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

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

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

04 April 2023

DATE SIGNATURE

CASE NUMBER: 13493/18

In the matter between:

R. S. L. obo T.M. PLAINTIFF

and

MEC OF HEALTH, GAUTENG DEFENDANT

SUMMARY: *Delict- Medical negligence- Failure to monitor the plaintiff and the foetus during labour- Whether the failure to monitor the plaintiff by of the hospital staff is causally linked to the foetus's brain damage- Legal principles on factual causation.*

ORDER

HELD: Judgment in favour of the plaintiff on merits.
HELD: The defendant is ordered to pay 100% of the plaintiff's agreed or proven damages.
HELD: The defendant shall pay the plaintiff's taxed or agreed costs of suit to date on a scale of attorney and client scale. The costs shall include the following costs-

The costs attendant upon obtaining the medico-legal reports including addendum reports;
The qualifying and or reservation fees of Dr J. Reid, Dr A. Keshave, Dr B. Alheit, Dr C. Sevenster, Sister Fletcher, Prof. J. Smith, Dr. Gericke.
The costs of any radiological or special medical investigation user by the above mentioned experts.
The qualifying, attendance and or preparation costs as can be allowed by the Taxing Master of Dr Sevenster, Sister Fletcher, Dr Alheid and Prof. Smith.
The costs attended by the appointment of two Counsels for their fees for 8, August 2022, 10 August 2022, 12 August 2022, 15 August 2022 to 19 August 20222 including reasonable fees for preparation of the heads of argument.
The costs of the attorneys of record subject to the discretion of the Taxing Master in preparation for trial, travelling costs, attendance at court and reasonable costs of consulting with the plaintiff to consider the offer.
The reasonable costs of the plaintiff to attending the medico-legal examination of both parties.
Costs consequent to the plaintiff's trial bundles, witness bundles including eight copies thereof.
Costs of holding pre- trial conferences and round table meetings including Senior Counsel and Junior Counsel charges.
Costs of holding expert meetings between the medico-legal experts appointed by the plaintiff.
Full travelling time, accommodation costs of the plaintiff, Dr Sevenster and Sister Fletcher and other related expenses thereof.
Costs occasioned by the condonation application, the locus standi application and costs, if any, occasioned by the application dated 10 August 2022.
The defendant shall pay interest on the prescribed rate on the plaintiff's taxed or agreed costs of suit calculated within thirty one days after agreement or from date after affixing of the Taxing Master's allocatur to date of final payment.
Any payment due in terms of this order shall be paid to the trust account – Werner Boshoff Inc, Standard Bank Lynwood Ridge, account number […], branch code 012-445 with reference W. Boshoff/MP/Mat715.

JUDGMENT

MNCUBE, AJ:

INTRODUCTION:

[1] This is an action for damages for medical negligence in the sum of R27 380 000,00 (twenty seven million three hundred and eighty thousand rand) that was instituted by the plaintiff on behalf of T.M. against the defendant. The plaintiff is the mother of T.M. The defendant is the Member of the Executive Council for the Department of Health, Gauteng in the representative capacity responsible for the healthcare in Gauteng Province. By agreement between the

parties, merits were separated from quantum in terms of Rule 33(4) of the Uniform Rules of Court and the proceedings were in respect of the merits.

[2] The evidential material consisted of oral evidence of the plaintiff and two expert witnesses as well as one expert witness called on behalf of the defendant and documentary evidence. Adv. Myburgh appears on behalf of the plaintiff and Adv. Makopo appears on behalf of the defendant.

FACTUAL BACKGROUND:

[3] On 27 June 2011 the plaintiff started having labour contraction and arrived at Lenasia Clinic at approximately 06h00. The labour progress was slow that a decision was made to have her transferred to Chris Hani Baragwanath Hospital (Baragwanath) by ambulance. The plaintiff was admitted at Baragwanath Hospital. Around 22h00 there were unsuccessful attempts to deliver the baby by means of a vacuum extraction or ventouse delivery. The plaintiff was taken to the theatre for an emergency caesarean section after midnight on 28 June 2011. The baby was born with an Apgar score of 1/10 one minute after birth and 5/10 ten minutes after birth. The baby T.M. was diagnosed with hypoxic ischaemic encephalopathy (HIE II). The plaintiff issued summons on 26 August 2018 for damages for the injury suffered by the baby T.M. against the defendant by virtue of vicarious liability. The defendant raised two special pleas which were addressed by means of court orders.

ISSUES FOR DETERMINATION:

[4] The only issue for determination was factual causation – specifically whether or not the staff at Baragwanath Hospital was negligent in their treatment of the plaintiff and baby T.M. during the plaintiff's maternity care, labour and birth of the baby and whether the negligence, if found, was causal to the baby's brain damage and cerebral palsy.

ONUS:

[5] The onus to prove all the elements of the claim for medical negligence on a balance of probabilities fell upon the plaintiff.

PLAINTIFF'S CASE:

[6] **The plaintiff** testified that she discovered that she was pregnant with T.M. after consulting a doctor who confirmed the pregnancy. On 27 June 2011 she went into labour and was transported to Lanesia Clinic. She described the labour in detail from the time of arrival at

the clinic. She informed the court that upon arrival at the clinic she was examined and it was confirmed that she was in labour. She was informed that she will be transferred to Baragwanath Hospital if the baby was not delivered within two hours. She testified that the labour progress was slow she was then transferred by ambulance to Baragwanath Hospital. Upon arrival at the hospital she was taken into an examination room where she was examined and her blood pressure was checked. She sat on a bench inside the examination room until her water broke and the nurse transferred her to a delivery room. At the delivery room a male doctor came and examined her and remarked that she had not progressed to where she was supposed to be. She overheard a discussion regarding administering medication to speed up the labour which was administered through the drip.

[7] The male doctor examined her again and made a remark about ‘not yet’ and left the room. After a while the male doctor who had examined her returned in company of another female doctor. The initial male doctor who had examined her then left the room leaving the female doctor who informed her that it was time to push. She testified that she queried the female doctor whether she did not have any option and the doctor remarked that first time mothers are not allowed to deliver by caesarean section instead of a natural birth. The female doctor made her to push but the baby would not come out until she became exhausted. The female doctor informed her to keep pushing as the baby’s head was visible and took her hand to feel the baby’s head. She attempted to push the baby out but failed. The female doctor left the room and returned with the male doctor where a decision was taken to perform an emergency caesarean section. Upon hearing the decision she started to cry and to panic but tried to compose herself in order not to affect the baby. She noticed on the monitor that the baby’s heart rate was dropping. She was given documents to sign and was advised that the theatre was full. After a while she was taken to the theatre.

[8] She informed the court that she was injected on her back. She felt the baby’s head being pushed back inside her. After the caesarean section was completed, she noticed that the baby was not breathing. The gender of the baby was revealed before she passed out. She testified that she had been a smoker and stopped when the pregnancy was confirmed at three months. In cross examination she testified that she did ask for an option of caesarean section but was told that she was on the verge to deliver. When asked how long she waited from the hospital reception to the examination room stated that she had no means to tell time. She indicated that on arrival at the hospital, the paramedic went to the reception area and opened a file on her behalf. She indicated that in the examination room there were other patients who

were in their own compartments therefore it was busy. She informed the court that she only noticed one nurse who was taking patients' vitals. When asked how long she waited before she was taken to theatre, she once again remarked that she did not know as she had no access to time. She conceded that the caesarean section was difficult and it took some time. She stated that she could not recall when she attended clinic due to passage of time but it was after the confirmation by doctor that she was three months pregnant. She conceded that she stopped smoking after the confirmation of pregnancy.

[9] **Lesly Ann Fletcher** is a retired nurse with a Master's degree in nursing. She testified that the guidelines for basic nursing care are for maternity care to standardize the level of patient care and to provide guidelines in event of complications during pregnancy and labour. These guidelines extend to doctors and are taught from basic nursing care to midwifery. She testified that there are different stages of labour which normally takes eight hours but if labour goes beyond eight hours it is considered prolonged. Cervix of a mother which is more than four centimetres dilated is in the active stage of labour and it was important to monitor the labour progress for the well-being of both mother and baby. She stated that in active stage of labour the heart rate is monitored every half an hour to check if the baby is coping with labour and the frequency of the contractions. She testified that in active labour phase nursing records are found in the Partogram which helps to identify early the lack of progress. In the plaintiff's Partogram it reflected that by 11h30 there was no change in the cervix dilation which stood at five centimetres and it crossed to the transfer line. She stated that there was no further recording on the Partogram from 11h30 until 19h47. She testified that in her opinion the nursing care at Lenasia Clinic was not completely acceptable because they did not monitor the heart rate hourly though she was satisfied with the decision to transfer the plaintiff. She stated that from 14h50 the plaintiff did not receive the full nursing care because there was no hourly monitoring which is in terms of the guidelines. She stated that the plaintiff's records reflected that at 16h30 the cardiotocography (CTG) was done.

[10] She testified that the CTG record on page 58 reflected a deceleration and a low foetal heartbeat. She stated that in her opinion the CTG was showing an abnormality coupled with the slow labour progress which required action. The plaintiff's CTG showed that at 17h30 she was in distress and from the nursing care perspective action should have been taken. The plaintiff's record showed that there was no further CTG after 18h30. She informed the court that on page 60 the CTG showed a deep deceleration and under those circumstances one ought to have called the doctor and inform the doctor that something was not right with the baby. She testified

that in her opinion the deep deceleration was a pathological concern yet the doctor prescribes a medicine which had an effect of was making contractions stronger and the uterine muscles to work longer. She stated that the plaintiff's records showed that she crossed an action line by a number of hours and when the doctor prescribed medication designed to accelerate labour in her opinion, monitoring should have been half hourly. Based on the plaintiff's records there was no monitoring until the doctor was called at 23h10.

[11] She explained that she differed from the opinions expressed by Dr Harris that the caesarean section was performed timeously. In her view, the procedure should have been done by 14h50 and if action had been taken earlier there would have been a different outcome. In cross examination it was put to her that there are exceptions where patients do not progress in labour, she conceded. She indicated that she was satisfied with the treatment at Lenasia Clinic except that the heart rate was not monitored half hourly. When asked whether she was critical of the actions taken by the doctor at Baragwanath Hospital, she remarked that she can voice her feelings about it. She was asked when in her opinion the baby should have been born, she stated that around 13h00 to 13h30 if the patient was progressing according to the guidelines. She testified that the record on Bundle F page 55 would not have caused the doctor to be concerned save for the slow progress of the labour. She testified that a non- reassuring CTG is enough to call a doctor. It was put to her that the record on F53 reflected a normal the foetal heart rate, she disputed that and remarked that the heart rate was below normal. She maintained that the Partogram showed a deceleration. She informed the court that the guidelines were also applicable to Baragwanath. She testified that at 23h10 the position of the baby was then discovered and she did not see the nurses' notes confirming the position of the baby. She testified that in her opinion the vacuum extraction should have been attempted earlier.

[12] **Dr Christiaan Sevenster** is a specialist obstetrician. He compiled the joint minutes and testified that he stood by its content. He informed the court that the second joint minutes were compiled after he received the clinical reports. He stated that he found that there was 'but for'. In his opinion, the fact that plaintiff was smoking did not have an impact or adverse outcome on the basis that there was no evidence of foetal growth restriction. He informed the court that Dr Tshabalala reported for the first time that the baby was in occipult posterior position at 23h10. He stated that the baby's position can be diagnosed by palpitation of the abdomen and vaginal examination. He informed the court that the position of the baby can have an impact on the duration of the labour as it can take longer. He testified that in the case of the plaintiff labour

was progressing slow and had crossed the alert line which implies that the midwife should have informed the doctor and try to find the cause for that doing differential diagnosis and then to institute the correct treatment.

[13] He explained that it was important to try to find the diagnosis for the slow progress of labour after the patient had crossed the action line for more than two hours. He testified that the guidelines make it mandatory to take action if there is slow progress of labour which includes monitoring. He went on to explain that oxytocin is a powerful agent that causes the contractions of the womb muscles which is usually administered via a drip. He could not find any factual evidence of the CPD[1] to account for the poor labour progress. He testified that the CTG was non-reassuring because there were decelerations evident at 16h40 and 17h10 which he would not have signed on. He reemphasised that the CTG were non-reassuring due to the decelerations. He indicated that the non-reassuring CTG readings were part of signals that show foetal distress. He informed the court that the implications of administering the Syntocinon is continuous foetal monitoring which can be detrimental to the foetal condition as the foetus has no time to re- oxygenate itself between the contractions.

[14] He testified that the mechanism of delivery of the baby does not cause brain damage, it can only cause vaginal and uterus tears. He informed the court that it was difficult to say when an injury occurs. He explained that in prolonged labour a baby becomes acidic which has an effect on the heart and the result is less oxygen on the baby's brain. He indicated that in the case of the plaintiff, continuous monitoring and re-evaluation in two hours and if there was no progress to perform caesarean section. He disagreed with the opinion of Dr Mbokota that there was a sentinel event which occurred. He indicated that in his opinion the injury occurred after the augmentation of the Syntocinon which placed the injury between 19h45 and the time the caesarean section was performed. He testified that given all the clinical information he would have tried to get the reason why the patient passed the line and would have monitored the contractions. He explained further that he would have done a abdominal and internal examination on the patient and if no augmentation was done, he would have done the caesarean section by 14h50. He testified that if he had been attending to the plaintiff, he would have delivered the baby before the decision to augment. He opined that if T.M. had been born prior to 19h47, there would not have been the injury and that the plaintiff constituted an emergency when she crossed the action line. In cross examination he indicated that he

[1]Cephalopelvic disproportion- a condition where the baby's head is too large to fit the pelvis of the mother.

interviewed the plaintiff in Afrikaans. He indicated that the plaintiff informed him that she noted time from the cell phone.

[15] He testified that during the interview, he did enquire from the plaintiff about smoking though he did not record that. When asked to elaborate on his acceptance that smoking had no impact, he informed the court that this was based on articles. He reaffirmed that in his opinion the weight of the baby of 3kg was within term. It was put to him that he was not in a position to say that smoking had no impact; he remarked that smoking was not a concern and there was no growth retardation. He testified that the position of the baby was only diagnosed at 23h10 yet the plaintiff was examined vaginally at 7h30, 9h30, 11h30, 14h30, 17h30, and between 20h00 and 21h00. He informed the court that midwives are taught what to feel and it was unlikely to miss. He indicated that he differed with Dr Mbokota's opinion that occipult posterior position was hard to diagnose. He conceded that the decision to perform vacuum extraction was correct. It was put to him that there were no signs of foetal distress, he indicated that the absence meconium did not exclude foetal distress. He informed the court that in his opinion, the caesarean section was performed due to the failed vacuum extraction attempts. He disagreed that the brain injury occurred during the caesarean section and opined that it occurred hours prior. He further opined that the deceleration was non-reassuring and he would not have signed the CTG on non-reassuring. It was put to him that the reading on page 59 (CTG) was due to the loss of contact, he disputed that. He opined that the hypoxic ischaemic injury probably occurred hours before the caesarean section which could have been when there was non-reassuring CTG aggravated by augmentation of Syntocinon and the mother bearing down.

[16] When he was referred to the MRI picture in relation to his opinion as to when the injury occurred, he deferred to the radiologists and remarked that augmentation of labour increased the hypoxia on the baby who had become acidic. When asked how the baby survived, he indicated that it was a miracle as it should be dead. He conceded that first time mothers (primigravidas) do take long to deliver but maintained that by 9h30 plaintiff should have been transferred from the clinic to the hospital when she did not progress. He testified that at the hospital the caesarean section should have been done within an hour or two especially for a patient who had passed the action line. It was put to him that there is no reference in the guidelines for continuous CTG monitoring and he agreed and remarked that was what it meant. It was put to him that Syntocinon was stopped before the surgery, he stated that there was no mention of stopping it. With that the plaintiff's case was closed.

DEFENDANT'S CASE:

[17] **Dr Meshack Mbokota** testified that he qualified as a medical practitioner in 1991 and proceeded to do his internship in Acronhoek. In 1995 he joined Baragwanath Hospital as a medical officer in the Department of Obstetrics and Gynaecology for six months. He proceeded to King Edward Hospital to specialise which he completed in 1999 and practised as a specialist. He obtained a Masters of Science and Health System Management in 2016. He is in private practice and doing medico-legal work. He informed the court that he produced two reports in bundle L, the first report he produced when he had no reference to the clinical records. He stated that when the plaintiff had an ultrasound she was found to be 31 weeks gestation. The clinical records reflected that the plaintiff was a smoker but did not indicate when she stopped smoking. The clinical records show that the plaintiff had five antenatal care visits and the plotting of the foetal growth was changed following the ultrasound which was done on 3 May 2011. He noted a discrepancy of four weeks in the symphysis fundal height measurement and the ultrasound. He testified that the plaintiff booked at 24 weeks at Thembalethu Clinic which was considered late.

[18] He informed the court that from his report, the plaintiff was estimated to be 40 weeks when she gave birth and the baby was 500 grams less than the average weight signifying intrauterine growth restriction. He indicated that the clinical records showed that the plaintiff was monitored as the labour progressed and the decision to refer her for further management was taken at 11h30 because of the slow progress of the labour. The reading of the Partogram showed the progress of labour at 7h30 was at four centimetres dilated to transfer line at 9h30 when she was five centimetres dilated. The 11h30 assessment was approaching action line. Foetal condition and maternal condition were normal. The next clinical record showed that she was transferred from Lenasia South Clinic to Baragwanath Hospital at14h50. The records showed good foetal movements and around 22h00 the plaintiff was experiencing labour pains. Vaginal examination was done and she was six centimetres dilated. The examining doctor found a reassuring CTG which he agreed with. He testified that there are three types of decelerations – early decelerations which occur prior to a contraction which do not mean much, a variable decelerations which occur anytime irrespective of contractions which mean there may be an element of occult cord compression and these decelerations are serious if they drop below eight beats per minute and late decelerations which start at the peak of contractions which means that the baby is taking long to recover from the effect of the contraction. With the late deceleration foetal distress is higher. He informed court that there three classification of interpreting a CTG as normal (reassuring) which meant there was nothing to worry about,

another was suspicious (non- reassuring) calling for close monitoring and the last was abnormal (pathological) which meant foetal distress calling for something to be done.

[19] He informed the court that on interpretation of the Partogram he differed from Dr Sevenster as he regarded the reading as normal as variable deceleration. He testified that the reading on pages 59 to 60 was loss of contract. He indicated that variability of foetal heart increases may look like late deceleration. He testified that the doctor's note had a mistake however a caesarean section was called for after the failed vacuum extractions. He explained that the effect of occipult posterior position was that it causes labour delays and in the plaintiff's case, the delivery was difficult because the baby's head was lodged into the pelvic and they needed to dislodge it via the vagina. He testified that accused profound injury occurs within twenty to thirty minutes prior to birth and the baby would die if the period was more than thirty minutes. The radiologists are unable to point to the exact time when the injury happens. He conceded that he disagreed with Dr Sevenster on the issue of impact of smoking. He opined that smoking in the first trimester the baby's organs are forming and toxins from smoking can go to the baby and affect vital organs such as the brain blood vessels would be affected. He further opined that Dr Sevenster ignored that prior to the placenta forming, toxins crossed to the baby and injury can occur. He indicated that the plaintiff had just crossed alert line and the slow labour progress was due to the occipult posterior position. He testified that the standard of care the plaintiff received at the clinic was in accordance to the guidelines.

[20] He testified that between the period 15h00 and 17h30 when the plaintiff was admitted he found that there was no substandard care. In cross examination when asked what caused the injury, he stated that the head compressed in the pelvis could have caused the hypoxia and opined that it could be due to umbilical cord compression while waiting for caesarean section. When asked if he was adhering to his duty to be objective, he insisted that he was. When asked had the plaintiff been brought to his practice if he would have acted in the same manner as he advocated in court, he said no and qualified his answer by saying the occipult posterior position was hard to diagnose and the plaintiff had deep transverse arrest. When asked to indicate on his report where he noted that there was deep transverse arrest, he indicated that it was implied. When asked further to indicate this on the joint minutes, he stated that it was also implied. He conceded that there was no record of monitoring from 19h45 to 23h10. He further conceded that there was no monitoring after oxytocin infusion.

[21] He conceded that there was no record that there was medicine used to stop the contractions. He conceded that IUGR[2] does not cause HIE rather it was placental damage which may cause HIE. He testified that the mother was responsible for the wellbeing of the unborn child. He conceded that the plaintiff was not assessed for IUGR but it was his opinion that there was IUGR. When asked if he would have let the baby wait for six hours past the action line, he remarked that he would have investigated the cause for the prolonged labour.
With that the defendant's case was closed. He conceded that there no one diagnosed the prolonged labour which was substandard. He conceded that there was no explanation for that prior to oxytocin infusion which was substandard however persisted that the administering of oxytocin was reasonable. He conceded that it would be unreasonable if the doctor used the CTG for the period 18h30. He conceded that it was dangerous to expose a foetus to prolonged labour with strong contractions. He conceded that the caesarean section was delayed but agreed with the decision to perform one. With that the defendant's case was closed.

THE EXPERTS' JOINT REPORTS[3]:

[22] In the joint minutes compiled by the geneticists, Dr G.S. Gericke and Dr L. Bhengu they agreed on the following facts-

a) The family history is uninformative with regard to possible underlying genetic susceptibility factors responsible for the current adverse neurodevelopmental outcome and in respect of antenatal history that there is no contributory information.
b) That during the plaintiff's gestational period, there was no history concerns about her or the baby were raised.
c) That the plaintiff's child is cared for at home and he can do some activities for himself (such as to run, dress and undress himself, feed himself).
d) That following a clinical genetic examination on the child, there were no dysmorphic features suggestive of CP-associated underlying clinical genetic disorders. They agree further that the child manifests a spastic diplegic cerebral palsy worse on the left side.
e) That the history and clinical findings do not contain information which point towards the presence of a condition other than the classic cerebral palsy. They agree that there were no infective structural or thrombotic disorders which were observed on the brain MRI. They agree that there were no features of mitochondrial or genetic neurodegenerative conditions described.
f) They agreed that the presentation in the child is that of intrapartum HIE event with no apparent genetic contribution.

[2]Intrauterine growth restriction.
[3]For full reports see Case Lines.

g) That after the availability of intrapartum hospital records it did not alter the paediatric genetic conclusions.

[23] In the joint minutes compiled by the nursing experts Dr Harris and Ms Fletcher they agreed on the following facts-

a) That the plaintiff had a normal pregnancy.
b) The history upon the plaintiff's arrival at Lenasia Clinic on 27 June 2011 until the baby was delivered.
c) That it is reasonable that a patient with a high risk factor be assessed timeously at an approximated time of thirty minutes on arrival at the hospital.
d) That during the course of the active phase of labour, it is reasonable that the foetal heart rate be assessed and documented on the Partogram every thirty minutes.
e) Given the fact that the plaintiff was transferred to Baragwanath Hospital it was probable that she had a high risk factor which would probably have been an indication for continuous CTG monitoring.
f) In the addendum joint minutes they agreed that the plaintiff was in an active phase of first stage of labour when she was admitted at Lenasia South Clinic.
g) That at 9h30 on 27 June 2011 the progress of the labour had crossed the alert line and at 11h30 the progress of the labour had crossed the transfer line.
h) That the decision to transfer the plaintiff was appropriate.

[24] In the joint minutes compiled by specialist Obstetricians Dr C Sevenster and Dr M. Mbokota they agreed on the following facts-

a) That at 11h30 the plaintiff's cervix was five centimetres dilated and there was slow labour progress.
b) That the plaintiff crossed the alert line on the Partogram and was transferred to Baragwanath.
c) That there was no factual record of maternal and foetal observation during the transferral to Baragwanath Hospital.
d) That at 19h47 the plaintiff's cervix was nine centimetres dilated.
e) That on 28 June 2011 at 00H45 a difficult caesarean section was done under spinal anaesthesia.

[25] In the joint minutes compiled by the paediatric neurologists Dr A. Keshave and Dr V. Mogashoa they agreed on the following facts-

a) That from the time of delivery there was neonatal encephalopathy with features in keeping with intrapartum hypoxia that was sustained.
b) That the MRI reports of the defendant's expert indicated that the MRI brain had the following injury pattern- bilateral symmetrical perirolandic , posterior putamen and sub rolandic periventricular white matter high signal intensities. This was in keeping with acute profound hypoxic ischaemic injury in a chronic stage of evolution.

[26] In the joint minutes compiled by the paediatricians/neonatologists Professor J. Smith and Dr K. Sanyane they agreed on the following facts-

a) That the pregnancy of the plaintiff carried to full term gestation and no complications of the antenatal or prenatal period were recorded.
b) That there is a paucity of maternal records and no primary factual records of the antenatal or intrapartum period.
c) That there is a paucity of primary factual neonatal records other that the neonatal discharge summary of Baragwanath.
d) The total absence of maternal records and paucity of neonatal records is deplorable since the Public Health Facility is compelled by the National Health Act to safe-keep records.
e) That the plaintiff was admitted at Lenasia South Clinic during the morning of 27 June 2011 around 6h00 and was regularly reviewed by the midwife until 12h00 when she was transferred to Baragwanath.
f) That prior to midnight a vacuum extraction was attempted twice which failed and a caesarean section was then performed.
g) That after the failed vacuum extraction the plaintiff was informed that the baby was 'struggling to breathe' as reference to the presence of foetal distress so a caesarean section was performed.
h) The intrapartum period is the probable period during which the hypoxic insult occurred which eventually resulted in HIE II and cerebral palsy.
i) That there was no other causal factor underlying the development of cerebral palsy other than HIE II.
j) That the infusing of Syntocin was prescribed around 19h47 which was a drug that poses significant risks to the maternal and foetal wellbeing if not properly supervidsed and monitored.
k) The second stage of labour was probably prolonged.

l) The decision to perform the caesarean section and the delivery was approximately one hundred minutes.
m) That the lack of nursing personnel and the delays in accessing theatre were present factors that indicated a modifiable and system- avoidable health risks to a labouring patient on 27 and 28 June.
n) The condition of the foetus and the excessive external forces were at play probably directly affecting foetal brain blood flow.
o) The baby was born in a significantly compromised condition.
p) The 1 minute Apgar score reflected that the baby was probably born in a state of secondary apnoea and required resuscitation.
q) The experts agree that the intrapartum period (during labour and birth) was the probable period during which the hypoxic ischaemic insult occurred which resulted in HIE II and cerebral palsy.

[27] In the joint minutes compiled by radiologists Dr T. Kamolane and Dr B. Alheit they agreed on the following facts-

a) That subperirolandic white matter and the posterior putamina injury are considered to be diagnostic of hypoxic ischaemic injury of the brain.
b) That the injury of the brain was likely to be central (acute profound pattern) hypoxic ischaemic in nature.
c) That the genetic disorder(s) as a cause of the child's brain damage was unlikely.
d) That there was no evidence of current or previous infective or inflammatory disease on the MRI sequences and that infective or inflammatory condition are unlikely causes of the child's brain damage.

SUBMISSIONS:

[28] All submissions made on behalf of the parties together with cited authorities have been considered. Counsel for the plaintiff contended in his oral submissions that the fact that the pre-trial minutes were not signed is indicative of the lack of care by the defendant. The argument was that the lack of care which borders on disrespect is the failure by the defendant to submit heads of argument. Counsel argued that Sister Fletcher was subjected to lengthy cross examination for the defendant to then concede to the injury. The contention was that the defendant's witness Dr Mbokota attempted to defend the undefendable which showed a measure of disrespect. The submission was that this matter is simply about the Partogram which was saying to the reader the baby needed help which was not forthcoming from the

defendant. The contention was that the defendant has instead come up with excuses for the injury of the baby. Counsel argued that Dr Sevenster's evidence was undisputed and that Dr Mbokota made concessions that some conduct of the doctors was substandard.

[29] Counsel for the plaintiff submitted in his oral argument that on the facts it was hard to say when the injury occurred however all the facts point to the fact that the injury occurred after augmenting labour which was sufficient to find negligence. Counsel prayed for punitive costs order against the defendant. In his heads of argument, Counsel outlined the legal principles on negligence and expert witnesses at great length. He argued that T.M. suffered a hypoxic ischaemic brain damage and resultant cerebral palsy which occurred between the oxytocin infusion and his birth at 00h55. The submission was that the second stage of labour was also severely prolonged. Having set out the legal principles on expert witnesses, Counsel argued Dr Mbokota's testimony ought to be disregarded on the basis of bias and unreliability. Dr Sevenster, on the other hand was critical of the time it took to perform the caesarean on the plaintiff. The argument was that the plaintiff was able to establish negligence. In response to the submission by the Counsel for the defendant, it was argued that what the defendant was advocating was that this court should disregard everything and submitted that the plaintiff required urgent medical care. Counsel referred to ***Van Wyk v Lewis 1924 AD 438*** in which it was held facts speak for themselves.

[30] Counsel for the defendant contended that the defendant could not have prevented the injury as it occurred when it was the time to do caesarean section. The argument was that there was no monitoring between 17h30 to 20h45 but there was monitoring before the caesarean section. The submission was that where the nature of the injury was acute profound injury which occurred within thirty minutes. Counsel contended that even if there was prolonged labour, there was no causal link to the injury suffered. The argument was that it was not in the pleadings that augmentation of labour contributed to the injury. Counsel referred to cases in which the appeal court was critical of the trial court for disregarding the radiologists minutes on acute profound injury. Counsel referred to ***Shange v MEC for Health for the Province of KZN***[4] Counsel also referred to ***NVN obo VKM v Tembisa Hospital and Another***[5] which came before the Constitutional Court for an appeal where the second judgment found on the facts that the decision to perform the caesarean section at 4h45 and the undertaking of the operation would not have averted the injury on the baby. Counsel made a concession that there was no monitoring, however dung the critical period prior to the caesarean section there was monitoring

[4] *Unreported case (9019/2017) ZAKZPHC which was delivered on 5 December 2019.*
[5] *2022 (6) BCLR 707 (CC) (25 March 2022).*

and there was no negligence. It was argued that there was no justification for punitive cost order. Counsel cautioned the court not to elevate guidelines to law. Lastly the submission was that the injury occurred during the period what could not have been prevented.

APPLICABLE LAW:

[31] The jurisdictional requirements for delictual claims are trite[6]. This means that the plaintiff needs to prove that the act or omission by the defendant must have been wrongful and negligent and caused the harm. It is trite that wrongfulness involves the breach of a legal duty of care. Wrongfulness involves causation which has two elements- legal causation and factual causation. In this matter the only issue for determination is factual causation.

[32] The determination is whether or not the defendant's conduct caused or materially contributed to the harm suffered by the plaintiff. Factual causation is determined by the application of the *conditio sine qua non* ('but for'). The plaintiff is required to prove on a balance of probabilities that the defendant's wrongful conduct was a necessary cause of the harm suffered. The defendant's conduct will be the factual cause of the harm suffered by the plaintiff, if but for the defendant's act or omission the harmful results would not have occurred. To apply 'but for' test, the court is required to make a hypothetical enquiry based on the evidence as to what would probably have happened but for the wrongful act or omission of the defendant. The plaintiff does not need to prove factual causation with certainty save to prove that the harmful results would have probably not have occurred but for the conduct of the defendant, thus using a process of reasoning that involves retrospective analysis[7].

[33] In ***Lee v Minister of Correctional Services 2013 (2) SA 144 (CC)*** para [38] it was held 'The point of departure is to have clarity on what causation is. This element of liability gives rise to two distinct enquiries. The first is a factual enquiry into whether the negligent act or omission caused the harm giving rise to the claim. If it did not, then that is the end of the matter. If it did, the second enquiry, a juridical problem arises. The question is then whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensure or whether the harm is too remote. This is terms legal causation.' At para [39] it was

[6]The proof is on a balance of probabilities of these elements- wrongfulness, negligence, causation and that the loss suffered was the result of the defendant's wrongful conduct/omission.

[7]See *Minister of Safety and Security v Van Duivenboden [2002] All SA 741 (SCA)* para [25] it was held '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 ordinary course of human affairs rather than an exercise in metaphysics.'

stated ‘Whether an act can be identified as a cause depends on a conclusion drawn from available facts or evidence and relevant probabilities.’

[34] In other jurisdictions, the ‘but for’ test still finds application. In ***Resurfice Corporation v Hanke***[8] the Supreme Court of Canada held ‘First, the basic test for determining causation remains the “but for” test. This applies to multi-cause injuries. The plaintiff bears the burden of showing that “but for” the negligent act or omission of each defendant, the injury would not have occurred.’

EVALUATION:

[35] There are factual disputes in this matter- the plaintiff’s version is that due to the negligence of the defendant which was due to the failure to attend to the plaintiff timeously and the failure to detect foetal distress and to perform caesarean section timeously that the plaintiff’s baby had birth asphyxia. The defendant’s version on the other hand denies negligence on the basis that all treatment administered to the plaintiff and the minor child was reasonable in the prevailing circumstances. As trite the proper manner in resolving factual disputes is for the court to make factual findings on (a) the credibility of the various factual witnesses; (b) their reliability; and (c) the probabilities. See ***Stellenbosch Farmers' Winery Group Ltd v Martell et Cie 2003 (1) SA 1 (SCA)*** para 5.

[36] On the basis that the only issue for determination is factual the legal representatives argued for different approaches to the issue- Counsel for the defendant contends that this issue must be determined by the nature of the injury to determine whether a breach of care was breached to wit being HEI II caused by acute prolonged injury. On the other hand Counsel for the plaintiff argues that this approach fails to consider all the prevailing circumstance which culminated in the injury suffered by the baby.

[37] By agreement the clinical and hospital records are admissible hearsay evidence in terms of section 3 (1) (a)of the Law of Evidence Amendment Act 45 of 1988 read with section 34(2) of the Civil Proceedings Evidence Act 25 of 1965. In the determination of the issue, the various joint expert reports were considered in totality with the oral testimonies within the ambit of probabilities and the common cause facts.

[38] Hereunder were some of the facts which were common cause-

[8]2007 SCC 7 para 21.

a) That the plaintiff arrived at Lenasia Clinic in labour and the progress was slow which caused her to be transferred to Baragwanath Hospital around 11h30.
b) At all material times from her admission to Lenasia Clinic until transferral to Baragwanath, the plaintiff was under medical and or nursing care of the staff within the course and scope of their employment to the defendant.
c) There were no records of foetal monitoring from the time she was transferred from the clinic until arrival at the hospital.
d) At the time the plaintiff was transferred Baragwanath Hospital, the Partogram reflected that she had passed action line.
e) It was common cause that monitoring and assessment of patients is done in terms of regulation guidelines.
f) It was common cause that the plaintiff's child T.M suffered a brain injury with the resultant cerebral palsy as a result of a hypoxic brain injury.

[39] The reliance by the Counsel for the defendant to the case of ***Shange*** is misplaced in my view on the basis that in Shange, the plaintiff had made a concession that the injury had occurred in the last ten to forty five minutes prior to delivery. In the ***Shange*** case, the court found that given the absence of an emergency in respect of the plaintiff and the acute profound injury probably occurred in the last ten to forty five minutes prior to the delivery the plaintiff was found to have failed to prove negligence. The facts of this present matter are distinguishable- the plaintiff had a prolonged labour, there was no investigation of the reasons for the slow labour progress and the time period in which the injury could have occurred was unknown. The reliance to the case of ***NVM*** by Counsel for the defendant is misguided on the basis of the issue before the Constitutional Court. I am in agreement with the second judgment in ***NVM*** which stated at para [112] that factual causation is quite often straightforward in medical negligence cases, as in this present matter.

<u>Findings on the credibility of the factual witnesses:</u>

[40] Three witnesses testified on behalf of the plaintiff- the plaintiff herself, Ms Fletcher and Dr Sevenster. The common thread in the versions by these witnesses is that there was negligence to monitor the plaintiff's labour progress which resulted in the birth asphyxia to the baby. I found the witnesses for the plaintiff credible. I am unable to find any biasness on Dr Sevenster The defendant called Dr Mbokota who was at pains to paint a picture that the plaintiff's treatment and labour management was reasonable. On the one hand, he concedes that he would have acted differently had she been one of his patients in his practice yet on the

same breath on the same facts he was at pains to convince this court that the defendant's action were excusable. The addition to his opinion that there was 'deep transverse arrest' expressed for the first time in cross examination had the unfortunate effect of making his objectivity as an expert questionable. On the one hand Dr Mbokota conceded that the failure by the medical staff to investigate the causes of prolonged labour was substandard yet on the same breath the administering of oxytocin was reasonable was with respect contradictory. As correctly cited by Counsel for applicant, Dr Mbokota's evidence did not pass the trite principles of an expert witness. By applying ***SS v RAF [2016] 3 all SA 637 (GP)*** in which Fabricius J stated that the most important duty of an expert is that he should provide independent assistance to a court. If follows that Dr Mbokota has fallen short of this duty which affected his overall impartiality and in turn his reliability as a witness.

[41] According to Ms Fletcher, she opined in the addendum joint minutes (Exhibit N1)' despite the increased risk posed by augmentation with Syntocinon to an already high risk labour, there was no recorded evidence of any monitoring of either the foetal or the maternal condition until approximately 3 hours later at 23h10, when the doctor was called to assist with Ms L since she had been "bearing down since 19h00". 'According to Dr Sevenster, Syntocinon works in the similar manner to oxytocin which accelerates labour. I found Ms Fletcher's opinion more in line with the guidelines on page 51 which recommends CTG monitoring after oxytocin infusion. Under such circumstances I was not convinced that the plaintiff received standard and reasonable the nursing care within the ambit of her constitutional rights.

[42] Dr Sevenster testified in a logical and clear manner. He has been able to articulate and substantiate his opinions. He is a credible and reliable witness. I could not find any biasness on his opinions. I found Dr Mbokota's opinion with special reference to the effects of smoking on a foetus to be of general nature this was due to the fact that there was no evidence that the plaintiff's smoking had any impact on baby T.M. In my humble view, it was an attempt to causally connect the brain damage suffered by T.M. to the earlier smoking which was contrary to the expert opinion expressed by paediatricians/ neonatologists. I found Dr Mbokota's opinions unhelpful for the following reasons- on the one hand he wanted this court to believe that the head which was lodged in the pelvic and possible umbilical cord caused the hypoxia yet does not address why the position of the baby was not discovered early if there was proper examination of the plaintiff. Following this hypothesis to its logical conclusion, it meant that the baby's position caused the labour to progress slowly yet inexplicably this has been the position from the time the plaintiff was admitted to the clinic. In other words, how come this was only

discovered by at 23h10? This brought about the question, how did all the staff from the clinic to the hospital not discover that fact? Whose duty was it to find the cause for the delay? The duty certainly was not upon the plaintiff. Either way one assessed the conduct of the defendant's staff, the failure to investigate the cause of labour delay constituted substandard care. It is for this reason that I found the version that the act of dislodging the baby's head from the pelvic as the probable cause for the hypoxia unconvincing.

Findings on the reliability of the factual witnesses:

[43] The testimony and opinions by Ms Fletcher were logical. I have found her to be a reliable witness whose opinion was helpful to this court. Having assessed the totality of the evidence, I was satisfied that Ms Fletcher's opinion that the plaintiff received a substandard nursing care was more probable and acceptable. Counsel for the defendant during cross examination of Dr Sevenster put it to him that there was no reference to continuous CTG monitoring in the guidelines. However if one has regard to monitoring of foetal condition during active per page 36 of the guidelines, it calls for half hourly before, during and after contractions. It followed that the opinion by Dr Sevenster that continuously was read in was more plausible.

[44] The plaintiff was a reliable witness. She articulated how the injury on her son came about. In instances where she could not comment she was confident to say so. The discrepancy with regard to time whether she informed Dr Sevenster or not in my view was immaterial. On material aspects she was clear.

[45] I have assessed the opinion s of both nursing experts and I was persuaded that Ms Fletcher's opinions are correct, logical and plausible. The averment by Dr Harris that the caesarean section was timeously performed was not factually correct. What was evident was that the decision was taken at 23h30 to perform the caesarean section yet it was performed after midnight. The version by Ms Fletcher was more plausible in that had there been continuous monitoring, the caesarean section performed much earlier the outcome would have been favourable. Ms Fletcher was an impressive witness who articulated her opinions logically. The version by Dr Sevenster tallied with that of Ms Fletcher in that the position of the baby was discovered around 23h00 which should have been discovered by either vaginal examination or abdominal palpitations. This led to one inference, that plaintiff received substandard nursing care.

Findings on the probabilities:

[46] In the joint minutes by the paediatrics, both Dr Gericke and Dr Bhengu agreed that they could find no contributory information on the family history with regard to possible underlying genetic susceptibility factors responsible for the adverse neurodevelopmental outcome. Both Dr Bhengu and Dr Gericke deferred to the obstetrician, however Dr Gericke opined '*Expert obstetric review indicated that there is adequate reason to suspect that intrapartum hypoxia was the cause of the neonatal encephalopathy in which a severely prolonged second stage of labour play a significant part.*' Lastly both of these experts agreed that the child presented intrapartum HIE event with no apparent genetic contribution. The opinions expressed by both these doctors proved one important fact, that the injury suffered by the plaintiff's child could not be linked to family genetics. Yet inexplicably the child suffers an intrapartum injury. I found the conclusions reached by Dr Gericke in that the prolonged second stage of labour together with the fact that there was no record of continuous CTG on a balance of probabilities led to the injury plausible.

[47] On the issue of the impact of smoking to the injury suffered by baby T.M. Dr Sevenster and Dr Mbokota in their joint minutes disagreed on the effect of smoking, however after evidence was holistically assessed, there was no evidence that smoking presented any adverse effect on the baby T.M. I found the opinion that there was no growth restriction as expressed by Prof. J. Smith persuasive. I found the evidence by Dr Sevenster that the CTG was non – reassuring more persuasive contrary to the defendant's version that it was nothing more than loss of contact.

[48] At 9h30 the Partogram showed that the plaintiff had crossed the alert line. The version by Dr Mbokota that action was only mandatory once there are complications after the patient has crossing the alert line on the Partogram was unconvincing. In my view, the contention suggested that all of the prevailing circumstances should be disregarded. To the contrary, a holistic view of all the facts was required. The common cause fact was that the plaintiff presented with a very slow labour. There was sporadic monitoring of the plaintiff rather than continuous monitoring of the mother and baby. The fact that the plaintiff crossed to an alert level on the Partogram was simply not a neutral factor which was verified by the decision taken at 11h30 to transfer her to Baragwanath. The fact that between 11h30 and 14h50 there was no factual record of foetal observation was material. The plaintiff was transferred to hospital as part of protocol due to the slow progress of labour and one would have expected records of observation during this period. This was another factor in my view that cemented the inference

that there was substandard care emitted to the plaintiff. The concession by Dr Mbokota that there were instances of substandard care was material. I accepted Ms Fletcher's testimony that monitoring every half hour was required on the plaintiff when she presented with such slow labour progress in order to monitor the foetus. I accepted Dr Sevenster that the plaintiff presented with an unusually lengthy period of labour, coupled with the decision to augment the labour the injury occurred prior to the caesarean section. There was no factual record showing there was half hourly CTG monitoring after augmentation of oxytocin to accelerate labour was done which would have monitored the effect on the foetal heart. The CTG reading of the heart rate described by Dr Sevenster as not being normal was persuasive as signifying of probable foetal distress. The fact that there was no meconium did not shift the probabilities in favour of the defendant.

[49] The guidelines clearly set out on page 52 what is regarded as abnormalities on the second stage of labour as poor progress. Secondly the guidelines clearly set out on page 51 that one of the indicators for continuous CTG monitoring is after oxytocin infusion. On the facts of this matter this was not so. The mere fact that the plaintiff got transferred to Baragwanath from Lenasia Clinic was not a neutral factor- the transferral signified to the attending medical practitioners that the patient was one who was in need of some specialist or higher level of care than the clinic. Instead, there was no evidence that proper investigations were conducted for the slow labour. It appeared that the plaintiff was not treated as an emergency case until 23h10 which was shocking. When the plaintiff who was in labour was admitted at Lenasia Clinic, a legal duty of care arose until the birth of the baby. The staff at all health facilities, whether they were nurses or attending physicians assumed a duty to care for the plaintiff and the baby. There was a duty to monitor the condition of both the plaintiff and the baby and to act appropriately.[9] I was satisfied that there was a breach of the duty to care in the form of lack of monitoring and the failure to take appropriate action which caused the baby to suffer injury. What made this matter even serious was the fact that the plaintiff requested another option (a caesarean section) which was denied to her which would have been at the earliest opportunity. This was within the backdrop of her evidence that she was too tired to push. Doctor Tshabalala's notes on the clinical records at 23h10 on 27 June 2011 reflects '*called to assist with patient who has been bearing down since change- over of staff: 19h00'.* The notes also reflect that '. . *2 units synto infusion running: fully dilated. Caput 2".* The reference to *'synto running'* was another material factor. The notes on Caesarean section clearly reflected that this was due to delayed second stage not because of failed vacuum extraction. All of these factors were not neutral.

[9]See *AN v MEC for Health Eastern Cape [2019] 4 All SA 1 (SCA) (15 August 2019*) para 3.

[50] Counsel for the defendant's argument that due to the nature of the injury (being acute profound injury) suffered by the plaintiff's baby, it was irrelevant that the plaintiff received substandard care and cites case law to substantiate was in my view misplaced. The context of the ratio in the cited cases was based on the facts of each case in that causation had not been proved. In ***AN v MEC for Health, Eastern Cape [2019] 4 All SA 1(SCA)*** (15 August 2019) the majority judgment found that it was not proved that there would have been sufficient time to deliver the baby. In ***AM obo KM v MEC for Health , Eastern Cape (699/17) [2018] ZASCA 141*** (1 October 2018) the majority judgment found that baby K suffered a HIE event immediately before delivery and the hospital staff would not have been able to make a difference to the outcome. The facts of this case are distinguishable on the basis that the evidence has shown that the monitoring was not done properly in accordance to the guidelines and that despite being an emergency case, the plaintiff had to bear down to push the baby and waited from around 23h15 until the operation. The evidence by Dr Sevenster showed that if the operation had been done earlier estimated time of 21h30 the results would have been different.

[51] By the time the plaintiff was transferred to Baragwanath, she had passed an action line. Even the defendant's own expert Dr Mbokota conceded that if he had been the physician he would have investigated the prolonged labour. To sum up, the following factors were material and shifted the probabilities in favour of the plaintiff that there was negligence- (a) the slow labour progress, (b) the late diagnosis of the baby's position, (c) the failure to continuously put the plaintiff on CTG monitoring due to the slow labour progress, (d) the non- reassuring CTG and (e) the decision to augment the already prolonged labour in instances when the patient had passed the action line. If the plaintiff had been monitored properly, then action would have been taken sooner and would not have resulted in prolonged labour. All of the experts agreed on physiology of labour during contractions and the effect to the foetus. The uncontested evidence by Dr Sevenster that prolonged labour may cause a baby to become acidic was material in also shifting the probabilities in favour of the plaintiff's version. The unchallenged testimony by the plaintiff was that upon arrival at Lenasia Clinic, she was informed that if she does not give birth within two hours she would be transferred. This brings about the question why did the transfer take so long to be effected? The only inference I could draw is that the plaintiff was not being monitored. This had a ripple effect on the treatment suffered by the plaintiff. The evidence was that by the time the plaintiff was transferred to Baragwanath, she had moved towards the action line on the Partogram yet inexplicably the plaintiff was not regarded as a case requiring monitoring in compliance to the guidelines on the basis of slow

labour progress. It was unfortunate that Dr Kamolane in his own report in bundle L did not mention how acute profound injury can also occurs, contrary to Dr Alheit who noted in bundle K *'Acute Profound HII develop over a short period of time during an obstetric emergency (sentinel event)* ***or can result from*** *final circulatory collapse in a neonate exposed to subthreshold hypoxia over a period of time.*" It was further unfortunate this was not addressed in the joint minutes.

[52] Applying ***Lee v Minister of Correctional Services*** supra to the facts, I was satisfied that the 'but for' was the lack of proper monitoring on the plaintiff. The lack of comment in respect of other causes for acute profound injury as indicated supra did not detract from one inference, that had there been proper monitoring on the plaintiff, this injury would not have occurred. To sum up, the plaintiff in my view proved on the balance of probabilities factual causation when all facts are assessed in totality.

CONCLUSION:

[53] In conclusion, having assessed all the factors cumulatively the probabilities shifted in favour of the plaintiff that the 'but for' was the lack of proper monitoring (in that the removal of the lack of monitoring had a direct result to the injury). It was evident that the lack of monitoring constituted substandard nursing care. There was causal link between the lack of monitoring and the injury suffered by T.M. I found that the defendant's conduct was negligent under the circumstances and had breached the duty to care and the negligence was the cause for the injury suffered by T.M. which was that hypoxic ischaemic insult occurred which resulted in HIE II and cerebral palsy.

COSTS:

[54] Counsel for the plaintiff is sought punitive cost order against the defendant and substantiate this by highlighting the conduct of the defendant in the failure to sign pre-trial minutes, the lengthy cross examination of Sister Fletcher. Counsel for the defendant argued that there was no justification for punitive costs. The issue of costs is a matter for the discretion of the court. It is trite that the purposes of punitive costs as an extraordinary rare award are to minimise the extent to which the successful litigant is out of pocket and to indicate the court's extreme disapproval of a party's conduct. I was persuaded that punitive costs are justifiable on

the facts of this matter.[10] The defendant accordingly ordered to pay costs on attorney and client scale including costs of Senior and Junior Counsels.

Order:

[55] In the circumstances the following order is made:

1. Judgment in favour of the plaintiff on merits.
2. The defendant is ordered to pay 100% of the plaintiff's agreed or proven damages.
3. The defendant shall pay the plaintiff's taxed or agreed costs of suit to date on a scale of attorney and client scale. The costs shall include the following costs-
   - 3.1 The costs attendant upon obtaining the medico-legal reports including addendum reports;
   - 3.2 The qualifying and or reservation fees of Dr J. Reid, Dr A. Keshave, Dr B. Alheit, Dr C. Sevenster, Sister Fletcher, Prof. J. Smith, Dr. Gericke.
   - 3.3 The costs of any radiological or special medical investigation user by the above mentioned experts.
   - 3.4 The qualifying, attendance and or preparation costs as can be allowed by the Taxing Master of Dr Sevenster, Sister Fletcher, Dr Alheid and Prof. Smith.
   - 3.5 The costs attended by the appointment of two Counsels for their fees for 8, August 2022, 10 August 2022, 12 August 2022, 15 August 2022 to 19 August 20222 including reasonable fees for preparation of the heads of argument.
   - 3.6 The costs of the attorneys of record subject to the discretion of the Taxing Master in preparation for trial, travelling costs, attendance at court and reasonable costs of consulting with the plaintiff to consider the offer.
   - 3.7 The reasonable costs of the plaintiff to attending the medico-legal examination of both parties.

[10]The defendant's failure to revert as committed in the pre-trial conference dated 22 July 2022. The later concession of unreasonable nursing care which necessitated the calling if sister Fletcher as a witness and the failure to file heads of arguments.

3.8 Costs consequent to the plaintiff's trial bundles, witness bundles including eight copies thereof.

3.9 Costs of holding pre- trial conferences and round table meetings including Senior Counsel and Junior Counsel charges.

3.10 Costs of holding expert meetings between the medico-legal experts appointed by the plaintiff.

3.11 Full travelling time, accommodation costs of the plaintiff, Dr Sevenster and Sister Fletcher and other related expenses thereof.

3.12 Costs occasioned by the condonation application, the locus standi application and costs, if any, occasioned by the application dated 10 August 2022.

3.13 The defendant shall pay interest on the prescribed rate on the plaintiff's taxed or agreed costs of suit calculated within thirty one days after agreement or from date after affixing of the Taxing Master's allocatur to date of final payment.

3.14 Any payment due in terms of this order shall be paid to the trust account – Werner Boshoff Inc, Standard Bank Lynwood Ridge, account number […], branch code 012-445 with reference W.Boshoff/MP/Mat715.

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MNCUBE AJ
ACTING JUDGE OF THE HIGH COURT
GAUTENG DIVISION, PRETORIA

Appearances:

On behalf of the Plaintiff	: Adv. S.J Myburgh assisted by Adv. A.L East
Instructed by	: Werner Boshoff Incorporated.
	: 953 Justice Mohamed Street, Brooklyn
	: Pretoria
On behalf of the Defendant	: Adv. N Makopo assisted by Adv.J Daniels
Instructed by	: States Attorney

: North State Building
: 95 Albertina Sisulu
: Johannesburg

Date of Judgment : 04 April 2023