REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, JOHANNESBURG

CASE NO: 24857/2015

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

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DATE
SIGNATURE

In the matter between:

MAHLABA ZINHLE obo KAMOHELO **Plaintiff**

and

MEC FOR HEALTH, GAUTENG PROVINCAL GOVERNMENT **Defendant**

J U D G M E N T

This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to SAFLII. The date and time for hand-down is deemed to be 10.30am on the 15 September 2022.

MAHALELO, J:

[1] On 4 October 2011 at approximately 09h00 the plaintiff gave birth to her first child, a baby boy called KM (the child/baby) at Ramokonopi Clinic in the Province of Gauteng. Subsequent to his birth, the child was diagnosed with cerebral palsy, which the plaintiff attributes to the substandard medical care rendered to her and her child prior and after the birth. The plaintiff now seeks damages from the defendant in both her personal capacity and on behalf of her child, as a consequence of the alleged negligence of the defendant's nursing staff who treated her at Ramokonopi clinic.

[2] By agreement between the parties, the question of the quantum of the plaintiff's claims is to stand over and the Court was requested to determine only the merits of the matter.

[3] During the trial, the plaintiff was represented by Mr. Machaba SC and Ms. Makopo represented the defendant.

THE ISSUES

[4] At the commencement of the trial the defendant accepted that the child suffers from brain damage and the other sequelae complained of. However, every other element of the plaintiff's claim was put in issue. The elements of causation in dispute therefore involved:

a) Whether the injuries were sustained during labour or as a consequence of some pre-exiting congenital or other condition suffered either by the mother or the foetus;

b) Whether the injuries were sustained before or after birth;

c) If the injuries were sustained during birth whether it involved an acute profound hypoxic-ischaemic insult.

[5] The defendant contended that the plaintiff did not produce any evidence to show that the medical staff were negligent, and even if they were negligent it did not cause or contribute to the HIE.

APPLICABLE LEGAL PRINCIPLES

[6] It is trite that in order to succeed in her delictual claim for damages, the plaintiff must establish that the wrongful and negligent conduct of the defendant's nursing staff, acting within the course and scope of their employment, caused her harm.[1]

[7] In *Oppelt v Department of Health, Western Cape*[2], Cameron J (for the minority) provided the following useful summary of the approach to matters of this nature with reference to *Kruger v Coetzee*1966 (2) SA 428 (A):

> "In our law Kruger embodies the classic test. There are two steps. The first is foreseeability - would a reasonable person in the position of the defendant foresee the reasonable possibility of injuring another and causing loss? The second is preventability - would that person take reasonable steps to guard against the injury happening?
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> The key point is that negligence must be evaluated in light of all the circumstances. And, because the test is defendant-specific ('in the position of the defendant'), the standard is upgraded for medical professionals. The question, for them, is whether a reasonable medical professional would have foreseen the damage and taken steps to avoid it.
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> In Mitchell v Dixon, the then Appellate Division noted that this standard does not expect the impossible of medical personnel: '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'
>
> This means that we must not ask: what would exceptionally competent and exceptionally knowledgeable doctors have done? We must ask: 'what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that the doctor is a human being and not a machine and that no human being is infallible. Practically, we must also ask: was the medical professional's approach consistent with a reasonable and responsible body of medical opinion? This test always depends on the facts. With a medical specialist, the standard is that of the reasonable specialist."

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[1] *Mtetwa v Minister of Health* 1989 (3) SA 600 (D&CLD) at 606 B-F; *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC) at para 34.
[2] 2016 (1) SA 325 (CC) at para 106-108

[8] While the court in *Oppelt* was required to assess the expertise and conduct of an orthopaedic surgeon and a neurosurgeon employed in a state hospital, I consider that the approach advocated by Cameron J may be applied *pari passu* to midwives and nurses employed at a dedicated obstetric clinic run by the defendant, where a degree of expertise in the handling of pregnancies and the delivery of children through natural childbirth was manifestly necessary.

[9] As to the level of care that the plaintiff was entitled to demand from the nursing staff of the Ramokonopi clinic, *Collins v Administrator, Cape*[3] provides a useful summary of the applicable test. The case involved the insertion by a nurse of a tracheostomy tube into a 16-week-old baby whose breathing was compromised and who required ventilation. The nursing staff in the unit where the baby was being treated were required to have training and experience in specialist care of paediatric tracheostomy patients. The learned Judge made the following observation.

> "The question that arises is whether the failure on the part of the hospital staff promptly to replace the tracheostomy tube amounted to negligence in the circumstances. It is trite law that a patient in the hospital is entitled to be treated with due and proper care and skill. The degree of care and skill that is required is that which a reasonable practitioner would ordinarily have exercised in South Africa under similar circumstances (see *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W)). The need for particular care and vigilance in the case of pediatric tracheostomy patients is obvious. Not only is the possibility of accidental decannulation readily foreseeable, but unless immediately remedied the consequences are fatal. Indeed, this need for care and vigilance is reflected in the staff allocated to the tracheostomy unit."[4]

[10] In my view, the plaintiff was thus entitled to demand that she and her unborn child be treated with the requisite degree of care and expertise expected of a duly qualified midwife.

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[3] 1995 (4) SA 73 (C).
[4] *Collins* above at 81I – 82B

[11] As will appear later, there was a series of guidelines which set the standard of care expected for maternity care in clinics, community health centres and district hospitals countrywide. It is not in dispute that the defendant's nursing staff at the clinic were obliged to treat the plaintiff in accordance with those guidelines and that if they failed to do so their conduct might establish negligence. Whether there was in fact such negligence is ultimately for the Court to determine, having had regard to the expert opinion placed before it.[5]

AN OVERVIEW OF THE MEDICAL EVIDENCE

[12] The plaintiff testified personally in regard to the merits. It is on record that she and the child were referred to a number of experts who compiled medical reports and settled joint reports among themselves. She presented the evidence of two expert witnesses namely Dr Lefakane, a paediatrician and Professor Nolte, the Nursing Specialist. The plaintiff procured a report from an expert radiologist, Dr Henning, who analysed an MRI scan of the child taken when the child was 6 years and 7 months for purposes of determining the cause of his cerebral palsy.

[13] It is necessary at this stage to deal with the joint minutes of the radiologists. Both Dr Henning and his counterpart for the defendant Dr Weinstein agree that there were hyperintense changes in the right perirolandic region which may be in keeping with a hypoxic ischemic encephalopathy with acute profound distribution. They agree that there were no changes associated with partial prolonged hypoxic ischemic encephalopathy. They both stated that the MRI by itself is unable to determine when this process occurred and what were all the causes that led to it. The experts further confirmed that there were no obvious MIR intracranial changes of infection and that there are no structural abnormalities.

[14] The defendant tendered the evidence of Dr Mogashoa, Sister Khanyile, Sister Mkhize and the expert radiologist, Dr Weistein. The approach of the court in evaluating the evidence of the experts placed before it was usefully summarized in *Medi-Clinic* (with reference to *Linksfield Park*) as follows:

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[5] *Medi-Clinic Ltd v Vermeulen* 2015 (1) SA 241 (SCA) at para 25

> "In para's 37-39 [of *Linksfield Park]* the court held that what is required in the evaluation of the experts' evidence is to determine whether and to what extent their opinions are founded on logical reasoning. It is only on that basis that a court is able to determine whether one of two conflicting opinions should be preferred. An opinion expressed without logical foundation can be rejected. But it must be borne in mind that in the medical field it may not be possible to be definitive. Experts may legitimately hold diametrically opposed views and be able to support them by logical reasoning. In that event it is not open to a court simply to express a preference for the one rather than the other and on that basis to hold the medical practitioner to have been negligent. Provided a medical practitioner acts in accordance with a reasonable and respectable body of medical opinion, his conduct cannot be condemned as negligent merely because another equally reasonable and respectable body of medical opinion would have acted differently."[6]

[15] It remains contentious between the parties whether the plaintiff received substandard care and whether that is the cause of the child's brain injury. Put differently the parties' contention is whether the substandard care, if any, is casually linked to the injury sustained by the child and the damages he suffered as a result.

BACKGROUND TO THE PLAINTIFF'S EVIDENCE AND THE TREATMENT SHE RECEIVED.

[16] The evidence establishes that the plaintiff was aged 17 years old when she gave birth to her first child. She is presently 25 years old. She testified that her highest educational achievement is grade 9 which she did at Dukathole Comprehensive High School. There she did life science as a subject and she understood about health and teenage pregnancy.

[6] *Medi-Clinic* above at para 5

[17] In April 2011, she realised that she was pregnant. She was in grade 9. She presented herself at Goba clinic to attend her Antenatal classes. Goba clinic is a walking distance from her home and she used to walk thereto every month. On the first occasion, she was checked, blood tests were taken and a card was opened for her. On the third day, she went to fetch the blood results which were all negative. She stated that she attended these classes from May to September 2011. She was taught about the food to eat, what to expect and where to go when the time of delivery came. On 3 October 2011 in the early morning, she began to experience pains on her lower abdomen and her grandmother accompanied her to Ramokonopi Clinic. She went straight to the Labour Unit and she presented the receptionists with her Antenatal card ("ANC") and thereafter she was taken aside in another room for testing her blood, BP, diabetes, and a belt (CTG) was put around her waist for the foetal heart rate ("FHR"). She was also examined manually and she was told that she was not in labour. She was made to wait for 2 hours and she was later examined the same way and she was once again told that the vulva was not yet opened. She was told to go home and do her exercises.

[18] While at home her pains did not subside. When she went to the toilet, she noticed blood in her urine, and she immediately told her grandmother who decided to take her back to Ramokonopi Clinic. It was at around 11h00 to 12h00. They went to the same receptionist and announced their return. Once again she gave her ANC to a nurse and was taken for the same examination again.

[19] She was once again asked to wait for two hours and she was informed once more that the route is not yet opened. She was told to go home. This time the pain became worse. She retuned back to Ramokonopi clinic late afternoon. She received the same treatment as in the morning and she was discharged. The pains became consistent and persistent. When her aunt knocked off she helped her mother to find transport and they took her to Natalspruit Hospital. They went straight to the labour Ward. Her mother explained to the nurses that they had been to Ramokonopi Clinic but that they were repeatedly turned away. The plaintiff informed the hospital staff of her ever-increasing labour contractions and pains. The Hospital staff perused her ANC and then informed them that she had to go back to Ramokonopi Clinic as she could not come to the Hospital without a referral letter.

[20] They went to Ramokonopi Clinic; it was now in the evening. The staff looked for a bed and the Plaintiff was admitted and advised to do her walkabout exercises. This

she did and after every two hours the nurse came and checked her. She was checked at 10h30, 00h00, 03h00, and 05h00. In the morning she was taken into the delivery ward. A nurse ruptured her membrane (broke her waters) with a needle-like structure and she gave birth to a son at 09h00. The child cried twice and stopped. He looked fine and the nurses him on her chest. She felt dizzy around that time and she was taken to a different room for her to sleep. When she woke up the nurses brought the child for her to breastfeed. The child could not suck. The nurses tried to help him to suck the mother's nipple to no avail. They then opened his mouth and found two blisters which had blood inside. They showed the blisters to her and stated that this was the reason the child could not suck. They undertook to arrange an ambulance to take her and the child to Natalspruit hospital.

[21] After about 3 to 4 hours an ambulance arrived and they were taken to the Natalspruit hospital. From Ramokonopi Clinic the child was put in an incubator with oxygen. They were both admitted, she at Ward 4, and the baby at Ward 2. She was woken up and was informed that she could express her breast milk into a cup and feed the child. She did this breastfeeding at regular intervals of 09h00, 12h00, 15h00 and 18h00. She did not see the child convulsing. The child appeared normal to her throughout. She would not have known that the child was not normal, except the lack of sucking because this was her first pregnancy. She was discharged the following day and the child was discharged the following week.

[22] The cross examination of the plaintiff focused on certain aspects of her evidence. The defendant sought to establish from her that she was an unbooked patient and only presented herself for the first time at the clinic 0n 3 October 2011. She denied this and stated that she attended all her classes at Goba Clinic and that she had a Card that she received from Goba Clinic. The Plaintiff was informed that if she attended these antenatal classes, she would have known that there was a register kept at Goba Clinic. She accepted this. It is important to note that the defendant failed to produce this Register to show the plaintiff the basis of his criticism.

[23] The plaintiff was shown page 3 of section E (CaseLines page 053 – 97) which was said to be the new Antenatal Card that was completed by Nurse Mkhize and contended that the times that were recorded therein indicated that she visited the clinic for the first time at 12h30. She insisted that she attended at Ramokonopi clinic much earlier than the first recorded time of 12h30.

[24] It is important to note that the very same document corroborates her evidence because it records at 12h30 that she was there earlier however, there was no recording of the tests or examination that was done to her. The plaintiff was informed that the nurses at Ramokonopi clinic deny that they had ruptured her membrane with a needle. She insisted even in re-examination that the nurses ruptured her membrane and that it did not rapture on its own. The defendant further stated that even if such was done, it would have been by an amniotic hook and not a needle. She was willing to concede that it could have been by that hook but the fact of the matter is that her water was broken and did not rapture spontaneously.

[25] The relevance of this evidence is that the plaintiff's case is that her pregnancy was uneventful and she was healthy. She contended that there had been insufficient monitoring of her unborn child during the latent and active phases of her labour.

[26] The plaintiff's expert, Prof Nolte, a midwife, is very critical of this in her evidence for two reasons, namely, that the relevant published guidelines require a CTG reading every half an hour during the active phase of labour and secondly, there did not appear to be readings at all during the crucial hours preceding birth, i. e. from 05h00 to 09h00. Prof Nolte was challenged that it did not necessarily follow that because there were no CTG readings recorded on the partogram, that in fact no monitoring had taken place during that period. The defendant's argument was that the inadequate recordal of the CTG readings did not mean that there was insufficient or negligent monitoring of the foetus during that period. Prof Nolte's response was that according to the guidelines that which is not recorded means it was never done. Prof Nolte testified about the decelerations that were noted on the CTG. She stated that they were not recorded anywhere and they ought to have been reported to a doctor immediately.

[27] Professor Nolte stated that without monitoring and recording of the contractions, one would not know the correct diagnosis of the decelerations and that makes the labour high risk. She stated that in this case the contractions were not monitored as there is no evidence thereof in pages 12 – 15 of section E (CaseLines page 053 – 106 to 053 – 109). According to her, it appeared that the machine was not connected to measure the contractions.

[28] Prof Nolte testified that from the reading of the CTG tracings on section E pages 1,2,13,14 and 15, from admission of the plaintiff at 20h26 to 3h00 during the latent phase, there was no monitoring at all. There was no evidence of foetal heart rate (FHR) monitoring from 20h20 to 3h00 and no FHR monitoring at all during the latent phase. In the active phase FHR monitoring was done from 03h00 to 05h00 and no more thereafter until the baby was born at 09h00. The FHR was to be done every 30 minutes until around birth at 09h00. Accordingly, there are four hours of no monitoring. With regard to the plaintiff's labour progress, Prof Nolte stated that according to the records the nursing staff stopped monitoring the plaintiff at 05h00 on 4 October 2011. They were expected to monitor the plaintiff on a two hourly basis until she was fully dilated. Therefore, there is about three hours of non-monitoring the progress of labour which is a substandard practice.

[29] Regarding the respiratory aspect of the child, Prof Nolte noted that the APGAR score was 8/10 in ten minutes which was an indication of a normal healthy crying baby. She stated that the points allocated for respiratory suggested that the child cried actively when he was born, however, it is not the case in this matter. Prof Nolte stated that because the medical records indicated that there were numerous variables in the plaintiff's pregnancy including decelerations it was necessary to monitor and record information in order to tell whether the child was compromised or not. Prof Nolte accepted that the progress of labour was normal up to 05h00 when the defendant's officials stopped monitoring. She stated that the lack of monitoring thereafter deprived the nurses to know if the child was compromised. The lack of monitoring of deceleration was another instance where no one knew the proper diagnosis because the CTG did not record the contractions. According to her, it did not matter whether the CTG was done at 17h00 because nothing of value was recorded therein and it was not clear if the baby was compromised or not.

[30] Prof Nolte referred to the plaintiff's ANC which suggested to her that the plaintiff was a booked patient and that she had been attending her antenatal classes. She noted that there were no concerns that were raised in section E of the maternity register at the clinic concerning the plaintiff's health and that of her child. She concluded that the pregnancy was un- eventful. She stated that the CTG showed non- reassuring heart rate as well as decelerations and these were worrisome and this would have been eliminated by proper monitoring of the foetus. A version was then put to her that the nurses will testify that the CTG machine was not working. What is problematic is that there was no evidence of that being recorded anywhere especially during the crucial period of labour. However, Prof Nolte responded that it was the responsibility of the nurses to see to it that the CTG machine was working or to report it as soon as possible. She stated further that even if the CTG scan at section E page 15 (CaseLines page 053-109) was done on the day of the plaintiff's admission she would still have found that the decelerations that were recorded were non-assuring and they ought to have been reported to a doctor and if there was no doctor present, the plaintiff should have been transferred to a hospital. Prof Nolte testified that the decelerations may have meant that the baby was not getting sufficient oxygen and would be at a risk. She explained that the nurses had to record the decelerations, report them to the doctor and record what the doctor's proposed solution thereto was. She stated that this was not done by the nurses at Ramokonopi Clinic and the nurses' failure resulted in the plaintiff having been deprived of the possibility of an appropriate medical care and the nurses placed the plaintiff and the baby in danger.

[31] Prof Nolte disagreed with what was indicated in the APGAR Scoring that the plaintiff delivered a healthy child. According to her, there were inconsistencies. The high score suggested that the baby was healthy whereas the not crying baby with breathing problems indicated otherwise. She concluded her evidence by stating that she and the defendant's counterpart Sister Smit were in agreement that the nurses who helped deliver the plaintiff's child delivered a substandard service.

[32] Dr SBI Lefakane (Dr Lefakane) testified that he started practicing as a Paediatrician since 1988. He specializes in treating diseases and illnesses of infants, new-borns, toddlers to adolescents. He is based at Lesedi private clinic. He prepared a report in this case and a joint minute with Dr Mathiva. He interviewed the plaintiff, examined the child and perused the medical records and the medico legal reports of other experts. He stated that the word "suctioned and put in an incubator O2'' as reflected on the birth records meant that the nurses who delivered the child deemed it necessary to suction the baby and that it could have been blood or some other fluid that the child ingested from delivery.

[33] He opined that putting the child in an incubator with oxygen was not sufficient as the child should have been resuscitated differently. He noted that the medical records reflected that the child needed help with resuscitation because there was a problem with its breathing and according to him putting such a child in an incubator with oxygen did not indicate active resuscitation.

[34] He explained that the APGAR scores were used to give an indication of the child's performance and they depended on the person completing it, but it looked at things like the heart rate, reflexes, muscle tone, respiratory, skin, etc. The higher the APGAR score the healthier the child and the lower the score the more compromised is the child. The scoring is done after an interval of one, five and ten minutes. In this case the baby's skin on the head could not have been normal as indicated because of the word "Caput ++". The same as genitalia because it is indicated that the baby "passed meconium at birth."

[35] Dr Lefakane further explained that if meconium is passed in utero it is called meconium stained liquor and if aspirated by the child it may cause foetal distress and respiratory problems. The stained liquor if aspirated may require the baby to be resuscitated and vigorous suctioning may be necessary depending on the amount aspirated. With regard to the APGAR scoring of 8/10 and 9/10 in 5 minutes and 10/10 in 10 minutes in this case, he stated that it meant that the child was vigorous and had normal respiratory efforts at birth. This according to him contradicted the medical records which reflected that the child was transferred to Natalspruit hospital because of chest problems and Sister Khanyile and Joja had written that the baby "did not cry at birth but breathing, suctioned and put under incubator having nasal flaring". He indicated that baby not crying at birth implicates the muscle tones and breathing and this was an indication of a baby in distress. He opined that "baby not crying" would also mean that the brain is affected.

[36] Dr Lefakane criticised the nurses for putting the child in an incubator when it had nasal flaring which according to him was an indication that it was struggling to breath on its own. He noted from the medical records that the child was unable to suck immediately after birth and had weak moro. This according to him suggested problems with the child's central nervous system relating to its neurological status. He also noted that the child had red blood filled blistered in the mouth. According to him, they could have been caused by trauma at the time that the child was suctioned and were not necessarily an indication of an infection more so that there is no evidence medically to support such a conclusion.

[37] Dr Lefakane considered and interpreted the evidence of the blood tests results that were performed on the child soon after it was born and stated that they indicated that there was no bacterial or viral infection. He noted that the child's platelets count was low. He suggested that this could be as a result of the bone marrow not producing enough platelets or the existing platelets being destroyed by a condition in the body. He stated that platelets could also be killed by medication, an infection, respiratory distress and neurological involvement. He excluded the presence of an infection based on the CPR testing results which according to him were normal. He however stated that low platelets are commonly found in Hypoxic Ischemic Encephalopathy(HIE). He opined that in this case, based on the medical records, the child suffered HIE during birth and this could be the cause of the decreased platelets.

[38] Dr Lefakane referred to the progress note of Dr Kasele of the Natalspruit Hospital who upon admission of the child queried Congenital pneumonia and Birth Asphyxia(BA). He noted that two blood tests were ordered on the same day and despite that, Dr Kasele had not made any diagnosis except the differential diagnosis that he had queried. Dr Lefakane further noted that Dr Abrahams queried congenital pneumonia and BA but that after investigations and tests were conducted, she concluded that the baby suffered from BA and HIE grade 2. In relation to the discharge note of the child which reflected the diagnosis as congenital pneumonia, Dr Lefakane disputed this and stated that the medical records did not indicate that the child had fever and the CPR results were normal therefore there was no evidence of the child suffering from congenital pneumonia. He suggested that the chest x-ray of the child could have evidenced the existence of congenital pneumonia but noted that no such x-ray was performed. He commented on the presence of metabolic acidosis and stated that it was an indication of HIE and raised carbon-dioxide.

[39] Dr Lefakane noted that according to the medical records the child was last monitored at 05h00 before it was born at 09h00. According to him if there was foetal distress as in this case or a need for medical emergency the nurses would not have known because that was not recorded. Further, the nursing staff at Ramokonopi and Natalspruit hospital should have done head cooling treatment on the baby and he regarded their failure to do so as substandard. He stated that this treatment is widely available in medical facilities. Sophisticated medical facilities use a cooling blanket that wraps the child and provide cooling and those that do not have much use a cooling cap with ice that is wrapped around the child's head. The child 's temperature is then measured by inserting a thermometer rectally According to him this ought to have been done within 12 hours of the child's life. He concluded that the baby suffered from intrapartum HIE and that there was no sentinel event during birth.

[40] During cross examination Dr Lefakane was criticised for not describing the type of CP that the child suffered. He was pressured to accept ACOG's interpretation or criteria of what type of hypoxia/CP was it that the baby suffered and that same was not consistent with ACOG's definition. He replied that he omitted that because he did not want to be found wanting if he was to be asked to explain same. He stated that ACOG is just but one of the sources that prescribe criteria of the types of CP that a baby can suffer. He however conceded that where he observed unequal distribution of moro, grasp and muscle strength, there could be a sign of CP with Hemiplegia. He was asked if the baby was spastic, he denied and he stated that it was likely that it was dyskinetic.

[41] Dr Lefakane was once more pressured to accept that the baby's intrapartum injury was not consistent with the criteria set by ACOG. He accepted that the baby's condition was not a straight forward dyskinetic intrapartum HIE as prescribed by ACOG. With regard to the diagnosis of congenital pneumonia by Dr Kasele he reiterated that it was only a differential diagnosis as there was nothing conclusive made by Dr Kasele, more so that there was no evidence of any tests conducted to confirm congenital pneumonia on the child. It was put to Dr Lefakane that the inborn errors could also be possible causes of HIE. He stated that those are also caused by calcium salts or potassium deficiencies and were mere electrolytes deficiencies which are just hypothetical causes and not applicable in this case. Dr Lefakane accepted that the plaintiff did not suggest that caesarean section was called for at any stage. However, in re-examination, he reiterated that because there was no monitoring from 5h00 – 9h00 on 4 October 2011, there was no way of telling that the foetus was in distress.

[42] Lefakane was further challenged that CRP and Blood culture tests would not necessarily rule out an infection. He accepted that blood culture would not, but CRP would definitely rule out any infection. He stated that one must not exclude the investigation of fever when seeking to find an infection and in this case there was no such. He accepted that ion gap is an indicator of elevated CRP and added that Ion Gap can also be elevated by heart failure, heart problems and respiratory distress. Dr Lefakane further confirmed that there were no results of diabetes tests which could have been tested on presentation at the clinic or hospital. He says those are basic investigations to a new patient. He suggested that the same testing could have also been done for HIV especially where the results were not available or the patient was new. However, in this case, the child was fed ARVs for over five (5) days after the mother's status was determined as negative. This is despite the fact that Nevirapine has severe side effects which may cause hematological effects. On the contention by the defendant that the inborn errors were also possible causes of HIE Dr Lefakane stated that those are also caused by calcium salts or potassium deficiencies and were mere electrolytes deficiencies.

[43] In re-examination, Dr Lefakane stated that all what the defendant is contending for were hypothetical causes of HIE and that in this case, they were not applicable. He stated that the electrolytes were not diagnosed as inborn errors. On respiratory distress and treatment at Natalspruit hospital, Dr Lefakane was informed that the nurses will testify that the child was not that sick to deserve the treatment mentioned by him. He denied this and indicated that from what he had seen as part of the record, i.e. the baby having nasal flaring soon after birth, the lab results evidencing respiratory distress syndrome, the baby was not in any satisfactory condition. He thus rejected the defendant's version.

[44] In amplification of his denial, Dr Lefakane added that he could have inserted an endotracheal tube so that the baby gets oxygen directly into its lungs. He further stated that even the treatment at Natalspruit hospital was inadequate. The putting of nasal prongs was the same in that it did not actively assist the baby to get oxygen directly into the lungs. He denied that the treatment given was acceptable.

[45] Dr Lefakane referred to the progress note of Dr Kasele of the Natalspruit Hospital who upon admission of the child queried Congenital pneumonia and Birth Asphyxia(BA). He noted that two blood tests were ordered on the same day and despite that, Dr Kasele had not made any diagnosis except the differential diagnosis that he had queried. Dr Lefakane further noted that Dr Abrahams queried congenital pneumonia and BA but that after investigations and tests were conducted, she concluded that the baby suffered from BA and HIE grade 2. In relation to the discharge note of the child which reflected the diagnosis as congenital pneumonia, Dr Lefakane disputed this and stated that the medical records did not indicate that the child had fever and the CPR results were normal therefore there was no evidence of the child suffering from congenital pneumonia.

[46] He suggested that the chest x-ray of the child could have evidenced the existence of congenital pneumonia but noted that no such x-ray was performed. He commented on the presence of metabolic acidosis and stated that it was an indication of HIE and raised carbon-dioxide.

[47] Lefakane noted that according to the medical records the child was last monitored at 05h00 before it was born at 09h00. According to him if there was foetal distress as in this case or a need for medical emergency the nurses would not have known because that was not recorded. Further, the nursing staff at Ramokonopi and Natalspruit hospital should have done head cooling treatment on the baby and he regarded their failure to do so as substandard. He stated that this treatment is widely available in medical facilities. Sophisticated medical facilities use a cooling blanket that wraps the child and provide cooling and those that do not have much use a cooling cap with ice that is wrapped around the child's head.

[48] The child 's temperature is then measured by inserting a thermometer rectally. According to him this ought to have been done within 12 hours of the child's life. He concluded that the baby suffered from intrapartum HIE and that there was no sentinel event during birth.

[49] During cross examination Dr Lefakane was criticised for not describing the type of CP. With regard to the diagnosis of congenital pneumonia by Dr Kasele he reiterated that it was only a differential diagnosis as there was nothing conclusive made by Dr Kasele, more so that there was no evidence of any tests conducted to confirm congenital pneumonia on the child. It was put to Dr Lefakane that the inborn errors could also be possible causes of HIE. He stated that those are also caused by calcium salts or potassium deficiencies and were mere electrolytes deficiencies which are just hypothetical causes and not applicable in this case. Dr Lefakane accepted that the plaintiff did not suggest that caesarean section was called for at any stage. However, in re-examination, he reiterated that because there was no monitoring from 5h00-9h00 on 4 October 2011, there was no way of telling that the foetus was in distress.

[50] Dr Lefakane was further challenged that CRP and Blood culture tests would not necessarily rule out an infection. He accepted that blood culture would not, but CRP would definitely rule out any infection. He stated that one must not exclude the investigation of fever when seeking to find an infection and in this case there was no such. He accepted that *ion gap* is an indicator of elevated CRP and added that *Ion Gap* can also be elevated by heart failure, heart problems and respiratory distress. Dr Lefakane further confirmed that there were no results of diabetes tests which could have been tested on presentation at the clinic or hospital. He says those are basic investigations to a new patient. He suggested that the same testing could have also been done for HIV especially where the results were not available or the patient was new. However, in this case, the child was fed ARVs for over five (5) days after the mother's status was determined as negative. This is despite the fact that Nevirapine has severe side effects which may cause hematological effects. On the contention by the defendant that the *inborn errors* were also possible causes of HIE Dr Lefakane stated that those are also caused by calcium salts or potassium deficiencies and were mere electrolytes deficiencies.

[51] In re- examination, Dr Lefakane stated that all what the defendant is contending for were hypothetical causes of HIE and that in this case, they were not applicable. He stated that the electrolytes were not diagnosed as inborn errors.

[52] On respiratory distress and treatment at Natalspruit hospital, Dr Lefakane was informed that the nurses will testify that the child was not that sick to deserve the treatment mentioned by him. He denied this and indicated that from what he had seen as part of the record, i.e. the baby having nasal flaring soon after birth, the lab results evidencing respiratory distress syndrome, the baby was not in any satisfactory condition. He thus rejected the defendant's version.

[53] In amplification of his denial, Dr Lefakane added that he could have inserted an endotracheal tube so that the baby gets oxygen directly into its lungs. He further stated that even the treatment at Natalspruit hospital was inadequate. The putting of nasal prongs was the same in that it did not actively assist the baby to get oxygen directly into the lungs. He denied that the treatment given was acceptable.

ABSOLUTION FROM THE INSTANCE

[54] The plaintiff closed its case after leading the evidence of the above three witnesses. The defendant applied for absolution from the instance. Counsel for the defendant referred to the plaintiff's amended particulars of claim referring to the allegations of negligence and submitted that the plaintiff failed to demonstrate any form of negligence on the part of the defendant. She argued that the evidence led is not sufficient to cast a duty on the defendant to adduce evidence, that there is no court that could, find for the plaintiff on her evidence. Further that the evidence led has not shifted the evidentiary burden to the defendant. She contended that the plaintiff failed to establish a *prima facie* case on the first enquiry relating to negligence and that the negligence caused the foetal compromise (i.e. cerebral palsy).

[55] She referred to the judgment of the court in *Claude Neon Lights (SA) Ltd v Daniel 1976 (4) SA 403 (A) at 409G*. Counsel for the plaintiff objected to the application for absolution. He contended that the plaintiff had made out a *prima facie* case upon which the court may find in her favour. He relied on several similar authorities to that of the defendant, namely *Hurtwitz v Neofytou* (23542/2015) [2017] ZAGPJHC 137 (2 June 2017) (unreported), where the court referred to the case of *Gordon Lloyd Page and Associates* and applied the test there as set out in *Claude Neon Lights (SA) Ltd v Daniel* 1976 (4) SA 403 (A) at 409G-H. He also referred to the case of *Liberty Group Limited t/a Liberty Life v K and D Telemarketing and Others* [2020] JOL 47303 (SCA) at paragraph [14] where the Court held:

> "The dictum from Steytler cited above makes it clear that it is established practise that a decision of absolution from the instance in a trial has the effect of a definitive sentence. Simply put, a decision on the sufficiency of evidence led in that suit, by way of an order of absolution from the instance, has a definitive effect and is susceptible to appeal. The court is functus officio and has no power or jurisdiction to hear any further evidence in relation thereto"

[56] I dismissed the application and undertook to give reasons in the judgment. The trite test for absolution from the instance is not whether the evidence led by plaintiff established what would finally be required to be established, but whether there is evidence upon which a court applying its mind reasonably to such evidence, could find or might find in favour of the plaintiff.

[57] In *Gordon Lloyd Page and Associates v Rivera and Another*[7] the Court referred to the test for absolution from the instance as follows:

> "The test for absolution to be applied by a trial court at the end of a plaintiff's case was formulated in *Claude Neon Lights (SA) Ltd v Daniel* 1976 (4) SA 403 (A) at 409G - in these terms:
>
> > '. . . (W)hen absolution from the instance is sought at the close of plaintiff's case, the test to be applied is not whether the evidence led by plaintiff establishes what would finally be required to be established, but whether there is evidence upon which a Court, applying its mind reasonably to such evidence, could or might (not should, nor ought to) find for the plaintiff. (*Gascoyne v Paul and Hunter* 1917 TPD 170 at 173; *Ruto Flour Mills (Pty) Ltd v Adelson* (2) 1958 (4) SA 307 (T).)'

[7] [2000] 4 SA 241 A at para 2

> This implies that a plaintiff has to make out a prima facie case - in the sense that there is evidence relating to all the elements of the claim - to survive absolution because without such evidence no court could find for the plaintiff (*Marine & Trade Insurance Co Ltd v Van der Schyff* 1972 (1) SA 26 (A) at 37G - 38A; *Schmidt Bewysreg* 4th ed at 91 - 2). As far as inferences from the evidence are concerned, the inference relied upon by the plaintiff must be a reasonable one, not the only reasonable one (Schmidt at 93). The test has from time to time been formulated in different terms, especially it has been said that the court must consider whether there is 'evidence upon which a reasonable man might find for the plaintiff' (*Gascoyne* (*loc cit*)) - a test which had its origin in jury trials when the 'reasonable man' was a reasonable member of the jury (*Ruto Flour Mills*). Such a formulation tends to cloud the issue. The court ought not to be concerned with what someone else might think; it should rather be concerned with its own judgment and not that of another 'reasonable' person or court. Having said this, absolution at the end of a plaintiff's case, in the ordinary course of events, will nevertheless be granted sparingly but when the occasion arises, a court should order it in the interests of justice. Although Wunsh J was conscious of the correct test, I am not convinced that he always applied it correctly although, as will appear, his final conclusion was correct."

[58] The above authorities echo the requirement that the evidence led must establish a prima facie case relating to all of the elements relating to the claim at the end of the plaintiff's case. Taking into consideration all the authorities above and the evidence presented by the plaintiff it is my view that the plaintiff has made out a prima facie case from which this court might find for her. There is evidence tendered which relates to the elements of the plaintiff's claim which may be sufficient for the court to find for the plaintiff.

EVIDENCE OF THE DEFENDANT

[59] Dr Mogashoa, a Paediatric Neurologist was requested to give an opinion by the defendant on the causes and extend of the child's neurological impairments. She had obtained the history of what had happened during labour and the delivery of the child from the plaintiff antenatal records, maternity records, neonatal records and MR1 report of radiologists. She referred to the ACOG statement which provides that "*to determine the likelihood that an acute hypoxic ischemia event that occurred with close temporal proximity to labour and delivery contributed to neonatal encephalopathy it is recommended that a comprehensive multi-dimensional assessment be performed of neonatal status and all contributing factors , including maternal medical history, obstetric antecedents, intrapartum factors (including fetal heart rate monitoring results and issues relating to the delivery itself), and placental pathology.*

[60] She referred to the following points made in the article: "*there are several well-defined patterns of brain injury and their evolution on MR1 that typical of hypoxic ischemic cerebral injury in new-born, including deep nuclear gray matter or watershed cortical injury. If a different pattern of the brain injury or evolution of injury exist on MR1 then alternative diagnoses should be genetic investigations)"*

[61] According to Dr Mogashoa, one has to look at clinical status of the baby during labour, during and at birth in the neonatal period, and subsequent outcome to determine if the baby fits the criteria for intrapartum hypoxia. She stated that there are certain requirements before one can diagnose neonatal encephalopathy and the causes thereof. She mentioned that ACOG looks at, *inter alia*, the condition of the baby at birth and refers to the APGAR scores, the condition of the baby in the neonatal period that speaks to neonatal encephalopathy and whether there was a sentinel event. Dr Mogashoa further stated that in accordance with ACOG guidelines, the ACOG task force on neonatal encephalopathy and CP reflects that multiple causes can lead to brain injury in term infants, not just oxygen deprivation around the time of birth. Therefore, ACOG requires that medical practitioners look for risk factors during the labour called proximal risk factors and then look at how labour was managed. This helps one to conclude when the insult occurred with regard to the APGAR scores. She stated further that according to ACOG statement, an APGAR score of less than 5 in ten minutes was more likely to result in HIE baby, while the score of above 5 in ten minutes would not. She noted in this case that the baby's score of 8 and 9 in ten minutes were high, accordingly, she opined that the injury to the baby was not in keeping with HIE.

[62] During cross-examination Dr Mogashoa refused to accept that the baby's condition was not properly reflected by the APGAR scores. She failed to explain why if the APGAR scores were high, was there mentioned of the baby having respirator problems or distress. She contended that the baby did not require suctioning but that the nurses simply incubated him out of caution. She however conceded that another possible reason for suctioning the baby was the aspiration of meconium stained liquor. She again later conceded that because the medical records reflect that the baby had respiratory distress this could be the reason he was placed in an incubator during his stay at Ramokonopi clinic and enroute in an ambulance to Natalspruit hospital and then put on nasal prongs supply of oxygen for three days. She also reluctantly accepted the diagnosis of birth asphyxia by Dr Abrahams and Dr Moyo who she accepted were also qualified paediatricians.

[63] With regards to the presence of multi system organ failure, Dr Mogashoa testified that ACOG required medical practitioners to evaluate and test for liver and kidney functioning. In this case, it was noted that the liver testing on the baby was done and it indicated elevated levels of urea and potassium. According to her, this was haemolysed but not reliable. She noted that Co2 was low at 10 moi/mc and there was an increased anion gap at 30moi/ml which suggested an increased acidity in the blood. This gave her the picture of an abnormal liver with an increased metabolic acidosis. She however also stated that the best way of testing metabolic acidosis was to do arterial blood gases. She accepted that this together with the umbilical cord blood testing were not done. On the question of metabolic acidosis, Dr Mogashoa stated the importance of checking the type of the acidosis first. She stated that if there was hypoxia, acidosis would be present because the baby then produced a lot of lactate acid. She also confirmed that HIE also causes acidosis. Dr Mogashoa testified that septicaemia, a form of infection in the body may also produce acidity.

[64] During cross examination she conceded that there was no testing of these that was done, there was no sonar and MRI genetic disorder and the child had no obvious symptomatic clinical problems.

[65] She stated that heart rate monitoring could also indicate abnormalities and that meconium could indicate fetal heart rate (FHR) abnormalities, however she deferred to the gynaecologists. On hemiplegia, she testified that in terms of ACOG's statement of 2014, an intrapartum HIE could be spastic or dyskinetic and it was necessary to determine the type of CP and to decide whether the injury sustained is apportioned to HIE or not. She was referred to the Occupational Therapist (OT)'s referral letter that requested a formal diagnosis for the baby for purposes of admitting him at a school for the disabled. She suggested that the statement by an OT was critical and worrying to her and sought an investigation into the issue. She was asked if she referred to a letter in page 61 of section E and she confirmed. To her, the statement meant that the HIE was not consistent with intrapartum HIE.

[66] Dr Mogashoa conceded during cross-examination that the baby's red blisters were not swabbed for laboratory testing. She also conceded that there was no lumber puncture testing and there was no presence of chorioamnionitis. On congenital pneumonia she stated that it is tested by taking x-trays of the chest. She conceded that this was not done. She therefore conceded that there was no evidence of congenital pneumonia and that only clinicians could test for it.

[67] The next witness for the defendant was Sister Mkhize, a midwife. Sister Mkhize testified that she had been a midwife for 17 years. On 3 October 2011 she was on duty at Ramokonopi clinic. She opened the ANC for the plaintiff at the time that she presented herself to the clinic because she did not have one. The plaintiff was however at clinic earlier on that day. She does not know what was done to her because nothing was recorded. She confirmed that everything that was done to the plaintiff earlier was supposed to have been recorded. She attended to the plaintiff's pains at 17h00 and the plaintiff was not yet in labour. At 17h10 she observed mild contractions on the CTG tracing. There were three contractions in ten minutes and they have intensity and time space. She explained that sometimes the FHR changes when there is pain caused by contractions and when this happens there is a decreased oxygen supply to the baby and in order to survive the baby compensates by using its own reserves of oxygen. Where the contractions are intense and prolonged that might put the baby in danger. She testified about decelerations. She stated that it meant that the FHR has dropped below 120bpm from below the baseline level and it could be with or without contractions and it could be before or after contractions. Decelerations could also happen on their own and if variable they may be dangerous to the baby. In relation to the reading of the CTG at page 053-109 she confirmed that the said CTG tracing contained the tracing of the mother and the baby's FHR.

[68] She stated that the CTG showed decelerations, which occurred after about five to ten seconds after the contractions. These were late decelerations which are dangerous to the baby because they occurred just after the contractions. She was asked if they were recorded anywhere and if they needed medical intervention. She conceded that they were not recorded and that they were not even reported to a doctor. She however sought to testify that the CTG continued for an extended period and there were no further decelerations. Sister Mkhize accepted Prof Nolte's evidence that the CTG tracing on CaseLines at 053-109 was a cause for concern and that a continuous running of the CTG tracing was necessary to carefully monitor the relationship between the contractions and the FHR. She agreed with Prof Nolte's evidence that upon realising the late decelerations, she ought to have called for intervention or guide from the doctor. When confronted with Professor Nolte's evidence that there was no continuous monitoring of the CTG and that there was no activation of the management of the noted late decelerations, and that meant that her conduct was substandard, she sought to suggest that there was some recovery. It was put to Sister Mkhize that her conduct of sending the plaintiff home after noticing the late decelerations was dangerous and substandard. She stated that she did not see then in 2011 that the decelerations were dangerous but it was only during the hearing of this matter and with further experience that she realised that the said decelerations were in fact dangerous to the baby. She therefore conceded that her conduct of sending the plaintiff home in light of the noted dangerous late decelerations was a substandard practice.

[69] Sister Khanyile also testified. She qualified as a professional nurse in 1990 and by 2011 she had been a professional nurse for over 20 years. She holds a diploma in midwifery and a certificate in neonatal care in ICU. On 04 October 2011 she was stationed at Ramokonopi clinic as a midwife. She started her duties at 07h00. She is the one who delivered the plaintiff's child and she completed the birth register as well as the summary of labour. She also completed the section dealing with the APGAR scores. She confirmed the scoring on the APGAR chart. She confirmed that the baby was suctioned and put in the incubator with oxygen. She stated that the reason was to remove mucus from the nose and to warm the baby with a free flow of oxygen. She suggesting that there was nothing wrong with the baby immediately after birth. She explained that Caputt ++ meant swelling on the scalp on the occipital area which could have been caused if the mother pushed before she was fully dilated. She had noted that the baby passed meconium at birth. She explained that the meconium was passed immediately after birth because the baby was distressed. She conceded that she did not record anywhere that the meconium was passed after birth and that it was clear. She also noted that the baby was born with nasal flaring and was not crying. She however scored the baby 10/10 in 10 minutes. She confirmed that the nasal flaring was an indication that the baby was not breathing with ease. She further noted that the baby had to be transferred to Natalspruit hospital. According to her, it was because of the blood filled blisters and nasal flaring. She described the condition of the baby immediately after delivery as tired, required air and passed meconium. She however stated that it was an alive baby.

[70] During cross-examination Sister Khanyile testified that she only looked at the plaintiff's hospital file after delivery of the baby because she was given a verbal report in the morning by the night shift nursing staff. She was informed that there was no record of the plaintiff being monitored after 05h00 on 4 October 2011. She stated that she was not aware that the plaintiff experienced strong contractions in the early morning. She was referred to labour Partogram which indicated that the plaintiff was 8cm dilated at 05h00 and that from there her labour progression was slow and abnormal. She confirmed that the plaintiff would have been expected to reach 10cm dilation at around 7am to 8am. She further confirmed that the plaintiff was fully dilated at 8h30 and that there was no record of her monitoring from 8h00 to 9h00.

[71] She testified that she was not aware of the late decelerations suffered by the baby and the mother- as testified to by sister Mkhize and Prof Nolte. Sister Khanyile testified that in the active phase of labour the plaintiff and the baby needed to be monitored hourly from 8cm dilation. From 9cm dilation monitoring should have happened at every 15 to 30 minutes' interval. She was asked if she did an assessment of the mother and baby before delivery. She confirmed, however, she stated that she did not record that anywhere. She was referred to the Nursing Guidelines and she confirmed that according to the Guidelines she had to record the findings of her assessment/examination. Upon being told that the plaintiff and her baby were not monitored between 05h00 to 9h00 on the 4th therefore she would not have known that the baby was in distress, she replied that the baby's ligour was clear. Once again she conceded that such information was not recorded anywhere. With regard to the fact that she conducted episiotomy on the plaintiff, she conceded that foetal distress could also be a reason for doing episiotomy.

[72] Sister Khanyile testified that on delivery of the baby the colour of his lips and tongue were blue. She stated that if the baby passed meconium in utero there would be a number of indications like blueish lips, the meconium will be all over the body, the baby would be listless and there would be irregular breathing pattern and the heart rate would drop. She was informed that in this case all the indicators were there. She replied that the baby was healthy.

[73] Dr Weinstein, the Radiologist called by the defendant also testified in addition to the evidence of the joint minute with his counterpart. He confirmed the contents of the joint minutes. He confirmed that the MRI scan of the child's brain was taken when he was 6 years and 7 months. He reiterated the conclusion he reached together with his counterpart of hypoxic Ischemic encephalopathy event of an acute profound distribution occurring at term. According to him the distribution pattern on the brain where the insult occurred indicated no partial prolonged changes. He explained that an acute profound hypoxic ischemic event means a sudden, not progressive event which damages only the deep brain structures. A partial prolonged event causes damage to the peripheral structures of the brain. According to Dr Weinstein, there was no sentinel event and timing and causes of the insult could not be determined through MRI, he deferred to the relevant experts. He continued to testify that there is a lot of literature supporting the view that a multifactorial investigation should be undertaken in order to determine a case of acute profound HIE.

[74] It is a principle of our law that for the plaintiff to succeed with its claim against the defendant it must establish on a balance of probabilities that its version is reliable and can be believed. Sister Khanyile and Sister Mkhize conceded to the fact that the plaintiff received substandard care at Ramokonopi clinic. What then remains for determination is whether the substandard care is the cause of the injury suffered by the child and the resultant damages.

CONGENITAL PNEUMONIA

[75] The plaintiff's contention is that the minor child's condition was caused by birth asphyxia, more particularly from hypoxia (inadequate oxygen to the brain) caused by prolonged labour. This birth asphyxia was, according to the plaintiff, of such a severity as to result in a hypoxic ischaemic injury (HIE grade 2) sufficient to result in the condition, in contrast to a hypoxic ischaemic insult that may not have brain-damaging consequences. The plaintiff contended that by the time the child was admitted to the Natalspruit hospital he had already suffered an HIE of sufficient severity to have resulted in irreversible brain damage (and the condition as described). The plaintiff contends that this HIE had taken place already during labour (intrapartum).

[76] The defendant's case was that although the child may have suffered from a hypoxic ischaemic insult during labour, that insult may at most may have been as a result of some other causes i.e. congenital pneumonia or some other infection not caused by any negligence on the part of the defendant of its staff. The defendant further disputed that any hypoxic damage to the foetus had been caused by prolonged birth (and so disputed that there had been birth asphyxia insofar as that is intended to be a reference to birth asphyxia caused by prolonged birth but that if there was such damage it had been caused by congenital pneumonia. The defendant's argument continued that its medical personnel could not be found negligent in relation to damage caused by congenital pneumonia as that damage was not preventable. It was understood by the experts that it was around that point that the attending doctor, in addition to birth asphyxia, diagnosed congenital pneumonia.

[77] The approach taken by the plaintiff was to dispute the diagnosis of congenital pneumonia, asserting through her experts both in their expert summaries and joint minutes, and during the trial that it was a misdiagnosis. The defendant on the other hand advanced the case that the diagnosis of congenital pneumonia was correct, and that this inflammatory disease of the lungs was to blame for the hypoxic injury to the child, and that its medical personnel could not be blamed for the damage caused by the disease. Furthermore, the defendant contended that the injury suffered by the child was in keeping with HIE of acute profound distribution as testified by its expert radiologist Dr Weinstein and therefore that could not be attributed to any negligence of its nursing staff. I am therefore required to decide on the probabilities whether the diagnosis of congenital pneumonia was correct, insofar as it is relevant to the issue of liability.

[78] Dr Lefakane testified that Dr Kasele in recording the diagnosis of congenital pneumonia had done so without conducting any tests. The experts in this case are agreed that chest x-rays of the child were necessary to determine the presence of congenital pneumonia and that such chest x-rays were never taken. Furthermore, Dr Lefakane stated that the diagnosis of congenital pneumonia was a differential diagnosis and not conclusive and that Dr Abrahams having conducted further examination of the child and also relying on the fact that the child had weak moro, could not suck and had convulsions on 5/10/2011 concluded that the child suffered from BA. From the medical records supplied the diagnosis of congenital pneumonia is not supported by evidence. I find the evidence of Dr Lefakane to be more persuasive on this point, and that the indications, on the probabilities, are not consistent with a diagnosis of congenital pneumonia. Therefore, on a balance of probabilities, I find that the diagnosis of congenital pneumonia is not established.

[79] Having found that the defendant has not succeeded in establishing that congenital pneumonia is the cause of the child's condition it is necessary to deal with the plaintiff's asserted case that the HIE sufficient to result in the condition was sustained intrapartum. It is necessary for the plaintiff to prove on a balance of probabilities that there is a causal nexus between the conduct relied upon (whether by way of commission or omission) and the damage. Whether or not this causal nexus has been established in a particular case is a question of fact that must be answered in light of the oral evidence and the relevant probabilities.

[80] In deciding the issue of causation, it is necessary first to determine whether there is a factual causal nexus between the act (or omission) and the harmful consequences, and then if such factual causation is established, to consider whether legal causation has been established. The exercise of considering factual causation is to ascertain whether the defendant's act or omission caused or materially contributed to the harm suffered.

[81] Before consideration can be given as to whether causation has been established (whether factual or legal) it is necessary to identify the loss-causing event as only then is it possible to, for example, make the hypothetical enquiry as to probably what would have happened but for the wrongful conduct of the defendant.

[82] In this instance, the radiologists are agreed that the condition occurred as a result of an acute-profound hypoxic ischaemic injury. The plaintiff's case is that this acute-profound HIE occurred during the intrapartum period. In the circumstances, it is first necessary for the plaintiff to prove on the probabilities that an acute-profound HIE occurred intrapartum, as only once that is established, can further questions be considered such as whether the wrongful act, which the plaintiff asserts, caused that loss, and does meet the requirements for causation. The respective radiologists, Dr Henning and Dr Weinstein agree that "the MRI demonstrates acute-profound HII that occurred in a term brain.

[83] The plaintiff contended that the defendant's staff, on the morning of 3 October 2011, unreasonably failed to conduct proper care of the plaintiff in that they ordered her to return home even while her urine showed traces of blood. They deliberately failed to sufficiently, adequately and reasonably monitor the CTG tracing when they were checking the plaintiff such that they did not know that the deceleration monitored was dangerous for the mother and the baby. From their above failure to adequately observe the CTG tracing, they failed to report the said dangerous deceleration to the doctor. They failed to monitor the contractions of the plaintiff and the effects they would have on the baby. Accordingly, they were unable to see that the baby was being compromised whilst in utero. They could, therefore, not take any decisive emergency action to assist the baby and the mother. They also failed to take the necessary tests such as diabetes and HIV. As a result, the baby was fed anti-retroviral medication when same was not necessary and dangerous.

[84] After admission, they failed to monitor the plaintiff's pregnancy during the Latent phase at all. They failed to monitor the mother's condition during the Latent Phase, at all. They failed to monitor the baby's foetal heart rate in accordance with the Maternal Guidelines, during the Active Phase. They failed to monitor the plaintiff's condition in accordance with the Maternal Guidelines, during the Active Phase. The failed to monitor both the mother and the child from 05h00 till the baby was born at around 09h00. The plaintiff says that all these failures and omissions culminated in a situation that the nurses failed to note the desperate state of the Plaintiff's pregnancy including the continued pressure that the severe contractions noted in the early hours of the morning were putting on the baby from, at the most, 05h00 to 09h00 when they stopped monitoring the plaintiff and the baby.

[85] The plaintiff further contended that at birth the defendant's staff failed to assess the bay's condition to determine whether or not the baby would be able to be born per vaginal. They failed to provide the baby with reasonable treatment soon after he was born, like cold cap treatment, and direct oxygen to his lungs. They continued to provide the baby with ARV treatment even after the mother's status had been found to have been negative.

[86] The plaintiff therefore contend that an assumption must not be made when considering whether a HIE is an acute-profound that it can only occur over minutes (in contrast to a longer period), notwithstanding what is generally understood by an injury being "acute". She referred to what was held in *M v MEC for Health Eastern Cape* that:

> "The court proceeded that on this argument there would have been ample forewarning of the impending catastrophe had the hospital staff acted properly and in accordance with what was required of them in practice. The lack of adequate monitoring constitutes a negligent omission. And factual causation, on this argument, is to be found in the creation of a situation where the foetus was placed at risk of, amongst others, hypoxia, which could have been averted by proper, adequate monitoring. In this regard reliance was placed on *Lee v Minister of Correctional Services*."[8]

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

[87] The SCA went further that: "*[I]n an article co-authored by Professor Buchmann the following conclusion appears: 'A labour related Intrapartum Hypoxia is a common and avoidable cause of perinatal death in South Africa, and the majority of these deaths occur in no risk situations where labour appears to be normal. The overwhelming problem seems to be failure to detect evidence of foetal distress. To prevent these unnecessary deaths the emphasis in labour and care should be close and careful monitoring of all women in labour, with particular attention to detail in foetal heart rate monitoring.'*

[88] The defendant's officials cannot reasonably and confidently explain to the Court what caused the damage to the baby's brain. From the expert evidence and literature this means that the baby's brain was deprived oxygen for a prolonged period of time. Dr Abrahams and Dr Moyo termed this as Birth Asphyxia. The Court must then ask itself, what is the likely cause of the harm to the baby's brain. Dr Abrahams, in the hospital records stated that it was caused by birth asphyxia and HIE grade 2.

[89] In other word, the said Dr Abrahams, as supported by Dr Lefakane, has found that the baby was deprived oxygen while in utero. This was the same answer which Dr Lefakane provided, after he excluded, congenital pneumonia, viral or bacterial infection. The only answer is that the baby suffered asphyxia possibly during birth. In this regard, something can also be said about the reliance by the plaintiff's experts on the Apgar score as not reflecting the correct condition of the child immediately after birth. The baby was said not to have cried, tired, required air and passed meconium, had nasal flaring and could not suck. In the evidence of Sister Mkhize the baby's lips were blue. I am of the view that this was not a reflection of a healthy baby as the defendant would want the court to believe.

[90] The substandard care afforded the plaintiff has been conceded by the experts. The next question that one has to ask is whether or not the said substandard service and lack of monitoring during the crucial hours of labour caused the harm herein and when could this injury have happened. Dr Lefakane stated that two hours before the birth is a critical time within which if anything untoward can be spotted, emergency remedial actions can take place. Prof Nolte, also testified that the said time from 05h00 to 09h00 is the most critical time for the baby.

[91] There being no evidence of a sentinel event, the plaintiff's baby was, in my view injured because the defendant's nurses were negligent, unreasonable and demonstrated substandard care by their failure to timeously recognise the risk factors like the late decelerations, blood in urine, etc. and not monitoring the plaintiff according to the acceptable standards provided for in the guidelines.

[92] I am therefore satisfied that foetal distress would have been averted and the plaintiff's child would not have sustained HIE had the defendant's staff properly monitored the plaintiff during labour. In the circumstances, I find, on the probabilities, that the defendant's staff failures culminated in an acute-profound HIE which occurred intrapartum sufficient to result in the condition of the plaintiff's child.

[93] Under the circumstances, I make the following order:

1. The defendant is liable for 100% of the damages of the Plaintiff as proven or agreed in her representative capacity for and on behalf of her child, resulting from the negligence of the staff at Ramokonopi Clinic resulting in the child suffering from cerebral palsy;

2. The defendant shall pay the costs of suit including such costs to include:

    a. The costs attendant upon obtaining the medical legal reports, addendums and joint minutes of the following experts:

        i. Professor W A G Nolte;

        ii. Dr S Lefakane;

        iii. Dr P Henning;

        iv. Dr M Mbokota;

    b. The qualifying, attendance, preparation, travelling fees, where applicable, of the aforesaid witnesses.

    c. The costs consequent upon the employment of a senior counsel.

3. The determination of the quantum of the said damages is postponed sine die.

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M B MAHALELO

JUDGE OF THE HIGH COURT

GAUTENG DIVISION, JOHANNESURG

This judgment was delivered electronically by circulation to the parties legal representation by e-mail and uploading onto caselines. The date and time of hand down is 10h00 on the 15 September 2022.

Appearances:

On behalf of the plaintiff	: Adv T Machaba SC
Instructed by	: Jerry Nkeli and Associates
On behalf of the defendant	: Adv N Makopo
Instructed by	: Johannesburg State Attorney
Date of judgment	: 15 September 2022