

SOUTH AFRICA / JUDGMENT

N.M v Member of the Executive Council for the Department of Health - Eastern Cape

(227/2017) [2024] ZAECBHC 32 (27 August 2024)

[2024] ZAECBHC 32

COURT
Eastern Cape High Court, Bhisho

BEFORE
Smith

CASE / FILE NUMBER
227/2017

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IN THE HIGH COURT OF SOUTH AFRICA
(EASTERN CAPE LOCAL DIVISION, BISHO)

Reportable/Not Reportable

Case no.: 227/2017

Matter heard on: 26 April 2024

Judgment

delivered on: 27 August 2024

In the matter between: -

N[...] E[...] M[...] Plaintiff and MEMBER OF THE EXECUTIVE COUNCIL FOR THE DEPARTMENT OF HEALTH – EASTERN CAPE Defendant

JUDGMENT

SMITH J

Introduction

- [1] The plaintiff instituted civil proceedings against the defendant in her personal and representative capacity on behalf of her minor child, W[...] (“the child”). The claim is based upon the alleged negligence of the medical or nursing staff of the Nessie Knight Hospital

(“the hospital”) which, according to the plaintiff, resulted in the child suffering from brain damage, leading to cerebral palsy. At the commencement of the trial, I ordered the separation of liability and quantum, and the matter consequently proceeded in respect of liability only, with the issue of quantum having been postponed sine die.

- [2] The following material facts are common cause. The plaintiff was admitted to the hospital on 26 April 2007, at 13h20, complaining of lower abdominal pain. There was no history of rupture of the membranes. She and the foetus were examined at 13h20. The foetus was in a cephalic presentation and longitudinal lie, and the foetal heartrate (FHR) was recorded as normal. The cervix was 6 cm dilated and the membranes were intact.
- [3] The drug Pitocin was administered at 10h00 the next day but the rate of timing and administration was not documented. The FHR was once again recorded as being normal. The child was born at 16h10 on 27 April 2007. It was common cause that the child suffered serious brain damage, and the defendant, inter alia, admitted that ‘the MRI features are diagnostic of an acute profound pattern of hypoxic ischemic brain injury in a term brain.’
- [4] The parties held several pre-trial conferences, which resulted in comprehensive agreements in respect a number of disputed issues. The defendant made the admissions after he was forced to abandon the only possible defence he could proffer
 - namely that there were genetic reasons for the injury - when that possibility was discounted by metabolic array and Whole Exome Sequencing (WES) testing. In both cases his expert, Dr Keshave, had clearly stated that if these tests were negative, then he concedes that the child has Hypoxic Ischemic Encephalopathy (HIE).
- [5] At the commencement of the trial, the plaintiff’s counsel contended that the effect of the admissions was that little, if any, lis remained between the parties. Because it appeared to me that the plaintiff’s counsel was correct, I invited the defendant’s counsel to explain which issues he considered as still being alive. The Court was then, for the first time, informed that the defendant recognised that the admissions were destructive of his defence and that he intended to withdraw them. The defendant thereafter brought a formal application for leave to withdraw the admissions, which was dismissed with costs on the attorney and client scale.
- [6] When the trial resumed, two exhibits were handed in, namely Exhibit A, containing admissions between the parties during the pre-trial conferences and Exhibit B, containing extracts from the joint minutes prepared by the experts. Although these documents were prepared by the plaintiff’s legal representatives, it was common cause that they correctly reflected the contents of the relevant pre-trial minutes and the various experts’ joint minutes.
- [7] The following are some of the more crucial admissions:

‘That pursuant to the medico-legal report of parties’ experts, Dr Hayes and Dr Zikalala, and the joint minute between Prof Lotz and Dr Zikalala:

7.1. The defendant admits that the MRI features are diagnostic of an acute profound pattern of hypoxic ischemic brain injury in a term brain.

7.2. The defendant admits that from the available hospital records, the clinical picture and the MRI picture, there are no indications of antenatal or postnatal causes that contributed to the brain injury of W[...].

7.3. That pursuant to the joint minute between Prof van Toorn and Dr Keshave –

7.3.1. The defendant admits that the maternity case records indicate no maternal medical condition and no evidence of placental infection.

7.3.2. The defendant admits that W[...]’s birth weight was 3200g (between 10th and 50th percentile) which is within normal limits and argues against intrauterine growth restriction.

7.3.4. The defendant admits that given the following three important features, it is agreed that an intrapartum insult is the likely cause of neonatal brain injury:

7.3.4.1. Evidence of fetal distress and/or fetal risk for hypoxia/ischemia (e.g. fetal heart rate abnormalities, sentinel event, fetal academia).

7.3.4.2. The need for resuscitation and/or low Apgar scores:

7.3.4.3. An overt neonatal neurological syndrome in the first hours and days of life.

7.3.5. The defendant admits that there was no evidence of a sentinel event (no cord prolapse, no placental abruption, no uterine rupture, no maternal collapse, no fetomaternal bleed and no traumatic delivery);

7.3.6. The defendant admitted that the active and second stage of labour represents the most dangerous time of labour when uterine (womb) contractions are at their most frequent and strongest.

7.3.7. The defendant admitted that every contraction decreases the flow of blood into the intervillous space, resulting in less oxygen rich blood available for transfer to the fetus.’

[8] It was clear from the contents of those exhibits that there was no real lis between the parties, since:

(a) It was admitted that there was an intrapartum hypoxic ischemic injury to the foetus.

(b) It was admitted that there was prolonged resuscitation necessary at the birth of the child.

(c) It was conceded that there was improper monitoring of the plaintiff who had become a high-risk patient due to the prolonged labour and the administering of Pitocin.

- [9] Despite these crucial concessions, the defendant's counsel refused to accept that where an intrapartum hypoxic ischemic injury occurred and there were clear risk factors involved which were not properly addressed through monitoring, the only logical inferences to be drawn is that there was causal negligence and that the defendant is liable for the injury to the child. However, the defendant's counsel attempted to pull defences out of the hat, such as the possibility of a perinatal stroke, a denial that HIE was present, a denial that the child had been in an injured state, and finally, that the injury was unforeseen because of the 'acute profound' nature thereof.
- [10] The defendant's stubborn refusal to nail its defensive colours to any particular mast, necessitated the plaintiff's legal representatives to call most of its witnesses. I must emphasize that those witnesses were not called to establish any of the issues that have been admitted but merely to explain to the Court the extent and meaning of those admissions. The result was that the cross-examination of the plaintiff's witnesses constituted a litany of irrelevant questions, most of which were ruled inadmissible.
- [11] During the course of the trial, defendant's counsel, after I expressed my dissatisfaction about the defendant's approach in respect of the admissions that had been made, informed the Court that he had discussed the matter with his instructing attorney and it was decided that he should draw a memorandum regarding the further conduct of the matter for the defendant's consideration.
- [12] After I allowed him an opportunity to consult with the defendant, counsel informed the Court as follows:
- (a) 'The defence of the Department is one, that notwithstanding sub-standard monitoring, the injury was not caused, rather such substandard monitoring did not lead to the injury.'
 - (b) 'The injury was neither foreseeable nor preventable. More particularly that it is common cause between the parties that this was an acute profound type of injury.'
 - (c) 'Now the third, the defence of the Department is that in all probability B[...] (sic) suffers from and continues to suffer from a perinatal stroke. And the evidence we will have to elucidate whether at the time that the injury occurred that asphyxia occurred, he had already had the stroke or it occurred thereafter. This will be a matter for evidence.'
- [13] Regarding (a), this issue has been dealt with in the admissions and was no longer part of the lis between the parties. I accordingly did not allow any cross-examination in respect of the perinatal stroke. And regarding (b), this defence is absent from any of the reports of defendant's expert witnesses. This is clearly an afterthought, not based on any of the experts' reports. Consequently, the issue of negligence is no longer in dispute and all that remains is the question of the causal link between the negligence and the injury.
- [14] The defendant has, at various stages of the proceedings, contrived to proffer the following, sometimes conflicting defences. First, there was the issue of metabolic insults. The tests were, however, negative. Then there was a theory about genetic testing. This also came up

negative. When the previous two defences fell away, the defendant's paediatric expert, Dr Keshave, suggested genetic causes. He had, however, conceded in an email that if the WES testing came up negative, then he would concede that the insult was HIE. The defendant then still identified a perinatal stroke as part of the lis. Therefore, as far as the defendant is concerned, the remaining lis between the parties was the perinatal stroke and the acute profound hypoxic ischemic event.

[15] In the final analysis therefore:

- (a) The possibility of a perinatal stroke had been excluded in terms of the pre-trial admissions and can consequently be ignored;
- (b) The issue of negligence is no longer in dispute;
- (c) The issue of any metabolic or genetic cause has not been identified as remaining a lis; and
- (d) The only other remaining defence, namely that of "acute profound injury" has not at any stage been raised in the defendant's expert reports.

[16] It was against the backdrop of these often confusing and contradictory array of contrived defences that the plaintiff was constrained to lead her evidence. Even though most aspects of the plaintiff's expert witnesses had been covered in the admissions, I have nevertheless allowed her to lead evidence - in what was essentially a 'belt and braces' approach - because of the opportunistic manner in which the defendant conducted his defence. I accordingly only summarise the most crucial aspects of their testimonies.

The evidence of Dr Gericke

[17] As mentioned, Dr Gericke, a geneticist, was called to explain to the Court what the result of the admissions are and not to prove them. Plaintiff's counsel went to great lengths to qualify Dr Gericke and to invite him to explain to the Court what an extremely specialised field genetics is. Although paediatric neurologists will have some knowledge of genetics, they will not be remotely as qualified as a geneticist to testify about genetics. The result is that Dr Gericke's testimony, to the extent that it has not been contradicted by credible and admissible evidence, must be accepted without reserve.

[18] It is not necessary to analyse his evidence in any detail as it was also common cause that there are no metabolic reasons for the brain injury. Moreover, there was also agreement between the two geneticists that there are no genetic indications for the child's brain injury and consequent cerebral palsy. During the cross-examination of Dr Gericke there was some attempt to deal with the significance of the WES test. Plaintiff's counsel, however, objected to the question on the basis that there was an agreement between the geneticists that there was no metabolic or genetic cause for the injury. This objection was upheld and all further cross-examination on this issue was stopped. There is therefore no reason why Dr Gericke's evidence cannot be accepted without any reservations.

Evidence of Prof Van Toorn

[19] Prof Van Toorn is a paediatric neurologist. His evidence was to the effect that, in considering what caused the brain injury, the clinician must look at all the relevant factors, including the MRI, the antenatal history, the history of complications during labour, and the post-natal treatment. Having regard to all of the above - including the fact that Oxytocin (Pitocin) was administered and not properly monitored - Prof Van Toorn had no doubt that the cause of the brain injury was a hypoxic ischemic insult during the labour process (intrapartum). He explained this aspect as follows in his report:

‘The very prolonged active phase of labour, the suboptimal monitoring labour, the depression at birth (poor one minute Apgar score), the need for prolonged resuscitation and neurological abnormalities (abnormal eye movements) shortly after the birth are all supported of intrapartum hypoxic ischemic encephalopathy.’

[20] Notwithstanding the admissions, defendant’s counsel insisted on asking the witness questions about the perinatal stroke. Prof Van Toorn explained that a perinatal stroke would be indicated quite differently on the MRI.

[21] When it was put to Prof Van Toorn that the injuries were not foreseeable, sudden, and not preventable, he replied that with the administration of Oxytocin and the uterus contracting, the injury is predictable and there should therefore have been proper monitoring.

[22] The cross-examination of Prof Van Toorn then dealt with two aspects, i.e. cord compression and the fact that “an acute profound insult” was indicated on the MRI. The questions regarding the perinatal stroke were disallowed for reasons explained above.

[23] Prof Van Toorn pointed out that in the joint minute between himself and Dr Keshave, he had invited Dr Keshave to identify the issues. He said further that Dr Keshave had not in any way dealt with the fact that an acute profound insult may be unforeseen and sudden nor had he at that stage mentioned the possibility of a perinatal stroke. Indeed, Dr Keshave had stated that:

‘In view of the above I feel that the test mentioned in point 28 need to be done – if they return negative then hypoxic injury seem to be the most likely cause of this condition.’

[24] And in an email to Prof Van Toorn after the further requested WES tests, Dr Keshave said that:

‘In view of the above – if WES test returns negative, I have nothing further to add – an HIE is a cause of his symptoms.’

- [25] Prof Van Toorn was then cross-examined about the possibility of cord compression. Although this had not been mentioned by any of the defendant's experts, Prof Van Toorn explained that a cord compression can compromise the rate of blood-flow to the brain. It was incorrectly put to him that the foetal heart rate was reassuring throughout as only the recordings that were done were reassuring. It also bears emphasize that these were not CTG recording but a 'moment in time' FHR.
- [26] He was then asked whether he could exclude cord compression. He replied that it was a possible cause of the brain injury. It would, however, only have been tolerated for a certain amount of time. If labour is prolonged there are two mechanisms in respect of the interference with the blood-flow, namely that the cord is compressed too long, or the placenta is interfered with. This is because of the contractions during labour. However, he was of the view that this would be speculative.
- [27] It was put to him that cord compression would not be visible and cannot be detected. He stated that it can be detected because during the time when there is cord compression distress of the foetus will be picked up by proper monitoring.
- [28] Insofar as cord compression being a sentinel event, Prof Van Toorn said that this would be a wrong description if regard is had to the American Congress of Obstetricians and Gynaecologists 2019 publication (ACOG). Prof Van Toorn testified that according to ACOG (2019) cord compression is not a sentinel event and it is 'partial over a long duration.'
- [29] It was put to Prof Van Toorn that the type of injury incurs in the last few minutes of delivery. He was, however, adamant that there was no sentinel event. In the event, there is an admission in the joint minutes that there was no sentinel event and defendant's counsel clearly stated during cross-examination of Prof Van Toorn that there was an agreement that there was no sentinel event.
- [30] It was further put to Prof Van Toorn that this type of injury (acute profound) is not foreseeable, sudden and not preventable. Prof Van Toorn said when Oxytocin is administered and the uterus is contracting, it cannot be said that the type of injury is not preventable. He pointed out if there is no sentinel event, there are risk factors such as the prolonged labour and the administering of Oxytocin or Pitocin. He could not agree that the injury would therefore be unforeseen. Prof Van Toorn explained what occurs when there is no sentinel event, saying that there is 'a crescendo and a slow build-up, then a complete collapse when the insult becomes an injury.' He explained that there is no neurological damage during the build-up to the crescendo and when the foetus cannot cope anymore, acute damage is caused.

- [31] Prof Van Toorn stated under cross-examination that there was foetal distress (whether this should have been picked up he deferred to the obstetrician), indicated by the risk factors and low Apgars, as well as the need for resuscitation. The neurological abnormalities were the seizures, which had been admitted in the joint minute as well as in the pre-trial admissions.
- [32] During re-examination plaintiff's legal representatives dealt with the article of Smith et al (which is in the bundle of authorities) as well as ACOG 2019. Prof Van Toorn made it clear that if ACOG 2019 had been published, it would not have been necessary to publish the article of Smith et al, of which he is a contributor. Both ACOG 2019 and the article (which has been peer reviewed) is authority for the fact that what has been described by the radiologists as 'acute profound' is not the type of injury which has for years been described as acute profound and caused by a sentinel event such as abruptio placentae, burst uterus, etc. Where there is no such sentinel event, and if there is evidence of inadequate monitoring or risk factors such as administering of Oxytocin or prolonged labour, the overall picture will indicate what the probabilities are. This is also confirmed in terms of ACOG.
- [33] Prof Van Toorn testified that one does not simply look at the MRI but at all factors, and in this regard, he referred to the following excerpt from ACOG which he read into the record:
- 'To determine the likelihood of an acute hypoxic-ischemia event occurring within close temporal proximity to delivery contributed to neonatal encephalopathy, it is recommended that a comprehensive multi-dimensional assessment be performed of neonatal status and all potential contributing factors, including material medical history, obstetric antecedents, intrapartum factors (including foetal heartrate monitoring result and issues relating to delivery itself, and placental pathology).'
- [34] Prof Van Toorn unequivocally stated that ACOG 2019 confirms that the type of injury contended for by the plaintiff in this case has now been recognised by that institution. With reference to the relevant portion of ACOG, he testified that the medical science now recognises the type of injury and brain damage occurring over a long period of time without causing any damage, until the final and complete breakdown causing the injury. He again emphasized the aetiology, namely that it is a cascade leading to a final crescendo, in other words, slow insults leading to eventual complete collapse over hours. He also reiterated that the foetal heartrate monitoring showed on the medical documents are of no value whatsoever as it is simply 'a moment in time' and not a cardiotocographical recording.

Evidence of Dr Ebrahim

- [35] The testimony of Dr Ebrahim's (an expert obstetrician) was also tendered against the backdrop of the common cause facts in terms of Exhibits A and B. He testified that because of the normal antenatal record there is no evidence of antenatal brain damage, and it is extremely unlikely that the child's disabilities due to brain injury occurred in the antenatal period. Regarding suggestions that there was nothing wrong with the child after birth, he refuted them, referring to the Apgar score after 10 minutes, which was 6 out of 10, with

extremities still blue and floppy.

- [36] He said that the first stage of labour was an excessive 25 hours. Pitocin, which was used to accelerate labour, is a potent stimulator of uterine contractions capable of independently causing foetal hypoxia, foetal distress and even perinatal death. It is therefore essential to ensure continued (or at least frequent intermittent) monitoring and placement when Pitocin is used in labour.
- [37] He said that each contraction causes an intermittent increase in intra-uterine pressure, which briefly reduces utero-placental vascular perfusion. A physiological but negative consequence for the foetus is a transient drop in tissue oxygen transfer. A healthy foetus with good reserves has built-in adaptive mechanisms to cope with this novel stress and emerges unaffected. But if its reserves were just about sufficient to cope with the usual demands of the antenatal period, it may become hypoxic and develop signs of distress during labour due to the additional stress caused by contractions.
- [38] He testified further that the Plaintiff was a low-risk antenatal patient but the risk status changed during labour. First, because her labour was prolonged, resulting in an unborn baby being exposed to a greater hypoxia risk for a longer period of uterine contractions, and second, from the increased frequency and strength of uterine contractions due to the use of Pitocin late in labour. Although the partograph and clinical notes show that the FHR was checked at half hourly intervals during the first stage of labour, apparently by intermittent auscultation by the nurse from about 08h30 until about 13h30 and then hourly until full dilation 15h30, there were no checks during the entire bearing down or pushing phase of the second stage. Indeed, the bearing down phase of the second stage of labour is the most hazardous period for the foetus. During this stage the risk of foetal hypoxia increases due to: (a) a reduction in placental perfusion from stronger and longer uterine contractions and maternal bearing down efforts; (b) a decrease in cerebral perfusion of the foetal head compression against the pelvis or pelvic floor; and (c) umbilical cord compression or possible tightening of a nuchal cord (if present) due to the foetal head descent.
- [39] In his opinion, since the foetal FHR was apparently completely normal in the entire first stage and there was no FHR monitoring in the second stage, it appears likely that undiagnosed foetal distress occurred in the second stage. If appropriate monitoring had been carried out in the second stage, foetal distress would have been diagnosed immediately and urgent delivery, most probably by vacuum extraction or forceps, would have resulted in an earlier birth of a healthy baby, without hypoxic injury.
- [40] He then explained why there would have been FHR abnormalities and testified that it is unlikely to occur without the foetus demonstrating certain pathogenic evidence, most commonly FHR deceleration or foetal bradycardia. He was therefore of the opinion that the apparently normal FHR record on the plaintiff's partograph is not an accurate reflection of the true status of the FHR during labour. It is highly likely that FHR abnormalities indicative of foetal hypoxia or foetal distress were not detected in labour because FHR monitoring was

not conducted correctly. If appropriate FHR monitoring by CTG had been implemented during labour, particularly if Syncocinin was administered, foetal distress would most probably have been diagnosed early enough to enable timeous delivery of the baby and he would most probably have been born in a healthy condition.

- [41] Dr Ebrahim then gave a well-reasoned exposition as to why it is likely that the damage occurred during the intrapartum period and could have been avoided if proper monitoring had been done. He then dealt with the foreseeability of the monitoring leading to the injury. This establishes not only negligence, but also causal negligence. He said the following in this regard, '[t]hus the omission of appropriate FHR monitoring in Ms M[...]’s labour is an omission of one of the essential aspects of midwifery care and the potential consequences for the foetus (and mother) are

common knowledge to all personnel involved in pregnancy care. If standard recommendations for labour monitoring were carried out, the outcome of this pregnancy is likely to have been the birth of a healthy baby and brain injury would not have occurred.'

- [42] The second part of Dr Ebrahim’s evidence dealt with the belated defence, the so-called ‘acute profound injury’, which occurs in the last 10 minutes or so of birth and is totally unpreventable. He dealt with the umbilical cord compression and in a scientifically compelling explanation he told the Court that this is highly unlikely to have occurred in the last 10 minutes of birth. He said that frequently FHR decelerations are triggered but neuro injury does not occur, and thus concluded that,

‘...the currently normal FHR record that was obtained by this substandard method of monitoring which was conducted in a substandard manner cannot be regarded as an accurate reflection of the state of health of the foetus in the hours before birth.’

And,

‘With the benefit of hindsight in particular knowledge of W’s condition of birth it is highly likely that an abnormal FHR prevailed over the significant amount of time, probably hours before W’s birth. It is also probable that this abnormal FHR was due to non-injurious cerebral hypoxia.’

- [43] These persuasive scientific arguments, based on the available undisputed facts, compel a finding that where there is no sentinel event and there is evidence of substandard monitoring during the intrapartum period, the insult leading to the eventual injury occurred over a number of hours and could and should have been identified during the course of labour had there been proper monitoring - which was not the case in this matter - and that early intervention would have saved the child from the devastating injury.

Applicable

legal framework

- [44] It is trite that the onus of proving negligence on a balance of probabilities rests with the plaintiff. Should the plaintiff establish that a legal duty was breached negligently, this would satisfy both the elements of unlawfulness and negligence.
- [45] The test was explained as follows in *Kruger v Coetzee*[1]:
- ‘For the purposes of liability culpa arises if –
- (a) a diligens paterfamilias in the position of the defendant (or his employees) –
 - (i) would foresee the reasonable possibility of his (their) conduct injuring another in his person or property and causing him patrimonial loss; and
 - (ii) would take reasonable steps to guard against such occurrence; and
 - (b) the defendant (or his employees) failed to take such steps.’
- [46] It need only be foreseeable that the plaintiff will suffer damages but the precise nature of the damages need not be precisely foreseeable at that stage.[2]
- [47] Although the onus of proving negligence is on the plaintiff, ‘the plaintiff does not have to adduce positive evidence to disprove every theoretical explanation which is exclusively within the knowledge of the defendant, however unlikely, that might be devised to explain (his paraplegia) in a way which would absolve the defendant and his employees of negligence.’[3]
- [48] It is trite that if a plaintiff is not in position to produce evidence on a particular aspect, less evidence will suffice to establish a prima facie case where the matter is peculiarly within the knowledge of the defendant. In such situations, the law places an evidentiary burden upon the defendant to show what steps were taken to comply with the expected standards. The onus nevertheless remains with the plaintiff.
- [49] In *Minister of Safety and Security and Another v Carmichele*[4] the Court confirmed that causation has two elements: -
- (a) The factual issue to be established on a balance of probabilities by the plaintiff by using the ‘but for’ test would involve the mental elimination of the wrongful conduct in the posing of the question as to whether upon such hypothesis, the plaintiff’s loss would have ensued or not; and
 - (b) The legal causation, namely whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is a juridical problem and considerations of policy may play a part in the solution thereof.
- [50] In *Caswell & Powell Duffryn Associated Collieries*[5] Lord Wright remarked:

‘Inference must be carefully distinguished from conjecture or speculation. There can be no inference unless there are objective facts from which to infer the other facts from which it is sought to establish. In some cases, the other facts can be inferred with as much practical certainty as if they had been actually observed. In other cases, the inference does not go beyond reasonable probability. But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture.’

[51] Regarding the inference to be drawn it was held in *AA Onderlinge Assosiasie Bpk v De Beer*[6]:

‘It is not necessary for a plaintiff invoking circumstantial evidence in a civil case to prove that the inference which he asks the Court to make is the only reasonable inference. He will discharge the onus which rests on him if he can convince the Court that the inference he advocates is the most readily apparent and acceptable inference from a number of possible inferences.’

[52] In *Reece and Others v Harris and Others*[7] the following was stated that a hypothesis: -

‘To be logically sound, it must be consistent with all the proved facts, and it must not postulate facts which have not been proved.’

[53] In *Oppelt v Department of Health*,[8] it was held that:

‘A plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.’

[54] The hospital staff is obliged to provide healthcare which has to be exercised with reasonable skill, care and diligence (see *Mathebula* (supra) at p 120, paragraph 92).

In *Mitchell v Dixon* 1914 AD 519 at 525 it was held that: -

‘A medical practitioner is not expected to bring to bear upon the case the highest possible degree of professional skill but is bound to employ reasonable skill and care; and is liable for the consequences if he does not.’

[55] The following was stated by *Boberg*[9]:

‘Obviously the ordinary reasonable man test of negligence cannot be applied to an activity calling for expertise that the ordinary man does not possess. One cannot judge assertions conduct by asking how diligent paterfamilias would have operated.’

[56] It has been held by the Supreme Court of Appeal that it cannot be argued that poor people who have to make use of public hospitals must expect worse treatment than other citizens.

[10]

Rulings regarding the defendant’s witnesses

- [57] During the course of proceedings on Monday, 26 February 2024, and before closing plaintiff's case, her counsel stated that he would object to any attempt by the defendant to lead evidence that was contrary to the admissions already made. He also stated that he would object to any attempt to lead evidence not properly set out in the medico-legal reports of the defendant's experts. He submitted that none of the defences identified by the defendant's counsel during the cross-examination of Prof Van Toorn was mentioned in the medico-legal reports and they had in any event been excluded in terms of the pre-trial admissions.
- [58] I then ordered the parties to furnish the Court with written submissions prior to close of business on 27 February 2024, setting out: (a) what the defendant intended to prove; (b) where this was dealt with by defendant's experts in their medico-legal reports; (c) submissions regarding whether they did not or did clash with the admissions already made.
- [59] Plaintiff's legal representatives established through comprehensive submissions, with reference to the medico-legal reports, that the remaining contentions appeared neither in the defendant's expert reports or fell foul of Exhibit A. Defendant's counsel, however, did not furnish a written list of submissions but did so in the form of an opening address, setting out what the defendant intended to prove.
- [60] First, it must be emphasised that defendant's legal representatives made absolutely no effort to identify where in the medico-legal reports of defendant's witnesses the issues so identified appeared. This was not surprising as they are not mentioned in any of the reports. In fact, the first point raised by defendant's counsel (which he indicated he would prove through Dr Janowski), namely that 'the plaintiff's FHR during labour and before delivery was in normal range, with good variability and without delayed or late decelerations and was monitored regularly', finds the opposite in the report of Dr Janowski. The latter said the following: [t]here is no record that EFM was done as per guideline recommended for the plaintiff being augmented with Oxytocin infusion, however continuous EFM was ordered by the doctor.' This also falls foul of the defendant's own identification of the issues during trial.
- [61] The defendant indicated that he would introduce evidence that there was no scientific basis to suggest that the injury occurred intrapartum, that there is no evidence of intrapartum hypoxia and that neither hypoxia nor ischemia can be assumed as having been the initiating causal mechanism. Further, that evidence will be led to the effect that neurological injury sustained by the child cannot be timed to the intrapartum period. This proposition was obviously contrary to the clear admission that, 'the injury was a hypoxic ischemic event occurring during the intrapartum period.'
- [62] I accordingly ruled that evidence to this effect, including any other evidence that would relate to any of the admitted issues, would be irrelevant and accordingly inadmissible. Defendant's counsel refused to close his case, and the Court was consequently constrained to declare it closed.

The plaintiff's submissions

- [63] The plaintiff's counsel submitted that the defendant attempted to create a sentinel event and through that to argue that it was a so-called 'acute profound' event which was not foreseeable, and which would have occurred in the last few minutes prior to birth. He argued that the defendant led no evidence to that effect at all and there was no mention of an 'acute profound defence' in defendant's expert summaries.
- [64] He submitted that the following common cause factual matrix apply to the child's injury:
- (a) A healthy mother and foetus entered the hospital;
 - (b) During the course of labour the mother became a high risk patient due to the seriously extended labour;
 - (c) At some stage a decision was made to augment the labour process by administering Pytocin;
 - (d) When Pytocin is administered, special care should be taken thereafter in terms of the maternity guidelines. There was no proper monitoring of the foetus from approximately 13:00 during the remainder of the birth process;
 - (e) The child was born suffering from hypoxic ischemic encephalopathy (HIE);
 - (f) The child suffered a hypoxic ischemic injury in the intrapartum period, i.e. during labour;
 - (g) There is no evidence of any extraneous factors impacting on the condition of the child, such as genetics, metabolic disorders, strokes, etc; and
 - (h) There is no evidence of a sentinel event. In fact, there is an agreement that there was no sentinel event, and it was unequivocally stated by defendant's legal representative to be the case during the cross-examination of Prof Van Toorn.
- [65] While the Supreme Court of Appeal on occasion found that even if there was negligence during the course of labour, this would not necessarily have the result that the defendant is liable as the negligence might not be causal to the final injury, which in the case of a sentinel event may be sudden, unforeseeable and unpreventable. A sentinel event has been defined as a sudden and unforeseen occurrence resulting in an immediate insult such as a burst uterus, abruptio placentae, etc. However, in the cases where the above finding was made, there was either an agreed sentinel event or the court found that there was such a sentinel event.
- [66] Plaintiff's counsel submitted that the science which has now evolved confirms what the plaintiff contends for in this case. The fact that there is agreement that there was no sentinel event in this case distinguishes from cases adjudicated on the basis of a finding that there was a sentinel event.

Defendant's

submissions

- [67] It was not surprising that, in the light of the comprehensive and crucial pre-trial admissions, the defendant was hard put to proffer an acceptable refutation to the compelling case presented by the plaintiff. The defendant's counsel has nevertheless made a valiant attempt to present some sort of argument in this regard.
- [68] Most of the points raised on defendant's behalf, such as the criticism that the plaintiff failed to testify, the assertion that the Court ascended into the arena, and the complaint that he was not allowed to call witnesses, can be dismissed out of hand. The only argument that warrants some consideration is that relating to the issue of the contended 'acute profound' nature of the injury and thus to the issue of causation. That argument went as follows.
- [69] Counsel for the defendant submitted that the child's injury, being the acute profound type, occurred suddenly, unexpectedly and was neither foreseeable nor preventable. The plaintiff's claim should therefore be dismissed on the facts and the law, especially as the child suffered an acute profound injury as opposed to a partial prolonged injury.
- [70] He argued that the court must have regard to the scientific features and mechanisms of an acute profound injury as opposed to a partial prolonged injury, as pronounced by the Supreme Court of Appeal in judgements which are binding on this Court. He submitted that it was disingenuous of the plaintiff's expert witnesses to testify that foetal irregularities will always show regardless of a clear distinction between partial prolonged and acute profound hypoxic ischaemic brain injuries. In this regard he referred to the Supreme Court of judgment in MEC for Health, Eastern Cape v Z M obo L M[11] where that Court dealt with the distinction and the mechanism from which these insults originate. The plaintiff's witnesses should therefore not have assumed that the plaintiff's labour was preceded by appearances of variable, late and prolonged decelerations and a drop of FHR.
- [71] He submitted that the science does not support the opinions expressed by the plaintiff's experts that hypoxic ischaemic brain injury can exist without being preceded by foetal heart rate abnormalities. In this regard he referred to a plethora of cases where courts drew distinction between acute profound and partial prolonged injuries. The plaintiff's expert evidence therefore lacks a proper scientific basis and is premised on wrong inferences. Consequently, this Court should reject this evidence.
- [72] The defendant's counsel also criticised Dr Ebrahim for changing his evidence regarding the monitoring of the plaintiff's condition prior to and during delivery. He had stated in the main report that the FHR was normal, which is a sign of wellbeing, and that the foetal distress was not foreseeable and preventable. He stated that the FHR monitoring was done properly until 15:30. His only issue with the 15:30 monitoring was that the existence or otherwise of decelerations was not reflected. In his testimony in Court. however, he criticised the standard of monitoring.

- [73] Insofar as causation is concerned, he argued that the question for consideration is whether the defendant's negligence as alleged
- which allegation is denied - caused the child's injury. In other words, is there a nexus between the failure to monitor the plaintiff and foetus, the failure to detect a heartbeat, the delay in causing her to deliver vaginally, and the administration of Oxytocin and the CP. In this regard he urged the Court to conclude that the probabilities are that the child's impairments are secondary to intrapartum hypoxia due to an acute profound hypoxia from a non-foreseeable and non-preventable event, in the last hours before birth, and that the acute insult was not proceeded by a partial prolonged insult.
- [74] He submitted that the inference that plaintiff asks the Court to draw is not the most apparent and acceptable one. The plaintiff has not proffered any factual evidence of the existence of a partial prolonged event or insult. He argued that considering the totality of the evidence, the defendant's expert opinions based on the clinical records and the radiologists MRI findings
- which are decisive - as well as the child's Agpar scores, his condition at birth, namely, that he cried, he sucked and he did not require extensive resuscitation, it is clear that the child's impairments are secondary to intrapartum hypoxia due to acute profound hypoxia from an unforeseeable and non-preventable event which occurred after 15:30 on 27 April 2010. Therefore, it must be concluded that nobody can be held liable for the brain damage suffered by the child.
- [75] None of the plaintiff's experts could testify that the nursing staff would have known that a particular treatment protocol was indicated. That being the case, no finding of causal negligence can be supported, or so defendant's counsel argued.

Discussion

- [76] In this matter there is no evidence of a sentinel event. The enquiry, however, does not end there. There is a now the peer review article by Smith et al explaining that studies have shown that although in certain cases the MRI may be indicative of an "acute profound insult" and not a partial prolonged one, it was clear that these insults had probably been caused over a number of hours, and that in all probability there would have been signs of distress of the foetus which could and should have been picked up through proper monitoring. This article has been unreservedly accepted by the Supreme Court of Appeal.
- [77] The science, however, goes further: The unchallenged evidence of Prof Van Toorn is that this syndrome is now recognised in ACOG 2019. In fact, Prof Van Toorn's evidence is that had ACOG 2019 come out earlier, it would have been unnecessary to have written the article of Smith et al referred to above. As mentioned, Prof Van Toorn is one of the authors of the article.

- [78] The defendant's experts made no reference in their reports of an 'acute profound injury' as a defence. The only conclusion that can be drawn from this is that the defence was contrived by the defendant and its legal representatives without reference to the defendant's expert summaries. The defendant's counsel was unsurprisingly unable to indicate where this appeared in any of the experts' reports.
- [79] Dr Van Toorn, who testified about the so-called 'acute profound' MRI findings and explained what it means, had not been confronted with cross-examination stating that witnesses would be called to testify the opposite. He was cross-examined on generalities only apparently obtained from some reported cases. It was never put to him that another expert differed from him to give him an opportunity to deal with it.
- [80] The 'golden thread' running through the cases where negligent causality has been rejected was that there was either an admitted sentinel event or alternatively the Court had accepted that there was a sentinel event.
- [81] Each case must of course be dealt with on its own facts and merits and it is an exercise in futility to refer to the facts of previous cases as authority.[12] The reasoning of the Court a quo in *The Member of the Executive Council for Health, Limpopo Provincial Government v LWM obo DM (LWM) and The Member of the Executive Council for Health, Eastern Cape Amicus Curiae*[13] and the that of the Supreme Court of Appeal are on all fours with the present case, save that as a result of the admissions made here, the facts are even more persuasive of causal negligence. The 'acute profound' findings had in any event been based on the existence of a sentinel event which caused a sudden and unforeseen catastrophic event that could not be foreseen or prevented by the medical staff. The undisputed scientific evidence adduced in this case has established that the position is now that if there is no sentinel event proven, then the insult must be approached on a totally different basis, namely:
- (a) If there is no partial prolonged injury to be seen on the brain on the MRI then it does not mean that there were not hours of foetal distress that should have been picked up with proper monitoring. What occurs is that there is a cascade of oxygen deprivation of the foetus which does not lead to interim brain damage but to catastrophic brain damage when the foetus can no longer manage;
 - (b) The proposition that all acute profound injuries are the same was rejected by the Supreme Court of Appeal. This is particularly relevant to the argument made by the defendant that as soon as the MRI did not show a partial longed injury, i.e. damage over a period of time, (but only damage once as an acute profound injury) then it means that there was a sudden and unforeseen insult which led to the acute profound injury. This is no longer the case. It will depend on the evidence in each case and the inferences to be drawn from such evidence which will be persuasive of the finding of causal negligence or not; and

(c) There is therefore no longer justification for the proposition that even though there might be the most serious negligence, it would be negligence in the air unless the injury is shown as a partial prolonged injury on the MRI.

[82] The defendant's reliance on what was said about medical issues in other cases has very little, if any relevance. The Court does not consider evidence in other cases as each case must be judged on its own merits. What this Court will have account of is the evidence given in this case as well as the recognition of medical articles and ACOG in other cases. However, I must still assess the references to these authorities in the light of the evidence given in this case.

[83] The criticisms of Dr Ebrahim are unfounded. He clearly explained that he had made a mistake. The important time was 13:00 and it is common cause that there was no proper monitoring after that. The 15:30 heartrate is a single heartrate and not one dealing with accelerations and decelerations and was therefore meaningless. This was fully explained by Dr Ebrahim.

[84] In LWM [14] the Supreme Court of Appeal dealt with the legal principles of causation as follows:

'It is well-established that causation has two elements, namely: (i) factual causation, determined by applying the 'but for' test; and (ii) legal causation, which answers the question of whether the wrongful act is linked sufficiently closely to the harm suffered; if the harm is too remote, then there is no liability.¹⁴ In *Za v Smith and Another*,¹⁵ Brand JA described the applicable test as follows:

"The criterion applied by the court a quo for determining factual causation was the well-known but-for test as formulated, eg by Corbett CJ in International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA 680 (A) at 700E-H. What it essentially lays down is the enquiry – in the case of an omission – as to whether, but for the defendant's wrongful and negligent failure to take reasonable steps, the plaintiff's loss would not have ensued. In this regard this court has said on more than one occasion that the application of the "but-for test" is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the background of everyday-life experiences. In applying this common sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this causal link with certainty (see eg Minister of Safety & Security v Van Duivenboden 2002 (6) SA 431 (SCA) para 25; Minister of Finance v Gore NO [2006] ZASCA 98; 2007 (1) SA 111 (SCA) para 33. See also Lee v Minister of Correctional Services [2012] ZASCA 30; 2013 (2) SA 144 (CC) para 41.)." (Own emphasis.)'

[85] The Court found that the thrust of the appellant's attack in the High Court was that there was an erroneous acceptance of the validity of the theory of Prof Smith published in a 2020 medical journal. Notwithstanding the criticism of the appellant and the contention that the article referred to should be rejected, both the Court a quo and the Supreme Court of Appeal were satisfied that the peer reviewed article was based on logic and real life experiences and research.^[15] Even more important than the article itself is the Appeal Court's finding that

the theory is backed up by a case study of 10 cases where the precise injury occurred with the precise same radiological findings.[16]

The court said the following in this regard:

‘Having considered the conspectus of the evidence, I am satisfied that the high court’s acceptance of Prof Smith’s evidence, that a series of partial intermittent, subacute/subthreshold hypoxic insults can result in this type of injury to the BGT deep nuclear structures including the perirolandic area was justified.’[17]

[86] In para [39] the Court stated that what distinguishes the two cases is that there was no evidence of a sentinel event in LWM whilst in AN v MEC (supra) there was agreement that there was a sentinel event. The absence or presence of a sentinel event appears to be the dividing line. This was the evidence of Prof Smith in LWM and Prof Van Toorn in the present case. The Court then repeated the differences between judicial and scientific sufficiency of proof, i.e. that the matter is decided on probabilities and inferences and not on scientific certainty.[18]

[87] In the present case the evidence went further. Prof Van Toorn in re-examination also referred the Court to ACOG 2019 and stated that if this publication had been available earlier, it would have made the article by Smith et al (including Van Toorn of course) superfluous, as that article states the same.

[88] In order to cohesively illustrate the differences between a situation where there is a sentinel event and where there is not, and the development of science from the time when AN was decided to when LWM was decided, the following findings in the latter judgment are significant:

- a. “... The test for establishing negligence is trite; it rests on two bases, namely, reasonable foreseeability and the reasonable preventability of damage and failure to act accordingly. What is or is not reasonably foreseeable in a particular case is a fact-bound enquiry.”[19]
- b. “[29] The appellant levelled considerable criticism at Prof Smith’s testimony and contended that his evidence and the article that he relied on ought to be rejected. I disagree. There is nothing illogical about Prof Smith’s opinion. It was not and could not be disputed that Prof Smith and his colleagues had identified 10 cases of patients with BGT pattern injuries (with no sentinel events and no fixed terminal bradycardia), where proper monitoring demonstrated that the babies had commenced displaying foetal distress at a median of about three hours before delivery. Thus, it was uncontroverted that such cases are possible and the only real remaining question on the merits is whether this probably was such a case.”[20]

(In this case the evidence in respect of the study was given by Prof Van Toorn in re-examination.)

- c. '[36] Furthermore, a lack of general acceptance of his theory cannot, without more, warrant a rejection of his theory, as it is backed up by a case-study. Clearly, there is no basis in law for rejecting Prof Smith's theory. The 10 cases on their own demonstrate that a series of partial intermittent, subacute/subthreshold hypoxic insults can cause an injury to the BGT deep nuclear structures including the perirolandic area with a pattern like that revealed by D M's MRI scan.'[21]
 - d. 'In my opinion, it is fallacious to posit that where a woman in labour has not been monitored by hospital personnel at all during the most critical stage of her labour, the MEC responsible for the relevant hospital should escape liability arising from the negligence of its employees purely on the basis that the exact timing of the hypoxic injury of an acute profound nature cannot be ascertained. To do so would be to ignore uncontested evidence that, on probabilities, shows a link between the negligence and the harm that ensued.'[22]
 - e. "[51] The amicus's contentions about the erroneous precedential value arising from reliance on Prof Smith's evidence have no merit. It is trite that each case is decided on its own merits. Each case's factual findings are based on the evidence adduced in that specific case. The amicus's contentions also fail to take into account that scientific conclusions are subject to revision. The periodic revision of ACOG recommendations attests to this. Trial courts should not fall into the trap of demanding an unduly high measure of proof from a litigant. As mentioned in Linksfield, the scientific measure of proof is the ascertainment of scientific certainty, whereas the judicial measure of proof is the assessment of probability.'[23]
- [89] In MEC v MM obo OM[24] the injury was of an acute profound type at full term. There was also an agreement in respect of the radiology and the radiologists were not called. Prof Van Toorn gave the same evidence that he did in the present case and the Court had no problem in accepting that in respect of an acute profound injury i.e. that it would show signs of foetal distress until the acute profound situation arises. This case also serves to illustrate that each case depends on its own facts and merits. In some case the Supreme Court of Appeal had found that the acute profound injury was sudden and unexpected (because there was a sentinel event). In this case it found the opposite in view of the evidence of Prof Van Toorn.
- [90] If regard is had to AGOG 2019 and the article by Smith, the evidence of Prof Van Toorn and Dr Ebrahim established the following:
- (a) There was egregious negligence in respect of the monitoring of the foetus and mother for a number of hours;
 - (b) There was a hypoxic ischemic insult that led to the injury during the intrapartum period;
 - (c) There was no sentinel event;
 - (d) There was no genetic or metabolic cause for the injury; and
 - (e) The perinatal stroke theory plays no role; `and

[91] The facts of MEC of Health and Social Development of the Gauteng Provincial Government v M[25], which the defendant contended supports its submissions, can be distinguished. That matter was heard on 7 March 2023 and the

judgment was delivered one year later, on the 5 March 2024. When the matter was argued a quo, the article of Smith et al was not yet available. The matter therefore proceeded through the Courts without the advantage of that article. In AN (supra)[26] the peer reviewed literature has now been radically changed by the article by Smith et al referred to in LWM (supra) and accepted by the Supreme Court of Appeal. The basis of the appeal was that there was no negligence proved by the plaintiff (the respondent). It therefore did deal with the causality of established negligence. That matter is thus distinguishable from the present case purely on this basis. It is also significant that this matter served in the Appeal Court without any of the abovementioned developments in science having been raised i.e. neither ACOG 2019 nor Smith et al.

[92] In my view birth asphyxia is, on the probabilities, the most obvious explanation for the child's injury. This has been conclusively proved through the pre-trial admissions as well as the explanatory evidence of the experts called by the plaintiff. The negligence has been admitted and thereafter it logically, by inference, follows that causal negligence has been established in respect of the hypoxic ischemic injury. Consequently, the elements of the delict have all been proved on a balance of probabilities.

[93] In summary then, the inferences to be drawn from the common cause facts in this matter are compelling and unavoidable, namely: (a) there were probably distress signals for hours prior to the birth which were either ignored or not picked up when it should have been done; (b) if it had been picked up, the interventions, such as a vacuum delivery and caesarean section, could have started far earlier and would have had a positive result; (c) as there was no sentinel event, a sudden and unforeseen catastrophic event which was not preventable can be excluded; and (d) there are no other outside causes for the injury in view of the admissions and the uncontroverted evidence; (e) in the circumstances there can only be one conclusion, and that is that the plaintiff has proven on a balance of probabilities that the inadequate monitoring of the hospital staff causally led to the hypoxic ischemic injury suffered by the child; and (f) that the defendant is therefore liable to compensate the plaintiff for any consequential damages.

Costs

[94] In my view the unacceptable manner in which the defendant conducted his defence warrants a punitive costs order. It should have been clear to the defendant, after the admissions were made in the various pre-trial minutes, that he had no defence whatsoever. The admission that the child suffered a hypoxic ischemic injury in the intrapartum period negated all the defendant's defences at the time. The fact that there were no defences available to the defendant if he were not allowed to withdraw the admissions, was acknowledged by his counsel on the first day of the hearing. There was then a disingenuous attempt to withdraw the admissions, which was disallowed with a punitive costs order. This

meant that the first four days of trial were wasted.

[95] The cross-examination of the plaintiff's witnesses proceeded without any version being put to them regarding what the defendant's witnesses may testify. The result of all of this is that the defendant dragged the trial out over several days in the full knowledge that he had no defence. It would consequently, in my view, be unfair for the plaintiff to be out of pocket, and she must therefore be fully indemnified in respect of her legal expenses.

[96] To avoid any uncertainty in this regard, I rule that the costs shall include the following trial days:

- (a) 8, 9, 10 and 11 February 2021: first appearance when withdrawals of admissions were dealt with and argued;
- (b) 17, 18 and 19 August 2021: when the evidence of Dr Gericke, Prof Van Toorn and Dr Ebrahim was lead;
- (c) 22 September 2021: matter postponed. Agreement between parties that costs be costs in the cause;
- (d) 19, 21, 22, 26, 27, 28 and 29 February 2024: cross-examination of Dr Ebrahim and various interlocutory proceedings in respect of reconstruction of record, and admissibility of further evidence; and
- (e) 8 September 2020, the date from which punitive cost order should follow being when the final pre-trial conference between the parties was held.

[97] In the result the following order issues:

- (a) The defendant shall be liable to pay 100% of the plaintiff's agreed or proven damages in her personal and representative capacities, arising from the brain damage suffered by W[...] ("the minor") at the Nessie Knight Hospital on 26 and 27 April 2007.
- (b) The aspect of quantum is postponed sine die in terms of the provisions of Rule 33(4) of the Uniform Rules of Court.
- (c) The defendant shall pay the plaintiff's taxed or agreed party and party costs of suit on the High Court scale (scale C) up to and including 8 September 2020, such costs including, but not limited to:
 - a. The costs of expert reports and summaries as defined by the Rules of Court (including consultations, qualifying fees, addendum reports and expert joint minutes, if any) of:

Prof J Lotz; Prof R van Toorn; Dr Ebrahim; Dr Hayes; and Prof Gericke.

- b. Plaintiff's traveling fees and expenses to and from medico-legal appointments in respect of all the experts at full rate and subsistence and accommodation expenses.
- c. The costs of senior and junior counsel at full rate.

- (d) The defendant shall pay the plaintiff's taxed or agreed costs on the scale as between attorney and own client from 9 September 2020 to date hereof, such costs including, but not limited to:
- a. The reservation costs of Prof van Toorn, Dr Ebrahim and Dr Gericke on 8 February 2021;
 - b. The reservation fees and attendance fees of Prof van Toorn, Dr Ebrahim and Prof Gericke on 17, 18 and 19 August 2021;
 - c. The reservation costs and attendance costs of Dr Ebrahim incurred during the period 19, 21, 22, 26, 27, 28 and 29 February 2024;
 - d. The trial fees of senior and junior counsel on 8, 9, 10 and 11 February 2021; 17, 18 and 19 August 2021; 22 September 2021; 19, 21, 22, 26, 27, 28 and 29 February 2024; 26 April 2024.
 - e. The costs and expenses of the plaintiff's attorneys relating to the transcript of the trial record.

J.E. SMITH

JUDGE OF THE HIGH COURT

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[1] 1966(2) SA 428 (A) at 430E.

[2] Botes v Van Deventer 1966

(3) SA 182 (AD) at 191A – G.

[3] Naude N.O. v Transvaal Boot and Shoe Manufacturing Co 1938 AD 379 at 392-3.

[4] 2004

(3) SA 305 (SCA).

[5] [1940] AC 152 at 169 – 170.

[6] 1982

(2) 603 (A) at 614G.

[7] 2012 1 583 (GSJ) at para 32.

[8] 2016 (1) SA 325 (CC).

[9] Boberg PQR, Law of Delict, 1984 at p 346. See also Premier KwaZulu-Natal v Sonny 2011(3) SA 424 (SCA) at 433D F.

[10] Premier KwaZulu-Natal v Sonny 2011

(3) SA 424 (SCA) at 433D – F.

[11] (576/2019)

[2020] ZASCA 169 (14 December 2020).

[12] The Member of the Executive Council for Health, Limpopo Provincial Government v LWM obo DM and The Member of the Executive Council for Health, Eastern Cape Amicus Curiae Case No 502/2021

[13] (31261/2015)

[2021] ZAGPPHC 139 (8 March 2021).

[14] LWM (supra) at para 24.

[15] LWM paras

[27] to [35].

[16] LWM para [36].

[17] LWM para [38]

[18] LWM para [51].

[19] LWM at para [19] and Pitzer v Eskom [2012] ZASCA 44 (SCA) para [24].

[20] LWM at para [29].

[21] LWM at para [36].

[22] LWM at para [47].

[23] LWM at para [51].

[24] Case number 697/2020 (SCA)

[25] [2024] ZASCA 21 (5 March 2024).

[26] Supra at para [25].

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