reasons for such order for later. These are then the written reasons for the order which I granted on 11 March 2026.

[2] As this matter involved a minor child, the identities of the parents and child, who is a patient at the applicant hospital, are redacted from these reasons. The child, AD, is currently 6 years old.

The order granted on 11 March 2026

[3] The order granted on 11 March was in the following terms:

IT IS ORDERED THAT:

1. *The matter is heard as one of urgency in terms of Rule 6(12) of the Uniform Rules of Court, and the forms and service provided for in the rules are dispensed with to the extent necessary.*

2. *This Honourable Court, in terms of section 129(9) of the Children's Act 38 of 2005 ("the Children's Act"), consents to:*

   2.1 *the surgical intervention for the below-knee amputation of the left leg and a Syme amputation of the right leg of the minor child, A… D… ("the minor child") born on 7 August 2019 as described in the founding affidavit of Dr Jessica Browne ("the surgical intervention"); and*

   2.2 *the administration of any further medical treatment to the minor child as determined by the minor child's treating medical team at the applicant which is in the best interests of the minor child,*

including but not limited to a psychological evaluation, assessment, therapy and counselling both pre- and post the surgical intervention.

3. *It is further directed that the minor child is to remain at the applicant hospital until the surgical intervention and required rehabilitation, including psychological counselling, be completed.*

4. *The first and second respondents are prohibited from removing the minor child from the applicant's hospital during the period referred to in paragraph 3 above.*

5. *The applicant's legal representative is required to serve a copy of this Order on the respondents per email, text message or Whatsapp immediately upon receipt of the Order.*

[4] The application revolved around the urgent need for surgical intervention (leg amputations) in respect of AD and her parents' continued refusal to provide their consent for such urgent surgical intervention. AD's parents were the first and second respondents in the application which first came before me on 10 March 2026 as an unopposed application. Only AD's father was present at Court together with his sister, AD's paternal aunt. The child's mother was absent as she spent every day at hospital with her daughter.

Proceedings on 10 and 11 March 2026

[5] On 10 March, the matter was called more than once but at approximately 15h00, it had to be postponed due to the unavailability of an interpreter to assist the

first respondent who is Xhosa-speaking, and as result of circumstances at Court on the day which were beyond anyone's control. I requested the input of the Family Advocate, Cape Town, in the form of a Memorandum to Court regarding the best interests of the minor child, notwithstanding that the matter did not involve a care and contact or guardianship dispute. The State Attorney, acting for the hospital, was requested to urgently serve the application on the Family Advocate, and subsequently Advocate Hofmeester attended to the matter and provided a Memorandum. AD' s father was warned to attend Court on 11 March 2026 at 09h00 for the hearing.

[6] On 11 March, the Registrar was requested to contact the father to remind him of the attendance at Court at 09h00. The Registrar reported back that AD's father indicated to her telephonically that he was in George and would not attend the proceedings. Counsel for the hospital later confirmed during the proceedings that her attorney was informed by AD's mother that her husband would not attend Court on the day. No opposing papers were delivered and the application thus remained unopposed.

The Notice of Motion

[7] In its Notice of Motion, the hospital sought the following urgent relief:

1. *That the matter is heard is one of urgency in terms of Rule 6(12) of the Uniform Rules of Court, and the forms and service provided for in the Rules are dispensed with to the extent necessary;*

2. *Directing that the applicant's Medical Superintendent be authorised to consent to:*

    2.1 *the surgical intervention for the below-knee amputation of the left leg and a Syme amputation of the right leg as described in the founding affidavit of Dr Jessica Browne ("the surgical*

intervention") of the minor child, A... D... ('the minor child") born on 7 August 2019; and

2.2 *the administration of any further medical treatment to the minor child as determined by the minor child's treating medical team at the applicant which is in the base interests of the minor child, including but not limited to psychological evaluation, assessment, therapy and counselling both pre and post the surgical intervention;*

3. *That the consent of the respondents be dispensed with in terms of section 129(6) of the Children's Act 38 of 2005 ('the Children's Act);*

4. *In the alternative to paragraphs 2 and 3 above, that this Honourable Court grants consent for the surgical intervention of the minor child, and any further medical treatment to the minor child as determined by the minor child's treating medical team at the applicant which is in the best interests of the minor child including but not limited to a psychological evaluation and assessment and therapy and counselling both pre and post the surgical intervention, as contemplated in section 129 (9) of the Children's Act, where the first and second respondents or refusing to give their consent;.*

5. *Directing that the minor child remain at the applicant until the surgical intervention and required rehabilitation including psychological counselling be completed;*

6. *Prohibiting the first and second respondents from removing the minor child from the applicant's hospital during the period referred to in paragraph 5 above;*

7. *Granting such further and/or alternative relief as this Court may deem to be in the best interests of the minor child.*

The hospital's case for urgent surgical intervention

[8] The deponent to the hospital's affidavit is Dr Jessica Browne, the Manager: Medical Services and one of two Medical Superintendents of the hospital. AD suffered from meningococcal septicaemia which is a blood infection caused by bacteria that releases toxins which damage blood vessels, leading to clots, poor circulation and necrosis[1]. In the case of AD, this condition caused necrosis of the tissue in her feet which resulted in gangrene to both feet.

[9] AD was admitted to the hospital on 19 January 2026 and was critically ill at the time. She presented with meningococcal septicaemia and had gone into septic shock. She thus required urgent admission to the intensive care unit (ICU) where she was intubated and ventilated for four days and required inotropic support. Dr Browne explained that the diagnosis of meningococcal septicaemia was confirmed on a blood culture. On 22 January 2026, it was noted that AD's feet had become progressively discoloured, a condition indicative of general ischaemia and gangrene of both feet.

[10] The hospital communicated the child's condition to her parents. An assessment was requested from general surgery to determine whether AD was a candidate for revascularisation[2] and the finding was that she was not a suitable candidate. It is evident from photographs attached to Dr Browne's affidavit that AD's feet were so discoloured and dark that there was no chance of a successful revascularisation and no restoration of perfusion as her muscles were not viable.

[11] According to Dr Browne, the only medical treatment for AD in such circumstances was surgical intervention in the form of amputations of both her legs, as follows:

right leg	–	Syme amputation; and
left leg	–	below-knee amputation.

[1] Tissue death
[2] Medical procedure whereby blood flow to tissues or organs suffering from ischemia, is restored

[12] Because of the significant risk of a further infection developing around the necrotic tissue of the feet, which would inevitably result in an extension of the area of the legs to be amputated, it was critical that AD received surgical intervention in the form of amputation as described above, as soon as possible. However, the problem lay in the fact that AD's parents refused to provide their consent for surgical intervention based on their traditional and religious beliefs.

[13] AD's parents wished to explore traditional medicine/healing as an option because, in their view, her condition could be cured without surgical intervention and therefore, without amputation of her legs. The parents conveyed to the hospital that the traditional healing would have to take place in the Eastern Cape, and this would therefore entail that the hospital would have to discharge AD to enable her to travel to the Eastern Cape for such purposes. However, as seen below, the parents were also not against traditional healing taking place in Cape Town, but it would still have meant that AD would have had to be discharged from hospital.

[14] In view of her serious medical condition, and that she was on strong pain medication which included opioids, the hospital's multi-disciplinary treating medical team was reluctant to discharge AD in such condition as the result could be fatal. This decision was conveyed to her parents. AD was administered Heparin to prevent ongoing coagulation.

[15] On 24 January 2026, AD was discharged from the ICU to the medical ward, and on 25 January, she was assessed by the orthopaedic team which included Associate Professor Anria Horn and Dr Sicelo Mkhize. The treatment plan was to define where the vascularity on AD's feet stopped. Dr Browne explained that demarcation of the infection was essential for the orthopaedic surgeons to determine the level and the extent of AD's leg amputations.

[16] At that stage, however, conflict arose between the parents and the hospital in that AD's parents refused to consent to surgical intervention for the leg amputations of their child. Her parents were consulted extensively and comprehensively advised regarding the reasons why the only definitive medical treatment for AD's lower limb gangrene was amputation of both legs, as set out above.

[17] The medical team also explained to the parents that to decide on the level of amputation, it was necessary that the extent of the gangrene had to be assessed. Notwithstanding all these detailed explanations by the hospital and its medical team, the parents remained steadfast in their refusal to consent to the surgical intervention. Considering such refusal, the surgical plan in respect of AD could not be documented.

[18] On 27 January, AD was assessed by Dr Krishna Thottekkat, a paediatrician from PaedsPal which is a paediatric palliative care organisation in Rondebosch attached to the hospital. It provides specialist consultative palliative care to babies and children referred by the hospital and Mowbray Maternity Hospital. The focus is on complex patients, where time is spent building generalist palliative care capacity to guide practise. As at the date of the application, Dr Thottekkat was involved in AD's pain management and other care services.

[19] At the time that Dr Browne deposed to the founding affidavit, and because of the severe pain in her feet, AD was administered with the following pain medication:

Morphine, an opioid medication used to treat acute pain[3];
Gabapentin, an anticonvulsant that treats nerve pain;
Clonidine, used for its pain relief properties; and
Paracetamol.

[3] During the hearing on 11 March, counsel for the hospital advised that AD had been weaned off morphine

[20] On 28 January 2026, the medical team noticed new areas of necrosis on AD's limbs which indicated that the gangrene was progressing. AD was experiencing uncontrolled pain which was being managed by the treating multidisciplinary team.

[21] On 10 February 2026, and pursuant to a family meeting, the parents again advised the hospital of their decision to have AD treated by way of traditional healing and traditional medicines. A tentative decision was made to discharge AD so that she could travel to the Eastern Cape with her parents to meet with the family elders regarding treatment with a traditional healer and to discuss surgical intervention.

[22] However, on 11 February, the orthopaedic surgeons assessed AD and decided against discharging her and allowing her to travel to the Eastern Cape because of her condition. The multi-disciplinary treatment team were of the view that such decision was made in the best interests of AD.

[23] On 12 February, the hospital conducted an ethics meeting with the clinical ethics representatives from the University of Cape Town (UCT) wherein AD's case was discussed at length, and all possibilities were considered and ventilated. The meeting concluded that it was not safe to discharge AD in circumstances where she was in extreme pain and had necrotic feet. In short, the meeting held the view that her overall condition did not warrant discharge from hospital.

[24] On 13 February, a clinical psychologist, Hilda du Plooy, from the hospital's Division of Child and Adolescent Psychiatry, and Consultation Liaison: Psychiatry and Psychology Services, received a request from the hospital's social workers to assess AD. The idea was to provide a short term psychiatric and psychological assessment, focussing on intervention for AD and her family in the event of them experiencing psychological, behavioural or adjustment difficulties related to her illness, hospitalisation and treatment. What was required was a psychological assessment and counselling for bi-lateral lower limb amputation.

[25] It transpired that AD's mother refused to consent to Ms du Plooy evaluating her daughter, as she was of the view that this was but another attempt by the hospital to change the parents' minds regarding consent to surgical intervention. At this stage, the parental consent was still being withheld. To add, the parents' refusal of consent remained based on their view that AD's feet, and her overall condition, could be saved by administering traditional medicine. Simply put, the parents wished to explore their cultural beliefs and practises with the medical team. After some discussion, the medical team's decision was to involve a traditional healer or cultural advisor to accommodate and respect the parents' wishes.

[26] Dr Browne explained that the hospital was culturally sensitive towards the family yet emphasised that AD's best interests should be prioritised. The hospital administration and its medical staff then involved cultural mediators and traditional healers in the hope to obtain the parents' consent to the surgical intervention as described above.

[27] On 17 February, AD was transferred to the orthopaedic ward, and a meeting was held with her parents to secure a traditional healer of the respondents' choice to visit her at hospital. For a week up to 23 February, the hospital's social workers consulted with the parents on the issue, but AD's father remained steadfast: his daughter was to attend a traditional ceremony in the Eastern Cape to heal her and he would not return her to Cape Town for a surgical intervention.

[28] Notwithstanding the father's decisive stance, the medical team and hospital continued to engage with AD's parents. After further discussion with the father, the hospital proceeded to invite a traditional healer of the parents' choice to the orthopaedic ward to assess AD. The healer arrived at the hospital, assessed AD and advised that he could cure her condition with oral medication, topical creams and ointment. However, the hospital made it clear that it could not allow traditional healing within its premises. Considering the hospital's stance, AD's father was of the view that

the process was incomplete as the hospital had refused to allow the healer to perform what he needed to do.

[29] The hospital-family engagement did not end there. A second traditional healer, who is also a psychologist, was arranged by PaedsPal to discuss the matter with AD's father and particularly, the view that the traditional healing did not have to take place in the Eastern Cape. This discussion eventually resulted in the parents inviting another traditional healer to attend the hospital for a meeting on 23 February. However, this healer cancelled the appointment on 22 February and accordingly failed to attend the hospital.

[30] Undeterred, and on 23 February, the hospital's clinical team, social workers and nurses met with AD's father to determine the position related to traditional healing, considering the previous cancelled appointment. The medical and nursing teams and social workers impressed upon the parents that any action taken would have to be in the minor child's best interests and that while the hospital was prepared to provide time to the parents to engage with traditional healers, given the seriousness of AD's condition, there would only be a certain period of time before it (the hospital) would seek legal advice in determining the child's best interests in the circumstances.

[31] During the afternoon of 23 February, another traditional healer attended on the hospital to assess AD. As with the previous healer, he advised that he would use oral traditional medication and lotion to cure AD's feet and there should then be an improvement within four days after commencement of the treatment. Furthermore, the traditional healer conveyed that he would be informed spiritually if there was no improvement in her condition and in that case, there would be a change of plan. AD's parents agreed to this plan and understood that the traditional healing treatment might fail. As before, the difficulty which the hospital faced was that traditional healing was not allowed within the hospital premises.

[32] The next day the hospital informed the parents of its decision not to allow traditional treatment in/on its premises. The engagement with the parents' cultural and traditional views on their daughter's healing did not end there as the hospital also requested the detail of the parents' elders. The result was that on 25 February, Dr Mkhize and a social worker, Vuyolwethu Dlwati, contacted Mr Dengane, the father's uncle. The latter was advised that AD's condition could not be cured and that there was a real risk that the infection could spread further up her legs.

[33] It was reported to Dr Mkhize and Mr Dlwati that Mr Dengane advised that the family was aware of AD's medical condition and had seen photographs of her gangrenous feet and legs. However, he expressed that the family insisted on pursuing traditional medicine before amputation, and if the traditional medicine did not improve AD's gangrene or achieve the desired result, then the family would return the child to the hospital. Mr Dengane made it clear to Dr Mkhize and Mr Dlwati that the family had no intention of changing their minds on this aspect.

[34] Dr Mkhize and Mr Dlwati assured Mr Dengane that AD's medical team respected the family's views and that the family (AD and her parents) would be supported throughout. However, at that stage, all indications were that the parents would not change their view about the refusal to consent to surgical intervention in respect of the child.

[35] The clinical team implored the parents to consider providing their consent to surgical intervention as they would have preferred to work with the parents to ensure proper aftercare of AD, including fitting a prosthesis, rehabilitation, physiotherapy and more. This would require the parents' full co-operation with the hospital. However, the parents maintained their refusal to consent to surgical intervention. It is noted that Dr Mkhize and Mr Dlwati deposed to confirmatory affidavits in respect of their involvement and discussions with AD's family.

[36] Aside from what is stated above regarding AD's diagnosis and intended surgical invention, the remaining significant aspects of Professor Horn's report may be summarized as follows:

[36.1] In light of a recent systematic review, up to 8% of children treated for meningococcal septicaemia require amputation of a limb.

[36.2] In AD's case, the definitive treatment for the lower limb dry gangrene was amputation of the legs, and the latter was determined only after observing the extent of the gangrene on her lower limbs.

[36.3] The gangrene was irreversible and there was a significant risk of infection setting in.

[36.4] AD was physically well and not acutely ill and her pain management was controlled by Dr Thottekkat.

[36.5] Professor Horn confirmed Dr Browne's averments that the hospital's surgical, medical and social worker teams all engaged with the parents throughout on all aspects regarding AD's diagnosis, treatment, the need for amputation and the benefit to be expected.

[36.6] In respect of AD's left leg, the gangrene extended to hind foot level and the lowest level of amputation possible was a below knee amputation. The gangrene in the right leg extended to mid-foot with the heel pad spared. The lowest level of amputation of the right leg was a Syme amputation or ankle disarticulation, with the result that AD would be able to weight bear on the amputation stump and derive significant functional benefit through a fitted

prosthesis. Weight bearing was not possible on the below knee amputation (left leg).

[36.7] AD was unable to stand on her feet and were she to develop an infection on the right side/leg, the Syme amputation would not be possible due to compromise of the tissue in her right foot.

[36.8] Professor Horn's view (supported by Dr Browne) was that the surgery should be performed urgently. Within two weeks after amputation, AD's wounds would have healed and rehabilitation could commence.

[37] Dr Browne referred to Ms du Plooy's report, which the latter confirmed under oath in her confirmatory affidavit. According to the report, in cases of lower limb amputation of a child patient, where the multi-disciplinary team observed trauma, anxiety, mood or behavioural problems by the patient or her/his family, prior to or post-amputation, psychological assessment and support are recommended. In the case of AD, as indicated earlier, the multi-disciplinary team made such recommendations, but the suggestion of a psychological assessment was rejected by her mother.

[38] Counsel on behalf of the hospital and Medical Superintendent submitted that the application was urgent and that notwithstanding Dr Browne's averments, which were supported by the multi-disciplinary medical team's confirmatory and supporting affidavits, the father's consent to surgical intervention of AD was still withheld. On the day of the hearing (11 March 2026), we were informed that the mother had eventually consented that AD should receive the surgical intervention determined necessary by the treating medical team.

[39] However, by 09h00 on 11 March 2026, it was evident that AD's father had not changed his mind and all indications were that he would not attend Court. It was safe

to therefore accept that he continued to refuse to consent to the surgical intervention. During the hearing, counsel addressed the Court on the legislative framework at play in the matter, as well as urgency, *locus standi* and the role of the High Court as upper guardian of minor children. These aspects are considered below, after having regard to the affidavits and annexures in support of urgent relief, the medical evidence and submissions on behalf of Dr Browne and the hospital.

Locus standi

[40] There is no doubt that in respect of this matter, the provisions of the Children's Act (the Act) loom large. It is evident that the hospital's continued engagement with the parents and attempts to obtain their consent for the surgical intervention proved fruitless, especially in respect of AD's father. The mother also resisted all attempts but as mentioned above, on the day of the hearing, the Court was advised that she had consented to the surgical intervention in respect of her daughter.

[41] In terms of section 31 of the Act, major decisions involving a child are taken by holders of parental rights and responsibilities as defined in section 18(2) of the Act. In terms of the latter section, parental responsibilities and rights include the responsibility and right to care for the child. In the case of AD, the parental responsibilities and rights thus fall on the shoulder of both her parents.

[42] Section 31(1)(a) makes it clear that a holder of parental rights and responsibilities must, in the case of major decisions involving the child, as set forth in section 31(1)(b), give due consideration to the views and wishes expressed by the child, bearing in mind the child's age, maturity and developmental stage. Similarly, the views of the other co-holder of parental rights and responsibilities must be considered before a major decision is taken.

[43] A major decision which is likely to significantly change or influence a child's health or well-being would include a surgical intervention for amputation of the child's legs. It is undisputed that AD was a child under the age of 12 years. Part 3 of the Act deals with protective measures relating to the health of children. In this regard, section 129(1) of the Act finds application as a child may be subjected to medical treatment or surgical operation only if consent is given therefor in terms of section 129(2) to (7) of the Act.

[44] In the circumstances of this matter, neither section 129(2) nor (3) find application as these sub-sections refer to a child over 12 years. Section 129 (7) and (8) also do not apply. The remainder of section 129, which I set out below, finds application in this matter:

> ***129. Consent to medical treatment and surgical operation***
>
> *(1) Subject to section 5(2) of the Choice on Termination of Pregnancy Act, 1996 (Act 92 of 1996), a child may be subject to medical treatment or surgical operation only if consent for such treatment or operation has been given in terms of either subsection (2), (3), (4), (5), (6) or (7).*
>
> *(2) ..*
>
> *(3) ..*
>
> *(4) The parent, guardian or care-giver of a child may, subject to section 31, consent to the medical treatment of the child if the child is-*
>
> *(a) under the age of 12 years; or*
>
> *(b) over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment.*
>
> *(5) The parent or guardian of a child may, subject to section 31, consent to a surgical operation on the child if the child is-*
>
> *(a) under the age of 12 years; or*

(b) over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the operation.

(6) The superintendent of a hospital or the person in charge of the hospital in the absence of the superintendent may consent to the medical treatment of or a surgical operation on a child if-

(a) the treatment or operation is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; and

(b) the need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required.

(7) ...

(8) ...

(9) A High Court or children's court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent in terms of this section refuses or is unable to give such consent.

(10) No parent, guardian or care-giver of a child may refuse to assist a child in terms of subsection (3) or withhold consent in terms of subsections (4) and (5) by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.

[45] In the absence of consent to the surgical intervention or operation, the Superintendent of a hospital may consent to the medical treatment of or surgical intervention/operation on a child in the circumstances set out in sub-section 6(a) and

(b). In AD's case, where the parents refused to consent to the surgical intervention and where the multi-disciplinary team feared a significant risk of further infection around the necrotic tissue of AD's feet, especially the right foot, her health and life was at risk.

[46] In the circumstances, given the real and imminent risk to AD's health and life where the parents' consent to surgery was refused, the Medical Superintendent on behalf of the hospital, stepped in and approached this Court, as she is allowed to do, in terms of section 129(6) of the Act.

[47] Section 27(1) of the Constitution protects citizens' rights to have access to health care services. In terms of section 28(1)(c), every child has the right to basic health care services. Significantly, section 28(2) states that a child's best interests are of paramount importance in every matter concerning the child.

[48] The aim of the Children's Act is to give effect to children's rights as contained in the Constitution and *inter alia*, to set out principles related to the care and protection of children. The paramountcy of the best interests of the child in every matter concerning the child is echoed in section 2(b)(iv) of the Children's Act, while one of the further objects of the Act is to promote the protection, development and well-being of children.

[49] With these objects and protections regarding children at the core of the Children's Act, it is important to also note that section 15 of the Act provides for the enforcement of a right in the Bill of Rights or in the Children's Act which has been threatened or infringed. The section states as follows:

> ***15 Enforcement of rights***
>
> *(1) Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights or this Act has been*

infringed or threatened, and the court may grant appropriate relief, including a declaration of rights.

(2) The persons who may approach a court, are:

(a) A child who is affected by or involved in the matter to be adjudicated;

(b) anyone acting in the interest of the child or on behalf of another person who cannot act in their own name;

(c) anyone acting as a member of, or in the interest of, a group or class of persons; and (d) anyone acting in the public interest.

[50] Section 8(2), read with sections 15 and 129(6) of the Children's Act allow the applicant, a public or State hospital[4], and the hospitals' Medical Superintendent, to approach the High Court with a view to protecting AD's right to life, health care and basic health services. In addition, the above-mentioned legislative framework allows for the hospital and/or Dr Browne to approach the Court in AD's best interests. I thus agree with Dr Browne that as Medical Superintendent, she had a duty in terms of the Children's Act, to act in AD's best interests and seek the protection of the child's rights.

[51] In view of the above discussion and findings, I conclude therefore that both the hospital and Dr Browne had the necessary *locus standi* to launch the application. The fact that Dr Browne is not cited as an applicant, is of no material consequence as she not only represents the treating hospital where AD is/was a patient but, as mentioned, the hospital's *locus standi* is established in terms of the provisions of sections 15(2) and 8(2) of the Children's Act.

Urgency and medical evidence

[52] There was no answering affidavit filed and the medical diagnosis and findings in Professor Horn's report and Dr Browne's affidavit stood uncontroverted. Importantly,

[4] Public health services

it was evident that at the time of launching the application, there was a significant risk of infection setting in around the necrotic tissue of AD's feet. It was clear from Dr Browne's affidavit, read with Professor Horn's report, that while the risk of infection remained high, in such eventuality where infection spread further in AD's right foot, the result could be a below the knee amputation instead of a Syme amputation. In those circumstances, it followed that AD's mobility would be hugely impaired, if not non-existent.

[53] The risk and threat of further infection and the spread of gangrene higher up AD's legs, plus the consequences thereof were hugely prejudicial and potentially life threatening to the young AD. Thus, the imminent risk to AD's health and life in the case of an urgent amputation where the gangrene had already spread beyond the demarcated areas, was impressed upon the Court during the hearing. Counsel reminded me that AD was only 6 years old, and that any further delay in the matter and the surgical intervention, elevated the serious risks for this young child.

[54] Generally, Courts regard matters involving minor children as inherently urgent. Having considered the application and submissions, my view was that any further delay would therefore mean that AD's constitutional rights to life, access to basic health care[5] and her right to dignity, would continue to be infringed while her father's consent to surgical intervention was being withheld. For all these reasons, the application was considered as extremely urgent.

[55] The medical evidence was set forth in considerable detail in the application and summarised above in the judgment. As mentioned, the evidence also comprised photographs of AD's which clearly depict the extent of the dry gangrene on her legs.

[56] In support of the application, Dr Browne and Professor Horn attached a medical review called *"Systematic Review of Invasive Meningococcal Disease: Sequelae and*

[5] Section 28(1)(c) Constitution

Quality of Life Impact on Patients and their Caregivers"[6]. It is apparent from this medical article, that invasive meningococcal disease (IMD) commonly causes life threatening meningitis or septicaemia.

[57] The authors of the review indicate that the *sequelae* in survivors include severe skin necrosis, amputation of limbs and scarring which require skin grafts. International studies conducted in children, adolescents and adults indicate that IMD survivors are affected not only by physical and neurological *sequelae*, and reduction in quality of life, but also by psychological and behavioural *sequelae*. It is apparent from the medical review that the disease has long-term, life-threatening consequences, which are irreversible and that the *sequelae* of survivors manifest physically, neurologically and psychologically.

[58] From the averments in Dr Browne's affidavit, as read with Ms du Plooy's report, it is evident that AD and her parents would need psychological support, pre- and post-amputation. Amputation of a limb is extremely serious, traumatic and would drastically change the quality of AD's life, hence she and her parents, as her immediate caregivers, would require psychological therapy to assist in any mental health challenges and/or negative feelings arising from or regarding the amputation of her limbs.

[59] In all circumstances, the evidence presented by the medical experts in the matter, as well as the report by Ms Du Plooy, were accepted. The gravity of the situation was made clear and appreciated by all concerned, including counsel, the Family Advocate and the Court. In view of the evidence, I thus accepted that AD's condition was irreversible and that the only acceptable and/or best medical treatment available for her in the circumstances, was surgical intervention in the form of a Syme amputation of the right leg and a below knee amputation of the left leg.

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[6] Infect Dis Ther (20B) 7: 421-438, by KJ Olbrich, D Műller, S Schumacher, E Beck, K Meszaros and F Koerber JB3)

The parents' refusal to consent to AD's surgical intervention

[60] Notwithstanding the fact that this was an unopposed application, it was a difficult and grave matter which weighed heavily on all. No minor child should have to undergo an amputation of her limbs, and no parent should have to hear that their young child, who had barely started out on the journey of life, has a life-threatening disease where amputation of her lower limbs was the only medical treatment available for her. I was mindful that the impact on the child, parents and rest of the family, must surely be profound and possibly devastating.

[61] It is therefore not an everyday occurrence for a hospital, represented by its Medical Superintendent, to approach the High Court urgently seeking relief to allow surgical intervention in respect a child and an order dispensing with the parental consent necessary for such operation. Counsel for the hospital and the Family Advocate emphasised the need for the High Court to step in. At the same time, counsel[7] remained mindful that parental authority must be respected and that AD's best interests were paramount and must be protected. After all, it is AD's right to basic health care services, life, dignity, care and protection which were at risk because of the parents' continued refusal of consent.

[62] As indicated above, section 129(1) of the Children's Act requires the consent of both parents for the surgical intervention to be performed on AD. In addition, section 7(1) read with section 1 of the National Health Act also require that the health service may only be provided with consent of the user or, as in the case of AD, the consent of her parents. Section 7(2) of the NHA states that:

> *(2) A health care provider must take all reasonable steps to obtain the user's informed consent.*

[7] Adv Mahomed for the hospital and Adv Hofmeester, Family Advocate

[63] It is accepted that up until the date of hearing, both parents refused to consent to the surgical intervention and that AD's mother only provided her consent on the hearing date. From the above, it was also the case that the consent was withheld on the basis that the parents wished for AD to receive traditional healing to cure her gangrenous feet and legs.

[64] Section 15(1) of the Constitution protects a citizen's right to religion, conscience, thought, belief and opinion, and section 30 recognises a citizen's right to participate in the cultural life of their choice. Significantly, these sections provide that the exercise of these rights should not be in a manner inconsistent with any provision of the Bill of Rights. On the other side of the scale, we have AD's constitutional rights to dignity[8] , life[9] and basic health care services[10], in addition to the recognition in section 28(2), that her best interests are/were of paramount importance in all matters concerning her.

[65] As illustrated above, the parents exercised their right to dignity, culture choice and religion by insisting that AD underwent traditional healing to cure the gangrene. The hospital, as a public health establishment[11] was required by section 7(2) of the NHA to take all reasonable steps to obtain the parents' consent to the surgical intervention.

[66] As can be seen from the facts presented by Dr Browne, the hospital clearly engaged constantly with the parents. The multidisciplinary medical team, as well as the social workers and psychologist requested of the parents to provide their consent given the serious nature of the disease, the fact that AD could not walk and was unable to travel to the Eastern Cape. Furthermore, the parents were apprised of the diagnosis, medical treatment, progress, assessments and the benefits of amputation. It is

[8] Section 10 Constitution
[9] Section 11 Constitution
[10] Section 28(1)(c) Constitution
[11] Section 41 NHA

apparent that the hospital and staff were keenly aware of the need to obtain the parents' consent, their traditional and cultural beliefs, and the need for their co-operation pre- and post-amputation.

[67] In respecting the parents' dignity and beliefs, the hospital engaged with traditional healers and the father's elder to accommodate such beliefs and invited traditional healers to assess the child in hospital. In this regard, no less than three opportunities were provided to the parents for traditional healing assessments. In view of the insistence that traditional healing could only occur in the Eastern Cape, the orthopaedic team conducted a further assessment to determine whether AD could travel to the Eastern Cape to undergo traditional healing, and as seen from Dr Browne's affidavit, supported by Dr Mkhize and Professor Horn, it was concluded that it was unsafe for AD to travel.

[68] By all accounts therefore, and mindful of the urgency of the situation, the hospital ensured that every attempt was made to involve the parents and obtain their consent. In this regard, the hospital was also mindful of section 129(1) of the Children's Act which requires parental consent for the child's medical treatment or surgical operation. As illustrated by the conduct of the hospital's medical and nursing staff, the social workers and psychologist, and PaedsPal, in my view, the hospital displayed a level of sensitivity and respect for the family's religious and cultural beliefs which was nothing short of admirable.

[69] However, the problem for the parents and the obstacles for the hospital, a public health establishment as defined in section 1 read with section 41 of the NHA, were the following:

[69.1] in terms of section 129(10) of the Children's Act, the parents were not allowed to refuse or withhold consent in terms of sub-section (4) and (5) because of their

religious beliefs unless they could show that there was a medically accepted alternative to the surgical operation (determined by AD's treating medical team);

[69.2] the proposed traditional healing by the two traditional healers, in the form of oral traditional medicine, topical creams and ointment, for all intents and purposes, did not fall under the banner of *"health services"* nor *"municipal health services"* as defined in section 1 of the NHA[12];

[69.3] neither of the traditional healers who assessed AD in the hospital ward provided a medically accepted alternative choice to the surgical operation, and it was incumbent on the parents, or at least the father, to have provided the hospital with a medically accepted alternative choice, as required by section 129(10) to the hospital or its Superintendent;

[69.4] all indications were that the hospital could not allow the practise of traditional healing within its premises, as indicated to the parents and the traditional healers on more than one occasion.

[70] Thus, in view of these factors and circumstances, the hospital satisfied the requirements of sections 7(2) of the NHA and 129(1) of the Children's Act. Furthermore, given the continued refusal of the father's consent based on his religious and cultural beliefs, contrary to section 129(10) of the Children's Act, the hospital was entitled to approach the Court on an urgent basis for relief as set out in the Notice of Motion and any further or alternative relief.

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[12] In terms of the NHA, *"health services"* mean (a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution; (b) basic nutrition and basic health care services contemplated in Section 28(1)(c) of the Constitution; (c) medical treatment contemplated in section 35(2)(e) of the Constitution; and (d) municipal health services.

The High Court as upper guardian of minor children

[71] In paragraph 2 of the Notice of Motion, the hospital sought an order that in terms of section 129(6) of the Children's Act, the Medical Superintendent was authorised to consent to the surgical intervention as described in the application. However, during the hearing and because AD's father continued to refuse to provide his consent, counsel requested the Court to consider granting the alternative relief sought in paragraph 4 of the Notice of Motion, namely, that in terms of section 129(9) of the Children's Act, the Court consents to the surgical intervention required for AD.

[72] After the hearing, and having considered the submissions, the Family Advocate's Memorandum and the application, I indeed granted an order in terms of section 129(9) of the Children's Act, along with further orders as set out above.

[73] The guiding principle in this matter is section 9 of the Children's Act as read with section 28(2) of the Constitution. These sections state that in all matters involving minor children, the best interest of the minor child is paramount. Applying this as the overarching principle , I was moved to grant an order in terms of section 129(9) of the Children's Act, rather than an order in terms of section 129(6).

[74] The decision to grant such order was based on several factors. Firstly, an order in terms of section 129(9) was indeed sought as an alternative order, hence it was always up to the Court to consider it as appropriate relief which was/is sanctioned in terms of the Children's Act.

[75] Secondly, and significantly, the common law vests a High Court with the authority and role as upper guardian of all minor children within its area of jurisdiction[13]. Ultimately, this Court was called on to strike a balance between respecting the religious

[13] Calitz v Calitz 1939 AD 56 at 63; Oosthuizen v Road Accident Fund 2011 (6) SA 31 (SCA) para [15]

and cultural beliefs of the parents to allow their child to receive or undergo traditional healing, versus the protection of the child's right to receive health services, her right to life and dignity, and the protection of her best interests.

[76] The facts of the case and the continued refusal of the father to provide consent presented a conflict between these competing rights of the parents to practice their religion and the exercise of their custom, and AD's rights. Guided by the principle that in all matters involving children, the best interests of the child is paramount, I refer to ***Hay v B and Others***[14], a matter where the parents of a baby/infant who required an urgent blood transfusion, objected to the acceptance of the blood transfusion as it was contrary to their religious beliefs. Having to weigh up the balance between the competing interests of the parents versus that of the infant, Jajbhay J had the following to say:

> *"In terms of section 28(2) of the Constitution of the Republic of South Africa, Act 108 of 1996, (the Constitution) a child's best interests are of paramount importance in every matter concerning the child. This is the single most important factor to be considered when balancing or weighing competing rights and interests concerning children. The duty to afford children protection falls on the law enforcement agencies, all right- thinking people and ultimately the Court, which is the upper guardian of all children. These are the principles which should apply in dealing with the first and second respondents' objections to the administration of the blood transfusion."*

[77] While ***Hay v B*** was decided prior to the enactment of the Children's Act, and therefore the section 129(10) limitation to a parents' religious and cultural objections where consent to medical treatment and surgical operation in respect of their child was required, I nonetheless align myself fully with the approach and *dicta* in ***Hay v B***.

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[14] 2003 (3) SA 492 (WLD) 492 at 494I – 495 A

[78] A similar view was held in ***Life Health Care Group (Pty) Ltd v JMS (As Parent and Guardian of the Infant Child MT)***[15], a judgment of the Gauteng Local Division, Johannesburg, which dealt with an application by a medical expert and treating doctor of an infant who faced imminent cardiac failure and respiratory distress and thus required a lifesaving blood transfusion, except that the parents objected to their child receiving a blood transfusion based on their religious beliefs. The Court in ***JMS***, in weighing up the competing interests of the parents and the bests interests of the infant, found the parents' refusal to consent to the transfusion as unlawful and it exercised its power in terms of section 129(9) of the Children's Act, and authorised the blood transfusion.

[79] In my view, the parents' persistence that AD was to be removed to the Eastern Cape for traditional healing; the father's verbalisation to the medical team that he would not return AD to Cape Town after the traditional healing ceremony; the parents' lack of providing a medically accepted alternative choice to the surgical intervention and the father's continued refusal to consent to the surgical intervention, all informed me that the father's objection based on religious and cultural beliefs and custom, placed AD's health, dignity and life at risk. This was not a case where AD, the medical team and the hospital, had time at their disposal. Thus, I was accordingly convinced that the limitation presented by section 129(10) of the Children's Act on the parents' rights in the Bill of Rights to exercise their religious beliefs and custom, was justified by section 36 of the Constitution.

[80] While I would not lightly interfere with parents' rights to consent and care for their child, this was a case where intervention in terms of section 129(9) was necessary and justified. I was mindful that the medical evidence presented that AD was physically well, but her condition because of the meningococcal septicaemia was such that she could not be discharged. There were further areas indicating that the infection had spread on her limbs and there was thus the immense risk of further infection to her lower limbs. The surgical intervention requested was, in the circumstances, the best

[15] [2014] ZAGPJHC 299 para [11] – [16]

medical treatment available for AD. In view of the evidence, AD would still, post-rehabilitation and with the provision of prosthetics and physiotherapy, be mobile.

[81] In all the above circumstances, I was therefore satisfied that the applicant made out a proper case for an order in terms of section 129(9) of the Children's Act, and the additional relief as set out in the order granted on 11 March 2026. In conclusion, the State attorney and counsel for the applicant, as well as the Family Advocate are thanked for their sensitivity in dealing with this matter. The multi-disciplinary medical and nursing teams, social workers, psychologist and the hospital, are commended for their approach to a very difficult matter: their approach to the parents' need to exercise their religious beliefs and the understanding of the principle that AD's best interests were (and are) of paramount importance, is appreciated by the Court.

M PANGARKER

JUDGE OF THE HIGH COURT

Appearances:

For applicant:	**Adv S Mahomed**
Instructed by:	**Ms N Mboto**
	State Attorney
	Cape Town

For respondents: No appearances

Family Advocate:	**Adv J Hofmeester**
	Cape Town