THE SUPREME COURT OF APPEAL OF SOUTH AFRICA
JUDGMENT

Not Reportable
Case no: 805/2024

In the matter between:

N K obo U K **APPELLANT**

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR THE DEPARTMENT OF HEALTH, EASTERN CAPE **RESPONDENT**

Neutral citation: *N K obo U K v MEC for Health Eastern Cape* (805/2024) [2026] ZASCA 105 (4 August 2026)

Coram: MOCUMIE, KATHREE-SETILOANE and COPPIN JJA, BASSON and CHILI AJJA

Heard: 4 November 2025

Delivered: This judgment was handed down electronically by circulation to the parties' representatives by email, publication on the Supreme Court of Appeal website, and released to SAFLII. The date and time for hand-down is deemed to be 11h00 on 4 August 2026.

Summary: Delict – medical negligence – whether negligent conduct of hospital staff causally connected to child's brain damage – causation not established.

ORDER

On appeal from: Eastern Cape Division of the High Court, Bisho, Laing J (with Rusi and Bands JJ concurring):

The appeal is dismissed with costs including those of two counsel.

JUDGMENT

Mocumie JA (Chili AJA concurring):

Introduction

[1] This case concerns the birth of a child, U K, who suffered a serious brain injury that manifested in the form of cerebral palsy. A claim for damages brought by his mother, Ms N K, in her private capacity and on behalf of U K for this injury, was dismissed in the Eastern Cape Division of the High Court of South Africa, Bisho (Bloem J – the high court). The dismissal was confirmed on appeal to the full court of the same division of the high court (Laing, Rusi and Bands JJ – the full court). The appeal is with special leave granted by this Court.

Factual background

[2] The salient facts, which are undisputed and fall within a fairly narrow scope, are as follows. In 2019, immediately after noticing that she was pregnant, Ms N K attended her antenatal clinic at Zwide Clinic. Throughout her pregnancy, she was treated for high blood pressure, which she was assured was common in pregnant women; she should not be worried about. She was given treatment.

[3] On 3 March 2019, whilst at home, Ms N K, who was then younger than 30 years of age,[1] suffered cramps and was taken to and admitted at the Dora Nginza Provincial Hospital, Qherbeha, (the hospital). She was admitted to a ward where she found other pregnant women. She underwent a routine assessment by a nurse on

[1] In the available medical records, Ms N K is referred to as both 30 years old and 25 years old at the time.

duty. This involved testing her for HIV/Aids, taking a urine sample and measuring her blood pressure. In 30 minutes, a doctor scanned her to evaluate the status of her pregnancy. The doctor told her that she was still far from giving birth. The doctor prescribed a substance, possibly Misoprostol,[2] a medication used to induce labour. She was given the prescribed medication at 14h00. In the evening, she suffered severe pains and, upon informing the nurse on duty thereof, she was given more Misoprostol.

[4] The next day, 4 March, those in the ward with her, advised her to remove her sanitary pad and present it to the nurse(s) on duty. It is worth noting that, upon admission on 3 March, she was not provided with a sanitary pad, nor was she informed of its availability by the nurse(s) on duty. So, she took out a panty liner and handed it over to the nurse to analyse her vaginal discharge. Her urine was tested, and her blood pressure was checked. The nurse found all in order. Around 12h00, a doctor examined her vaginally by inserting two fingers. He said she was still far from delivery and prescribed more medication. Around 14h00, she complained of pains around her abdomen and was given a substance, possibly Misoprostol. Once more in the evening, she complained of the severity of the cramps and was again given the same medication.

[5] On 5 March, she again complained of pains, and possibly Misoprostol was once more administered. Soon thereafter, she was examined by a doctor, her urine was tested, her blood pressure was measured and a Cardiotocography (CTG), to record the foetal heart rate, was performed. Again, that evening, a substance, possibly Misoprostol was administered twice because the cramps were severe. However, she was not yet ready to deliver as the nurses discussed amongst themselves.

[6] On 6 March, she underwent the same routine as in the past two days: vaginal examination, urine test, blood pressure, and foetal heart rate scan. And again, on this day, the fourth day, she received no adverse report about herself or the foetus. She

[2] The high court accepted without any objection from the MEC during the trial that what was given was Misoprostol. However, whatever the medication's name was, it was common cause that she was given some medication repeatedly to induce labour.

was told the doctor would be checking on her to determine why she had not given birth yet.

[7] On the morning of 7 March, the nurse on duty ran the routine examination. The doctor on duty was surprised that she was still not in labour. She then examined her vaginally and ruptured her membranes artificially 'to break her water'.[3] The doctor advised her that if she was not going to give birth that day, a caesarean section (C-section) would have to be performed. After the doctor left, during the night, around 21h00, a young nurse on duty again did a vaginal examination. She reported that Ms N K was still far from delivery. An older nurse instructed that she be transferred to the labour ward. She was examined again, and a CTG was done. Again, no abnormalities could be detected, except that she was not delivering the baby as expected.

[8] Thereafter, she was instructed to lie on the bed, hold her thighs, and push, unassisted. She heard one nurse say that the baby's head was emerging. She asked for assistance but did not get any. Someone else, not the nurse in that section, came into the ward and attended to her. That person left the ward to seek assistance somewhere else. Ms N K testified that she felt weak and stopped pushing because she had been pushing unassisted for a long time. A fourth nurse came in and reprimanded the other three, who were not assisting Ms N K. She used a vacuum extractor to assist with the delivery without success. Even the high court noted that '[t]wo of the unhelpful nurses stood on either side of her bed and, with their hands on her abdomen, tried to push the baby in the direction of the birth canal. She was in pain and requested to be taken to theatre'.

[9] Upon the arrival of a doctor, the nurses stopped pushing Ms N K on her stomach. Ms N K was injected twice. The baby, U K, was ultimately born. He did not cry. He was taken to another room. Then he started to cry after being hit on the backside. After some minutes, the doctor came back into the room and informed her that the baby's brain was damaged because of the prolonged labour. She was taken to theatre to remove the placenta for testing. U K was taken to a high care unit and

[3] Artificial rupturing of the membranes, together with other methods, is used to induce labour.

put on a cooling machine, which broke down because, as she was told, it was not serviced. She saw U K two days after his birth. He had seizures. After three weeks, he was discharged to the nursery. He was sleepy all the time. Thereafter, he was transferred to a private hospital, Mercantile hospital, which confirmed that U K's brain was damaged.

[10] Ms N K's medical records were lost, except for her histology report, the blood gas analysis, a Magnetic Resonance Imaging scan (MRI), and the CTG mentioned above. This discovery was only made the day before the trial commenced, according to Dr Ziefred Desmond McConney (Dr McConney), the clinical manager and delegated information officer of the hospital. It is disconcerting that important documents on which a plaintiff in a medical negligence case relies to prove their case can be lost or possibly stolen while in the hospital's custody. According to Dr McConney, this is not the first of such cases from the hospital in question.

[11] Ms N K instituted an action for damages of R 28 200 000 in the Eastern Cape Division of the High Court, Bisho (the high court), in both in her personal and representative capacity as U K's biological mother, against the Member of the Executive Council for the Department of Health, Eastern Cape (the MEC) who, as the political head of the Department of Health, Eastern Cape (the department), is responsible for the department's contractual and delictual liabilities.

[12] The parties agreed (as stipulated in para 1 of the relief sought by the plaintiff), to a separation of the issues in terms of rule 33(4) of the Uniform Rules: the merits were separated from the quantum, with the matter proceeding only on the question of liability and quantum being postponed *sine die.*

Before the high court

[13] The issues for determination before the high court were two-fold. Firstly, whether the medical staff employed by the MEC at the hospital were negligent in the care and treatment of Ms N K during her labour and U K's delivery. And secondly, if so, whether such negligence caused U K to suffer a severe brain injury resulting in cerebral palsy.

[14] Ms N K testified and called two expert witnesses to support her case and discharge the onus upon her on a balance of probabilities: Dr C Ndjapa Ndamkou (referred to as Dr Ndjapa throughout the proceedings in the trial and full court), a specialist gynaecologist and obstetrician and Dr Amith Keshave (Dr Keshave), a paediatric neurologist. The MEC led no evidence by the medical staff that attended to Ms N K during her hospitalisation but relied on two experts for her case: Dr Krzysztof Andrzej Janowski, an obstetrician, and Dr Yavini Reddy, a paediatric neurologist. Dr McConney, the third witness for the MEC testified on the loss of Ms N K's medical records whilst in the care of the hospital.

[15] Dr Ndjapa, testified that Ms N K's had attended the local clinic for her prenatal check-ups from the moment she discovered that she was pregnant. That she had high blood pressure for which she was given treatment. Significantly, and relevant in these proceedings, Dr Ndjapa noted that she was admitted to the hospital for three weeks for signs of pre-eclampsia, a more adverse medical condition.[4]

[16] Crucially, on the evidence relating to the cause of U K's asphyxia, Dr Ndjapa stated that:

'Based on the information that I received and had available, it is my opinion that there was *no evidence to suggest that the injury most likely occurred prior to the onset of labour after 36 weeks, and that my opinion was that labour was induced according to the report 40 weeks, induction was prolonged over 96 hours.*

…

[I]f you have chorioamnionitis in the antenatal period, you [are] likely to have a preterm birth. Our case was a term pregnancy and worst-case scenario, if you have chorioamnionitis during the antenatal period, this patient will have clinical signs and most of the chorioamnionitis that you will get during the antenatal period, they tend to [deliver] prematurely.' (Emphasis added.)

[17] All the experts who testified considered only the histology report, the blood gas analysis, the MRI, and CTG to provide their respective opinions as these were the only documents that were discovered. Of all these reports, the histology report and the blood gas analysis featured prominently and formed the basis of the conclusion

[4] Pre-eclampsia is a serious, sometimes fatal, blood pressure disorder occurring after 20 weeks of pregnancy or postpartum, characterised by high blood pressure and signs of organ damage, often proteinuria (protein in urine).

the MEC's medical team drew, which both courts accepted wholesale to conclude that U K's asphyxia was caused by chorioamnionitis. The histology report provides the following diagnosis of the placenta: 'Severe acute chorioamnionitis with maternal and foetal inflammatory response.'

[18] In a joint minute by two radiologists, Dr Z Zikalala for the MEC and Dr B Alheit for Ms N K, the experts agreed that:

'- The MR study displays features of hypoxic ischaemic injury of the brain.

- [T]he MR findings make the diagnosis, in the appropriate clinical context, of a dominant. *Watershed zone hypoxic ischemic injury (prolonged partial pattern) [is] highly probable.*

- Dr BA submits that the atrophy of central structures and the hyperintensities in these structures suggest additional PBGT [Perirolandic Basal Ganglia and Thalamus]/Central hypoxic ischaemic injury to the brain.

- Thus, the findings are in keeping with a *Mixed pattern of dominant Watershed zone Ischaemic (prolonged partial pattern) and PBGT/Central ischaemic injury.*

- [T]he findings of the MRI study suggest that the genetic disorders as a cause of the child's brain damage are unlikely but not excluded in light of the signal changes of the Dentate nuclei and posterior Pons. Further clinical, genetic and metabolic assessment is advised.

- *[T]here is no evidence of current or previous infective or inflammatory conditions on the various MRI sequences and [they] agree that inflammatory or infective conditions are unlikely as direct causes of the child's brain damage.*

- [A] review of the clinical and obstetrical records by appropriate specialists in the field of Neonatology and Obstetrics to be essential in determining the cause and timing of this hypoxic ischemic injury.' (Emphasis added.)

[19] In another joint minute, the paediatric neurologists, Dr Keshave for Ms N K and Dr Reddy for the MEC, agreed on some issues, but not all. I highlight only the most relevant, speaking to the timing of the insult. They agreed that the clinical presentation was 'in keeping with the ACOG criteria (2017), for the type of cerebral palsy associated with intrapartum hypoxic ischaemic injury.' They furthermore agreed that there was 'clear evidence of neonatal encephalopathy at the time of birth, which persisted for over a week.' To this Dr Keshave added that 'the neonatal encephalopathy is further supported by the maximum Hypoxic Ischaemic Encephalopathy (HIE) Score – 12 on day 8 of life. The neonatal encephalopathy is also in keeping with the criteria set out by JJ Volpe (2018) for intrapartum hypoxic ischaemic injury'. However, Dr Reddy added that 'the neonatal encephalopathy was

of moderate severity following birth', and continued stating that '[i]n this case, the presence of chorioamnionitis which is a chronic placental lesion, makes an acute intrapartum event as the sole underlying pathogenesis of neonatal encephalopathy much less likely'.

[20] They reference an article by McLennan *et al* titled *'Cerebral palsy: causes, pathways, and the role of genetic variants*' in which the authors state:

'- Chorioamnionitis, funisitis, and, in particular, necrotizing funisitis are all evidence of infection predating labour and are associated in all epidemiological studies with an increased risk of cerebral palsy.'

Dr Keshave pointed out that:

'- The ambiguous role of chorioamnionitis was confirmed in that infants with neonatal encephalopathy due to presumed HIE, with the highest incidence in the infants without brain injury and those with the most extensive brain injuries.

. . .

- In [U K]'s case, the CRP was within normal limits, indicating the role of chorioamnionitis to have played a lesser role than the prolonged second stage, with multiple vacuum extraction attempts.

- The Grading of neonatal encephalopathy is at Grade 3 (High). Once again not in keeping with the neonatal encephalopathy secondary to chorioamnionitis.'

To this Dr Reddy responded:

'- The CRP and grade of neonatal encephalopathy [are] not definitive tool[s] to assess the implication of chorioamnionitis.'

Dr Keshave stated that:

'- The role that chorioamnionitis played in this matter, when one compares the obstetric management of labour, favours a greater role for prolonged labour in this case, as the main cause of his injury and current clinical presentation.'

[21] Dr Janowski for the MEC, in his expert report, stated that the timing of an insult can be categorized into four groups: prenatal, perinatal, post-neonatal (acquired), and uncertain. Prenatal refers to the period before the onset of labour, perinatal to the period shortly before, during or after birth and acquired (post-neonatal) to insults occurring from 28 days to 5 years of age. He could not tell the court what the likely cause of the infection was during pregnancy and what circumstances propelled him to identify such a stage. This is because he did not have the facts, as he did not consult Ms N K before he produced his report. Dr Reddy testified that chorioamnionitis

primes the brain for injury. In the scheme of things, the MRI scan as part of the prenatal procedure cannot be ignored or given less prominence when the evidence as a whole is assessed as the high court and full court did. In other words, it is not only the histology report that is relevant to determine what was the cause of the brain injury. The MRI is relevant because it could detect any infection in the brain prenatally. What is of importance is that Dr Reddy conceded during cross-examination that not every child with chorioamnionitis will have an adverse outcome, as the other experts of the MEC seemed to suggest.

[22] In her claim against the MEC, in her amended particulars of claim, Ms N K alleged that the medical staff at the hospital were negligent in several respects, which caused or contributed to U K's brain injury. These grounds included the medical staff who were responsible for her care upon admission to the hospital until U K's delivery:

'[a] failed to prevent the onset of chorioamnionitis[5] during the antenatal period when the plaintiff was in the care of the defendant's employees and institutions.

[b] failed to treat the chorioamnionitis when, by reasonable care and skill expected of medical practitioners treating a pregnant woman, it ought to have been detected and treated with the appropriate care and treatment administered to prevent any further particulars associated with the infection.

[c] failed to detect the onset of chorioamnionitis, through the prevention of prolonged and protracted labour, which exacerbated the infection.

[d] failed to prevent and to take reasonable steps to prevent the complications associated with chorioamnionitis.

[e] failed to prevent the repeated . . . vaginal examinations of the plaintiff, over the numerous days in labour, which caused and/or contributed to the onset of chorioamnionitis.'

[23] Ms N K further alleged that as a result of the negligent conduct of the medical staff, she endured prolonged labour, which led to a failure to timeously deliver U K. Consequently, U K 'suffered a hypoxic ischemic incident[6] due to perinatal asphyxia,[7]

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[5] According to the MEC, this translates to an admission of chorioamnionitis as a pre-existing medical condition. This argument is dealt with below.

[6] A hypoxic ischemic incident is a serious medical event during which the brain and other organs do not receive sufficient blood flow (this is referred to as ischemia) and therefore are deprived of adequate oxygen (this is referred to as hypoxia).

[7] Perinatal asphyxia occurs when blood flow or gas exchange to or from the fetus is disrupted immediately before, during or after birth. It can lead to severe systemic and neurological complications due to reduced oxygen and blood supply to vital organs, including the brain, liver and muscles.

causing him to sustain severe brain damage, as a result of which he suffered from cerebral palsy, mental retardation,[8] and epilepsy' since birth. U K is 'unable to talk, has dysfunctional limbs or limitations to the use of limbs, and has not reached any of the milestones to be anticipated in normal development'. He will be 'disabled permanently and has lost all amenities of life'. U K has a life expectancy of at least 40 years from the date of summons.

[24] In her plea, the MEC denied any negligence of the medical staff, which was alleged to have led to U K's brain injury. She pleaded that although U K suffered hypoxic ischemic encephalopathy and consequently cerebral palsy, there was no negligence on the part of her medical staff. If the court found that there was any negligence on the part of her employees, she contended, such negligence was not causally linked to U K's brain injury. The MEC advanced that U K was born asphyxiated as a result of placental insufficiency due to an infection – chorioamnionitis – and fetal response to it, which occurred before the onset of labour and occurred in the absence of the alleged prolonged labour.

Findings of the high court

[25] The high court found, based on Ms N K's unrefuted evidence, that the treating staff were negligent.[9] Consequently, it examined only the issue of causation. It found that there was no evidence that the substandard monitoring had adversely affected U K. This was because Ms N K had indicated that during the evening of 7 March 2019, prior to U K's birth the following morning, a nurse had checked the results of a CTG and declared that everything had been satisfactory, and that Ms N K would shortly be required to start the process of delivery. If there had been any problem at that stage, then the nurse would have mentioned this. Moreover, Ms N K's cervix would not yet have been fully dilated, so the high court reasoned.

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[8] Correctly known as intellectual disability but commonly known as mental disability.

[9] *N K on behalf of U K v MEC for Department of Health* (unreported, case no. 827/2019, Eastern Cape Division, Bhisho, delivered on 11 October 2022) (high court judgment) para 18: 'I will examine the issue of causation *on the assumption, without finding, that the treating staff were negligent* by causing the plaintiff to endure a prolonged and protracted labour, subjecting her to sub-standard care by not monitoring her and the child at regular intervals, attempting to vacuum extract the child and applying fundal pressure and failing to intervene after misoprostol had been given to her'.

[26] Furthermore, the high court found that U K's pH level at birth was normal. There had also been no evidence to demonstrate that reliance by the medical staff on vacuum extraction and fundal pressure had caused the brain damage. The same could be said for the administration of Misoprostol, which may have been used to induce labour. It was undisputed, said the high court, that U K's condition had been compromised at the time of delivery. This was in keeping with the diagnosis that his brain had sustained an injury because of a significant lack of oxygen. The question to be determined was, according to the high court, when the injury had occurred.

[27] The high court concluded:

'[T]he answer as to when the child's brain was injured lies in the histological report on the evaluation of the placenta. . . The histological report would not have revealed that the chorioamnionitis was acute and severe, exhibiting a fetal inflammatory response with the presence of funisitis and vasculitis unless the mother contracted it a few days or weeks before the onset of labour. That finding excludes a finding that the damage to the child's brain occurred intrapartum. In the circumstances, I find that even if it were proved that the prolonged second stage of labour, induced labour and standard monitoring may have caused damage to the child's brain, it would have happened at a stage when the child's brain had already been damaged over a few days or weeks by the insufficiency of oxygen and nutrients from the placenta, caused by chorioamnionitis.'

Findings of the full court

[28] On appeal, the full court confirmed the judgment and order of the high court. It found in favour of the MEC on both negligence and causation, despite the high court finding in favour of Ms N K on the issue of negligence, and the MEC not cross-appealing. It held that the probable medical reason for the injury was a hypoxic event that took place prior to the commencement of labour. It agreed with the high court that, even if it were proved that the prolonged second stage of labour, induced labour and sub-standard monitoring may have caused damage to the child's brain, it would have happened at a stage when the child's brain had already been damaged over a few days or weeks by the insufficiency of oxygen and nutrients from the placenta, caused by chorioamnionitis. Furthermore, it too accepted as reasonable the evidence of the MEC's experts, that chorioamnionitis, which the experts alleged was the cause of the injury, can be subclinical or silent (asymptomatic, without fever or overt signs

in the mother), thus unlikely to have been detected prior to the examination of the placenta, after U K's birth.

[29] The full court was not persuaded that Ms N K had proved the medical staff had been negligent in their management of her labour. However, in light of the concession by the MEC that that CTG monitoring was an inadequate tool for detecting a silent type of infection such as chorioamnionitis, the full court proceeded to consider causation. It found that there was simply no causal link. Consequently, it dismissed Ms N K's appeal with costs. Thus, this appeal, with special leave of this Court.

Issues for determination before this Court

[30] The core issue for determination, assuming as the high court did, based on Ms N K's unchallenged evidence that the medical staff was negligent, is whether such negligence was the cause of the injury to U K's brain, ie causation.

The law

[31] The requirements for a successful claim in delict are well-established. A plaintiff must prove conduct (a positive act or an omission), causation, wrongfulness, fault (intention or negligence), and harm. Wrongfulness involves a breach of a legal duty. The wrongful conduct must cause the wronged person to suffer loss. Thus, in a case such as this, the plaintiff must prove that the damage that she has sustained has been caused, at least, by the defendant's negligence.

[32] The general rule is that (s) he who asserts must prove. In a civil case, a plaintiff does not need to prove that the inference that she asks the court to draw is the only reasonable inference; it suffices for her to prove that the inference that she advocates is the most readily apparent and acceptable inference from several possible inferences. At the conclusion of the trial, the task of the court is to decide whether, on all the evidence, the probabilities and the inferences, a plaintiff discharged the onus of proof resting upon her on a preponderance of probability. She need not establish the causal link with certainty, but is only to establish that the wrongful conduct, which was also negligent, was the most probable cause of the loss. This 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 experience.[10]

[33] Medical negligence cases invariably involve technical medical terminology and evidence to resolve, first, the different and often conflicting versions of the patient and the doctor, and second, the technical and conflicting expert evidence. The correct approach to the evaluation of expert medical evidence was authoritatively laid down by this Court in *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* (*Linksfield*).[11] What is required in the evaluation of such evidence is to determine whether and to what extent their advanced opinions are founded on logical reasoning, with the following in mind: (a) The court is not obliged to absolve a defendant from liability for negligent medical treatment or diagnosis merely because expert evidence indicates that the conduct conformed to accepted medical practice. (b) The court must be satisfied that the expert opinion relied upon has a logical basis, meaning that the expert has properly considered the comparative risks and benefits and reached a defensible conclusion. (c) If a body of professional opinion fails to take into account an obvious and avoidable risk, the opinion may be regarded as unreasonable, even if it is widely or almost universally held. (d) Accordingly, a defendant may still be held liable despite support from professional opinion if that opinion cannot withstand logical analysis. (e) Nevertheless, courts should be cautious in rejecting the views of competent experts, as the assessment of medical risks and benefits is primarily a matter of clinical judgment. (f) Courts should not decide cases merely by preferring one expert view over another where both opinions are logically defensible. (g) Only where an expert opinion lacks any logical support will it fail to serve as the benchmark against which the defendant's conduct is assessed. (h) Finally, it should be noted that expert scientific witnesses often evaluate likelihood in terms of scientific certainty, which may differ from the legal standard of proof.[12]

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[10] *Goliath v MEC for Health, Eastern Cape* [2014] ZASCA 182; 2015 (2) SA 97 SCA para 19; *A N v MEC for Health, Eastern Cape* [2019] ZASCA 102; [2019] 4 All SA 1 (SCA) para 48 citing *Minister of Safety and Security v Van Duivenboden* [2002] (6) SA 431 (SCA) para 25.

[11] *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188; [2002] 1 All SA 384 (SCA) (Linksfield) paras 36-40 citing the decision of the House of Lords in the medical negligence case of *Bolitho v City and Hackney Health Authority* [1998] AC 232 (H.L.(E.)) (*Bolitho*), especially relevant dicta from the speech of Lord Browne-Wilkinson.

[12] Ibid, *Linksfield* at 36 – 40 referring to *Bolitho* at 241G-243A.

[34] The opinions of expert witnesses involve the drawing of inferences from facts. The inferences must be reasonably capable of being drawn from those facts. If they are tenuous or far-fetched, they cannot form the foundation for the court to make any finding of fact. Furthermore, in any process of reasoning, the drawing of inferences from the facts must be based on admitted or proven facts and not matters of speculation.[13]

Negligence

[35] The test for establishing negligence is trite.[14] It rests on two bases: reasonable foreseeability and the reasonable preventability of the damage.[15] What is or is not reasonably foreseeable in a particular case is a fact bound enquiry.[16] The first step in proving this is to prove that the wrongful conduct of the staff caused the baby to suffer brain damage. Therefore, even if a defendant is found to have negligently failed to act as a reasonable person in their position, this alone has never been sufficient to establish delictual liability. The enquiry is therefore only one, namely whether the plaintiff, having regard to all the evidence in the case, has discharged the onus of proving, on balance of probabilities, that the negligence averred against the defendant, is the cause of the plaintiff's injury, and consequent damages.

Causation

[36] To establish the causal link between an act or omission and the harm suffered, a litigant must establish not only factual causation but also legal causation. Most recently, the Constitutional Court reaffirmed the test for establishing causation in *N V M obo V K M v Tembisa Hospital and Another* (*N M V obo V K M*)[17] where it stated:

'It is trite that *the enquiry into factual causation asks the question whether the wrongful conduct or omission was a factual cause of the loss.* After citing *Siman* this Court in *Lee* described that enquiry as follows:

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[13] *A M and Another v MEC for Health, Western Cape* [2020] ZASCA 89; 2021 (3) SA 337 (SCA) para 21.
[14] *Kruger v Coetzee* 1966 (2) SA 428 (A); [1966] All SA 490 (A).
[15] *Jacobs and Another v Transnet Ltd t/a Metrorail and Another* [2014] ZASCA; 2015(1) SA 139 (SCA) 113 para 6.
[16] *Kruger v Coetzee* fn 14 at 430G.
[17] *NVM obo VKM v Tembisa Hospital and Another* [2022] ZACC 11; 2022 (6) BCLR 707 (CC) paras 56-57.

"The enquiry as to factual causation generally results in the application of the so-called 'but for' test, which is designed to determine whether a postulated cause can be identified as a causa sine qua non *of the loss in question. This test is applied by asking whether but for the wrongful act or omission of the defendant the event giving rise to the loss sustained by the plaintiff would have occurred."*

…

[A]pplying this test, no mathematical or scientific exactitude is required. As this Court said in *Lee*:

"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 ordinary person's mind works against the background of everyday-life experiences."' (Emphasis added)

Application of the law to the facts

[37] To determine whether Ms N K has discharged the onus which rests upon her, it is necessary to consider how the injury to U K's brain occurred factually, entailing a proper assessment of the evidence regarding the medical reasons for the injury (factual causation). It is trite that a trial court's factual findings are correct unless it is found to have misdirected itself. They cannot be disturbed on appeal simply because the appellate court would have reached a different conclusion had it been the court of first instance. The reason for this was stated by this Court in clear terms in *R v Dhlumayo,*[18] which remains good law and has been endorsed in numerous cases of this Court and the Constitutional Court, as follows:

'The trial Judge has advantages – which the appellate court cannot have – in seeing and hearing the witness and in being steeped in the atmosphere of the trial. Not only has he had the opportunity of observing their demeanour, but also their appearance and whole personality. This should never be overlooked.'[19]

[38] Having accepted, as the high court correctly did, that there was negligence on the part of the medical staff, the question remains whether, but for the negligent conduct, the injury would have been sustained (factual causation) and whether the negligence of the medical staff is linked to the harm sufficiently closely or directly for legal liability to ensue or whether the harm is too remote (legal causation). In answering this question, whether the medical staff could have prevented the injury by

[18] *Rex v Dhlumayo and Another* 1948 (2) SA 677 (A) at 705.
[19] *S v Pistorius* [2014] ZAGPPHC 793; 2014 JDR 2127 (GP).

exercising reasonable care and skill is the issue.

[39] It is trite that the facts on which an expert's opinion, which is in dispute, is based must have been proven and that a court must have regard to the cogency of the expert's process of reasoning. The facts on which expert witnesses express an opinion must be capable of being reconciled with all other evidence of the case.[20] The evidence of Ms N K is therefore an important consideration.[21] It is for these reasons that the finding that the MEC's medical staff was negligent, as found by the high court, remains.

[40] This case must be approached on the basis that at the time Ms N K gave birth, she did not give birth when she was expected to, medically, within 40 weeks, had suffered inexplicable abdominal pains over five days, from 3 March until she gave birth on 8 March, 2019, and consequently endured a prolonged second stage of labour. In addition to Ms N K, Dr Ndjapa, whom she consulted after her discharge from the hospital, testified. Dr Ndjapa stated in his expert report that:

'It is most probable that [U K]'s Birth Asphyxia was due to a combination of factors such as Chorioamnionitis due to prolonged labour and repeated vaginal examination, failed vacuum, as well as the inappropriate application of fundal pressure, inappropriate fetal and maternal monitoring.'

[41] As I indicated, the MEC's medical experts relied primarily on the histology report to form their opinion on what caused the insult. The histology report lists the following as present on the microscopy of the cord: vasculitis, funisitis, and under the membranes and chorionic plate. It lists as present: chorioamnionitis (inflammation type: acute, location: chorioamnionitis, intensity: confluent), and vasculitis of the chorionic plate vessels. Under 'Diagnosis', the following is written:

'Singleton placenta with a weight of 553g. Severe acute chorioamnionitis with maternal and foetal inflammatory response.'

[42] Vasculitis refers to inflammation of a blood vessel or blood vessels, and funisitis refers to inflammation of the umbilical cord's connective tissue, which occurs

[20] *Bee v Road Accident Fund* 2018 (4) SA 366 (SCA); [2018] ZASCA 52.
[21] Ibid paras 73-74.

with chorioamnionitis. Funisitis and chorionic vasculitis are the hallmarks of fetal inflammatory response syndrome, a condition characterized by an elevation in fetal plasma concentrations, associated with the impending onset of preterm labour, a higher rate of neonatal morbidity (after adjustment for gestational age), and multi-organ fetal involvement. This syndrome is the counterpart of systemic inflammatory response syndrome in adults; however, in foetuses, it is a risk factor for short- and long-term complications, including cerebral palsy.[22] According to an article included in the record '[a]cute chorioamnionitis is evidence of intra-amniotic inflammation, and not intra-amniotic infection'. [23]

[43] A summary of the medical evidence given by the experts on both sides makes it clear that the obstetricians' evidence was at odds. Each was adamant about their viewpoint. And even substantiated those views. These were mutually destructive opinions which must be treated differently when the evidence is analysed to acknowledge their divergence. A trial court cannot simply, without more, prefer one opinion over the other or reject one and discard the other on the basis that one opinion is justified with reference to medical literature or that conclusions were based on logical reasoning and grounded in fact when such opinions do not refer to logic in the context of the peculiar facts of the particular case.

[44] As has been stated before, expert scientific witnesses tend to evaluate probabilities in terms of scientific certainty. The responsibility of the courts adjudicating cases where scientific evidence plays a critical role is to bring into the picture all other evidence presented and juxtapose it with scientific evidence to avoid a prejudged approach and conclusions.[24]

[45] I have considered all the expert evidence presented. However, as cautioned by this Court in *Linksfield*, such medical evidence cannot be accepted without reference to other evidence, in this case, Ms N K's unchallenged evidence that the monitoring of her labour was hopelessly inadequate. Notably, despite being adamant

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[22] C J Kim, R Romero, P Chaemsaithong, N Chaiyasit, B H Yoon, Y M Kim '*Acute chorioamnionitis and funisitis: definition, pathologic features, and clinical significance*'. American Journal of Obstetrics and Gynaecology 2015 29 – 52.
[23] Ibid at 30.
[24] *Linksfield* fn 12 para 40.

on the setting in of the injury, during cross–examination, Dr Reddy was constrained to concede that her earlier diagnosis was based on wrong information.

[46] It seems to me that the high court and full court focused on Dr Reddy's evidence-in-chief and paid little or no regard to the concession and retraction she made during cross-examination, wherein she capitulated on that evidence and stated: 'I agree and that was my mistake from a misunderstanding on how the report was written. So there was severe acute chorioamnionitis with a maternal and foetal inflammatory response, so we know that the foetal inflammatory response gives you a much higher risk of damage to the placenta. *So, I will withdraw my statement about the foetal placental thrombosis from the previous report.* But like I said, severe acute chorioamnionitis with a foetal inflammatory response still gives you a high probability of damage to the foetus and even if we take Dr Keshave's initial from this report, he said 56 percent of the patients, you know, in that group had MRI abnormalities. And then you are looking at a prolonged second stage where 2 percent had problems.' (Emphasis added.)

[47] One of the trite principles of our law is that each case must be decided on its own merits. What distinguishes this case from similar cases is the following. All experts agreed that chorioamnionitis is a rare, silent infection that is not detectable in the weeks before labour, nor during labour, until, as in this case, the placenta is taken for testing and only then do the results point to it. That is not the issue on these facts. The issue is that it is on record that Ms N K suffered from extreme pains from day one; that is why she came to the hospital in the first place. Yet, from 3 March until 8 March, the hospital did not pick up any abnormality.

[48] The MEC has made no averments that the medical staff did their utmost to address the excruciating pains she obviously endured from day one of her admission, considering her pre-existing high blood pressure diagnosed as pre-eclampsia, which by definition can lead to complications during labour if unattended. No extra precautions were taken. No extra tests were done when she did not deliver within the 40 weeks, and there were 96 hours of prolonged induction without any meaningful intervention, according to Ms N K's and Dr Ndjapa's uncontradicted evidence. The obvious intervention was a C-section, which the doctor on duty stated, on 6 March already, would be necessary should she not have delivered by 7 March. It is on record that Ms N K herself asked if she could be taken for a C-section, but she received no

response. On the contrary, she was left to her own devices, screaming and crying for assistance.

[49] This does not change the test for a causal link but confirms that once a patient is in the care of the hospital, as Ms N K was, the medical staff were legally obliged to take care of her, taking into account that she had high blood pressure and was going into the extra time of her labour. That she was inexplicably not fully dilated despite having gone far beyond the normal 40 weeks and three days into labour and into the second stage of labour, when strangely and beyond comprehension, the cervix was not fully dilated. She was at that stage, three weeks late. This ought to have raised alarms. Medical staff in their position would have acted reasonably, prepared her for a C-section under the supervision of the doctor on duty. There is no evidence on where the doctor on duty was between 21h00 on 7 March and 05h50 on 8 March when this medical crisis unfolded. All we have is the doctor's untested utterances upon her arrival that the medical staff was to blame for the condition that U K was born in, not her. The medical staff therefore failed to act in accordance with their legal obligation.

[50] It is correct, as stated in medical literature, that chorioamnionitis is a silent infection that cannot be detected earlier on until tests have been done on the placenta and can cause brain injury to a baby before being born.[25] However, medical literature also states that brain injury can be caused by, amongst others, artificial rupturing of the placenta and continued vaginal examination, as it probably happened in Ms N K's instance on the strength of her testimony. Brain injury can also be caused by a prolonged second stage of labour. This we know occurred as she was in labour since 21h00 until 05h50, ie over eight hours, under conditions where she was not assisted and had stopped pushing due to fatigue.

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[25] The following articles, with some relied on by the expert witnesses, are included in the record: J C Harteman, P G Nikkels, M J Benders, A Kwee, F Groenendaal, L S de Vries '*Placental pathology in full-term infants with hypoxic-ischemic neonatal encephalopathy and association with magnetic resonance imaging pattern of brain injury'* The Journal of pediatrics 2013 163(4): 968-95; R M McAdams and K M Adams Waldorf '*Influence of infection during pregnancy on fetal development, Reproduction'* 2013 1;146(5): R151-62; A H MacLennan, S C Thompson, Gecz J. '*Cerebral palsy: causes, pathways, and the role of genetic variants*' American Journal of Obstetrics and Gynecology 2015 213 (6):779-88 ; W Wu, G J Escobar, J K Grether, L A Croen, J D Greene, T B Newman '*Chorioamnionitis and cerebral palsy in term and near-term* infants' Journal of the American Medical Association 2003 26;290(20):2677-84; K M Adams Waldorf and R M McAdams '*Influence of infection during pregnancy on fetal development*' Reproduction 2013 1;146(5):R151-62.

[51] It is in light of what the medical experts stated in the paragraphs above that I am bound to accept that chorioamnionitis could have pre-existed before the second stage of labour commenced and compromised U K's birth. However, even if this is the case, from a logical point of view and as Ms N K's team of medical experts explained reasonably, the prolonged labour was exacerbated by the artificial rupture of the placenta, lack of monitoring after the labour-inducing medication was introduced, repeated vaginal examination, non-compliance with the supervision requirements in terms of the National Maternal Guidelines (Maternal Guidelines)[26], the several attempts of vacuum extraction which failed and prolonged fundal pressure applied.

[52] Counsel for Ms N K submitted in his heads of argument and before this Court that:

'Antenatally, she frequently visited Zwide Clinic and immediately after she noticed she was pregnant. She was treated for high blood pressure (BP) and she was told that it is normal for a pregnant woman to have it. There is no history of infection. The evidence reflects that the plaintiff had no risk factors associated with infection. None was pointed by anyone in the Courts below.'

[53] Thus, contrary to what was pleaded by the MEC, the experts of Ms N K proposed that chorioamnionitis was not the only probable cause of the insult to U K, but, when combined with other negligent conduct listed above, it likely contributed to

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[26] The National Maternal Guidelines 4th edition (2016), which apply to clinics, community health centers and district hospitals in South Africa, are published by the government, which would have been applicable in 2021, can be accessed at: https://knowledgehub.health.gov.za/system/files/elibdownloads/20204/CompleteMaternalBook.pdf. Under the heading of '*Management of the second stage of labour*', the guidelines provide as follows: 'The second stage starts when the cervix reaches full dilatation (10 cm) and ends with delivery of the baby. Time (up to two hours) can be allowed for the head to descend onto the pelvic floor if foetal distress and cephalo-pelvic disproportion (CPD) have been ruled out. The bladder should be empty or emptied, using a catheter if necessary. The observations of the active first stage of labour should continue. Efforts at bearing down are only encouraged when the foetal head starts to distend the perineum and the woman has an urge to push. When the woman is ready to push (bear down): • always communicate clearly with the woman to gain co-operation • *be supportive and encouraging* • put the woman in a suitable position: propped up, sitting, squatting, kneeling, semi-Fowler's or wedged supine. *Avoid the flat supine position (lying flat on the back)*, as the pregnant uterus will compress the aorta and inferior vena cava • *encourage pushing/ bearing down only during contractions* • *listen to the foetal heart after every second contraction* • protect the perineum when the foetal head crowns • dry the baby and place the baby on the woman's abdomen, skin to skin, for her to hold immediately after delivery for at least an hour. Postpone all routine neonatal procedures that are not lifesaving (e.g. washing, weighing and non-urgent medical procedures) . . .' (Emphasis added.) See also *AN* paras 35-37.

the insult. They go a step further to state that '[i]n [U K]'s case, the CRP was within normal limits, indicating chorioamnionitis to have played a lesser role than the prolonged second stage, with multiple vacuum extraction attempts'.[27]

[54] The MEC's medical expert reports, did not factor in nor include in their expert conclusions, Ms N K's evidence, her prenatal medical history (ie that she was in good medical condition except for her high blood pressure which she was assured was normal in all pregnant women); her medical condition from the date of her admission (ie severe pains for which she was given medication every morning and evening and sometimes twice in the evening when they were severe); the bad treatment she received during labour; the duration of her labour without the supervision of a doctor at the critical moment when the baby's head emerged and the medical staff applying fundal pressure and attempted vacuum extraction which failed more than three times; the number of hours that elapsed (21h00 to 05h50) since the manifestation of labour up to U K's delivery, and the prolonged induction, 96 hours (counting from the day Ms N K was admitted and complained of severe stomach pains), according to Dr Ndjapa's uncontested evidence – which supports the proposition that Ms N K's delivery fell within the category of prolonged labour within the contemplation of the Maternal Guidelines – and the bad treatment she received throughout her labour even post labour where the placenta was left inside her womb and had to be removed by operation after the episiotomy was sutured after the delivery.

[55] Ms N K's medical experts made the point that the insult could have been prevented by proper and reasonable care and monitoring in accordance with the prescripts of the Maternal Guidelines, once labour-inducing treatment was introduced, to be alert to any unforeseen developments. And at the very least, it could have been minimized had the medical staff taken reasonable measures even after this prolonged second stage of labour, when it was evident that Ms N K was not dilating as anticipated and is normally expected for a full-term pregnancy taking into account her medical history, which although at first blush seemed uncomplicated was a high risk one considering the pre-eclampsia Dr Ndjapa referred to. And the fact that Ms N K was instructed to push unassisted/guided for a first-time pregnancy,

[27] According to Dr Keshave in the joint minute, relying on the study by J.C Harteman, see fn 25.

contrary to the Maternal Guidelines, which apply to all pregnant women regardless of being in a private hospital or community health care centre.

[56] All these factors, cumulatively, lead me to the ineluctable conclusion that the medical staff's monitoring of Ms N K's labour was hopelessly inadequate, resulting in the insult U K suffered. The MEC made no attempt whatsoever to gainsay Ms N K's damning testimony regarding the treatment she received at the hands of the medical staff. That being so, she accordingly took the risk of judgment being given against her.

[57] The question whether an adverse inference is to be drawn from the failure by a party to call a witness is a question of fact.[28] This Court held in *Minister of Safety and Security v Lincoln*[29] that where witnesses were identified but inexplicably not called to testify in support of a case, without any suggestion that any of them were unavailable to testify, an inference that they would not support the case is justified. In this matter, for the reasons given above, I conclude that an adverse inference is justified.

[58] What the trial court did was simply to accept the medical evidence without more, which would have entailed asking questions and seeking further information after presenting hypothetical scenarios, or better still real-life cases, to test the reasonableness of the medical evidence. This was, of course, not possible because the parties agreed to admit the medical experts' reports without the pathologists and radiologists testifying. The trite enquiry on the treatment of expert evidence, endorsed in *Linksfield*, could consequently not be undertaken. It follows that without such an enquiry, the full court erred in finding that the medical staff of the MEC did what they could under the circumstances, and that even with their intervention, U K would still have suffered an injury to his brain. The conclusion the full court drew is contrary to what the Constitutional Court in *Lee* termed 'common sense, based on the practical

[28] *Elgin Fireclays Limited v Webb* 1947 (4) SA 744 (A) 749 to 750; *Munster Estates (Pty) Ltd v Killarney Hills (Pty) Ltd* 1979 (1) SA 621 (A). See also *Olifant v Shield Insurance Co* 1980 (1) SA 903 (C).
[29] *Minister of Safety and Security v Lincoln [*2020] ZASCA 59; (2) SACR 262 (SCA); [2020] 3 All SA 341 (SCA) 2020 para 49.

way in which the ordinary person's mind works against the background of everyday-life experiences'.[30]

[59] It follows that the *post facto* opinion of the MEC's medical experts, without any reference to what Ms N K experienced, cannot be accepted as based on logical reasoning. It is disconnected from what actually transpired, as related by Ms N K, with supporting medical evidence, and is the most reasonable and probable that could have happened.

[60] As the matter (whether the medical staff was negligent and whether their negligence led to UK's brain insult) had been fully explored in the evidence, at the conclusion of the trial, the task of the trial court was to decide whether, on all the evidence and probabilities and inferences, Ms N K had discharged the onus of proof resting upon her on a preponderance of probability. In my view, she unquestionably had. In the result, the appeal must succeed.

The Amended Particulars of Claim

[61] One thing I may be remiss in is this. What I have stated in the above paragraphs in respect of the pre-existence of chorioamnionitis is not clearly pleaded in the amended particulars of claim, as counsel for Ms N K conceded during his interaction with the bench. Above I list the grounds contained in the amended particulars of claim,[31] the first includes the failure of the medical staff 'to prevent the onset of Chorioamnionitis during the antenatal period when the plaintiff was in the care of the [MEC's] employees and institutions'.

[62] Based on this wording, counsel for the MEC argued as follows:

'To state that perinatal means around labour is totally wrong and incorrect. Perinatal means before delivery from the 28th week of gestation through the first 7 days after delivery,' with reference to Stedman's Medical Dictionary 2012. . . we once again point out that the issue of chorioamnionitis antenatally forms part of the plaintiff's case.'

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[30] *Lee v Minister of Correctional Services* 2013 (2) SA 144 (CC*)* para 47.

[31] See para 22.

[63] It is trite that the object of pleading is to define the issues, and parties will be kept strictly to their pleas where any departure would cause prejudice or would prevent full enquiry. But within those limits, the court has a wide discretion. For pleadings are made for the court, not the court for the pleadings. And where a party has had every facility to place all the facts before the trial court and the investigation into all the circumstances has been as thorough and as patient as in this instance, there is no justification for interference by an appellate tribunal, merely because the pleading of the opponent has not been as explicit as it might have been.[32]

[64] The Constitutional Court in *Eskom Holdings Soc Ltd v Vaal River Development Association (Pty) Ltd and Others*[33] puts it as follows:

'It matters not, even if the Ngwathe residents have not specifically alleged that one of the grounds of review will be that Eskom took its decision for an ulterior purpose. *Although ordinarily parties must be held to their pleadings, courts must not be dogmatic about this.* Just under a century ago, Innes CJ held in *Robinson*: . . .' (Emphasis added and footnotes ommitted.)

[65] On these facts, even though the word 'antenatal' appears in one of the grounds listed in the amended particulars of claim, it is not Ms N K's whole case that the failure to prevent, detect or treat the chorioamnionitis when she visited the antenatal clinics was the only factor leading to U K's condition. She testified in depth in the high court about a range of other conduct by the MEC's medical staff that probably led to U K's condition. The diagnosis of chorioamnionitis in the pathology report is not in dispute. It is the timing of its onset and severity, as well as its causal link to cerebral palsy, that are in dispute.

[66] On all of these aspects, the experts testified that there is some uncertainty in the literature and the expert witnesses in that regard contradicted each other. The

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[32] *Spearhead Property Holdings Ltd v E&D Motors (Pty) Ltd* [2009] ZASCA 70; 2010 (2) SA 1 (SCA); [2009] 4 All SA 417 (SCA).*M M v MEC for Health; Eastern Cape* [2023] ZASCA; 2023 JDR 3800 (SCA**)** 130 para 28. See also D E Van Loggerenberg *Erasmus: Superior Court Practice* RS 26, 2025, D1 Rule 18-3.

[33] *Eskom Holdings Soc Ltd v Vaal River Development Association (Pty) Ltd and Others* [2022] ZACC 44; 2023 (4) SA 325 (CC); 2023 (5) BCLR 527 (CC); para 277; *Damons v City of Cape Town* [2022] ZACC 13; [2022] 7 BLLR 585 (CC); (2022) 43 ILJ 1549 (CC); 2022 (10) BCLR 1202 (CC) para 117, *Fischer and another v Ramahlele and others* [2014] ZASCA 88; 2014 (4) SA 614 (SCA); [2014] 3 All SA 395 (SCA) para 13.

issue is therefore that there is medically no way to say with certainty that the cerebral palsy was caused by antenatal chorioamnionitis. The determination of whether this has been stated on a balance of probabilities will be contingent upon the conspectus of the evidence, ie that of the expert witnesses along with that of Ms N K. Above I deal with the mutually destructive versions of the medical experts.

[67] If all the facts are taken into consideration, the averment that Ms N K's amended particulars of claim seems to suggest that Ms N K accepted that chorioamnionitis pre-existed and by implication that it was the sole cause of the insult to U K's brain injury, does not on its own exonerate the MEC from liability where Ms N K succeeded in proving both negligence and causation on the part of the medical staff. Moreso when the MEC's case did not rest on how Ms N K pleaded.

[68] The MEC understood what Ms N K's pleaded case entailed, imperfect as it was, and pleaded to it properly. The MEC also did not raise an exception against the pleadings, either before the high court, nor before this Court. She did not challenge the pleadings on any ground, including that the particulars of claim are excipiable. Thus, even on this leg, the MEC would still not come home dry.

Costs

[69] Last, the issue of costs. This Court in *A N v MEC, Health, Eastern Cape*,[34]in 2019, six years ago, had this to say on the prevalence of these matters of medical negligence in the hospitals of South Africa, and in particular hospitals in the Eastern Cape. I can do no better than to quote the relevant passage, which states:

'It is appropriate to say something about the prevalence of matters such as these. Far too often this court is confronted with serious and serial negligence in hospitals falling under the respondent. Whether or not the negligence can be said to have caused harm in the delictual sense, it is clear that studied neglect of standards has become pervasive in many such hospitals. Those reliant upon their services are receiving substandard care. During the hearing, this situation was put to counsel for the respondent. The response was that this sad state of affairs and the need for urgent remedial intervention had pertinently been brought to the attention of the relevant authorities. Despite this, such conduct does not appear to have abated significantly, if at all. The situation is to be deprecated. In the light of this, even though

[34] *A N* fn 10 para 28.

the respondent succeeded in resisting the appeal, counsel quite properly did not seek to advance any argument for a costs award against the appellant. No such award shall be made as a mark of displeasure. In addition, it is directed that this judgment be forwarded to the respondent, and the National Minister under whom health services fall, in the hope that this situation will be urgently addressed.'

[70] The remarks made in the preceding paragraph are apt, albeit that Ms N K is the successful party. I have deliberately chosen to refer to this passage in *A N* above to mark the continuing dereliction (studied neglect) of the medical staff of their duties insofar as they lost Ms N K and U K's medical records, which could have given all the courts through which this matter went a clearer picture, particularly because the medical staff was not called to testify.

[71] Dr McConney explained the dire situation of missing medical records, particularly those where letters of demand have been issued against the MEC as part of prosecuting civil claims against. The loss of such records not only prejudices the plaintiffs in similar matters but also the MEC, where the full picture may, in appropriate cases, exonerate her, for justice not only to be done but seen to be done.

[72] There is a correlation between socio-economic conditions and the prevalence of cerebral palsy.[35] The condition is a manifestation of the systemic inequalities in our society. The discrepancy between private health care and public health care is also brought into sharp relief by the incidence of the condition. This case is no exception.

Order

[73] In the result, I would have granted the following order:

1 The appeal is upheld with costs, including the costs of two counsel.

2 The order of the full court is set aside and is substituted with the following: 'The MEC for the Department of Health, Eastern Cape, is held liable for the negligence of her employees at Dora Nginza Provincial Hospital, which led to

[35] A recent study estimates that high-income countries account for 4% of worldwide cerebral palsy cases, whereas low- and middle-income countries account for 96% thereof. The period prevalence in high income countries is estimated at 1.6–2.9 per 1000 of the population and 2.3–3.7 for low- and middle-income countries. See B O Olusanya '*Cerebral palsy in young children: bridging the global data gap*.' The Lancet Global Health 2025 Volume 13 Issue 10 E1663 - E1664 accessed at https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(25)00268-2/fulltext.

the brain injury suffered by the minor child, U K, on 8 March 2021, represented by his mother, Ms N K.'

3 The matter is remitted to the high court (differently constituted) to deal with the quantum of damages.

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B C MOCUMIE

JUDGE OF APPEAL

Kathree-Setiloane JA (Coppin JA and Basson AJA concurring)

[74] I have read the judgment of my sister Mocumie JA. I am, however, unable to agree with the order and her underlying reasoning that the appeal succeeds. The order is premised on the failure of the medical staff to take all reasonable steps to prevent the hypoxic ischemic insult to U K, and that their negligence caused U K to suffer a severe brain injury. Accordingly, the first judgment concludes that the full court erred in upholding the conclusion of the high court that the damage to the child's brain was caused by chorioamnionitis, which set in before the onset of labour.

[75] The issue on appeal is whether the full court erred in reaching its decision. For this Court to conclude that it did, it must find that the full court failed to recognize demonstrable errors by the high court in accepting the expert testimony of Drs Reddy and Janowski, which was grounded in objective medical evidence. As noted in the judgment of the full court, apart from the evidence of Ms N K, the only medical evidence before the trial court consisted of the Road to Health Chart, the MRI, the histopathology/histology report on Ms N K's placenta, and the arterial blood gas analysis.

[76] The starting point is whether the histology report and the blood gas analysis were admissible. On behalf of Ms N K, it was argued that they were not. There are, however, three reasons why this issue need not detain us. First, the question of admissibility was raised for the first time during argument in the appeal before the full

court. Second, her counsel had introduced this evidence at trial in the high court and expressly confirmed that it was not in dispute. Indeed, as the full court found, the admissibility of the histology and blood gas reports was never contested at trial. They had been discovered, included in the trial bundle, considered by the various experts, and featured extensively in both the evidence and the argument.

[77] The third reason is that, in paragraphs 12.16 to 12.20 of the particulars of claim, Ms N K expressly pleaded the presence of chorioamnionitis during the antenatal period. Notably, the only evidence of antenatal chorioamnionitis appears in the histology report. This demonstrates that Ms N K herself relied on that report from the outset of the case.

[78] Dr Janowski, who testified for the MEC, conceded that the monitoring provided by the hospital's support staff was sub-standard. On the basis of this concession, the full court proceeded to consider causation and held that there was no causal link between the sub-standard monitoring and U K's severe brain injury. Even if the monitoring was deficient, the question for purposes of causation is whether it was the most probable cause of the injury, or whether, as the MEC contended, the onset of chorioamnionitis – undetectable and asymptomatic – was the more probable cause. The timing of the chorioamnionitis is central to this determination.

[79] Ms N K's pleaded case is that the chorioamnionitis was antenatal. In other words, it occurred before the birth of U K. This is consistent with the evidence of Drs Reddy and Janowski. They concluded that chorioamnionitis which set in before the birth of U K was the cause of the injury to U K's brain. The objective evidence which is pivotal to the question of causation, in this case, is the histology and blood gas analysis. The histology report contains the diagnosis of the placenta: 'Severe acute chorioamnionitis with maternal and foetal inflammatory response'. This diagnosis was obtained within 14 minutes of the birth of U K. The time of U K's delivery was 05h50 and the results were available at 06h04. It is not in dispute that the blood gas would have been taken immediately after birth from U K's umbilical cord.

[80] Dr Reddy testified that the definitive means of determining the cause of the brain injury to a baby was through the examination of the placenta, emphasizing that no other method provides greater insight into the events surrounding birth. Concerning the decisiveness of the histology report in this case, she testified that:
'But here it is black and white and cannot be disputed. So, although there are a lot of things in this case that are supposition, the one thing we have that is not supposition is the histology report and that cannot be ignored. The South African Obstetric Association has added placental histology as part of any work up for a child born in a non-ideal condition. They have said you have to look at the placenta; you have to do a blood gas. So that is the importance of that. Everywhere in the world, placentas are being looked at.

[81] Dr Reddy further testified that, in addition to the histology report, a second piece of objective evidence indicating that U K's brain injury occurred prior to labour – rather than as a consequence of a prolonged second stage – was the blood gas analysis which revealed the presence of chorioamnionitis. She emphasized that the blood gas analysis constituted direct scientific evidence, not hearsay or opinion, and confirmed the existence of chorioamnionitis in the placenta. Dr Reddy's evidence was consonant with that of Dr Janowski who, with reference to research conducted by Higgins,[36] described blood gas analysis, 'as the most objective determination of foetal metabolic condition'.

[82] Dr Reddy testified, relying on the histology report and blood gas analysis, that severe acute chorioamnionitis with both maternal and foetal inflammatory responses introduced the likelihood of placental foetal vascular malperfusion (FVM). By restricting foetal blood flow and oxygen delivery to the brain, the FVM primed the baby's brain for injury. The presence of acute chorioamnionitis, accompanied by an inflammatory foetal response, resulted in placental insufficiency and ultimately a hypoxic-ischaemic injury that caused U K.'s cerebral palsy. In support, she cited MacLennan's article, which observed: 'Evidence of intra-uterine infection, evidenced by histological [acute] chorioamnionitis in the placenta and membranes … is associated with a four-fold increase in [cerebral palsy] … in term infants.' [37]

[36] Chris Higgins, *Umbilical-cord blood gas analysis'* (October 2014 acutecaretesting.org).
[37] AH MacLennan et al, '*Cerebral Palsy: Causes, pathways and the role of genetic variants'* accepted on 15 May 2015, American Journal of Obstetrics and Gynaecology (December 2015), 779 at 782.

[83] Contrary to the conclusion reached in the first judgment, Dr Reddy's evidence concerning the presence of infection or chorioamnionitis does not conflict with the joint minute of the radiologists who agreed, on the basis of the MRI sequences, that 'inflammatory or infective conditions are unlikely as direct causes of the child's brain damage'. Dr Reddy explained that the radiologists were referring to a direct cerebral infection, such as meningitis, which would be detectable on an MRI.

[84] In cross-examination, Dr Reddy accepted that no direct infection of the brain was present. She emphasized, however, that 'the infection is of the placenta, which caused impaired blood flow to the brain'. Her evidence was that the radiologists could only exclude direct infection, not an indirect placental infection such as chorioamnionitis which is not detectable on MRI. She further clarified that an MRI of a baby's brain cannot disclose the underlying cause of injury, and therefore the radiologists could not exclude chorioamnionitis as a causal factor. No evidence was adduced to contradict Dr Reddy's testimony that the onset of acute chorioamnionitis in the placenta was an indirect cause of U K's brain injury, nor to impugn her interpretation of the joint minute.

[85] On the question of when the initial brain injury may have occurred, Dr Reddy opined that it most likely took place prior to the onset of labour, after 36 weeks of gestation. She localized the injury to the final four weeks of pregnancy, explaining that had it occurred earlier, U K would have exhibited growth retardation for which there was no evidence. She further stated that the injury could have arisen independently of a prolonged second stage of labour. Although she acknowledged that such a prolonged stage is a recognized risk factor for acute brain injury, she maintained that, in her view, the injury predated it.

[86] On this point, Dr Janowski testified that, given the presence of acute chorioamnionitis and both maternal and foetal inflammatory responses, U K's brain injury could not have occurred during the brief period when Ms N K was admitted to hospital, induced, examined with unsterile gloves, or when an attempt was made to rupture the membranes. He explained that chorioamnionitis develops over time typically two to three weeks before delivery, though its precise onset cannot be determined, as there are 'no tools' to detect it. Not even CTG monitoring can reveal

its presence, he said, because 'it is silent, there are no warning signals, it is happening without any warning; that is why it is so important to examine the placenta'.

[87] Dr Reddy confirmed that CTG monitoring is an inadequate tool for detecting infections such as the onset of acute chorioamnionitis, given its asymptomatic nature. She distinguished the acute or subclinical (silent) chorioamnionitis present in this case from clinical chorioamnionitis, which manifests with maternal fever, abdominal pain, and elevated infection markers. Her evidence was consistent with that of Dr Janowski, who testified that the acute chorioamnionitis in the placenta went undetected precisely because it was asymptomatic. He explained that only about 15 percent of acute chorioamnionitis cases present with symptoms such as uterine tenderness, high temperature, or elevated pulse rate. Both Drs Reddy and Janowski agreed that U K's brain injury was not preventable, as severe acute chorioamnionitis typically progresses without symptoms.

[88] The histology and blood gas analysis indicated the presence of vasculitis and funisitis in the placenta. In Dr Janowski's opinion, the presence of these two conditions in the placenta confirmed: the severity of the acute chorioamnionitis and that the injury to the brain occurred prior to the onset of labour but after 36 weeks of gestation. Dr Reddy agreed. She testified with reference to the academic articles of McClennan and Volpe that the presence of funisitis indicates that the event or injury to the brain would have happened prior to labour. Volpe observed that based on its histological features, FVM is considered to evolve in most cases over a subacute to chronic period prior to delivery and not closer to delivery than approximately 48 hours.[38] Maclennan observed that chorioamnionitis, funisitis and, in particular, necrotizing funisitis are all evidence of infection predating labour and are associated in all epidemiological studies with an increased risk of cerebral palsy.[39]

[89] Ms M K produced no evidence to counter the academic studies on the subject. Nor, as correctly held by the full court, did she challenge the assertion that 'the presence of funisitis indicated that the onset of chorioamnionitis had, in fact,

[38] JJ Volpe, '*Placental assessment provides insight into mechanisms and timing of neonatal hypoxic-ischemic encephalopathy*', Journal of Neonatal-Perinatal Medicine 12 (2019) 113.
[39] AH MacLennan et al at 783.

pre-dated the commencement of labour'. Crucially, the presence of funisitis and vasculitis in the placenta was not adequately addressed by Drs Keshave and Ndjapa in their testimony. Dr Ndjapa maintained that there was no evidence of chorioamnionitis arising in the antenatal period and dismissed Dr Reddy's views as speculative. He, however, failed to properly engage with the histology report and blood gas analysis. Although he cited the histology findings in his expert report, he neglected to address the significance of acute chorioamnionitis coupled with chronic vasculitis and funisitis. Despite this omission, he concluded that 'there was no evidence that the injury occurred prior to labour and after 36 weeks' gestation'. In my view, there is no basis to question the full court's conclusion that Dr Njapa's opinion evidence was incomplete and left material gaps in explaining the factual causes of the injury.

[90] The full court further found that Dr Keshave gave insufficient consideration to the implications of chronic vasculitis and funisitis in the placenta. While he acknowledged the presence of chorioamnionitis, he relied on an article by Harteman to conclude that it played a lesser role than other factors, because U K's C-reactive protein level was normal. Yet he produced no authority to counter the academic views of MacLennan and Volpe, instead asserting that the studies were inconclusive regarding the impact of chorioamnionitis. He also failed to address the significance of severe acute chorioamnionitis with a foetal inflammatory response, which – according to Drs Janowski and Reddy – substantially increases the risk of foetal brain injury.

[91] Dr Janowski and Dr Reddy concluded that the probable cause of U K's brain injury was not, among other factors, a prolonged second stage of labour, induced labour, or sub-standard monitoring, but rather acute chorioamnionitis accompanied by vasculitis and funisitis, which predated labour and was asymptomatic. It was therefore undetectable and not preventable. Their evidence is cogently reasoned and firmly grounded in the objective documentary evidence that was available to them. Where appropriate, they drew upon credible academic research and empirical or epidemiological studies to substantiate their views. In excluding a prolonged second stage of labour as a causal factor, Dr Reddy acknowledged that it is a recognised risk for acute brain injury but demonstrated that the likelihood of an abnormal outcome in such cases is only 1.5 percent. She further accepted that while chorioamnionitis in

the placenta does not invariably result in an abnormal outcome, it materially increases the risk. In my view, this does not diminish the cogency of her testimony regarding the implications of severe acute chorioamnionitis in the placenta.

[92] Dr Reddy also made other concessions where necessary. She acknowledged that she had misinterpreted the histology report in relation to the presence of placental thrombosis. Nonetheless, she maintained that acute chorioamnionitis with a foetal inflammatory response, as in this case, carries a high probability – approximately 70 percent – of foetal injury. As the full court held, her concession on thrombosis did not affect her conclusions regarding the severity or timing of U K's brain injury.

[93] In contrast to the evidence of Drs Reddy and Janowski, the testimony of Drs Keshave and Ndjapa revealed shortcomings, as it gave insufficient attention to the objective documentary evidence on record and lacked support from empirical studies or research. The high court was correct in accepting the evidence of Drs Reddy and Janowski, as it was logically reasoned and firmly grounded in fact. Consequently, the full court did not err in dismissing the appeal against the high court's order, holding that, on a balance of probabilities, U K's cerebral palsy was caused by a hypoxic-ischaemic injury sustained before the commencement of labour, resulting from placental FVM. This condition had arisen from severe acute chorioamnionitis, accompanied by chronic vasculitis and funisitis, and had been asymptomatic in nature. For these reasons, the appeal against the order of the full court must be dismissed.

[94] In the result, I make the following order:
The appeal is dismissed with costs, including those of two counsel.

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F KATHREE-SETILOANE

JUDGE OF APPEAL

Appearances

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