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

CASE NO: 55763/2020

DOH: 28 – 05 September &

06 October 2023

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

......................................12 MARCH 2024
SIGNATUREDATE

In the matter of:

S[...] N[...] P[...] **Plaintiff**

Obo A S[...] S[...]

AND

MEMBER OF THE EXECUTIVE COUNCIL **Defendant**

FOR HEALTH, GAUTENG

JUDGEMENT

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

Bam J

A. INTRODUCTION

1. The main issue to be decided in these proceedings is whether the defendant, through their personnel who were then employed at Thelle Mogoerane Hospital, TMH[1], were negligent in treating and caring for AS[...] S[...] (A), more particularly in failing to adhere to the existing Guidelines for Prevention, Screening and Treatment of Retinopathy of Prematurity (ROP). A secondary issue, in the event the defendant is found to have been negligent, is whether such negligence caused A's blindness. A was born at TMH on 30 September 2015, with extremely low birth weight (ELBW) of 0.820g[2], at a gestational[3] age of 27 weeks. Due to A's extremely low birth weight and gestational age, it was mandatory in terms of the existing Guidelines[4] that A be screened for ROP between 4 to 6 weeks' chronological age or 31 weeks' post

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1 Thelle Mogoerane Hospital is a Provincial hospital. It used to be called Natalspruit Hospital.

2 A's birth weight is recorded in various records as 0,820kg, 0,840kg. For purposes of the defendant's negligence, this minor variation is irrelevant as will be shown in the course of this judgment.

3 This judgment uses gestational, chronological and post menstrual ages to identify A's weight at various stages. Gestational age is the age since the mother's last day of menstruation. Chronological age is age from the day a baby is born. Post menstrual age is the combination of gestational and chronological age.

4 The two guidelines referred to during evidence are: (i) the National Guidelines: Prevention of Blindness In South Africa, (2002 Guidelines); and (ii) the Guideline For Prevention, Screening And Treatment Of Retinopathy Of Prematurity, (2013 Guidelines), by L Visser, R Singh, M Young, H Lewis, N McKerrow (ROP Working Group, South Africa).

menstrual age, whichever comes later, and continually thereafter at 1 to 2 weeks' intervals, as determined by the Ophthalmologist, until she was between 42 and 45 weeks' post menstrual age or her eyes had completely vascularised or until she had been successfully treated for ROP where it had been identified. The threshold, according to the Guidelines is usually reached at 37 weeks post menstrual age. Accordingly, it is important that the baby be assessed before they reach 37 weeks.

2. Uncontroverted evidence led during the trial established that A was discharged on 3 December 2015, when she was about 36 weeks' post menstrual age[5], with no follow up appointment for ROP screening[6]. On 16 February 2016, A was seen by a doctor at TMH who diagnosed her with retinal detachment and retinal bleeds on her the left and right eyes, respectively[7]. She was referred to St John's Eye Clinic at Chris Hani Baragwanath Hospital, (St John's) where it was confirmed that she is blind, due to bilateral stage 5 ROP. The experts were resolute in their findings that the failure of the defendant's staff at TMH to arrange proper and timeous screening appointments and discuss the risks and the importance of screening with her parents, led to her blindness. The plaintiff, in her representative capacity as the mother and the natural guardian of A wants the defendant held liable for A's damages.

3. The defendant denies that they were negligent in any way. In what may be described as a total disregard of the Guidelines, they claimed to have screened A for ROP during November 2015, when she was between four to six weeks. They further

5 27 weeks (which is when A was born) + 9 weeks = 36 weeks post menstrual age
6 Caselines R15- Trial bundle.
7 Trial bundle: Caselines R17.

claimed to have no knowledge whether the specialist doctors, doctors and nurses who treated A at TMH were employees of the defendant. In addition to what is stated in their plea, the defendant says it was not their responsibility to arrange follow-up appointments for A upon discharge[8]. At the start of the trial the parties took a consensual order separating the issue of liability from quantum. In the result, the trial dealt only with the question of the defendant's liability while the quantification of the plaintiff's damages is held over for later determination.

4. The plaintiff's case was led through the testimony of three witnesses. They are Dr Lombard, a Paediatrician, the plaintiff, and Dr Weitz, an Ophthalmologist. The defendant called a factual witness, Dr Macala, an Ophthalmologist, to testify about protocols at TMH at the time. Two further experts were involved in this case. They are Professor Lotz, a diagnostic radiologist whose report confirmed the diagnosis of ROP and Dr S Ballot, a gynaecologist and obstetrician appointed by the defendant. Dr Ballot, whose report was accepted by the plaintiff, confirmed A's date of birth, gestation age and birth weight. Professor J Lotz had been appointed by the plaintiff and his report was accepted by the defendant.

Status of documents

5. It is appropriate to first record that the neonatal records pertaining to A were missing from the start. By the time the parties had their first pre-trial conference, it was no secret that the neonatal records requested from TMH had not been forthcoming.

8 See Fourth pretrial conference minute: C70 paragraph 4.3.4 (d)

There is a letter to this effect from the CEO of TMH dated 19 September 2019[9] where it was recorded that patient files are stored by way of a patient management system, which at the time was inaccessible due to a technical problem. Further follow up letters were sent[10] throughout 2020 to no avail. Having said that, this case, as may already be apparent from the version put up by the defendant, is about the defendant's failure to screen and arrange follow-up appointments for A as set out in the Guidelines.

6. The parties according to the pre-trial minute of 17 May 2021, agreed that the documents filed of record are what they purport to be without either party necessarily admitting the correctness of the documents, with the result that either party may rely on copies without the need to produce originals[11]. Similarly, the parties agreed that the clinical and hospital records constitute admissible hearsay evidence in terms of the provisions of Section 3 of the Law of Evidence Amendment Act[12] and section 34 of the Civil Proceedings Evidence Act[13]. The minute clearly sets out that the agreement relates only to admissibility and not necessarily the weight of the evidence in question, in that not every entry will necessarily be accepted as correct by either party or their witnesses[14].

Refusal to be bound by the experts' joint minutes

7. It is necessary to briefly mention the defendant's rejection of the experts' joint minutes

9 Caselines R:13
10 19 February 2020: Caselines T:19
11 First pre-trial conference, paragraph 5.3 Caselines C-8.
12 Act 45 of 1988
13 Act 25 of 1965
14 *Ditto,* Paragraph 5.5.1, Caselines, C-9.

which was made known on 23 August 2023, five days before the trial started. Significantly, the defendant led no expert evidence during the trial. I return to this issue later in this judgment, including the defendant's reasons for rejecting the joint minutes.

B. PARTIES

8. The plaintiff, Ms N[...] S[...], born Zenzile, is an unemployed adult female. She resides in Katlehong, Germiston, Gauteng Province and is suing in her representative capacity as mother and natural guardian of A, a toddler of 9 years.

9. The defendant is the Member of the Executive Council for Health, Gauteng. She is cited in terms of Section 2(2) of the State Liability Act[15], with her address set out in the pleadings as Bank of Lisbon Building, 37 Sauer Street Johannesburg. The defendant was also served via the State Attorneys at 316, Thabo Sehume Street, Pretoria.

C. PLAINTIFF'S CASE

10. The first witness to take the stand was Dr Lombard[16], a paediatrician. Dr Lombard had provided a summary of his evidence[17] in which he, *inter alia*, explains the condition of Retinopathy of Premature, referred to as ROP, the risk factors, questions of who to test, when to test and when to stop testing, and the three lines of defence. His testimony in this regard was confirmed by the joint paediatric and

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15 Act 20 of 1957

16 This is generally permissible where the factual foundation on which the experts' opinions rests is not in issue. See in this regard *HAL obo MML v MEC for Health, Free State* (Case no 1021/2019) [2021] ZASCA 149 (22 October 2021), paragraph 214.

17 Caselines E36-66.

ophthalmic minutes, and by Dr Weitz's individual report. Lastly, I set out Dr Lombard's conclusions and opinion with regard to the standard of care and treatment received by A from TMH.

11. Dr Lombard is qualified by amongst others, his status as consultant at the Sefako Makgatho Health Sciences University[18] (SMU) Neonatal Unit from 1985 to 1988 and as practitioner in private practice since 1988. He has been teaching at SMU since 1988. In 2002, he was appointed Senior Consultant General Paediatrics and Cerebral Palsy. He has been co-ordinator of paediatrics course/s for final year medical students at SMU since 2003. He is also an examiner for the SA College of Paediatrics, which appointment began in 2009. In June 2018, Dr Lombard successfully completed a course in Introduction to Medico Legal Practice through UCT. Although he retired from full-time employment in 2019, he continues to do work on a part-time basis which includes clinic for high-risk neonates, in particular cerebral palsy neonates at SMU.

Dr Lombard's evidence

12. Dr Lombard explained during his examination in chief that ROP is a disease of abnormal vascular blood vessels in the retina. The retina is the innermost layer of the eyeball responsible for interpreting impulses and is photo-sensitive. When a preterm baby is born, their eyes are not completely vascularised. In other words, the blood vessels on the retina are not completely formed. Whilst the baby is still in the uterus, they are in a relatively hypoxic environment, meaning, an environment with poor

18 Then called MEDUNSA.

oxygen supply. However, the poor oxygen supply does not affect the baby as the placenta does everything for the baby, until the umbilical cord has been severed. When a preterm baby is born, they are suddenly in an environment that has more oxygen. As the baby starts growing and gaining weight and for complicated reasons, the vascularisation continue to grow but in an uncontrolled fashion. Due to the uncontrolled growth, the retina starts detaching. This is called retinal detachment and it can lead to blindness.

13. Aside from the doctor’s oral testimony, he explained in his report that ROP is a major complication of preterm birth. It varies from mild, which resolves spontaneously, to severe, leading to retinal detachment and blindness. He enumerated several risk factors that may lead to ROP. These include low birth weight, (especially below 1500g); low gestational age, (less than 32 weeks); oxygen therapy; and sepsis. He says in his report that irrespective of what the underlying cause or additional risk factors, ROP is widely regarded as a preventable cause of childhood blindness. One of the most important aspects of prevention is ophthalmological screening and treatment of vulnerable infants, referred to as the secondary line of defence in the Guidelines.

14. He mentioned in his report that the 2013 Guidelines inform that all infants born prior to 32 weeks gestation and weighing less than 1500 g should be screened for ROP between 4 - 6 weeks’ chronological age or between 31 - 33 weeks post menstrual age (whichever comes later). Preterm infants weighing between 1500 -

2000 g may also be at risk of ROP if they have risk factors such as a family history of ROP and should also be screened. If the gestational age is unknown, the chronological age should be used. Dr Lombard explained that the threshold is usually reached by 37 weeks post menstrual age. It is therefore important to assess the baby before 37 weeks. After the initial screening follow-up screening appointments will be determined by the ophthalmologist on the basis of retinal findings at 1 - 2 weeks' intervals. The conclusion of screening should be based on age and retinal ophthalmological findings which should include either regression of ROP, full retinal vascularisation or gestational age of 45 weeks.

Dr Lombard's opinion

15. Finally, Dr Lombard referred to research which demonstrated that early treatment of ROP (ETROP) and following protocol resulted in favourable outcome of between 80 - 85%. He added that the risk of ROP and the importance of screening should, according to the guidelines, be discussed in detail with parents. His findings in respect of A were as follows:

(i) Based on his analysis of the available records, there was failure on the part of the defendant's staff to arrange A's follow up screening appointments, after the November 2015, that is if one accepts the defendant's claims that A had been screened in November.

(ii) There was failure to screen A before her discharge on 3 December. The importance of this date is that by 9 December 2015, A would have reached the threshold of 37 weeks post menstrual age. Thus, it was critical that she be

assessed before she reached 37 weeks as mandated by the Guidelines.

(iii) The guidelines were not adhered to in that the risk of ROP and the importance of screening were not discussed with A's parents. This statement was confirmed by the plaintiff during her evidence, which was not disturbed during cross examination.

(iv) He concluded, based on the failures manifested in A's case, that the standard of care she received did not meet the standard set out in the Guidelines, which represented accepted practice for a considerable time, well before A's birth.

(v) Had A been appropriately and timeously screened and followed up in accordance with the guidelines, there is good no reason to believe that her ROP would not have been identified and treated to salvage her vision.

(vi)As a result of the substandard care provided to A, the golden opportunity to save her sight, as mandated by acceptable practice, was missed.

Joint minutes with Dr Lewis

16. Dr Lombard referred to the joint minutes he had signed with Dr Lewis and noted that they both agreed that (i) A had stage 5 ROP. (ii) ROP is a preventable cause of childhood blindness and that in terms of the Guidelines, medical staff working in neonatal units should take every possible step to ensure that vulnerable infants are screened, which includes the initial referral to the ophthalmologist as well as ensuring that the baby has a follow-up appointment on discharge and, the risk of ROP and the importance of screening must be discussed with the parents. (iii)The arrangement to follow up A at the ROP clinic on 11 February 2016 was not in accordance with the

guidelines and amounts to substandard care. (iv)That whilst deferring to the ophthalmologists on the likely outcome with appropriate care, statistically, blindness can be prevented in more than 50% of cases. On that basis, had A been appropriately screened, she would in all probability not be blind today. I may add that even the defendant's own witness, Dr Macala conceded that if things went as they should — meaning according to the Guidelines — one would have expected that when A was discharged on 3 December, the discharge note would provide for ophthalmological follow-up appointments.

18. During his examination in chief Dr Lombard was asked with reference to his and Dr Lewis' conclusions, whether the absence of neonatal records prevents one from arriving at the conclusions they had arrived. His answer was an emphatic, 'No.' When asked to expatiate, he stated that the conclusion they arrived at was based on information recorded in more than one place, that the baby was not seen and was not given a follow-up appointment. He was further asked, with reference to the defendant's claim that it was not the responsibility of the hospital staff to ensure that the baby had follow-up appointments for screening upon discharge, whether he agreed with the defendant's assertions. His answer was, 'I would find it difficult to agree with that.' Dr Lombard further confirmed, just as the defendant's own witness, Dr Macala did, that the doctors and specialist doctors who treated A at TMH were employees of the defendant.

19. Dr Lombard's cross examination took the form of querying whether he had seen

the originals of certain documents such as the discharge form[19], and the referral to St John's Eye Clinic[20] and whether he knew who had authored the documents. He was asked about the file numbers appearing on some of the records. There was no version put to Dr Lombard to comment on. I will return to this issue later in this judgment. Cross examination in short was uneventful. Dr Lombard's findings of fact and his opinion were left undisturbed. He was excused with no re-examination. Later in this judgment I deal with the legal principles relating to expert evidence and the legitimacy or otherwise cross-examining an opponent on matters that are common cause.

Plaintiff's evidence

20. The next witness to take the stand was the plaintiff. The plaintiff testified about her maiden name, her marital name, where she stayed, when her baby was born, and where the baby attended clinic. She said that after their discharge from hospital, she began to notice that A was not following anything with her eyes. When she lifted something colourful in front of her, she did not appear to follow same. She went to the casualty department of TMH. There, they directed her to the correct department. She said she had not been advised to take A for any eye check up. The plaintiff was cross-examined on her pregnancy, the demised twin, her experiences of preeclampsia and renal failure. She was firm on the fact that no one had ever discussed anything about the need to have A's eyes examined or monitored, and the first time she ever heard anything about A's eyes was when she was examined on 11 February 2016 and

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19 Caselines R:15.
20 Caselines R:17.

informed that it was too late. It is at this point that it was put to the plaintiff that after the November screening, the defendant would have scheduled further screening appointments, had there been a need to do so. The plaintiff simply replied, '… how was A going to be blind then?' I need not underscore the inappropriateness of inviting a lay witness to comment on legal technical and medical matters as opposed to addressing factual matters with her. The plaintiff was excused with no re-examination, leaving her version on the factual issues in tact.

Dr Weitz

21. The final witness to testify was Dr Weitz. Dr Weitz has been involved in the field of Ophthalmology for more than 21 years. He spent eight and a half years in Ophthalmology in the public sector rotating between Tshwane District Hospital, TDH, Steve Biko Academic Hospital, SBAH, and Kalafong Academic Hospital. Dr Weitz is currently in private practice. He has published articles locally and internationally and is involved in lecturing activities. Dr Weitz's testimony was largely based on his report which is wholly confirmed by the joint minutes signed with Dr Kunzman. Both doctors were requested to report on the ophthalmological management and status of A. In addition to agreeing on the detail of who to screen, when to screen, when and how follow up screening is determined, and when screening should be stopped as set out in the two Guidelines, they further agreed, based on the history and records at their disposal:

(i) That A was not adequately screened for ROP during her hospital stay, if she was screened at all, nor was her mother informed of the risks of ROP and the

importance of screening.

(ii) That A suffers from bilateral stage 5 ROP and that A has no light perception vision in both eyes.

(iii) That even if the initial ROP screening had showed no ROP, the guidelines recommended regular follow-up screening examinations at 1 - 3 weekly intervals.

(iv) That A, based on her birth weight and gestation age, should have been screened according to the guidelines, which did not happen.

(v) That her treatment or the lack thereof, constitutes substandard care.

22. Dr Weitz was asked during cross examination whether he had seen the maternity register, and the maternity case records. It was further s pointed out that he produced an opinion without being furnished with all the records. What was not put to the doctor were the respects in which the missing maternity records would have had a bearing on his opinion. He was asked whether a neonatologist's report would have been useful to his work, had there been one. He said that such neonatologist's report would have been useful but to a very low degree, mentioning that he had the benefit of Dr Lombard's report. He further went on to explain that the risk factors for ROP are indiscriminate supply of oxygen, low birth weight and low gestation. Then there are a whole host of other minor drivers or risk factors. In the case of this particular baby, those were overshadowed by the prematurity of the baby and her gestation age.

23. Dr Weitz was asked whether the plaintiff had informed him that there had been screening in November 2015, the doctor replied that he had not been informed,

adding that, he had not seen any clinical notes, clinical drawings indicating the zones and the bleeds and follow ups. He was asked whether he knows what treatment had been afforded to the baby, given the missing neonatal records. The doctor answered that whilst it may be correct that no one knows what was done, it was not done properly. He added, the mere fact that the baby was blind lends itself to a high probability that whatever was done was not done properly. The defendant did not put any version to Dr Weitz to comment on. As a consequence, his opinion was left undisturbed. There was no re-examination and the plaintiff closed her case after Dr Weitz's examination.

D. DEFENDANT'S CASE

24. The defendant called Dr Macala, an ophthalmologist who was called as a factual witness. Dr Macala testified about how they used to screen babies at TMH. He made the point that he left at the end of January 2016. He had no recollection of the specific details relating to A's care, stating that it was a long time ago. He confirmed the protocol of who to screen, when to screen and when such screening would be stopped, as per the 2002 and 2013 Guidelines. During cross-examination, Dr Macala stated that he was under the employ of the defendant whilst working at TMH. On the specifics relating to A, Dr Macala conceded that there was no evidence that A had been screened for ROP nor is there any record suggesting that follow-up screening appointments were made upon A's discharge. Specifically with reference to the discharge note, he confirmed that had things gone according to the Guidelines, one would expect to see a follow-up appointment for A upon discharge. He agreed that

given A's discharge on 3 December, the follow-up appointment recorded on the discharge note, of 11 February 2016, was not in accordance with the Guidelines. There was brief re-examination after which the defendant closed their case.

E. THE LAW

Legal principles pertaining to agreements made during a pre-trial conference

25. Early in this judgment I had touched on the agreement reached by the parties during their first pre-trial conference in May 2021. That agreement pertained to the status of documents including the hearsay admissibility of same. As may be seen from the defendant's rejection of the experts' joint minute, the reasons had to do with the fact that the information or records furnished to the experts was incomplete or the defendant had not admitted the accuracy of the records. The principles regarding agreements of fact reached during a pre-trial conference are tried. In *Rademeyer* v *Minister of Correctional Services*, it was confirmed that it is salutary, that absent special circumstances, a party may not resile from agreements of fact deliberately reached during pre-trial conference[21]. See also *MEC for Economic Affairs*, *Environment & Tourism* v *Kruizenga* (169/2009) [2010] ZASCA 58 (1 April 2010), paragraph 4; *Filta-Matix (Pty) Ltd. v Freudenberg and Others* (258/96) [1997] ZASCA 110; (27 November 1997), paragraph 18 - 19. Such conduct, it is said, undermines the whole purpose of Rule 37 which is designed to limit issues and curtail the scope of litigation.

26. The upshot of the agreements reached by the parties during their first pre-trial

21 Case No 05/15044, [2008] ZAGPHC, at paragraph 4.

conference, to which the defendant must be held, is that it was illegitimate of the defendant to cross-examine the opponent's witnesses — both of whom were experts — about the reasons they had accepted copies of several records[22], as opposed to originals and whether the authors of the records were going to testify. Nothing in the agreement precluded the defendant from challenging the content of the documents or any entry they wished to challenge and demonstrating the impact on the opinion and joint minutes. Nothing of that sort was done.

Legal principles regarding expert evidence

Status of joint minutes

27. The legal position is as expressed in Thomas v BD Sarens (Pty) Ltd:

> '[9] The general principle is that a decision on what constitutes the facts on any issue is the preserve of a court. (See: State v Harris 1965 (2) SA 340 (A) at 365C) There is only one category of exception: ie, when the parties agree on the facts. Even if a court might be sceptical about a set of agreed facts, there is no licence to go behind the parties' agreement, at least in a civil matter, just as the admitted facts on the pleadings are not to be interrogated by a court.
>
> [11] Where the experts called by opposing litigants meet and reach agreements about facts or about opinions, those agreements 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.'[23]

28. The court in *Glenn Marc Bee* v *The Road Accident* Fund added:

> '[65]… Effective case management would be undermined if there were an unconstrained liberty to depart from agreements reached during the course of pre-trial procedures, including those reached by the litigants' respective experts. There would be no incentive

22 The records include R15, R16 and R17.

23 (2007/6636) [2012] ZAGPJHC 161 (12 September 2012), paragraph 9, and 11.

for parties and experts to agree matters because, despite such agreement, a litigant would have to prepare as if all matters were in issue…

[67] It is unnecessary, in the present case, to decide whether a litigant needs to have good cause for repudiating an agreement reached by his or her expert. Certainly litigants should not be encouraged to repudiate agreements for 'tactical' reasons. Whatever may have been the attitude to litigation in former times, it is not in keeping with modern ideas to view it as a game. The object should be just adjudication, achieved as efficiently and inexpensively as reasonably possible. Private funds and stretched judicial resources should only be expended on genuine issues.'[24]

29. In *Hal* v *obo MML* v *MEC for Health, Free State*:

'A clear distinction in principle needs to be drawn between factual evidence given by an expert witness and the opinions expressed by that witness. As to the former, there is no difficulty in applying Bee to the facts on which the experts agree, any more than there is a difficulty where the parties themselves reach agreement on factual issues. The opinions of the experts stand on a completely different footing. Unlike agreements on questions of fact, the court is not bound by such opinions. It is still required to assess whether they are based on facts and are underpinned by proper reasoning. '[25]

F. DISCUSSION AND CONCLUSION

30. According to the minutes of the fourth pre-trial conference which was held on 23 August 2023[26], the defendant refused to be bound by the joint minutes on the basis that the documents furnished to the experts were either incomplete and/or the correctness thereof had not been admitted. Implicit in the statement is that the defendant willingly invited experts to provide an opinion based on information they knew was incomplete, until the opinions came out pointing to a conclusion

24 (093/2017) [2018] ZASCA 52 (29 March 2018), paragraphs 65, 67.

25 Note 12, paragraph 220.

26 Caselnes C67: The joint minutes of the Ophthalmologists were signed on 8 August 2023 and uploaded on 11 August 2023. The minutes of the Paediatricians were signed on 11 August and uploaded on Caselines on 15 August 2023.

unfavourable to their case. One must keep in mind the agreement reached by the parties at their first pre-trial conference, on the status of documents as set out in paragraph 26 of this judgment. Importantly, during the fourth pre-trial conference, the defendant refused to identify the aspects they considered incorrect in the content of the documents and further would not state the respects in which the incompleteness or incorrectness materially impacted either the individual opinions or the joint minutes.

31. Finally, the defendant did not challenge the plaintiff's version. Thus, details that such as A's date of birth, her low gestation age, birth weight, and the fact that the plaintiff was A's mother, were not challenged at all. Simply, the defendant had neither a plan nor evidence to undermine these details, which, in any event, were confirmed by their own expert, Dr Ballot. To demonstrate that the refusal to be bound by the joint minute was done for no justifiable reason, the defendant led no expert evidence. Strikingly, the defendant also failed to put their version to the experts called by the plaintiff. In the result, whatever was in the individual expert reports and confirmed in the joint minutes, remained as it was before the trial. In *Pezzutto* v *Dreyer and Others*, it was said:

> '… It is true that it does not follow merely from the fact that a witness's evidence is uncontradicted that it must be accepted. It may be so lacking in probability as to justify its rejection. [38] But where a witness's evidence is uncontradicted, plausible and unchallenged in any major respect there is no justification for submitting it to an unduly critical analysis, which is what the trial judge seems to have done.'[27]

32. It follows that the refusal to be bound by the joint minute was done for tactical

27 (209/90) [1992] ZASCA 46; 1992 (3) SA 379 (AD); [1992] 2 All SA 81 (A) (27 March 1992), paragraph 37; See also *S v Boesak* (105/99) [2000] ZASCA 24 (12 May 2000), paragraph 51.

reasons and is reflective of the deplorable strategy adopted by the defence in this litigation.

Negligence

33. The test for negligence is set out in *Buthelezi* v *Ndaba*. The question is:

> '[15] … 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 in his field. If the "error" is one which a reasonably competent practitioner might have made, it will not amount to negligence.'[28]

34. The experts in this case spoke with one voice with regard to the risk of ROP confronting vulnerable preterm infants born with low gestation age of 32 weeks and under, with birth weight of 1500 g or less. Even babies weighing between 1500 g and 2000 g are at risk of ROP, according to the Guidelines. The experts were clear on the need to comply with the Guidelines that existed long before A had been born, the need to discuss the risks of ROP, the importance of screening with the parents of the infant, the mandatory screening, the initial screening, the intervals, the threshold, and when to stop screening. Their views on the probability of success were backed by research. They made the point that had the Guidelines been complied with, with the requisite standard of care, there is no good reason to doubt that A, in all probability, would have vision today. I conclude the that the defendants were negligent and it is their negligence that led to A's blindness.

Appropriate scale of costs

35. The plaintiff seeks a special costs order based on the manner the defendant

28 (575/2012) [2013] ZASCA 72; 2013 (5) SA 437 (SCA) (29 May 2013), paragraph 15.

conducted themselves throughout this litigation. The defendant's obstructive conduct is pellucid from their jousting around the joint minutes, their refusal to concede details accepted by their own experts, such as the plaintiff is the mother of A, A's birth weight and gestation weeks at birth. The defendant refused to concede the previously mentioned details in circumstances where they had no evidence to rebut the plaintiff's version. They further made no attempt to put a version to the witnesses called by the plaintiff except for the attempt at cross-examining the plaintiff on legal technical and medical matters. In the course of cross-examining the plaintiff there were repeated invectives directed at the plaintiff's attorney, if not the plaintiff's legal team as a whole. The *ad hominem* course of cross-examination continued despite the court's repeated admonition.

36. The principles governing costs have been articulated by superior courts on a number of occasions. In *Public Protector* v *South African Reserve Bank*, Mogoeng CJ, writing for the minority stated the principles thus:

> '… As correctly stated by the Labour Appeal Court—
>
> "[t]he scale of attorney and client is an extraordinary one which should be reserved for cases where it can be found that a litigant conducted itself in a clear and indubitably vexatious and reprehensible [manner]. Such an award is exceptional and is intended to be very punitive and indicative of extreme opprobrium.'[29]

37. See also the footnote 26 in *Public Protector* with reference to: '*Madyibi v Minister of Safety and Security* 2008 JDR 0505 (Tk) (Madyibi) at paragraph 31, in which Petse ADJP, as he then was, states that—

29 [2019] ZACC 29, at paragraph 8.

> "[t]he principle that I have been able to extract from other decisions of our courts that I have had recourse to . . . is that our courts have awarded costs on the punitive scale in order to penalise dishonest, improper, fraudulent, reprehensible, or blameworthy conduct or where the party sought to be mulcted with punitive costs was actuated by malice or is otherwise guilty of grave misconduct so as to raise the ire of the court in which event a punitive costs order would be imperatively called for."

38. Contrary to the plaintiff's assertions, I am not about to penalise the defendant for defending the case. I am further prepared to overlook the numerous instances during the trial where the defendant's counsel made gratuitous attacks against the plaintiff's attorneys. Those attacks were subsequently withdrawn following encouragement from the court that the parties resolve the issue amongst themselves. Having said that, the conduct of the defendant, as evidenced by in their defendant's heads of argument stands on a different footing. I do not to intend to reproduce all of the inflammatory statements made by the defendant but a few striking examples will suffice. In paragraph 5.4.4.6 of their heads there is a cynical and veiled attack directed at the plaintiff's legal representative/s. In this regard, the plaintiff, rather than the attorney, is accused of making inaccurate and blatantly misleading allegations in the <u>particulars of claim</u> which, so it is claimed, sent the defendant on a three year long, time consuming, and costly wild goose chase, in search of documents to defend baseless allegations. No lay litigant drafts particulars of claim. The attack is directed at the legal representatives.

39. The plaintiff's legal team is further insulted and accused of abusing the court's processes to generate fees using fabricated cut and paste versions of other cases. They are accused of dishonesty, of making up spurious allegations which tend to

incriminate the defendant for baby A's blindness[30]. I say nothing about incrimination in civil proceedings. It is hard to understand the rationale for the *ad hominem* arguments. It is even harder to fathom how counsel can make such allegations about colleagues without a shred of evidence. Counsel for the plaintiff had intimated that they intend to take the matter to the Legal Practice Council for their attention. Costs on attorney/client scale are warranted.

Order

40. The question of liability is hereby separated from the quantum of the plaintiff's damages.

41. The plaintiff's case is upheld.

41.1 The defendant must pay the plaintiff's proved or agreed damages.

41.2 The defendant must pay the plaintiff's costs, including the costs occasioned by the employment of two counsel, on a scale as between attorney and client.

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NN BAM

JUDGE OF THE HIGH COURT, PRETORIA

Date of Hearing:	**28 August – 05 September &**
	06 October 2023
Date of Judgment:	**12 March 2024**

30 See paragraph 11.1 defendant's heads of argument.

Appearances:

For Plaintiff:	**Adv JF Mullins SC with Adv LA East**
Instructed by	Paul du Plessis and Associates
	c/o KMG & Associates
	Rietondale, Pretoria
For the Defendant:	**Adv M Botma and Adv MH Mhambi**
Instructed by:	State Attorney, Pretoria