THE SUPREME COURT OF APPEAL OF SOUTH AFRICA

JUDGMENT

Not Reportable
Case no: 1032/2022

In the matter between:

WYNAND DU PREEZ N O **APPLICANT**
(In his representative capacity of
Estate Late NPN 6910/2023)

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH & SOCIAL DEVELOPMENT OF THE EASTERN CAPE PROVINCE **RESPONDENT**

Neutral citation: *Du Preez N O v The Member of the Executive Council for Health of the Eastern Cape Province* (1032/2022) [2024] ZASCA 147 (28 October 2024)

Coram: NICHOLLS, KGOELE, SMITH JJA and COPPIN and MJALI AJJA

Heard: 02 September 2024

Delivered: This judgment was handed down electronically by circulation to the parties' representatives by email, publication on the Supreme Court of Appeal website, and release to SAFLII. The date and time for hand down is deemed to be 28 October 2024 at 11h00.

Summary: Reconsideration of application for leave to appeal – s 17(2)(*f*) of the Superior Courts Act 10 of 2013 – whether exceptional circumstance exists – claim for medical negligence damages – brain injury sustained during birth – whether hospital staff were negligent – if so, whether such negligence caused the brain injury – no exceptional circumstances.

ORDER

On application for reconsideration: referred by Petse AP in terms of s 17(2)(*f*) of the Superior Courts Act 10 of 2013:

The application for leave to appeal is dismissed.

JUDGMENT

Kgoele JA (Nicholls, Smith JJA and Coppin and Mjali AJJA concurring)

[1] This is an application for reconsideration in terms of s 17(2)(*f*) of the Superior Courts Act 10 of 2013 (the Act)[1]. The application stems from an action for damages instituted by Ms Veliswa Ngqobongo (Ms VN) on behalf of her minor child (PN). The claim was dismissed by the Eastern Cape Division of the High Court, Port Elizabeth (the high court). Ms VN applied for leave to appeal, which was denied by the high court on 17 June 2022. She petitioned this Court for leave to appeal which was dismissed on 12 September 2022. Aggrieved by the dismissal of her petition, she applied to the President of this Court to reconsider the application for leave. On 19 December 2022, the Acting President of this Court granted the application for reconsideration of this Court's descision to refuse leave. He further referred the application for oral argument in terms of s 17(2)(*d*) of the Act, and the parties were informed that they should be prepared to argue the merits of the appeal.

[1] Section 17(2)(f) provides that where leave to appeal has been refused by two judges of the Supreme Court of Appeal, the President of the Supreme Court of Appeal may refer the decision for reconsideration and, if necessary, variation.

[2] The factual background relevant to the consideration of this application is this. In her representative capacity, Ms VN instituted an action on behalf of her daughter, PN, against the MEC, for damages in respect of the injuries suffered by PN at the time of her birth. The allegations were that the injuries were sustained due to the negligence of the staff employed by the MEC. It is common cause that PN was born on 25 October 2009 at the Dora Nginza hospital, Gqebhera, and that she suffered from cerebral palsy.

[3] Unfortunately, PN passed away on 7 May 2023 at the age of 13 years, after the pleadings were closed but before the hearing of this application. As a result, Ms VN was substituted in this application by the Executor of the estate, Mr Du Preez (the applicant).

[4] The issues for determination by the high court were twofold. First, whether the medical staff employed by the MEC were negligent in the care and treatment of Ms VN during labour and the delivery of PN, and if so, whether such negligence caused PN to suffer a severe brain injury resulting in the cerebral palsy.

[5] Before the high court, the applicant alleged that the hospital staff were at least negligent in three respects, which caused or contributed to the brain injury suffered by PN. These were: (1) an unchecked and un-remedied tapping of the foetal reserves during labour, which resulted in the foetus being unable to cope with the event that ultimately caused it to sustain the brain injury; (2) the application of excessive forceful fundal pressure to Ms VN's pregnant abdomen that injured the foetus (PN); and, (3) the ineffective resuscitation of PN after birth. The applicant called three expert witnesses to support these propositions, namely Dr Hofmeyer, a specialist

obstetrician and gynaecologist, Professor Kirsten (Prof Kirsten), a specialist neonatologist and Professor Nolte (Prof Nolte), a professor of nursing.

[6] The MEC denied liability, pleading that there was no negligence on the part of the hospital staff. In support of its denial, the MEC called Sister Minnaar, who monitored Ms VN's labour along with two colleagues, Sisters Laminie and Bosman, all being professional nurses. In addition, two expert witnesses, Dr Nel, an obstetrician and gynaecologist, and Professor Cooper (Prof Cooper), a paediatrician and neonatologist, testified on behalf of the MEC.

[7] Shortly before the application was heard in this Court, the applicant applied for the introduction of new documentary evidence. The MEC opposed the application. The new evidence which the applicant sought to introduce was a letter, dated 23 August 2024, and penned by Dr van der Walt, the medical doctor involved in PN's resuscitation by administering four doses of adrenalin.

[8] The new evidence sought to be introduced would, if it were allowed, impact the factual matrix that will underpin this Court's reasoning and findings in respect of the application for reconsideration. It is therefore necessary for me to deal with the application for its admission upfront.

[9] During the hearing in the high court, the MEC stated that he wished to call Dr van der Walt as a witness but was unable to locate him. The applicant's legal team eventually managed to find him in Canada. A detailed account of the numerous attempts made to locate him is set out in the affidavit filed in support of the application. According to the applicant, the purpose of the evidence is to corroborate the expert evidence of Prof Kirsten, who, the applicant submitted, was of the firm

view that the fact that adrenalin was administered by Dr van der Walt demonstrated severe bradycardia (very low heart rate), probably of less than 60 beats per minute.

[10] In the letter a series of questions, crafted by the applicant's legal team, were put to Dr van der Walt. His answers to most of the questions were that he could not recall the specific details as it had been almost 15 years since the incident. Regarding administering adrenalin, and whether 'it was possible that he would have given adrenalin if the heart rate was normal', he said that 'his usual practice' is to give adrenalin if he found the patient to have no pulse or severe bradycardia.There is no indication whether this was his usual practice at the relevant time.

[11] The test for the admission of further evidence on appeal is set out in *S v de Jager*[2] and also in *Moor and Another v Tongaat-Hulett Pension Fund and Others*.[3] It is as follows:

(a) There must be a reasonably sufficient explanation, based on allegations which may be true, why the new evidence was not led in the court *a quo*;

(b) There should be a *prima facie* likelihood of the truth of the new evidence; and

(c) The evidence should be materially relevant to the outcome of the case.

[12] In *Rail Commuters Action Group & Others v Transnet Limited t/a Metrorail and Others,*[4] the Constitutional Court re-affirmed the decisions of this Court that new evidence can be admitted on appeal only in exceptional circumstances. Further, it stated that one of the most important criteria was that the 'evidence tendered must

[2] *S v de Jager* 1965 (2) SA 612 (S) at 613 C-D.

[3] *Moor and Another v Tongaat-Hulett Pension Fund and Others* [2018] ZASCA 83; [2018] 3 All SA 326 (SCA); 2019 (3) SA 456 at para 36.

[4] *Rail Commuters Action Group & Others v Transnet Limited t/a Metrorail and Others* [2004] ZACC 20; 2005 (2) SA 359 (CC); 2005 (4) BCLR 301 (CC).

be *weighty and material* and presumably to be believed, and must be such that if adduced it would be practically conclusive, for if not, it would still leave the issue in doubt and the matter would still lack finality'.[5] (Emphasis added.)

[13] I agree with the applicant that he managed to prove the first requirement, taking into consideration the reasons provided as to why the evidence was not produced at the time of the hearing. However, I am not convinced that the applicant succeeded in satisfying the second and third requirements.

[14] According to the applicant, this evidence is necessary to counter Sister Minnaar's version that the minor child's heart rate was 120 bpm when Dr van der Walt arrived. The applicant contends that if the heart rate had been 120 bpm, no adrenalin was required, as opined by Dr Kirsten. The contention of the applicant is that this evidence will also add to the other aspects of the whole picture that the ten minutes of resuscitation performed by Sister Minnaar was woefully inadequate and negligent. It would undoubtedly have compounded the brain injury.

[15] I disagree with the applicant's contention that the new evidence is relevant to the outcome of the case. In my view, the 'new evidence' is irrelevant. The high court indicated that even if it were assumed in favour of the applicant that the resuscitation of PN by the hospital staff after her birth was negligent in the manner suggested, the crucial question is whether such negligence was causally connected to the injury sustained by PN. The high court's conclusion that 'it was not proven that the negligence, if any, on the part of the hospital staff during resuscitation contributed to an already existing severe injury to the brain' is fatal to this submission. In the

[5] Ibid para 41.

circumstances, the evidence regarding the issue of resuscitation which the applicant seeks to introduce is irrelevant and will have no bearing on the outcome of the application for reconsideration.

[16] In addition, Dr van der Walt's conjecture as to why he could have administered four doses of adrenaline is not only irrelevant but amounts to *ex post facto* speculation. What is significant is that Dr van der Walt does not, in his response, purport to reflect on what 'his usual practice' was at that time (in 2009), when he was an intern. He only states what his 'usual practice' is presently.

[17] The submission that the new evidence is *prima facie* correct or the truth suffers the same fate. It is clear that Dr van der Walt honestly admits that he has no recollection of this particular child or the circumstances surrounding her birth or resuscitation. Furthermore, in his notes, he recorded that he arrived in the labour ward at 23:45 on 25 October 2009 (10 minutes after PN's birth), and that on 'initial examination' he found a neonate heart rate of 120 beats per minute, 'gasping respiration 2-3/min, a flaccid tone, pink, no response to stimulation, this with bag-mask ventilation by nurse for [approximately] 10 min.' These notes are the contemporaneous records of what happened at the time.

[18] It is also of concern that Dr van der Walt did not reply to the leading question posed by the applicant's legal team as to whether the heart rate recorded by him (120 bpm) was as a result of his own observations or was provided to him by the midwives. The significance of this is that the recording is at odds with the contention that the new evidence will counter the evidence of Sister Minnaar that the heart rate was 120 beats per minute. Instead, it materially corroborates the version of Sister Minnaar.

[19] I cannot conclude without emphasising that the documentary evidence sought to be introduced is a mere letter wherein Dr van der Walt was requested to reply to questions crafted by the applicant's attorney. It was not in the form of an affidavit. Therefore, no weight can be attached to it. Furthermore, the prejudice caused to the MEC is that his counsel will not be able to cross-examine Dr van der Walt. As a result, the application for the introduction of the new documentary evidence is refused.

[20] I now return to the application for the reconsideration of this Court's order refusing the applicant leave to appeal. The applicant relied primarily on expert evidence in support of the propositions made before the high court. The expert opinions were based on the cardiotocograph (CTG) trace, the notes of the hospital staff, and the views expressed in the reports compiled by the doctors and specialists from both parties.

[21] It is not necessary to deal with the evidence of these witnesses in detail since the main issues to be adjudicated upon, have been crystallised. However, it is essential to summarise the undisputed evidence of these witnesses relevant to the grounds raised in this application. First, the clinical records indicated that during the first stage of labour, Ms VN experienced a spontaneous rupture of her membranes at 19:00 on 25 October 2009. The amniotic fluid from her uterus was and remained clear - there was no meconium. The hospital staff discontinued the CTG monitoring approximately an hour into Ms VN's labour.

[22] The evidence revealed the following. During the second stage of labour, Ms VN started bearing down at 23:25 and not at 22:15 (which was an incorrect reading

by the applicant's experts of the entry made by Sister Minnaar in the medical records). This was the erroneous premise upon which all of the applicant's experts expressed their opinions.

[23] PN was born in a "severely compromised condition" and required immediate resuscitation. PN was born with neurological (brain) injury and a low Apgar score at one minute of life, which improved to 5/10 after 5 minutes. The hospital staff called Dr van der Walt to assist with the resuscitation. He arrived in the labour ward approximately ten minutes after the birth of PN. He took over the further resuscitation and administered four doses of adrenalin to PN. PN's foetal heart rate after the birth and during the resuscitation was recorded independently by both Sr Minaar and Dr van der Walt as about 120 beats per minute. PN was born with some caput and moulding (of the then still mobile cranial bones) of "+1".'

[24] The evaluation of the evidence and reports of the expert witnesses of both parties by the high court reveals that the following key aspects were either agreed upon or ultimately conceded to. Regarding the monitoring of the labour, Dr Hofmeyr conceded that CTG monitoring is not a substitute for good clinical observation and judgment. The use of and interpretation of CTG tracings as a determinant of negligence is unreliable. Dr Hofmeyer acknowledged that worldwide the use of CTG monitoring has not reduced the incidences of foetal compromise. Dr Hofmeyr and Professor Kirsten reported that Ms VN's labour "progressed well" until full dilation. Having regard to the partogram in particular, Dr Hofmeyr conceded that Ms VN probably endured a normal first stage of labour up to the time of full dilation.

[25] Regarding the cause of the injuries, both the Magnetic Resonance Imaging ("MRI") brain reports by radiologists Prof. Lotz and Dr Alheit Lotz are to the effect

that PN suffered an "*acute profound (central) hypoxic-ischaemic injury involving the deep grey matter"* and that these injuries in a term infant *"occur suddenly"* or *"over a short period of time"* and *"progress rapidly"*. It was recorded that: PN suffered the acute, profound hypoxic-ischaemic brain injury intrapartum during the second stage of labour; that almost total disruption of the blood supply and oxygen to the brain of PN must have endured for a minimum period of ten minutes; the aforesaid acute profound brain injury led to PN suffering from cerebral palsy; there was no known sentinel event which caused the hypoxic-ischaemic event. Although the experts could not identify the cause of the hypoxic ischaemic event, they all accepted the fact that an acute profound injury can occur in the absence of an identifiable "sentinel event".

[26] In considering an application of this nature, the Constitutional Court remarked in *Liesching and Others v S*[6] that, s 17(2)(*f*) was not intended to afford disappointed litigants a further attempt to procure relief that had already been refused. It was designed to enable the President of the Supreme Court of Appeal to deal with a situation where injustice might otherwise result. The threshold for granting an application in terms of section 17(2)(*f*) is therefore high. The applicant has to satisfy this Court that the circumstances are truly exceptional to hear this matter again after the application for leave to appeal was dismissed by the court of first instance and this Court (by two colleagues).

[27] As in the high court, the applicant in this Court first challenged the adequacy of the monitoring of the applicant's labour during the first stage of labour. The submission was that the high court did not give sufficient attention to the fact that

[6] *Liesching and Others v S* [2018] ZACC 25; 2018 (11) BCLR 1349 (CC); 2019 (1) SACR 178 (CC); 2019 (4) SA 219 para 139.

during the first stage of labour, the foetus showed signs of distress. As a result, so it was argued, the foetus reached the second stage of labour in a compromised condition and was, therefore, unable to cope with the event that ultimately caused it to sustain the brain injury.

[28] Several propositions were advanced as a basis for the above submissions. These were: that the midwives did not properly interpret the decelerations recorded by the CTG, which decelerations provided evidence of foetal distress; the hospital staff stopped the CTG monitoring at a critical point; the foetal head descended slowly, which indicated that the passage of the foetus through the birth canal was somewhat obstructed hence the degree of the caput was huge. The applicant thus argued that the foetus suffered a tapping of her reserves as a result of these shortcomings. The condition, according to the applicant, was exacerbated by the fact that no doctor was called to advise on a properly controlled method of delivery, including the possibility of delivery by ventouse or caesarean section.

[29] The grounds of appeal relied upon by the applicant in the application for leave to appeal are basically a rehashing of the three issues raised during the trial before the high court. They are in the main factual matters that the high court determined after evaluating all the evidence. The applicable test has always been that a court of appeal will not lightly interfere with the factual findings of a trial court unless there is a demonstrable and material misdirection or a finding that is clearly wrong.[7] The principles to be applied to guide an appeal court in dealing with an appeal purely on the facts have been set out extensively in *Rex v Dhlumayo and Another*.[8]

[7] *Mashongwa v PRASA* [2015] ZACC 36; 2016 (2) BCLR 204 (CC); 2016 (3) SA 528 (CC) para 45.
[8] *Rex v Dhlumayo and Another* 1948 (2) SA 677 (A) at 705 – 706.

[30] In addition to the above, the principles dealing with opinion evidence are trite. In the law of evidence, "opinion" means any reference from observed facts, and the law on the subject is derived from the general rule that witnesses must speak only to that which was directly observed by them.[9] An expert's opinion represents his reasoned conclusion based on certain facts or data, which are common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bold statement of his opinion is not of real substance.[10]

[31] The cogency of an expert opinion depends on its consistency with the proven facts and on the reasoning by which the conclusion is reached.[11] In general, it is crucial to bear in mind that it is ultimately the task of the court to determine the probative value of the expert evidence placed before it and make its own findings with regard to the issues raised.[12]

[32] Applying the principles as mentioned earlier, I am of the view that the criticism that the high court misdirected itself in finding that the foetus was not in a weakened state and suffered a tapping of her reserves just before the second stage of labour started cannot be sustained. The same applies to the finding that there was evidence of an obstructed labour based on the degree of the caput. First, the high court dealt with the issue of the interpretation of the CTG monitoring and the obstructed labour issue pertinently in its judgment. Furthermore, these propositions

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[9] Cross on Evidence 7th Ed at page 489; See also *McGregor and Another v MEC for Health Western Cape* (1258/2018) [2020] ZASCA 89 (31 July 2020) at para 21.
[10] *Ruto Flour Mills (Pty) Ltd v Adelson* (1) 1958 (4) SA 235 (T) at A-B.
[11] *MEC for Health and Social Development, Gauteng v TM obo MM* (380/2019) [2021] ZASCA 110 (10 August 2021) at para 125.
[12] *Van Wyk v Lewis* 1924 AD 438 at 447.See also *MEC for Health, Eastern Cape v ZM obo LM* (576/2019) [2020] ZASCA 169 (14 December 2020) para 11.

are inconsistent with the evidence of the applicant's expert witness, Dr Hofmeyer, who eventually conceded that Ms VN probably endured a normal first stage of labour up to the time of full dilation.

[33] Secondly, it was common cause amongst all the experts that the foetus suffered a severe acute, profound central brain injury intrapartum during the second stage of labour, which only lasted 20 minutes, of which only the last 10 minutes involved active pushing by Ms VN. Not a single expert witness, including those called by the applicant, suggested that there might have been an injury indicative of a partially prolonged hypoxic-ischaemic brain injury. All the experts agreed that these kinds of injuries occur suddenly or over a short period, progress rapidly, and are unanticipated.

[34] Lastly, the applicant is conspicuously silent about the fact that Ms VN's amniotic fluid was recorded as normal and that there was no meconium present. The significance of this, as all experts agreed, is that the presence of meconium may be indicative of foetal distress. The submission by the applicant that the foetus may have been in a compromised condition from the outset, amounts to nothing more than speculation. As the high court correctly found, there is no measure to determine in what condition the foetus arrived at the event that caused the injury. There was, therefore, insufficient evidence before the high court to conclude that the foetus was in distress in the first stage of labour, or that the labour was prolonged, thereby rendering the foetus unable to cope with the catastrophic event shortly before birth.

[35] The next challenge by the applicant is based on the evidence tendered by Ms VN that a male security guard was asked to exert physical pressure (fundal pressure) to her abdomen shortly before she gave birth, as the foetus was 'stuck'. Sister

Minnaar, who testified on behalf of the MEC, denied these averments. The applicant criticised the high court for preferring the evidence of Sister Minnaar over that of Ms VN on this aspect. Apart from the fact that this ground of appeal is based on factual matters, it also calls for the trite principles applicable when a court evaluates two mutually destructive versions. There is no indication in the high court's judgment that demonstrates that its assessment of the credibility of these two witnesses, i.e. Ms VN and Sister Minnaar, the reliability of their version, the weighing of the probabilities or improbabilities of the particular aspects of their versions, were clearly wrong. In my view, this criticism must fail.

[36] The last challenge to the high court's findings is premised on the contention that the resuscitation undertaken by the hospital staff, particularly Sister Minnaar, was inadequate and poor. Her evidence was that the minor child, who was born without any inherent respiratory effort, was bagged (oxygen applied through an ambubag) for 30 seconds. The bagging was then halted for 30 seconds whilst the heart rate was assessed. This method of resuscitation went on for ten minutes. After that, a period of 5 minutes passed when there was no resuscitation until Dr van der Walt arrived. According to the applicant, this explanation is an admission that the resuscitation by the hospital staff was improper. Much emphasis was placed on Prof Kirsten's opinion that inadequate resuscitation would cause exponential injury to the brain.

[37] To bolster this submission, the applicant argued that all the experts testified that the neonate requires continuous respiratory support during resuscitation. Thus, according to the applicant, stopping every 30 seconds for 30 seconds over ten minutes is partly the reason why the minor child's recovery was so poor. The applicant further relied on the opinion of Prof Kirsten, who testified that the first

thing to do in resuscitating a neonate with a low heart rate, is to apply cardiac compressions. And in this case, the argument continued, it is common cause that cardiac compression was not done. The applicant contends further that failure to give cardiac compressions rendered the resuscitation futile as the heart requires mechanical encouragement to restore blood circulation (with the necessary oxygen), which will show up in improved skin colour and temperature.

[38] Lastly and in addition to the above, the applicant relies on the opinion expressed by Prof Kirsten that the only reasonable conclusion that can be drawn from the administration of adrenaline by Dr Van der Walt during the birth of PN is that the foetal heart rate was below 100 beats per minute and probably as low as 60 beats per minute. Furthermore, that the use of adrenaline would be a last resort to normalising the heart rate. The applicant maintains that they ought to have succeeded at the very least on this point and 50% apportionment of the damages should have been awarded in favour of the applicant following the findings in *Minister of Safety and Security & Another v Rudman & Another*.[13] In the alternative, the applicant sought 100% of the damages based on the reasoning of the English authorities.[14]

[39] Unfortunately, all of the above submissions made by the applicant fly in the face of the undisputed evidence of the experts that the minor child suffered an extremely severe and profound brain injury intrapartum and was born flat, cold and apnoeic. The extent, if any, to which the alleged sub-standard resuscitation aggravated an already existing brain injury, as correctly found by the high court,

[13] *Minister of Safety and Security & Another v Rudman & Another* [2004] ZASCA 68; 2005 (2) SA 16 (SCA); [2004] 3 All SA 667 para 81. In that matter, divisibility of damages was raised and the court found that where it is difficult to separate the damage, then a policy decision is necessary to make a finding. The court awarded the plaintiff in that matter 50% for the interrupted rescutitation.

[14] *CNZ v Royal Bath Hospitals NHS Foundation Trust and Another* [2023] EWHC 19 (KB) at 391. In that matter, the court found that any delays in excess of the first ten minutes, contributed materially to the brain damage.

could not be proven with any degree of certainty by all the experts, leaving it in the realm of speculation. This Court lamented reliance on speculative opinions of experts in *MEC for Health and Social Development, Gauteng V TM obo MM.*[15]

[40] The applicant misses the point that all the experts agreed that it is impossible to prove any material contribution to the already extremely severe brain injury sustained *in utero*. Therefore, the arguments regarding the divisibility of damages including the reasoning in the English authority relied upon by the applicant are misplaced. In addition, the high court thoroughly evaluated these arguments and the opinions of Prof Kirsten, and cogent reasons were provided for the rejection thereof. I am not persuaded that the rejection thereof by the high court can be disturbed.

[41] In conclusion, it is also important to state that it is trite that negligence is not presumed but must be established by substantive evidence. The applicant (the plaintiff in the high court) bore the overall burden of proof, to show what the required standard of skill and competence was in this matter. And in the final analysis, negligence ought to be determined by the court in the light of all the evidence.[16] In my view, the high court did precisely that.

[42] The applicant failed to demonstrate that exceptional reasons exist for leave to appeal to be granted by this Court. The upshot of these findings is that the applicant did not meet the stringent test required in this application and has merely re-argued all the factual submissions made before the high court.

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[15] Footnote 6 above at para 126.
[16] *Meyers v MEC of Health, Eastern Cape* 2020 (3) SA 337 (SCA) at para 69.

[43] The MEC did not press for an order of costs against the applicant. I fully agree that this is the correct approach. There is no reason whatsoever why the applicant should be mulcted with costs of this application.

[44] The following order is made:

The application for leave to appeal is dismissed.

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A M KGOELE

JUDGE OF APPEAL

Appearances

For appellant:	W L Munro SC
Instructed by:	W Langson & Associates, Gqeberha
	Webbers Attorneys, Bloemfontein
For respondent:	C J Mouton SC (with A Rawjee SC and N Karsan)
Instructed by:	The State Attorney, Gqeberha
	The State Attorney, Bloemfontein.