Editorial note: Certain information has been redacted from this judgment in compliance with the law.

REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

REPORTABLE: **NO**/YES
OF INTEREST TO OTHER JUDGES: **NO**/YES
REVISED.

.....12 February 2024
SIGNATUREDATE

CASE NO:58051/2018

DOH 7 - 11 August 2023

In the matter of:

ADV W du PREEZ N.O. obo

B[…] R[…] S[…] **Plaintiff**

AND

MEC FOR HEALTH, GAUTENG **Defendant**

JUDGMENT

THIS JUDGMENT HAS BEEN HANDED DOWN REMOTELY AND SHALL BE CIRCULATED TO THE PARTIES BY E-MAIL AND BY UPLOADING ON CASELINES. THE DATE OF HAND DOWN IS DEEMED TO BE 12 FEBRUARY 2024

Bam J

1. This is a claim for delictual damages. The main issue is whether the defendant was negligent in their treatment, care and management of B[...] R[...] S[...], (the minor). In the event it is found that they were so negligent, the next question is whether the minor's injuries were caused by such negligence. The minor was born prematurely[1] on 4 May 2011 with an extremely low birth weight, ELBW, of 1.1 kg, at Steve Biko Academic Hospital, SBAH. To keep her alive, she had to be fed intravenously. The minor was injured on her right foot when the intravenous line (drip) extravasated[2] (went into the tissue). The tissue around her right foot as a result necrosed, leaving the minor with a permanent injury. Now aged 12, the minor suffers from a flexion contracture of the right ankle, with a limited range of motion and an unsightly scar. In simple language, B[...] suffers from a severe and debilitating deformity of the right foot. It is projected that she is going to need treatment in the future.

2. In his particulars of claim, the plaintiff alleges that the defendant, acting through their

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1 At about 37 weeks' gestation period.

2 extravasated or tissued refer to a drip running into the tissues as opposed to through the veins.

nurses and doctors who were employed at SBAH at the time, owed a duty of care to the minor, to ensure that the treatment and management meet the standard reasonably expected of a provincial hospital caring, *inter alia*, for prematurely born neonates. It is the applicant's case that the defendant breached the duty of care by leaving the drip site[3] unchecked for a period of ten hours during the night of the 20th through to the 21st of May 2011. The plaintiff wants the defendant held liable for the minor's damages. The defendant denies being negligent. They say that extravasation of intravenous lines in neonates is fairly common because of their small blood vessels and absent soft tissue support. While the defendant admits that the minor suffered permanent injuries, they say such injuries do not flow from their negligence but from the well-known risk posed by intravenous lines.

3. At the start of the trial, the parties took a consensual order separating liability from quantum. The trial therefore concerned the issue of liability while the issue of quantum is held over for later determination. In terms of the pretrial minute of 7 July 2023, the parties had agreed that all documents, hospital records, nurses and doctor's contemporaneous notes are what they purport to be and are admissible. As such, there would be no need to produce the originals of such documents during the trial. The expertise of each of the expert witnesses was not in issue as the parties had already agreed to same.

A. Parties

4. The plaintiff, Adv W du Preez, is an officer of this court. He was appointed curator *ad*

3 The place where the drip had been inserted.

litem to the minor in terms of the order issued by this court on 24 May 2023.

5. The defendant is the Member of the Executive Council for Health, Gauteng. They are cited in terms of the provisions of section 2(2) of the State Liability Act[4]. The defendant's elected address is the Office of the State Attorneys, 316 Thabo Sehume Street, Pretoria.

B. Background

6. The following is either common cause or was not seriously disputed: In order to keep the minor alive, given her extremely low birth weight, she had to be fed intravenously, a substance known as the Total Parenteral Nutrition, TPN. TPN contains a vesicant[5]. The experts were agreed that it is when the TPN infiltrates the tissue that danger arises. The record shows that on at least six occasions before the incident in question, the drip had extravasated. On each of those occasions, the hospital staff had intervened timeously and changed the drip to an alternative site. On the night of 20 May 2011, the record shows that the last time the drip site was monitored was at 21h00. It was again checked on the morning at 07h00 on 21 May. Thus, for a period of ten hours, the drip site was not monitored. When the nurses checked on the morning of 21 May, they found that the minor's foot had gone black and or discoloured. The following is an extract from the note made by the nurses in the nursery file following the discovery:

'Baby received from night staff, condition of the baby stable…Baby right foot found

4 Act 20 of 1957.

5 A vesicant is a substance that can inflict severe and permanent tissue damage when extravasated, Leon Alexander, 'Extravasation Injuries: A Trivial Injury Often Overlooked with Disastrous Consequences'; September 2020, online article published in the National Library of Medicine.

swollen ++ and black discolouration. Dr … informed…Drip in situ on the left hand……'

7. All the experts were in agreement that by then, the injury was irreversible. The doctors waited for demarcation, (to see how far the dead tissue can be traced). *The record shows that the hospital staff had put in place a plan to monitor the infant on a three hourly basis. This plan was to some degree followed, albeit not perfectly*[6]*. On at least six occasions, according to the record, the drip extravasated. Regular monitoring and assessment of the drip site led to timeous identification and management of all six extravasation episodes. As such, the baby suffered no permanent injuries.*

C. Merits

8. The plaintiff's case was led through the testimony of three witnesses namely, Dr A Birrell, Dr AJ Botha, and a specialist nurse, Ms E Janse van Rensburg and the defendant's, through Dr Mohamed Yusuf Chohan and Professor Ballot. Professor Ballot could not comment on the question of negligence as the relevant bundle of documents were not provided to her. In short, the only witness led by the defendant to contest the claim of negligence was Dr Chohan.

Plaintiff's case

9. The first expert witness to testify was Dr Anthony Birrell, an orthopaedic surgeon. Dr Birrell's testimony was based on his report and subsequent addenda[7] and the joint minute he had signed with the defendant's expert, Dr Maafelane. He was taken through the hospital records and confirmed the minor's birth weight and the fact that

6 See Caselines nurses notes from 15 to 20 May 2011.
7 E 562 of Caselines.

she was fed via a drip carrying the TPN. He confirmed that the TPN contains a vesicant. For the most relevant part, Dr Birrell referred to the hospital records[8] pertaining to the night of 20 May 2011, from about 21h00 to 07h00 of the next day. Based on the record, he pointed out that the drip site had not been checked for a period of ten hours and remarked that it was unacceptable given the six previous episodes of extravasation. In his opinion, it was critical that the hospital staff regularly monitor the drip site in order to intervene timeously in the event of the drip tissuing. The doctor went as far as suggesting that even monitoring on an hourly basis may have been necessary for given history of extravasation on at least six episodes.

10. Dr Birrell was asked whether he agreed with the saying in nursing, 'if it is not recorded, it has not been done'. He agreed with the statement. Referring to the joint minutes between himself and Dr Maafelane, he confirmed that in their joint opinion, the minor's injuries were caused by the substandard treatment administered by the defendant. The doctors used the word negligence in their joint note. They concluded that the plaintiff has a claim against the defendant.

11. Prior to dealing with Dr Birrell's cross examination, it is necessary to record that the defendant had at no stage repudiated the joint minutes signed by Dr Birrell and Dr Maafelane. Later in the judgment, I deal with the legal status of joint minutes and the question whether it was legitimate of the defendant to cross examine Dr Birrell on matters covered by the joint minute. Dr Birrell was asked whether he had any legal qualification to justify the conclusion that the defendant had been negligent. He said

8 Folder M page 56 – 59.

he was astounded by the defendant's decision to litigate given the joint conclusion he and Dr Maafelane had reached regarding the sub-standard care afforded to the minor. He also mentioned that the joint conclusions were founded on the failure of the defendant to monitor the drip site over a period of ten hours, on an infant who could not complain of pain along with the extensive history of the drip having extravasated on several occasions. The doctor was referred to the Neonatal High Care Chart[9]. It was suggested, with reference to the various ticks on the chart, that at 24h00 and in the hours subsequent thereto the drip site had in fact been checked. He denied that the drip site, being the baby's foot, had been checked. Dr Birrell distinguished between checking the TPN, which is what the ticks were about[10] in his view, and checking the drip site, which is the part of the infant where the drip has been inserted. He replied that the note in the High Care Chart related to checking the TPN, which is achieved by looking at the apparatus.

12. The doctor was asked whether the volume of the fluid flowing from the TPN had any influence on how quickly necrosis may develop. Dr Birrell replied that the drip should run at a certain pace. As such, there can be no explanation that the swelling had developed because the pace of the drip had increased. He added that in his professional opinion, it is not possible that tissue can go into necrosis in a few hours. He said necrosis develops over a long period and could develop over days. There was no re-examination for Dr Birrell.

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9 Caselines J59.

10 The notes on the high care chart recorded that the TPN had been checked at various times.

Dr Botha

13. The second witness was Dr Botha, a specialist physician. The key aspects of his testimony, which is also set in his report and subsequent addenda[11] may be summarised thus: He confirmed that extravasation was common among neonates. He referred to the hospital records[12], where the nurses had made a note that the baby was to be monitored on a three hourly basis with a provision to report abnormalities. He also referred to various notes which clearly demonstrate that the site of the drip had been inspected. For example, on 17 May 2011 at about 21h30[13] and on 18 May at about 18h30, where the note makes it explicit that the drip site is intact or not swollen, as part of the monitoring and assessment. To Dr Botha, this was a clear sign that the staff were aware of the challenge of extravasation with this particular baby. He explained the various stages or degrees of extravasation injuries highlighting that moderate to severe injuries potentially develop over a period of four hours to days. Grade 1, he said, was characterised by pain at site with swelling. Grade 2 would, in addition to the signs in grade one, be characterised by brisk capillary refill[14]. Grade 3 is characterised by the signs in grade 2 plus there would be marked by swelling and blanching[15], cool to touch and increased capillary refill. The last and final grade, Grade 4, is characterised by pain at site, very marked swelling, blanching, cool to touch and poor capillary refill and evidence of cutaneous breakdown (skin breakdown)

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11 Caselines 519 - 522 report dated July 2023; Addendum and articles, 3 August 2023: Caselines : 567 – 600.

12 Caselines J 204.

13 J202.

14 Capillary refill time is part of a routine assessment of unwell children. It is a simple test to measure the time it takes for colour to return to the end of a finger after pressure is applied, using a thumb and forefinger. Normal capillary refill time is usually 2 seconds or less, while a capillary refill time of 3 seconds or more is an important warning sign for serious illness or risk of death in children, Primary Care Health Science..phc.ox.ac.uk.

15 'Blanching skin is a term used to describe skin that remains white or pale for longer than normal when pressed. This indicates that the normal blood flow to a given area does not return promptly. Capillary refill time is one of many tests that assess the status of people who are at risk for shock,' www.verywellhealth.com.

of necrosis.

14. He referred to the nurses' notes of 20 May at 21h00 up to 21 May at 07h00, and remarked it was unacceptable that the drip site had not been checked for a full ten hours, given the baby's history of extravasation. According to Dr Botha, careful observation and monitoring would have enabled early detection and intervention, just as they had done in the previous occasions. When asked, he denied that necrosis can occur within one hour, pointing that he is not aware of any academic research to that effect. Dr Botha's description of the various stages of necrosis, which stood uncontroverted, was supported by academic research. He stressed, relying on three academic articles, all of which were based on real life studies, that early detection of extravasation was key in preventing permanent injuries. When detected early, he said, simple interventions such as elevation of the limb, flushing with saline and changing the Intravenous line site prevents tissue damage and permanent scaring.

15. He referred to the six instances in which the drip had extravasated and highlighted that regular monitoring and examination enabled the nurses to detect early signs and intercede by stopping the infusion and reinserting the drip in alternative sites, thus averting permanent injuries in all six instances. Dr Botha was asked, with reference to the Neonatal High Care Chart[16], in particular the entries for 21h00, 24h00 and 03h00 o'clock, whether any of the entries provided evidence that the drip site had been inspected. He denied that the site had been inspected and asserted that the entries refer to monitoring the TPN which can be done by checking the apparatus without assessing the drip site. He also affirmed the saying, 'If

16 Caselines J-59.

something is not recorded, it has not been done'. He concluded his testimony by affirming that the minor's injuries were caused by the defendant's failure to monitor and assess the drip site on the night of 20 May through to the morning of 21 May.

The disparities between Dr Botha's and Dr Chohan's opinion

16. Dr Botha was invited to comment on the views expressed by Dr Chohan in their joint minutes. The question the doctors were discussing asked whether '*meticulous monitoring of the minor's intravenous line was a critical aspect of the child's management*'[17]. Both doctors agreed that meticulous monitoring of the drip site was indeed a critical aspect of the child's management. Dr Chohan however, qualified his answer with the following:

(i) There is no evidence that monitoring was not done.

(ii) There was no specific protocol in place at the time to encourage monitoring.

(iii) There is also no evidence that a specific protocol would have benefitted the patient (minor) as superfluous protocols take squander time needed for critical care duties.

(iv) The fact that the drip was changed so often is an indication that the staff were checking and monitoring the line often enough.

17. Dr Botha made the point that the records provide no evidence of monitoring the drip site on during the night of 20 May after 21h00 and all the way to 07h00 in the morning on 21 May. He mentioned that the nurses themselves had devised a plan to monitor the baby on a three hourly basis and report abnormalities. He refuted that the

17 Caselines H39- paragraph 2.5.

nurses would do something and not record it, given the history of extravasation. He also referred to the statement that, 'If something is not recorded, it has not been done'. He was further invited to comment on Dr Chohan's statements as recorded in point 7 of their joint note. The question the doctors were discussing reads: '*Failure to prevent and detect the early signs of extravasation in this child was the direct cause of the permanent damage to the right foot and ankle, particularly with regard to frequent monitoring and recording of the site of insertion and the latency of the line*.'[18]

18. The doctor agreed that the minor's permanent injury was due to the defendants' failure to detect early signs of extravasation while Dr Chohan disagreed. Dr Chohan suggested that early detection of the extravasation would not have made a difference on this particular baby. Extravasation, he said, is clinically apparent only after it has already happened and there is very little that can be done to reverse the effects except to address the consequences, which was done in this case. Dr Botha disputed the statement that early detection would not have made a difference pointing to the six instances in which the hospital staff had timeously detected extravasation and interceded by removing the drip and reinserting it in alternative sites. In all six instances the minor was saved from permanent injuries. He referred to his opinion, which is backed by research, and emphasised that early detection was key to preventing permanent injury. Respectfully to Dr Chohan, his opinion on this point, which was not supported by any academic research, was directly contradicted by the facts and the research articles supporting Dr Botha's opinion. On the six occasions that the drip had extravasated, the minor was saved from permanent injury because

18 Caselines H40, paragraph 7.

the staff, through regular monitoring and examination, had identified that the drip had extravasated and intervened timeously by removing and reinserting the drip in alternative sites, whereas, on the night of 20 May up until the next morning, no such intervention was made because no one had inspected the drip site. On this score, Dr Botha's opinion must prevail.

19. Dr Botha was cross-examined on whether he stood by his assertion that necrosis takes hours and even days to materialise, he confirmed that it is so that necrosis is not something that occurs in one hour. He confirmed once again that where the record says nothing about inspecting the drip site, it must be accepted that it did not happen. He was asked about the source of authority for his statements that regular monitoring such as hourly intervals was required for this particular baby. He responded that his assertions were founded on his professional opinion based on the circumstances of this case as informed by the research he had undertaken. There was no re-examination for Dr Botha.

Sister Emmerentia Janse van Rensburg - Specialist nurse

20. Ms Janse van Rensburg's testimony was based on her report and the joint minute she signed with the defendant's specialist nurse, Ms Liezl Naude. The key aspects of her testimony may be summarised thus: She noted that documentation is an important aspect of nursing. She confirmed a statement that is used in training nurses and relevant to recording as follows: '*If it has not been documented, it has not been done.*' She said that as nurses, they are trained on the importance of record

keeping from the early stages. On the question of how one determines the intervals of monitoring a patient, she stated that the process begins by evaluating the patient. She referred to various categories of vulnerable patients such as neonates, babies born prematurely, the elderly, and patients in comma. She stated that the needs of the patient determine how often the patient must be monitored. She stated that with this particular baby monitoring on hourly intervals was necessary because of the history of extravasation.

21. With reference to the joint minute[19], she confirmed that she and Ms Naude agreed that the lack of care over a period of ten hours on the night of 20 May through to the morning of 21 May led to the baby's permanent injuries. They further agreed that there is no record evidencing any evaluation of the patient to determine the baby's needs which would have informed the staff of the necessary intervals of monitoring. Ms Janse van Rensburg was cross examined on the source of authority for her assertion that the baby needed to be monitored on hourly intervals. She replied that the needs of the patient determine the frequency of inspection. This issue is not only covered in the defendant's own specialist nurse's report but also by the nurses' joint minute, which was not disputed by the defendant. There was no re-examination for Sister Janse van Rensburg. The plaintiff closed his case after this witness.

Defendant's case

22. The first and only expert witness led by the defendant to contest the case of

19 H 44.

negligence was Dr Mohamed Yusuf Chohan, a specialist physician. The key aspects of his testimony[20] may be summarised as follows[21]: He confirmed that extravasation in neonates is a fairly common and acceptable incident. He mentioned that one cannot diagnose necrosis without a biopsy. He spoke about protocols and cautioned against placing reliance on protocols developed in developed countries as they normally do not find relevance in resource constrained environments such as Africa. Dr Chohan ended his examination in chief by stating that while there had been an adverse event, which provides healthcare workers with valuable lessons to do things better, there was in his view, 'no deliberate act of negligence' and thus a penalty is not the correct course of action to take in this matter. He maintained that he was impressed by the extent of record keeping in this particular case.

23. Dr Chohan was cross examined on whether he agreed with the statement pertaining to record keeping in nursing which states that, 'If it is not recorded, it has not been done'. He acknowledged the statement as true. He conceded that early detection and intervention will make a difference. He also conceded that on the six occasions where extravasation had occured, early detection and intervention mitigated the harm suffered. He agreed that once necrosis sets in, it cannot be reversed. Having acknowledged the statement that if something is not recorded it has not been done, Dr Chohan made a 360 degree turn stating that hospital staff had in fact inspected the drip site on the night of 20 May to 21 May but forgot to make the note. He maintained that it can happen in a busy ICU. The doctor however, finally

20 F23 June 2023.

21 Dr Chohan's report is supported by an article which may be found on Caselines F141.

conceded that, given the history of this baby, the standard of care afforded to her on the night of 20 May to 21 May at 07h00 fell short from the standard of care she had previously received.

D. Assessment of expert evidence

24. Perhaps starting with the functions of expert witnesses as expressed by the court in M and another v MEC Health, Western Cape (1258/2018) [2020] ZASCA 89 (31 July 2020), paragraph 17 would be helpful:

> '…The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.'

25. As to the principles of assessing expert evidence, these have been espoused in a long line of cases. In *MEC for Health and Social Development, Gauteng* v *MM on behalf of OM,* it was said:

> '…The opinion must be properly motivated so that the court can arrive at its own view on the issue. Where the opinions of experts differ, the underlying reasoning of the various experts must be weighed by the court so as to choose which, if any, of the opinions to adopt and to what extent. The opinion of an expert does not bind a court…'[22]

22 (Case no 697/2020) [2021] ZASCA 128 (30 September 2021), paragraph 17; *Buthelezi* v *Ndaba* (575/2012) [2013] ZASCA 72 (29 May 2013), paragraph 14; *AD and Another v MEC for Health and Social Development, Western*

26. It is worth mentioning that the standard is proof on a balance of probabilities, not scientific proof[23]. In *Michael and Another* v *Linksfield Park Clinic (Pty) Ltd and Another* said*:*

> ’Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and were invited to express the prospects of an event’s occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty per cent chance and so on…. ‘

27. Finally, on the status of opinions and findings of fact agreed to by experts appointed by the parties, such agreements, as was stated in *Thomas* v *BD Sarens (Pty) Ltd*:

> ‘[11]… bind both litigants to the extent of such agreements. No litigant may repudiate an agreement to which its expert is a party, unless it does so clearly and, at the very latest, at the outset of the trial….
>
> [14] The upshot of these principles is that it is illegitimate to cross-examine an opponent’s witness to undermine an agreed position on fact or on opinion unless, before the trial begins, the opinion of a party’s own expert has been formally repudiated. No litigant shall be required to endure the risk of preparing for trial on a premise that an issue is resolved only to find it is challenged.’[24]

28. Finally, the test for negligence is set out in *Buthelezi* v *Ndaba*. It is,

> ‘always whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of a reasonably competent practitioner

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Cape Provincial Government (27428/10) [2016] ZAWCHC 116 (7 September 2016), paragraph 39.

23 Footnote 21 at paragraph 6.

24 (2007/6636) [2012] ZAGPJHC 161 (12 September 2012), paragraphs 11 and 14; *Glenn Marc Bee v The Road Accident Fund* (093/2017) [2018] ZASCA 52 (29 March 2018), paragraph 66: ‘… Where, as here, the court has directed experts to meet and file joint minutes, and where the experts have done so, the joint minute will correctly be understood as limiting the issues on which evidence is needed…’

in his field. If the "error" is one which a reasonably competent practitioner might have made, it will not amount to negligence.'[25]

E. Discussion

29. Drs Birrell and Maafelane concluded that the defendant's conduct in failing to monitor the drip site over a period of 10 hours on the crucial nite of 20 May, given the baby's history of extravasation, was substandard and negligent. One might say, as counsel for the defendant pointed out during cross examination, that the conclusion of negligence is for the court to draw, based on the established facts. However, it does not take away the doctors' conclusions that the care afforded to the minor was substandard and was the cause of the baby's injuries. On the authority of *Glen Mac Bee* and *BD Sarens,* that conclusion is binding on the defendant. Dr Birrell went further during examination and explained that the defendant's conduct of failing to monitor the drip site over a prolonged period, given the danger posed by the vesicant when it infiltrates the tissue, and the history of extravasation, was unacceptable and substandard. The specialist nurses' conclusions likewise, are binding to the defendant. They too concluded that the minor's injuries were caused by the defendant's lack of care over the night of 20 May through to the morning of 21 May and the failure to evaluate the baby for its needs to establish, *inter alia,* the frequency of monitoring intervals. The court accepts the opinion expressed by the Orthopaedic surgeons and the specialist nurses. The opinions were well grounded and were consonant with the facts as established during the trial.

30. Dr Botha was clear that the minor's injuries were caused by the substandard care

25 Note 22, paragraph 15.

provided by the defendant. His opinion on the degrees or stages of extravasation injuries stood unconverted. His opinion on the benefit of early detection and management of extravasation injuries was contradicted by that of Dr Chohan. Dr Chohan initially submitted that early detection and management of extravasation would not have made any difference in this case. His opinion argued protocols and misattribution of the result to protocols. In the end, Dr Chohan conceded when he was confronted with these cold facts during cross examination that in all the six instances where the staff had discovered extravasation timeously, the baby was saved from permanent injuries but he continued to argue that the part of the foot where the drip is located may have made the difference. When he was asked where in the foot the drip was inserted, he said he would need to read the hospital record.

31. To validly pursue this argument, the doctor had to trace the location and the exact spot on the foot of the baby of the drip in the previous instances of extravasation and compare it to the exact location of the drip on the baby's foot on the night of 20 to 21 May otherwise the point made no sense at all. Accordingly, it must be rejected. In any event, Dr Chohan finally conceded that the standard of care in the last ten hours of 20 to 21 May 2011 was substandard compared to the care the baby had previously received. I conclude that the defendant was negligent. Based on the expert opinion, the minor's injuries were caused by the defendant's negligence.

F. Costs

32. The plaintiff seeks punitive costs. The essence of the plaintiff's case is that the

defendant refused to settle the matter notwithstanding that the plaintiff had made an offer without prejudice, the Calderbank offer, based on the conclusions reached by the experts in the joint minutes. It is trite that costs are a matter for the trial court. I have considered the circumstances of this case and this includes the injuries suffered by the minor, the conduct of the defendant and the conduct of their witnesses, Drs Chohan and Ballot. I have also considered the plaintiff's argument and the cases on which he relies. Firstly, I am not persuaded that the defendant has done anything wrong in publicly running a trial and contesting the case. Secondly, and importantly, I am of the view that a public trial whilst costly to the state, has the advantage of advancing and upholding transparency and accountability, two constitutional values we must cherish. There may be those cases where, based on the case made on paper, a trial may be considered foolish and may very well and rightfully attract punitive costs. I am less persuaded that such an approach is warranted in this case.

Order

33. The following order is issued:

1. The plaintiff's case succeeds with costs.

2. The defendant must pay the plaintiff's agreed or proven damages.

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N.N BAM
JUDGE OF THE HIGH COURT,
GAUTENG DIVISION PRETORIA

Date of hearing:	**07 – 11 August 2023**
Date of judgment:	**12 February 2024**

Appearances:

For Plaintiff:	**Adv J.S.M Guldenpfennig SC**
	Adv D.P Viller
Instructed by	Werner Boschoff,
	Brooklyn, Pretoria
For Defendant:	**Adv S Malatji**
Instructed by:	State Attorneys
	Pretoria