THE NEED FOR LEGAL REFORM IN MEDICAL NEGLIGENCE CASES CONCERNING CEREBRAL PALSY IN SOUTH AFRICA

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ABSTRACT

South Africa is facing a medico-legal storm that is threatening to paralyse its healthcare system, particularly the delivery of essential healthcare services that include maternal and foetal health. There is a rapid increase in cerebral palsy (CP) negligence litigation, accompanied by the burgeoning value of related claims. CP cases have thus become one of the main factors depleting a province's health budget. There also seems to be no consistency in litigation of alleged negligence giving rise to a child suffering from CP. Each court deals with the merits in its own way, as there are no specific guidelines for determining whether CP resulted from negligence or not.

As there is currently no legislation in South Africa regulating medical negligence litigation, cases of alleged medical negligence are dealt with according to the requirements of the law of delict, which includes that damages ought to be settled "once and for all" in monetary value. The Constitutional Court case of *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37 opened a proverbial 'door' for the development of the common law (in the absence of legislation) to deviate from the "once and for all" rule and the payment of a lumpsum for damages. Although it is the duty of Parliament to change laws, the *DZ* case did open a 'door' provided that each case concerning CP should still be evaluated on the merits of the specific case. A few selected cases are discussed in this research, highlighting when the open 'door' was used or not. Some judges specifically investigated whether the state could provide the services *in lieu* of a "once and for all" payment. The DZ case thus forms the background to the analyses of the different selected cases.

The disbursement of a lump sum can also, when necessary, be converted into incremental payments. While some judges adhere to the Constitutional Court's guidance, others take different approaches, leading to inconsistencies in how CP cases are handled. Due to this lack of uniformity, it is argued in this research that it is essential to adopt alternative adjudication methods.

This research suggests alternative approaches to handling CP cases, such as mediation (taking note of the fact that mediation has been an alternative dispute resolution for years, but it is not yet compulsory in CP cases); formal parliamentary

development of the common law; using assessors instead of expert witnesses in court cases concerning CP; the possible capping of claims in CP instances; the involvement of the Department of Health in all CP cases as well as the accountability of the staff involved in CP cases. In conclusion it seems that not one of the proposed recommendations is a perfect fit and further research or deliberations are necessary.

KEY TERMS: Cerebral palsy, Hypoxia, Asphyxia, Encephalopathy, Ischaemia, Perinatal, Prenatal, Medical negligence, “Once and for all” rule, Damages, Quantum

ABSTRAK

Suid-Afrika staar 'n medies-regsstorm in die gesig wat dreig om sy gesondheidsorgstelsel te verlam, veral die lewering van noodsaaklike gesondheidsorgdienste wat moeder- en fetale gesondheid insluit. Daar is 'n vinnige toename in serebrale gestremdheid-nalatigheidsgedinge, gepaardgaande met die groeiende waarde van verwante eise. Serebrale gestremdheidsake het dus een van die hooffaktore geword wat die plaaslike gesondheidsbegroting uitput. Dit is kommerwekkend, aangesien daar geen konsekwentheid blyk te wees in litigasie van beweerde nalatigheid wat aanleiding gee tot 'n kind wat aan serebrale gestremdheid ly nie. Elke hof hanteer die meriete op sy eie manier, aangesien daar geen spesifieke riglyne is om te bepaal of serebrale gestremdheid die gevolg is van nalatigheid of nie.

Daar is tans geen wetgewing in Suid-Afrika wat mediese nalatigheidseise reguleer nie, en daarom word gevalle van beweerde mediese nalatigheid hanteer volgens die vereistes van die deliktereg, wat insluit dat skadevergoeding "eens en vir altyd" in monetêre waarde vereffen moet word. Die Konstitusionele Hofsaak van *LUR, Gesondheid en Maatskaplike Ontwikkeling, Gauteng v DZ* [2017] ZAKH 37 het die 'deur' oopgemaak vir die ontwikkeling van die gemenereg om af te wyk van die "eens en vir altyd"-reël en die betaling van 'n enkelbedrag vir skadevergoeding. Alhoewel dit ‘n verpligting van die Parlement is om die reg te verander het die DZ-saak 'n 'deur' oopgemaak, maar elke saak rakende serebrale verlamming moet steeds op die meriete van die spesifieke saak geëvalueer word. ’n Paar uitfgesoekte sake word

bespreek in hierdie navorsing wat spesifiek aandui wanneer die oop ‘deur’ gebruik was en wanneer nie. Sommige regters het spesifiek nagevors of die staat dienste kon verskaf al dan nie in die plek van die “eens en vir altyd”-reël. Die *DZ*-saak vorm dus die agtrergrond tot die analisering van die sake.

Die uitbetaling van 'n enkelbedrag kan ook, indien nodig, in inkrementele betalings omgeskakel word. Terwyl sommige regters die Konstitusionele Hof se riglyne volg, volg ander verskillende benaderings, wat lei tot teenstrydighede in hoe serebrale verlammingsake hanteer word. As gevolg van hierdie gebrek aan eenvormigheid is dit noodsaaklik om alternatiewe beregtingsmetodes te gebruik.

Hierdie navorsing stel alternatiewe voor soos mediasie (inaggenome dat hierdie manier van probleemoplossing reeds lankal bestaan maar steeds nie verpligtend is nie); formele Parlementêre verandering van die gemenereg; die gebruik van assessors instede van deskundige getuies; die moontlike beperking van bedare wat uitbetaal mag word vir serebraalgestremde kinders; die betrokkenheid van die Departement van Gesondheid in alle gestremdheidsake sowel as die toerekenbaarheid van die personeel wat betrokke is by ‘n serebraal gestremde kind se saak. Dit blyk egter dat nie een van die voorstelle ‘n gepaste oplossing allen bied nie en dus is verdere navorsing of beraadslagings nodig.

SLEUTELTERME : Serebrale verlamming, Hipoksie, Asfiksie, Enkefalopatie, Isgemie, Perinataal, Prenataal, Mediese nalatigheid, "Eens en vir altyd"-reël, Skade, Quantum

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ACRONYMS / ABBREVIATIONS

Apgar	Appearance, pulse, grimace, activity and respiration Each is scored on a scale of 0 to 2, with 2 being the best score.
CC	Constitutional Court
CP	Cerebral palsy
CTG	Cardiotocograph
HC	High Court
HIE	Hypoxic ischaemic encephalopathy
MEC	Member of the Executive Council
MRI	Magnetic Resonance Imaging
SCA	Supreme Court of Appeal
SAJBL	South African Journal for Bioethics and Law
SALRC	South African Law Reform Commission
SAMJ	South African Medical Journal
WHO	World Health Organization

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Background to the study

South African's transition to a constitutional democracy has ushered in a lot of changes in its citizenry's way of participating in decisions affecting them . These changes are most notable within the spheres of human rights, which are protected by the Bill of Rights[1] that is enshrined in the Constitution of the Republic of South Africa, 1996 (hereinafter 'the Constitution'). This is accompanied by the emergence of the Constitutional Court (hereinafter 'the CC') as the apex court to protect and enforce these rights as a positive development in the country's vernal democracy. However, a consequence of this increased awareness about human rights, particularly patients' rights, led to a tremendous upsurge in litigation to protect a perceived breach of individual rights, especially in the personal injury context.[2] As per sections 12(1)(c) and 12(2) of the Constitution, 'personal injury claims involve the fundamental right to freedom from all forms of violence and security of the person and bodily integrity'.[3] The significance of the judgment in the 2017 CC case of *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37 (hereinafter 'the *DZ* case') cannot be over-emphasised in this context. Although the case does not address a specific human right as entrenched in the Bill of Rights, it was an application to the CC for the development of the common law as per section 39(2)[4] and section 173[5] of the Constitution in cases concerning cerebral palsy (CP).

Apart from the fact that the number of CP claims instituted have increased, the amount and compensation claimed and awarded have also risen which constitutes a major

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1 The Constitution Chapter 2.

2 MS Pepper and MN Slabbert 'Is South Africa on the verge of a medical malpractice storm?' (2011) 4(1) SAJBL 29-35.

3 The *DZ* case fn 3.

4 Section 39(2) states that 'when interpreting any legislation, and when developing the common law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.'

5 Section 173 states that 'the Constitutional Court, Supreme Court of Appeal and High Courts have the inherent power to protect and regulate their own process, and to develop the common law taking into account the interests of justice.'

cause for concern.[6] No legislation currently exists in South Africa to specifically address legal claims in the medical field, which means that claims based on medical negligence concerning CP are dealt with under the common law, particularly the law of delict. Based on the prevailing circumstances befalling the country's medical sector, it is necessary to take pause to consider whether the traditional common law system is still the most appropriate way to deal with claims of CP associated with medical negligence in the current dispensation of governance. Hence, there is a need for the exploration of potential alternatives to dealing with CP medical negligence cases.

The increase in CP medical negligence litigation, with its concomitant relief sought and awarded, is a major negative concern for the healthcare sector. The menace of the claims instituted, and money paid out, adversely affects the healthcare sector, as the health departments pay millions of rands for its liability every year as compensation towards injured patients who have successfully proven their claims in court.[7] These monies are derived from the budget of the Health Department in the specific province concerned, which is budgeted for the general operations of the healthcare system, but instead is used to pay off the lump sum compensation awarded to patients by the Court.

The provincial pay-outs increasingly put pressure on the budgets of provincial health departments, where funds are shifted away from service provision in order to pay the claims. The rate at which the claims are increasing is nothing short of alarming.[8] This becomes a zero-sum calculation, where, as more claims awarded and paid out, the less money is available for service delivery and the quality of service become undermined as a result. This may even result in increasing negligence propagating

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6 See for example *NVM obo VKM v Tembisa Hospital and Another* [2002] ZACC 11; *TM obo MM v Member of the Executive Council for Health and Social Development, Gauteng* [2022] ZACC 18; *S v Life Health Group (Pty) Ltd and Another* (10227/2014) [2071] ZAKZDHC 12; *Member of the Executive Council for Health, Gauteng Provincial Government v PN* [2021] ZACC 6; *Mashinini v The Member of the Executive for Health and Social Development, Gauteng Provincial Government* (335/2021) 53 (18 April 2023); *The Member of the Executive Council for Health, Eastern Cape v DL obo AL* (117/202) [2021] ZASCA 68 (03 June 2021).

7 See for example *NG obo CG v member of Executive Council Responsible for Health Eastern Cape Province* (289/2019) [2024] ZAECBHC 15 (11 June 2024) where a claim for R28 675 443.02 was instituted and *LT obo ST v Member of the Executive Council for Health, Eastern Province Cape* (21/2015) [2019] ZAECMHC 60 (15 October 2019), in which R32 million was claimed.

8 RK Ramdass *Medico-legal aspects of cerebral palsy: A handbook for legal and healthcare practitioners* (Juta 2024) 2.

more claims, thereby giving rise to a vicious circle. If not addressed, this may possibly contribute to the collapse of the entire healthcare system.

Based on data from the Department of Health, contingent liabilities for alleged medical negligence by provincial facilities have increased exponentially over recent years, having reached about R98 billion in 2019, up from R55 billion in July 2017.[9] Taking into consideration the national budget allocated to health, the deleterious impact the current status quo may have on healthcare service delivery – in particular the progressive path towards universal coverage – is self-evident.[10]

Medico-legal claims present a significant challenge, with the majority stemming from alleged medical negligence linked to birth-related complications, particularly CP. These claims, often filed against provincial health departments, total hundreds of millions annually, placing immense pressure on provincial health budgets.[11]

In response to this growing financial strain, the South African Law Reform Commission released a paper emphasising that, for a developing country like South Africa—where the Constitution guarantees the right to access healthcare services— higher spending on healthcare is a welcome phenomenon.[12] However, it should be noted that the self-same budget amount for the provision of actual healthcare services is also being used to pay out CP medical negligence cases, which implies that a significant amount of the sum budgeted for healthcare has to be diverted away from its intended purpose, thereby reducing the funding of an already severely burdened healthcare system.

Health departments cannot afford to deplete requisite funds to keep the healthcare facilities operational in good condition and offering quality service to the citizenry. It is therefore necessary to salvage the health sector through legal reform of the current court processes, which stand to paralyse the system if no cogent action is taken for its regulation. It is obvious that an urgent need exists to deal with these litigation claim

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9 C Bateman 'NHI Bill set to worsen SA's medico-legal nightmare – experts' (Medical Brief, 18 September 2019) <https://medicalbrief.co.za/archives/nhi-bill-set-to-worsen-sas-medico-legal-nightmare-experts/> accessed 20 November 2023.

10 Department of Health 'National Health Insurance for South Africa' <https://www.health.gov.za> accessed 20 November 2023.

11 Anon 'Criminalising medical errors and what's at stake' <https://medicalbrief.co.za/criminalising-medical-errors-and-whats-at-stake/> accessed 20 June 2024.

12 South African Law Reform Commission (SALRC) Issue Paper 33, Project 141 'Medico–legal claims' (20 May 2017) 15-16. <http://www.justice.gov.za/salrc/dpapers.html> accessed 1 November 2023.

pay-outs, as these claims against the hospitals in relation to cases of CP have indeed reached a financially unsustainable level, placing the broader population at certain risk.[13]

1.2 Problem statement

The upsurge in CP medical negligence litigation and the outsized increase in compensation claimed and awarded by South African courts proves a substantive concern. Amounts awarded to successful claimants constitute a serious threat to the public health sector, mainly on the sector's ability to continue delivering services to most citizens. Money spent on these claims from the provincial health budgets is money not being allocated to essential healthcare priorities. The compensation paid out after a successful CP claim cannot accurately be budgeted for, because they are unpredictable and case specific, and this invariably renders the health sector liable to reallocate funds from their budgets to pay such claims. Consequently, critical budgets are diverted away from the delivery of other vital healthcare services, causing facilities to be consistently under-funded, and leading to even more court cases as a result.

Judgments given by different courts vary with regards to the arguments and expert testimonies that determine whether negligence was the cause of CP. Cases also differ concerning the determination of the *quantum* of the case as well as the "once and for all rule" and the payments of damages in a lump sum after the CC in the *DZ* case opened the 'door' for the development of the common law. Although certain courts have followed the lead given by the *DZ* case, formal legal reform in CP cases is necessary for consistency.

1.3 Research questions

The main research question asks whether there is a need for legal reform in medical negligence cases concerning CP in South Africa after the *DZ* case opened the 'door' for the development of the common law. To adequately answer the main question, the following sub-questions will be raised and answered:

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[13] Anon 30 January 2019 "Provincial Health Services at risk over R80.4bn in medical negligence claims" https://www.medicalbrief.co.za/provincial-health-services-risk-r80-4bn-medical-negligence-claims accessed 3 November 2023

- What did the court say in the *DZ* case and how did it influence cases following the judgement?
- Why are CP cases a problem area in medical negligence litigation?
- What is CP in medical terms?
- How is medical negligence leading to CP in law determined and what is currently lacking in the legal framework?
- How does CP pay-outs after successful claims affect the financial sustainability of the healthcare system?
- Why are existing legal mechanisms inadequate and what alternatives are there for claims based on alleged medical negligence culminating in CP?

1.4 Objectives, aim and significance of the research

1.4.1 Objectives of the research

The main objectives of the research are:

- To indicate the effect of the *DZ* case on CP litigation
- To indicate how the medical fraternity explains CP and why this is an issue concerning negligence
- To indicate that the current pay-outs of damages suffered due to medical negligence giving rise to CP is unsustainable in the public sector
- To indicate that even though the CC opened the 'door' for the development of the common law in CP cases, this is insufficient as it still depends on the facts of each case, or the arguments lead by the defence
- To indicate that formal legal reform is thus required
- To propose alternative solutions to the handling of CP cases and the escalation in pay-outs ordered by the courts for CP cases

1.4.2 Aim of the research

This research aims to propose possible solutions to dealing with the increase in medical negligence claims resultant from CP against the state, and to explore alternative options for the adjudication of CP cases, as well as a reform of the way in which damages are determined and awarded in CP cases.

1.4.3 Significance of the research

Medical negligence cases culminating in CP is one of the leading challenges faced by the public health sector in South Africa. This could be attributed to the fact that millions of rands are paid out by public hospitals to the victims of medical negligence and this reality holds dire consequences. For instance, health establishments are unable to realise their duty to provide healthcare to the millions of disadvantaged as provided for in section 27(1) of the Constitution, as funds meant to provide healthcare are used for the payment of medical negligence claims. Furthermore, medical practitioners now opt to practise defensive medicine to avoid being sued for medical negligence and this invariably tantamount in compromised healthcare for patients.

This study will enhance the knowledge of medical negligence claims related to CP in South Africa. This will be useful for planning in provincial healthcare. Having knowledge and a better understanding of the claims arising from CP will assist in improving planning of services, education and dealing with cases in need of reform. The study will also animate the epidemiological research about CP in South African court cases, taking cognisance of the high litigation costs that emanate from it.

The study is important as it aims to provide potential solutions for the problems of claims of medical negligence posed by CP, hence assisting in filling the gaps of information about the challenges faced by parents when the need for CP negligent tests arises. It will aid policy makers by providing appropriate information to health practitioners and government, which will aid them in implementing the reform needed in CP cases. As of date there is no research conducted specifically on CP cases in alleged medical negligence on this level.

1.5 Research methodology

The research is a desktop analysis of readily available data in the form of existing statistical compilations, legal documents from the relevant provincial and national departments and literature by scholars. No field research will be conducted. Primary and secondary data collection is used to carry out this research. Primary data will be sourced from legislation and judicial decisions on the subject matter of the research while the secondary data will be sourced from opinions of writers expressed in written works like books, journal articles and internet sources. The collected data is appropriately referenced and stored on the researcher’s personal computer.

1.6 Literature review

1.6.1 Background

Coetzee and Carstens conducted an overview of the state of medical malpractice and compensation in South Africa in 2011.[14] They argued that an increase in medical litigation can be correlated to factors like the realisation of constitutional rights, enhanced accessibility to information, improved transparency and accountability in terms of the prevailing legislation, and a high degree of awareness of patients' rights.[15] Also included in the reasons that have been advanced for this astounding figure of pay-outs, are 'inadequate quality of care, weak capacity in provincial medico-legal teams, poor administration of medical records, and high profitability for law firms specialising in this area'.[16]

Following a medical negligence incident, compensation may be claimed for:

- past and future medical expenses;
- loss of income or earning capacity;
- pain and suffering (general damages).[17]

1.6.2 Common law

Under common law, compensation for all these aspects must be paid in monetary form and must be claimed in a single legal action.[18]

The unpredictability and variability of large compensation awards make it difficult for health departments to budget accurately. As noted, they are often required to scramble to reallocate funds from the existing budgets to cover these unexpected expenses, which can have significant consequences. The severe consequences of diverting funds away from healthcare were starkly illustrated when the Eastern Cape Health Department's account was frozen due to court orders related to medical negligence

14 L C Coetzee and P Carstens 'Medical Malpractice and Compensation in South Africa' (2011) 86 Chicago-Kent Law Review 1263–1301.
15 Coetzee and Carstens 'Medical Malpractice' 1263.
16 Coetzee and Carstens 'Medical Malpractice' 1263.
17 *ME obo NP M […] v MEC for Health Gauteng* Case no 9257/2017 (21 January 2022) para 2.
18 C Visser and JM Potgieter *Visser and Potgieter's Law of damages* (3rd edn Juta 2012) 153.

claims. This left the department unable to pay its service providers, resulting in a crisis where toxic medical waste piled up at healthcare facilities, placing both patients and staff in immediate danger.[19]

1.6.3 The legislature

To tackle this unsustainable situation, the State Liability Amendment Bill was introduced in Parliament in 2018. The Bill proposes that, when the state is held liable for compensation, courts must either order periodic payments for future care (medical treatment and loss of earning capacity must be limited to the injured person's lifetime), or the court may require the state to provide the necessary treatment at a public health facility, *in lieu* of monetary compensation.[20] This aims to ensure that compensation is paid in such a way that prioritises the injured person's needs while it also does not burden the State with large upfront payments.[21]

The legislature's slow response led to the Bill lapsing but was revived in 2019. The Portfolio Committee on Justice and Correctional Services received a briefing from the Health and Justice Department, but it was sent back, expressing disappointment at the lack of critical information, including research from the South African Law Reform Commission.[22] The Chairperson stated that there is no urgency to pass the Bill, which misrepresents the need for swift reform. While the Committee is right to ensure thorough information, the courts have intervened to develop the law in the absence of legislative action.

1.6.4 The *DZ* case

Courts are now (subsequent to the *DZ* case) considering a move similar to the State Liability Amendment Bill, to develop the common law to allow the State to provide

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19 Anon 'Toxic mess: Debt crisis leads to medical waste pile up at Eastern Cape hospitals' <https//www.dailymaverick.co.za/article/2021-03-08-toxic-mess-debt-crisis-leads-to-medical-waste-pile-up-at-eastern-cape-hospitals/> accessed 1 May 2024.

20 State Liability Amendment Bill B16-2018 s 2 A (1).

21 State Liability Amendment Bill B16-2018 s 2 A (2).

22 Parliamentary Communication Service Media Statement 'Justice Portfolio Committee Sends State Liability Amendment Bill back to Department' (26 January 2021) <https//www.Parliament.gov.za/press-releases/media-statement-justice-portfolio-committee-sends-state-Liability-amendment-bill-back-department> accessed 1 May 2024.

medical services in the public sector instead of lump sum payments to injured patients. Alternatively, they may opt for periodic payments through a trust, managed by a case manager and trustee. These trusts could include claw back schemes that entail the returning of unused funds to the State if the injured party passes away, or top-up schemes to replenish funds if they run out during the injured party's lifetime.[23]

This approach prioritises the injured person's needs and ensures responsible management of resources. The legal path to this development was paved in the *DZ* case. The court established that it is possible for courts to expand the common law to include payment 'in kind' or periodic payments as compensation if the necessary factual basis is established. This approach aligns with the State Liability Amendment Bill, which proposes structured settlements for claims against the State due to wrongful medical treatment. The Bill suggests that instead of lump sum payments, compensation could be provided through periodic payments or medical services in the public sector. Additionally, a trust-based compensation model seeks to prioritise the well-being of the injured party, while ensuring resources are managed responsibly.

This ruling laid the groundwork for the recent developments in the legal landscape, where the application in the *DZ* case was brought to the CC by the Member of the Executive Council for Health and Social Development in Gauteng (Gauteng MEC). Although leave to appeal was granted by the CC because the matter raised constitutional issues,[24] in the final instance, the appeal was dismissed with costs. The respondent was DZ, who gave birth to WZ at a public hospital in 2009.[25] During labour, WZ suffered a shortage of oxygen (asphyxia) and ended up with CP, due to the hospital's failure to timeously perform a caesarean section.[26] The Gauteng MEC has conceded liability in the High Court (HC). The only issue remaining in the HC was thus 'the extent of the compensation to which WZ was entitled'.[27] However, in an amended

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23 The *DZ* case para 7.

24 The *DZ* case para 8.

25 As per fn 1 of the *DZ* case '… the minor victim … ought to be anonymous. This is in the best interests of the child, not merely in light of the child's right to privacy, but because when the child becomes an adult the many physical disabilities suffered by the child will result in vulnerability. If the sums of money at the child's disposal as a result of this judgment are readably to be found out on the internet, there will be a risk of the child losing that money to inappropriate friends, fortune hunters or even thieves. The child's parent, the respondent, must also be anonymous in order to ensure the effectiveness of the order.'

26 The *DZ* case para 1.

27 The *DZ* case para 1.

plea before the HC, the Gauteng MEC indicated that she wanted to satisfy the award in respect of future medical expenses by undertaking to pay service providers directly for future medical expenses as and when they might arise, within 30 days of presentation of a written quotation. She argued that her actions were permitted under the common law, and if they were not, then the common law should be developed in accordance with sections 39(2) and 173 of the Constitution.[28]

The HC and the Supreme Court of Appeal (SCA) dismissed the amended plea. The SCA held that the "once and for all" rule in common law precludes a defendant from satisfying an award of delictual damages in respect of future medical expenses in the manner sought by the Gauteng MEC.[29] The SCA declined to develop the common law in terms of section 39(2) of the Constitution, on the grounds that there was no evidence before it to suggest that such development proves necessary to promote the spirit, purport, and objects of the Bill of Rights. It also cautioned that the legislature, rather than the judiciary, ought to be the primary engine of law reform.[30]

The MEC Gauteng then approached the CC. The Eastern Cape MEC for health and the MEC for health in the Western Cape were admitted as *amici curiae* (friends of the Court).[31] The Eastern Cape MEC sought to ensure that the decision in this matter does not prevent her from raising two defences, namely: (1) the "public healthcare defence", according to which delictual claims for future medical expenses against public health authorities may be satisfied through the provision of health services in the public healthcare sector; and (2) the "undertaking to pay" defence, according to which medical services or supplies that cannot be provided in the public healthcare sector can be paid for as and when they arise.[32] The Western Cape MEC similarly sought to ensure that this Court's decision does not pre-empt consideration of the ambit of the "once and for all" rule in relation to certain mechanisms that she is devising in order to deal with claims against public healthcare providers for alleged negligence.[33]

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28 The *DZ* case para 2.
29 The *DZ* case para 2.
30 The *DZ* case para 3.
31 The *DZ* case para 3.
32 The *DZ* case para 6.
33 The *DZ* case para 7.

The CC held that it would be inappropriate for the common law to be developed in *this* [the *DZ* case] case, because the Gauteng MEC failed to adduce a factual basis in favour of development.[34] The possibility for future development of the common law where the appropriate evidence was presented on these disputed issues was not excluded. However, the CC confirmed that it is currently open to defendants who wish to dispute a claim for future medical expenses to adduce evidence that it would be reasonable for a plaintiff to obtain less expensive medical services, for example, in a public healthcare facility.[35]

The CC in this judgement was also of the opinion that the common law does not prohibit periodic payments of delictual damages.[36] The "once and for all" rule acts to regulate judicial process by ensuring that a claimant ought to sue for all his or her damages, accrued and prospective, arising from one cause of action, in one action. This serves to avoid a multiplicity of lawsuits and ensure that there is an end to litigation, in line with the principle of *res judicata*.[37] The rule does not govern *how* payment of a judgment debt is to be executed once final judgment is given. The execution of a judgment debt is governed by section 173 of the Constitution, which grants all superior courts the power to regulate their own processes. While damages are ordinarily paid in a lump sum, where facts are pleaded that show it is in the interests of justice to allow for periodic payment, a superior court may grant such an order.[38] What is also noteworthy is that all the CC judges agreed on the final verdict, albeit based on different reasons. The implication of the *DZ* judgment is that the 'door' is now open to compensating victims of medical negligence in alternative ways, without bankrupting the State or running the risk of the collapse of public healthcare services in some provinces. Apart from addressing this issue in the dissertation, attention will also be given to the delineation of CP and the fact that some medical authors feel the conclusion that CP is a result of a shortage of oxygen during birth or after birth is an oversimplification.[39]

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34 The *DZ* case para 7.
35 The *DZ* case para 8.
36 The *DZ* case para 75.
37 The *DZ* case para 78.
38 The *DZ* case para 81.
39 I Bhorat and others 'Cerebral palsy and criteria implicating intrapartum hypoxia in neonatal encephalopathy – an obstetric perspective for the South African setting' (2021) 111 SAMJ 277.

The judgement in the *DZ* case brought some necessary direction and clarity on the development of the common law in CP cases. It also opened the 'door' to further developments, giving recognition to the principle of compensating plaintiffs for damages suffered at the hand of the State, while acknowledging the constraints that the State is operating under. Considering the serious financial predicament most provincial departments of health find themselves in – due in large part to not insignificant medico-legal pay-outs – the case could have a major positive impact. After judgement was given in the *DZ* case, a question arose as whether provincial health authorities (MECs) already involved in lawsuits concerning CP *before* the *DZ* ruling, which are not yet finalised concerning the determining of the *quantum* of the case, ought to request courts to develop the common law principles allowing payment 'in kind', or periodic payments. While some high courts allowed this, the SCA disagreed.[40] They ruled that if a case had already been decided on its merits before the *DZ* case and the MEC had agreed to pay 100% of the damages, this implied a lump sum payment was intended. Therefore, any attempt to amend their pleading to include the new common law developments ought to be rejected.[41]

In April 2021 the Constitutional Court ruled in the case of *MEC for Health, Gauteng Provincial Government v PN* [2021] ZACC 6 (hereinafter 'the *PN* case'), rejecting the SCA's approach. The Court held that the word "pay" is not limited to a lump sum payment and that agreeing to pay 100% of damages only determines liability, not method of compensation. The court further stated the date of the *DZ* ruling is irrelevant, and that litigants always have the right to seek development of the common law. This means that the HC has the power to develop the common law, where MECs can amend their pleadings to this development, regardless of whether the case was launched or decided on its merit before the *DZ* ruling if damages have not been finalised.[42]

1.6.5 Peroration

40 The *DZ* case para 82.
41 The *DZ* case para 86.
42 The *DZ* case para 87.

This research will first explain CP in a medical context, whereafter medical negligence will be explained in a legal context, after which it will be shown how the courts apply the requirements of a delict when dealing with birth-related CP cases. The different judgements of CP cases will be analysed to show comparisons and differentiations in the court's interpretation of alleged negligence in cases in which the baby was born paralysed or became paralysed due to negligence. Focus will also be placed on the role of experts when adjudicating medical matters.

As already indicated, South Africa is facing an unprecedented number of medical negligence cases based on CP, which alone threatens to paralyse the country's healthcare services. The high number of court cases alleging medical negligence during the birth process is indicative of a problem based on medical negligence over the past years, even more so since the emergence of the constitutional democracy.

Where claims cannot be defended successfully in court, settlements in the form of monetary compensation are paid from provincial healthcare budgets (as already indicated), draining funds allocated towards the provision of essential health services.

Apart from the increase in the numbers of claims instituted, the exponential rise in the compensation claimed and awarded constitutes a major cause for concern, as there is no specific legislation currently in South Africa to address legal claims, and specifically the *quantum* thereof, in the medical field.

Medical practitioners as well as nursing staff are legally required to comply with defined standards of practice, which require that the professional services they provide do not put patients at risk unnecessarily. When they fail to exercise the necessary degree of skill and care that is expected of a reasonably competent practitioner or nurse in a particular area of medical practice, it may be argued that medical negligence has occurred. The research will therefore discuss the test for medical negligence in detail, as well its application in CP cases.

CP 'is a common, permanent, but non-progressive disorder of movement and muscle tone that causes impairment of the ability to engage in activities and participate fully in life. In other words, CP is a condition that affects muscle development and

coordination leaving a person paralysed.'[43] In most cases, it results from lack of oxygen reaching a baby's brain while they are still in the womb, or during a prolonged birth.[44] However, it can also result from developmental issues, and in very rare instances, in flawed genes.[45] The Centre for Disease Prevention and Control reported that CP has emerged as a major public health problem in children around the world.[46]

Bhorat and others indicate that numerous factors and causes are associated with CP.[47] They argue that the introduction of standardised guidelines concerning CP would help tremendously to indicate hypoxia-ischaemia, stating the following:

> Medico-legal cases involving CP in SA courts are mainly judged on MRI and CTG findings to assess causation and liability. These two modalities that retrospectively attempt to determine causation in courts are inadequate when used in isolation. Unless a holistic scientific review of the case including contributing clinical facts (antepartum, intrapartum and neonatal), foetal heart rate monitoring, MRI and placental histology is carefully considered, success for the plaintiff or defendant in a court of law will depend on eloquent legal argument rather than true scientific causality.[48]

Thomas and Johnston also take a stance against litigation after CP.[49] They feel the main driver of CP cases is electronic foetal monitoring (CTG), yet its false positive rate exceeds 99 percent.[50] The monitoring of the foetal heart rate in their opinion does not predict CP, but increases the rate of caesarean sections.[51] They propose that a no-fault system for birth related issues ought to replace the current fault-based litigation.[52] They refer to the worldwide endeavours to alter court processes for CP cases as those cases are 'unpredictable, unjust, costly, inefficient, lengthy, encourage defensive

43 SALRC 'Medico-legal claims' 12.
44 M Bax, Rosenbaum and Paneth 'Proposed definition and classification of cerebral palsy' (2005) 47(8) Developmental Medicine & Child Neurology 571–576.
45 St George's University Hospitals, NHS Foundation Trust <https://www.stgeorges.nhs.uk>COP_CP> accessed 20 August 2023.
46 NHS Foundation Trust 2023.
47 Centre for Disease Prevention and Control 2016 'Cerebral Palsy' <https://www.cdc.gov/ncbddd/cp/data.html> accessed 19 August 2023; Bhorat and others 'Cerebral palsy' 277.
48 Bhorat and others 'Cerebral palsy' 278.
49 T P Sartwelle and J C Johnston 'Cerebral palsy litigation: Change course or abandon ship' (2015) 30(7) Journal of Child Neurology 828-841.
50 Sartwelle and Johnston 'Cerebral palsy' 830.
51 Sartwelle and Johnston 'Cerebral palsy' 838.
52 Sartwelle and Johnston 'Cerebral palsy' 840.

medicine, and benefit[…] only a few cerebral palsy children and their families.'[53] There is thus a need for an alternative approach to CP cases.

1.7 Conclusion

In this introductory chapter, the background to the research has been explained. The problem statement was identified, as well as the research questions that will be answered.

Lawsuits related to CP often focus on oxygen deprivation during birth and alleged negligent care as the cause of CP. Standardised guidelines could improve detection of oxygen deprivation during birth. This will invariably reduce the over reliance of South African courts on MRI[54] and CTG[55] findings in determining liability. However, as explained above, experts argue that the methods currently used are insufficient and that a comprehensive review of clinical factors, fetal heart rate monitoring, and placental histology is necessary for exact confirmation and detection of the main cause of CP. This will be investigated in greater detail in the chapters to follow. First, it is necessary to explain CP in the medical context, mainly as reported in case law.

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53 G Whittaker 'Medical Malpractice in the South African Public Sector Cape Town' [2021] Actuarial Society of South Africa <https//www.actuarialsociety.org.za> accessed 1 May 2024.

54 *BKM obo NB v MEC for Health, Northwest Province Government* (726/2016) [2024] ZANWHC 3 (3 January 2024) (hereinafter 'the *BKM* case') fn 34: 'Magnetic Resonance Imaging (MRI) is a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in the body'.

55 The *BKM* case fn 3: 'Cardiotocograph (CTG): A tracing be means of electronic transducer which monitors the foetal heart (cardio) as well as the maternal contractions (toco) and this is seen as a continuous monitor on a screen and can be printed simultaneously on paper (graph)'.

CHAPTER TWO

CEREBRAL PALSY IN THE MEDICAL CONTEXT

> *The interaction between the law and medicine can, and usually does, present complex challenges, particularly where… a minor suffers a hypoxic ischaemic (HI) event during the birth process.*[56]

2.1 Introduction

This research concerns the law in cases of medical negligence culminating in CP. It is thus necessary to closely consider some medical aspects of CP, without providing an extensive and unnecessary medical exposition. Rather, the aim is to facilitate deeper consideration of the primary research question, by broadly explaining the possible causes of CP, and how it could be prevented in certain situations, so as to avoid medico-legal action. The medical explanations in connection to CP have predominantly been gathered from reported cases.

According to Ramdass, CP as a clinical entity is attributed to William John Little, who in 1861 delivered 'a monograph in which he proposed for the first time an association between perinatal asphyxia [shortage of oxygen] and poor neurological outcomes later in life'.[57] CP 'describes a group of permanent disorders of the development of movement and posture, causing activity limitation, that are attributed to non-progressive disturbances that occurred in the developing fetal or infant brain'.[58] According to the author, 'the motor disorders of CP are often accompanied by disturbances of sensation, perception, cognition, communication and behaviour, epilepsy and secondary musculoskeletal problems.'[59] CP is mainly caused by abnormal brain development or damage to the developing brain.[60]

The etiology of CP can be described as prenatal (before birth), perinatal (during birth), or postnatal (after birth), and this can often be determined by physical examination

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56 *M v MEC for Health, Eastern Cape* (699/17) [2018] ZASCA 141 (1 October 2018) para 45.
57 Ramdass *Medico-legal aspects of cerebral palsy* 7.
58 Bax, Rosembaum and Paneth 'Proposed definition 569.
59 Bax, Rosenbaum and Paneth 'Proposed definition' 573.
60 Sartwelle and Johnston 'Cerebral palsy' 830.

and neuroimaging of the infant's brain.[61] The World Health Organisation (WHO) defines the perinatal period as 22 weeks of gestation[62] to seven days of life, while the postnatal period refers to the period after birth.[63] There is no certainty about the causes of CP, 'but evidence indicate it could be attributable to infections, birth injuries and poor oxygen supply to the brain before, during and immediately after birth.'[64] CP is not a progressive diagnosis, but secondary complications such as contractures are common.[65] Risk factors increase the likelihood of a child developing CP. However, it is essential to note that the presence of a relevant risk factor does not guarantee the development of CP. These risk factors may be questioned by a defendant should a case concerning negligence during birth be investigated, and it is therefore necessary to briefly indicate what these risk factors might be, which makes the possibility of CP higher than in normal deliveries, or little to no risk births.

2.2 Risk factors associated with cerebral palsy

The following are certain risk factors associated with CP:

- Low birth weight: Children born weighing less than 2,5 grams, particularly those under 1,5 grams, have a higher risk of developing CP.[66]
- Premature birth: Birth before 37 weeks of gestation, especially before 32 weeks, increases the risk of CP. Advances in intensive care for premature infants have improved survival rates, but these children often experience medical complications that elevate the CP risk.[67]
- Multiple births: Twins, triplets, and other multiple births carry a higher CP risk, especially if a co-born child dies before or shortly after birth. This increased risk is partially attributed to the higher incidence of preterm birth and low birth weight in multiple pregnancies.[68]

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61 B S Russman and S Ashwal 'Evaluation of the child with cerebral palsy' (2004) 11(1) Seminars in Paediatric Neurology 47 -57.

62 The *BKM* case' fn 4: 'Gestation is the period during which a fertilised egg cell develops into a bay that is ready to be delivered.'

63 World Health Organization Maternal and Perinatal Health (2013) <http://www.who.int/maternal> accessed 4 June 2024.

64 Ramdass *Medico-legal aspects of cerebral palsy* 8.

65 Bax, Rosenbaum and Paneth 'Proposed definition' 571-576.

66 B van Naarden and others 'Birth prevalence of cerebral palsy: A population-based study' https://stacks.cdc.gov.viw.cdc/37361/cdc_37361_DS1_pdf accessed 4 June 2024.

67 Van Naarden and others https://stacks.cdc.gov.viw.cdc/37361/cdc_37361_DS1_pdf

68 S R Bonellie, D Currie and J Chalmers 'Comparison of risk factors for cerebral palsy in twins and singletons' (2005) 47(9) Dev Med Child Neurol 587-591.

- Assisted reproductive technology (ART) infertility treatments: Children conceived through certain ART treatments have an elevated CP risk, primarily due to increased rates of preterm delivery and multiple births.[69]
- Infections during pregnancy: Specific viral (chickenpox, rubella, cytomegalovirus) and bacterial (placental, foetal membrane, or maternal pelvic) infections can elevate the CP risk by triggering cytokine production in the foetal brain and bloodstream. [70]
- Jaundice and kernicterus: Untreated severe jaundice can lead to kernicterus, potentially causing CP and other conditions, especially in cases of ABO or Rh blood type incompatibility between mother and child.[71]

It is also possible for a child to develop CP normally within one month after birth, or postnatally, 'due to infections such as meningitis, injuries, or complications arising from problems in the flow of blood to the brain (known as hypoxia)'.[72]

Most CP cases that culminate in court are associated with either a *sentinel event* that took place before birth, or during birth, or due to *a prolonged birth,* during which the foetus experienced a lack of oxygen supply, but no specific event can be pinpointed to indicate when it happened.

2.3 Lack of oxygen during birth resulting in cerebral palsy

2.3.1 A sentinel event

A sentinel event is a catastrophic sudden event that ought to be recorded immediately by the doctor, midwife or nurse, as their response to such an event is determinant of whether negligence will be established or not. Sentinel events could be an abruption of the placenta, which means bleeding from a normal placenta causing it to detach completely or partially from the uterine wall.[73] Alternatively, the placenta may block the

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69 S Goldsmit and others 'Cerebral palsy after assisted reproductive technology: a cohort study' (2018) 60(1) *Dev Med Child Neurol* 73.

70 A MacLennan, S Thompson and J Gecz 'Cerebral palsy: causes, pathways and the role of genetic variants' (2015) December American Journal Obstetrics & Gynecology 779-788.

71 'Cerebral Palsy: Causes and Risk factors of Cerebral Palsy' <https://www.cdc.gov/Other/disclaimer.html> accessed 19 August 2024.

72 'Cerebral Palsy: Essential Information for Parents' <https://www.webmd.com/children/understanding-cerebral-palsy-basic-information> accessed 19 August 2024.

73 The *BKM* case fn 37 and para 62.

neck of the uterus and thus interfere with a normal delivery.[74] The umbilical cord could be pushed into the vagina ahead of the baby, becoming compressed, and thus cutting off the oxygen supply to the baby, or there could be a tear in the uterus depriving the baby from oxygen leading to hypoxic ischaemic encephalopathy (HIE).[75]

In the case of *Magqeya v MEC for Health, Eastern Cape* (699/17) [2018] ZASCA 141 (1 October 2018) (hereinafter 'the *Magqeya* case') Majiet JA indicated that hypoxia is a prolonged reduction in oxygen supply to the brain and ischaemia is a restriction in blood supply, which leads to a shortage of oxygen. Such a 'hypoxic ischaemic event [of a catastrophic nature] can be described as lack of oxygen and inadequate perfusion of oxygen through the blood to the brain which causes damage to the brain.'[76] In this case it was established that the baby's CP was caused 'by an acute, profound hypoxic ischaemic injury.'[77] This can be deducted from an MRI scan of the child's brain.

Majiet JA gave a judicial explanation of HIE that reads as follows:

> The foetus is completely dependent upon the mother for nutrition and oxygen, transmitted through the umbilical cord from the mother's placenta. During the onset of labour the contractions of the uterus (commonly known as 'labour pains') affect the placenta. As the contractions increase in strength, the blood vessels in the placenta become constricted and the blood supply to the foetus via the umbilical cord contains increasing levels of carbon dioxide and less oxygen. Monitoring of the foetal heart rate occurs by means of a cardiotocograph (CTG), which also measures the uterine contractions. CTG readings will convey to nursing staff monitoring the patient three important facets of heart normality; (a) the average (baseline) heart rate which, as stated, should be between 110-160 beats per minute; (b) the baseline variability of the heartbeat which normally should be between 5 – 10 beats per minute; and (c) accelerations in the heartbeat. Early and late decelerations of the heartbeat are related to contractions of the uterus. Late decelerations occur after the commencement of uterine contractions and recovers some time after the contractions had ceased. A foetal heart rate below 90bpm and a series of late decelerations of the heartbeat are cause for concern, as they may suggest that the foetus is in distress. They are referred to in medical parlance as 'non-reassuring foetal heart rate'. Depending on the severity of the foetal distress, it may be necessary to expedite the delivery by performing an urgent caesarean section. Absent timeous intervention, the increasing levels of reduced oxygen supply to the foetus (hypoxia) will result in brain damage.[78]

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74 The *BKM* case fn 38 and para 62
75 The *BKM* case para 62.
76 The *Magqeya* case para 8.
77 The *Magqeya* case para 8.
78 The *Magqeya* case para 9. See also *K.X v Member of the Executive Council for Health, Western Cape* (5088/2017) [2021] ZAWCHC 200 (13 October 2021) (hereinafter 'the *K.X* case').

In CP cases, it is crucial to determine whether there was a catastrophic event that caused the brain damage, or whether it occurred after an extended time, as can be the case with a prolonged birth. To determine the difference, MRI scans and the interpretation thereof by experts in paediatric neurology and radiologists are used. If a sentinel event happened and is shown on MRI scans, the next question to be asked is as to what the response of the medical team was treating or assisting the women when the event happened. If there was no immediate reaction to mitigate the brain damage it might be a case for negligence, if an emergency caesarean section is carried out or other means to help the baby's oxygen flow is administered, then it would be more difficult to prove negligence. All will depend on the records kept by the medical workers, which in most cases are lacking in the public sector.

2.3.2 Prolonged labour

Prolonged labour and CP often go hand in hand because of the complications with a prolonged birth. 'Labour that lasts for 18 to 24 hours or more increases the risk of CP developing in the baby. Time is thus a significant risk factor for this condition'.[79] If labour is prolonged, for whatever reason and the baby is already in the birth canal, the doctor should use instruments to pull the baby out. The use of instruments like forceps or a vacuum extractor can cause damage to a baby's skull by literally crushing it with too much force. This can easily lead to brain damage, which causes CP.[80]

Another cause of brain damage leading to CP is oxygen deprivation to the foetus or new born, known as birth asphyxia. The longer the baby is deprived of oxygen, the more severe the damage may be.[81] Things that can cause birth asphyxia are also associated with prolonged labour and includes, among other aspects, haemorrhaging, a large baby that gets stuck in the mother's pelvis, complications with the umbilical cord, shock in the mother, tearing of the placenta from the uterus, or abnormal presentation of the baby as it emerges from the uterus and birth canal.[82] Prolonged labour is a problem that many women face when giving birth especially if it is the first

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79 Centres for Disease Control and Prevention 'Causes and risk factors of Cerebral palsy' (2013) <http://www.cdc.gov> accessed 19 August 2024.

80 American Academy of Family Physicians 'Cerebral Palsy in Children: what you should know' <https://www.aafp.org/pubs/afp/issues/2006/0101/p101.html> accessed 23 August 2024.

81 Centres for Disease Control and Prevention <http://www.cdc.gov> accessed 23 August 2024.

82 National Institute of Neurological Disorders and strokes 'Cerebral Palsy: Hope through Research' (2013) <http://www.ninds.nih.gov> accessed 23 August 2024.

child. But with the proper care from doctors and nurses, there do not have to be any lasting complications. What is essential is the early diagnosis of possible obstacles in the birth process which should be treated instantly for the best outcomes. Many cases of CP could be avoided with better medical care.

To prevent harm, medical staff ought to assess foetal heart rate every 30 minutes during active labour. If foetal distress is suspected, staff ought to take emergency measures, including turning the mother onto her left side, administering oxygen, setting up a Ringer's Lactate drip,[83] conducting a vaginal examination[84] and, if necessary, arranging for a caesarean section to be performed.

In summary, the difference between a sentinel event (an intrapartum acute profound brain injury or an acute profound injury) and an intrapartum prolonged partial brain injury was explained by an expert obstetrician and gynaecologist, Dr Buchmann in the case of *The Member of the Executive Council for Health, Eastern Cape v Zimbini Mpetsheni obo Luyanda Mpetsheni* (576/2019) [2020] ZASCA 169 (14 December 2020) as follows:

> An acute profound injury is severe, with total or near-total asphyxia (deficient supply of oxygen); it is of short duration, and a sudden onset and generally occurs 30 minutes before delivery. A prolonged partial injury is less severe, with partial asphyxia; it develops slowly over several hours; it is often preceded by a deteriorating foetal heart rate that gives a warning of developing hypoxia, that is, lack of oxygen.[85]

When the cause of CP has been established and it is HIE, it may be argued that it could have been prevented as it was foreseeable, yet the necessary steps to prevent it was not taken, this is important from a medico-legal perspective.

2.3.3 How to determine a case of lack of oxygen

To determine whether the lack of oxygen was the reason for the CP, an MRI should be done as it is currently the only way it can be detected. 'The MRI is accepted as the

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83 The *BKM* case' para 93 'A Ringers Lactate drip is used to administer the drug oxytocin (Syntocinon) administered to stimulate contractions'.

84 The *BKM* case para 31.

85 *Member of the Executive Council for Health, Eastern Cape v Zimbini Mpetsheni obo Luyanda Mpetsheni* (576/2019) [2020] ZASCA 169 (14 December 2020) para 4.

'frozen' image of hypoxic brain injury irrespective of how long after the injury the MRI was performed'.[86] Ramdass explains the MRI patterns as follows:

> The MRI pattern may be in keeping with an acute profound hypoxic-ischaemic episode, which is usually associated with a sentinel event such as antepartum haemorrhage, uterine rupture or cord prolapse. Another well recognised injury is the watershed injury pattern that suggests partial prolonged hypoxia. This is generally due to the foetus being exposed to hypoxia-ischaemia, which is less than total hypoxia and ischaemia, but over a longer period. There may be a mixed pattern of both acute and partial prolonged hypoxia, in which case there is injury in the watershed areas of the brain involving the deep grey matter.[87]

In litigation, experts in the fields of neurology, paediatrics and radiology will be called to testify on the MRIs to determine the causal link between the CP and the possible cause thereof. This is a possible shortcoming in the legal process, as too much emphasis is placed on the MRI only, while cord blood analyses and placental histology could also help in finding the cause for CP, but these tests are not done in the public sector, due to budget constraints.[88]

To accurately interpret an MRI scan and understand the nature of the suspected injury, it is essential to consider the patient's medical history and rule out infections as well as metabolic or congenital abnormalities.[89] Basal ganglia and thalamic lesions are commonly linked to CP.[90]

The last aspect of the medical approach to CP is to state what the guidelines are for nurses, mid-wives or doctors involved in the birth process, as in many CP cases, these guidelines were not followed or there are no records indicating what specifically happened during the birth process.

2.4 National Maternal Guidelines for South Africa

86 Ramdass *Medico-legal aspects of cerebral palsy* 20.
87 Ramdass *Medico-legal aspects of cerebral palsy* 26.
88 Ramdass *Medico-legal aspects of cerebral palsy* 20.
89 Ramdass *Medico-legal aspects of cerebral palsy* 23.
90 Ramdass *Medico-legal aspects of cerebral palsy* 23.

The National Maternal Guidelines published in 2007[91] clearly emphasise that all women in labour ought to be monitored closely.[92] The Guidelines were updated in the fourth edition in 2016, but interestingly in all cases discussed in this research, mention is only made of the 2007 Guidelines.

In terms of the 2007 Guidelines, the first stage of labour consists of two sub-phases, namely: (1) the latent phase, during which the cervical dilation is less or equal to 3cm dilation; and (2) the next phase where the dilation is 4cm until the cervix is fully dilated. The second stage is from full dilation until delivery, and the third stage is from delivery of the foetus until delivery of the placenta.[93]

During the active phase of labour[94] the following should be done:[95]

1. The maternal blood pressure and heart rate[96] ought to be monitored hourly, the temperature should be monitored four-hourly, and the urine volume should be measured and tested two-hourly.
2. The foetal heart rate should be monitored half-hourly, listening before, during and after a contraction. If it is a low-risk patient, intermittent auscultation or the process of listening, usually with a stethoscope or a hand-held doppler device, is sufficient.[97]
3. The colour and odour of the liquor or amniotic fluid[98] should be observed every two hours to check if membranes have ruptured.
4. The frequency and strength of contractions ought to be monitored hourly.
5. The cervical dilation, level of the presenting part and presence of caput[99] and moulding[100] must be assessed two-hourly.

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91 The Department of Health 'Guidelines for Maternity Care in South Africa 2007' (hereinafter 'the Maternity Guidelines 2007') https://knowlegdehub.health.gov.za/elibrary/guidelines-maternity-care-south-africa-2007 accessed 20 November 2023.

92 *AN v MEC for Health, Eastern Cape* (585/2018) [2019] ZASCA 102 (15 August 2019) par 35.

93 *Member of the Executive Council for Health, Eastern Cape v DL obo AL* (117/2020) [2021] ZASCA 68 (03 June 2021) (hereinafter 'the *AN* case') fn 1.

94 Active labour is from 4cm cervical dilation until full dilation (10cm) see the *BKM case* fn 12.

95 Maternity Guidelines 2007, see also the *BKM* case para 23.

96 A normal heart rate ranges between 120 and 160 beats per minute.

97 The *BKM* case para 24 and fn 14.

98 Amniotic fluid or liquor is a clear slightly yellowish liquid that surrounds the foetus during pregnancy. The *BKM* case fn 13.

99 Caput is the temporary swelling of the soft parts of the head of a newly born infant that occurs during labour, due to the compression of the muscles of the cervix of the uterus. The *BKM* case fn 8.

100 Moulding is the changing of the shape of the bone of the skull, which is brought about by the pressures that it is subjected to when passing through the birth canal. The *BKM* case fn 9.

During the second stage of labour (cervical dilation 10cm) 'the foetal heart rate should be auscultated every 5 minutes or with every second contraction.'[101]

The management of the second stage of labour states as follows:

> From the time that full dilation of the cervix is first noted, up to 2 hours may pass before the mother starts to bear down. Time can only be allowed for the head to descend onto the pelvic floor if foetal distress and cephalopelvic disproportion have been ruled out. The bladder should be emptied, using a catheter if necessary. The observations of the first stage of labour should continue. Efforts at bearing down are only encouraged when the foetal head starts to distend the perineum and the mother has an urge to push.
>
> When the mother is ready to bear down:
>
> - Always communicate clearly with the mother to gain co-operation.
> - Be supportive and encouraging.
> - Put the mother in a suitable position: propped up, sitting, squatting, kneeling, semi-Fowler's or wedged supine. Avoid the flat supine position as the uterus will compress the aorta and inferior vena cava.
> - Encourage pushing only during contractions.
> - Listen to the foetal heart rate between every contraction.
> - Protect the perineum when the head crowns.
> - Gently suction the baby's mouth and nostrils while awaiting restitution and external rotation.
> - Record the times of onset of the second stage, onset bearing down efforts and delivery.[102]

Under the heading of "emergencies during labour" the following is stated concerning foetal distress:

> This is suspected when the following signs are observed:
> - Baseline foetal heart rate $\geq$ 160 beats per minute.
> - Baseline foetal heart rate $\leq$ 110 beats per minute.
> - Variability persistently < 5 beats per minute on CTG, in the absence of sedating drugs
> - Late decelerations of the foetal heart rate.

<u>Management of foetal distress</u>

1. Explain the problem to the mother.
2. Lie the mother in a left lateral position.
3. Give oxygen by face mask at 6 L/minute.
4. Start an intravenous infusion of Ringer-Lactate to run at 240 mL/hour.
5. Do a vaginal examination for cervical dilation and to exclude cord prolapse: If vaginal delivery is imminent (cervix fully dilated), deliver immediately, by vacuum extraction if necessary. If vaginal delivery is not imminent, give hexoprenaline 10 micrograms IV and prepare for immediate caesarean.
6. Arrange urgent transfer from a community health centre to hospital.[103]

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101 The *BKM* case para 37.
102 The *AN* case para 36.
103 The *AN* case para 37.

As pointed out earlier, there is enough guidance to assist anyone working in a maternity ward, but the guidelines are often not followed, and records are not kept, which makes it very difficult should the health workers have to prove that they did everything according to the guidelines. In the absence of records indicating that the guidelines were followed during the birth process and considering the number of CP cases that end up in court, medical staff are not adhering to the prescriptions regarding how to handle the birthing process.

The National Maternal Guidelines, initially published in 2007, must be regularly updated to reflect ongoing progress in medical science. Continuous advancements in clinical knowledge, the development of new pharmaceutical therapies, and the publication of recent evidence-based clinical trials necessitate these revisions. The 2016 edition of the *Maternity Guidelines for Clinics and District Hospitals* illustrates this need clearly, where it incorporates critical new content such as the use of blood and blood transfusion products, early warning observation charts, and professionalism in healthcare. These additions underscore a strong commitment to improving patient safety and ensuring that healthcare providers are equipped with the most current and effective practices. However, despite these additions, most cases only refer to the 2007 Guidelines.

Key Updates and Revisions in the 2016 edition[104]

Antenatal Care - Why the change? The shift from simply issuing antenatal cards to implementing more comprehensive antenatal care protocols reflects a deeper commitment to quality over formality. The 2016 guidelines introduced structured, evidence-based approaches like Basic Antenatal Care Plus (BANC Plus), which increased the number of recommended visits and emphasised early detection of complications. This was in response to research showing that fewer visits were linked to higher perinatal mortality.

Human Milk Banks - Why include them? South Africa has faced high rates of neonatal mortality, especially among preterm and low-birthweight infants. The inclusion of National Guidelines for Human Milk Banks led to advancements in health

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104 Department of Health 'Guidelines for Maternity Care in South Africa (2016)' (hereinafter 'the Maternity Guidelines 2016') https://knowlegdehub.health.gov.za/elibrary/guidelines-maternity-care-south-africa-2016 accessed 10 August 2023.

by promoting safe donor milk as a life-saving alternative when mothers were unable to breastfeed. This aligned with global best practices and WHO recommendations for neonatal nutrition.

Maternal Health Indicators - Why the emphasis on data? By incorporating findings from the 1998 and 2016 *Demographic and Health Surveys*, the guidelines signalled a shift toward data-driven decision-making. This allowed policymakers and clinicians to tailor interventions based on real-world trends—such as disparities in antenatal care access, or maternal mortality rates across provinces.

Clinical Guidelines - Why update them? Medical science does not stand still. The 2016 edition integrated new evidence-based treatments, updated drug protocols, and refined diagnostic criteria. For example, the management of conditions like gynaecology and obstetrics emergencies were revised to reflect the latest research and WHO guidance.

Edition Updates - Why does this matter? The fact that this was the fourth edition underscores a culture of continuous improvement. It shows that South Africa's Department of Health is committed to evolving with the times—responding to emerging health challenges, new technologies, and lessons learned from previous maternal health audits.

The updates of South Africa's maternal care guidelines were driven by a growing body of global and local evidence that challenged long-standing assumptions about labour progression and maternal care practices. The updates reflect a broader commitment to improving maternal outcomes by grounding clinical practice in the latest research and adapting it to local needs. The below outline how the key revisions can be justified.

Reassessment of Labour Progression Norms - Traditional benchmarks like the 1cm per hour cervical dilation rule was found to be overly rigid, and not reflective of natural labour patterns in many women. New research showed that healthy labour can progress more slowly—especially before 6cm dilation—without compromising outcomes. This prompted a shift toward more individualised, evidence-based monitoring.

Reduction of Unnecessary Interventions - The updated guidelines aim to reduce overuse of interventions such as early amniotomy and oxytocin augmentation, which

were often applied to meet outdated labour timelines. By aligning care with more realistic labour curves, the updated edition supports safer, less invasive management of childbirth.

Integration of WHO Recommendations - The revisions incorporate WHO's updated intrapartum care standards, which emphasise respectful maternity care, patient autonomy, and the importance of minimising harm through unnecessary procedures. This ensures that South Africa's practices are aligned with the standards of international best practice.

Contextual Relevance - The guidelines were tailored to reflect the realities of South African healthcare settings, including resource constraints and the need for practical, scalable tools. This makes them more applicable and effective across diverse clinical environments.

2.5 Conclusion

In this clinical chapter, attention was given to what CP entails in medical terms and what the possible causes thereof could be. It must be emphasised that 'it would be fallacious to assume that CP equals malpractice.'[105] From a legal point of view, as will be discussed in the next chapter, experts prove indispensable to determining when the lack of oxygen occurred, meaning whether due to a sentinel event or due to a prolonged birth, as the reaction of the healthcare workers on indications of a lack of oxygen to the foetus proves the determining factor in establishing whether or not there was negligence. Most CP cases are believed to have been caused by oxygen deprivation before or during labour. However, 'this theory faced opposition when medical interventions like electronic foetal monitoring and caesarean sections reduced the number of stillbirths and infant deaths, yet cerebral palsy prevalence rates remained constant.' [106]

In a report published by the Actuarial Society of South Africa (ASSA) written by Gregory Whittaker, an actuary and medico-legal damages expert, he points out that it is now widely accepted that CP is often caused by several sequential factors, rather

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105 Ramdass *Medico-legal aspects of cerebral palsy* 22.
106 SALRC 'Medico-legal claims' 175-177.

than a single cause. ‘Contributing factors can include maternal obesity, alcohol consumption and smoking, infections, and birthweight.’[107] If his allegations are true, this makes standarised measurements of CP essential and requires a completely new approach by courts dealing with CP cases. As indicated above each case of CP begins with establishing whether the foetal hypoxia causing the brain injury occurred, and when it occurred. Once that is done, the legal process of proving liability follows as will be discussed in the following chapter.

[107] G Whitter ‘Medical Malpractice in South African Public Sector’ (2021) Cape Town Actuarial Society of South Africa 55-60 <https://www.acturialsociety.org.za.> accessed 19 August 2024.

CHAPTER THREE

MEDICAL NEGLIGENCE: A LEGAL PERSPECTIVE

Medicine is what might be. Law is what is.[108]

3.1 Introduction

The concept of accountability for medical negligence dates to ancient civilisations. The Hammurabi Code (circa 2030 BC) prescribed severe penalties, including amputation, for medical practitioners whose negligence resulted in patient death or disability.[109] Similarly, in ancient Greece, negligence leading to a patient's death was punishable by the same.[110] However, over time, the legal framework governing medical negligence has evolved significantly. Today, more nuanced and equitable approaches determine the consequences of medical negligence, ensuring fair outcomes for both practitioners and patients. Case law has progressed to address these complex issues more effectively, replacing harsh historical penalties with more reasonable and just solutions.

South Africa has a National Department of Health with the Minister of Health as its head. The Minister of Health plays a critical role in ensuring the well-being of the population. According to the National Health Act, the Minister is responsible for protecting, promoting, improving, and maintaining the health of the population, within the limits of available resources.[111] There are nine Provincial Health Departments each headed by the Member of the Executive Council/Committee (MEC). When a patient suffered damages in the public sector, he or she will sue the MEC of Health of the specific province in which the incident occurred, because he or she is the political head of that provinces' department of health as envisaged in the State Liability Act 20 of 1957. The Act states that the political head of a province ought to be sued as he or she is vicariously responsible for the delictual actions and commissions or omissions

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108 Ramdass *Medico-legal aspects of cerebral palsy* vii.

109 BS Bal 'An Introduction to medical malpractice in the United States' (2008) 467(2) Clinical Orthopaedics and Related Research 339 -347. <http://www.ncbi.nlm.nih.gov/pmc/articlesPMC2628513/> accessed 22 August 2020.

110 Bal <http://www.ncbi.nlm.nih.gov/pmc/articlesPMC2628513/> accessed 22 August 2024.

111 National Health Act 61 of 2003 s 3(1).

committed in health centres under its care.[112] The principle of vicarious liability determines that one party (the employer) is held responsible for another's (the employee's) wrongdoing, even if the first party did not do anything wrong.[113] An employer is liable for damages caused by an employee's wrongdoing if it occurred while the employee was performing his or her duties. This same rule applies to government employees,[114] where, if a government employee commits a wrongful act while working, the government as the employer can be sued.

When a pregnant woman enters a hospital where she going to give birth, there is a duty undertaken by the hospital to treat her with the necessary care and skill. If things go wrong the patient will be able to institute legal action. If she proves negligence on a balance of probabilities, she will be able to claim damages. As stated at the beginning of this research, personal injury claims are dealt with in term of the common law, as there is no specific statute regulating medical negligence. The law of delict is part of the common law of obligations, and to be successful with a medical negligence claim, a claimant must prove all the elements of a delict, *viz* conduct, wrongfulness, causation, fault, and damages.

3.2 Elements of a delictual claim

3.2.1 Conduct

Conduct should be a voluntary act, or an omission by a human being.[115] Conduct, in the context of this research will almost always be an omission in the sense that the medical staff did not follow the Guidelines referred to above, or did not perform a caesarean section timeously, resulting in harm to the baby. It is essential to note that only voluntary actions or omissions are considered negligent. Involuntary actions, such as those resulting from a medical condition, are not deemed negligent unless the person was reckless in creating the situation. For instance, an epileptic driver who has

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112 See the State Liability Act 20 of 1957 as well as the case of *K […] v The MEC for Health for the Province of KwaZulu-Natal* (D7918/2015) [2022] ZAKZDHC 8 (9 February 2022) para 3.

113 P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (LexisNexis 2007) 545; D McQuoid-Mason and M Dada *A-Z of Medical Law* (Juta 2011) 433; DJ McQuoid-Mason 'Vicarious and Strict Liability' (2011) 30 LAWSA par 285.

114 Coetzee and Carstens 'Medical malpractice' 1271.

115 J Neethling, JM Potgieter and C Visser *Neethling, Potgieter and Visser Law of Delict* (7th edn LexisNexis 2015) 25; Carstens and Pearmain *Foundational Principles* 496; JR Midgley and JC van der Walt 'Delict' (2011) 8 LAWSA para 58.

a seizure and causes an accident is not liable, but if they knowingly neglected their treatment and undertook to drive despite their condition, their conduct could be seen as negligent.[116]

3.2.2 Wrongfulness

The act or omission will be wrongful if it infringes on a legally protected right or breaches a legal duty.[117] The consequences of conduct (as explained above), may thus be defined as being wrongful if 'public considerations demand that in the circumstances the plaintiff has to be compensated for the loss caused by the negligent or intentional act or omission of the defendant'.[118] The test for determining wrongfulness is based on societal norms and expectations.[119] In essence, if a doctor's actions infringe upon a patient's legally recognised rights, their conduct will be deemed wrongful. This assessment relies on community standards (*boni mores*) of what is considered just and fair and which are 'by necessity underpinned and informed by the norms and the values of our society, embodied in the Constitution.'[120]

As indicated above, in most CP cases it is concluded that the healthcare staff that attended to a woman who is giving birth, did not follow the Maternity Guidelines and therefore committed an omission, in other words they did *not act* as was expected of them. The *locus classicus* concerning the wrongfulness of an omission is the case of *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) at 597, where it was stated:

> Our law has developed to the stage where an omission is regarded as unlawful conduct [wrongful] when the circumstances of the case are of such a nature that the omission not only incites moral indignation but also that the legal convictions of the community demand that the omission ought to be regarded as unlawful and that the damage suffered ought to be made good by the person who neglected to do a positive act. In order to determine whether there is unlawfulness the question, in a given case of an omission, is thus not whether there was the usual 'negligence' of the *bonus paterfamilias* but whether, regard being had to all the facts, there was a duty in law to act reasonably.

The courts will consider a failure to act, or an omission, wrongful only where there is a legal duty on the defendant to act positively. If a pregnant woman enters a maternity

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116 J R Van der Walt and J C Midgley *Principles of Delict* (4th edn 2016) 91.
117 Neethling, Potgieter and Visser *Law of Delict* 33.
118 I Dutton *The practitioner's guide to medical malpractice in South African law* (SiberInk 2015) 31.
119 *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D).
120 Ramdass *Medico-legal aspects of cerebral palsy* 28.

establishment, there is a duty of care on the health workers to treat her with the necessary skill and professionalism because of this duty on them, if they do *not* act as expected, it could be accepted as being *prima facie* wrongdoing, depending on each specific case.[121]

In the case of *K.X v Member of the Executive Council for Health, Western Cape* (5088/2017) [2021] ZAWCHC 200 (13 October 2021) concerning CP (hereinafter 'the *K.X* case'), the judge at paragraphs 110-111 addressed the wrongfulness by referring to the Oppelt case[122] in which it was stated:

> …the wrongfulness enquiry is based on the duty not to cause harm and that, in the case of negligent omissions, the focus is on reasonableness of imposing liability. An enquiry into wrongfulness is determined by weighing competing norms and interests, The criterion of wrongfulness ultimately depends on a judicial determination of whether, assuming all other elements of delictual liability are present, it would be reasonable to impose liability on the defendant for the damages flowing from specific conduct. Whether conduct is wrongful is tested against the legal convictions of the community which are by necessity underpinned by the norms and values of our society, embodied in the Constitution.

3.2.3 Causation

There must be a causal link between the defendant's conduct or omissions and the plaintiff's harm. Both factual and legal causation must be proved. Factual causation means there is a direct link between the conduct or omission and harm.[123] The test for factual causation is the 'but for' test. This test asks whether the harm would have occurred to the claimant 'but for' the defendant's action or omission.[124] Legal causation means that the harm should not be too remote from the conduct or no conduct and must be proven to be linked to the conduct or omission. This test asks whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as stated, the loss is too remote.[125] The test for legal causation include the 'foreseeability test, the direct consequence test and the adequate-cause test.'[126] The

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121 Dutton *The practitioner's guide* 46.

122 *Oppelt v Department of Health Western Cape* 2016 (1) SA 325 (CC) para 51.

123 Carstens and Pearmain *Foundational Principles* 523 to 524.

124 Neethling, Potgieter and Visser *Law of Delict* 183, Carstens and Pearmain *Foundational Principles* 509.

125 Neethling, Potgieter and Visser *Law of Delict* 25; Carstens and Pearmain *Foundational Principles* 496; Midgley and van der Walt 'Delict' (2011) 8 LAWSA para 58.

126 DJ McQuoid-Mason 'Public health officials and MECs for health should be held criminally liable for causing the death of cancer patients through their intentional or negligent conduct that results in oncology equipment not working in hospitals' (2017) 102 SAJBL 285.

foreseeability test asks whether a reasonable person would have foreseen harm arising from his or her actions or omissions. It does not require the person to have foreseen the exact nature or extent of the harm. The direct consequence test states that a person is liable if his or her actions or omissions led directly to the harm suffered and there were no intervening acts between the defendant's action and the harm suffered. The adequate-cause test determines that a person is liable if his or her actions are closely associated with the harm suffered.[127]

The SCA observed in the case of *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) in paragraph 25 that:

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

In a case of CP, the claimant would thus argue under causation that 'but for' the negligence (omissions) of the healthcare staff, the baby would not have developed CP. The MRI findings usually underscore a hypoxic-ischaemic brain injury, which is in line with the determination of CP if all other causes of CP have been eliminated and therefore the MRI is currently evidence of a probable cause of the CP.[128]

In the *K.X* case concerning CP referred to above, the judge also addressed causation. Gamble J quotes extensively from *Lee v Minister of Correctional Services* 2013 (4) SA 144 (CC), a case concerning a sentenced prisoner who contracted tuberculosis due to the omission of Correctional Services.[129] He then applies the test laid down in the *Lee* case to CP cases by saying a court should ask itself whether it is probable that the child would have suffered an HIE if the staff had taken reasonable steps to prevent it.[130] If the answer is no, then there was an omission and a causal link to the damages suffered by the child. He also found that legal causation was present by saying:

> I am satisfied that the omission by the MOU staff to act timeously when the proverbial alarm bells were ringing is not too remote for purposes of determining causation. After all, the Guidelines required an immediate referral to MMH when

127 McQuoid-Mason 'Public health officials' 285.
128 Ramdass *Medico-legal aspects of cerebral palsy* 28.
129 The *K.X* case para 101.
130 The *K.X* case paras 102-107.

the late decelerations were noted, and the MOU staff simply ignored the prescripts thereof.[131]

3.2.4 Fault

Fault is established by intentional or negligent conduct, determined objectively by comparing the defendant's actions to those of a reasonable person. Intent is assessed subjectively, while negligence is assessed objectively.[132] Fault is deemed to have occurred if the defendant acted either in a reprehensible state of mind (intent), or with insufficient care (negligence). Fault concerning CP is always negligent, as it could be accepted that no healthcare worker would intentionally harm a mother giving birth.

3.2.5 Damages

Harm must have been suffered by the claimant[133] and this must be compensable in monetary terms.[134] If the merits of the case warrants it, the common law could be developed that the damages suffered could be paid differently. As indicated earlier a claimant may claim past and future medical costs, loss of income, and general damages which includes pain, suffering and the loss of amenities of life.

According to the Uniform Rules of Court, Rule 33(4) the merits (liability) should be separated from the *quantum* of the case. This means that a claimant will start the legal process by arguing the merits or facts of the case first, and if he or she is successful, then the court will determine the *quantum* of the damages suffered and how it should be paid out in future. The determination of the *quantum* and the exorbitant amounts claimed are a major concern in this research, as indicated at the outset. Without belabouring the issue here, as it will be argued in a chapter to follow, experts are used to determine future medical costs, loss of earning capacity, and general damages. The case of *ME obo NPM v MEC for Health, Gauteng* (9257/2017) [2022] ZAGPJHC 29 (21 January 2022) is an example of the extent to which experts are utilised. In the case the following, experts gave evidence on what the child suffering from CP would need in future, namely: psychiatrists, physicians, architects, educational psychologists, physiotherapists, speech and language therapists, dentists, mobility experts,

131 The *K.X* case para 109.
132 Neethling, Potgieter and Visser *Law of Delict* 129; Carstens and Pearmain *Foundational Principles* 303.
133 Neethling, Potgieter and Visser *Law of Delict* 222.
134 Neethling, Potgieter and Visser *Law of Delict* 222.

ophthalmologists, orthotists and prosthetists, ear nose and throat surgeons, occupational therapists, urologists, gastroenterologists, economist, actuaries, and industrial psychologists. All the experts indicated the costs associated with the services they would provide totalling to a cost of R13 million.[135] Concerning the general damages in the case, an amount of R2 million was awarded,[136] with R2 387 242 awarded for loss of earnings.[137] This is but one example of what the *quantum* in a CP case could be.

3.3 The test for medical negligence

The test for negligence was formulated by Holmes JA in the 1966 matter of *Kruger v Coetzee* as follows:[138]

> For the purposes of liability culpa arises if –
>
> (a) a *diligens paterfamilias* in the position of the defendant –
>
> (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
>
> (ii) would take reasonable steps to guard against such occurrence; and
>
> (b) the defendant failed to take such steps.

Medical negligence amounts to more than a mere error or a procedure being unsuccessful, or a procedure not having the desired effect. The test is whether a reasonably competent medical practitioner or nurse in the position of the medical practitioner or nurse complied or would have foreseen the likelihood of the harm of the type complained of and taken steps to guard against it. If the medical practitioner or nurse ought to have foreseen the likelihood of harm and failed to take steps to guard against it, it may be argued that the healthcare worker is in breach of the legal duty of care due to the patient, and that such breach resulted in injury to the patient. It is evident that the test for negligence applied in medical negligence cases cannot be the same as the customary reasonable man test used to determine negligence in other

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135 *ME obo NPM v MEC for Health, Gauteng* (9257/2017) [2022] ZAGPJHC 29 (21 January 2022) (hereinafter 'the *ME* case') paras 9-25 .

136 The *ME* case para 33.

137 The *ME* case para 37. See also *PM obo TM v MEC for Health, Gauteng Provincial Government* (A 5093/2014) [2017] ZAGPJHC 346 (7 March 2017) which addresses the determination of the *quantum* of a claim.

138 *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430 E–F.

delictual claims. In the case of a medical practitioner or nurse, the test is adapted to the standard of the reasonable medical practitioner or nurse, or the reasonable medical specialist in that field, with a similar degree of professional skill, in the same circumstances as the defendant.[139] The court articulated the test for negligence in relation to a medical practitioner in *Mitchell v Dixon* through Innes ACJ who stated:

> A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.[140]

In *Van Wyk v Lewis* 1924 AD 438 at 461 Wessels AJ noted, 'We must place ourselves as nearly as possible in the exact position which the surgeon found himself when he conducted a particular operation, and we must then determine from all the circumstances, whether he acted with reasonable care or negligently.' In other words when it is assessed whether the staff during the birth process was negligent or not, the judge should be put in a position by the help of experts and witnesses to be in more or less exactly the same space as the healthcare worker was to determine how he or she should have acted. It can be explained as in the case of *Khonongo v MEC for Health, Eastern Cape* 2023 JDR 4549 (ECB), where the court said at para 36:

> The deviation from employing the recommended standard of treatment (and the unexplained departure therefrom owing to the absence of a factual witness), in circumstances where the defendant's medical and nursing personnel reasonably ought to have foreseen the consequences of the deviation and ought to have taken steps to guard against such consequences, constitutes negligence.

According to McQuoid-Mason and Dada, professional negligence in healthcare occurs when a doctor or nurse fails to meet the expected standards of skill and care, causing harm to a patient. This failure is measured against the standards of a reasonably competent doctor or nurse in their specific field.[141]

As indicated above, the test for professional negligence as it pertains to medical practitioners or nurses is an objective test comparing the conduct of a particular practitioner or nurse to the conduct of the hypothetical reasonable practitioner or nurse in the same circumstances. When a hospital accepts a patient, its staff owes him or

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139 Carstens and Pearmain *Foundational Principles* 619; D McQuoid-Mason 'Medical Professions and Practice' (2008) 17(2) LAWSA part 2.

140 *Mitchell v Dixon* 1914 AD 519 para 525.

141 McQuoid-Mason and Dada *A-Z* 339.

her a duty to attend to and treat him or her with due and proper care and skill. The hospital's medical practitioners or nurses must exercise that degree of care and skill that a reasonable medical practitioner/nurse would ordinarily have exercised in South Africa under similar circumstances.[142]

To be held responsible for another person's loss, a defendant's conduct—whether an act or a failure to act—must be both wrongful and negligent, and said conduct must be the cause of that loss.[143] In South Africa, as indicated earlier, the surge in medical negligence lawsuits threatens the Department of Health's ability to fulfil its constitutional obligations of providing healthcare to citizens, thereby highlighting the need for urgent reforms in developing a specific legislation that will deal with this particular problem.

3.4 The res ipsa loquitur doctrine

The *res ipsa loquitur* doctrine, which translates as 'the thing speaks for itself' or 'the case speaks for itself,' has been a topic of debate in medical negligence cases in South Africa. This doctrine implies that, if an incident occurs under circumstances that would not normally happen without negligence, but there is no direct evidence, an inference of negligence is made.[144]

In medical negligence cases, the doctrine's application has been contentious. Some courts[145] and authors[146] argue that it does not apply, citing *Van Wyk v Lewis* as precedent.[147] However, others propose it as an evidentiary aid that could be developed for such cases.[148] The case of *Goliath v MEC for Health, Eastern Cape* (085/2014) [2014] ZASCA 182 (25 November 2014) appears to have settled the matter. Ponnan

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142 DJ McQuoid-Mason 'What constitutes medical negligence? (2010) 7 Journal of the South African Heart Association 248-251.

143 Carstens and Pearmain *Foundational Principles* 284.

144 Carstens and Pearmain *Foundational Principles* 567; McQuoid-Mason and Dada *A-Z* 359.

145 See for example *Mitchell v. Dixon* 1914 AD 519; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W); *Castell v De Greef* 1994 (4) SA 408 (C).

146 SA Strauss *Doctor, Patient and the Law* (2nd edn Van Schaik 1991) 245.

147 *Van Wyk v Lewis* 1924 AD 438.

148 P van den Heever and N Lawrenson 'Inference of negligence – is it time to jettison the maxim res ipsa loquitur?' [2015] De Rebus; P van den Heever and P Carstens '*Res Ipsa Loquitur* and Medical Negligence: A Comparative Survey' (2011) 22(3) Medical Law Review 450-452; B Patel 'Medical negligence and res ipsa loquitur in South Africa' (2008) 1(2) SAJBL 59; See further *Goliath v Member of the Executive Council for Health, Eastern Cape* 2015 2 SA 97 (SCA) (hereinafter 'the Goliath case') and *Ntsele v MEC for Health, Gauteng Provincial Government* 2013 2 All SA 356 (GSJ).

JA stated that the maxim 'could rarely, if ever, find application in cases based on alleged medical negligence.'[149] This view aligns with Lord Denning MR's statement in Hucks v Cole, where he notes that 'A doctor should not be held negligent simply because something went wrong.'[150]

Instead of relying on *res ipsa loquitur*, courts prefer the expression 'a prima facie case'. Lord Justice Hobhouse explained in the case of *Ratcliffe v Plymouth and Torbay Health Authority* that *res ipsa loquitur* is not a principle of law, but rather, a guide to identify when a *prima facie* case is being made.[151]

In practice, this means that patients bear the burden of proving negligence. The maxim does not apply automatically, as patients must prove the existence of a legal duty owed to him or her; along with breach of that duty; and resulting damages suffered by him or her to establish medical negligence.

3.5 Conclusion

In this chapter the focus was on the legal requirements for medical negligence. As stated already, the law of delict is relevant. Thus, the requirements for a delict have been discussed as well as the test (as it materialised through the courts) for medical negligence. The burden of proof is on the plaintiff or the person alleging the negligence, in most CP cases it is the mother who institutes action on behalf of her minor child who suffers from CP. Whilst the legal requirements for a delict may seem straightforward at first sight, in practice it is very difficult to prove causation. To assist the court, expert witnesses are used, and this comes with its own unique problems as the plaintiff may use certain experts while the defendant uses other, yet they come to completely different conclusions which leave the court with more questions than answers. In the chapter addressing recommendations it is argued that it might be a better option for the judges to use assessors instead of each of the parties using their team of expert witnesses.

What is clear at this stage is that the courts follow the requirements of a delict and they apply the test for causality, but courts have differed in the way in which they approach

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149 The *Goliath case* para 6.

150 *Hucks v Cole* [1968] 118 New LJ 469 ([1993] 4 Med LR 393) as cited by Ponnan JA in the *Goliath* case par 9.

151 *Ratcliffe v Plymouth and Torbay Health Authority* [1998] EWCA Civ 2000 (11 February 1998) as cited by Ponnan JA in the *Goliath* case para 12.

this element of a delict, as will be indicated later. Sometimes causation seems obvious only to be contested, and the court to find that there was no causation between what happened during the birth process and the end result – a child suffering from CP. In the next part of this research attention is given to different court cases and how they interpreted the *DZ* case, but also how they approached causation and/or the other elements of a delict.

CHAPTER 4

CEREBRAL PALSY CASES

4.1 Introduction

In Chapter 2 the possible medical causes of CP were addressed. Chapter 3 highlighted the test for medical negligence and the legal framework under which CP cases fall. This chapter examines the complexities of CP cases and judicial responses, providing context for discussing the court's shortcomings in handling these cases. To address the intricacies of CP cases, South African courts deal with CP cases with sensitivity and consideration of the medical facts involved. The legal teams engage the services of medical experts who assists the court to make unbiased judgements by helping the judges to understand complex issues inherent in these medical matters.

As discussed in the previous chapter, when negligence is suspected, culminating in a child suffering from CP, a case of alleged medical negligence will be taken to court based on a delict, where all the elements of a delict must be proven, namely conduct, wrongfulness, causation, fault, and damages. The plaintiff, usually the mother on behalf of the child in CP cases, bears the onus of proving her case on a balance of probabilities. The merits and the *quantum* of a case ought to be separated according to Rule 33(4) of the Uniform Rules of Court. This means that a plaintiff must prove the merits of the case first, where, if negligence is established by proving all the elements of a delict, the amount of damages claimed will be addressed in a separate case. If the plaintiff does not prove negligence on a balance of probabilities, then it is not necessary to argue the amount of damages claimed and the case is closed. Damages that could be claimed if negligence is proved, include past medical expenses, future medical expenses, loss of amenities of life, pain and suffering and loss of future income. As indicated in the introduction to this research, the *DZ* case[152] opened the ‘door’ for the development of the common law in such a way that damages need not be paid in a lump sum anymore (the “once-and-for-all” rule), and where the state can now offer services and incremental payments for damages suffered depending on the

[152] *MEC for Health and Social Development, Gauteng v DZ* [2017] ZACC 37.

facts of each specific case. In this regard a CC case is discussed, which followed the *DZ* case, although the HC and the SCA adjudicated the matter *before* the *DZ* case.

This chapter focuses on case law. Specific cases were selected based on the extent to which they illustrate the examples and reinforce the key points previously discussed. Notably, they highlight the pivotal role of expert witnesses, including the number of experts engaged and their respective areas of specialisation. In examining these cases, the expert witnesses' involvement and expertise receive focus, without delving into the specifics of their testimonies so as to avoid redundant case summaries. When consensus is lacking in a chosen case, it suggests uncertainty. In such a case, both perspectives, meaning the majority judgement and the minority judgement, will be presented, accompanied by relevant commentary. The primary CC case of *DZ*, will not be revisited, as it has already been thoroughly examined in Chapter 1.

First, CP cases that ended up in the CC will be analysed, followed by cases from the SCA, and then the HCs.

4.2 Case law concerning cerebral palsy in South Africa

4.2.1 Constitutional Court cases

4.2.1.1 *Member of the Executive Council for Health, Gauteng Provincial Government v PN* [2021] ZACC 6 (1 April 2021)

The case of the *Member of the Executive Council for Health, Gauteng, Provincial Government v PN* [2021] ZACC 6 (hereinafter 'the *PN* case') proves to be of relevance as it concerns the interpretation of Moshidi J's judgement in the HC, specifically as to whether it appropriately determines the manner of compensation.[153] The question was asked as to what happens if, in such case that the *quantum* of a CP case and the merits were separated, the judge on the merits finds the defendant 100% liable for the damages suffered, is the manner of compensation then *res judicata*[154] and does it mean that the payment of the damages should be in one lump sum sounding in money as per the 'once-and-for-all' common law rule.[155]

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153 The *PN* case para 1.

154 *Res judicata* means that if a matter has been adjudicated by a competent court it may not be pursued further by the same parties.

155 In the case of *Evins v Shield Insurance Co Ltd* 1980 (2) SA 814 (A) Corbett JA said at 835C: 'Expressed in relation to delictual claims, the rule is to the effect that in general a plaintiff must claim in one action all damages, both already sustained and prospective, flowing from one cause of action.'

The *PN* case involved a claim for damages exceeding R32 million by PN, the mother of a child who suffered from CP due to birth injuries that occurred because of the negligence of the hospital staff at a State healthcare facility.[156] The applicant, the MEC for Health, Gauteng, asked the CC to develop the common law, allowing compensation through public healthcare services (the so-called 'public healthcare defence') or future payments (the 'undertaking to pay defence').[157] She approached the CC because the judgement in the HC was given prior to the judgement in *DZ* which, as indicated in Chapter One, opened the 'door' for the common law to be developed concerning the payment of damages after the merits of a medical negligence case has been proven. The MEC thus wanted the CC to order that the damages ought to be paid by providing services in the public sector, where the monetary aspect ought to be paid in instalments.

To take a step back, Moshidi J's judgement in the HC stated that the MEC had to pay 100% of the plaintiff's agreed or proven damages. The case for the determination of the amount of damages claimed, was heard in another court by Van der Linde J, who stated that the words 'to pay' used by Moshidi J 'were simply language for an order to compensate' the plaintiff.[158] In other words, he felt that how or where the plaintiff ought to be compensated is not necessarily in a lump sum sounding in money. His judgement was overturned by the SCA, who noted that Moshidi J had nothing else than a lump sum payment in mind, when he gave judgement, due to the fact that no plea for the development of the common law was before him at the time. The SCA thus held that Moshidi J's order requires compensation in a lump sum, but that MEC in the appeal to the CC argued that this interpretation limits the development of the common law and affects healthcare obligations.

Reference has also been made to the *DZ* case, in which the CC has already confirmed that the common law may, with the support of '[f]actual evidence to substantiate a carefully pleaded argument', be developed by a court to allow for the public healthcare and undertaking to pay defences.[159] The CC held that the fact that the judgment in *DZ*

156 The *PN* case para 2.
157 The *PN* case paras 3-4.
158 The *PN* case para 7.
159 The *PN* case para 26.

had not yet been handed down at the time Moshidi J granted his order bears no relevance. This is because a development of the common law was always open to courts under sections 39(2) and 173 of the Constitution. Additionally, in terms of section 172(1)(b) of the Constitution, courts deciding constitutional matters are afforded a wide discretion to grant any just and equitable remedy.[160]

The CC thus in the *PN* case upheld the appeal, setting aside the SCA's order. The CC judges unanimously decided that the word 'pay' in the HC order did not necessarily mean that compensation had to be paid in a single lump sum of money. Instead, it left room for alternative compensation methods, such as the provision of physical items or medical services through the public healthcare sector. The Court's decision provides flexibility in compensation for medical negligence cases, considering the needs of the claimant and the capabilities of the public healthcare sector. Madlanga J for the CC also emphasised that the Constitution guarantees in section 27 that everyone has the right of access to healthcare, while section 28(1)(c) gives every child the right to basic healthcare services. If R32 million is spent on one child, other healthcare services may suffer. An extract of an article was quoted in the case, stating the following:

> The most worrying consequence of the excessive medical malpractice litigation against the state is that it may potentially undermine the department of health's ability to provide public healthcare in future… In other words, the problem is that an already overwhelmed and underfinanced public healthcare sector is exposed to the ever-increasing amounts of malpractice claims.[161]

The CC's decision is a significant win for fairness, healthcare access, and the development of the common law in South Africa. By upholding the 'public health defence', as elucidated in the *DZ* case, the court reaffirms that everyone has the right to access healthcare services. This defence is crucial in ensuring that medical facilities and professionals prioritise patient care over financial concerns.

In this specific case, paying a lump sum of R32 million would severely impact the Department's annual budget, likely crippling its ability to deliver essential services to

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160 The Constitution s 172(1).

161 The *PN* case para 28. See also B Wessels 'The expansion of the state's liability for harm arising from medical malpractice: Underlying reasons, deleterious consequences and potential reform' (2019) 1 TSAR 15.

the citizenry. The court's unanimous judgment prevents this financial burden, thereby safeguarding the well-being of the broader population.

It is worth noting that the CC plays a vital role in shaping the country's legal landscape. As the highest court in South Africa, it has the power to decide on constitutional matters and other cases that raise important points of law. Its decisions have far-reaching implications, influencing the development of the common law and ensuring that the rights enshrined in the Constitution are protected.

4.2.1.2 *NVM obo VKM v Tembisa Hospital* [2022] ZACC 11

The case of *NVM obo VKM v Tembisa Hospital* [2022] ZACC 11 (hereinafter 'the *Tembisa* case'), is of interest here as it concerns CP, however, the justices of the CC were not *ad idem*. Majiedt J gave the minority judgement supported by three justices. Rogers AJ gave the majority judgement supported by four justices and the then Acting Chief Justice, Zondo. This is significant as it clearly illustrates that there is no clarity in medical negligence cases concerning CP, and the interpretation of facts may differ to indicate the uncertainty in the field of medicine, even more so in the context of CP.

The case in the High Court

In the HC case,[162] a mother claimed that the negligent omission by medical staff at Tembisa Hospital caused her baby to be born with CP. The mother was admitted to the hospital on 3 April 2009, and gave birth naturally at 05:10 on 4 April 2009, despite being diagnosed with cephalic-pelvic disproportion which required a caesarean section. The midwives did not record any monitoring of the foetal heart after 03:15 and when they ultimately realised the foetus was under stress, it was too late to perform a caesarean section.[163]

The case in the HC was only concerning causation, as the MEC accepted that there was negligence in that the midwives did not monitor the foetal heart rate consistently. A case is not won if all the elements of a delict are not proven on a balance of probabilities as stated earlier. The fact that the State accepted that they were negligent did not finalise the matter, as all elements of a delict had to be proven, of which

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162 *NVM obo VKM v Tembisa Hospital*, unreported judgement of the High Court of South Africa, Gauteng Local Division, Case No 14/26684 (24 March 2017).

163 The *Tembisa* case para 53.

causation was the most difficult. There was a need for proof, indicating that the omission, that is – a failure to monitor the foetus regularly on the part of the medical staff – caused CP. The HC paid particular attention to the unchallenged expert evidence of Doctor Pistorius (an obstetrician and maternal foetal medicine specialist) and Professor Kirsten (a neonatologist) who testified on behalf of the plaintiff.[164] The HC concluded that, with proper monitoring, the staff would have detected the warning signs that the baby was in distress earlier, and if they then applied the necessary emergency measures, the baby would not have had brain damage. The Court thus ruled in favour of the mother, finding that the hospital's negligent omission caused the baby's CP.

The appeal

The respondents appealed (with permission) the outcome in the HC to the Full Bench.[165] The Full Court stated that they basically had to decide on the following criteria:

> …had there been adequate monitoring, warning signs would have been picked up and that there was then enough time to engage proper emergency measures which would have avoided the brain injury.[166]

The Full Court argued that, from the point of foetal distress being discovered, there was *not* enough time for a caesarean section. They therefore said the Court *a quo* erred in incorrectly applying the 'but for' test. They ought to have applied the 'but for' test differently. There was not enough time from the time a decision to perform a caesarean section was taken, to actually performing it. It was thus not possible to perform a caesarean section quickly enough to prevent neurological *sequelae* of an acute profound hypoxic event.[167] The Full Court concluded that the plaintiff did not show that the negligence *caused* the child's condition; 'the circumstances that caused the cerebral palsy occurred too late to have taken steps that would as a matter of probability have prevented the cerebral palsy.'[168]

The Constitutional Court judgement

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164 The *Tembisa* case para 8.
165 *Tembisa Hospital v MN obo VK*, unreported judgement of the High Court of South Africa, Gauteng Local Division, Johannesburg, Case No A5010/2018 (20 September 2019).
166 The *Tembisa* case para 15.
167 The *Tembisa* case para 17.
168 The *Tembisa* case para 19.

VKM's mother then appealed to the CC. She argued that the HC applied the 'but for' test correctly and the Full Court 'obfuscated the test in its approach.'[169] The MEC and Tembisa Hospital argued that the Full Court were right, as the hospital could not have prevented the brain damage, even if the foetal heart rate had been monitored correctly.[170] The CC stated that there are two requirements to be met before leave to appeal in the CC could be allowed. First, it must be established that the matter falls within the jurisdiction of the Court in the sense that it raises a constitutional issue or an arguable point of law of general public importance. Secondly, the interests of justice must warrant the granting of leave to appeal.[171]

The minority judgment, penned by Majiedt J, found that the case implicated healthcare rights guaranteed by section 27 of the Constitution and raised important questions about the flexibility of the test for factual causation in CP cases. The judgment held that this case *is* a constitutional matter, because it implicates the healthcare rights guaranteed by section 27 of the Constitution and the state's related duty under section 7(2) to respect, protect, promote and fulfil the rights in the Bill of Rights.

The minority judgement stated that:

> The legal question goes beyond the ordinary application of factual causation, since what must be considered is the flexibility of the test for factual causation, and how it may be used to accommodate a set of facts that is inherently subject to uncertainty. Cases of medical negligence involve such facts, given the great uncertainty that exists in any – or at least many – medical treatment cases… This legal question – concerning the flexibility of the test for factual causation – is closely connected to the right of access to healthcare service in this case… questions of medical negligence in state-operated hospitals that implicate the rights of women and children to healthcare and the rights of new-born babies to have their best interests protected, certainly engage this Court's jurisdiction.[172]

The minority judgment thus held that this matter raises an arguable point of law insofar as the Court is required to consider important questions on the need to consider the flexibility of the test for factual causation, particularly considering the differing approaches adopted by our courts in CP cases.

169 The *Tembisa* case para 20.
170 The *Tembisa* case para 30.
171 The *Tembisa* case para 31.
172 The *Tembisa* case paras 44-46.

On the merits, the minority judgment held that the applicant adduced sufficient evidence to prove factual causation, in the context of a harm which is replete with uncertainties. They reasoned that in the absence of any countervailing evidence from the respondents, the unchallenged evidence of the applicant's medical experts, particularly that of Professor Kirsten and Doctor Pistorius, together with the admitted facts and the joint minute of the obstetricians, the applicant's claim for damages was proven. They further held that the negligent failure by the hospital staff to conduct adequate monitoring of the foetal heart rate during the critical period, denied them the opportunity to detect the warning signs of the onset of hypoxia. That, in turn, resulted in the failure to take emergency measures to afford the foetus more time until a caesarean section could be arranged.

In contrast, the CC majority judgment, written by Rogers AJ, held that the Court's jurisdiction was *not* engaged, as the case did not raise a constitutional issue, or an arguable point of law. The majority judgment emphasised that the Court does not have jurisdiction to decide purely factual matters, even if a lower court has made an error or gone badly wrong on the facts. It further emphasised that the Court could analyse evidence and make factual findings where a determination of such facts was reasonably necessary in order to answer or to give a practical effect to the Court's decision on a constitutional matter or on an arguable point of law; but not otherwise. It cited authority relating to its constitutional jurisdiction, confirming that it will only engage in contested factual issues if they are 'connected with a well-grounded constitutional issue.'[173]

The majority disagreed with the minority judgment's reliance on sections 27 and 7(2) of the Constitution, and on the proposition that accountability and responsiveness in a healthcare system raised constitutional issues pertaining to medical negligence in public hospitals, implicating the 'rights of women and children'. They explained that wrongfulness and negligence were not in issue. The question was one of factual causation. They found that sections 7(2) and 27, and considerations of accountability and responsiveness, shed no light on the answer to that question. They further held

[173] The *Tembisa* case paras 88-89.

that, if section 27 were implicated in the present case, it would apply to every medical negligence case, even though the issues raised by the case were purely factual.

Finally, the majority judgment disagreed with the minority judgment that the application of the test for factual causation in medical negligence cases raised an arguable point of law with constitutional implications. They explained that difficult or borderline cases of factual causation can arise in any kind of case for delictual or contractual damages. Conversely, they found that factual causation is often straightforward in medical negligence cases. They further found that the application of an established test to particular facts is not a question of law. For these reasons, the majority judgment held that the Court's jurisdiction was not engaged. This made it unnecessary to discuss the merits.[174]

The *Tembisa* case was selected for consideration as part of this research as it underscores the difficulties inherent to CP cases. While the main issue in the *Tembisa* case was whether or not it should be allowed in the CC or not, it also draws attention to the original two cases that preceded the CC case. In the HC case, medical experts were used to help the court understand CP. Testimony from medical experts, including obstetricians and paediatricians were utilised, to establish the standard of care expected during childbirth and whether the hospital's actions deviated from this standard. The neonatologists helped with the clarification of the causes and timing of the child's brain damage, and radiologists analysed the brain imaging done after birth to assess foetal distress and potential injuries. Neurologists explained the nature and extent of the child's CP and its correlation with birth events.

From a personal point of view, I support the minority judgment as it advocated for a more nuanced approach to causation, considering the complexities of CP cases, and thereby recognising the potential for multiple contributing factors, which often contribute to harm and the need for a more just outcome for victims. The minority judgement proposed a less rigid application of the 'but-for' test, allowing for the consideration of multiple factors contributing to the harm. They also suggested that, in certain cases, an inference of causation could be drawn from the hospital's breach of

174 See also *TM obo MM v Member of the Executive Council for Health and Social Development, Gauteng* [2022] ZACC 18 - a case of CP that ended up in the CC - a unanimous judgement was given by the CC that the facts did not invoke the jurisdiction of the CC.

duty, even if direct evidence was lacking. The minority judgement finally also recognised constitutional elements in the case, specifically the right to access to healthcare and the rights of children, which I argue ought to be included in the consideration of CP cases.

4.2.2 Supreme Court of Appeal cases[175]

4.2.2.1 *AN v MEC for Health, Eastern Cape* (585/2018) [2019] ZASCA 102

This matter originated in the HC before Dawood J who found that the mother (plaintiff) did not prove that the negligent failure to monitor the mother and foetus caused the damage to the baby.[176] The Supreme Court of Appeal (SCA) made a significant ruling in the case of *AN v MEC for Health, Eastern Cape* (585/2018) [2019] ZASCA 102 (15 August 2019) (hereinafter 'the *AN* case'). The judgement was not unanimous, where four judges gave the majority judgement and Molema JA gave a dissenting judgement, once again underscoring the intricate nature of the issues requiring consideration in CP cases.

AN was admitted to hospital on 2 October 2013. She was expecting her first child, and she had slightly exceeded full term. The delivery appeared uncomplicated until staff noticed the Apgar scores of the baby were low and there was a possibility of damage[177] to the newborn. The Apgar score is a quick assessment that doctors and nurses use to see how well a newborn baby is doing immediately after birth, typically at one minute and five minutes after delivery. It evaluates five key aspects, namely : the baby's skin colour viz whether pink all over or slightly blue; their heart rate to determine its strength

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175 See also the following cases: *The Member of the Executive Council for Health, Eastern Cape v Zimbini Mpetsheni obo Luyanda Mpetsheni* (576/2019) [2020] ZASCA 169 (14 December 2020) – appeal upheld; *MEC of Health and Social Development of the Gauteng Provincial Government v M* (272/2022) [2024] ZASCA 21 (05 March 2024) – appeal upheld; *The MEC for Health & Social Development, Gauteng v TM obo MM* (380/2019) [2021] ZASCA 110 (10 August 2021) – appeal upheld; *MEC for Health, Western Cape v Q* (928/2017) [2018] ZASCA 132 (28 September 2028) – appeal upheld; *Magqeya v MEC for Health, Eastern Cape* (699/17) [2018] ZASCA 141 (1 October 2018) – appeal dismissed; *The Member of the Executive Council for Health, Eastern Cape v DL obo AL* (117/2020) [2021] ZASCA 68 (03 June 2021) – appeal upheld; *MEC for Health and Social Development, Gauteng v MM obo OM* (697/2020) [2021] ZASCA 128 (30 September 2021) – appeal dismissed; *The Member of the Executive Council, Department of Health, North West v NAM obo TN* (035/2020) [2021] ZASCA 105 (26 July 2021) – appeal upheld; *MM v MEC for Health, Eastern Cape* (580/2022) [2023] ZASCA 130 (11 October 2023) – appeal dismissed.

176 The *AN* case para 2.

177 The *AN* case para 9.

and regularity; their reflexes by seeing how they respond to gentle stimulation, their muscle tone based on how actively they move, and their breathing to determine if they are crying strongly or struggling. Each area is given a score from zero to two, and all the scores are added together for a total up to ten, which means the baby is in excellent condition. Even lower scores can be completely fine - this just helps the medical team know whether the baby needs any immediate care. The baby in the *AN* case needed care and it was established he was born with CP due to an acute profound hypoxic ischaemic (a sudden insult) event cutting the blood flow to the foetus.[178]

Damages were claimed on behalf of the baby who suffered brain damage during birth due to alleged negligence on the part of hospital staff at All Saints Hospital in Engcobo, a state facility. The negligence emanated from the hospital staff's failure to properly monitor the mother and foetus during labour, thus constituting an omission. The main issue was whether the hospital staff's negligence directly caused the brain damage.[179] The judges reviewed the legal framework for establishing factual causation in such cases, referencing relevant case law such as *Lee v Minister for Correctional Services* 2013 (2) SA 144 (CC) addressing factual causation and *Mashongwa v Passenger Rail Agency of South Africa* 2016 (3) SA 528 (CC) addressing wrongfulness.[180] The court examined the medical evidence presented by experts, including the cause of the brain damage (acute profound hypoxic-ischaemic insult) and the sudden, total, and persistent interruption of blood supply to the brain, likely due to cord compression (referred to as a sentinel event). The experts reached a consensus that the damage occurred during the second stage of active labour. They further agreed that the sentinel event was the direct cause of the damage. Importantly, they noted that cord compression cannot be detected after the fact, making it a critical aspect to monitor a foetus during labour. To mitigate the risk of damage, the experts emphasised that expedited delivery via vacuum extraction was the most effective course of action.

The experts *disagreed* on two crucial points, which were: (1) whether there would have been warning signs of a sudden interruption to the blood supply; and (2) if no warnings

178 The *AN* case para 9.
179 The *AN* case para 1.
180 The *AN* case paras 3-8.

were present, whether an expedited delivery could have prevented the brain damage.[181]

The appellant's experts argued that monitoring would have detected warning signs, allowing for expedited delivery and prevention of damage. However, this opinion was speculative and contradicted by peer-reviewed literature as the literature suggests that foetal monitoring may not detect sentinel events as sentinel events can occur without warning and damage from sentinel events happens rapidly.[182] Given these findings, it proves unlikely that an expedited delivery would have prevented damage. The exact timing of the sentinel event could not be determined, and damage often occurs within 10-22 minutes. The majority of judges thus concluded that the appellant failed to prove that monitoring would have detected warning signs; an expedited delivery could not have prevented damage and the respondent's negligence did not directly cause the brain damage. The judges agreed that while the hospital staff was grossly negligent in monitoring the mother and foetus during delivery, the negligence didn't directly cause the brain damage. The interruption in blood supply to the foetus was sudden, total, and persistent, resulting in a complete lack of oxygen to the foetal brain. They ruled that timely intervention through an emergency delivery couldn't have prevented the damage and the appeal was dismissed.

Minority judgement

However, in a minority judgement Molema JA disagreed, arguing that causation had been proven, and the appeal should thus succeed. The judge concurred with the main judgment's finding of wrongdoing but disagreed with its conclusion on causation. This once again underscores the difficulty of proving all the elements of a delict in alleged negligence in CP cases. In my support of the minority judgement, certain aspects of the judgement by Molema JA will be highlighted henceforth.

The test for negligence requires reasonable foreseeability and preventability of damage. The Maternity Guidelines 2007 emphasise close monitoring of women in labour. The Guidelines outline procedures for managing the second stage of labour and foetal distress (as discussed in chapter 2 of this thesis). The appellant's evidence

181 The *AN* case para 19.
182 The *AN* case para 24.

showed that her labour was inadequately monitored, particularly the foetal heart rate against uterine contractions. The nurses' actions fell short of the applicable standards. The appellant's evidence indicated that she experienced severe pain and requested a caesarean section, which was dismissed. She was left unattended during labour, and the foetal heart rate was not monitored. A cleaning staff member raised alarm when noticing the baby's head stuck in the vaginal opening.[183] Molema JA thus found that the hospital staff were negligent, and that the appellant proved it on a balance of probabilities.[184] However, wrongful conduct must cause the wronged person to suffer loss as pointed out at the beginning of the case.[185]

Concerning causation, the judge stated the following: [t]he issue is whether the hospital staff's negligence caused the baby's brain damage leading to CP. In other words, the appellant must prove *a causal link* between the negligence and the harm.[186] It was undisputed that the appellant received substandard care. Professor Smith's evidence excluded congenital factors or genetic abnormalities, and no evidence suggested interventions were impossible or unsuccessful. The judge cited the precedents for the 'but for' test as discussed in the *Van Duivenboden*[187] case, the *Gore*[188] case, the *Lee*[189] case and the *Mashongwa*[190] case, emphasising that a plaintiff need not establish causation with certainty, but rather show it was probable and the 'but-for' test only assesses whether the harm would have occurred without the negligence. Causation thus depends on whether the harmful conduct is closely connected to the harm. The minority judgement represented the decision that causation in this case had been proven and that the appeal ought to have been successful.

Expert witnesses

This case is also relevant to this research if the roles of the experts in this case are analysed according to the directions given to evaluate expert evidence in *Michael and*

183 The *AN* case paras 34-46.
184 The *AN* case para 46.
185 The *AN* case para 3.
186 The *AN* case para 47.
187 *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 25.
188 *Minister of Finance and others v Gore NO* 2007 (1) SA 111 (SCA) para 33.
189 *Lee v Minister for Correctional Services* 2013 (2) SA 144 (CC) para 40.
190 *Mashongwa v Passenger Rail Agency of South Africa* 2016 (3) SA 528 (CC) para 65.

Another v Linksfield Park Clinic (Pty) Ltd and Another (1) (361/98) [2001] ZASCA 12 (13 March 2011) (hereinafter 'the *Linksfield* case'). According to the *Linksfield* case, expert evidence, which are mostly opinions, must be relevant and based on a logical foundation.[191] In other words the court should assess whether expert opinions are logically reasoned and founded on facts. If one analyses the experts in the *AN* case the following is significant:

The evidence of Doctor Murray, a senior specialist obstetrician and gynaecologist at Tygerberg Hospital and a lecturer at the Department of Obstetrics and Gynaecology at Stellenbosch University, testified for the appellant. She explained that the decelerations of the foetal heart rate occur during contractions and the heart rate should be taken before, during and after each contraction or every five minutes.[192] Note should be taken that the foetal heart rate is usually monitored by cardiotocographs (CTG's), but that the hospital did not have these and monitoring was done by auscultation.[193] She also pointed out that, when it comes to labour, every minute counts, and that even in the face of a sentinel event, attempts ought to be made to mitigate the risk of harm to both the mother and the baby.[194]

Both parties accepted the report by Professor Andronikou who interpreted the Magnetic Resonance Imaging (MRI) scan of the baby's brain. The professor concluded that there was an insult to the brain due to a hypoxic ischaemic injury of an acute and profound nature, meaning a sudden total, persistent lack of blood supply to the brain. The professor continued to note that if there is cord compression, the mother ought to be turned on her side to relieve the pressure on the umbilical cord, where the head had already engaged in the pelvis a vacuum extraction or forceps delivery should be done. Professor Buchmann agreed with this view.[195]

The evidence of Professor van Toorn, Head of Paediatric Neurology at Tygerberg Children's Hospital and Stellenbosch University, testified that '[d]uring labour, the blood to the brain is supplied from the placenta along the umbilical cord. If there is an

191 The *Linksfield* case paras 34-40.
192 The *AN* case para 12.
193 The *AN* case para 10.
194 The *AN* case para 41.
195 The *AN* case paras 13 and 15.

inadequate supply of oxygen, the brain shunts the limited blood from the peripheries to the deep grey matter.'[196] He further pointed out that the MRI scan showed only damage to the grey matter of the baby's brain.[197] It was his contention that if monitoring had taken place, as prescribed, the warning signs would have been detected and the damage could have been avoided.[198] The majority of judges did not agree with him and held that "[h]is opinion that… warnings would have been observed if proper monitoring had been carried out, does not hold water."[199]

The dissenting judgement by Molema JA favoured Professor van Toorn's opinion as his views were supported by the conclusion of Doctor Murray and his opinions were corroborated by published articles on animal models, human studies and practical experience.[200]

Professor Smith, a neonatologist, conceded that a cord compression results in a sudden, total interruption of blood supply to the foetus and could be referred to as a sentinel event.[201]

Professor Buchmann, an obstetrician testified that the sentinel event probably occurred 30 minutes prior to the birth of the baby which means there would not have been sufficient time to deliver the baby and avoid the damages suffered.[202] Molema JA pointed out that Professor Buchmann stated in one of his articles that '[w]omen who are pushing in the second stage of labour should not be left alone, and foetal heart rate auscultation must be done after each contraction to confirm return to baseline. This will allow early detection of foetal bradycardia so that appropriate action can be taken.'[203] Yet, he claimed a basal ganglia injury, despite Dr. Andronikou's report not mentioning it and therefore exceeded expertise in radiology, leading to speculative opinions.[204]

196 The *AN* case para 13.
197 The *AN* case para 14.
198 The *AN* case para 20.
199 The *AN* case para 21.
200 The *AN* case paras 53-55.
201 The *AN* case para 16.
202 The *AN* case paras 24-25.
203 The *AN* case para 42.
204 The *AN* case para 62.

As indicated earlier, the experts agreed that a sentinel event caused the brain damage, but they differed on whether the brain damage could have been prevented.[205] The minority judgement believed the hospital staff's negligence led to inadequate monitoring. The appellant's evidence, Dr. Murray's testimony, and Prof. Buchmann's article demonstrated that proper monitoring could have prevented the brain injury hence the appeal should have succeeded.

Both judgments condemned the hospital's negligence, highlighting a pattern of gross negligence in the department. The court expressed concern about pervasive negligence in hospitals under the respondent's jurisdiction, emphasising the need for urgent remedial action. The SCA directed that the judgment be forwarded to the relevant authorities, including the National Minister of Health, in the hope of urgently addressing this critical issue. This ruling underscore the importance of proper medical care and attention during childbirth. It also highlights the need for accountability and improvement in healthcare services to prevent such incidents in the future. Despite the respondent's success, no costs award was made against the appellant. The appeal was dismissed.

I concur with Molema JA's minority judgment, and my agreement is rooted in several key aspects of her ruling. Firstly, Judge Molema convincingly established a causal link between the hospital staff's negligence and the baby's brain injury, demonstrating that proper monitoring and management would have likely prevented the injury. Furthermore, Judge Molema's critical evaluation of expert testimony was instrumental in shaping her judgment. She astutely highlighted the limitations of Professor Buchmann's expertise in radiology, while also acknowledging the credible evidence presented by Professor van Toorn. This analysis lends significant support to the conclusion that the injury was indeed preventable.

Judge Molema also emphasised the importance of adhering to established guidelines and protocols during labour. The judge’s examination of the case revealed that deviations from these standards resulted in substandard care, which further reinforces the causal link between negligence and injury. In addition, Judge Molema correctly applied the ‘balance of probabilities’ standard, concluding that the appellant's evidence

[205] The *AN* case paras 17-19.

and expert testimony collectively establish a sufficient connection between negligence and injury. Ultimately, Judge Molema's judgment is characterised by well-reasoned and methodical analysis, as she meticulously addresses each point of contention and provides clear explanations to support her conclusions, hence Judge Molema's minority judgment presents a compelling case for holding the hospital staff liable for the baby's injury, emphasising the importance of adequate medical care and adherence to established guidelines, but unfortunately the majority judgement stands and once again emphasises the complexities of CP cases.

4.2.2.2 *The MEC for Health and Social Development, Gauteng v TM obo MM* (380/2019) [2021] ZASCA 110

The case of the *MEC for Health and Social Development, Gauteng v TM obo MM* (380/2019) [2021] ZASCA 110 (10 August 2021) his case (hereinafter 'the *TM* case') was selected as it once again did not have a unanimous judgement. The majority judgement included three judges of appeal, and the minority judgement was given by two dissenting judges. The case concerns CP due to alleged negligence of hospital staff during a baby's birth. The child suffered permanent brain damage due to lack of oxygen during delivery. Although the HC ruled in favour of the plaintiff, the SCA overturned the decision. The main arguments centred around the hospital's duty of care, operational theatre capacity, and staffing shortages.

TM (25) was pregnant with her child MM and there were no complications with her pregnancy. On 30 July 2010 her blood pressure was taken by a clinic, and the foetal heart rate was checked. She had to go to the clinic again on 20 August, but the nurses were on strike. She went again on 27 August, but the clinic was still closed. On the same day she experienced abdominal pains and was admitted to the maternity section of the Charlotte Maxeke Hospital – a public facility. According to the records, she was in her early active stage of labour. The CTG readings were normal but at 15:45 it showed abnormalities, and a decision was taken to perform a C-section at 16:00.[206] The C-section could not be performed immediately as another patient was in theatre and yet *another* patient was scheduled for a C-section before TM. TM was therefore third in the row. TM's C-section only commenced about two and a quarter hours after

[206] The *TM* case para 9.

the decision for a C-section was taken.[207] The baby suffered an intrapartum hypoxic-ischaemic injury which resulted in CP.

High Court case

The HC had to address the following questions: (a) whether the plaintiff herself was negligent (by not going to another clinic when the nurses at the clinic she visited earlier were on strike); (b) whether the negligence was the cause of the outcome and contributed to the outcome; (c) whether the staff were negligent and (d) whether both the plaintiff and defendant were liable for the outcome.[208]

The plaintiff testified herself and two experts gave opinions on her behalf, they were Doctor Murray, a specialist obstetrician and gynaecologist and Professor Smith, a paediatrician and neonatologist. Three specialists testified for the MEC, namely Doctor Chauke, an obstetrician and gynaecologist specialising in maternal and foetal medicine, Doctor Marishane, a specialist gynaecologist and obstetrician, and Doctor Bolton, a paediatrician.[209]

Appeal issues

The brain injury to the baby happened in the public healthcare system, highlighting concerns about resource constraints, staffing, and quality of care. The case also focused on the critical area of maternal and child health, where timely and adequate medical care is essential. The claim alleged substandard care, emphasising the need for accountability and improved healthcare standards. The allegations of negligence were the failure to employ suitable medical practitioners and nursing staff, inadequate equipment for the performance of a timely C-section and the failure to ensure proper patient assessment, monitoring, and management of the labour.

The MEC denied negligence and claimed contributory negligence on TM's part, but the court rejected this argument since TM sought damages on behalf of her child, and contributory negligence cannot be applied to a child *in utero*.[210] The MEC's main issue was that she was not responsible for negligence occurring before the plaintiff's

207 The *TM* case para 10.
208 The *TM* case para 13.
209 The *TM* case para 14.
210 The *TM* case para 5.

admission as a patient in hospital. She also denied being responsible for the sub-optimal theatre use and that poor resource management constitutes negligent conduct.[211]

The dissenting judges, Ledwaba AJA and Saldulker JA, argued that the appeal should have been dismissed due to the negligence displayed by the hospital staff. They argued that the duty of care only arose when TM was admitted to the hospital at 12:55, referencing the case of *AN v MEC for Health, Eastern Cape* [2019] ZASCA 102.

The judges accepted Doctor Chauke's explanation for having only one operational operating theatre due to budgetary constraints, citing *Soobramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17. They noted that patients were taken to theatre on a 'first come first served basis' without assessing urgency.[212]

The judges emphasised the importance of prioritising C-sections, preferably by a senior doctor. However, no records showed that Doctor Sibeko evaluated emergencies, and Doctor Chauke testified that the principle in obstetric care prioritises the mother's health.[213]

The MEC's team admitted to owing TM a duty of care, but medical records showed no effort to improve her condition while waiting for the C-section. Expert witnesses testified that this omission indicated substandard care.

The judges believed that negligence occurred between the decision to perform the C-section and the actual procedure. They referred to *Moshongwa v PRASA* [2015] ZACC 36, stating that the standard for determining negligence differs between individuals and state organs.

The judges suggested that the hospital should have checked with other hospitals for assistance, citing the un-amended Hospital's Policy for Admission of Patients from Casualty. They also referenced the Guidelines for Maternity Care in SA 2007, which states that C-sections should be performed as soon as reasonably possible.[214]

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211 The *TM* case para 6.
212 The *TM* case para 25.
213 The *TM* case para 27.
214 The *TM* case para 34.

The judgment in the *TM* case was influenced by several key factors. The judges criticized TM's legal team for inadequate pleadings, taking a “scattergun approach” and lacking knowledge of the facts when the summons was issued in June 2014. Furthermore, the lack of expert opinion, aside from Doctor Andronikou’s report, which did not link the baby’s condition to negligence, was a significant issue.

The judges also noted that certain issues, such as the non-utilisation of the second theatre, downtime issues, and referral issues, were not specifically pleaded, making it challenging for them to consider these factors. Additionally, the evidence presented was deemed insufficient to conclude that the MEC was negligent in having only one functioning maternity theatre or that the baby would have been delivered sooner if transferred.

The complexity of medical decision-making was highlighted by the differing views of Professor Bolton and Professor Smith on the CTG readings. The judges emphasised the importance of maintaining accurate medical records, citing section 13 of the National Health Act 61 of 2003.

The expert opinions presented in the case were also contradictory. Professor Smith stated that MM's brain injury likely occurred during the last hour of labour, while Doctor Marishane disagreed with this “final-hour hypothesis,” citing uncertainty about when the damage occurred. Professor Bolton rejected the analogy of a foetus succumbing to hypoxia over time, stating that it was inconsistent with an acute-profound insult.

The court faced significant challenges in establishing causation due to unclear timing of the injury, disagreements among experts, a lack of evidence on key issues, and the complexity of obstetric care and brain injury mechanisms. Ultimately, the judges concluded that TM failed to prove that the baby would not have suffered from CP if the C-section had been performed sooner.

The ‘but-for’ test, also known as the causation test, determines whether a defendant’s negligence caused the plaintiff’s harm. It asks whether the plaintiff’s harm would not have ensued but for the defendant’s wrongful and negligent conduct. This test is based on common sense and everyday life experiences; however, the plaintiff must establish that, more likely than not, the harm would not have occurred without the defendant’s negligence.

If applied correctly, the 'but-for' test could have potentially led to a successful claim for TM. However, her legal team's incorrect allegations and pleadings hindered this. The *TM* case highlights the importance of effective legal representation and thorough preparation in medical negligence cases, particularly those involving complex conditions like CP.

To improve outcomes and achieve justice, the legal and medical communities must address issues like vague and generic claims, better research on scientific causes, and thorough discovery of records. Improved expert witness briefing is also crucial. By addressing these concerns and implementing reforms, families like TM's can receive better service, leading to improved outcomes and justice.

4.2.3 High Court cases

4.2.3.1 *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* (4314/15) [2019] ZAGPJHC 504

In the *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* (4314/15) [2019] ZAGPJHC 504 (18 December 2019) (hereinafter 'the *MSM* case') the High Court (HC), Gauteng Local Division, Johannesburg, heard a case involving medical negligence in a public hospital that resulted in a child, K, suffering from CP. The plaintiff, K's mother, sought damages for amongst others, future medical expenses. The defendant, the MEC for Health, argued that instead of paying damages in full, the court should order the public hospital to provide K's future medical needs. The MEC also proposed periodic payments instead of a lump sum.[215] The court considered the CC's judgment in the *DZ* case and decided to develop the common law in *this* case to allow for compensation in kind. This means that instead of monetary damages, the hospital would provide medical services in future to the child.

The court discussed the 'public healthcare defence', which allows defendants to argue that public healthcare is equally as effective and moreover cheaper than private

[215] The *MSM* case para 4.2.

healthcare. The court also recognised the need to balance the interests of justice with the depletion of public healthcare resources. The court provided guidelines for developing the common law, considering the context of the case, evaluating whether the existing common law rule offends the Constitution or wider interests of justice, and assessing the wider consequences of the proposed change. The court heard testimony from various witnesses, including Ms. Bogoshi, the CEO of Charlotte Maxeke Johannesburg Academic Hospital, who testified that the hospital *could* provide the necessary services to K, including speech therapy, physiotherapy, and occupational therapy. Doctor Medupe Modisane, the Acting Deputy Director General: Hospital Services, Gauteng Department of Health, also testified about the department's plan to provide services to CP patients and the availability of resources.

Doctor Thomson, a specialist at the Neurodevelopmental Clinic, described the clinic's multidisciplinary approach to treating CP patients and confirmed that K would receive priority treatment. Professor Robertson, an orthopaedic specialist, outlined the Orthopaedic Unit's capacity to provide regular monitoring and surgical interventions. Doctor Mohamed, a psychiatrist, described the psychiatric services available at the hospital and confirmed that K would receive excellent treatment.

Other witnesses included Doctor Ahmed, a urologist, who confirmed that the hospital offers urodynamic studies, catheters, and equipment; Doctor Patel, a dentist, who described the Wits Oral Health Clinic's specialised treatment and teaching unit; and Doctor Makualele, an ear, nose, and throat specialist, who discussed treatment options for hyper salivation.

The witnesses were also cross-examined, with Ms. Bogoshi being questioned about planning for the public healthcare defence, and the hospital's ability to provide required services. Doctor Modisane was questioned about the lack of a written policy framework, implementation of the plan, and resource allocation. Doctor Mohamed was questioned about how K would receive priority treatment at the Child and Adolescent Family Unit.

The court found that Charlotte Maxeke Hospital had the capacity to provide comprehensive care to K, with specialised units and equipment available. The court also found that the MEC had established that the hospital *can* provide the necessary

services, and that there was merit in the MEC's plea not to order private sector payments.

The court thus developed the common law to permit compensation in kind, rather than only monetary compensation in this specific case. The court therefore ordered the defendant to provide treatment in kind and lump sum payments for non-identified services.

The implications of the judgment include strengthening arguments against the sole application of the “once and for all” rule, highlighting administrative difficulties in implementing alternative compensation methods, and emphasising the need for effective planning, cost analysis, and scalability. The court’s order encompassed the development of the common law for compensation in kind, the direction to the MEC to provide identified services at a public hospital, the instruction to the MEC to pay a lump sum for non-identified services and damages, and the establishment of a way for the plaintiff to seek an alternative order if the MEC fails to provide services.

This case is of great importance in the CP debate, yet one should not forget that this is only *one* case and *one* child, that according to testimony would receive excellent services in the public health sector. One cannot avoid raising the question regarding all the other victims. Would each CP case entail a case of this magnitude to get services at the appropriate level from the State? The future will only learn, but it is my contention that this is not viable due to the administrative burden to follow the child through his or her whole life to see whether he or she is getting the right medical treatment needed for his or her condition.

4.2.3.2 *TN obo BN v Member of the Executive Council for Health, Eastern Cape* (36/2017) [2023] ZAECBHC 3

The Eastern Cape High Court in Bisho heard a case involving severe birth injuries to a baby during birth. He is now 11 years old. The injuries were due to alleged negligence at a public hospital. BN suffers from CP, intellectual impairments, epilepsy, and other disabilities. His mother, TN, sought compensation for his lifelong medical expenses.

At the crux of the case *TN obo BN v Member of the Executive for Health, Eastern Cape* (36/2017) [2023] ZAECBHC (7 February 2023) (hereinafter ‘the *TN* case’) lies a

contentious debate surrounding the defendant's proposed 'public healthcare remedy' and 'undertaking to pay remedy', colloquially referred to as the '*DZ* defences'. The defendant posited that providing a substantial lump sum for future medical expenses would deplete the public healthcare system, advocating instead for a more incremental approach, wherein the defendant would provide medical care as needed, either directly or through private sector payments.[216]

The court was faced with the question as to whether the common law should be developed as per the *DZ* case, allowing for ongoing medical care instead of a lump sum payment.[217] Throughout the proceedings, the court has meticulously examined evidence furnished by a diverse array of witnesses, including experts in physiotherapy, occupational therapy, architecture, economics, and medicine.

The defendant's witnesses included Doctor Wagner and Doctor Saloojee, who both testified on the defendant's capability to provide medical services to the child at a reasonable standard of care. Andrew Donaldson, an economist, offered insights into the state's limited resources and the imperative to prioritise spending on more desperate patients than just one child. He also testified on the financial implications of the defendant's proposed remedies.

The court also carefully considered the testimony of additional witnesses, including Godfrey Howes, a forensic accountant, who conducted an exhaustive investigation into medico-legal claims and uncovered significant irregularities in the management of trusts established to manage future damages awards.

The court considered the defendant's proposal, and the evidence presented. The court ultimately ruled that the defendant had established the public healthcare sector's capability to provide reasonable medical services. Moreover, the court has determined that the public healthcare defence and undertaking to pay remedies are constitutionally justifiable. The court then developed the common law in this case to accommodate the public healthcare and undertaking to pay remedies, therein departing from the traditional "once and for all" rule.

In its judgment, the court ordered the defendant to provide a lump sum award of R2,136,146.00, in conjunction with a 'public healthcare remedy' and an 'undertaking

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216 The *TN* case para 3.
217 The *TN* case para12.

to pay' remedy. Additionally, the court mandated the provision of two caregivers, physiotherapy and occupational therapy regimes, home alterations, and private case management.

This judgment has significant implications for medical negligence cases culminating in CP in South Africa, particularly regarding public healthcare and undertaking to pay remedies, development of the common law, provision of medical services and supplies, and caregiving requirements. The court's decision highlights the need for a balanced approach that considers the needs of the claimant, the capabilities of the public healthcare system, and the financial implications of the proposed remedies. As such, it is essential to engage in a nuanced analysis of this judgment, recognising its potential to shape the trajectory of CP litigation in South Africa.

A final comment of the extent of this case involving CP needs highlighting. The defendant used 17 experts and in Annexure A, attached to the judgement, is a list of all the future consultations, therapies and surgeries the child would need, including: dieticians' consultations, clinical psychology, physiotherapy, occupational therapy, orthotic consultations, orthopaedic consultations, rehabilitation consultations, speech therapy, dental consultations, nursing costs, caregiver costs and various medical items. This case is therefore of essential importance to see the intricacies and costs involved with CP cases and it underscores the need for change as is clear from the case, the current way of adjudicating CP cases is not sustainable, legal reform is necessary especially because this is just once again *one* case. Whilst this specific case received so much attention, what about all the other children suffering from CP which never end up in court?

4.3 Insights gathered from the examination of the selected cases discussed

4.3.1 The DZ case

The *DZ* case has not been discussed in this chapter as it has been analysed at the beginning of this research. To complete the insights, I gathered from the discussions of the cases in this chapter I felt it is necessary to include comments on the *DZ* case. The importance of the *DZ* case cannot be overstated. The *DZ* case which revolved around compensation for CP after medical negligence was proven, the court ruled in favour of the respondent, awarding a substantial amount for damages, including future

medical expenses as discussed earlier. The case also changed the landscape for future CP cases. A key point of contention in the *DZ* case was whether the appellant, the MEC, Gauteng, should pay these expenses as a lump sum (the "once and for all rule"), or periodically by supplying health services as and when needed.

The court acknowledged that the common law could be developed to include structured settlements and treatment in kind, allowing for more flexibility in awarding damages. This approach enables the consideration of alternative compensation methods, which can be tailored to the specific needs of each case. Furthermore, the court recognised that periodic payment orders are allowed in South Africa's common law, providing an additional option for compensation.

However, the court in *DZ* dismissed the appeal, citing the common law rule of "once and for all", which requires the court to determine the entire amount of damages in a single judgment. Notably, the court left room for developing the common law to allow for periodic payments in *certain* circumstances, provided there is cogent evidence and careful consideration of the facts. Consequently, High Courts can now order periodic payments if it is in the interests of justice and proved on the facts, allowing for a more nuanced approach to compensation.

In this instance note should be taken of the recent case of *BN obo AN v MEC for the Department of Health Eastern Cape* (1013/2021) [2025] ZAECMHC 20 (25 March 2025) (hereinafter 'the *BN* case'), in which Rusi J had to 'determine whether the defendant is permitted in law to satisfy a final court order sounding in money in periodic payments.'[218] The case concerns a child suffering from CP and the MEC was found liable for BN's proven and agreed damages. An amount of R4 773 595.00 was awarded, plus the costs of the legal battle.[219] The defendant (the MEC) wanted to pay the amount in two instalments that are six months apart, as they argued that the payment of a lump sum 'will materially and detrimentally impact its ability to discharge its statutory and constitutional obligations to provide access to healthcare to everyone; and to deliver public healthcare services to the inhabitants of the Eastern Cape Province.'[220] There was *no* agreement between the plaintiff and the defendant

218 The *BN* case para 2.
219 The *BN* case paras 7-8.
220 The *BN* case paras 10-11.

concerning the lump sum amount and therefore the plaintiff's legal team argued that the defendant should comply with the legislation.

In terms of section 3(3)(a) of the State Liability Amendment Act 14 of 2011:

> (3)(a) A final court order against a department for the payment must be satisfied –
>
> (i) within 30 days of the date of the order becoming final; or
>
> (ii) within the time period agreed upon by the judgement creditor and the accounting officer of the department concerned.

Thus, the plaintiff wanted the payment to be according to section 3(3)(a)(i) of the State Liability Amendment Act – within 30 days.

Section 38(1)(f) of the Public Finance Management Act 1 of 1999 determines that the accounting officer of a department (in the context of this research - the Department of Health) to settle all contractual obligations and pay all money owing, including intergovernmental claims, within the prescribed or agreed period.

The judge stated categorically 'that in the absence of an agreement between the accounting officer of a department and the judgement creditor the doors of period payments are closed.'[221] He continued that the request for periodical payments is a special plea that must be pleaded, and evidence must be led to establish whether the parties involved agree.[222] The law permits periodic payments, but only where a case has been made out for such a relief.[223]

By analysing cases that were adjudicated after the *DZ* decision my intention was to highlight the flexibility in awarding damages on a case-by-case basis, particularly in CP medical negligence cases. Ultimately, the common law *can* be developed on a case-by-case basis to include alternative compensation methods, providing a more adaptable and responsive approach to compensation and an advantage to the provincial health departments' budgets. The only question one is left with is whether following the 'open door' created by the *DZ* case is enough or should there be a whole *new* approach to CP cases not only developing the common law.

Notice should also be taken that although the *DZ* case is seen as the opening of the 'door' to the development of the common law, in the case itself, it was stated that the

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221 The *BN* case para 24.
222 The *BN* case para 24.
223 The *BN* case para 30.

fact that the *DZ* case was adjudicated in the CC is not the sole requirement for the development of the common law, as the development of the common law was always open to courts under sections 39(2) and 173 of the Constitution. Also, in terms of section 172(1)(b) of the Constitution, courts deciding constitutional matters are afforded a wide discretion to grant any just and equitable remedy as also stated earlier.

4.3.2 The indispensability of experts

Proving causality, as discussed before, is a crucial step in determining liability for medical negligence or personal injury claims in South African courts, particularly in complex cases like CP. This involves establishing a direct link between the defendant's actions or omissions and the harm or injury suffered by the plaintiff.

To establish causality, South African courts use the ‘but for’ test, which requires the plaintiff to prove that the harm or injury would not have occurred *but for* the defendant’s actions. In other words, the plaintiff must demonstrate that the defendant’s conduct was the direct cause of their injury.

Experts play a vital role in helping the courts to determine causality, especially in complex cases like CP. Experts provide specialised knowledge and opinions to assist the court in understanding the medical facts to make an informed decision. Medical experts, for instance, provide opinions on the standard of care, diagnosis, treatment, and causation of injuries. Engineering experts offer expertise on technical aspects, such as product design, manufacturing, or maintenance of health equipment. Economic experts assist in calculating damages, including loss of income, medical expenses, and future care costs. In the *MSM* case, for, example, 18 experts were used.

While experts are indispensable in helping the courts determine causality, their services can be costly. The fees charged by experts vary widely, depending on their qualifications, experience, and the complexity of the case. Factors contributing to the cost of experts include the time and effort required to review extensive documentation, conduct research, and prepare detailed reports. Thus, experts possess unique skills and expertise, which come at a premium. They may also be required to testify in court, which can involve additional fees for time spent away from their practices.

Establishing causality in South African courts relies heavily on expert testimony. While experts are essential in helping the courts to make informed decisions, their services are costly as already pointed out. As such, parties involved in litigation must carefully consider the benefits and costs of engaging experts in their cases and if experts are used, legal practitioners should at least brief the experts well on what is expected of them without them fighting their cases for them or the expert becoming a 'hired gun'. The legal team and the experts must work together and be well prepared for whatever might happen in court. The *TM* case discussed above, being an example of bad lawyering in a CP case.[224]

Using many experts also does not seem to be an answer to the complexities of CP cases. Although they may help with understanding the medical issues, they sometimes differ or contradict themselves. Expert witnesses and the utilisation of their expertise do not seem to be the ideal solution for determining or adjudicating CP cases.

4.3.3. Development of the common law

In the last two cases discussed – the HC cases - the common law *was* developed but taking cognisance of the lengths of time which the courts take to do this, the question could be asked if it is sustainable. The pace of developing the common law in South Africa through court decisions is slow, and the complexity of CP cases raises concerns about the sustainability of this approach and the significant emotional toll on families affected by CP. Given the lengthy and intricate nature of these cases, which often involve multiple experts, it's impractical to expect that every CP case can be handled in the same manner. As a result, a shift in approach to addressing these cases is necessary and imperative.

Consequently, this has led to a pressing need for reform considering the challenges inherent in the current approach, it is imperative that a paradigm shift occurs. The escalating caseload of CP cases in South Africa, coupled with limited access to justice for affected families and the necessity for timely resolution of cases, collectively

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224 M Slabbert and M Labuschaigne 'Alleged negligence and cerebral palsy: Bad lawyering and a disappointing outcome: *The MEC for Health & Social Development Gauteng v TM obo MM* (380/2019) [2021] SCA 110 (10 August 2021)' [2022] THRHR 275-286.

underscore the imperative for change. Furthermore, the current system's shortcomings necessitate a comprehensive re-evaluation.

To address the complexities associated with CP cases, alternative approaches must be explored. Notably, alternative dispute resolution mechanisms, such as mediation could potentially mitigate the length and cost of court proceedings. Additionally, streamlining expert testimony through the utilization of joint experts or limiting the number of experts could also contribute to reduced costs and complexity. Moreover, establishing specialised courts or tribunals to handle CP cases could facilitate the development of expertise and efficiency in handling these intricate cases. Lastly, legislative reform aimed at providing no-fault compensation or alternative approaches could also alleviate the need for protracted and complex litigation. These aspects are addressed in the next chapter but, before this is done, it is necessary to highlight some general problems with CP cases, not only those issues that were already highlighted by discussing specific cases.

4.4 Problems faced with cerebral palsy cases

In this part of the chapter, I am highlighting some of the problems I have identified concerning issues in CP cases to set the scene for the next chapter, in which recommendations are made, which could change, and possibly better the approach to handling disputed CP cases.

4.4.1 Expert witnesses

As gathered from the cases above and indicated in what one could have learned from the discussed cases, expert evidence is extremely important in CP cases. The reason being that medical aspects concerning CP are highly technical and it is especially necessary to prove or disprove whether there is a link (causation) between what the healthcare workers did and the result of a child suffering from CP. But it is important to note that the testimonies and/or opinions of expert witnesses are only part of the evidence that a court must consider.[225] Expert evidence thus do not trump all other evidence, and judges are allowed to disagree with an expert witness if he or she can

[225] P van den Heever and N Lawrenson *Expert evidence in clinical negligence: A practitioner's guide* (Juta 2015) 13.

provide reasons for such a disagreement. A judge therefore must derive his or her finding from *all* the factual evidence as well as those given by witnesses.[226]

It is necessary though to focus a bit closer on expert witnessing.

4.4.1.1 Who can be an expert witness?

An expert witness is an individual with specialised knowledge, training, education, skills, or experience in a particular field or discipline, who is supposed to provide objective, unbiased opinion evidence in court to assist the judge in understanding complex or technical issues relevant to the case. His or her expertise permits him or her to testify to an opinion that will aid a judge in resolving a question that is beyond the understanding or competence of lay persons.[227] With this expert witness knowledge available to a court, it will help the court to understand the issues of a case and reach sound and just decisions.[228] In South Africa the definition and value of a medical witness had been referred to in various cases for instance *Van Wyk v Lewis* (1924), *Mohammed v Shaik* (1978) and *Michael and Another v Linksfield Park Clinic and Another* (2001).[229]

In the case of *S v Huma and Another*,[230] it was stated that an expert witness is *not* to further the cause of a particular party, but to assist the court to come to a proper decision and finding on technical and scientific matters. This assistance to court does not revolve around the 'opinion', but indeed the witnesses' competency whilst also considering knowledge, experience and expertise. Unfortunately, by reading various court cases where experts testified, one cannot but wonder who of them are 'hired guns', meaning they testify in a particular manner to further the case for the plaintiff or defendant, depending on which side recruited them.

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226 Van den Heever and Lawrenson *Expert evidence* 13.

227 I Knoetze-Le Roux 'Expert evidence v Science – nature, purpose, admissibility with reference to SA and US authority' [2008] De Rebus 26-29. In the USA, a jury must be helped by a medical expert witness to reach a correct finding.

228 S Grobler 'The Role of the expert witness' (2007) March South African Gastroenterology Review 11 -14.

229 *Van Wyk v Lewis* 1924 AD 438; *Mohammed v Shaik* 1978 (4) SA 523 (N) para 528G; *Michael and Another v Linksfield and Another* 2001 (3) SA 1188 (SCA) para 1189G.

230 *S v Huma and Another* 1995 (2) SACR 407 (WLD) para 409d-e. In this case mainly involving ballistic expert witnesses it was mentioned that especially in pro deo cases, that if necessary medical and psychiatric expert witnesses for the defendants must be appointed in the interest of justice (para 409f)

To be considered an expert witness in South Africa, an individual typically possesses a combination of specialised knowledge, skills, or experience in a specific field or discipline, as well as formal qualifications, training, or certifications in their area of expertise. They usually have relevant practical experience in their field and are recognised by their peers as an authority in their field. Furthermore, they must be impartial and unbiased, providing objective expert opinion and they should not assume the role of an advocate.[231]

When providing testimony, the expert witness should state the facts and assumptions upon which their opinion is based. They must consider all material facts, including those that may detract from their opinion. If an issue falls outside their expertise, they must clearly state this.[232] If insufficient data is available, the expert witness must emphasise that their opinion is provisional. They must also be available for cross-examination by the opposing party. If the truth cannot be ascertained without some qualification, this must also be stated.[233]

For expert evidence to be admissible in a South African court, it must meet specific criteria. The evidence must be relevant to the case, reliable, and based on sound methodology. The expert witness must be qualified and experienced in their field and impartial and unbiased. By providing objective, unbiased expert opinions, expert witnesses play a crucial role in assisting South African courts in reaching informed decisions. But as stated earlier there is room for 'hired guns' who are not impartial. In the next chapter I therefore argue that it might be better to use expert witnesses to assist the judge as an assessor and not the specific plaintiff or defendant.

4.4.1.2 The relevance of the expert witnessing

In medico-legal cases, expert medical opinions play a crucial role in ensuring fair and informed decisions. Since judges typically lack medical expertise, courts rely on expert testimony to clarify complex medical issues. This approach is consistent with other

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231 Articles by lawyers https://www.hg.org/legal-articles/the-role-of-expert-evidence-in-south-africa-27251 accessed 10 September 2024.

232 The case *National Justice Compania Naviera S.A. v Prudential Assurance Co Ltd* 1993 (2) Lloyds Reports 68-81 sets out these duties.

233 Articles by lawyers https://www.hg.org/legal-articles/the-role-of-expert-evidence-in-south-africa-27251 accessed 10 September 2024.

fields, such as engineering, chemistry, and accounting, where expert opinions are also valued.

To be admissible in court, expert medical opinions must meet specific criteria. The opinion must be relevant and able to significantly assist the court in reaching a just and reasonable decision.[234] This is supported by previous case law, for example, *S v Melrose*.[235] This means that the expert witness should provide objective, unbiased opinions based on their expertise and experience.

However, there are limitations to expert testimony. For instance, experts should not express opinions on hypothetical scenarios or facts that contradict other evidence.[236] Additionally, the court must carefully evaluate the expert's qualifications, experience, and credibility.

In the case of *Mohamed v Shaik*,[237] the court questioned the qualifications of a medical practitioner with an MBChB degree and four years of experience.[238] According to the court he was not an adequately qualified authoritative figure, under doubtful circumstances and facts, to discuss a (specialist) pathologist's report. Formal qualifications are not always so essential and thus especially when highly qualified academic professors are called upon, they are in fact "expert medical witnesses" instead of the reasonable and fair "medical expert witness" highlighting the need for a nuanced approach when assessing expert witnesses.[239]

Ultimately, the court should prioritise evidence based on actual events over expert opinions. Caution is necessary when accepting expert opinions that contradict probabilities or other evidence.[240]

Another challenge arises with hearsay evidence. Expert witnesses generally cannot base their opinions on statements from individuals not called as witnesses. However,

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234 P J Schwikkard and others *Principles of Evidence* (3rd edn Juta 2010) 93.

235 *S v Melrose* 1985 1 SA 720 (Z) para 724I.

236 Schwikkard and others *Principles of Evidence* 96.

237 *Mohamed v Shaik* 1978 4 SA 523(N) para 528G.

238 Medicus Baccalaureus; Chirurgus Baccalaureus degree (MB ChB) denotes the accepted medical degree at most universities with health and medical faculties.

239 An 'Expert Medical Witness' would in this writer's opinion be a highly qualified professional (i.e. a professor) with a niche interest and expertise that would emphasise and discuss exceptional medical knowledge (i.e. a rare syndrome), whereas 'Medical Expert Witness' the emphasis would be on the reasonable professional's standard of skills and knowledge and opinion on an acceptable course of action to be used in medical negligence and malpractice litigation.

240 Schwikkard and others *Principles of Evidence* 99.

experts may refer to textbooks and be allowed to do so provided conditions are met as set out in *Monday v Protea Assurance Co Ltd.* [241] It must be shown that the expert witness can confirm the accuracy of the information through their own knowledge and experience. The textbook or publication must be reliable and written by an authoritative figure. If all the stated requirements are met, the court however can rely upon publications referred to as credible and trustworthy.[242] The court's decisions must be based on all the facts presented. Expert witnesses can provide valuable insights due to their specialised knowledge and skills, helping the court draw informed conclusions.[243] However, expert testimony is only relevant when it stays within its scope and doesn't encroach on legal matters or statutory interpretations.[244] The court has the final say in determining whether expert evidence is necessary and admissible.[245] In essence, while expert witnesses can provide crucial insights, the court maintains control over the admissibility and weight of their testimony.[246] The court also decides whether an expert witness is qualified and whether their testimony is valuable and acceptable. Expert witnesses must be aware of the principles and rules governing the admissibility of their expert opinions.[247]

Expert witnesses play a crucial role in CP cases in South Africa due to the complex nature of these cases. CP cases often involve intricate medical issues, such as the causes and consequences of birth asphyxia or hypoxia, the effects of premature birth or low birth weight, and the role of genetic factors in the development of CP. To navigate these complexities, the court relies on expert witnesses, typically medical specialists or experts in related fields, to provide clarity on these issues. These experts help the court understand the medical nuances, enabling informed decision-making.

Establishing causation and liability is a critical aspect of CP cases. Expert witnesses are often called upon to provide opinions on whether the defendant's actions or omissions caused or contributed to the child's CP. They also assess whether the

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241 *Menday v Protea Assurance Co Ltd* 1976 1 SA 565 (E) para 569D.
242 Schwikkard and others *Principles of Evidence* 101.
243 DT Zeffert and A Paizes A *The South African Law of Evidence* (LexisNexis 2009) 321.
244 Zeffert and Paizes *Law of Evidence* 322.
245 Zeffert and Paizes *Law of Evidence* 323. Referring also to the *Linksfield* case where four expert witnesses were allowed to testify, all with differing opinions.
246 Zeffert and Paizes *Law of Evidence* 326.
247 Zeffert and Paizes *Law of Evidence* 103.

defendant breached their duty of care, resulting in the plaintiff's injuries. By providing objective opinions, expert witnesses help establish causation and liability. In addition to addressing causation and liability, expert witnesses are also instrumental in assessing the *quantum* of damages in CP cases. They provide opinions on the plaintiff's life expectancy, future medical needs, the cost of future care and treatment, and the child's loss of earnings and earning capacity. This information is crucial in determining the appropriate amount of damages to award. But, once again there should be caution as some experts, apart from their own costs, inflate their opinions unnecessarily to put the child suffering from CP in an exclusive position instead of just making his or her life comfortable.

In CP cases in South Africa, various types of expert witnesses are commonly utilised to provide critical evidence that helps the court understand the complex issues involved. These expert witnesses specialise in different fields and offer unique insights that shed light on various aspects of CP cases. Among the types of expert witnesses used are paediatric neurologists, who provide expertise on the neurological aspects of CP.[248] Obstetricians and gynaecologists offer insights into the prenatal and perinatal care provided to the mother, which may be relevant to the development of CP.[249] Neonatologists are also crucial in CP cases, as they provide expertise on the care provided to new-borns, particularly those born prematurely or with low birth weight.[250] Rehabilitation specialists help the court understand the long-term care and treatment needs of individuals with CP. Life care planners play a vital role in assessing the future needs of individuals with CP, including their medical, educational, and social requirements.[251] Economists and actuaries provide expert opinions on the cost of future care and treatment, as well as the loss of earnings and earning capacity.[252] These expert witnesses collectively provide a comprehensive understanding of the complex issues involved in CP cases, enabling the court to make a finding.

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248 *AM v MEC for Health Eastern Cape* (401/2021) [2024] ZAECBHC 19 (6 August 2024) (hereinafter 'the *AM* case').

249 *JA obo DA v MEC for Health Eastern Cape* (456/2017) [2020] ZAECBHC 26 (20 December 2020).

250 The *AM* case para 5.

251 The role of Life-care Planners in shaping the Outcome of Medical Legal Cases <http://www.iclcp.com> accessed 14 April 2025.

252 'The Actuary Acting as Expert Witness in Cases Involving Compensation for Loss of Future Earnings' Presented at the Actuarial Society of South Africa's 2012 Convention 16-17 October 2012, Cape Town Convention Centre <https://www.up.ac.za> accessed 14 April 2025.

4.4.1.3 The *locus classicus* on expert witnessing: *Michael and Another v Linksfield Park Clinic and Another* (1) (361 /98) [2001] ZASCA 12 [2002] 1 ALL SA 384 (A) (13 March 2001). [253]

A young scholar underwent rhinoplasty at a clinic after breaking his nose during a sporting event. He ended up in a permanent vegetative state.[254] His parents sued on his behalf. The private company owning the clinic where the operation was performed was the first defendant and the anesthetist was the second defendant.[255] Among the clinic's employees involved in the events of the day, were a registered sister in general charge of anesthetics and recovery, and a registered sister who was the anesthetic sister assigned to this particular operation.[256] The clinic was sued due to its vicarious liability towards its employees.

The patient developed cardiac arrest after receiving cocaine to control bleeding, possibly combined with anesthetic gases and a heart rate blocker.[257] Resuscitation efforts were hindered by a malfunctioning defibrillator machine, despite hospital staff claiming it had been tested earlier that day.[258] The patient suffered permanent brain damage. Five expert witnesses testified.[259] The trial court found the cause of the cardiac arrest was in all probability cocaine toxicity.[260] The court *a quo* also found no negligence but allowed the appeal.

Concerning the expert evidence in the SCA the judge stated:

> [I]t is perhaps as well to re-emphasise that the question of reasonableness and negligence is one for the court itself to determine on the basis of the various, and often, conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their [the experts] essential reasoning.[261]
>
> [W]hat is required in the evaluation of [expert] evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning.[262]

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253 The *Linksfield* case. It is mentioned that in the presence of various and often conflicting expert opinions presented, the court must decide using guidelines like credibility, examining, and logical analysis. If the expert opinion cannot be logically supported, it will fail to be the reference to which a defendant's conduct is assessed.

254 The *Linksfield* case para 1.

255 The *Linksfield* case para 2.

256 The *Linksfield* case para 5.

257 The *Linksfield* case paras 11-14.

258 The *Linksfield* case paras 17 -19.

259 The *Linksfield* case para 28.

260 The *Linksfield* case para 29.

261 The *Linksfield* case para 34.

262 The *Linksfield* case para 36.

The judge also referred to the case of *Bolitho v City and Hacney Health Authority* [1998] AC 232 (H.L.(E)). He summarised the *dicta* in that case as follows:

> The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached 'a defensible conclusion'.[263]

The judge consciously and purposeful thought of how to handle and asses the medical expert evidence, setting limitations for the medical expert evidence.[264] The SCA encountered challenges in evaluating conflicting expert opinions on the anesthetist's conduct.[265] Analysis of the essential reasoning would be considered more important before the court decides and reaches its own conclusion.[266] It was noted during the appeal that in the court *a quo*, none of the expert witnesses could express, even collectively, what the acceptable and reasonable anaesthetic practice entailed.[267]

Furthermore, the court noted that doctors cannot be absolved of responsibility solely based on expert opinions. Instead, a doctor's conduct must be evaluated according to sound medical practices. This means that the court will assess whether the doctor's actions align with established medical standards, rather than relying solely on the opinions of experts. Ultimately, the court has a critical role to play in evaluating expert evidence. This involves carefully assessing each expert's testimony to determine whether it is based on *logical reasoning*. If an expert's opinion overlooks obvious risks, it may not be considered reasonable, even if it is widely held by others in the field.

It was held that a decision of the court could be swayed if a body of opinion is not able to withstand logical analysis.[268] Despite finding that the anaesthetist presented false evidence to exonerate him, the appeal was ultimately unsuccessful and that the trial judge's decision to dismiss the claim was upheld.[269] The court's decision highlighted

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263 The *Linksfield* case para 37.

264 Carstens and Pearmain *Foundation Principles* 785.

265 The *Linksfield* case as discussed in Carstens and Pearmain *Foundation Principles* 785.

266 The *Linksfield* case as discussed in Carstens and Pearmain *Foundation Principles* 786.

267 Carstens and Pearmain *Foundation Principles* 788.

268 The *Linksfield* case as discussed in Carstens and Pearmain *Foundation Principles* 785. The court did mention that medical expert witnesses tend to assess a case in terms of scientific certainty and not in terms of a balance of probabilities.

269 The *Linksfield* case as discussed in Carstens and Pearmain *Foundation Principles* 785. Costs were awarded for the plaintiffs, and the anaesthetist was reported to *the Health Professions Council of South Africa.*

the importance of critically evaluating expert evidence and considering the logical basis of expert opinions.

This landmark South African case highlighted a crucial aspect of expert testimony in medical negligence cases. Despite the four medical experts presenting differing opinions, the court applied the English *Bolam*[270] and *Bolitho*[271] tests, which consider even minority views. The court ultimately emphasised the importance of considering only scientifically correct and logical evidence.

The case also underscored the distinction between scientific and judicial proof. While the medical profession sets standards for reasonable behavior, the court is not bound by these standards if the reasoning is illogical. Therefore, expert medical opinions must be objective, reflect accepted medical practices, and be grounded in logical reasoning.[272] The credibility and reliability of expert witnesses are paramount, as judgments rely heavily on their testimony. Expert witnesses must be aware of this responsibility and ensure their opinions are trustworthy and objective.[273] The judgment provides valuable insights into the role and responsibilities of expert witnesses in legal proceedings. The court's emphasis on several key factors serves as a guide for ensuring the credibility and reliability of expert testimony.

The court stressed the importance of expert witnesses having the necessary qualifications and expertise in the relevant field. This ensures that their opinions are informed and based on a deep understanding of the subject matter. Furthermore, expert witnesses must be objective and impartial, with no vested interest in the outcome of the case.

They must disclose any potential conflicts of interest or biases, ensuring that their opinions are unbiased and trustworthy.[274] Effective communication is also crucial, as the court highlighted the need for expert witnesses to communicate their opinions clearly and concisely, avoiding technical jargon and complex terminology. This

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270 The *Linksfield* case as interpreted by M Ndou 'Assessment of contested expert medical evidence in medical negligence cases: A comparative analysis of the court's approach to Bolam/Bolitho test in England, South Africa and Singapore' (2019) Speculum Juris 33.

271 Ndou 'Assessment of contested' 33.

272 Carstens and Pearmain *Foundational Principles* 790.

273 Carstens and Pearmain *Foundational Principles* 791.

274 *Schneider NO v Aspeling* [2010] 3 All SA 332 (WCC) 332, *National Justice Compania Navierasa v Prudential Assurance Co Limited* 1993 (2) Lloyd's Reports 68 at 81 as quoted by Ndou 'Assessment of contested' 57.

enables the court to fully understand their opinions and make informed decisions. In addition, expert witnesses must disclose their methodology and assumptions, being transparent about any limitations or uncertainties in their opinions. This allows the court to evaluate the reliability and credibility of their testimony.[275]

Ultimately, the court demonstrated how to evaluate the credibility and reliability of expert witnesses, including assessing their qualifications, experience, and objectivity. This ensures that only trustworthy and reliable expert testimony is considered in legal proceedings, providing a fair and just outcome.

This case has significant relevance to expert witnessing, particularly in medical negligence cases. The judgment provides guidance on the use of expert evidence in such cases, which often involve complex medical issues that require specialized knowledge and expertise.

Moreover, the case offers valuable insights into the evaluation of expert evidence, highlighting the importance of assessing the credibility and reliability of expert witnesses and their opinions. This includes examining their qualifications, experience, and objectivity, as well as their methodology and assumptions.

The case equally demonstrates the court's role in regulating expert evidence, ensuring that expert witnesses meet the necessary standards of expertise and impartiality. This includes scrutinising their qualifications, experience, and objectivity, and ensuring that their opinions are based on reliable methodology and assumptions. By regulating expert evidence in this way, the court can ensure that only trustworthy and reliable expert testimony is considered in legal proceedings.

In conclusion, the *Linksfield* case is a valuable resource for expert witnesses, lawyers, and judges, providing guidance on the use of expert evidence in medical negligence cases and beyond.

4.4.2 Reverse reasoning in cerebral palsy cases

275 Carstens and Pearmain *Foundational Principles* 791.

Although reverse reasoning did not occur in any of the cases discussed above it seems to be a method followed by some lawyers and I feel it is necessary to highlight it as a problem in the context of CP cases. Reverse reasoning in CP cases refers to a legal strategy used in medical negligence claims where the plaintiff (typically the mother of the child suffering from CP) argues that the defendant's (typically the healthcare providers) actions or omissions were the cause of the child's CP, even if the exact mechanism of injury is not clear. In other words, it means the mother approaches an attorney, or the attorney approaches the mother and because the child suffers from CP a conclusion is reached by them that there should have been negligence. This might be induced from opportunistic lawyering which is a bad practice and should not be condoned for any reason.

Reverse reasoning cases in the context of CP claims involve a unique approach to establishing negligence. In these cases, the plaintiff infers negligence on the part of the defendant based on the circumstances surrounding the birth or medical treatment the mother or child received at a public hospital. The plaintiff argues that the defendant's actions or omissions were the likely cause of the child's CP, even if the exact detail of when and how CP developed is unclear.

The doctrine of *res ipsa loquitur*, which means 'the facts speak for itself', is often relied upon in these cases. This doctrine creates a rebuttable presumption that the defendant's negligence caused the injury.[276] Certain events may trigger reverse reasoning cases, such as birth asphyxia, delayed diagnosis, or medication errors. For instance, if a child is born with CP and the plaintiff argues that the defendant's failure to monitor foetal distress or respond promptly to complications during delivery caused the injury, this could be a reverse reasoning case. The argument is because the child is suffering from CP there must have been negligence.

However, these cases also come with challenges and limitations. One of the primary challenges is proving causation, as the plaintiff must still establish that the defendant's actions or omissions *caused* the child's CP. Expert testimony often plays a crucial role in establishing the causal link between the defendant's actions and the child's injury.

276 SALRC 'Medico-legal claims' 30.

Furthermore, the defendant may rebut the plaintiff's inference of negligence by providing alternative explanations for the child's injury. This can create a complex and contested legal landscape, requiring careful consideration of the evidence and expert opinions. Two cases in which remarks on reverse reasoning were highlighted are briefly discussed to expand on the meaning and/or misuse of reverse reasoning.

4.4.2.1 *MEC for Health, Western Cape v Q* (928/2017) [2018] ZASCA 132

This case revolved around a claim of medical negligence against the MEC for Health in the Western Cape. The respondent, a mother, alleged that the medical staff's negligence during her pregnancy and labour led to her child's CP.

The court's judgment focused on the issue of negligence and causation. The respondent's experts argued that the medical staff's failure to perform investigations and intervene timely resulted in the child's brain damage. However, the court found that the respondent's experts employed reverse reasoning to establish negligence. In paragraph 50 of the judgement Dambuza JA said:

> The fact that harm had been occasioned was not, on its own, proof that the medical staff had caused it, or that they had done so negligently, or even that it had resulted in the brain injury. In *Goliath v Member of the Executive Council for Health, Eastern Cape*[277] this court warned against reverse reasoning of this kind as follows: '… to hold a doctor negligent simply because something had gone wrong, would be to impermissibly reason backwards from the effect to the cause'.[278]

The court's criticism of the respondent's experts' approach suggests that they inferred negligence from the adverse outcome rather than establishing a causal link between the alleged negligence and the harm suffered.

In essence, the court held that the respondent failed to prove that the medical staff's negligence caused the child's CP. The court's decision underscores the importance of establishing a clear causal link between alleged negligence and harm in medical negligence cases. The appeal was upheld.

4.4.2.2 *MEC of Health and Social Development of the Gauteng Provincial Government v M* (272/2022) [2024] ZASCA 21

277 The *Goliath* case para 8.
278 The *Goliath* case para 9.

This case is another example of a case of reverse reasoning which revolved around a claim of medical negligence against the MEC for Health in the Gauteng Provincial Government. The plaintiff, Ms. M, alleged that the medical staff's negligence during her pregnancy and childbirth led to her child suffering from CP.

The court's judgment focused on the issue of negligence and causation. The plaintiff's experts argued that the medical staff's failure to perform investigations and intervene timely resulted in the child's brain damage. However, the court found that the plaintiff's experts employed reverse reasoning to establish negligence, as stated in the judgment:

> In this case there was no evidence of a sentinel event. The contention that sentinel event would have been detected and avoided if reasonable care had been taken is based on reverse reasoning that because L suffers from CP there must have been a detectable and avoidable sentinel event during his birth. The courts have cautioned against commencing with an unfavourable outcome and working backwards in search of a cause. … a plaintiff's attorney 'can take any foetal monitor strip and make a malpractice case out of it.[279]

The court criticized the plaintiff's experts for inferring negligence from the adverse outcome rather than establishing a causal link between the alleged negligence and the harm suffered. The court held that the plaintiff failed to prove that the medical staff's negligence caused the child's CP. Ultimately, the court upheld the appeal, setting aside the order of the full court that held the MEC liable for damages.

The use of reverse reasoning links with the concerns raised with expert witnesses as in both cases the expert witnesses' opinions were critisised for using reverse reasoning instead of focusing on causation as a requirement to prove a case of alleged medical negligence culminating in CP.

4.4.3 The Contingency Fees Act 66 of 1997

Most medical negligence cases are based on a contingency fee agreement between the attorney and the client. I highlight this as a problem in CP cases because some lawyers will take on CP cases only because of the *quantum* claimed in these cases.

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279 *MEC of Health and Social Development of the Gauteng Provincial Government v M* (272/2022) [2024] ZASCA 21 para 26.

They then put in every effort possible to win the case (even if it entails reverse reasoning) and get their share of the final awarded amount.

The Contingency Fees Act 66 of 1997 regulates contingency fee agreements between attorneys and their clients. A standard contingency fee arrangement has been formulated to provide greater access to justice for the general public by way of the "no win, no fee" arrangement prescribed by Act. According to this arrangement, a legal practitioner will only receive a fee for his or her services where he or she concludes the client's case successfully.[280] The Act aims to regulate contingency fees in South Africa, ensuring fairness and transparency in agreements between attorneys and their clients. The primary objectives of the Act are to regulate contingency fees and protect clients from excessive or unfair fees. At the heart of the Act is the definition of a contingency fee, which is a fee contingent upon the successful outcome of a matter. To prevent excessive fees, the Act sets a maximum contingency fee of 25% of the total award or settlement. However, in cases where the settlement is successfully concluded, a practitioner may receive twice as much as the previously agreed settlement but not exceeding 25% of the final award.

The Act also emphasises transparency through disclosure requirements. Attorneys must clearly disclose the terms of the contingency fee agreement to their clients, including the percentage of the fee and the circumstances under which it will be payable. Furthermore, clients have fourteen days from the date of signature to withdraw from the contingency fee agreement.[281]

To ensure clarity and specificity, contingency fee agreements must be in writing, signed by both the attorney and the client, and written in clear and concise language.[282] The agreement must specify the percentage of the contingency fee, the circumstances under which it will be payable, and any other relevant details.[283]

The Act prohibits certain practices, including charging excessive fees and misleading clients about the terms of the contingency fee agreement or the likelihood of success.

280 Contingency Fees Act s 2(2).
281 Contingency Fees Act s 3(3)(h).
282 Contingency Fees Act s 3(1)(a).
283 Contingency Fees Act s 3.

Attorneys who contravene the Act may face penalties, including fines, suspension, or even being struck off the roll.[284]

The Contingency Fees Act aims to promote transparency, fairness, and accountability in contingency fee agreements, ultimately protecting clients' interests and promoting access to justice. The Act makes it possible for patients, who would normally not be able to afford litigation, to institute legal proceedings on a 'no win no fee basis'. This has contributed to the increase in medico-legal litigation especially concerning CP as the amounts claimed in these cases are millions of rands.

Although the Act and its objectives are noble in that it gives a poor person access to court proceedings, it has also created a way for some attorneys to think it is easy to make a lot of money in CP cases. This approach links with the previous problem identified in CP cases, namely 'reverse reasoning' as attorneys might convince a mother of a child suffering from CP to institute action to determine whether medical negligence was responsible for the child's condition. If the attorney is then successful, he will make quite a lot of money due to the extent of the claims in a CP case.

4.4.4 No guidance nor uniformity of Magnetic Resonance Imaging (MRI) for cerebral palsy detection

The use of MRI's for detecting of CP is hindered by several challenges and thus also a problem with CP cases. Despite its potential as a diagnostic tool, the lack of standardised protocols, inadequate training and expertise, technical limitations, and limited understanding of CP pathophysiology all contribute to inconsistencies and uncertainties in MRI-based diagnoses.

Different hospitals and radiology departments may employ varying imaging techniques, resulting in inconsistencies in image quality and interpretation, leading to variability in image acquisition and analysis. Inadequate training and expertise among radiologists and neurologists also pose significant challenges. These professionals may not receive sufficient training or have adequate experience in interpreting MRI scans for CP, leading to variability in interpretation. Different experts may interpret the same MRI scan differently, resulting in inconsistencies in diagnosis and treatment.[285]

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284 Section 35 (10) of the Legal Practice Act 28 of 2014.

285 C Nel, JK Bezuidenhout and HC Thomson 'Magnetic resonance imaging finding and the clinical characteristics of children with cerebral palsy at the public sector hospital in Gauteng Province,

Technical limitations of MRI scans also affect its reliability in detecting CP. Image quality can be compromised by factors such as motion artifacts, magnetic field in-homogeneities, and signal-to-noise ratio limitations. Moreover, MRI may not be able to detect subtle brain injuries or abnormalities, particularly in the early stages of cerebral palsy.[286]

Finally, the limited understanding of CP pathophysiology complicates the development of a single, universally applicable MRI protocol. CP is a heterogeneous condition with multiple underlying causes and mechanisms, making it challenging to create a standardized approach to MRI-based diagnosis.[287]

4.4.5 No guidance nor uniformity of Cardiotocography (CTG) for cerebral palsy detection

There is no national registry or other standardised system for monitoring the prevalence of CP in SA.[288] This according to me is thus also a problem in CP cases. A CTG is a tool used to assess foetal well-being during pregnancy and childbirth, but its effectiveness in detecting CP is hindered by several challenges.

One major issue is the lack of standardised interpretation guidelines for CTG tracings. Different healthcare providers may interpret the same tracing differently, leading to inconsistencies in diagnosis and treatment. Furthermore, healthcare providers may not receive adequate training on CTG interpretation, resulting in misinterpretation of tracings. For example, in the case of *Z.K. v MEC for Health, Eastern Cape* Case No: 3180/2014 (15 March 2018) concerning CP a nurse testified as follows concerning CTG's:

> She knew how to use a CTG and she had learned in her studies about variability, beat to beat, decelerations and contractions. Under cross-examination, however, she stated with regard to the day in question…That time I was still learning, I had one month in maternity. I was new neh? I wasn't sure about CTG's and all those procedures. I was

South Africa' (2022) 16 (14) South African Journal Child Health 232-238; SJ Korzeniewski and others 'A systematic review of neuroimaging for cerebral palsy' (2008) 23(2) Journal of Child Neurology 216 -227.

286 EN Mason and others 'Evaluation of the impact of magnetic field homogeneity on image quality in magnetic resonance imaging: a baseline quantitative study at 1.5 T' (2023) 54 Egyptian Journal Radiology and Nuclear Medicine 146 <https://doi.org/10.1186/s43055-023-01097-8> accessed 24 April 2025. Anon 'The Isocenter and the importance of magnet homogeneity' <https://www.gehealthcare.co.uk/article/the-Isocenter-and-the-importance-of-magnetic-homogeneity> accessed 24 April 2025.

287 Bhorat and others 'Cerebral palsy' 280-288.

288 Brooks, Campbell and Whittaker 'Survival of South African' .

> early from school neh. And I was still learning and I was doing everything slowly… I didn't know everything… even the CTG we were taught in class about CTG, all those features, but we did not write it in the test, we did not write it on exams, imagine, and even in the practical we don't look on the CTG we only focus on the deliveries we need to have. So imagine I had only one month and I am still learning the CTG, I am not sure about the CRTG, so please consider that.[289]

CTGs also has limited sensitivity and specificity, which can lead to false positive or negative results. This can result in unnecessary interventions or failure to detect foetal distress. Additionally, CTG has limited predictive value for CP, as many cases may not be associated with abnormal CTG tracings.[290]

Another challenge is the variability in CTG classification systems. Different systems, such as the International Federation of Gynecology and Obstetrics and Dawes-Redman systems, exist, but there is no universally accepted system.[291] This can lead to inconsistencies in interpretation and diagnosis.

4.4.6 Non-adherence to maternity guidelines

Non-adherence to maternity guidelines concerning CTGs is also a significant concern in South Africa. Despite the existence of comprehensive guidelines, healthcare providers often fail to follow them, contributing to the prevalence of CP. Key guidelines that are not being followed include those for intrapartum care, foetal monitoring, and timely interventions. The consequences of non-adherence to guidelines concerning CTG's are severe. It increases the risk of CP, as delays in recognising and responding to foetal distress can lead to birth asphyxia and brain damage. Non-adherence can also lead to maternal and foetal morbidity, including complications during labour and delivery. Furthermore, it can result in litigation and financial burdens on the healthcare system, as well as emotional distress for families affected by CP.

4.4.7 Variations in court approaches to cerebral palsy cases in South Africa

In South Africa, the judiciary has taken varied approaches when adjudicating CP cases. These differences can be attributed to several factors, including the complexities inherent in medical negligence cases, the discretion afforded to judges,

289 *Z.K. v MEC for Health, Eastern Cape* Case No: 3180/2014 (15 March 2018) para 19.
290 *Z.K. v MEC for Health, Eastern Cape* Case No: 3180/2014 (15 March 2018) para 104.
291 CWG Redman and Moulden M 'Avoiding CTG misinterpretation: A review of Dawes-Redman CTG analysis' [2021] British Journal of Midwifery 1-5.

and the evolving nature of the common law but it currently creates problems when comparing judgments of CP cases.

On one hand, some courts have proactively developed the common law to address the intricacies of CP cases. This involves re-examining existing principles, adapting them to new circumstances, or establishing new precedents. On the other hand, other courts have adopted a more conservative approach, focusing primarily on the merits and *quantum* of the case. This approach entails applying established principles and precedents to determine liability and damages.

Several factors contribute to these variations. Judicial discretion plays a significant role, as judges have considerable latitude when interpreting the law and applying it to specific cases. The complexity of medical negligence in CP cases is another factor, as the intricate medical issues involved can make it challenging for courts to navigate and apply the law consistently. Furthermore, the common law is constantly evolving, with new precedents and principles emerging, which can lead to different approaches as courts respond to these developments.

The implications of these variations are significant. Inconsistent outcomes can result, potentially leading to unequal treatment of similar cases. The lack of consistency can also create uncertainty and confusion for healthcare providers, patients, and the courts themselves. Ultimately, there is a need for clarity and consistency in the law to ensure that CP cases are judged fairly and in accordance with established principles

4.5 Conclusion

This chapter started by focusing on selected court cases concerning CP. Cases adjudicated in the CC were highlighted. Two cases in the SCA followed and then some HC cases were discussed. By analysing these court cases some principles were identified, where-after the chapter indicated the specific challenges in CP cases to set the stage for what is to follow in the next chapter.

The variations in court approaches to adjudicating CP cases in South Africa reflect the complexities of medical negligence cases, judicial discretion, and the evolving nature of the common law. While some courts develop the common law, others focus on the merits only or once the merits have been proved the *quantum.* These variations

highlight the need for clarity and consistency in the law to ensure fair and just outcomes for all parties involved.

Lawyers are also not completely innocent when it comes to case selection. Some may use reverse reasoning to prove a case while others may only take a CP case as they will benefit from a contingency fee agreement. All of this complicates CP cases which I argue need legal reform. In the next chapter recommendations are made on how CP cases could be handled differently to have a more standarised approach or to curb the excessive amounts paid out after a successful CP case.

CHAPTER FIVE

RECOMMENDATIONS AS POSSIBLE SOLUTIONS TO CEREBRAL PALSY CASES

5.1 Introduction

As indicated at the beginning of the research, in recent years South Africa has seen a marked increase in CP cases ending up in court, particularly against public healthcare institutions. These lawsuits pose significant financial, ethical, and systemic challenges to the health sector. As the burden on the state grows - both in terms of litigation costs and the impact on service delivery - it becomes imperative to explore viable, sustainable solutions to curb this trend.

There is without doubt a significant problem of increased CP medical negligence litigation that requires urgent action to save the health system as the value of the claims tend to consume the bulk of the finances allocated to each province. The nation's public healthcare sector is particularly suffering because of a surge in CP birth injury claims. If no action is taken to salvage or regulate the system, it will culminate in a total collapse or paralysis of the health system.

As indicated earlier, there is no specific legislation that deals directly with this problem, which means that alleged medical negligence cases concerning CP that ends up in litigation, are still addressed by the common law.[292] If a claimant proves negligence, compensation may be claimed for past and future medical expenses, loss of income or earning capacity and pain and suffering. The common law contemplates that compensation on all these heads must be made in monetary terms and must be claimed in one action "once-and-for-all".[293]

This chapter elucidates strategic interventions aimed at reducing the frequency and severity of these lawsuits. The focus is on enhancing legal reform, fostering transparency and developing alternative compensation frameworks that balance justice for affected families with the long-term viability of healthcare systems. By addressing these remedial strategies, this analysis seeks to contribute to a more

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292 SALRC 'Medico-legal claims' para 1.2.
293 The *DZ* case para 16.

resilient and equitable healthcare landscape in South Africa. The study has effectively tackled the central issue of whether legal changes are necessary in handling medical negligence cases linked to CP in South Africa. Along the way, it also explored the related sub-topics in depth, achieving the aims that were set out from the beginning.

The CC laid the groundwork for the legal development of compensation claims in 2007 with its landmark ruling in the *DZ* case. The court held that it was permissible to develop the common law to allow for alternative forms of compensation, such as payments in kind or periodic payments, provided there was a solid factual basis to support such innovation.[294] The CC's decision in the *PN* case*,* discussed in the previous chapter, was a significant milestone in the development of the common law regarding CP medical negligence claims. The court essentially ruled that the word "pay" in compensation agreements isn't set in stone, and that agreements to pay 100% of damages only cover liability, not the method of compensation.[295]

This decision overturned the SCA's approach, which had limited the ability of provincial health departments (MEC's) to seek alternative compensation arrangements when the time for the *quantum* to be determined arose. This ruling empowers High Court's to develop the common law and allows MECs to request flexible compensation arrangements, such as instalment payments or payments in kind, even if the case was initiated or decided before the precedent-setting *DZ* case.

The CC made it clear that whether or not the landmark case of *DZ* had been decided, it's always possible for litigants to ask the court to develop the common law and to preclude a claimant from doing so, would affect his or her right of access to court.[296] It must always be remembered that the payment of huge sums claimed as damages in litigation may compromise the rights of other citizens to access healthcare services as enshrined in section 27 of the Constitution.[297]

5.2 Recommendations

5.2.1 Development of the common law

294 The *DZ* case paras 57-58.
295 The *PN* case paras 23 – 24.
296 The *PN* case para 27.
297 The Constitution section 27.

South Africa's laws around medical negligence claims need a serious overhaul. There is an urgent need to update and refine the legal framework to better handle medico-legal cases. Without decisive intervention, the current system risks becoming unsustainable and ultimately paralysed. This concern has been echoed in numerous submissions received in response to the South African Law Reform Commission's Issue Paper 33 on Project 141 addressing medico-legal claims.

At the heart of medico-legal litigation lie foundational principles of the common law, particularly those pertaining to the law of obligations, the law of delict, and the legal test for medical negligence. The alarming rise in medical negligence claims specifically for CP —both in frequency and in the quantum of damages awarded— has become a matter of significant public concern. Individuals who suffer harm due to the negligent conduct of health practitioners seek legal recourse to obtain compensation for the damages incurred. However, such claims are governed by the common law's "once-and-for-all" rule.

As articulated by Visser and others, this rule stipulates that in actions for compensation arising from a delict, breach of contract, or similar cause, the plaintiff must claim all damages—past and future—at once, provided they stem from a single cause of action.[298] While this principle has traditionally justified the awarding of lump sum payments, its continued application has come under scrutiny.

The CC addressed the potential evolution of this rule in the landmark *DZ case*.[299] The *DZ* judgment offers a detailed reflection on how courts should approach the development of the common law, highlighting their constitutional duty to ensure that legal rules evolve in line with justice and democratic values.

This development is grounded in section 39(2) and section 173 of the Constitution, which requires courts to assess whether a rule conflicts with the spirit, purport, and objects of the Bill of Rights. In terms of the former section, the court must, among other things, enquire whether the existing common law rule offends section 39(2). In other words, is it at odds with the normative framework of the Constitution and the Bill

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298 JM Potgieter, L Steynberg and T Floyd *Visser and Potgieter's Law of Damages* (3 ed Juta 2012) 153.

299 The *DZ* case.

of Rights? In terms of section 173, the enquiry is wider. The question there is whether, even if the common law is constitutionally compliant, there are wider interests of justice that necessitate its development.[300] In terms of both sections, courts must identify the existing common law position, consider its rationale, and determine whether reform is necessary. If so, they must decide how the law should be developed and assess the broader impact of such change.[301] While the *DZ* judgment affirms that the legislature is the primary agent of law reform, courts retain a vital role, especially where legislative action is unlikely.[302]

Given the dire financial circumstances faced by many provincial health departments—exacerbated by substantial medico-legal payouts—the Court's decision holds the promise of alleviating systemic strain. The CC provided critical guidance on the development of the common law in relation to compensation for medical negligence. Their judgment affirmed the principle that plaintiffs are entitled to redress for harm suffered at the hands of the state, while simultaneously acknowledging the fiscal and operational constraints under which the state functions.[303] The CC also opened the door to alternative forms of compensation, such as structured settlements, which may include periodic payments or payment in kind.[304] Notably, the Court's decision was unanimous, though the judges arrived at the same conclusion through differing legal reasoning. These divergences, while academically stimulating, do not detract from the practical implications of the judgment.

The CC's ruling in the *DZ* case paves the way for compensating victims of medical negligence (CP) in a manner that is both equitable and financially sustainable, thereby safeguarding the viability of public healthcare services. Nonetheless, provinces must still present well-substantiated cases, particularly regarding the capacity of public health facilities to deliver care that meets requisite standards. The contrast between successful and unsuccessful arguments in this regard is evident in two cases: *MSM*

300 The *DZ* case para 32.
301 The *DZ* case para 31.
302 The *DZ* case para 34.
303 The *MSM* case para 32.
304 The *DZ case* paras 51-55.

obo KBM v MEC Health, Gauteng[305] and *PH obo SH v MEC Health, KwaZulu-Natal*[306] (hereinafter 'the *PH* case')

In the *MSM* case, the Gauteng Local Division in Johannesburg ordered the MEC to provide specific medical services to the child KBM at a designated public hospital.[307] Conversely, in the *PH* case, the KwaZulu-Natal Local Division in Durban found the MEC's assertions regarding the adequacy of public healthcare facilities to be vague and unconvincing.[308] Both courts rejected the MEC's attempts to rely on the public healthcare defence, underscoring the necessity of presenting credible and detailed evidence.

The imperative to reform the legal framework governing medico-legal claims specifically concerning CP is both urgent and unavoidable. Structured settlements, incorporating periodic payments and non-monetary compensation, offer practical advantages and a more sustainable approach to redress. Such reforms are essential to preserving the integrity of the healthcare system while ensuring justice for victims suffering from CP. But, in order to understand the development of the common law as allowed in the *DZ* case better, it is necessary to finally pay closer attention to the developments allowed in the case.

5.2.1.1 The public healthcare defence

To address the growing concern of depleting the finances of a Department of Health, they introduced a legal strategy known as the public healthcare defence. Rather than compensating claimants with money, the department proposes that individuals requiring ongoing medical treatment receive care through public healthcare facilities. This shift aims to preserve financial resources while still meeting the medical needs of those affected. The rationale behind this defence is rooted in the idea that many claimants would rely on public healthcare regardless of the outcome of their claims. By offering treatment instead of cash, the department seeks to manage its fiscal responsibilities more sustainably. It can significantly reduce the financial burden on a health department. Ultimately, the strategy reflects an effort to balance the rights of

305 The *MSM* case.
306 The *PH case*.
307 The *MSM* para 32.
308 The *PH* para 24.

individuals harmed by medical negligence with the need to maintain a functioning and well-resourced public health system.

Positive aspects of invoking the public healthcare defence

The concept known as the "public healthcare defence" first emerged in the case of *DZ*. In that matter, the Gauteng Department of Health was held liable for over R23 million, with nearly R20 million allocated for future medical expenses. The department attempted to argue that it should be allowed to pay for these expenses directly as they arose, rather than providing a lump sum. However, the court rejected this approach, finding it inconsistent on the facts of the specific case, with the established "once-and-for-all" rule. Despite this setback, the MEC for Health of the Eastern Cape, acting as a friend of the court, introduced two alternative arguments. The first was the "public healthcare defence," which proposed that future medical costs could be met through services provided by the public healthcare system. The second was the "undertaking to pay defence," which suggested that the department would cover the cost of any medical services that the public sector was unable to provide. Although the Gauteng Department of Health's attempt was unsuccessful, the CC showed greater openness to the arguments advanced by the Eastern Cape MEC.

The "public healthcare defence" was later properly presented before the Gauteng HC in the *MSM* case. In this case the court considered whether compensation could be provided in kind rather than in cash. It concluded that, in the broader interests of justice, the common law should evolve to allow such an approach. This meant that if the public healthcare system *could* offer the same standard of care as the private sector, the Department of Health would not be required to pay monetary compensation for future medical expenses. Further development of this defence occurred in the *TN* case. In this case, the court clarified that the standard of care provided by the public sector did not need to match that of the private sector exactly. Rather, it only needed to meet a reasonable standard to satisfy the requirements of justice and fairness. This is positive as it may be very difficult to give the same standard of care in the public sector as is available in the private healthcare domain.

Negative aspects of invoking the public healthcare defence

Prior to the *Mashinini* case, a Department of Health could offer medical services through public healthcare systems instead of paying damages in a lump sum to plaintiffs. These services only had to meet a reasonable standard, which was generally easier to satisfy as indicated above. Given this, it raises the question: why did the Department fail to successfully invoke the public healthcare defence in *Mashinini*? In the case, the SCA found that the Department had *not* presented sufficient evidence to counter the expert testimony of Professor Bizos. He argued that the structure and functioning of public healthcare institutions made them incapable of delivering the specialised and immediate care required by the appellant, who suffered from complex medical conditions.[309] Because the Department did not challenge this testimony, and the appellant's evidence remained uncontested, the court ruled that compensation should be paid in monetary form—specifically R879 314.00.[310] The absence of rebuttal evidence was critical, and the court's decision appeared to hinge on Professor Bizos's expert opinion.

This ruling has sparked debate, with some suggesting it could signal a shift back to awarding monetary compensation for medical expenses rather than relying on in-kind services. However, the *Mashinini* judgment does not overturn the right of the court to develop the common law. Instead, it underscores the importance of the Department meeting its burden of proof when relying on this defence. The case should be seen as an exception, rather than a change in the rule. It illustrates that when the Department fails to convincingly demonstrate its ability to provide future medical care at a reasonable standard—comparable to that of the private sector—the court may award monetary compensation instead.

The public health care defense failed again in the case of *Phakama Ngalonkulu v The Member of the Executive Council for Health of Gauteng* [2019] ZASCA 66, in which the court dealt with a birth injury sustained at Chris Hani Baragwanath Hospital that left a child with CP due to the negligence of the staff. Back in April 2017, the trial court found the Gauteng Health Department fully responsible for the damages suffered by the plaintiff. However, a dispute later arose over how those damages should be paid.

309 *Mashinini v Member of the Executive Council for Health and Social Development Gauteng* Provincial Government (335/2021) [2021] ZASCA 53; 2023 (5) SA 137(SCA) (18 April 2023) para 19 (hereinafter 'the *Mahinini* case").

310 The *Mashinini* case para 24.

The plaintiff appealed a decision that allowed the Department of Health to pay compensation, either through public healthcare services, or in periodic installments. The plaintiff argued that once liability was confirmed, the Department of Health could no longer use these alternative payment methods. The appeal was successful. The court ruled that the Department of Health could not rely on the public healthcare defence, or make periodic payments, hence full financial compensation was required.

Litigants should understand that the 'public healthcare defence' remains valid and accepted by the courts. Nonetheless, whenever a state organ invokes this defence, it *must* be prepared to prove that it *can* deliver the required medical services to a reasonable standard. Without such proof, the defence may not succeed. In essence, the judgment reinforces the principle that the state must earn the right to offer compensation in kind by proving its healthcare system can meet the required standard. This could lead to more thorough litigation and potentially reshape how medical negligence claims are defended in South Africa.

5.2.1.2 Periodic payments

Periodic payments are a way of compensating someone through regular instalments over time**,** rather than giving them a single lump sum upfront. In medico-legal cases, this typically applies to patients (or their families) who have won a legal claim due to medical negligence. This method is being explored as an alternative to one-time-lump-sum payouts, which have placed significant financial strain on the public healthcare system.

By spreading payments over time, the Department of Health can better manage its budget and continue providing essential services. The State Liability Amendment Bill, introduced in 2018, seeks to empower courts to order these ongoing payments when damages are awarded against provincial or national health departments. This reform is viewed as a crucial step toward relieving pressure on public healthcare resources.

Periodic payments in the form of an annuity could be awarded for future maintenance, loss of earnings and the portion of future medical care, treatment, rehabilitation and therapy, that the court is not satisfied the state would be able to deliver or where the health service delivered by the state is not of an acceptable standard. Annual periodic

payments should be the default compensation option for covering future costs that aren't provided by the state.[311]

The underlying principle for the calculation of future loss of income should be changed and be premised on a structured format or a guideline based on the average national income, or the average income of the area where the claimant lives.[312]

When a court finds that government services are either inadequate or entirely absent, it is more appropriate to award compensation through regular annual payments, particularly in situations where the support being claimed is not already provided by the state. This approach is consistent with principles laid out in South African jurisprudence, such as in *Motswai v Road Accident Fund* where the court underscored the value of structured settlements as a mechanism for guaranteeing ongoing care and financial support over time.[313] But, what are the positive and negative aspects of future payments in instalments?

Positive aspects of periodic payments

Periodic payments offer certain advantages, particularly for the uncertainty surrounding the life expectancy of a child with CP, which makes accurate forecasting difficult. Periodic payments can reduce speculation—especially when they include top-up clauses (letting the claimant request additional funds if new needs arise) and claw-back clauses (allowing the defendant to recover unused funds if the child passes away earlier than expected).

Breaking down payments into smaller periodic installments could help a Department of Health to manage their costs better and more efficiently without exhausting resources in a single pay-out for damages suffered at the hands of negligent healthcare workers. This approach ensures continuity in healthcare delivery, preventing disruptions that might arise from financial constraints.

311 SALRC 'Medico-legal claims' 388.
312 G Whittaker 'Medical Malpractice A Roundup Developments' [2022] South African Actuary Magazine 72.
313 *Motswai v Road Accident Fund* [2013] ZAGPJHC 99 (2 May 2013) para 8.

For individuals who require long-term care, rehabilitation, or ongoing assistance, periodic payments provide consistent coverage, supporting their needs well into the future. Families also benefit from the predictable income stream, which allows for better financial planning and stability. Additionally, these payments can be adjusted if the claimant's medical condition evolves, or if associated costs rise, offering a flexible solution that adapts to changing circumstances.

Negative aspects of periodic payments

Periodic payments can present several challenges, particularly in relation to inflation and taxation. If these payments aren't adjusted to account for inflation, their actual purchasing power may diminish over time—this is especially problematic for long-term claims. Legally, enforcing periodic payments tends to be more complex than awarding a lump sum, often requiring ongoing supervision, meticulous record-keeping, and potential modifications, all of which can be burdensome for both the payer and the recipient. Additionally, individuals receiving fixed payments might feel constrained, especially if their financial needs evolve or they prefer a different approach to managing their funds. To accommodate periodic payments effectively, clearer guidelines should be considered in future to regulate periodic payment. The MECs of Health should also be vary of the fact that they could only plead for periodic payment if an agreement is reached with the claimant before judgment is given.[314]

Recommendation

Concerning the development of the common law, my recommendation is first that the legislature should legislate the requirements for medical negligence and the test to be applied to determine whether there was negligence or not. Secondly, the envisaged act should also address the exact requirements for the public healthcare defence, delineating what needs to be proved, how it must be proved, and at what stage of the proceedings it must be proved. Thirdly, the envisaged act should also address when and how payments in instalments can be offered or argued. The act could even include some aspects I am going to discuss below, like compulsory mediation, the use of assessors, and the sanctions towards healthcare workers who should be held accountable if negligence in CP cases are established.

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314 The *BN* case para 15.

5.2.2 Mediation

Mediation presents a viable solution for resolving medical negligence disputes, offering a more efficient, accessible, and equitable approach. In line with the constitutional goal of expanding access to justice, the state is urged to provide alternative methods for resolving disputes beyond traditional courtroom proceedings. Mediation serves as a promising alternative.[315] The process of mediation involves a neutral third-party mediator who facilitates negotiation between parties to reach a mutually acceptable solution.[316] Mediation offers a dignified and non-threatening environment for resolving disputes, promoting a level playing field. Unlike litigation, mediation doesn't aim to declare a winner or loser but instead empowers parties to create their own solutions.[317]

Mediation can be described as a guided negotiation process, where a neutral third-party facilitator helps conflicting parties communicate effectively and work towards a mutually acceptable agreement with a key advantage of preserving relationships between doctors and patients.[318] The South African Law Reform Commission's 2001 report on mediation (SALRC report) offers important perspectives on how mediation functions within the country:[319] It emphasises that the process should be entered into willingly by all parties, without any form of pressure or coercion. A core expectation is that mediators maintain a position of neutrality, acting without bias or favouritism. The confidentiality of the process is also underscored, ensuring that all discussions and communications remain private. Ultimately, the report reinforces that the power over decisions and outcomes lies entirely with the parties themselves, affirming their control throughout the mediation journey.[320]

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315 M Heywood and A Hassim 'Remedying the maladies of 'lesser men or women': The personal, political and constitutional imperatives for improved access to justice' (2008) 24(2) South African Journal on Human Rights 263–280.

316 Anon 'What is Mediation and Why South Africa is Embracing it' https://www/mediationacademy.co.za/single-post/what-is-mediation-south-africa accessed 1 June 2025.

317 Anon 'What is Mediation and Why South Africa is Embracing it' https://www/mediationacademy.co.za/single-post/what-is-mediation-south-africa accessed 1 June 2025.

318 WT Oosthuizen and PA Carstens 'Medical malpractice: The extent, consequences and causes of the problem' (2015) (78) THRHR 269-284; M S Pepper and N M Slabbert 'Is South Africa on the verge 29-35; J Walters 'Mediation – an alternative to litigation in medical malpractice' (2014) 104(11) SAMJ 717-718.

319 SALRC 'Medico-legal claims'.

320 SALRC Discussion Paper 168, Project 94 'Alternative Dispute Resolution: Mediation Act For South Africa' https://www.justice.gov.za/salrc/dpapers.htm 32-34 accessed 1 June 2025.

Successful mediation relies on confidence in the mediator and trust in the process. Therefore, mediators require specialised training in medical negligence cases to effectively facilitate dispute resolution. The SALRC Report describes the mediation process as a sequence of structured interactions aimed at resolving disputes collaboratively. It begins with a pre-mediation phase, where the mediator meets with each party individually to explain how mediation works and to confirm their willingness to engage. Once that groundwork is laid, the parties come together, and the mediator formally introduces them while re-emphasising the mediation framework. Each side then has the opportunity to present their perspective on the conflict, offering insight into the issues that need resolution. This leads into the negotiation phase, during which the mediator actively facilitates communication, helping the parties explore possible solutions. If the discussions are fruitful and an agreement is reached, the mediator supports both parties in drafting a clear and mutually acceptable settlement agreement.[321] Cognisance should be taken that mediation is not something new and existed for a long time as an alternative dispute mechanism, but it is not yet compulsory to mediate medical negligence cases, except in the North Gauteng division of the High Court. It is not prescribed for CP cases, and it is my argument that it could assist matters if the parties in CP litigation could rather mediate the issue. But what are the specific positive and negative aspects of mediation?

Positive impacts of mediation in CP cases

Mediation offers a range of practical advantages that make it an appealing alternative to traditional litigation. It's often a more affordable option, allowing parties to resolve disputes without incurring the high costs typically associated with court proceedings. Beyond the financial aspect, mediation tends to be quicker, helping to avoid the long delays that court cases often face.[322] Importantly, it fosters an environment where relationships can be preserved, especially when *ongoing* interaction between the parties is necessary or desirable. Another key benefit is that mediation places the decision-making power directly in the hands of the people involved, rather than leaving outcomes to a judge.

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321 SALRC 'Alternative Dispute Resolution'' 214.

322 'Why Choose Mediation Over Litigation' https://curranattorneys.co.za/why-choose-mediation-over-litigation/ accessed 1 June 2025.

Mediation is increasingly seen as a promising way to resolve medical negligence claims in South Africa, and for good reason. Unlike traditional litigation, mediation encourages a more cooperative atmosphere where both sides can openly share their concerns and work toward a solution without the hostility that often accompanies court battles. It also gives the parties involved more control over both the process and the outcome, which is rarely the case in litigation or arbitration.[323]

One of the most appealing aspects of mediation is its speed. Legal proceedings can stretch on for years, draining both emotional and financial resources. Mediation, on the other hand, tends to resolve disputes much more quickly, easing the burden on patients and healthcare providers alike. It's also far more cost-effective, avoiding the hefty legal fees, expert witness costs, and extended court appearances that come with litigation.

Privacy is another major benefit. Mediation takes place behind closed doors, safeguarding the reputations of medical professionals and protecting the personal details of patients—unlike public trials, which are open to public scrutiny.[324] This discretion can be especially important in cases where ongoing care is involved, as mediation helps preserve the relationship between patient and provider. Its informal nature makes it more approachable and less intimidating for patients. Mediation offers patients a chance for emotional healing. It can provide space for explanations, apologies, expressions of empathy or regret, and even forgiveness—helping individuals find closure and restore valued relationships.

The South African legal process is also beginning to encourage mediation more actively. Rule 41A of the Uniform Rules of Court requires parties to consider mediation before heading to court, and claimants must complete Form 27 to indicate whether they agree or oppose the process.[325] Support for mediation is also growing within the medical community. Organisations like the Medical Protection Society and other

323 'Why Choose Mediation Over Litigation' https://curranattorneys.co.za/why-choose-mediation-over-litigation/ accessed 1 June 2025.

324 'Why Choose Mediation Over Litigation' https://curranattorneys.co.za/why-choose-mediation-over-litigation/ accessed 1 June 2025.

325 Rule 41A (2): Court-Annexed Mediation in South African Civil Litigation, SALRC 'Medico –Legal Claims' 367.

clinician societies are backing the approach.[326] The Judge President of the Gauteng High Court has proposed making mediation mandatory in that division.[327] Globally, countries such as the United Kingdom and Canada have already embraced mediation for medical disputes, offering South Africa a proven model to follow.[328]

Negative impact of mediation on CP cases

Despite all the positive aspects mentioned above, mediation in medical negligence claims presents a range of significant challenges that can undermine its effectiveness. One of the key limitations is that mediation outcomes are typically private and do not establish legal precedent unless they result in a formal settlement. This lack of precedent can impede broader reforms and leave medical standards ambiguous.[329]

Another concern is the imbalance of power between the parties involved. Patients, often less informed and lacking legal representation, may feel overwhelmed when negotiating with healthcare professionals or insurers. This dynamic can lead to settlements that are less favorable to the more vulnerable party.[330]

Accountability is also a contentious issue. Because mediation prioritises resolution over assigning blame, healthcare providers may escape public scrutiny or disciplinary consequences, even in cases involving serious negligence. This can be deeply unsatisfying for claimants seeking justice and transparency.[331]

Despite the legal framework encouraging mediation—such as Rule 41A, which requires parties to consider it before pursuing litigation - many claimants remain

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326 MPS urges clear rules, tailored guidance and training to make draft Mediation Bill a success https://www.medicalbrief.co.za/mps-supports-mediation-bill-but-urges-training-and-clear-rules/ accessed 1 June 2025.

327 Gauteng High Court proposes mandatory mediation for civil cases: https://groundup.org.za/article/Gauteng-high-court-proposes-mandatory-mediation-for–civil-cases/ accessed 1 June 2025.

328 SALRC 'Medico–legal claims' 324, 376 and 404

329 G R Clarke and L T Davies 'ADR Arguments for and against use of mediation process: Particularly in family and neighbourhood disputes' [1991] QUT Law Journal 91

330 Clarke and Davies 'ADR Arguments for and against' 92

331 Clarke and Davies 'ADR Argument for and against'' 93.

skeptical. Their reluctance often stems from a desire for public justice, mistrust of the process, or the belief that litigation may yield higher compensation.[332]

Cultural and professional attitudes further hinder the adoption of mediation. In South Africa, it remains under utilised, with many legal practitioners defaulting to litigation and viewing mediation as a secondary option. Finally, mediation offers no certainty of resolution. Since it is a voluntary process and only binding if both parties agree, failed mediation can lead to additional costs and delays as parties revert to litigation.[333] If mediation does not seem to be the ultimate answer to medical negligence disputes, other possible options should thus also be scrutinized.

Recommendation

Concerning mediation my recommendation is that all CP cases should go for compulsory mediation before a court date should be awarded. Only in instances where the mediation was not successful should a court date be considered.

5.2.3 Assessors

Assessors serve as vital contributors to the judicial process, especially in cases that demand specialised knowledge or technical expertise.[334] When appointed by the court, their responsibility centres on helping the presiding officer navigate intricate issues, ensuring that justice is not only pursued but appropriately administered.[335] Through their insights and professional understanding, assessors bring clarity to complex matters, thereby enhancing the court's ability to make decisions that are both fair and accurate. Their role is not simply advisory—it strengthens the integrity of legal outcomes and ensures that nuanced details do not go overlooked.[336] In light of this, I argue that the use of assessors becomes particularly important in CP cases, where

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332 In the case of *Msiza v Director-General, Department of Rural Development and Land Reform* and Others (LCC 133/2012) [2016] ZALCC 12, 2016 (5) SA 513 (LCC) (5 July 2016) where the Land Claims Court emphasised the role of judicial discretion in determining "just and equitable compensation," which often leads claimants to believe that litigation offers a better financial outcome than mediation.

333 T J Simmons 'Mandatory Mediation: A Better Way to Address Status Offenses' (2006) 21(3) Ohio State Journal on Dispute Resolution 1043.

334 H Lerm 'Two heads are better than one: Assessors in High Court civil cases' https://www.saflii.org/za/journals/DEREBUS/2012/34.pdf accessed 10 October 2024.

335 Lerm 'Two heads are better than one' 2; SALRC 'Medico-legal claims' 381.

336 Lerm 'Two heads are better than one' 2.

the subject matter is highly specialised and often difficult for those without medical training to fully grasp. Including assessors in CP cases can significantly contribute to well-informed judgments and uphold the standards of justice. The appointment of assessors in civil matters as noted by Lerm is restricted to the lower courts, as neither the Supreme Court Act 59 of 1959 nor the Uniform Rules of Court provide for the appointment of assessors in civil proceedings in the superior courts.[337]

In South Africa, there has been a noticeable lack of progress in exploring the use of assessors for complex civil cases.[338] Although judges possess the authority to enlist such support, there remains a visible hesitancy to do so. This underutilisation highlights the need for a more clearly defined and systematic approach.[339] Incorporating the role of expert assessors directly into the Uniform Rules of Court may offer a constructive solution. Having an assessor with specialised knowledge, experience, and analytical skills relevant to the case, could reduce the risk of judicial errors and cut down on costly appeals. Moreover, this added expertise would likely enhance the efficiency of proceedings and foster greater trust in the legal system among the public.[340]

Assessors should have distinct attributes meaning they should be experts in the field of CP and/or medical law as such to provide credible and informed advice to the judge. They should operate independently and be allowed to offer impartial and objective insights that support the court's decision-making process.[341] Rather than making judgments themselves, assessors should contribute by advising and guiding the court with their specialised knowledge.[342]

Positive impact of using assessors in CP cases

Using assessors in CP cases could bring a range of advantages that significantly enhance the fairness, efficiency, and credibility of the legal process. These professionals—often medical experts or forensic psychologists—could offer specialised insight that could help courts navigate the complexities of medical

337 Lerm 'Two heads are better than one' 2; SALRC 'Medico-legal claims' 381.
338 Lerm 'Two heads are better than one' 2.
339 Lerm 'Two heads are better than one' 2.
340 Lerm 'Two heads are better than one' 5.
341 Lerm 'Two heads are better than one' 2.
342 Lerm 'Two heads are better than one' 5.

evidence. Their evaluations should be grounded in expertise and objectivity, which minimises the risk of biased or uninformed judgments and ensures that decisions are based on sound, evidence-driven analysis.[343] Assessors could play a crucial role in accurately quantifying the physical, psychological, and emotional impact of injuries, which could lead to more appropriate and just compensation for claimants. Their reports, which are admissible in court, should carry substantial weight and lend credibility to the legal arguments presented, strengthening the overall case.[344]

Efficiency is another advantage. By clarifying facts early in the litigation process, assessors could help to streamline proceedings and reduce unnecessary delays. Their involvement could also prevent the courts from relying on non-expert sources such as textbooks or anecdotal evidence, which can result in flawed rulings and misjudgments.[345]

The use of assessors could also provide protection for all parties involved. Their impartial evaluations could ensure that both claimants and defendants are treated fairly. Legal teams, including lawyers and insurers, could also benefit from the detailed and credible reports assessors provide, which support informed decision-making and strengthen case strategy.[346]

Finally, assessors could contribute to reducing the systemic burden on South Africa's legal and healthcare systems. As CP cases continue to rise, their expertise could help manage the growing volume and complexity of cases. This might not only improve case outcomes but also has the potential to ease the financial strain on the public health sector, making their role increasingly vital in the broader legal landscape.

Negative impact of using assessors in CP cases

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343 Lerm 'Two heads are better than one' 1.

344 M Slabbert 'Road-Accident-Fund: Serious Injury Claims and Judicial Precedent: The Supreme Court of Appeal Has Spoken' 624 https://www.journals.co.za/doi/pdf/10.10520/EJC148910; SALRC 'Medico-legal claims' 383.

345 Lerm 'Two heads are better than one' 5; G Moodley 'Do we need more experienced judges, or should we use experts and assessors better?' https://www.derebus.org.za/do-we-need-more-judges-or-should-we-use-experts-and assessors-better/ accessed 10 October 2024.

346 T Bekker 'The role of expert evidence in civil litigation: A critical analysis (Part 1)' (2023) 48(1) Journal for juridical Science 160-178 https://doi.org/10.38140/jjs.v48i1.7123 accessed 10 October 2024.

The use of assessors in CP cases in South Africa, though intended to provide expert insight into complex medical matters, can inadvertently introduce a range of challenges that raise serious concerns about fairness, cost, and systemic bias.[347] One of the most pressing issues is the potential for bias and lack of objectivity. Assessors are often drawn from the same professional circles as the defendant medical practitioners, which can compromise their impartiality.[348] Without rigorous vetting, there's a risk that assessors may lean in favor of the medical establishment, thereby undermining the fairness of the proceedings.[349]

Another concern lies in the inconsistency of expertise. South Africa lacks a standardised panel or accreditation system for medico-legal assessors, resulting in varied qualifications and levels of competence.[350] Courts may sometimes rely on assessors who do not possess adequate experience in the specific medical field relevant to the case, which can affect the quality and reliability of their input.

The involvement of assessors also tends to escalate the financial burden of litigation.[351] This is particularly problematic for claimants who already face significant resource constraints. Moreover, the presence of assessors can inadvertently undermine judicial authority. In highly technical cases, judges may defer too heavily to the opinions of assessors, which risks shifting the basis of verdicts from legal reasoning and evidence to expert interpretation. This dynamic can dilute the role of the judiciary and compromise the integrity of legal outcomes.[352]

Finally, unlike judges, assessors are not subject to the same level of public scrutiny.[353] Their influence on case outcomes is often not clearly documented or open to challenge.[354] Even when their role is officially advisory, their input can carry

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347 Sartwelle and Johnston 'Cerebral Palsy' 828-841; the *Linksfield* case paras 62 and 63;
348 The *Linksfield* case paras 29 and 106.
349 The *Linksfield* case paras 66 and 68.
350 The *Linksfield* case para 70.
351 The *Linksfield* case para 107.
352 The *Linksfield* case para 109; G Moodley 'Do we need more experienced judges, or should we use experts and assessors better?' [2025] De Rebus 51.
353 J Kriegler 'Judge Hlophe betrayed the nation with his greed' [2017] Advocate https://www.gcbsa.co.za/law-journals/2007/december/2007-december vol020-no3-pp33-34.pdf, accessed 20 October 2024.
354 *Van der Walt v S* (CCT180/19) [2020] ZACC 19,2020 (2) SACR 371 (CC) paras 6,32 and 33.

disproportionate weight, further complicating the pursuit of justice in medico-legal claims.[355]

Recommendation

The recommendation concerning assessors is that they should be appointed to assist the judge with difficult medical terminology or procedures, in other words the assessors should actually replace the expert witnesses that each party to the dispute uses. This will eliminate the using of 'hired guns' as indicated under the discussion of the expert witness. The assessors' only responsibility will be to assist the judge and therefore he or she will not be part of either the plaintiff's or defence's team.

5.2.4 Capping of claims in cerebral palsy cases

Capping of claims refers to a legal or policy approach that sets limits on the amount of compensation awarded in cases of medical negligence – most notably in instances involving children who develop CP due to alleged negligence during birth. These caps may be applied to various forms of compensation, including general damages for pain and suffering, anticipated medical costs, or projected loss of income. The intention behind this mechanism is to ease the financial strain on provincial health departments, which have accumulated billions in contingent liabilities from medico-legal claims.[356]

In response, the South African Law Reform Commission and several provincial governments have considered introducing reforms focused on CP-related claims.[357] Proposed measures include structured settlements, legislative changes, and actuarial models to ensure consistent compensation while minimising the financial risk for public institutions.[358]

Ultimately, the challenge lies in striking a balance between providing fair recompense to affected families and maintaining the long-term sustainability of public healthcare funding. It's important to note that courts continue to evaluate each case individually,

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355 K Mudzuli 'Absence of assessors during trial leads to dramatic overturn of life sentences' https://www.conviction.co.za/absence-of-assessors-during-trial-leads-to-dramatic-overturn-of-life-sentences/ accessed 10 October 2024; *S v Nkumanda* (CA&R45/2023) [2024] ZAECMKHC 31 (19 March 2024).

356 SALRC 'Medico-legal claims' 386 - 387.

357 SALRC 'Medico-legal claims 387.

358 SALRC 'Medico-legal claims' 387 – 388.

relying on expert medical evidence, causation, the level of negligence involved, and application of these caps varies across different provinces.[359]

One of the more hotly debated aspects of CP is the idea of limiting how much compensation can be awarded in these cases, commonly referred to as the 'capping' of claims.[360] Since there's no formal legislation addressing the capping of medical negligence pay-outs specifically, comparisons are often drawn with the framework used by the Road Accident Fund (RAF), which serves as a point of reference.

Put simply, capping claims means placing a ceiling on the amount of money a person can receive as damages for injuries sustained. The rationale is to keep pay-outs fair and within reasonable bounds, preventing excessive strain on both the healthcare system and those found liable.[361] When it comes to the RAF, which compensates individuals hurt in road accidents, their guidelines offer structured limits depending on the type and severity of injury.[362] For example, pain and suffering-or general damages-can range from R250 000 to R400 000. Expected future medical costs are capped between R250 000 and R500 000, while compensation for lost income could fall between R200 000 and R400 000 per year, influenced by factors like the person's profession, age, and potential earnings.[363] Although these could serve as guidelines for capping amounts in CP cases it is necessary to find out what are the positive side of 'capping' and what is negative about it.

Positive impact of capping claims in CP cases

Capping CP claims could have a range of strategic advantages, especially within the public health sector. One of the most significant benefits is the financial protection it offers to the department of health.[364] In recent years, the cost of medico-legal claims has surged dramatically, with billions of rand being paid annually. By placing a cap on these claims, provincial health departments can limit their financial exposure, helping to preserve critical funds for essential services. This approach also brings greater

359 SALRC 'Medico-legal claims' 386; the *MSM* case and the *TN* case.
360 SALRC 'Medico-legal claims' 387.
361 The *TN* case*;* SALRC 'Medico-legal claims' 386 – 387.
362 The Road Accident Fund Amendment Act 19 of 2005.
363 The Road Accident Fund Amendment Act 19 of 2005.
364 'Capping the cost of negligence' News24.com; https://www.news24.com/capping-the-cost-of-negligence-20150429 accessed 10 October 2024,

predictability to budgeting processes, allowing governments to allocate resources more effectively without the constant threat of unpredictable, massive payouts.[365]

From a legal standpoint, capping claims contributes to a more efficient justice system. It can discourage excessive or opportunistic litigation, particularly cases inflated by legal firms aiming for large settlements.[366] Moreover, it promotes faster resolution of disputes, often through mediation or structured settlements, rather than drawn-out court proceedings.[367]

The healthcare system itself stands to benefit significantly. Resources that would otherwise be consumed by large payouts can be redirected toward improving infrastructure, recruiting skilled professionals, and enhancing the overall quality of patient care.

Negative impact of capping claims in CP cases

Capping CP claims carries several significant disadvantages that can impact both individuals and the broader justice system. One of the most immediate concerns is the reduction in compensation for victims. Those who suffer from severe medical negligence—especially children with CP—may receive less than what is fair or necessary to cover lifelong care, rehabilitation, or loss of income.[368] This limitation can leave vulnerable individuals without adequate support.

Another consequence is the erosion of accountability within the healthcare sector.[369] When financial consequences are minimised, healthcare providers and institutions may feel less compelled to uphold high standards of care.[370]

Legal inequity also becomes a pressing issue. Wealthier individuals may still find ways to pursue private legal avenues or circumvent caps through alternative claims, while

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365 L Prinsen 'The leading causes' 1140-1142.
366 Prinsen 'The leading causes' 1140-1142.
367 'Executive Summary Medico-legal claims' https://coding.samedical.org/file/1794 accessed 10 October 2024.
368 'Capping the cost of negligence' News24.com.
369 'Capping the cost of negligence' News24.com.
370 'Impact of medico-legal claims on service delivery access and quality' Medical brief (2024) https://percept.co.za/medico-legal-brief-five-impact-of-medico-legal-claims-on-service-delivery-access-and-quality/ accessed 12 October 2024; SALRC 'Medico-legal claims' 390-391

poorer claimants are left with limited options. This disparity risks deepening inequality in access to justice and undermines the principle of fairness.[371]

Moreover, the imposition of arbitrary caps could face constitutional challenges. South Africa's Constitution guarantees the right to access courts and to claim damages for harm suffered. If caps infringe on these rights, they may be deemed unconstitutional, prompting legal scrutiny and resistance.[372]

Public trust in both the healthcare and legal systems may also suffer. When victims perceive that the system prioritises institutional protection over individual justice, confidence in these systems can erode, leading to broader societal disillusionment.[373]

Finally, introducing caps may inadvertently increase legal complexity. Disputes could arise over the interpretation of what constitutes "general damages" versus "special damages," or whether certain exceptions apply. This could result in additional litigation, complicating the very system the caps aim to streamline.[374]

Recommendation

In order to make an informed recommendation pertaining to the capping of claims or pay-outs, further research and contemplation is necessary. My recommendation is that such an enterprise, which falls outside the scope of this dissertation, should be undertaken.

5.2 5 Medical guidelines determining the cause of cerebral palsy

Additional research into CP's underlying pathophysiology mechanism is necessary. It will ensure that the mechanisms contributing to the condition are better identified and addressed. It is crucial to prioritise the refinement of MRI techniques so that detection and diagnosis become more accurately and timely.[375] Elevating the effectiveness of

371 B Wessels and G Speechly 'The Bill of Rights and State Liability for Medical Negligence: A Case for Judicial Development of the Common Law (Part 1)' (2023) 37 Spec Juris 1–21 ,
372 'Capping the cost of negligence' News24.com.
373 SALRC 'Medico-legal claims' 11.
374 'Capping the cost of negligence' News24.com.
375 Bhorat and others 'Cerebral Palsy' 280-288.

these protocols could lead to earlier interventions and improved outcomes for those affected.[376]

CP is frequently misunderstood as stemming primarily from birth-related injuries, yet this notion fails to capture the full complexity behind its development.[377] Although birth trauma-such as acute intrapartum hypoxia caused by asphyxia during delivery-can indeed contribute to CP in some instances, it is not the leading cause.[378] Intrapartum refers to the period during birth,[379] while hypoxia describes a lack of oxygen reaching bodily tissues,[380] and asphyxia is a condition that arise when the body is deprived of oxygen.[381]

A baby born under these conditions is said to be suffering from hypoxic ischemic encephalopathy (HIE), which "is a type of brain dysfunction that occurs when the brain doesn't receive enough oxygen or blood flow for a period of time. Hypoxic means not enough oxygen; ischemic means not enough blood flow; and encephalopathy means brain disorder".[382] Research demonstrates that this factor is not the predominant cause. In reality, only a small percentage of CP cases are solely attributed to birth trauma.[383] This indicates that CP has a much more intricate and multifactorial origin than previously believed.[384]

Bhorat and others caution against reducing the causes of CP to a single, oversimplified explanation-especially in high-stakes cases before the courts.[385] The widespread belief that CP is a direct consequence of adverse events during birth and therefore

376 Bhorat and others 'Cerebral Palsy' 284.
377 Bhorat and others 'Cerebral Palsy' 285.
378 I Bhorat and others 'Cerebral palsy and its medico-legal implications in low-resource settings – the need to establish causality and revise criteria to implicate intrapartum hypoxia: A narrative review' (2023) 113(7) SAMJ 29-34.
379 Merriam-Webster Online Dictionary www.merriam-webster.com; SALRC 'Medico-legal claims' 175.
380 Oxford English Dictionary 6 ed (Oxford University Press 2007); SALRC 'Medico-legal claims' 175.
381 Merriam-Webster Online Dictionary www.merriam-webster.com: SALRC 'Medico-legal claims' 175.
382 University of California, San Francisco 'Neonatal hypoxic ischemic encephalopathy' Bennioff Children's Hospitals, (The Regents of the University of California 2020-2021) www.ucsfbenioffchildrens.org/conditions/neonatal-hypoxicischemic-encephalopathy accessed 10 October 2024.
383 MacLennan, Thompson and Gecz 'Cerebral palsy' 779; GG Buttigieg 'Lessons from the Great Medico-Legal Chapter of Cerebral Palsy' (2017) 5 Neurol Disord 335.
384 Buttigieg 'Lessons' 335; Ramdass *Medico-legal Aspects of Cerebral Palsy* 8-9.
385 Bhorat and others 'Cerebral Palsy' 280-288.

preventable has triggered a wave of high-value litigation targeting obstetricians.[386] This trend has not only driven up insurance premiums sharply but has also placed considerable strain on healthcare delivery systems.[387]

Despite these assumptions, studies indicate that only a small percentage—roughly 10 to 14 percent—of CP cases are actually linked to intrapartum hypoxia.[388] In reality, most cases have little or no connection to such birth-related complications. CP is a multifactorial condition, shaped by a complex interplay of factors including antenatal insults, priming of the foetal brain and undetected prenatal conditions.[389]

Understanding the complexities of CP will allow for a deeper, more accurate view of this multifaceted condition, helping us to move beyond simplistic explanations. CP's origins are not limited to a single factor; rather, they arise from an intricate combination of influences spanning the prenatal, perinatal, and postnatal periods.[390] When it comes to CP cases in our courts, the assignment of liability frequently hinges on medical imaging results such as MRIs and CTG tracings. Yet this approach falls short, as it overlooks other essential aspects of clinical evaluation.[391]

Establishing a true cause of CP and determining liability requires a thorough analysis of the entire medical scenario. This includes examining the clinical context surrounding the birth, assessing foetal heart rate patterns, interpreting neuroimaging outcomes, and analysing placental pathology. Only by considering all of these elements together can a well-rounded and informed conclusion be reached.[392]

Failure to consider these factors may result in court decisions being unduly influenced by persuasive legal arguments rather than empirical evidence.[393] Bhorat *et al* expanded on the criteria established by the US Cerebral Palsy Expert Task Force in

386 Buttigieg 'Lessons' 335; Bhorat and others 'Cerebral Palsy' 286.
387 Buttigieg 'Lessons' 335.
388 Bhorat and others 'Cerebral Palsy' 287.
389 Buttigieg 'Lessons' 335; Bhorat and others 'Cerebral Palsy' 287; Ramadass *Medico-legal Aspects of Cerebral Palsy* 8-9.
390 Buttigieg 'Lessons' 335; Bhorat and others 'Cerebral Palsy' 280.
391 Buttigieg 'Lessons' 335; Bhorat and others 'Cerebral Palsy' 282.
392 Buttigieg 'Lessons' 335; Bhorat and others 'Cerebral Palsy' 284.
393 Buttigieg 'Lessons' 335; Bhorat and others 'Cerebral Palsy' 286.

2014[394] that can be applied to assist with the determination of whether an acute hypoxic-ischaemic event occurred during labour and delivery.[395]To determine whether a new-born's brain injury was caused by oxygen deprivation during labour, they added placental histology to the existing criteria.[396] This addition brought the total checklist items to ten, creating a comprehensive and thorough framework for determining the causes of CP.[397]

The 10 Criteria are summarised below:[398]

1. **Case definition:** Neonatal encephalopathy is a syndrome characterized by disturbed neurological function in new-borns born at or after 35 weeks of gestation.

2. **Apgar score:** Low Apgar scores at 5 and 10 minutes after birth may indicate intrapartum asphyxia, but this assessment is subjective and doesn't always correlate with other clinical information.

3. **Cord pH:** Foetal umbilical artery pH below 7 or base deficit above 12 mmol/L increases the likelihood of neonatal encephalopathy due to intrapartum hypoxia.

4. **Multi-system organ failure:** New-borns with brain damage and organ failure are more likely to have suffered hypoxic-ischemic injury.

5. **Intrapartum sentinel events:** Events like placental abruption, uterine rupture, cord prolapse, or sudden foetal bradycardia during labor can increase the risk of birth asphyxia.

6. **Foetal heart rate monitor patterns:** CTG tracings can assist in diagnosis when combined with other clinical findings, but interpretation is subjective.

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394 The task force included the American College of Obstetrics and Gynaecology and the American Academy of Paediatrics. (also referred to by MacLennan, Thompson and Gecz) 'Cerebral palsy' 79–788.

395 The term "ischaemic" is derived from "ischemia", which is "what happens when there is a decrease in blood supply to tissues, leading to a decrease in oxygen and nutrients to the affected area" Top doctors United Kingdom 'Ischemia' www.topdoctors.co.uk/medical-dictionary/ischaemia accessed 15 October 2024.

396 Bhorat and others 'Cerebral palsy' 287.

397 Bhorat and others 'Cerebral palsy' 287.

398 Summary of ten criteria as set out and explained by Bhorat and others 'Cerebral palsy' 287.

7. **Neuroimaging studies:** MRI performed at the right time or in conjunction with other information can provide valuable insights. However, MRI results alone cannot determine if the injury occurred during labour if performed after three weeks of life.

8. **Evidence of other proximal or distal factors:** Certain factors present during pregnancy can make newborns more vulnerable to oxygen deficiency during labour.

9. **Developmental outcome:** Spastic quadriplegic or dyskinetic cerebral palsy is consistent with hypoxic-ischemic brain injury.

10. **Placental histology:** Examining the placenta can reveal abnormalities that affected foetal health, providing additional evidence for birth asphyxia.

These stated criteria can help determine if a new-born's brain injury was caused by lack of oxygen during labour, providing valuable guidance in medico-legal settings.

Positive impact of medical guidelines in CP cases

Medical guidelines can significantly influence CP claims in South Africa, serving as important reference points in determining standards of care.

Negative impact of medical guidelines in medico-legal negligence cases

Medical guidelines significantly present a range of challenges that complicate both litigation and the delivery of healthcare in South Africa. One major issue is that these guidelines are not legally codified; they function as best-practice recommendations rather than binding rules. As a result, courts rely on common law principles, which can lead to inconsistent interpretations from case to case.[399] Additionally, the guidelines themselves often suffer from ambiguity and variability. When they lack specificity—particularly in complex clinical situations—they become open to interpretation, making it difficult to determine whether a healthcare practitioner acted negligently or reasonably.

Another concern is that some guidelines may be outdated or incomplete, failing to incorporate the latest medical advancements or reflect the realities of local healthcare systems. In legal disputes, this can unfairly disadvantage practitioners who adhered

[399] Executive Summary Medico-legal claims https://coding.samedical.org/file/1794 accessed 10 October 2024.

to these guidelines in good faith. Moreover, there is a tendency in litigation to treat guidelines as rigid standards, overlooking the nuances of individual patient care. This overreliance can result in unjust outcomes for providers who deviate from the guidelines for sound clinical reasons.

Resource constraints further complicate matters. Many guidelines assume access to ideal infrastructure and resources, which are often lacking in South Africa's under-resourced public hospitals. Practitioners working in these environments may be unfairly judged for not meeting standards that are practically unattainable. Finally, the growing public awareness of healthcare rights and legal recourse has led to an increase in medico-legal claims. [400] When guidelines are misapplied or misunderstood, they can contribute to this surge by fostering unrealistic expectations of care.

Recommendation

Having medical guidelines to check for CP will be welcomed, but it should be medically sound and accepted by everyone. As a lawyer I cannot make recommendations with regards to the exact guidelines, but further deliberations and developments will be of great assistance.

5.2.6 Department of Health involvement

First, the Department of Health must establish a centralised system for tracking CP cases. Their legal teams should also be aware of the requirements for the public health defence as discussed in the research. Furthermore, the legal teams should also know that they could only raise a defence for periodic payment if there is an agreement between the parties – as also discussed previously in this research. The database could also be instrumental in producing accurate life expectancy assessments, which are a key component in determining compensation.[401]

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400 Executive Summary Medico-legal claims https://coding.samedical.org/file/1794 accessed 10 October 2024.

401 N Ndebele 'The causes, extent and effects of medico-legal claims on healthcare delivery in South Africa' [2024] Social sciences and education research review https://doi.org/10.5281/zenodo.15258153 accessed 1 September 2024; Bhorat and others 'Cerebral palsy' 287.

To streamline the resolution of medical disputes, healthcare providers or the public sector should embed a mediation clause into their patient agreements.[402] This clause would establish mediation not merely as a possibility but as a *required* first step before escalating to legal proceedings. It should lay out a clear process for initiating mediation, complete with structured timelines leading up to the meeting. In preparation, all parties involved should pre-select a mediator or mediation service and agree on a schedule to ensure the process is timely and effective. By doing so, providers show a genuine commitment to resolving conflicts in a way that prioritises patient care and expediency.[403]

The Department of Health could also consider codifying the 'open door' created in the *DZ* case to develop the common law as standard practice in CP cases. This would entail that the legal team for the state should raise the public healthcare defence and ask for payments in increments in CP cases against a Department of Health, but they should reach an agreement before it is argued in court as indicated above and they should make sure they have the necessary evidence to substantiate such requests.

The national and provincial health departments should also be empowered to investigate CP cases for their own records and take meaningful administrative action against healthcare providers when necessary, such as starting disciplinary processes or notifying the healthcare workers' regulating bodies such as the HPCSA or the Nursing Council about alleged negligence on the part of one of their registered people so that those bodies could take further action, such as imposing fines or revoking licenses. This would reinforce accountability and uphold higher standards across the healthcare system.

Positive effect of the Department of Health's involvement in CP cases

South Africa's different Departments of Health play a crucial role in managing CP cases. By introducing secure systems for tracking and managing medico-legal claims, the department can streamline processes, reduce delays, and enhance transparency.

402 L Boulle and K Kelly *Mediation: Principles, process, practice* (Butterworths 1998) 226-236; SALRC 'Medico-legal claims' 367.

403 SALRC 'Medico-legal claims' 367.

The provincial departments of health is well-positioned to distinguish between legitimate and fraudulent claims, this could be done by developing clear protocols to follow in the case of CP. By working along-side the South African Law Reform Commission, the department should support legislative changes in the context of CP claims. Given that these claims have a huge cost effect on the health department's budgets each year, the Department's active participation would allow for better control of expenses, ensuring that more funding can be directed toward essential health services for the masses.

Moreover, the different health departments could invest more in training and accountability among healthcare professionals, which could help reduce negligence incidents. If they were to follow a more proactive approach it will send a strong message to healthcare workers about its commitment to patient safety and justice, helping to restore public confidence and drive meaningful reform across the health system.

Negative effect of the Department of Health's Involvement in CP cases

The different departments of health should evaluate CP cases better and not deny liability where it is clear there was negligence. Money should not be wasted on litigation where it is clear the healthcare professionals did not act as they should have. Resources that should be allocated to improving healthcare infrastructure and services should not be used for a lengthy trial.

This financial redirection has led to a noticeable deterioration in healthcare services. Facilities are increasingly under-resourced, struggling to maintain operations, upgrade equipment, and recruit sufficient staff.[404] Poor infrastructure not only hampers service delivery but also contributes to medical errors, which then generate further claims, creating a damaging cycle.[405] Compounding this issue is the continued reliance on

404 'South Africa's Medical Negligence Crisis' https://www.thinkglobalhealth.org/article/south-africas-medical-negligence-crisis accessed 10 October 2024.

405 'Impact of Medico-Legal Claims on Provincial Health Budget and Mitigation Measures' https://pmg.org.za/committe-meeting/375901/ accessed 10 October 2024; SALRC 'Medico-Legal Claims' 16.

manual record-keeping. Without electronic health records, defending against claims becomes challenging, as patient data is often incomplete or missing.[406]

Healthcare workers are also deeply affected. Many operate in high-pressure environments that are understaffed and lack essential resources, leading to low morale and a heightened risk of mistakes. Furthermore, systemic issues and inadequate oversight have resulted in a lack of accountability, allowing negligent behaviour to persist and eroding public trust in the health system.

Maternal and neonatal care has emerged as a particularly high-risk area. A significant number of medico-legal cases stem from birth-related injuries, such as cerebral palsy, which require lifelong care and impose a heavy financial burden on the system. Delays in emergency response—such as patients waiting hours for ambulances or being neglected by staff—have led to tragic outcomes and costly lawsuits.[407]

Finally, the legal and administrative aspects of these claims present their own challenges. Litigation is often complex and prolonged, especially when negligence is difficult to prove due to missing or incomplete records. This not only delays justice but also consumes valuable time and resources that could otherwise be directed toward improving patient care.

Recommendation

It is imperative that the Department of Health should become involved with CP cases. Not only to have more accurate statistics, but in order to better brief the legal teams involved in possible litigation.

5.2.7 Accountability of transgressors linked to cerebral palsy

Individuals responsible for causing CP through negligence or misconduct in South Africa can be held accountable through several formal channels. Legal proceedings

406 'Health Department faces billions in malpractice claims' https://www.iol.co.za/sundayindependent/news/2022-09-21-health-department-faces-billions-in-malpractice-claims/ accessed 10 October 2024.

407 'Health Department faces billions in malpractice claims' https://www.iol.co.za/sundayindependent/news/2022-09-21-health-department-faces-billions-in-malpractice-claims/ accessed 10 October 2024.

may be initiated by affected families, including civil lawsuits for medical negligence. If successful, the courts can award compensation for medical bills, emotional suffering, and lost income.[408]

Professional regulatory bodies also play a critical role. Organisations like the Health Professions Council of South Africa (HPCSA) and the South African Medical Association (SAMA) investigate complaints against medical practitioners whereas the Nursing Council discipline nurses. These bodies may impose various sanctions, ranging from suspension and fines to mandatory training and restrictions on practice. In severe cases where medical professionals have acted with extreme negligence or intent to harm, criminal charges such as culpable homicide or assault may be brought forward. The National Prosecuting Authority (NPA) handles these prosecutions.

Oversight is further reinforced through institutions like the Office of Health Standards Compliance (OHSC) and the South African Nursing Council (SANC), which ensure that nurses and healthcare providers adhere to established standards. They conduct disciplinary hearings and can enforce penalties including license cancellation, fines, and compulsory continuing education.

Legal professionals aren't exempt either. Bodies like the Legal Practice Council (LPC) investigate lawyers suspected of misconduct in CP cases. Consequences for attorneys may include being struck off the roll, fined, or subjected to practice limitations. The Attorneys Fidelity Fund (AFF) also investigates cases of dishonesty or negligence by lawyers and can demand repayment of funds and administer disciplinary action.

Altogether, the system is designed not only to ensure accountability for harm caused but also to uphold high standards of care and justice for those impacted by CP.

Positive effects of holding individuals accountable for CP negligence cases

Holding individuals accountable when their actions—such as medical negligence—contribute to the onset or worsening of CP can lead to meaningful change on personal,

408 SALRC 'Medico-legal claims' 53.

societal, and systemic levels. This kind of accountability can serve as a powerful deterrent, sending a clear message to professionals like medical staff that negligence carries serious consequences. As a result, it could encourage a stronger commitment to safety protocols and ethical standards.

Beyond individual behaviour, accountability can drive broader improvements in healthcare systems. Institutions may be prompted to reassess and enhance their procedures surrounding prenatal, perinatal, and neonatal care. These changes can also inspire policy reforms aimed at better protecting vulnerable populations from preventable harm, ultimately raising the standard of care and fostering a more responsible and compassionate healthcare environment.[409]

The long-term effects of holding individuals accountable for actions that contribute to conditions like CP due to negligence can be profound and far-reaching. When professionals know they'll be held responsible for their actions, it could cultivate a culture of vigilance and integrity. Over the years, this could lead to a noticeable decline in negligent practices, as fear of repercussions is replaced by a genuine commitment to doing things right. Medical institutions may begin to prioritise continuous training, transparent reporting, and rigorous oversight, all of which contribute to safer environments for patients.

On a systemic level, accountability often sparks legislative and regulatory changes. Governments and health boards may introduce stricter standards, better monitoring systems, and more robust patient protection laws. These reforms don't just patch holes—they reshape the framework of care delivery, making it more equitable and resilient.

For affected patients, long-term accountability can bring emotional closure and financial support through legal remedies. It also validates their experiences, reinforcing the idea that harm caused through negligence should not go unanswered. Over time, this can shift public attitudes, reduce stigma and increasing empathy for those living with CP. Ultimately, accountability doesn't just correct past wrongs—it builds a foundation for a more ethical, transparent, and compassionate future in healthcare.

409 SALRC 'Medico-legal claims' 261-266.

Negative effects of holding individuals accountable for CP negligence cases

Holding individuals accountable for causing CP, particularly in cases involving alleged medical negligence, is a deeply complex and emotionally sensitive matter. One of the main challenges lies in the ethical and legal intricacies surrounding such claims. CP often arises from a combination of factors—ranging from prenatal conditions and complications during birth to genetic influences—making it difficult to attribute the condition to a single cause. Simplifying this complexity by assigning blame to one person can obscure the broader medical realities and lead to unjust outcomes.[410]

Medical professionals frequently work under intense pressure, and accusations without clear evidence of negligence risk damaging reputations and careers unfairly. This can also influence how the public perceives CP. When the condition is portrayed as the result of wrongdoing, it may reinforce harmful stigmas rather than fostering empathy, understanding, and inclusion.[411]

Moreover, the fear of legal repercussions can alter the way healthcare is delivered. Providers might resort to defensive medicine, ordering excessive tests or procedures not out of medical necessity but to shield themselves from potential lawsuits.[412] This approach can burden healthcare systems and detract from patient-centered care.

Financially, litigation related to CP can be both costly and time-consuming, diverting valuable resources away from treatment and rehabilitation. A rise in negligence claims may also lead to higher insurance premiums for medical professionals, which could, in turn, reduce access to care—especially in communities that are already underserved.[413]

Recommendation

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410 SALRC 'Medico-legal claims' 347.

411 *Y Naidoo* 'Mother's claim dismissed in cerebral palsy case' https://www.medicalprotection.org/southafrica/casebook-and-resources/medicolegal-articles-and-features/view/mother-s-claim-dismissed-in-cerebral-palsy-case accessed 10 October 2024: The *Member of the Executive Council for Health, Eastern Cape v DL obo AL* (Case no 117/2020) [2021] ZASCA 68 (03 June 2021).

412 SALRC 'Medico-legal claims' 8.

413 SALRC 'Medico-legal claims' 15- 18.

There should be accountability where negligence was the cause of CP. The recommendation is that the Provincial Department of Health where the transgression occurred should be responsible for a disciplinary hearing. If the healthcare worker is then found guilty at such a hearing, the outcome should be escalated to the different controlling bodies for sanctioning in line with their mandates. Legal representatives involved in CP cases who use hired guns, prolong the proceedings, or change 'the truth' to suit them should also be reported to the relevant controlling body.

5.3 Conclusion

South Africa is facing a troubling rise in medical negligence lawsuits linked to CP, which has significantly deepened the health department's medico-legal debt. This growing crisis is highly perturbing hence putting pressure on the healthcare system, prompting provincial health leaders to look to the courts for solutions. They've begun requesting permission to offer alternative compensation to families, such as medical care at public hospitals or ongoing payments rather than one-time financial settlements. The CC has supported this move, affirming that HCs have the authority to evolve the common law to accommodate such changes.

Some courts have already approved these alternative approaches, allowing provincial departments to provide care through state hospitals. But without a nationwide plan to meet the needs of patients requiring specialised medical attention, continued court involvement remains necessary in cases with high-cost treatments.

A more effective solution would be a structured compensation model—one that blends lump sum payments, instalments, and direct service delivery, tailored to suit each individual case. Ultimately, the aim is to curb the number of negligence claims and swiftly challenge those that lack merit. In instances where CP results from medical errors, the government must implement a reliable and fair compensation mechanism-one that supports affected families while ensuring that limited healthcare resources aren't stretched too thin.

As South Africa begins rolling out its National Health Insurance Scheme, which promises wider healthcare access, there's an urgent need for policymakers to factor in the surge of negligence claims tied to CP. Without proper safeguards, the increased

demand on public hospitals could invite even more legal challenges, further straining the system.

In this chapter I have indicated possible ways in which CP negligence cases could be adjudicated differently. Not one of the recommendations, after analysing the positive and negative sides of the recommendation seem to be the perfect solution, but each recommendation could make a difference. Further studies and negotiations on a higher level than allowed in this research is thus imperative. What is to follow is my final conclusion on the research.

CHAPTER SIX

CONCLUSION

6.1 Introduction

The South African government carries a constitutional obligation to ensure that every individual within the country has access to health care services.[414] To fulfill this duty, the state must adopt reasonable legislative and other measures, within the limits of its available resources, to progressively realise this right for all citizens.

The Country's Department of Health has been facing a surge in CP litigation, with claims reaching substantial amounts.[415] These payouts significantly deplete the provinces' health budgets, which in turn threatens the quality and delivery of healthcare services. Notably, the departments do not allocate funds specifically for litigation, making the financial impact even more severe.[416]

At the heart of many of these legal claims lies the interpretation of the common law principle known as the "once-and-for-all" rule. This rule dictates that all claims stemming from a single cause of action—whether current or future—must be resolved in one final judgment.[417] Its original intent was to prevent repetitive lawsuits, protect defendants from harassment, and avoid conflicting rulings.[418] However, the rule does not explicitly prohibit the possibility of periodic payments for future medical costs.

South Africa's legal framework, particularly sections 39(2) and 173 of the Constitution, provides for the evolution of the common law when it conflicts with constitutional values or undermines the interests of justice. The CC, the SCA, and HCs all possess the inherent authority to regulate their procedures and develop the common law in line with justice. When interpreting legislation or evolving customary or common law, all judicial bodies are mandated to uphold the spirit and objectives of the Bill of Rights.

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414 The Constitution s 27 .
415 J Malherbe 'Counting the costs: The consequences of increased medical malpractice litigation in South Africa' [2013] SAMJ 83-84.
416 SALRC 'Medico-legal claims' 15-16.
417 Neethling, Potgieter & Visser *Law of Delict*.
418 The *DZ* case para 16.

In recent rulings, courts have found that the rigid application of the "once-and-for-all" rule—especially when it mandates lump-sum monetary compensation—can violate the interests of justice. As a result, courts have begun to allow compensation in kind, balancing individual rights with broader public interests. This shift highlights a tension introduced by Section 173, where the needs of individual claimants may conflict with the welfare of the general public relying on public health services.[419]

Given the limited resources of the Department of Health, the growing number of medico-legal cases poses a serious threat to the realisation of the constitutional right to health care.[420] The financial burden of large payouts, particularly in cases involving CP births, increases the department's vulnerability to further claims and liability.[421]

6.2 Research questions answered

The main research question was whether there is a need for legal reform in medical negligence cases concerning CP in South Africa after the *DZ* case opened the 'door' for the development of the common law. This main question has been followed by sub-questions to answer the main question.

The first sub-question was: **What did the court say in the DZ case and how did it influence cases following the judgement?** What the court said in the DZ case has been addressed in the first chapter and how the court either applied the direction given by the court or not has been discussed in the other chapters. It should also be remembered that the *DZ* case forms the backbone of the whole dissertation.

The second sub-question was: **Why are CP cases a problem area in medical negligence litigation?** This question was answered mainly in the introductory chapter but is addressed in other chapters as well.

Sub-question three was: **What is CP in medical terms?** This question was answered in Chapter 2 in which CP was medically defined. The risk factors associated with CP has been addressed as well as the difference between a sentinel event and prolonged labour as possible causes for CP. The contents of the National Maternal Guidelines was also highlighted.

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419 The *MSM* case para 180.
420 SALRC 'Medico-legal claim' 21-22.
421 The *MSM* case para 184.

Sub-question four was: **How is medical negligence leading to CP in law determined and what is currently lacking in the legal framework?** This was answered in Chapter 3 in which it was indicated that medical negligence is a civil action based on the law of delict. The elements of a delict were discussed, as well as the test for medical negligence as it was established by the courts. The problems with this common law system (the law of delict) are evident throughout the thesis and were highlighted again in the chapter concerning the alternatives to the common law position.

For example**,** Chapter 4 focused on court cases concerning CP. Cases ending up in the CC were fist discussed, highlighting its relevance to the *DZ* case. This was followed by cases that ended up in the SCA and then cases ending up in the HCs. Each time the relevance of the *DZ* case was pointed out. At the end of the chapter insights gathered from the selected cases were summarised and the problems identified in CP cases were discussed, being expert witnessing, reverse reasoning, the Contingency Fees Act, no uniformity concerning MRIs, no uniformity concerning CTGs, the non-adherence to the Maternity Guidelines and the varying court approaches to CP cases.

Sub-question five was: **How does CP pay-outs after successful claims affect the financial sustainability of the healthcare system?** This was addressed in Chapter 1 and in the case discussions.

The last sub-question was: **Why are existing legal mechanisms inadequate and what alternatives are there for claims based on alleged medical negligence culminating in CP?** The alternatives have been addressed in Chapter 5 as possible solutions. The solutions proposed were the formal development of the common law - not only on an ad-hoc basis as decided by courts – and the pros and cons of such an approach have been indicated. The second possible solution put forward was mediation. Once again, the positive and negative aspects of mediation were highlighted. The use of assessors is also a possibility and the positive and negative aspects surrounding assessors have been indicated. Another solution might be the 'capping' of claims but as with all the other recommendations, there are positive as well as negative aspects concerning the capping of claims. Properly informed medical guidelines determining the cause of CP will make a significant contribution. The involvement of the Department of Health could also alter the discourse, but there are

also positive aspects as well as negative aspects concerning their involvement. Lastly it has been suggested that the staff who are involved in cases of alleged medical negligence ending up in a baby suffering from CP should be held accountable. This could make a huge difference, but once again there are positive aspects on this recommendation as well as negative aspects.

Thus, taking all the facts presented in answering the sub-questions into consideration, the main research question, whether there is an urgent need for legal reform in medical negligence cases concerning CP in South Africa, has been answered affirmatively. There is clearly a need for legal reform in medical negligence cases involving CP.

6.2 Final conclusion

The growing number of medico-legal claims is a serious concern, highlighting deep-rooted issues within the public health system. These systemic weaknesses have compromised the quality of care and left the system increasingly exposed to legal action. The financial burden of these claims diverts funds away from essential improvements in healthcare infrastructure and services. This creates a vicious cycle: under-resourced systems lead to more negligence, which in turn results in further claims. Ultimately, patients bear the brunt of this breakdown, facing reduced access to care and rising costs as the system struggles to cope.

While calls for reform are well-founded, they will only yield meaningful change if the root causes of negligence and the surge in legal claims are thoroughly examined and understood. The ideal solution lies in preventing harm before it occurs but while this is not so easy to address attention should be given to other solutions for CP cases.

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