

SOUTH AFRICA / JUDGMENT

P.M obo A.M v MEC, Department of Health North West Provincial Government (754/2016) [2020] ZANWHC 6 (6 February 2020) [2020] ZANWHC 6

COURT

North West High Court, Mafikeng

BEFORE

N G Laubscher

CASE / FILE NUMBER

754/2016

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IN THE HIGH COURT OF SOUTH AFRICA

NORTH WEST DIVISION, MAHIKENG

CASE NO.: 754/2016

In the matter between:-

P[...], M[...] obo

Plaintiff

A[...] M[...]

and

THE MEC, DEPARTMENT OF HEALTH ,

Defendant

NORTH WEST PROVINCIAL GOVERNMENT

JUDGMENT

LAUBSCHER AJ

PRELUDE

- [1] Res perit domino. This means “the damage rests where it falls”, or in other words “every person must bear the damage he or she suffers”. This phrase represents a fundamental principle in our law and serves as the point of departure in any matter where the question of delictual liability stands to be adjudicated.[1]
- [2] However, under certain circumstances and upon the meeting of a number of well-established requirements the law of delict will allow the departure from the above referred to fundamental principle and a resultant shifting of the liability to bear the damage then moves from the person who suffered same to a defendant who becomes liable vis-à-vis the sufferer.
- [3] For a plaintiff to effect this shift of liability to a defendant, five requirements must be satisfied, which, simply put, are the following: (a) an act or conduct, which may include an omission (b) which is wrongful
- (c) for which a defendant is culpable (d) which resulted in loss or damage (e) the occurrence of which is causally connected to the aforestated act or conduct of a defendant.
- [4] The question to be adjudicated in casu is whether the Plaintiff can shift the liability for the damages which her minor child, A[...], suffered as a result of an injury which he sustained to the Defendant. In order to do so, the Plaintiff bears the onus to prove the facts satisfying the requirements set out above, on a balance of probabilities.[2]

THE PARTIES AND A BRIEF BACKGROUND

- [5] The Plaintiff in this matter is P[...] M[...], an adult married female who launched this action in her capacity as the mother and natural guardian of her minor son, A[...] M[...], born on 5 October 2006 (hereinafter referred to as “AM”). Mr Du Plessis SC appeared at the trial of the matter on behalf of the Plaintiff.
- [6] The Defendant is THE MEMBER OF THE EXECUTIVE COUNCIL FOR THE DEPARTMENT OF HEALTH IN THE NORTH WEST PROVINCE, who was sued herein in his/her representative capacity and who is vicariously liable for claims arising against the personnel and staff employed by the said department. Me Montsho-Moloisane SC assisted by Mr Mmolawa appeared at the trial of the matter on behalf of the Defendant.
- [7] The broadly stated common cause facts in this matter, which also set out the background against which the pleadings, evidence and legal position must be regarded, are as follows:
- [7.1] The Plaintiff was born on 2 March 1989 and has one child, AM, who was born 5 October 2006. During her pregnancy she was observed and treated at the Maboloka Clinic which resorts under the Department of Health, of which the Defendant is the responsible Member of the Executive Committee.
- [7.2] On all accounts and leading up to the events of 5 October 2006, the Plaintiff’s pregnancy was uneventful and can be considered normal and without complications.

[7.3] On 5 October 2006 the Plaintiff started to experience “pains” and walked to the Maboloka Clinic where she was examined and when the said clinic closed at approximately 16:00, she went to the Letlhabile Clinic where she arrived “...after 17:00, before 18:00...”. At the Letlhabile Clinic she was examined on arrival and allocated a bed. She was informed by the nursing staff at the Letlhabile Clinic that she is not near delivery yet. During these examinations a “foetal scope” was utilised to examine the heartrate of the foetus. The examinations of the Plaintiff at the Maboloka Clinic earlier the day and upon her arrival at the Letlhabile Clinic did not indicate any complications.

[7.4] Approximately an hour after the Plaintiff arrived at the Letlhabile Clinic her membranes ruptured. The Plaintiff was examined again approximately 15 minutes before she gave birth to AM. During

this examination no abnormalities were reported to the Plaintiff. At approximately 22:00 her pain intensified and she called out to the nursing staff. AM was born shortly thereafter. The birth process did not take long, approximately 10 minutes. During the birth process the nursing staff applied pressure to the Plaintiff’s abdomen. When AM was born he did not cry. There was a debate amongst the nursing staff of whether AM was still-born or not. However, after a few minutes AM started crying and thereafter commenced to suckle from the Plaintiff’s breast.

[7.5] The following day the Plaintiff and AM were discharged where after the Plaintiff submitted AM for scheduled and regular check-ups as recorded on the Road to Health Chart of AM.

[7.6] From an age of approximately 11 months the Plaintiff started realising that the development of AM is not on par with that of other children in her frame of reference and AM was subsequently diagnosed with Cerebral Palsy.

[7.7] Subsequent to the birth of AM he suffered no external trauma which could have resulted in the foretated condition.

[7.8] A number of additional detailed facts were also common cause between the expert witnesses involved in this matter. In view of the fact that these details are of material importance in this matter, the Court shall refer to these issues when the Court deals with the joint minutes of the expert witnesses below.

[8] An issue of considerable concern and a reoccurring issue, if one has regard to the contents of the reports submitted by the expert witnesses in this matter, is the fact that, except for the Road to Health Chart, there are no medical records available setting out the events which transpired regarding the treatment of the Plaintiff at the Maboloka Clinic or the Letlhabile Clinic. Most importantly, records of the monitoring of the Plaintiff in the hours before the birth at the Letlhabile Clinic. The Court deals later in this judgement with the Defendant’s explanation as to why the medical records were not available.

[9] The Road to Health Chart of AM did set out certain details: Amongst other information written on this chart is the baby's name, the institution where AM was born and his birthweight of 2870 grams. AM's head circumference of 33cm and length of 47 cm were also recorded therein.

[10] This chart also expressly records that at AM's birth the umbilical cord was "...around the neck x2 and very tight...". As will be evident below, this fact carries material importance in this matter according to both parties, albeit from different

perspectives. Importantly, this chart also reflects that AM's APGAR scores[3] were recorded as 6 and 9 at 1- and 5-minute intervals, respectively. These APGAR scores, as reflected on the chart can be considered as normal. As will be addressed below, the Plaintiff's expert witnesses questioned the correctness of these AGAR scores, having regard to the common cause fact that AM was not crying at the time of his birth. Also of importance and recorded on the chart is the gestational age of AM at birth, which fact was recorded to have been "at term", i.e. a fully developed pregnancy.

SEPARATION OF MERITS AND QUANTUM

[11] By agreement between the parties the issue of liability and the issue of quantum were separated and the Court was called upon to only adjudicate the issue of liability. In the pleadings before the Court the Defendant raised a special plea premised on the Plaintiff's alleged non-compliance with the peremptory provisions of the Institution of Legal Proceedings Against Certain Organs of State Act, Act 40 of 2002. The Defendant did not persist with this special

plea. The matter then proceeded to trial on evidence on the issue of the merits. The Court deals with the certain events

which transpired during the hearing of the matter under the heading "Costs" below.

THE CONTENTS OF THE PLEADINGS, RELEVANT TO THE ISSUES TO BE ADJUDICATED

[12] Subsequent to setting out the facts that AM was born on 5 October 2006 by means of a normal vaginal delivery and after "several hours of labour" (also referred to in paragraph 4.4 of the particulars of claim as "the prolonged labour") the Plaintiff states in paragraph 5 of her particulars of claim that: "The umbilical cord was wrapped tightly around Amohelang's neck. As a result of the Plaintiff's prolonged labour and the failure to timeously perform a Caesarian section to deliver A[...], A[...] suffered a hypoxic-ischaemic incident due to perinatal asphyxia, causing him to sustain severe brain damage as a result of which he is suffering from spastic cerebral palsy, mental retardation and quadriplegia ("the complication")." (Court's emphasis)

[13] To this averment the Defendant pleaded, in paragraph 13 of the Defendant's plea, as follows:

“Defendant admits that at the time of delivery, the nursing staff observed that the umbilical cord was tightly wrapped around A[...]’s

neck.

Defendant pleads specifically that the nursing staff was not responsible for, nor were they the cause of the umbilical cord being wrapped tightly around A[...]’s neck.

Save as aforesaid, each and every allegation herein contained is denied as if specifically traversed and Plaintiff is put to the proof thereof.” (Court’s emphasis)

[14] The Plaintiff proceeds to plead in paragraphs 6 of her particulars of claim that:

“6.1 The complication occurred as a result of the negligence of the Defendant alternatively, as a result of the negligence of the defendant’s employees and/or authorized representatives, further alternatively, as a result of the combined and cumulative negligence of the Defendant, his/her/their aforesaid employees and/or agents.

6.2 The aforesaid negligence constitutes a breach of the legal duty which rested on the Defendant, his/her/their employees and his/her/their authorized representatives.” (Court’s emphasis)

[15] In paragraph 7.1 of her particulars of claim the Plaintiff pleaded that the Defendant (the MEC) was negligent in one, more or all the following aspects:

“7.1.1 he/she/they failed to permanently, alternatively, temporarily employ the service of a suitably qualified and experienced medical practitioner who would be available and able to examine, manage and/or give appropriate advice in respect of the patient’s labour (particularly the Plaintiff) and to perform a Caesarian section if and when required at the aforesaid hospital/clinic;

7.1.2 he/she/they failed to ensure that at least one medical practitioner as referred to in paragraph 7.1.1 above was in attendance at all material times;

7.1.3 he/she/they failed to permanently, alternatively, temporarily employ the services of suitable qualified and experienced nursing staff, who would be able to assess, monitor and/or manage the Plaintiff’s labour;

7.1.4 he/she/they failed to ensure that the Letlhabile Healthcare Centre was suitably, adequately and/or properly equipped to enable the timeous and proper performance of a Caesarian section if and when required;

7.1.5 he/she/they failed to take any and/or all reasonably required steps to ensure proper, timeous and professional assessment of patients, their monitoring and management of labour and assistance at the birth process;

7.1.6 he/she/they failed to implement such steps as could and would reasonably be required to prevent the occurrence of the complication;

7.1.7 he/she/they failed to avoid the complication when, by the exercise of reasonable care and diligence, he/she/they could and should have done so.”

[16] The Defendant denied the above referred to averments made by the Plaintiff and pleaded that: “...his employees performed the delivery with the utmost skill, care and due diligence reasonably required an expected of them.”

[17] As to the Defendant’s employees and/or authorized representatives, the Plaintiff pleaded in paragraph 7.2 of the particulars of claim that they were negligent in one or more, or all of the following respects, “...in that he/she/they:

7.2.1 failed to properly and/or sufficiently assess and examine the Plaintiff upon her admission;

7.2.2 failed to monitor the Plaintiff’s labour and foetal well-being appropriately, with sufficient regularity, or at all;

7.2.3 failed to note or appreciate, either sufficiently, timeously or at all, the Plaintiff’s labour was not progressing appropriately or as required in the circumstances;

7.2.4 failed to request assessment and/or examination of the Plaintiff by a qualified medical practitioner upon her admission at the Chris Hani Baragwanath Hospital (sic!)[4];

7.2.5 failed to perform or request performance of accurate and/or proper cardio-topographic tracings (“CTG tracings”) of the foetal heart rate and maternal contractions and/or failed to recognize that the foetal heart pattern on the cardio-topograph was completely unsatisfactory;

7.2.6 failed to monitor the foetal heart rate appropriately, timeously or with sufficient frequency and/or at all and/or failed to detect that Amhelang was in foetal distress;

7.2.7 failed to note and or appreciate the significance of the lack of appropriate and/or timeous progress of the Plaintiff’s labour;

7.2.8 failed to monitor, either appropriately, timeously, with sufficient frequency and/or at all, the plaintiff’s labour and/or failed to heed the Plaintiff’s requests for urgent medical assistance and/or ignored such requests;

7.2.9 failed to perform a proper and accurate partogram;

7.2.10 failed to summons, timeously or at all, for purposes of assessment, advice and/or appropriate action, the assistance of a specialist gynaecologist, alternatively, a suitably qualified medical practitioner, further alternatively, any other medical practitioners in circumstances where it was necessary and/or indicated to do so;

7.2.11 failed to perform or request to be performed, timeously or at all a Caesarian section on the Plaintiff in circumstances where it was necessary and/or indicated to do so;

7.2.12 failed to advise the Plaintiff, timeously or at all, that prolonged labour and/or a failure to perform a Caesarian section timeously, could jeopardise the health of the Plaintiff’s unborn child;

7.2.13 failed to inform the Plaintiff, timeously or at all, of any and all circumstances which would or could prevent the nursing staff and/or the attendant medical practitioner from rendering reasonable medical, nursing and/or midwifery services with such professional skill and diligence as could reasonably be expected of medical practitioners, nursing and/or midwives;

7.2.14 failed to obtain a comprehensive and/or complete and/or sufficient obstetric history from the Plaintiff;

7.2.15 failed to provide and/or render the requisite reasonable medical, surgical, nursing and midwifery services with such professional skill and diligence as could reasonably be expected of medical practitioners, nurses and/or midwives in the particular circumstances;

7.2.16 failed to ensure that the emergency Caesarian section was performed without delay;

7.2.17 failed to prevent the delay in delivering A[...] and the consequences thereof when, by the exercise of reasonable skill, care and diligence, such consequences could and should have been prevented;

7.2.18 failed to provide and/or render adequate and/or appropriate neo-natal resuscitation immediately after the birth of A[...];

7.2.19 failed to prevent A[...] from suffering hypoxic-ischaemic incident, causing him to sustain severe brain damage, as a result of which he is suffering from cerebral palsy, mental retardation and quadriplegia when, by the exercise of reasonable skill, care and diligence, it could and should have been prevented.”

[18] To all these averments the Defendant pleaded in paragraph 15 of the Defendant’s plea, as follows:

“Defendant denies that he breached any legal duty or at all as his employees exercised reasonable care during delivery of A[...] despite him having the umbilical cord tightly wrapped around his neck.

Save as aforesaid, the remainder of the allegations herein contained are denied as if specifically traversed and Plaintiff is put to the proof thereof.”

[19] The Plaintiff then proceeds to plead in paragraph 8 of her particulars of claim that as a result of the breach of the legal duty, referred to in paragraph 7 of the Plaintiff’s particulars of claim, AM:

“8.1 suffered foetal distress and perinatal birth asphyxia, with resultant brain damage, cerebral palsy mental retardation and quadriplegia;

8.2 experienced pain, suffering and discomfort and will continue to experience pain, suffering and discomfort in future as a result of:

8.2.1 cerebral palsy;

8.2.2 mental retardation;

8.2.3 quadriplegia;

8.2.4 marked development delay and speech deficits;

8.2.5 behavioural problems.

8.3 underwent hospital/clinic, medical and related treatment and will

undergo such treatment in future, the details of which are set out hereunder;

8.4 required and will require various modalities of therapy, special

adaptive aids and devices, specialize schooling, permanent and continuous care, the details of which are set out hereunder;

8.5 experience a loss of amenities of life and will experience such a

loss in future, as would be experienced by a person of the same age and status as A[...] who suffered the same complication as was suffered by him, particularly, the inability to function independently and to enjoy the freedom of independent and unrestricted mobility, and the permanent lack of meaningful privacy, social interaction and communication, parenthood, and living and growing old with a loved one;

8.6 experience a permanent and total disability and will experience same in the future;

8.7 will experience a loss of earnings, alternatively, earning capacity,

in future as a result of permanent and total inability to generate any meaningful income;

8.8 will in future suffer psychological problems;

8.9 will require the services and protection by a Trustee, to protect any and all funds awarded for his future care and treatment;

8.10 is permanently disfigured as a result of the cerebral palsy.” (Court’s emphasis)

[20] In paragraph 16 of the Defendant’s plea, the Defendant pleaded to these averments as follows:

“Defendant denies that his employees / nursing staff are the cause of the complications / sequelae suffered by A[...] as they exercised the skill, care and diligence reasonably required and expected of them.” (Court’s emphasis)

[21] The Plaintiff elected not to file any replication to the Defendant’s plea. The Court must adjudicate the matter within the parameters of issues presented by the pleadings and the Court will more fully deal with same below.[5]

THE JOINT MINUTES PREPARED BY THE EXPERT WITNESSES

[22] Before the Court proceeds to summarise the evidence given during the trial of this action it is of importance to have regard to the contents of the joint minutes prepared by the expert witnesses which the parties presented to the Court. The contents of these summaries not only serve to delineate issues which are common cause in the action, but it also serves to emphasise and summarise issue of discord between the parties, which stand to be adjudicated.

[23] On 20 July 2017 the radiologists Professor J Lotz (for the Plaintiff) and Dr T Kamolane (for the Defendant), subsequent to having access to an MRI brain scan of AM done during 2017, compiled a joint minute in which the following is stated:

“1. This joint minute has been prepared between Professor Jan Lotz (JL – on behalf of the Plaintiff) and Dr. Thabo Kamlane (TK – on behalf of the Defendant). This joint agreement is presented as a constructive attempt to present to the Court the image features of the MRI brain scan and to advance a diagnosis for the described pattern.

2. The experts agree that the scan is indicative of a hypoxic ischemic injury of a term brain chronic stage of evolution.
3. The experts agree that the dominant pattern of injury in this case is acute profound in nature.
4. The experts agree that the findings of the MRI study suggest that genetic disorders as a cause of the child’s brain damage is unlikely.
5. The experts agree that the MRI findings suggest that inflammatory or infective causes unlikely as causes of the child’s brain damage.
6. The experts agree that a review of the clinical and obstetrical records by appropriate specialists in the field of Neonatology and Obstetric to be essential in determining the cause and probable timing of this hypoxic ischemic injury. “ (Court’s emphasis)

[24] On 22 August 2019 the radiologists Dr A I Ranchod (for the Plaintiff) and Dr T Kamolane (for the Defendant), subsequent to also having access to the MRI brain scan of 2017, as well as a 2019 MRI scan, compiled a joint minute of which the contents are similar to that of the joint minute referred to above, save for paragraph 2 of this minutes which reads as follows: “2. The experts agree that the scan is indicative of a Hypoxic Ischemic Injury of a term infant at a chronic stage of evolution.”.

[25] Two obstetric experts also provided the Court with a joint minute. They did not testify at the trial of the matter, but the contents of their joint minutes is of importance, in the view of the Court, in that it confirm inter alia that the Plaintiff’s pregnancy was without any complications prior to going into labour. On 1 July 2019 Sr Rentia Smit and Prof AGW Nolte compiled a joint minute of which the contents read as follows:

“Sr Rensia Smit and Prof AGW Nolte agreed on the following aspects:

1. Pregnancy

There is not enough information to come to a conclusion about the maternal and foetal condition during pregnancy, but it seemed as if both were in a satisfactory condition. The mother had no illnesses or other complications.

2. Labour

Sr. Rensia Smit and Prof AW Nolte disagreed on the following aspects:

Prof A Nolte:

It is very difficult to come to a conclusion on the conduct of the midwives in the light of the very little information available. The midwives who cared for Ms. Motaung during her labour delivered sub-standard care in that they did not:

- Do or observations of the fetal or maternal condition, according to the Maternity Guidelines (2000), between 19:30 and 22:00.

Sr Rensia Smit:

No records are available to make a conclusion about the nurse standard of care and conduct according to the Maternity Guideline.” (Court’s emphasis)

[26] Of essential importance in this matter is the joint minute compiled by the paediatric neurologist’s Dr A Keshave (on behalf of the Plaintiff and referred to as “AK”) and Dr V R Mogashoa (on behalf of the Defendant and referred to as “VRM”). This joint minute was signed by Dr Keshave on 30 November 2017 and by Dr Mogashoa on 22 July 2018. It is important to have regard to the complete contents of this minute which reads as follows:

“1. AK agrees with VRM’s report dated 15 May 2017 and quotes her summary of the case as per verbatim. “A[...] has dyskinetic cerebral palsy, microcephaly, global developmental delay, intellectual impairment and multiple contractures.” This keeping with the clinical features AK found in his assessment and report dated the 20 March 2017.”

2. AK agrees with VRM’s report that this is unlikely to be due to the following:

13.1 Neonatal meningitis

13.2 Septicaemia

13.3 Structural abnormality

13.4 Metabolic Disorder

13.5 Genetic abnormality

13.7 Stroke

13.8 Drugs

AK does differ from VRM in the conclusion that VRM makes in 13.6 of her report – that Amohelang’s current condition is not due to HIE, as he was not resuscitated at birth and the Apgar score were not in keeping. AK would like to highlight that Apgar scores can be written in error, and that Ms. M[...] indicated to AK and documented in his report that A[...] required resuscitation after delivery.

Dr Mogashoa is of the opinion that clinical history should be supported by clinical signs she draws attention to the following definitions as found in Volpe’s Neurology of the Newborn.

Ischaemia refers to insufficient perfusion or, more specific, insufficient cerebral blood flow.

Hypoxic – Ischemic encephalopathy refers to altered behaviour in the newborn, characteristic of a disturbance in central nervous system functioning. According to Volpe “the occurrence of a recognizable neonatal neurological syndrome after signs of intrauterine asphyxia is the single most useful indicator that a significant hypoxic-ishaemic insult to the brain has occurred”.

The features of the clinical syndrome are described in the report of Dr Mogashoa, features of the syndrome include feeding difficulty,

decreased level of consciousness, lethargy, poor sucking and seizures.

Dr Mogashoa highlights that A[...] did not have any of these features in the neonatal period, he was active, cried and sucked well from the breast, this means that there was no encephalopathy in the neonatal period, absence of the clinical syndrome implies that the insult to the brain did not occur during labour.

3. The above statement holds true and AK refers to the Joint Minutes from the Radiologists, dated 20 July 2017, which indicates, the MRI features are unlikely to be due, genetic abnormalities, inflammatory and infective disorder. The pattern is that of hypoxic ischemic injury of a term brain at a chronic stage of evolution, and the dominant feature is acute and profound in nature.

Dr Mogashoa refers to the ACOG 2014 statement wherein it is stated that the ideal time for imaging for neonatal encephalopathy is at 7 to 14 days of the life, abnormal imaging findings in keeping with hypoxia at this point supports that the hypoxic insult occurred during labour, the available MRI performed in childhood tells us that there was an insult to the term brain it does not tell us the exact timing of the insult, a term brain is from about 35 weeks to the first month of life.

Dr Mogashoa highlights therefore that absence of an overt neonatal syndrome or encephalopathy, apgars above 5 at 1 and 5 minutes do not support a diagnosis of intrapartum hypoxia, in this case there was a nuchal cord which may have contributed to hypoxia in utero even before labour.

4. AK is of the opinion that the hypoxic insult occurred at the time of delivery, as Ms Motaung reports that A[...] required resuscitation and did not cry at birth. AK also highlights VRM report, where Ms M[...] had identified that the nurses informed her A[...] was dead and then came back to give her A[...]. This could be interpreted as A[...] being taken away to be resuscitated.

Dr Mogashoa documented the history as given by the mom, the history that the baby was resuscitated does not mean that there was hypoxic injury especially in this case where there was no encephalopathy and the baby was discharged the following day and not admitted to the nursery.

Dr Mogashoa reiterates the importance of finding all records and avoiding speculation which is not supported.

5. Both AK and VRM agree to defer the management of the pregnancy and labour to an obstetrician.

Dr. Mogashoa: Agrees.

6. AK agrees with VRM that medical records would assist in this matter.” (Court’s emphasis)

[27] From the contents of the joint minutes prepared by the expert witnesses it is inter alia evident that:

[27.1] It is common cause between the expert witnesses that:

- (a) AM suffered a hypoxic ischemic injury which resulted in “...dyskinetic cerebral palsy, microcephaly, global developmental delay, intellectual impairment and multiple contractures...”;
- (b) the dominant pattern of AM’s injury in this matter is “acute profound” in nature;
- (c) the Plaintiff’s pregnancy was without complications.

[27.2] It is in dispute between the expert witnesses:

- (a) whether the Plaintiff received sub-standard care during her labour due to insufficient observations of the foetal or maternal condition, and more specifically whether the care was sub-standard to the precepts set out by the Maternity Guidelines (2000);
- (b) whether AM had encephalopathy in the neonatal period;
- (c) what the (i) cause and (ii) the timing of occurrence of the hypoxic ischemic injury suffered by AM was.

[28] There is no doubt that AM suffer the brain injury as referred to above, nor was it in contention that AM’s brain injury was caused as a result of hypoxia and that this hypoxia was the result of an injury of an “acute profound nature”, as opposed to a long/medium (or combination) term hypoxic event which can develop over hours (also referred to as a

“partial prolonged hypoxia”). In the view of the Court this matter pivots around the questions of when did the hypoxic ischemic injury occur and could it be prevented. The fact that it was common cause between the parties in this matter that the injury was “acute profound” in its nature is of importance in answering the above referred to questions. In this regard the Court refers to the following two paragraphs in the matter of Luyanda v Member of the Executive Council for Health, Eastern Cape[6] where the following pertinent issues and differences between an “acute profound” and a “partial prolonged” injury are stated as follows:

“[71] A litigant in an action such as the present one is in a sense confounded by a finding of an acute profound injury as opposed to a mixed one including features of a partial prolonged type, as was demonstrated by Mr. de Bruyn’s “Aha!” moment when Dr Ndjapa-Ndamkou appeared to concede that his assessment of the lead up of the child’s injury was rather of a classic partial prolonged type of event than one fitting in with Dr Pretorius’

supplemented finding of an acute profound injury. This is because (as was spelt out in Prof Buchmann’s testimony based on medical literature) the latter injury is limited to a sentinel event, involves an unremitting supply of oxygen to the child’s brain for a period of 30 minutes and, more importantly, would come upon unexpectedly and without warning so that, on an application of the applicable legal principles, hypothetical substandard management of the plaintiff’s labour would be irrelevant as it would have played no role in the occurrence of the injury. It becomes facile to argue then that such an event would also not have given the staff enough time to perform a caesarian section or other obstetric intervention so as to have successfully averted the outcome. On an argument in support of a partial prolonged type of event however there would be a gradual development of hypoxia and the lack of monitoring would be relevant

because there would be ample forewarning of an impending catastrophe if the staff were vigilant and picked up what they ought to have in the peculiar circumstances. An abnormal heart rate would be detected during uterine contractions assuming proper monitoring and a caesarian section could be performed (urgently if necessary) to expedite delivery. The lack of adequate monitoring (conceded in this instance) would constitute a negligent omission, and factual causation, on this argument would be found in the creation of a situation where the child is placed at risk of, amongst others, hypoxia, which could have been averted by proper, adequate monitoring.

[72] This is demonstrated by the SCA’s split finding in Magqeya v MEC for Health, Eastern Cape where the majority of the court held that, following upon the parties’ acceptance of the report of the radiologist in that case that the features “are those of a chronic evolution of a global insult to the brain due to hypoxic ischaemic injury, of the acute profound type, most likely occurring at term”, that the failure (even assuming negligence on the part of the hospital staff to examine and properly monitor the mother at the key times) would have had no causal effect on what happened or in causing the hypoxia. In that matter too the court a quo had ostensibly not enjoyed the benefit of any specialist neurological input on the typical features of these injuries or their peculiar causes as suggested in literature (or any oral

testimony from the radiologist). In the result the fate of the appellant (plaintiff) was dispensed with (appeal dismissed) on the simplistic basis that: “Whilst such failure (the assumed negligence) may well have been relevant had we been concerned with what was described as a ‘partial

prolonged type brain injury’ that occurs over hours, it is not for ‘an acute profound type’, as in this case.” (Court’s emphasis)

[29] The Plaintiff’s expert paediatric neurologist, Dr Keshave is of the view that AM’s condition “... is due to hypoxic injury sustained during the perinatal period...”. [7] In the summary of his findings, [8] Dr Keshave states the following:

“1. The baby was born with symmetrical growth retardation if he was a term infant. He also could have been premature, which could explain the symmetrical low growth parameters.

2. The Apgar scores were essentially normal and the infant was normal after birth, able to suck and discharged a day later, which is

standard practice for a normal term infant, without problems. Without the actual hospital records these Apgar scores could not be verified.

3. The cord was tight around the neck which could explain the brain injury but not correlate with the history of an essential normal infant after birth.

4. The brain insult, noticed on the MRI, could have happened from 37-weeks pregnancy onwards and without any hospital records could not be further investigated.

5. The history of the mother with an infant not crying for 15 minutes, did not correlate with the Apgar scores, but could be indicative of possible brain injury suffered during the labour process. Especially important is the history of the mother that the nurses

initially have informed the mother the infant is still birth. This could be significant information in the absence of hospital records. [9]

6. I therefore conclude that the cause of A[...]’s cerebral palsy is not clear and that the necessary hospital records are necessary to establish whether the insult to the brain have occurred during the birth process.” (Court’s emphasis)

[30] Dr Murray, the expert obstetrician and gynaecologist who testified on behalf of the Plaintiff also produced a written report. [10] Having regard to the contents of the pleadings (specifically the issues relating to the “tight nuchal cord”) and the two crux questions in the matter as alluded to by the Court above, the following extracts from this report are of importance:

“25. Cord around the neck occur commonly in deliveries and is often considered to be a risk factor for adverse outcome. A cord around the neck is a risk for cord occlusion and therefore reduced blood and oxygen delivery to the fetus. Descent of the fetus and the second stage of labour theoretically tighten this loop of cord thereby worsening the constriction and further hampering oxygen delivery. It is usually only considered to be a risk for hypoxia if the cord is tightly around the neck or multiple times around the neck, as may be the case in this matter.

26. Some epidemiological studies have shown an increase risk of vertebral palsy with tight nuchal cord of up to 5 x the baseline risk of controls (Nelson and Grether, AJOG 1998 and O’Callaghan et al, ACOG 2011).
27. However, other studies have shown that up to 34% of babies have a nuchal cord at delivery, and up to 8% have a tight nuchal cord. These studies show no difference in low Apgar scores, perinatal mortality, acidosis at birth, fetal distress, need for CS or need for neonatal ICU admission. (Bernard et al, Perinatal outcome associated with nuchal umbilical cord, Clin Exp Obstet Gynecol. 2012; 39(4), Henry et al, Neonatal outcomes following a tight nuchal cord. J Perinatal, 2013:33(3), Ghosh and Gudmundsson, Nuch cord in post term pregnancy, J Perinat Med, 2008: 36(2), Sheienr et al. Nuchal cord is not associated with adverse perinatal outcome. Arch Gynecol Obstet 2006: 27(2), Kong et al. Neonatal outcome and mode of delivery in the presence of nuchal cord. Arch Gynecol Obstet 2015 Jan.).
28. In other words, nuchal cord is common and not usually associated with adverse outcome although a link with CP has been demonstrated in some epidemiological studies. A good outcome is expected in the vast majority of cases.
29. In cases, where the nuchal cord is severe enough to result in fetal hypoxia prior to birth, then would be signs of cord compression which manifest in the form of variable fetal heart rate decelerations, which should be readily evident if appropriately fetal monitoring is performed, by intermittent auscultation. In other words, if the nuchal cord was severe enough to have resulted in fetal hypoxia, there would probably have been warning of this during labour and would have allowed for transfer to hospital for possible expedited delivery. Failure to monitor adequately would mean that these warning signs are missed.

....

33. It is alleged that A[...] M[...] developed cerebral palsy as a result of an intrapartum hypoxic injury which occurred as a result of substandard care received at Maboloka and Lethabile Clinic. In order to fully explore this allegation, it is important to establish 3 factors:
 - a. Did the injury most likely occur during the intrapartum period or could it have occurred during the antenatal or postnatal period?
 - b. Is there evidence of intrapartum hypoxia? To determine this, it is important to ask the following questions:
 - i. Was the fetus at increased risk of intrapartum hypoxia?

- ii. Did a sentinel occur which can reasonably be seen to have caused intrapartum hypoxia?
 - iii. Was there evidence of fetal hypoxia? Alternatively, was the monitoring of the fetal condition adequate enough to detect fetal hypoxia?
 - iv. Did the fetal condition change during the course of labour from normal to abnormal?
 - v. Was the baby born in a condition compatible with intrapartum hypoxia?
 - vi. Was the neonatal course in keeping with intrapartum sustained hypoxia ischaemic injury?
 - vii. Is the current neurological condition of the child and MRI in support of an intrapartum sustained hypoxia neurological injury?
- c. Finally, was the care at Maboloka and Letlhabile Clinic of a substandard nature, and can any deficiencies in care reasonably be seen to have either resulted in a neurological injury, or been an inadequate and inappropriate response to intrapartum complications thereby exposing the fetus to the risks of ongoing hypoxia.
34. I cannot make definitive comment about the antenatal course in the absence of antenatal records. That said, there is no obvious suggestion of a complicated pregnancy. I say so far, the following reasons:
- a. The fetus was probably an appropriately grown singleton fetus whose normal birth anthropometry suggests an adequate intra-uterine environment to support normal growth. The normal head circumference specifically makes the likelihood of any significant preterm brain injury low.
 - b. Labour most likely occurred at term when neonatal risks are low.
 - c. The mother attended care regularly.
 - d. There is no description of any pregnancy complications occurring at least nothing was relayed to the mother.
 - e. The MRI times, the injury to the term period.
35. I am unable to comment on the postnatal course and whether or not any factors in the post-natal period can either have caused a neurological injury de novo or potentiated the effect of any neurological injury sustained prior to delivery either before or during labour. That said, according to the maternal version, the baby was born in a poor condition and this means the fetus was probably compromised in utero prior to delivery, resulting in the poor condition of the baby at birth. Furthermore, because this falls outside of my area of expertise, I am also unable to comment on whether or not any other disorder or abnormality could have resulted in neurological impairment and delayed development.

36. Whether or not the fetus suffered intrapartum hypoxia cannot be determined from the maternal version alone. Causation would need to be determined by the paediatric and radiology expert to assess whether the child's outcome can be best explained by intrapartum sustained hypoxia or whether other reasons for neurological damage may have been present. If the decision is that the child's current conditions most likely explained on the basis of intrapartum-sustained hypoxia, then the unmonitored labour would prove a significant risk factor. For the sake of completeness, and answer the questions as set out in 33b:

- a. In my opinion, there is no clear reason as to why the fetus would have become distressed. That said, it is unknown why some

fetuses tolerate labour well and others do not. This is why all labours must be appropriately monitored to detect those fetuses which are at risk and intervene appropriately.

- b. Cord around the neck is unlikely to have been the sole factor responsible for adverse neurological outcome, mainly due to the reason that the nuchal cord usually causes a transient decrease in fetal oxygenation, tolerated well by most babies and not well linked

in the literature to long term neurological injury. However, if the fetus was already in a compromised condition leading up to the second stage of labour, the extra hypoxia stress brought about by nuchal cord may have exacerbated the poor condition of the baby and meant that the baby had no reserve left with which to buffer any additional hypoxic stress.

- c. There is also no description of a sentinel event. Typically, a sentinel event is an obstetric emergency often involving a "call for help" which puts the mothers and/or foetus's life at immediate risk and is usually associated with sudden and dramatic cessation of oxygen delivery to the fetus, and I think would usually be apparent to the mother.
- d. The description of the FHR being checked on arrival to Lethabile Clinic implies the fetal condition was reassuring at the onset of labour. The fetal condition throughout the course of labour is unknown due to the absence of records and also because there is no description of any fetal monitoring being performed during the active stage of labour.
- e. If it is agree that the maternal version is in keeping with a baby born in a severely compromised and lifeless state, then it must

be accepted that the condition changed from normal to poor during labour.

- f. I will defer all comments in respect the condition of the baby at birth as well as the neonatal course to the respective experts who will have to opine on whether or not the baby showed signs of hypoxic ischaemic encephalopathy or whether or not and whether there are sufficient records to support this." (Court's emphasis)

[31] The expert paediatric neurologist who testified on behalf of the Defendant, Dr V R Mogashoa states in her written report that:

[31.1] “12.3.4. A[...] was not encephalopathic in the neonatal period according to history given by Ms. Phadi, he fed well from the breast, he was alert and moving all his limbs and he did not have any convulsions.”[11]

[31.2] “17.1 The cause of A[...]’s impairments are not clear.”

[31.3] “17.2 The claim of the plaintiff is that A[...]’s impairments were caused by intrapartum hypoxia, however the apgar score and the neonatal course of the baby do not support a diagnosis of intrapartum hypoxia, with reference to the Samat staging that is discussed in 9.2 of this report, a baby who develops cerebral palsy secondary to HIE should have encephalopathy in the neonatal period. A[...] did not have encephalopathy, he was well enough to be discharged home according to history given by Ms. Phadi.”[12]

[d] Dr Mogashoa presented the following summary of her report:[13]

“A[...] is a 10 year old boy who has dyskinetic cerebral palsy, microcephaly, global developmental delay, intellectual impairment, right hand bilateral archilles tendon contractures.

I am of the opinion that his impairments were not caused by intrapartum hypoxia because he was well and not encephalopathic in the neonatal period.

The diagnosis of cerebral palsy and radiological findings that support an aetiology of a global hypoxic do not imply that there was intrapartum hypoxia because the insult in my opinion could have occurred anytime from 37 weeks up until the first month of life.

I am of the opinion that it is important that all of the mom and the child’s records should be found starting with the antenatal card, to access how the pregnancy was managed, to the intrapartum and paediatric records. I defer to the expert obstetricians for discussion on the complications of a nuchal cord and for more detail and analysis on the management of the labour process. Neonatal Encephalopathy and Neurological Outcome, Second edition. Report of the American College of Obstetricians and Gynecologists Task Force on Neonatal Encephalopathy, Paediatrics Volume 133, 5 May 2014.” (Court’s emphasis)

A SUMMARY OF THE EVIDENCE BEFORE THE COURT

[32] The Plaintiff herself, Dr Keshave and Dr Murray testified during the trial as witnesses in the case for the Plaintiff. A considerable portion of the Plaintiff’s testimony was common cause between the parties. The evidence adduced on behalf of the Plaintiff was in summary as follows:

[33] The Plaintiff:

[33.1] She testified that she had been attending the Maboloka Clinic during her pregnancy and there were no complications. The pregnancy was uneventful. She was a young expecting mother of 17 years

old at the time.

[33.2] She started feeling pains on the morning of 5 October 2006, and she went to Maboloka Clinic. There she was examined and told she was in early labour. The clinic closed at 16:00 and she was

told to go to Letlhabile Clinic. She arrived at the Letlhabile Clinic "...after 17:00, before 18:00...". She was accompanied by her mother, who subsequently left. Upon her arrival she was examined. She was informed by the nursing staff at the Letlhabile Clinic that she is not near delivery yet. During these examinations a "foetal scope" was utilised to examine the heartrate of the foetus.

[33.3] She was the only patient and there were four nursing staff on duty.

Approximately an hour after the Plaintiff arrived at the Letlhabile Clinic her membranes ruptured. The Plaintiff was examined

again. During the examinations no abnormalities were reported to the Plaintiff. At approximately 22:00 her pain intensified

and she called out to the nursing staff. AM was born shortly thereafter.

[33.4] Two nurses assisted her with the birth of AM. The birth process did not take long, approximately 10 minutes. During the birth process the nursing staff applied pressure to her abdomen. At the time when AM was born he did not cry. The nurses "clapped" him on his hands and feet. One of the nurses said AM was dead, but the other nurse disagreed. After a few minutes AM started crying and thereafter commenced to suckle from her breast.

[33.5] The following day at approximately 10 o' clock the Plaintiff and AM was discharged where after the Plaintiff submitted AM for scheduled and regular check-ups as recorded on the Road to Health Chart of AM. AM received all his scheduled immunisations. Initially, the Plaintiff noted nothing wrong with AM and he appeared

normal. No problems were immediately detected during the check-ups at the clinic.

[33.6] From an age of approximately 11 months the Plaintiff started realising that the development of AM is not on par with that of other children. She was referred to a hospital in Ga-Rankuwa. AM was then diagnosed with Cerebral Palsy. The Plaintiff confirmed that subsequent to the birth of AM he suffered no external trauma which could have resulted in the foretated condition.

[33.7] During cross examination:

[a] the Plaintiff testified that the only problem which she experienced during her pregnancy was that she felt nauseous at times;

[b] both she and the foetus was examined on her arrival at Letlhabile Clinic and she was told that all is well with her and the foetus;

[c] the heartrate of the foetus was monitored by the nursing staff and they utilised a foetal scope to do so;

[d] shortly after she was examined on her arrival her membranes ruptured, this was approximately at 19:00;

[e] she was again examined by the nursing staff approximately 15 minutes before she gave birth at approximately 22:00;

[f] during this examination she was told that the heartrate of the baby is “fine”;

[g] after the birth she saw that the umbilical cord was wrapped around AM’s neck, she cannot dispute the fact that it was tightly wrapped around the neck, as per the Road to Health Chart entry;

[h] although she apparently stated to Dr M K Malebane[14] that she was examined after her “water broke” the Plaintiff insisted that she was not examined at that point in time.

She steadfastly insisted under cross-examination that she was only examined when she arrived at the clinic and again approximately 15 minutes before she gave birth at 22:00. In both instances it was relayed to her by the nursing staff who examined her that all was well with her and the baby;

[i] she confirmed that the labour was not prolonged and took approximately 10 minutes. The birth process commenced at approximately 22:00;

[j] she confirmed that AM was sucking well from her breast;

[k] she testified that her mother and two sisters did not see anything wrong with AM during the initial few months of his life. Nor did the Plaintiff;

[l] the Plaintiff was confronted with the fact that she did not realised earlier that AM’s development was not meeting the set milestones.:[15]

[34] It was argued on behalf of the Defendant that the Plaintiff was evasive during cross-examination.

[35] Dr Amith Keshave:

[35.1] He testified that he is a paediatric neurologist and an expert in this field of medicine. He referred to his curriculum vitae as set out in his report.[16]

[35.2] He confirmed the contents of the joint minutes compiled by him and Dr V R Mogashoa as referred to in some detail above. The Court is not repeating the contents of these joint minutes here..

[35.3] He questioned the correctness of the APGAR scores reflected on the Road to Health Chart of AM in view of the fact that there was a debate between the nursing staff of whether AM was alive at birth.

He testified that having regard to the fact that the baby was looking as if it was “demised” the baby neurological state was “...more of child with neonatal encephalopathy”. Later in his testimony he explains the term “...neonatal encephalopathy...” as follows: “So, encephalopathy

basically means that the child has a poor neurological state. Meaning that the child has some degree of deficit in either movement, in being floppy, or there are seizures, or not sucking, not moving, or decreased responsiveness. So basically, it's a decreased level of consciousness, is what we would term as encephalopathy. And in the newborn period that can be quite subtle, or it can be quite severe when a child presents with seizures, for example."

[35.4] He confirms that he differs from Dr Mogashoa on the question of AM's

neurological state was that of a baby presenting with "...neonatal encephalopathy...". He is of a positive view and Dr Mogashoa of a negative view on this issue. This difference between the experts witnesses on this point is of importance and the Court will later deal therewith.

[35.5] Dr Keshave testified about the extent of AM's injury and the effect the injury has on his development. The details of this testimony need not be dealt with in detail at this point in time of this matter.

[35.6] He testified that foetal heartrate is normally monitored by means of a CTG machine, but that a foetal scope can also be utilised. However, according to him, it is more difficult to obtain an accurate

reading by utilising a foetal scope. A CTG machine gives a more accurate reading.

[35.7] Dr Keshave testified that "...something happened at the time of the birth...". He explained his aforestated opinion as follows:

"So as I said, when you're looking at the clinical pattern that the child presented with, and the history that the mom gave, that during labour, then after labour being told that the child was demised, and the nurses weren't too sure. That tells you that something happened at the time of birth."

During the records also, there isn't an indication that the child was admitted to hospital or anything like that. So now you've got this event that happened at the time of birth. You've got a clinical picture of a child who presents as a dystonic cerebral palsy and we know that the main cause in South Africa is because of birth asphyxia.

And then from the examination or investigation point of view you've got the MRI scan that shows that there is an acute profound injury, also in keeping with underlying birth asphyxia.

So now you've got all three aspects. The history, the clinical examination, and the investigations all pointing to the fact that this birth asphyxia.

So, as a result the diagnosis of cerebral palsy due to birth asphyxia was made."

"Yes, Now, Doctor, I just want to look at the defendant's version for a moment. Their version is that the hypoxia in this case was due to the umbilical cord around the neck, which is also called a nuchal cord, is that right? ...Yes, that's right."

And that, in other words, that was what caused the acute profound injury to this child's brain. Alright, so let's just look at that for a moment. If that is correct, what would one have expected as far as encephalopathy is concerned in this child? ...The child would have had encephalopathy if that's the case.

You can't have that injury without encephalopathy. ...Ja, you can't have that degree of injury without encephalopathy.

Alright. So, there must, on their version, and on what you are telling the court, there must have been encephalopathy. ...Yes. Ja."

Alright. She goes on. She says:

"The child did not have any of these features in the neonatal period. He was active, cried and sucked well from the breast. This means that there was no encephalopathy in the neonatal period. Absence of the clinical syndrome implies that the insult to the brain did not occur during labour."

Do you agree with that? ...No. I disagree. The reason for that is because you've got the history that the mom gave. That the child came, did not cry, was taken away, presumed dead, then given back to her. So that, to me, is an indication that there was encephalopathy that was present at the time of birth. Or just after delivery."[17]

[35.8] He also stated that AM's condition was the result of "...an acute profound insult, where it's a sudden loss of blood and oxygen to the brain...". This was the "...dominant picture...".

[35.9] A very important portion of Dr Keshave's evidence is his response when he was requested to comment on a statement made by Dr Mogashoa to the effect that:

"Abnormal imaging findings, in keeping with hypoxia at this point supports that the hypoxic insult occurred during labour. The available MRI performed in childhood tells us that there was an insult to the term brain. It does not tell us the exact timing of the insult. The term brain is from about 35 weeks to the first month of life"

His response was:

"Now, all of that you agree with? ...Yes, I do. But just to sort of elaborate with regard to that, is that there is no mention after the time of delivery, that the mom took the child back for admission. So, you know, the only thing you've got is that event at birth where the child was taken away, presumed dead, and brought back. Thereafter, there was no other event that the mom took the child back in that first month. And also, she went religiously for her immunisation schedules, and there was nothing there that the nurses picked up, to say 'Okay, your baby's sick.'" (Court's emphasis)

[35.10] In summary he states:

"So just to summarise, Doctor. The fact that this child or that the MRI scan in this case showed acute profound injury, can one say that in such a case there would have been warning signs beforehand? ... Yes, that's true."

Why do you say that? ...Because before you get that acute event, there would have been some degree of distress, with each sort of contraction during the course of labour, which, if the mom was monitored appropriately, would have been identified. And in this case, without the monitoring being done, the labour was sort of progressed and so the child got worse and worse and worse, until that acute event then occurred”.

[35.11] During cross examination:

[a] Dr Keshave conceded that a tight nuchal cord can cause a hypoxic insult, but he qualified his concession by stating:

“It does, but it’s the compression, and all I’d like to say as a last statement is that it’s the compression of the cord and not the strangulation that causes the hypoxia injury”. In this regard it important to note that he explained that the tightness of the nuchal chord does not strangulate the foetus but the tightness result in the loss of blood flow through the nuchal cord to the foetus.

[b] As to the time when and within which the acute profound insult could occur, Dr Keshave gave the following answers:

- (i) “Could it have happened shortly during that time? At the time of delivery. ...The thing is that, yes, it’s an acute injury, but it’s an acute injury that sometimes can take maybe minutes to half an hour even, in order to occur. So yes, it’s acute, but it’s not like it’s a single event. It can take up to half of hour of that insult to result in that acute profound injury. The fact that it’s acute means that it’s a sudden decompensation. The duration of that injury one cannot identify

without recording.” (Court’s emphasis)

- (ii) “Yes, but do you agree that whether you call it nuchal cord compression or strangulation, the fact is there was deprivation of oxygen supply to the brain of the neonate? ...Yes, that’s what happened. Intrapartum [intervened] ...Yes. ...

at the time of delivery. ...I cannot time when it happened, but I can tell you that an acute profound injury occurred”;

- (iii) “COURT: Yes, if you can comment on that statement. The evidence is that the mother testified yesterday that just before

the delivery, approximately 15 minutes, there was an examination and the foetal heart rate was, according to the mother, fine. It was normal.

...The thing is, this acute profound event could have happened just before the nurse also assessed the child. Because it’s when that cord was compressed, and that duration of that cord.

So, it could have been that when she assessed the child at that time ... I mean, it's speculation. The accuracy of the examination and all of that. It's based on the mom's history. But from what I can say is that maybe that acute insult occurred just before the nurse examined. That's a possibility"; (Court's emphasis)

(iv) "Is it possible that this nuchal cord could have become very tight around Amohelang's neck at the time of passage through the birth canal? At the time of birth. Is it possible? ... Possibly.

Is it possible? ... It's possible.

Would you blame anyone if it became very tight at that time? Or just [cross talking] [indistinct]. Would you blame anyone if the cord became very tight around the child's neck at the time of delivery? ...No. Obviously not". (Court's emphasis)

[35.12] The Court requested Dr Keshave to comment on the Plaintiff's testimony that when she was examined approximately 15 minutes before the birth of AM all was reported as well and normal. His response were as follows:

"In your expert views. If you look at the chronology of events, you've examined the child, and you've diagnosed the child, and that's in your report. ... Yes.

Taking the evidence that was given. ... Yes.

That approximately 15 minutes before the birth. ... Ja.

The heart rate was normal. ... Ja.

What is your comment on that? Is it possible that that could be correct if 15 minutes before the birth the heart rate was correct, could that result in the injury which you saw when you examined the child? ... No. No. That's where I'm a bit concerned.

If you think that is for another expert, I want your opinion if you can give it. ...My opinion would be – and I don't mind commenting on that – is that I strongly feel that either that was incorrect but something happened just before that period.

And for me that 15 mins, I doubt that that baby was fine. Prior to being delivered.

For the type of injury that you saw and diagnosed, the injury should have happened longer before 15 minutes? ...Yes.

That is what the court is trying to establish. ...Yes, Yes". (Court's emphasis)

[36] Dr Murray:

[36.1] She testified that she is an expert in the field of obstetrics and gynaecology.

[36.2] She was of the view that the discharge of the Plaintiff from the one clinic which was closing and then being transported to another clinic exposed the Plaintiff to a gap in the care rendered to her.

[36.3] Dr Murray testified as to the norm for the monitoring of a mother during the stages of labour. Her explanation was as follows:

“But just you know what does the guidelines for maternity care in South Africa state as far as the monitoring of pregnant women is concerned during the various stages.

...So in latent labour, I am going to especially more reference the foetal condition. But in latent labour the foetal heart should be monitored every two hours and then the other assessments are done four hourly. In active labour the foetal heart should be assessed every 30 minutes. The maternal vitals are done every hour. That is her blood pressure and pulse and she is examined every two hours. But the foetus must be assessed every 30 minutes.

So active labour is from stage when the cervix is 4 centimetres dilated? ...Until fully dilate.

So that the last six hours? ...Yes. So, the last six hours up until point she starts pushing will be expected that the foetus, well the foetus should be assessed every 30 minutes.” (Court’s emphasis)

[36.4] The importance of regular monitoring was explain by Dr Murray in the following terms:

“If one, if there is no proper monitoring or adequate monitoring, in other words if you do not do it every half an hour I mean would one then be able to pick up if there was a problem with this foetus? ... No.

The only sign would be a change in the foetal heart rate. There sometimes are other signs. But I mean the sign we would look for would be a change in the foetal heart rate”.

[36.5] Dr Murray was also requested in her testimony in chief to address the issue of the nursing staff applying pressure to the Plaintiff’s abdomen whilst she was in labour. This expert gave the following response on this matter:

“We then have evidence doctor of the nurses assisting the plaintiff you know to deliver the baby and one of the nurses applying funnel pressure. Pressure from the top on the stomach to get the baby out. Just your comments on that? Whether that is advisable? ... Okay so I think it is important to note that the second stage of labour, it is quite complicated, the baby sort of have to navigate the maternal pelvis, which is sort of a C shape. So, the baby’s head sort rotates and enters the pelvis and there is a process the baby follows to be born. Now, this practice of pushing on a mother’s stomach literally refers to, and it is often done really hard, otherwise it does not do anything. Literally somebody pushing from the top and pushing to try to aid delivery or to get the baby out faster. So, it is called funnel pressure. There is absolutely no place for funnel pressure in any sort of obstetrics.

It is contra indicated. It is dangerous and it is, it does not really achieve anything. So, the studies will show that it does not make it quicker and all it does I risk injury to the mother from physically [indistinct] all of that force on her stomach, like cracking a rib or which can be done. Plus damaging the baby. It is kin to trying to I do not know, carry a big coach through a doorway. You need to get it through the right way that it fits. You cannot just hold it here and push as much as you can, because will get damaged and that is why funnel pressure is not indicated at all.

The other thing in respect of funnel pressure is that it would not be routine in a, well it should never be routine. But you also would not expect it to be done unless there was a problem or urgency of some sort. Because, why else would you have a mother, if she was pushing, would someone attempt to help her, if there was not a need for some sort of help”. (Court’s emphasis)

[36.6] Dr Murray’s testimony in chief also addressed the important question of the timing of the occurrence of the injury. She testified as follows in this regard:

“...So in terms of timing injury, although there is no records to cast light on the antenatal period. The fact that the MRI times the injury to the term brain. That the foetus was well grown. That labour most likely occurred at term. Based on the size of the baby. So, at the right time. That there was no description to the mother that the pregnancy was complicated would lead me to believe that it is unlikely that the injury occurred in the antenatal period. So, before labour. I obviously would not comment on the course of the baby after birth. As that falls outside of my field. So, I would defer, defer, defer that.

If there is evidence from the mother that no significant events occurred to this baby afterwards, it was, he was never taken up to hospital or you know what would your comment be generally? ... Well then, then that times it to labour as being the most likely time. Then because of the absence of records in this case I cannot make a definitive comment from her version alone that there was hypoxia. Because that has to be looked at from many angles. Including the MRI, the paediatrician, etcetera.

But just for the sake of completeness to go through what my thought process at the time, I have said that from the maternal version there is no obvious reason as to why the foetus would become distressed. But as I mentioned we often do not know why some foetuses do and other do not. That I do not believe that cord around the neck is the fact responsible for the adverse neurological [neurological] outcome. That there is no obvious sentinel event. So sentinel event is a obstetric emergency or event that happens during labour that, for example if you were to have a mother in labour and all of a sudden she has a heart attack or her uterine, her uterus ruptures or the baby half delivers and the shoulders get stuck that would be an obvious event where you would say oh that is where everything went wrong. Most sentinel events are not, what is the word, well they are fairly dramatic. That there be a call for help and the mother would be aware that something had happened.

So, the fact that nothing was described that would indicate an event lead me to say that there was no obvious sentinel event. Normally the mother would be, risk her health. She might be bleeding and there does not seem to be any suggestion of that. Then I further through that she describes the foetal heart being checked when she arrived at Lethabile clinic and then thereafter the monitor was quite infrequent. So, the wellbeing of the baby through the labour seems uncertain. That said I cannot say there is. I cannot find evidence of foetal distress because I do not have records to comment on the foetal condition. If it is agreed that the description of the baby being born in such a poor state is correct, then the foetal condition would have changed through the course of labour. So that would then time that injury to labour and have it be hypoxic”. (Court’s

emphasis)

[36.7] During cross examination:

[a] Dr Murray conceded that the Plaintiff was monitored according to the applicable guidelines and standards but she remain adamant that the monitoring of the foetal heartrate was “infrequent” and not in accordance with the applicable guidelines. She also stated the following regarding the monitoring of the foetus:

“Let us accept the evidence of the plaintiff that she was assessed at 18:00. Both mother and unborn child. 18:00 two hours later she says she was, according to what you read she was again assessed. Then we know from her evidence in chief yesterday 15 minutes before 22:00 again checked for the third time in less than four hours. Put it from 18:00 to 22:00 I mean it is about four, let, it is about four hours. In the four hours being assessed three times according to the guidelines for maternity care in South Africa by professor Boegman would you say it was, there was substandard monitoring of the plaintiff herself?”

...If you are referencing solely maternal blood pressure, blood pressure, pulse, urine etcetera, then the monitoring there was probably sufficient monitoring”; (Court’s emphasis)

[b] she testified that a CTG machine is more reliable than a foetal scope to establish the heartrate of a foetus;

[c] she conceded that the transfer of the Plaintiff from the Maboloka Clinic to the Letlhabile Clinic, having regard to the version of the mother that all was well with mother and baby when she arrived at the Letlhabile Clinic, “...would not have made a difference...”;

[d] She stated regarding the use of a foetal scope:

“So, you have already told his Lordship that the use of foetal scope for somebody in her condition who was so in that condition, uneventful pregnancy was perfect. There was nothing wrong with that. ...Yes. The use of Foetal scope as a means of monitoring the foetal heart was appropriate. Yes”;

[e] Dr Murray persisted in her view that funnel pressure should not be applied and that it is “...dangerous....”;

[f] she confirmed that the Plaintiff’s labour was not prolonged;

[36.8] The Court requested Dr Murray to address the following two issues, which are of importance regarding her testimony:

[a] The timeframe of the 25 minutes between the last monitoring of the foetus and the finalisation of the birth of AM after 22:00:

“COURT: Doctor, I understand the predicament you are in, having no records. If we take it that the baby was fine, the heart rate of the baby was fine 15 minutes prior to the labour and let us say the labour then takes 10 minutes which takes us to 25 minutes. There is evidence that when the baby was born it was in a stillborn state. In fact, the nurses through the baby was stillborn. Is that possible that within that time the baby could go from being fine as assessed, according to the mother and according to the midwife form being fine 25 minutes ago to being born in a stillborn fashion? According to your

medical experience?

...So, it is difficult to explain. If the timeline is correct and the foetal was delivered 15 minutes after being let us say completely well it would be difficult to say what magnitude of event could have happened to have caused the foetus to be born so poorly. Because if you were to say, if you were to say there is a problem and the baby is delivered within 10 minutes that is really rapid rescue of a distressed foetus.

So, to me I find it, I find it, I cannot explain how the foetus would go from well to not well within 15 minutes. So, and I have said, I mean. I do not know where it went wrong necessarily. So, I am only left with, what is the word? I can propose possibilities. So, that either the foetus maybe was not as well as it was thought 15 minutes before and maybe was in a deteriorating condition or

perhaps, I mean I do not know if the 10 to 15 minutes interval perhaps that was longer. I do not know but would in the absence

of an obvious obstetrics catastrophe it would be difficult to explain a very severe change in such short a period of time”; (Court’s emphasis)

[b] Regarding the issue of the tightly wrapped nuchal cord:

“COURT: Doctor, at the end of the day in the interest of justice the court must make a finding. So, what you are saying is if the cord was so tight there would have been warning signs prior to that being the case. That is your testimony. Do I understand that correctly? ...

Yes. So what I am saying is that the only explanation that we have on apgar in the factual records of where there might have been a problem lies in the description of the nuchal cord. But based on evidence and based on how common it is, it is unlikely in my opinion to be the cause of the insult. I would, Dr. Malebane says the same thing. I mean this is not a disagreement between us. But in the absence of records I would be completely unable to pin point exactly what the cause was or where things went wrong. I can only put together what there is. But I think that on the probabilities it would not be expected that the cord would have been the sole cause and would have occurred without warning.

Not without warning” ...Yes.

If there were no warning like we established from the court’s earlier question to you then you say the time period would have been too little; ...Yes.

To create this kind of, the stillborn baby syndrome. ...So, had it been the case that things changed from perfect to bad within a space of minutes then it could not have been.

Yes. 15, 20 minutes. ...Then it could not have been avoided.

But then you also testified that the end result would not have been a stillborn type of baby. ...The outcome would not be expected. So, it does not. It is hard to add it up completely, but there is a lot of unknown, well not unknown variables, but there is a lot of uncertainty, mainly because of absent records.” (Court’s emphasis)

[36.9] During re-examination, Dr Murray addressed the issue of the occurrence of a “sentinel event” in the following manner:

“Yes, by the mother’s version, the second stage was not long. And so it would be very difficult to explain how a fetus went from being in a good condition to be born in a bad condition over such a short period. Uhm, had there been a catastrophe in that period would explain it.

But there does not seem to be one. So, it would. It is quite difficult to explain how that would have happened other than to say that fetus then perhaps was uhm, compromised, leading up to the second stage”.

[37] The Defendant in turn adduced the evidence of Dr Mapinda and Dr Mogashoa during the trial. Their evidence were, in summary, as follows:

[38] Dr Mapinda:

[38.1] Dr Mapinda is the physician who manages and oversees all the clinics in the Madibeng region, including the Letlhabile and Maboloka clinics.

[38.2] He confirmed that the Maboloka Clinic closes at 16:00 because it is a low-level care facility and the said clinics (both Letlhabile and Maboloka) are not equipped with CTG machines for monitoring foetal heartrates. Mothers with complications are referred to hospitals where CTG machines are available. In fact, he testified that both clinics are low-level care facilities which will only deal with patients which show no complications. If any complications are detected with a patient, the patient is referred to a high order facility where there are permanent doctors on staff.

[38.3] Foetal scopes are utilised by these clinics to monitor foetal heartrate.

[38.4] He also explained that as a result of the relocation of the Letlhabile Clinic the clinic’s records were transported to the Babopong Community Health Centre in Madibeng and certain records, including the Plaintiff’s records went missing. He endeavoured to find the records but could not do so.

[38.5] During cross-examination and the re-examination that followed Dr Mapinda testified that there was no evident complications during the pregnancy of the Plaintiff and also not during the early stages of

labour. This meant that the Plaintiff was not referred or transferred to a higher order (higher risk) medical care facility

where doctors are available. In this instance, such a facility was the Rustenburg Hospital, which is two hours' drive away from the Letlhabile Clinic. Ambulances to transport patients are also not resident at the Letlhabile Clinic, but are stationed in Brits which is approximately 24 kilometres from the clinic.

[39] Dr Mogashoa:

[39.1] Dr Mogashoa is (like Dr Keshave who testified on behalf of the Plaintiff) a paediatric neurologist and an expert in this field of medicine. She referred to and confirmed the contents of her written report.[18] She made one important addition to her written report during her testimony. She added to the contents of paragraph 13 thereof by adding an additional sub-paragraph below the last sub-paragraph (which was paragraph 13.8), a new paragraph 13.9, which should read: "Sentinel event – could be nuchal cord".

[39.2] On the issue and effect of the nuchal cord Dr Mogashoa testified in some detail and the following (albeit prolonged) explanation where she confirms that a tight nuchal cord, in her opinion, constitutes

the occurrence of a sentinel event, is of importance:[19]

"So, like I said earlier a lot has been written about cord around the neck and the literature varies a lot because some literature says it is just a noose or just a necklace, but there have been a lot of reports of babies who had in particular tight around, cord, tight cord around the neck or multiple loops around the neck.

So, obviously if it is a simple cord around the neck that is not tight one does not anticipate any problems, but ones there are multiple loops around the neck of the baby and also ones there is a tight cord around the neck one worries about that.

Like I have stated there have been numerous reports of infants, new born babies who adverse outcomes from tight cord around the neck or cords that were of multiple loops and the problem that is reported with regards to a tight cord around the neck in particular is the fact that, that when one looks at the anatomy of the cord, the cord is made, it is what supplies the baby's nutrition, blood everything that the baby requires to survive in uterus is dependent on the placenta which is connected to the baby though the, the cord and the cord has got three blood vessels. One blood vessel is, is actually the umbilical vein which is a very thin. The cord has three blood vessels, one of those blood vessels is one umbilical vein and the umbilical vein transports nutrients through the blood to the baby so that would be the umbilical vein. The problem with the umbilical vein is that when one looks at it, it is very thin. It is very thin walled vessel and the other two vessels, I mentioned three vessels,

the other two are the umbilical arteries. So, the arteries have got a thicker wall and are therefore not easily collapsible.

So if ones goes back then and looks at the one umbilical vein that goes from the placenta to the baby the risk is that when that vein, which I said is thin walled and easily compressible, when it gets compressed around the neck of the baby, it gets occluded and there have been reports with a tight cord around the neck compression of the umbilical vein so therefore meaning that there is no blood supply to the baby from the umbilical vein.

COURT: So, it is a compression of the umbilical vein? ...Yes.

And that then leads to no blood to the baby. ...Yes, M'Lord and if there is compression of the umbilical vein the umbilical arteries their responsibility is actually to, to collect blood and take it back to the placenta. So, what happens is that the umbilical arteries then because they are more resilient, they are more thick walled they do not get collapsed very easily. So, what happens is that the baby's blood can be drained because the arteries are not compressed and the blood is there for taken to the placenta, but the blood is not going to the baby.

....but at the same time lack of supply from compression of the umbilical vein results in lack of blood supply and lack of oxygen to the baby.

COURT: Just before you proceed. The lack of a supply blood to the baby also then translates into a lack of supply of oxygen? ...Of oxygen and blood to the baby M'Lord.

MRS MOLOISANE: Yes. That kind of a scenario would it be attributable to the conduct of any of the attendant midwife or medical doctors, we know here is at the clinic where there are no medical doctors, but would it be attributable to any human conduct external factors? ...No M'Lord it is in internal factor.

...

I do not know if any of my colleagues spoke about sentinel events, but sentinel events are events that occur suddenly and are not anticipated. So examples of sentinel events would be anything that causes sudden loss o blood supply to the baby anything and common examples would be a mother who suddenly for whatever reason collapses maybe from a pulmonary embolism or she has a sudden heart attack or there is sudden cord prolapse where the cord just prolapses through the vagina because with sudden prolapse of the cord through the vagina when after rupture of membranes then the cord can be trapped at the mouth of the cervix and that sudden trapping of the cord would then lead, result in sudden lack of blood supply and oxygen to the baby. So that would be called a sentinel event. Other examples of sentinel events M'Lord would be uterine rupture for example. So those are things that give you anything that will give you a sudden lack of oxygen to the baby.

THE COURT: The nuchal cord phenomenon would you consider in your expert opinion that is a sentinel event?

...I would consider it as a sentinel event because for example if the baby turns or as the baby descends thru the birth canal if that cord is already in settling the neck of the baby gets suddenly it get twisted around the neck of the baby that can give one therefore a presentation of the sentinel event because it is sudden conclusion at the level because it is now in settling. So it is unlike a cord that is just straight and not being, not occluded that can present sentinel event with sudden loss of blood supply and oxygen to the baby". (Court's emphasis)

[39.3] Dr Mogashoa referred to and confirmed the contents of paragraph 5.7[20] of her report which reads as follows:

"According to Mrs Phadi the baby was fine when given to her and fed well from the breast, he was crying, opening his eyes and moving all limbs. He did not have any jaundice, nor did he have convulsions. Mom and baby were discharged the following day. On discharge she was told to take baby to Maboloka Clinic after 3 days. At the day 3 follows up mom was told that baby was fine at home baby was fine".

[39.4] She then proceeded to state the relevance of the facts referred to above, interpreted from a clinical perspective, as follows:

"So, the reason why I thought we should go thru this page was because from my understanding this, actually should ideally be, be supported by clinical records that state what the baby was like in the neonatal period, but points 5.7 and 5.8[21] is obtained from the history suggested that this baby was not in careful of pathetic or neonatal period.

...A careful of pathetic baby a baby who has head hypoxic brain injury during labour has be behave in a specific way. He has to have specific symptoms and this baby did not have any of those symptoms of hypoxic ischemic injury that occur during labour. (Court's emphasis)

[39.5] The Plaintiff's version that AM was crying and feeding a few minutes after birth was raised with Dr Mogashoa during her testimony in chief and her response was as follows:

COURT: And that do you deduce from the fact that he feed well and was crying, opening his eyes, moving limbs did not have jaundice and no convulsions.

...Yes M'Lord. The jaundice bit was just to look for other causes or the type of similar causes that the child had. Babies who have had hypoxia during labour will be depressed at birth they, they will require resuscitation one also wants to know the extent of the resuscitation that was performed, but if it is hypoxia that is significant enough to result in brain damage to the baby the baby has to behave in a certain way. As an indicator that was a lack of oxygen to the brain that resulted in damage to the brain does not get damaged during labour and you get a baby who is feeding well in the neonatal period. Because when there is lack of oxygen to the brain suffers and therefore the baby has to have what we call encephalopathy in the neonatal period and encephalopathy is, is just a term that means the brain is not working as it should be working and features of encephalopathy.

And you are saying that means that the brain?

... Suffered. So, a baby will not be well in the neonatal period if they had lack of oxygen during labour and clinical features of encephalopathy, so encephalopathy means the brain is not working properly. It is not doing what it is supposed to do and the function of the brain is to maintain a normal level of consciousness so the baby should have, should be sleepy and they should be lethargic if they, the brain is not working properly. Some of them especially if it is hypoxia that is severe enough to cause brain damage the babies would have neonatal seizure so they will have fits in the first 24 hours of live. Typically, they will have seizures or fits soon after they were born that is number 2. So, there will be leofric, they will be sleepy and unresponsive. Number 2 they will, usually they will have a neonatal seizure depending on the severity of the neonatal encephalopathy. Number 3 the function of the brain is to control the body and to control primitive reflexes of the body and a primitive reflex is to eat and to suck and to be awake. So that is why a lot of things we cannot ask the mother because those are things we test for medically, but if a baby is able to suck that is a sign that there is no neonatal encephalopathy.

So babies will demonstrate specific signs like I explained so if it is about the level of consciousness if the brain is impaired the level of consciousness will be low baby will be unresponsive there will be leofric when mom touches them the baby will not cry because what babies do is to breath, eat, cry, pass urine and pass stools. So, babies, who have abnormal functions of the brain will, will have features of abnormal function.

Babies who had hypoxic injury will have features of abnormal function of the brain like poor sucking so typically babies who have had hypoxic brain injury will have poor sucking. So latter in my report I, I go into detail about what are the clinical features of encephalopathy secondary to hypoxia and they there are three stages, but the typical features would be poor sucking, depression level of consciousness lethargy and seizures. So that is the reason why I wanted us to go thru the history as obtained from the mother to determine from her because unfortunately it would be nice to have clinically records, but we do not have clinically records, but based on what the mother told us and all my colleagues this baby was not encephalopathy in the neonatal period and babies who have had hypoxic brain injury should have clinically features of encephalopathy. A baby cannot have damage do the brain during labour, but have a normal neonatal period."

[39.6] Further, and importantly, as to the time when the injury occurred, Dr Mogashoa testified that:

"In this case based on the history, that is why in the joint minute I stated that I would ideally what to find the clinically records that detailed this child's clinical status in the neonatal period. But this child was not encephalopathy in the neonatal period and when a child is not encephalopathy back at the neonatal period that then should prompt the clinician to say if one concludes that there was hypoxia, when exactly did the hypoxia occur. Could this hypoxic injury to the baby have occurred even before the neonatal period or even after the neonatal period that is a possibility.

Because M'Lord for one to ascribe neonatal encephalopathy secondary to intrapartum that is hypoxic during labour, one cannot have hypoxic during labour 2 hours earlier and have a baby, who is normal in the neonatal period been discharged the following day. If that happens that

baby at home they will detect that the baby is not well, the baby will have poor sucking, the baby will not be well even if they go to follow up at the clinic the baby will not be well. Because the brain was affected a few hours before delivery the baby will not be well and not have signs of any encephalopathy.

Yes M'Lord, So what the Magnetic Resonance Imaging interestingly does not tell us is that Magnetic Resonance Imaging is not pointing to injury occurring during labour,

Yes. ...So this injury could easily have occurred even before labour because, sorry, so it could be before labour, but would you not then have, then have the situation where the baby would also not be able to suck? ...So it would be, it would have to be much earlier before labour because remember what the radiologist study is a picture so the radiologist will tell you that there are features on Magnetic Resonance Imaging of acute profound hypoxic to the term brain what they mean this I stated in the joint minutes is that a term brain is a matured brain, it is not a brain during labour, it is a brain in anywhere from 36 weeks gestation 35, 36 weeks gestation to about 44 weeks gestation. So this injury to the brain occurred any time in that period, any time, so 36 weeks anywhere to 34 weeks and you will get exactly the same type of injury and for one to be able to say this injury that we are seeing in his child or cared during labour in the intrapartum period on clinical grounds number 1 the child is supposed to have features neonatal encephalopathy on radiological grounds one can only say the injury occurred during labour if the Magnetic Resonance Imaging is done in the first week of life preferably before 14 days of life.

If a Magnetic Resonance Imaging is done 10 years after the child is born the radiologist can only say this is a picture of hypoxia. This hypoxia occurred to the term brain which is any time between 36 weeks and 44 weeks they cannot tell you that.

So that is the reason why as clinicians our duty is to try and put pieces of the puzzle together and the part of the puzzle that is missing here is the fact that this baby was not encephalopathy in the neonatal period.

If the, if the baby had encephalopathy in the neonatal period it would have been very easy for all of us to come and say you know that the baby was depressed at birth had no [...] occurs and poor sucking, stayed in hospital for a long time. Had seizures, definite neonatal encephalopathy and the outcome is disconnection cerebral palsy, but it is the reason why none of us can say that.

If anyone of us says that, I think that would really not be correct, because you cannot say that especially in a baby who did not have neonatal encephalopathy.

So this could have occurred anytime in neutral even before she presented in labour especially with a history of cord around the neck times two any time the cord could have lost supply with obstruction to the umbilical what do you call it, the umbilical vein and untied again. That period resulted in hypoxic to the baby so because one is able to time the delivery with a baby who is very depressed at birth and that is the reason why, if a baby has had hypoxic injury during labour, they will be depressed at birth and they will be depressed in neonatal period with features of neonatal encephalopathy." (Court's emphasis)

[39.7] During cross examination:

[a] Dr Mogashoa confirmed that hypoxia is the cause of AM's injury, but that a time cannot be put to when this injury occurred;

[b] she conceded that the one-minute APGAR score must have been lower on the version of the Plaintiff that AM was lifeless just after birth;

[c] she was not willing to make the same concession regarding the five-minute APGAR score because the Plaintiff's version is that AM recovered, started crying and feeding and was given to the Plaintiff and was fine;

[d] Dr Mogashoa confirmed her view that the nuchal cord contributed and is the likely cause of the hypoxic event and she re-affirmed her view that the tight nuchal cord represented a sentinel event, notwithstanding Dr Murray's view to the contrary;

[e] she stated that the time at which the injury causing event occurred cannot be pin-pointed with any certainty. It could even have occurred anti-partem (as explained in paragraph [39.6] above) and not inter-partem as alleged on behalf of the Plaintiff;

[f] in respect of the Plaintiff's version that AM presented with encephalopathy because AM was considered to be dead when he was born, Dr Mogashoa remain of the view that such a diagnosis is not in keeping with the fact that AM was crying and suckling from his mother's breast shortly after birth.

[g] On being confronted with the version advanced by Dr Keshave that AM could have had undetected seizures, Dr Mogashoa was of the view that if that is the case AM would not have been able to suckle from his mother's breast.

[h] Dr Mogashoa also referred to the contents of the last part of paragraph 3 of the joint minutes drawn up between herself and Dr Keshave in which she stated: "Dr Mogashoa highlights therefore that absence of an overt neonatal syndrome or encephalopathy, apgars above 5 at 1 and 5 minutes do not support a diagnosis of intrapartum hypoxia, in this case there was a nuchal cord which may have contributed to hypoxia in utero even before labour."

[40] Regarding the evidence of the expert witnesses: Dr Keshave, Dr Murray and Dr Mogashoa it must be stated that each of these witnesses are: firstly, experts in their field and secondly, they gave their evidence in a credible and professional manner. From the interaction which the Court had with all three of them it was clear to the Court that they endeavoured, in all honesty, to assist the Court to do justice in this matter. The expert witnesses were in the view of the Court equally credible although they placed the emphasis of their testimony on different portions of the Plaintiff's version of events. The Court also has no reason to doubt the correctness of the Plaintiff's evidence and cannot agree with the argument raised on behalf of the Defendant to the effect that the Plaintiff was evasive in her testimony. Dr Mapinda was not called as an expert witness, but his credibility as a witness is also not in issue, in the view of the Court.

[41] The position in this matter is therefore similar to that experienced by Dawood J in the matter of *Nontangane v Member of the Executive Council for Health*, EC[22] when he states:

“(a) This matter turns on probabilities and credibility does not play a role since all the experts were equally credible.

(b) In *National Employers General Insurance v Jagers Co Ltd*[23].Eksteen AJP held as follows on page 3:

‘it seems to me, with respect, that in any civil case, as in any criminal case, the onus can ordinarily only be discharged by adducing credible evidence to support the case of the party on whom the onus rests. In a civil case the onus is obviously not as heavy as it is in a criminal case, but nevertheless where the onus rests on the plaintiff as in the present case, and where there are two mutually destructive stories, he can only succeed if he satisfies the Court on a preponderance of probabilities that his version is true and accurate and therefore acceptable, and that the other version advanced by the defendant is therefore false or mistaken and falls to be rejected. In deciding whether that evidence is true or not the Court will weigh up and test the plaintiff’s allegations against the general probabilities. The estimate of the credibility of a witness will therefore be inextricably bound up with a consideration of the probabilities of the case and, if the balance of probabilities favours the plaintiff, then the Court will accept his version as being probably true. If, however, the probabilities are evenly balanced in the sense that they do not favour the plaintiff’s case any more than they do the defendant’s, the plaintiff can only succeed if the Court nevertheless believes him and is satisfied that his evidence is true and that the defendant’s version is false. This view seems to me to be in general accordance with the views expressed by Coetzee J in *Koster Ko-operatiewe Landboumaatskappy Bpk v Suid-Afrikaanse Spoorwee en Hawens* (supra) and *African Eagle Assurance Co Ltd v Cainer* (supra). I would merely stress, however, that when in such circumstances one talks about a plaintiff having discharged the onus which rested upon him on a balance of probabilities that he was telling the truth and that his version was therefore acceptable. It does not seem to me to be

desirable for a Court first to consider the question of credibility of the witnesses as the trial Judge did in the present case, and then, having concluded that enquiry, to consider the probabilities of the case, as though the two aspects constitute separate fields of enquiry. In fact, as I have pointed out, it is only where a consideration of the probabilities fails to indicate where the truth probably lies, that recourse is had to an estimate of relative credibility apart from the probabilities.’

(d) The fact that they differed from each other did not mean that they were per se demonstrating bias for or against the party that had called them to testify but merely that their assessment of the facts was different.

(e) Accordingly:

i) Both the plaintiff’s witnesses and the defendant’s witnesses were equally credible;

ii) The issue is the correctness of their findings; and

iii) Which of their versions is more probable.”

[42] Before the Court proceeds to deal with the issue of the balance of probabilities, it is of importance to have regard to the effect which the already stated common cause fact, i.e. that AM injury was of an “acute profound” nature, has in this matter.

AN “ACUTE PROFOUND INJURY” AS OPPOSED TO A “MIXED” ONE INCLUDING FEATURES OF A “PARTIAL PROLONGED” TYPE OF INJURY

[43] It is common cause in this matter that AM suffered a hypoxic ischemic injury of an “acute profound” nature. This is not the first time that a court of law has been confronted with this phenomenon. It is unquestionable that each case must be adjudicated according to its own merits and the peculiar and specific facts of each matter, as well as the inherent

probabilities and improbabilities contained therein. No two cases are identical in all respects. That being said, there is also nothing untoward for a trial court to have regard to the manner in which other courts have expressed themselves when confronted with similar factual scenarios and or occurrences. In other words, there is nothing untoward in having regard to the manner in which other courts have dealt with similar issues or facts. A hypoxic ischemic injury of an “acute profound” nature as a phenomenon in itself is such an issue.

[44] In the matter of AM obo KM v Member of the Executive Council for Health, Eastern Cape[24] the Supreme Court of Appeal was confronted with the following issues:

[44.1] The injury suffered in the matter was described as a “...brain injury as a result of global Hypoxic Ischemic Encephalopathy... due to Hypoxic Ischemic injury of the acute profound type...”;

[44.2] Professor Smith of Tygerberg Children’s Hospital and Stellenbosch University testified as an expert witness:

[a] “The process of – this child’s injury occurred in utero by the nature of the MRI scan which reveals an acute profound type injury, the injury probably occurred within the last hour of birth.”[25]

[b] “[t]he foetal condition changed from reassuring to non-reassuring, in that 22 to 145 minute period before delivery, which is in accordance with scientific evidence.”[26]

[c] “It is more likely, M’Lord, these articles, and the times now I am going to refer to, tells you that anything between 22 minutes and a 146 minutes before the baby is born, during that period, the foetal heart will then show changes of a baby who developed a non-reassuring condition. We then debated also shorter periods, because we were talking about acute and profound Hypoxic Ischemic injury to the brain. That type of injury follows closer to birth, and that period that I initially when I first appeared in court earlier this year, showed, or told the Court that that acute insult can take from ten minutes to 46 minutes before the baby is born. So within that warning period of 22 minutes to 146 minutes, and that 10 to 46 minutes is in the range that Counsel for the defendant took me yesterday where we discussed this 22 minutes period that you require for such

an acute and a profound injury to occur. I hope I made myself clear.”[27] (Court’s emphasis)

[44.3] Professor Buchmann of the Department of Obstetrics and Gynaecology of the University of Witwatersrand testified as an expert witness that:

[a] “We know from the subsequent findings that it was an acute profound incident that it was short and severe, and that it, and we also know that the contractions are strongest at the end of labour.”[28]

[b] “[O]ne would search for a sentinel event, that could have caused the Hypoxia in a case of AM, [29] there is no evidence of any sentinel event. No cord prolapse, no knot in the cord, no placental abruption, no ruptured uterus and no difficult delivery. On the abovementioned premise, one is left with a possibility that the baby suffered a Hypoxic event immediately before delivery. That could have been related to uterine contractions, but it must be pointed out, that unless there are obvious sentinel events and the placenta has not been examined, the cause of Hypoxia Ischemia is normally unknown.”[30]

[44.4] The SCA then proceeds to state with regard to the evidence of the above referred two expert witnesses: “It thus came to be accepted that baby K suffered a HI event immediately before delivery. At such a late stage in labour, according to Professor Buchmann, the staff would not have been able to make a difference to the outcome. That is because if foetal distress had been detected at that stage, a caesarean section would have taken about an hour to arrange and the appellant would have delivered spontaneously before then as she in fact did at 10 o’clock. Professor Smith agreed. He testified: ‘Between 09:00 and 10:00 if you pick up an abnormal foetal heart rate at that point in time expediting delivery with a caesarean section is not going to be of assistance because it will take much longer to perform a caesarean section.’[31]

[44.5] The SCA then proceeds to dismiss the plaintiff in the court a quo’s appeal, stating: “It was for the appellant to prove on a balance of probabilities that the conduct complained of caused the harm. Assuming in the appellant’s favour that the MEC’s employees negligently failed to: (i) re-examine the appellant on the 4 and 8 hour mark after her admission and (ii) properly monitor the appellant between 23h45 and 8h20, such failure could have had no causal effect on what happened after 8h20 on 5 May 2010. Whilst such failure may well have been relevant had we been concerned with what has been described as ‘a partial prolonged type brain injury’ that occurs over hours, it is not for ‘an acute profound type’, as in this case.”[32]

[45] In the matter of *Nontangane v Member of the Executive Council for Health*, EC[33] the Court was also faced with the task of adjudicating the issue of liability under circumstances where it was common cause from the contents of the MRI scan that the child in that matter suffered a “...global insult to the brain due to hypoxic ischemic injury (HIE) of an acute profound nature occurring at term”.[34]

[46] Various expert witnesses gave evidence in the above referred to matter including the following witnesses for the plaintiff: Dr Linda Murray (who testified in this matter as well), Professor Johan Smith the head of the Neonatal Services at the Tygerberg Children's Hospital (who's evidence was also referred to by the SCA in the

AM obo KM referred to above), Professor van Toorn head of Paediatric Neurology at Tygerberg hospital in Cape Town. Professor Johannes Buchmann, also referred to above, gave evidence on behalf of the Defendant. Dawood J carefully analysed the evidence and proceeded to make inter alia the following findings:[35]

[46.1] In respect of the evidence of the defendant's expert witness, Prof Buchmann:[36]

"(g) Professor Buchmann however stated that although that is what he relied on, the exclusion of that would not change his opinion since it was still an acute profound event that would have occurred in the last half an hour prior to delivery according to the articles relied upon and therefore even with no monitoring the outcome would have been the same.

(h) The substandard care and failure to adequately monitor was not a causative factor in this case according to him.

(i.) His opinion as to how the insult and resultant injury occurred and that it was an acute profound is as already indicated in keeping with the medical authorities cited and I find it the more probable explanation as these are the only available medical authorities at this time that have been peer reviewed and despite the criticism levelled that it was not of a big enough sample and old it is authoritative until contrary findings and outcomes are made in peer reviewed published articles."

[46.2] In respect of the plaintiff's expert witnesses the following is stated by the trial court:[37]

"(j) The Plaintiff's experts' opinions in other litigated matters accordingly cannot be accepted as being authoritative without knowing the full history of each case and having that data checked by experts in the relevant fields and peer reviewed.

(k) As already indicated I accept that Professor Buchmann had the necessary expertise necessary to express an expert opinion even on those areas that appeared to infringe upon the Paediatric neurologists areas of expertise when he said there is an overlap.

(l) The available authoritative literature on the issue do not draw a distinction between the insult in the manner that Professor van Toorn did and his findings are not tested to determine their accuracy by his peers nor published. This does not make it untrue but it cannot be said to be as probable as the tested and published literatures. Plaintiff's experts' version in the best case scenario would be as probable as that of the defendant though the authorities make the defendants version more at probable thus ruling out a causal connection between the substandard care and the ensuing injury.

- (m) A great deal was made about whether or not cord compression qualifies as a sentinel event with the plaintiff's experts stating that it was not one of the known events however is clear that cord compression or other events also fall under the definition of

sentinel event in addition to the most common and usual forms that are easily and readily identifiable and Professor Smith had made reference to a sentinel event in his report and they accordingly eventually conceded that it could be a sentinel event.

- (n) Professor Buchman's version that this was a sudden occurrence and there was no time to have acted to prevent the incident is more probable than the plaintiff's expert that there must have been forewarning and that prompt action could have resulted in the baby being delivered earlier reducing or eliminating the HIE. He indicated concurringly why their opinion in this regard was not acceptable in this particular case and scenario where the foetal head was already engaged in the pelvic head.
- (o) The Plaintiff experts' theory is at present unsubstantiated in any medical authority." (Court's emphasis)

[46.3] As to the conclusion reached by the court, Dawood J stated:

"(p) The plaintiff has accordingly failed to demonstrate a causal connection between the substandard care and the injury that ensued on a balance of probabilities."

[46.4] The court accordingly dismissed the plaintiff's claim for a lack of causality, after stating: "I am able to conclude that indeed on a balance of probabilities the nurses in the employ of the defendant were negligent, however I am unable to conclude in light of the facts and evidence led in this case that on a balance of probabilities that that negligence caused the injury to the minor child."

[47] The above referred to matter of Nontangane v Member of the Executive Council for Health, EC was then taken on appeal to the Supreme Court of Appeal and as recent as 15 August 2019 the Supreme Court of Appeal in the matter of AN obo EN v Member of the Executive Council for Health, Eastern Cape[38] upheld[39] the trial court's finding in the matter. It is important to refer to the following issues which were addressed and pronounced on by the SCA in this appeal:

[47.1] The court of appeal set out the basic principles governing such claim as follows:

"It is worth briefly sketching the legal landscape governing such a claim. '[I]n order to be liable for the loss of someone else, the act or omission of the defendant must have been wrongful and negligent and have caused the loss.' Wrongfulness involves the breach of a legal duty. The legal duty in the present matter arose when the mother was admitted to the hospital in labour. The staff assumed a duty to care for mother and fetus during the birth process without negligence, in other words, as would reasonable staff in their position. More particularly, they had a duty to monitor the condition of mother and foetus and act appropriately on the results. They negligently failed to do so, in breach of that legal duty. Their conduct was thus wrongful. But this, in and of itself, has never been sufficient to found delictual liability. The wrongful conduct must cause the wronged person to suffer loss. The first step in proving

this is to prove that the wrongful conduct of the staff caused the baby to suffer brain damage. The appellant accordingly bore an onus to prove this. Wrongfulness should not be conflated with factual causation.”[40] (Court’s emphasis)

[47.2] As to the test of “factual causation” the court stated: “The test for factual causation is whether the act or omission of the defendant has been proved to have caused or materially contributed to the harm suffered. Where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach is what caused the harm suffered.”[41] (Court’s emphasis)

[47.3] The SCA framed the causality test, which in the view of this Court also the test to be applied in casu, as follows: “In the present matter, the question must be asked: Would the brain damage have been avoided if the hospital staff had properly monitored the mother and foetus and had acted appropriately on the results? If so, factual causation is established. If not, factual causation has not been established and one is left with only wrongful

conduct without proof that it caused the harm suffered.”[42] (Court’s emphasis)

[47.4] The Supreme Court of Appeal accepted that nuchal cord compression constituted a sentinel event as the trial court did in the hands of Dawood J.[43]

[47.5] Much like the present matter, the SCA states the following: “The experts differed on two main issues. First, whether there would have been any warnings of an impending sustained total interruption to the blood supply. If so, the argument went, monitoring would have detected the warnings. The birth could then have been expedited and damage averted. Secondly, and if not, whether it would have been possible to prevent any damage to the brain when the sentinel event occurred.”[44]

[47.6] The expert witness Professor Van Toorn stated (according to the court) that: “If monitoring had taken place according to the guidelines, therefore, a change in the foetal condition would have been observed. Such a change would be signalled by decelerations in the foetal heart rate during contractions. The delivery could then have been expedited and the damage avoided.”[45]

[47.7] The Supreme Court of Appeal was however of the view that there are two predominant difficulties with this view: Firstly, it was speculative[46] and secondly, authoritative literature does not support this view.[47]

[47.8] The court then concludes that there was “...in all probability no warning...” and proceeds to state: “...the issue is whether, when the sentinel event occurred, there would have been sufficient time to avoid the damage by expediting the delivery. The obvious first factor in this enquiry is that counsel for the appellant candidly admitted that it could not be proved when the sentinel event occurred. Without being able to do so, it could not be said at what time monitoring would have alerted the staff to this event.”[48] (Court’s emphasis)

[47.9] As to the occurrence of a sentinel event and the timeframe for a response once same has occurred, the Supreme Court of Appeal's views were expressed as follows: "The experts agreed that, where a sentinel event occurs, damage takes place within a short period of time. Professor Van Toorn

testified that a total interruption to the blood supply gives rise to an 'insult'. If 'you have a severe insult and if that is sustained you end up with brain damage very rapidly'. Professor Smith agreed that, in the third group in Murray, the average time to delivery after the observation of the sentinel event was 22 minutes. In other words, the damage was done during this period. Professor Buchmann, the respondent's expert obstetrician, referred to Rennie where damage began to accrue within 10 minutes of a sentinel event. I have already mentioned that the experts agreed that an expedited delivery in the hospital would have taken at least 20 minutes from when it was commenced. Before commencement, a doctor would have had to be called. The doctor would have had to assess the situation. This would have taken time. It is unrealistic to expect those things to have happened in less than 10 minutes. As already mentioned, the authors concluded that '[m]ore severe encephalopathy was associated with . . . acute sentinel events shortly before delivery'. Professor Buchmann testified without challenge that the sentinel event would probably have occurred in the 30 minutes prior to 06h45. His opinion is borne out by the literature referred to by both parties." [49] (Court's emphasis)

[47.10] The Supreme Court of Appeal then came to the conclusion that as a result, it was not proved that there would have been sufficient time in which to deliver the baby so as to avoid damage and as a result, causation could not be determined. [50] The court proceeded to state that: "In any event, if the damage would probably have occurred within the median time mentioned in Murray of 22 minutes, no remedial action

could have averted it. An expedited delivery could not have been performed inside that period. There is thus no basis on which the court a quo could find that damage could have been prevented if monitoring had taken place." [51]

[47.11] As to the "negligent conduct" of the hospital staff and its effect, the Supreme Court of Appeal was of the following view: "In any event, I have no difficulty with the proposition that the negligent conduct of the hospital staff in failing to monitor created

a risk. It is, however, important to analyse the risk which was created to evaluate whether it can be said to have caused the brain damage suffered by the baby. The risk created was, first, that warnings of an impending sentinel event would not be detected and, secondly, that if a sentinel event did occur, this would not be detected within a reasonable time. As to the first, I have found that the appellant was correctly held not to have proved that there were any warnings of an impending sentinel event. This risk cannot, therefore, be said to have caused the brain damage. As to the second, for factual causation to result, it must be shown that if the sentinel event had been detected within a reasonable time, intervention within a reasonable time would probably have prevented the brain damage. This, too, I have concluded was not proved by the appellant. In other words, in this matter, it cannot be said that the creation of risk by the negligence of the

hospital staff caused the brain damage suffered by the baby.”[52]

[48] Having regard to the fact that this Court has already stated that the expert witnesses were all credible and that the matter turn on probabilities, the Court will be remiss not to make a comment regarding the issue of probabilities and its relation to the onus of proof.

PREPONDERANCE OF PROBABILITIES

[49] In the England matter of *Miller v Minister of Pensions*[53] the often quoted Lord Denning expressed the legal test in respect of the discharging of the burden of proof in the following manner:

“...the case must be decided according to the preponderance of probability. If at the end of the case the evidence turns the scale definitely one way or the other, the tribunal must decide accordingly, but if the evidence is so evenly balanced that the tribunal is unable to come to a determine conclusion one way or the other, then the man must be given the benefit of the doubt. This means that the case must be decided in favour of the man unless the evidence against him reaches the same degree of cogency as is required to discharge a burden in a civil case. That degree is well settled. It must carry a reasonable degree of probability, but not so high as is required in a criminal case. If the evidence is such that the tribunal can say: ‘We think it more probable than not’, the burden is discharged, but, if the probabilities are equal, it is not.’” (Court’s emphasis)

[50] In the matter of MEC for the Department of Health for the Province of Kwazulu-Natal v Franks[54] Snyders JA referred to the matter of *Ocean Accident and Guarantee Corporation Ltd v Koch*[55] with approval and referred specifically to the following quote from this matter: “As to the balancing of probabilities, I agree with the remarks of SELKE, J, in *Govan v Skidmore*, 1952 (1) SA 732 (N) at p. 734, namely ‘. . . in finding facts or making inferences in a civil case, it seems to me that one may, as Wigmore conveys in his work on Evidence, 3rd ed., para. 32, by balancing probabilities select a conclusion which seems to be the more natural, or plausible, conclusion from amongst several

conceivable ones, even though that conclusion be not the only reasonable one’. I need hardly add that “plausible” is not here used in its bad sense of “specious”, but in the connotation which is conveyed by words such as acceptable, credible, suitable.” (Court’s emphasis) The aforementioned guidelines must therefore be utilised by this Court in weighing the probabilities in this matter. This entails looking at the evidence adduced on behalf of the parties

[51] That being said, the Court shall now turn to the evaluation of the evidence and the making of findings in respect thereof. Having regard to what is stated above, the Court concurs with the following statement made by Van Der Linde J in the matter of *IK obo KK v MEC for Health, Gauteng Province*: [56]

“[218] Before the discussion progresses, it is necessary for the correct perspective to remind oneself that the mere fact that baby K is burdened with an injury does not make the staff of the defendant’s hospital causally negligent. A plaintiff is still burdened with having to prove on a balance of probabilities what actually happened; that the staff should have

picked it up; and that the staff could have prevented the consequences of the event.

[219] As to the yardstick by which the conduct of the defendant's staff is gauged, the law expects of them to act in accordance with a notional standard set by a reasonable professional with their experience and qualification in their circumstances." (Court's emphasis)

EVALUATION OF THE EVIDENCE AND FINDINGS

[52] The facts in this matter are peculiar and quite unique in that it does not entirely support the opinions and resultant conclusions presented by the Plaintiff's expert witnesses, nor that of the Defendant's expert witness.

[53] What is established as fact herein and not in dispute is that:

[53.1] the Plaintiff's pregnancy was uncomplicated;

[53.2] the results of the examinations conducted on the Plaintiff and the foetus by the nursing staff at the Maboloka Clinic and the Letlhabile Clinic on 5 October 2006 raised no concerns of complications with the foetus or the Plaintiff, the last of these examinations being approximately 15 minutes before the birth of AM took place at approximately 22:00. It was suggested on behalf of the Plaintiff that these examinations might not have been carried out correctly, but there is no concrete evidence to support this – especially in view of the absence of records – and hence the pursuance of this line of arguing will

only lead down the slippery slope of speculation;

[53.3] the second and final stage of labour which occurred at approximately 22:00 on 5 October 2006 was not prolonged and lasted approximately 10 minutes;

[53.4] when AM was born the nuchal cord was tightly wrapped around his neck twice, the occurrence of which is not extraordinary, nor preventable;

[53.5] directly after his birth AM did not cry notwithstanding external stimulus and the nurses differed in opinion as whether he was dead or alive;

[53.5] after a few minutes, AM started crying, he was handed to the Plaintiff and he then commenced to suckle from her breast,[57] mother and child was in such a state of apparent wellness that they were released from the clinic the following morning;

[54.6] AM suffered a "hypoxic ischemic injury" of an "acute profound nature" which resulted in dyskinetic cerebral palsy, microcephaly, global developmental delay, intellectual impairment and multiple contractures;

[54.7] the manner in which the hypoxic ischemic injury occurred were "acute profound" in its nature and not likely due to neonatal meningitis, septicaemia, a structural abnormality, a metabolic disorder, a genetic abnormality, a stroke or drugs.

[55] Dr Keshave is of the opinion that the aforementioned hypoxic injury occurred during AM's birth, hence AM was encephalopathy just after his birth. Dr Keshave's opinion pivots arounds this point. Dr Keshave's opinion is supported by the evidence that AM was not crying at birth and considered by one nurse as still born. The problem is however that AM state changed within minutes after being born. It is of importance, regarding Dr Keshave's evidence, that the Court adjudicate same having regard to the following:

[55.1] He stated in his written report that : "The brain insult, noticed on the MRI, could have happened from 37-weeks pregnancy onwards and without any hospital records could not be further investigated." This statement is in line with the testimony of Dr Mogashoa where she states in her report and in her testimony: "The diagnosis of cerebral palsy and radiological findings that support an aetiology of a global hypoxic do not imply that there was intrapartum hypoxia because the insult in my opinion could have occurred anytime from 37 weeks up until the first month of life."

[55.2] He also states in his written report that: "I therefore conclude that the cause of Amohelang's cerebral palsy is not clear and that the necessary hospital records are necessary to establish whether the insult to the brain have occurred during the birth process."

[55.3] An important part of Dr Keshave's testimony is set out in paragraph 35.11 above where he inter alia confirms the following: "...it's an acute injury, but it's an acute injury that sometimes can take maybe minutes to half an hour even, in order to occur. So yes, it's acute, but it's not like it's a single event. It can take up to half of hour of that insult to result in that acute profound injury. The fact that it's acute means that it's a sudden decompensation. The duration of that injury one cannot identify without recording." and "...I cannot time when it happened, but I can tell you that an acute profound injury occurred..."

[55.4] Dr Keshave readily admitted that without the benefits of records detailing the progress of monitoring his not able to give an opinion which does not include a measure of speculation.

[56] Dr Murray testified that the occurring of this insult would have been preceded by fluctuations (the lowering) of the foetal heartrate which should have been evident to the nursing staff during regular examinations of the foetal heartrate. This was her version in her testimony in chief. This version was however altered later in her testimony when she referred to the occurrence of a "catastrophe" in the following manner: "Yes, by the mother's version, the second stage was not long. And so it would be very difficult to explain how a fetus went from being in a good condition to be born in a bad condition over such a short period. Uhm, had there been a catastrophe in that period would explain it."

[57] Dr Murray was somewhat reluctant to admit that a tight nuchal cord could present a sentinel event which could result in AM's injuries within several minutes and without prior warning. This however was the evidence of Dr Mogashoa and same is supported by the authorities and expert witnesses as referred to in the matters set out in paragraphs

[43] to [48] above. The Court will referred to these authorities in more detail below.

- [58] Dr Murray also testified that applying funnel pressure is a practise which falls short of the acceptable standard of care and that the foetal monitoring was not in accordance with the acceptable standard of care, i.e. every half an hour during active labour in the first stage of labour. No evidence was adduced by the Defendant to counter Dr Murray's testimony in this regard. This Court has no difficulty in finding that the practise to apply funnel pressure and the omission to monitor the foetus in accordance with the maternity guidelines constitutes negligence on the Defendant's part.[58]
- [59] However, no clear link between the applying of the funnel pressure and AM's injuries has been established by the Plaintiff. The effect of the sub-standard monitoring on the question of liability is, in the view of the Court, negated by the fact that the Plaintiff and the foetus were examined approximately 15 minutes before the Plaintiff gave birth at approximately 22:00 and all was found to be well with the foetus. Apart from speculative conjecture that the examination/monitoring may not have been executed correctly, no evidence or facts were adduced to render it probable that the result of the examination/monitor was not as it was relayed to the Plaintiff by the nursing staff.[59]
- [60] No direct and clear evidence was presented as to which cause or solution should have been adopted by the present and available nursing staff at the Letlhabile Clinic if a complication with the foetal heartrate was in fact diagnosed timeously, or if such cause or solution were in fact practically executable under the circumstances, or could have prevented the occurrence of the injury altogether.[60]
- [61] The fact that there was no evident complications during the pregnancy and the early stages of labour (on the Plaintiff's own version) meant that the Plaintiff was not referred or transferred to a higher order medical care facility where doctors are available to perform a Caesarean birth should it be required. In this instance, such a facility was the Rustenburg Hospital, according to the testimony of Dr Mapinda. Transferring the Plaintiff to Rustenburg was not an

option, as such a transfer would have taken far in excess of two hours for the reasons stated in Dr Mapinda's evidence.

[62] Having regard to the pleadings in this matter:

[62.1] It is the Plaintiff's case that:[61]

- (a) the umbilical cord was wrapped tightly around AM's neck; and
- (b) as a result of the:
 - (i) Plaintiff's prolonged labour; and
 - (ii) the failure to timeously perform a Caesarian section to deliver AM, AM suffered a hypoxic-ischaemic incident due to perinatal asphyxia;

- (c) the hypoxic-ischaemic incident occurred as result of the Defendant or his employees' negligence.

[62.2] That is the case set out by the Plaintiff which the Defendant had to meet. The Defendant denied the allegations and pleaded that the nursing staff was not responsible for, nor were they the cause of the umbilical cord being wrapped tightly around AM's neck.[62]

[62.3] The Plaintiff therefore had to prove the contents of its particulars of claim on a balance of probabilities.

[62.4] During the trial it was established that the labour was not prolonged (nor was there any complications) and the issue of a "...Caesarean section to deliver..." AM was not part of the Plaintiff's case during the trial of the matter.[63] It is of importance to note the contents of the Defendant's plea on this very issue, i.e the Defendant pleaded "specifically" that "...the nursing staff was not responsible for, nor were they the cause of the umbilical cord being wrapped tightly around A[...]s

neck..."

[63] Dr Mogashoa, giving her evidence on behalf of the Defendant, disputed that AM's injury occurred during the second stage of labour because of the absence of a "...recognizable neonatal neurological syndrome..." presented as inter alia "...feeding difficulty, decreased level of consciousness, lethargy, poor sucking and seizures...", in short she differs from Dr Keshave as to the presence of neonatal encephalopathy. She finds supports for her view in the fact (again on the Plaintiff's own version) that AM was within minutes after the birth crying and feeding from the Plaintiff's

breast. She also finds support for her opinion in the APGAR scores as set out on the Road to Health Chart.

[64] Dr Keshave testified that the APGAR scores set out on the Road to Health Chart are in all likelihood incorrect. His views in this regard can only be partially possible. The APGAR score may probably be incorrect in respect of the one-minute account as stated therein (at the stage when AM was not crying), but the five-minute score reflected by the APGAR scores are probably correct, because shortly after birth AM cried and was handed to his mother and began feeding. The Court therefore cannot find that both the APGAR scores were probably incorrect.

[65] Dr Mogashoa's version that there were no neonatal encephalopathy presented by AM, in turn, is not supported by the fact that AM was immediately after birth considered as still born because he did not cry. That state of affairs however changed shortly after AM's birth.

[66] Dr Mogashoa testified that a nuchal cord wrapped tightly around the neck of a foetus in her opinion constitutes a sentinel event. Dr Murray differed from this view as already stated. There is considerable support for Dr Mogashoa's opinion in the matters of AM obo KM v Member of the Executive Council for Health, Eastern Cape,[64] Nontangane v Member of

the Executive Council for Health, EC and its subsequent appeal as per AN obo EN v Member of the Executive Council for Health, Eastern Cape.[65] The Court accepts the evidence of Dr Mogashoa in this regard over the version of Dr Murray.

[67] Having regard to the version of the Plaintiff, the expert witnesses adduced at the trial and the contents of the existing authorities addressing the subject as referred to herein above, it is the finding of this Court that it is a real probability that the tightly wrapped nuchal cord around AM's neck presented a sentinel event which:

[67.1] could have remained imperceptible at the stage of the final examination of the Plaintiff and the foetus 15 minutes before the Plaintiff commenced giving birth to AM (which itself lasted for approximately 10 minutes); or

[64.2] even if detected at that stage, could not have been mitigated or prevented from giving rise to AM stated injury.

[68] None of the expert witnesses for either party could with any degree of certainty state when AM's injury occurred. Their opinions (on both sides) involves a measure of speculation, which position is to a large extent caused and exacerbated by the absence of medical records. The expert witnesses for both the Plaintiff and the Defendant each expressly stated this fact in their written reports and their evidence during the trial of the matter. For this Court to be able to find in favour of the Plaintiff there must be some measure of certainty as to when the injury occurred and that same was in fact preventable as pleaded in the Plaintiff's particulars of claim.[66] This would have cause the balance of probabilities to sway in the Plaintiff's favour. This was not achieved by the Plaintiff. In the words of Lord Denning as referred to above, the Plaintiff fails to satisfy the onus of prove even "...if the probabilities are equal...".

[69] Whilst on the subject of the absence of the medical records. The Court has no doubt that the absence of the Plaintiff's medical records reflecting the details of the treatment which she received at the Maboloka Clinic and Letlhabile Clinic has a negative influence on this matter, and worryingly so. In this regard the Court refers to the implications highlighted by Spilg, J in the matter of Khoza v MEC for Health and Social Development, Gauteng[67] which this absence of medical records may have in litigation:

"In summary, the failure to produce the original medical records which are under a hospital's control and where there is no acceptable

explanation for its disappearance or alleged destruction-

- (a) may result in the inadmissibility of 'secondary' evidence if the interests of justice so dictate, whether such evidence is of a witness who claims to have recalled the contents of the lost document or to have made a note of its contents on another document;

- (b) cannot of its own be used to support an argument that a plaintiff is unable to discharge the burden of proof because no one now knows whether the original records would exonerate the defendant's staff from a claim of negligence;
 - (c) may result in the application of the doctrine of *res ipsa loquitur* in an appropriate case;
 - (d) may result in an adverse inference being drawn, that the missing records support the plaintiff's case in matters where the defendant produces other contemporaneous documents that have been altered, contain manufactured data or are otherwise questionable, irrespective of whether the evidence of secondary witnesses called in support is found to be unreliable or untruthful.”
- [70] The evidence of Dr Mapinda tendered an explanation for the missing records, i.e. the moving of the Letlhabile Clinic to new premises and the removal of the records from the Letlhabile Clinic to Madibeng as a result of the move, where same could not be subsequently traced. Although this state of affairs is highly unsatisfactory, the Court has no reasons to doubt the correctness of Dr Mapinda’s evidence, nor can the Court come to any conclusion (or was it argue that the Court should) that foul play was involved. The Court cannot in this matter draw any inference that the records were intentionally lost or destroyed to obscure facts. It is however negligent not to ensure the safeguarding of such important material containing such vital information. The Court shall deal with this issue again when the Court deals with the issue of costs.
- [71] Having regard to all the evidence before the Court, the Court is although able to conclude on a balance of probabilities that the nursing staff at Letlhabile Clinic in the employment of the Defendant was negligent for the actions and omissions as stated herein above, the Court is unable to conclude that on a balance of probabilities, such negligence did factually cause the injury to AM.
- [72] This means that the Plaintiff has not satisfied the burden of prove which rested on her in this matter, i.e. to prove on a preponderance of probabilities that the negligent omission of the Defendant’s employees caused and resulted in the injury to AM. The prior to last requirement referred to in paragraph [3] above was not satisfied by the Plaintiff and hence - *res perit domino*.
- [73] The Court is also satisfied that the facts and evidence in three other matters which the Court considered and wherein it was held that a hypoxic ischemic injuries of an “acute profound” nature occurred and liability was attributed to the Defendant, are clearly distinguishable from the facts and evidence in this matter.

These matters are: *S M obo T M v MEC for Health and Social Development, Gauteng Province*, [68] *Luyanda v Member of the Executive Council for Health, Eastern Cape* [69] and *NM obo TM v Member of Executive Council, North West Department of Health*. [70]

[74] This having been found, the Court however (and again) aligns itself with the sentiments expressed by Dawood J in the matter of Nontangane v Member of the Executive Council for Health, EC[71] wherein the following was stated regarding the plight of the injured minor child:

“(q) The plight of this child is clearly pitiable and heart wrenching however there has to be some casual connection between the omission and the condition of the child to find the defendant liable to compensate the plaintiff Advocate De Bruyn SC aptly quoted the case of Medi-Clinic v Vermeulen 2015

(1) SA 241 SCA 252

[33] where the following was said: ‘33. In conclusion, the plaintiff has suffered such terrible consequences that there is a natural feeling that he should be compensated. But, as Denning LJ correctly remarked in *Roe v Ministry of Health and Others*; *Woaley v Same* [1954] EWCA Civ 7; [1954] 2 ALL ER 131 (CA) at 139 ‘But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. ...We must insist on due care for the patient at every point, but we must not condemn as negligent that which is only a misadventure’.

(r) I unfortunately despite my sympathies lying with this child and my strong condemnation for the failure to adequately monitor cannot find that there is a causal connection between the negligent conduct and the resultant insult and injury.

(s) Sub-standard and negligent care in this case did not in the circumstances cause or causally contribute to the minor child’s condition but an acute profound event, in all probability, caused the resultant incident which by its very nature was sudden and not preventable as there was insufficient time to deliver by any other means due to time constraints. Professor Buchman’s evidence in this regard is preferred to that of Dr Murray in light of the practical difficulties he eluded to in the scenarios she considered.” (Court’s emphasis)

COSTS:

[75] In as far as an order relating to costs herein is concerned the “basic rule” is that the making of a cost-order remains in the discretion of the court and this discretion must be exercised judicially. Furthermore, the “general rule” is that the successful party is normally entitled to an order for costs of the litigation in its favour.[72]

[76] In this matter the Court is of the view that the above referred to “general rule” should be departed from. To this end, it was argued on behalf of the Plaintiff that this matter could have been finalised in three days. Instead it took one whole week. The blame for the delays can be attributed to the manner in which the case for the Defendant was conducted. The Court was referred in this regard to the matter of *Phalafala and Others v MEC for Health, Gauteng Province*. [73] This departure from the “general rule” has two components with which the Court will deal with separately. These are as follows:

[76.1] The costs of Wednesday 28 August 2019 and Thursday 29 August 2019: On the aforementioned days and as a result of the Defendant not being able to proceed with the matter because of a lack of availability of witnesses, the greater part of the day could not be utilised for the trial to proceed. However, the Plaintiff's legal team had to remain in attendance in Mahikeng because of the Defendant's witnesses arriving the following days only. This was the case with both Dr Mapinda and Dr Mogashoa. This resulted in the incurrence of unnecessary costs for the Plaintiff. Having regard to the extent of the evidence adduced by both parties, the trial in this matter could have been finalised within three days and one additional day for the presentation of arguments. The Court is of the view that the Defendant should be liable for the costs of the Plaintiff for these two days.

[76.2] The costs of Monday 26 August 2019, Tuesday 27 August 2019, Friday 30 August 2019 and 22 September 2019: The Court has already stated above that the standard of care received by the Plaintiff was not up to the guidelines and standards as expected (although this mere fact not causing the injury to AM). The matter was further complicated by the absence of the medical records, the safe keeping of which falls on the Defendant. If the records were available the matter might have taken a different turn altogether. It might have dissuaded the Plaintiff from litigation and launching the claim and not incurring the legal costs which she did, or it might have swayed the matter the other way. Be that as it may, under the circumstances the Court is of the view that it is just and equitable and in the interest of justice not to burden the Plaintiff, who are undoubtably already in financial dire in having to care for AM, with an order to pay the costs of the litigation in this matter. The Court therefore exercise its discretion to depart from the "general rule" in favour of the Plaintiff.

[77] Accordingly, this Court make an order in the following terms:

1. The Plaintiff's claim is dismissed.
2. The Defendant is ordered to pay the Plaintiff's wasted costs, including the costs of senior counsel, in respect of Wednesday 28 August 2019 and Thursday 29 August 2019 on an attorney and client scale.
3. Apart from the order as to costs made in paragraph 2 above, no order as to costs is made in this matter.

N G LAUBSCHER

ACTING JUDGE OF THE HIGH COURT,

APPEARANCES

DATE OF HEARING :

26-30 AUGUST 2019 & 22 SEPTEMBER 2019

DATE OF JUDGMENT : 06 FEBRUARY 2020

COUNSEL FOR PLAINTIFF : ADV DU PLESSIS SC

COUNSEL FOR DEFENDANT : ADV MONTSHO-MOLOISANE SC &
ADV MMOLAWA

ATTORNEYS FOR PLAINTIFF : ENVER SWARTZ ATTORNEYS, MMABATHO

ATTORNEYS FOR DEFENDANT : STATE ATTORNEY, MMABATHO

[1]

Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA 2006

(1) SA 461 (SCA) at paragraph [12].

[2]

See Luyanda v Member of the Executive Council for Health, Eastern Cape (114/2014) [2019] ZAECBHC 7 (15 March 2019) at paragraph [77],] and also South African Bank of Athens v 24 Hour Cash CC (A3027/2016) [2016] ZAGPJHC 217 (11 August 2016) at paragraph [6], Lee v Minister of Correctional Services 2013 (2) SA 144 (CC) at paragraph [39] and AM obo KM v Member of the Executive Council for Health, Eastern Cape (699/17) [2018] ZASCA 141 (1 October 2018) at paragraph [65].].

[3]

Being a “...qualitative indication of a new-born’s general wellbeing within the first ten minutes of life”.

[4]

It is common cause that the Plaintiff was treated at the Maboloka
Clinic and the Letlhabile Clinic.

[5]

See K v K (4843/2015) [2017] ZAFSHC 82 (8 June 2017) at paragraph 11 wherein the following is stated: “Parties are generally limited to their pleadings. ‘The object of pleading is to define the issues so as to enable the other party to know what case he has to meet. The parties are, therefore, limited to their pleadings: a pleader cannot be allowed to direct the attention of the other party to one issue, and then at the trial attempt to canvas another. However, since pleadings are made for the court . . . it is the duty of the court to determine what are the real issues between the parties and, provided no possible prejudice can be caused to either party, to decide the case on these real issues. . . .The general principle is that the parties will be held to the issues pleaded unless there has been a full investigation of the matter falling outside the pleadings...’ See Farlam et al Erasmus, Superior Court Practice at D1/128 – 130; Du Toit obo Dikeni v Road Accident Fund 2016

(1) SA 367 (FB) par 43.”

[6]

(114/2014) [2019] ZAECBHC 7 (15 March 2019) at paragraphs

[71] and [72].

[7]

Exhibit “D”, page 23.

[8]

Exhibit “D”, page 29 to 30.

[9]

Note the emphasis placed by Dr Keshave on this issue i.e. AM being non-responsive and appearing “dead” at birth, and the different emphasis placed on the matter by Dr Mogashoa as will be highlighted below.

[10] Exhibit “D”, page 65 et seq.

[11] Note the emphasis placed by Dr Mogashoa on this issue i.e. AM being

responsive, suckling, moving his limbs and having no seizures, and the different emphasis placed on the matter by Dr Keshave as highlighted above.

[12] Exhibit “E”, page 32. Also Note that references to Me “Phadi”, is references to the Plaintiff.

[13] Exhibit “E”, page 33 to 34.

[14] Exhibit “E”, page 13 in the report of Dr Malebane.

[15] In view of the facts agreed upon by the experts from both the Plaintiff and the Defendant is not necessary to deal with the details of this portion of the cross-examination in any detail. AM’s

injury and the extent thereof is documented and agreed by the experts. The time of the diagnosis or the reasons why same was only made approximately a year after AM’s birth is not strictly relevant to the issues which stand to be adjudicated.

[16] Exhibit “D”, page 14 et seq. The Court has quoted from the contents of this report above. The expertise of this witness is not in contention and it is therefore not necessary to comprehensively deal with this credentials.

[17] Again, the Court draws attention to the fact that the expert witness for the Plaintiff and the expert witness for the Defendant place their respective emphasis on different portions of the Plaintiff’s

version of events.

[18] Exhibit “E”, page 26 to 34 and the Court has already quoted certain portions thereof.

[19] It is of importance when dealing with the evidence of Dr Mogashoa to note that the Supreme Court of Appeal has confirmed in the matter of AN obo EN v Member of the Executive Council for Health, Eastern Cape (585/2018) [2019] ZASCA 102 (15 August 2019) at paragraphs [16] and [17] that “...a cord compression resulting in a sudden, total persistent interruption of blood supply to the foetus could be referred to as a sentinel event.”

[20] Exhibit “E”, page 28.

[21]

Referring to the APGAR scores.

[22]

(1742/2015) [2018] ZAECMHC 52 (29 March 2018) at paragraph 7(e) et seq, confirmed on appeal in the matter of AN obo EN v Member of the Executive Council for Health, Eastern Cape (585/2018) [2019] ZASCA 102 (15 August 2019).

[23]

(Footnote as per the quote because the reference to the authorities

is of importance) 1984 (4) SA 432 (ECD) at 440 to 441. See also Kruger v Coetzee 1966 (2) SA 428 (A) and De Maayer Serobro v RAF 2005 (5) SA 588 (SCA) at, 597 D – F.

[24]

(699/17) [2018] ZASCA 141 (1 October 2018), the majority of the Court comprising Ponnann JA, Swain JA and Zondi JA.

[25]

Paragraph 59.

[26]

Paragraph 61.

[27]

Paragraph 62.

[28]

Paragraph 59.

[29] The same abbreviation was utilised for the injured infant as herein.

[30]

Paragraph 63.

[31]

Paragraph 64.

[32]

Paragraph 65.

[33]

(1742/2015) [2018] ZAECHMHC 52 (29 March 2018).

[34]

Paragraph 5.

[35]

Paragraph 8.

[36]

Paragraph 8(g) to (i).

[37]

Paragraph 8(g) to (i).

[38]

(585/2018) [2019] ZASCA 102 (15 August 2019).

[39] By a majority of four to one, the majority comprising Gorven AJA,

Cachalia JA, Tshiqi JA and Weiner AJA.

[40]

Paragraph [3].

[41]

Paragraph [4]. Also see Minister of Police v Skosana 1977

- (1) SA 31 (A) at 34E-G wherein Corbett JA (as he then was) defined causation in the law of delict. The first requirement is a factual one relating to the question whether the negligent act or omission in question caused or materially contributed to the harm giving rise to the claim. The so-called “but for” test applies. If factual causation is not proven, it is the end of the matter. The second requirement is a sufficient link between the negligent act or omission and the harm suffered, or put otherwise, legal causation. A flexible approach is followed in this regard as set out in Standard Chartered Bank of Canada v Nedperm Bank Ltd

[1994] ZASCA 146; 1994

(4) SA 747 (A) at 764I – 765A in which “factors such as reasonable foreseeability, directness, the absence or presence of a novus actus interveniens, legal policy, reasonability,

fairness and justice all play their part.” This more “flexible” approach was evidently endorsed by the Constitutional Court in the matter of *Lee v Minister for Correctional Services* 2013 (2) SA 144 (CC) and tempered in the Constitutional Court matter of *Mashongwa v Passenger Rail Agency of South Africa* 2016 (3) SA 528 (CC).

[42]

Paragraph [8].

[43]

Paragraph [17]. This view also accords with the views expressed by Dr Mogashoa in this matter.

[44]

Paragraph [19].

[45]

Paragraph [20].

[46]

Paragraph [21].

[47]

Paragraph [22].

[48]

Paragraph [23].

[49]

Paragraph [24].

[50]

Paragraph [25].

[51]

Paragraph [25]

[52]

Paragraph [26].

[53] [1947] 2 All ER 372 at 374A-B and adopted by the Supreme Court of Appeal (as it is now known) in South Africa in Ocean Accident and Guarantee Corporation Ltd v Kock 1963 (4) SA 147 (AD).

[54]

(329/10) [2011] ZASCA 84 (27 May 2011) at paragraph 10.

[55] 1963

(4) SA 147 (A) at 159B-D.

[56]

(28516/16) [2018] ZAGPJHC 580 (8 October 2018) at paragraphs [218]

and [219]. Also see Minister of Safety and Security v Van Duivenboden 2002(3) All SA 741 (SCA); 2002(6) SA 431 (SCA) at paragraph [12] and Goliath v MEC for Health, Eastern Cape 2015 (2) SA 97 (SCA) at paragraph [8], which cases were also cited as authority by Van der Linde J.

[57] The contents of paragraph 12.3.4 of Dr Mogashoa's written report (Exhibit "E", page 30) state that AM: "...fed well from the breast, he was alert and moving all his limbs and he did not have any convulsions."

[58] See paragraph 7.2 of the Plaintiff's particulars of claim, as quoted above.

[59] In the words of Gorven JA in AN v MEC for Health, Eastern Cape supra: "Would the brain damage have been avoided if the hospital staff had properly monitored the mother and foetus and had acted appropriately

on the results? If so, factual causation is established. If not, factual causation has not been established and one is left with only wrongful conduct without proof that it caused the harm suffered."

[60] The only evidence addressing this issue was adduced during the end of cross-examination and the beginning of re-examination of Dr Mapinda when he testified and confirmed that if birth complications arise at a low risk facility such as Letlhabile Clinic when a mother is in the final stages of giving birth the midwives must attend to same. The transfer of the patient will not be an option because the nearest hospital is in Rustenburg which is approximately a two hour drive away from the Letlhabile Clinic. The ambulances to transport such a patient in turn are stationed in Brits, which in turn is approximately 24 kilometres from the Letlhabile Clinic. Hence, if a patient is considered a risk or if there is complications with the pregnancy the patient will be referred to the hospital facility (high risk or high order facility).

[61]

Paragraph 5 and 6 of the Plaintiff's particulars of claim as quoted above.

[62]

Paragraph 13 of the Defendant's plea as quoted above.

[63] In fact neither the written reports compiled by Dr Keshave (Exhibit "D", page 14 to 23) or Dr Murray (Exhibit "D", page 65 to 80) deal in any detail with this issue. There is only one reference to the execution of an "expedited CS" by Dr Murray on the bottom of page 79 of Exhibit "D" wherein she states: "Possible earlier delivery (if indicated), appropriate monitoring and timeous reaction to a fetal heart rate abnormality (if same occurred) in the form of expedited CS, assisted delivery or intrapartum resuscitation, could have prevented on adverse outcome if it is decided that the brain injury likely occurred during labour".

[64]

Referred to supra in detail.

[65] Both matters referred to supra in detail.

[66] IK obo KK v MEC for Health, Gauteng Province supra at paragraph [218] as quoted above and wherein it is stated that: "...a plaintiff is still burdened with having to prove on a balance of probabilities what actually happened; that the staff should have picked it up; and that the staff could have prevented the consequences of the event...".

[67] 2015

(3) SA 266 (GJ) at 279 and also referred to in the matter of S M obo T M v MEC for Health and Social Development, Gauteng Province (2017/9251)

[2018] ZAGPJHC 630 (16 November 2018) at paragraph 13.

[68]

(2017/9251) [2018] ZAGPJHC 630 (16 November 2018).

[69] Supra at paragraph 77.

[70]

(CIVAPPF01/2019) [2019] ZANWHC 45 (12 September 2019).

[71]

(1742/2015) [2018] ZAECMHC 52 (29 March 2018) at paragraph 7(e) et seq.

[72]

Cilliers The Law of Costs, LexisNexis at paragraph 2.03.

[73]

(2015/20604) [2019] ZAGPPHC 465 (16 August 2019) at paragraph 76.

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