

SAFLII Note: Certain personal/private details of parties or witnesses have been redacted from this document in compliance with the law and [SAFLII Policy](#)

REPUBLIC OF SOUTH AFRICA



**IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG**

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

CASE NO: 13524/2018

.....

Date

.....

ML TWALA

In the matter between:

E G obo S G

PLAINTIFF

AND

**THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH, GAUTENG PROVINCIAL
GOVERNMENT
DEFENDANT**

JUDGMENT

TWALA J

- [1] The plaintiff sued the defendant out of this Court in her capacity as mother and natural guardian of her minor son, S G (“S”) for damages arising out of the negligence of the hospital and its staff during the birth of S on the 8th of August 2014 at the Yusuf Dadoo Hospital (“the hospital”).
- [2] At the commencement of the hearing the defendant brought an application in terms of Rule 33(4) of the Rules of Court for the separation of the merits of the matter from its quantum. It argued that it did not have sufficient time to prepare for the issue of quantum which the plaintiff claims to be R29 million and that it was not possible to determine same at the allocated time of the trial.
- [3] The application was vehemently opposed by the plaintiff on the basis that the defendant has had ample time to prepare for the trial of the matter and that the separation of the issues will result in the delay in the finalisation of the matter. This, so was it argued, will prejudice the plaintiff since S requires urgent medical attention as a result of the injuries he sustained.
- [4] It is not unreasonable for the defendant to seek a separation of the issues in cases of this nature for it involves a substantial amount of money. The defendant is dependent on the public purse and it should at all times exercise proper caution and care when it is confronted with claims of this nature. It is

my respectful view therefore that there is nothing untoward in the defendant applying for separation of the issues in this case. There is no prejudice that would be saddled with the plaintiff should the separation be ordered. Further, there is no merit in the argument that S requires urgent medical attention for he is currently receiving same at the institutions run by the defendant. I therefore granted the order that the merits be dealt with and that quantum be postponed for determination to a later date.

- [5] Further, the defendant brought an application to withdraw the joint minute of Dr Cooper and Dr Kara since it was no longer going to call Dr Cooper as an expert witness. Although the plaintiff opposed the application, I granted the application since the defendant duly gave its notice so to withdraw the joint minute before the commencement of the proceedings.
- [6] It is on record that S was referred to a myriad of medical experts who compiled a number of medical legal reports and settled joint minutes amongst themselves. Further, the experts agree in their testimony that the plaintiff received substandard care when she was admitted at the hospital during the course of her labour. The parties agreed that the joint minute of the radiologist be admitted in evidence. What remains contentious between the parties is whether such substandard care is the direct cause of S's brain injury. Put differently, the bone of contention is whether the substandard care received by the plaintiff at the hospital on the 7th and 8th August 2014 is the causal link to the injury sustained by S and the damages he suffered as a result.
- [7] It is to be noted that because of time constrains the plaintiff was not the first to testify in her case but some of the expert witnesses. However, to bring

matters into the proper context, I propose to start with the evidence of the plaintiff and thereafter proceed with that of the other witnesses.

- [8] Ms E G (“Ms G”) who is 26 years of age, testified that she last received her periods on the 7th of November 2013 and she undertook a pregnancy test on the 2nd of December 2013 which tested positive. She did not immediately attend the clinic for she was afraid, what would be the reaction of her parents. She attended the Itsoseng Clinic for the first time on the 18th of March 2014 when it was confirmed that she was 16 weeks pregnant. She was assessed by the nursing staff at the clinic and found to be healthy with no complications or sickness at the time and was given some vitamin tablets for pregnant women and a return date which was in April 2014. She continued to attend the clinic on a monthly basis in compliance with the dates given to her and at all times the nurses examined and assessed her and advised her that everything was fine with her pregnancy. She was never given any medication at the clinic during the period March 2014 to July 2014 except for the vitamin tablets normally given to pregnant women.
- [9] On the morning of the 7th August 2014 she woke up feeling pains on her lower abdomen. She asked her neighbour about these intermittent pains and was advised that she should attend to hospital for she might be experiencing labour pains. She arrived at the hospital around 10H00 and was directed to the maternity section. She came across a steel or burglar gate where she found a cleaner who instructed her to sit outside just in front of the gate as the cleaner was on the other side of the burglar gate. She could not sit still as she was struggling with pain but kept on moving up and down trying to alleviate the pain. After some time had passed, a nursing sister came and ushered or called her and the other two (2) pregnant ladies through the burglar gate. It was around 16H00 when they were called into a room where

they sat until another nursing sister came and asked what was wrong with her. The nursing sister looked at her clinic card and told her that she was not due to deliver the baby yet and must go home. She refused to go home since she was experiencing excruciating pains at the time. Another nursing sister came in and started to massage her stomach and instructed her to breathe in and out and promised to call someone who will assist her. The time was now around 17H00 since supper was being served.

[10] Another nursing sister came in and told her to take off her clothes and lay on the bed where after she placed a belt on her stomach which printed some strip of paper after it failed the first time. Nothing was done on her thereafter as she was instructed to sit on a chair after the belt was removed. She could not remember if her blood pressure was taken then but the sister did not insert her fingers in her vagina nor did she take her urine sample at the time. She continued to move around to alleviate the pain in her lower abdomen. It was after 22H00 when she was taken to a room where she was put on a bed and the nursing sister assessed her by inserting her (the sister) fingers into her vagina. The sister then said to another that someone is going to give birth tonight. As the pains continued, she kept on moving up and down and when she felt bilious, she went to the bathroom. On her way to the bathroom, her water broke – thus she screamed for help and a sister came and took her to the delivery room where a bed was prepared and the sister assisted by pressing her stomach whilst she was pushing. The nursing sister then put a silver dish/basin between her legs and left the room.

[11] She kept on pushing as she was directed by the nursing sister until the baby fell out and hit the silver dish/basin which in turn hit the bed and made a noise. This attracted the attention of the sister who then came in and cut the umbilical cord and took the baby. The sister came back to clean her and

thereafter took her to where the baby was in an incubator. She was instructed to sleep in the room where she delivered the baby and that in the morning she should go and breast feed the baby. On the morning of the 8th August 2014 she met a doctor as she went to breast feed the baby and the doctor told her that the baby was brain damaged for he did not get enough oxygen.

[12] She testified further that she has never taken drugs nor smoked or drank intoxicating liquor in her life. She kept a healthy lifestyle and ate properly during the pregnancy. She rested and slept enough and did not take any medication for any illness during the pregnancy nor was she given any medication in the labour ward on her admission on the 7th of August 2014. She and the baby were kept in hospital until the baby was discharged at the end of August 2014.

[13] She testified under cross examination that she attended all her check-up dates at the clinic. She reiterated that it was about 17H00 when a belt was put on her stomach. It was the only time a belt was put on her stomach and fingers were also inserted once in her vagina at about 22H00. She denied having been assessed by a doctor and not a male doctor for that matter. She denied having been given medication at the hospital nor was she told that she was being treated for hypertension. She insisted that her water broke when she was on her way to the bathroom and that nobody assisted her at the time. It is a female doctor who told her the baby is brain damaged and that it did not get enough oxygen. She denied that anybody raised issues about her being underweight during the pregnancy nor that the baby was not growing well. She did not know her weight before she fell pregnant. She was never told that the baby was wasted nor that the baby's skin was peeling. It was her first baby and it looked fine to her at birth. The baby is currently attending clinic and receives medication and therapy from a nearby hospital. However,

the baby consults privately for the medication which is not available at the clinic and the hospitals that are in rural areas.

[14] Sister Lesley Fletcher who retired in 2018 testified that she has been a nurse and especially as a mid-wife working in the maternity ward for 40 years. She has been teaching nursing care in the maternity ward in Leratong Hospital and later joined the private health care centre. She wrote policies and procedures for the maternity unit and has recently submitted a dissertation to the University of the Witwatersrand on “*The Quality of Nursing Care in the Maternity Ward*”. She has prepared a report on the quality of nursing care in this case and on the 4th of April 2019 she prepared and signed a joint minute with Sister Smit. She did not interview the patient but prepared her report and based her opinion on the hospital records provided to her.

[15] She testified that the antenatal history of the patient is important to determine the health of the mother and the baby during pregnancy. It demonstrates whether the mother was suffering from any illness during the pregnancy and how that illness was treated by the antenatal clinic. According to the antenatal clinic card, the plaintiff was tested for HIV on her first visit to the clinic and again later during her visits which is normal and in accordance with the guidelines as published for Clinics and Public Health Facilities. The antenatal history of the plaintiff showed that she did not experience any complications or illness during her pregnancy until she was admitted in hospital at 17H30 on the 7th of August 2014 when, for the first time, she presented with a high blood pressure of 144/106 and a plus 3 protein in her urine. Although the doctor was called and he prescribed medication for the blood pressure of the plaintiff at the time, he did not come to assess and examine the plaintiff. A partogram should have been immediately put on the plaintiff to monitor her condition and the foetal heart rate. This was not done

and the plaintiff's blood pressure was only measured again at 20H49 when it was recorded to have come down to 146/88. It was still on the high range and a doctor should have been called to advise if they should continue with the treatment, but this was not done by the nursing staff. According to the guidelines, the plaintiff's blood pressure was to be monitored 2 hourly and the foetal heart rate every half an hour. High blood pressure and protein in the urine compromises the supply of blood to the placenta and by extension to the foetus.

- [16] She testified further that the full term of pregnancy is 40 weeks and the mother on average gains between 10 and 15 kilograms in weight. In the present case, the plaintiff was 3-4 cm dilated at 17H30 when she presented with hypertension and plus 3 protein in the urine. She was therefore at the active phase of labour. The doctor promised to come and assess the plaintiff when he was called at 17H30 but only came at 23H20. The partogram which is an essential tool to monitor the progress of labour, the mother's condition and the foetal heart rate, was only put on the plaintiff at 23H20 when she was 8 cm dilated. The cardio-techno-graph (CTG) should have been used continuously from the time the plaintiff presented with hypertension to monitor the foetal heart rate and its reaction to the contractions. The CTG at 21h49 showed that the foetus was in distress since the heart rate had late decelerations and it came under the baseline of 150 beats per minute which was indicative that the foetus had hypoxia – meaning the supply of oxygen in the blood was diminished. The nurses should have called the doctor to examine the plaintiff at that stage. Action should have been taken with uterine resuscitation to improve the oxygen supply to the foetus by making the mother to lay on her left side. Vaginal examination was to be done with the fingers to avoid cord strangulation of the foetus. She opined that the healthcare given to the plaintiff on that day was not in accordance with the

guidelines for the maternity ward and was therefore substandard. If action was taken to deliver the baby at 22h00 when the CTG showed that the foetus was distressed, the baby would have been saved and the outcome would have been different from what it is today.

[17] When it was put to her under cross examination that witnesses for the defendant will testify that the baby was postdate, she testified that she was not aware of that because there was no record that the baby had a particular colour and the first assessment of newly born was not completed. She did not have some of the documents which now form part of the bundle of documents before the Court. The guidelines are necessary to follow but she has not compared them to world standards. She agreed that the situation in public hospitals in the Republic is not ideal but the nurses should have continued monitoring the plaintiff even if there was only one CTG available. They should have used other means like the stetoscope to check the foetal heart rate and insert their fingers into the vagina to check the dilation. It was not right for the doctor, even if he had 90 patients to attend to, to take more than 4 hours to attend to the plaintiff who had a high risk pregnancy. She insisted that if they performed a caesarean section immediately they realised at 22H00 that the foetus was distressed, they would have delivered the baby at 23H00 and the possible result would have been a healthy baby. She was not aware that the baby was growth restricted but if it was, then more monitoring was required since it was predisposed to the risk of distress.

[18] Dr Yatish Kara, a paediatrician, testified that he has been in private practice for 22 years and had his primary interest in neonatal care although he practices in all fields of paediatrics, new-born, intensive care up to developmental paediatrics and treats children up to 17 or 18 years of age. He is a part-time consultant at the University of KwaZulu Natal. He prepared a

report in this case and a joint minute with Prof. Cooper. He interviewed the plaintiff, examined the minor child and perused the hospital records and the medical legal reports of other experts.

[19] From the hospital records, on admission the palpation was 29 weeks whereas the antenatal card recorded 32 weeks measured 4 weeks earlier. There was plus 3 protein in the urine and a blood pressure of 144/106. This meant the mother had gestational proteinuric hypertension (GPH) which factors should have raised concerns with the midwife and that the baby has platooned from 32 weeks to 37 weeks. This was a high risk pregnancy and needed to be vigilantly monitored. Action was taken by contacting the doctor who prescribed medication for the hypertension and promised to come but only came to assess the plaintiff 5 hours 20 minutes later at 23H20. Active labour should have commenced soon after admission and the partogram should have been commenced then but it was only commenced at 23H20. The common cause of growth restricted baby is placental insufficiency. However, the placenta in this case was said to be normal and had normal weight. The baby was born in a very poor condition. There was no proper assessment of the plaintiff at the time of admission at 17H30 when she was diagnosed as being in the latent phase when she was in fact in the active phase of labour.

[20] There was no recording of the foetal heart rate before 21H50 when the foetus distress was observed on the CTG. The presence of meconium and a CTG which is non-reassuring makes it likely that the foetus was compromised. The baby was resuscitated immediately after birth and its apgar score was recorded as 3/10 and 5/10 in the first minutes of life. It was diagnosed with overt neurological syndrome in the first hours or day of life. The presence of these factors, the results of the MRI scan and the suspicion of birth asphyxia

and the type of cerebral palsy that this child suffered, makes it probable that the cerebral palsy was due to an intrapartum hypoxic ischemic insult. Foetal growth restriction makes intrapartum injury more likely because the foetus is less equipped to deal with the stresses of labour. A growth restricted baby has low reserves of stored glucose and labour being a hypoxic event, ie, the uterine contractions restrict blood supply to the foetus only for seconds, it cannot tolerate the interruption of blood supply and it runs a high risk of brain injury. It is critical for the obstetric team to manage a growth restricted foetus with extra vigilance to prevent such injury and this was not done in this case.

- [21] The baby's birth weight was 2060g and that places the baby just above the third percentile. It did not cry, reflexes, grasp and sucking were all absent. The doctor assisted with the resuscitation of the baby in the ward and on admission it was diagnosed with birth asphyxia with hypoxic ischemic encephalopathy (HIE) within 24 hours after it was born. A cranial ultrasound was done and it was recorded as normal which means that there is no evidence to support that the injury occurred before labour. An injury must have occurred a week or more before birth if it were to show on the ultrasound or for the ultrasound to be abnormal when done after birth. Antenatal insults account for 10% of hypoxic ischemic injury and often potentiated by events in labour. If the injury occurred before labour, it was made worse, because the baby was growth restricted, during labour. Babies with intrauterine growth restriction are at high risk and predisposed to distress when dealing with labour. The baby suffered multiple seizure episodes on its first day of life. This makes the encephalopathy to be a grade 2 or grade 3 which means it is moderately severe or severe. This sets the tone as to when most likely the injury occurred and in this case it probably occurred during labour.

[22] He testified further that there are two types of cerebral palsy that are dominant in cases of intrapartum hypoxic injury being spastic quadriplegia and dyskinetic cerebral palsy. S has dyskinetic cerebral palsy because the MRI scan shows hypoxic ischemic insult which makes it 80% probable that the injury occurred during labour. It was recorded that he was admitted for meconium aspiration and growth retardation and that he had respiratory distress which may have been due to acidosis. Acidosis occurs when the baby's blood becomes acidic due to an accumulation of lactic acid which is formed from the breakdown of glucose stored in the foetus. Hypoxic ischemic injury means that the tissues of the body are not receiving the blood and oxygen supply and the body stops using the stored glucose to make energy so that the lungs, liver, kidneys, brain and the heart can function. A by-product of this process is the lactic acid, the accumulation of which causes the baby to breathe rapidly. The standard basic care for the new-born who is born under compromised circumstances is to test blood gas because it gives an indication of the foetal acid base balance just before delivery but this was not done. The presence of metabolic acidosis in a baby born in a compromised condition is highly predictive of intrapartum hypoxia ischemia. The respiratory distress of the baby may have been caused by metabolic acidosis or the inhalation of the meconium.

[23] He testified that there was no record of the weight and the measurement of the head circumference of the baby taken at birth to determine whether the baby was postdate or growth restricted. It is recorded that he had convulsions within 24 hours and the MRI scan done after delivery shows a partial prolonged and acute profound hypoxic ischemic insult. A partial prolonged insult is an injury that occurs over a long period of time and affects the human brain. An acute profound insult occurs later on when the initial

compensation fails and affects the centres vital for life (the white matter). These injuries occur over a period of hours and minutes. When hypoxic ischemic occurs the body first compensate by diverting blood from the non-core areas, then the heart gets compromised and the foetal heart rate becomes abnormal and then there is brain compensation and the use of the energy that is stored to keep going. When the compensation fails, then there is a prolonged partial watershed injury, which when it fails further, then the acute profound compartment. When there is lower levels of blood in the brain, it becomes a factor for lower levels of sugar. There are no other abnormal features which he found to make him think that the brain was damaged for any other reason other than hypoxic ischemic injury and that is also confirmed by the MRI. The cause of the cerebral palsy in S is a hypoxic ischemic injury. As a result S is, in his opinion blind and perhaps deaf and cannot receive or express information.

- [24] He admitted under cross examination that an injury may occur before labour but that in the present case there is no evidence to that effect. This pregnancy was of high risk and it was not recognised as such. The events at birth make it less likely that an antenatal insult was the cause of the brain injury. He insisted that intrauterine growth restriction (IUGR) is not a cause of HIE but is a factor of hypoxia and puts the foetus at a higher risk to HIE. Skin peeling is a feature of IUGR but not proof of placenta insufficiency and there is no evidence of placenta insufficiency in this case as the placenta was recorded as normal and of average weight. There was no concern of the foetus on admission at 17H30 which makes it highly unlikely that the injury occurred before labour. He disagreed that the partial prolonged insult started weeks before labour otherwise the CTG tracing at 17H30 would have indicated foetal distress but the foetal condition was normal. A lot of babies

are born with skin peeling but that does not signify that its brain was compromised. Even wasted babies are born with normal brain function.

[25] He retorted that poor placental function or insufficiency may cause partial profound brain damage weeks prior to labour but stated that it was unlikely in this case considering that the condition of the foetus was normal on admission at 17H30 – hence he opined that it occurred during labour. If there was damage on the foetus 2 – 3 weeks before labour, the ultrasound done after birth would have picked it. He disagreed with the proposition that an acute profound injury occurs only 45 minutes before delivery and stated that it can occur even 3 hours before delivery depending whether there is a sentinel event. A partial prolonged injury develops to an acute profound injury – it is a continuum between the partial prolonged and the acute profound injury.

[26] Dr Kudakwashe Fanwel Chimusoro, a specialist obstetrician and gynaecologist, testified that he prepared a medical legal report in this case based on the antenatal and hospital records and information obtained from the plaintiff. He testified that the plaintiff last had her menstrual period in November 2013 – her expected delivery date was end of August or early September 2014. Her clinic record noted that there was no family history, no diabetes, no disability and no risk factors were highlighted. No abnormalities were noted and there was nothing of concern. She did not have any sexually transmitted disease. The growth of the baby was plotted above the 5th percentile on the clinic card and was growing on average. In the whole, this was a healthy pregnancy and all the parameters were in keeping with the pregnancy at 32 weeks.

- [27] The plaintiff was diagnosed on admission with the blood pressure of 144/106 and protein plus 3 in her urine. This meant the blood vessels were taking strain and the plaintiff needed monitoring and attention to avoid complications. The abdominal examination showed that the baby was not growing well since the palpation was 29 and the SF height 32 when the gestational period was 37 weeks. She was a high risk pregnancy with GPH and if it was classified as moderately severe or severe, then the baby should have been taken out by caesarean section if it was not big enough to withstand the stresses of labour. If labour were allowed to proceed in the normal course, then it was supposed to be closely and electronically monitored. Once the plaintiff was given medication for the blood pressure, then it must be monitored so that the blood pressure does not suddenly drop because the baby's heart might stop. The guidelines prescribe that if medication is prescribed for the blood pressure, then the patient should be monitored and the blood pressure be checked every 2 hours, and the foetal heart rate every 30 minutes. There is no record of any monitoring of the maternal status. These were 2 high risk factors in the pregnancy and needed intense and close monitoring by the senior midwife and the doctor, but this was not done. At 20H49 the blood pressure was measured at 146/88. Although it was still on the high side, it was reasonable but there was no urine testing which makes the assessment incomplete. There was no close monitoring of the plaintiff as required by the guidelines – hence the care was substandard.
- [28] He testified further that intrauterine growth restriction (IUGR) occurs due to placenta insufficiency which is when the placenta cannot give the baby what it needs. A growth restricted baby is prone to damage and or cannot cope with the stresses of labour. It suffers foetal distress as it is not getting oxygen or energy since the blood supply to the uterus is disrupted. During labour the

foetal heart rate is used to determine the condition of the foetus and the heart beats should be 110 – 160 per minute. A growth restricted baby start slowing down the heart rate to conserve energy. However, IUGR is not an absolute cause of cerebral palsy but is only a factor for foetal distress. To determine whether the baby was growth restricted, the record of the head circumference, its height and weight at birth is required and this was not done. The weight of the baby was 2 060g at birth and was above the 3rd percentile. Since the foetal heart rate was recorded as fine on admission, then the strong likelihood is that the cerebral palsy happened during labour. Something else was required to eventuate the risk even if the baby was in the 3rd percentile. More monitoring was necessary for this kind of pregnancy and it was not done.

[29] He testified that the assessment that the plaintiff on admission was at the latent phase of gestation was a misdiagnoses since she was 3-4 centimetres dilated. The plaintiff was diagnosed with GPH and a growth restricted baby – thus as she was at an active phase of labour, she needed continuous monitoring and this was not done. It is surprising that the doctor only saw her at 23h20, having been informed of her condition at 18H00. The baby did not suffer brain damage before presentation at hospital on the 7th of August 2014 since the foetal heart rate was recorded as normal at 17H30. If there was something wrong or the baby had suffered some injury before then, the foetal heart rate would have shown certain signs and not make a normal recording.

[30] The CTG scan at 21H49 was not pathological and the baby was therefore still in a reasonable condition as it was accelerating and decelerating normally in response to the plaintiff's uterus contractions. Later, at 22H10 the CTG was pathological as the foetal heart rate took long to resume the

140 beats per minute as it started to conserve the energy. The foetal heart rate dropped to below 100 (70) per minute as it was now in distress. This causes the profound injury due to a lack of and or insufficient supply of blood and oxygen to the baby. To survive, the baby directs the supply of blood to the inner part of the brain which is more important than the outer brain. If the baby was taken out at 17H30, it would have been a small baby but with no brain damage. At 22H10 the hospital staff should have intervened with an intrauterine resuscitation as there were 3 decelerations and proceed to speed up delivery by caesarean section but they did not, instead they allowed labour to continue. No action was taken to save the baby nor was monitoring with a partogram initiated at this stage and that is substandard care given to the plaintiff.

[31] Nothing was recorded between 22H10 until 23H20 when the doctor arrived for the first time to assess the plaintiff and the CTG results were again misinterpreted as normal whereas it was non-reassuring. The partogram was only initiated at this stage and there is only one entry in relation to the partogram. The artificial rupturing of the membrane does not seem to have been done by the doctor as he did not record the meconium. There is no indication or record that the staff was aware that the plaintiff would deliver at 00H10. The baby was resuscitated at birth and the Apgar score was recorded in the first 5 minutes as 3/10 and 5/10 but this was an assisted score since the doctor resuscitated the baby at birth. The baby was not postdate and the peeling of skin was not because of growth restriction but lack of the blood supply and the fat that comes with it.

[32] He testified under cross examination that it is unlikely that the baby suffered any injury before the plaintiff presented on the 7th August 2014 since the foetal heart rate was recorded as normal on admission. Skin peeling could

have been caused by the incubator or by IUGR as the baby had no reserves to make the brown fat to protect its skin. From an obstetrician's perspective, the injury could not have happened before delivery. The CTG on admission was not pathological and the baby was not showing any distress – thus the baby was in a reasonable condition. He agreed that the baby was not growing well in the womb but that it was not distressing as it adjusted to its environment.

- [33] He conceded that the CTG scan is not 100% correct but stated that it was a useful tool and guide which alerts the paediatric team to investigate further by doing other tests. However, there was inaction in this case although the CTG scan showed that the plaintiff had protein plus 3 in its urine and a blood pressure of 144/106. Foetal heart rate is key to determine whether there was an injury before labour. He disputed that the CTG scan is junk science with a 99% false positive. The CTG scan has its limitations but it is valuable in high risk patients such as the plaintiff.
- [34] He testified that the hospital staff had the ability to pick up the problem and offer assistance but failed to do so and that was substandard care given to the plaintiff. If the hospital did not have the capacity, it was supposed to refer the plaintiff to a hospital which had the capacity. A patient with GPH and protein in her urine needed constant monitoring at intervals of 2 hours, even if they did not have the CTG scan, they should have used the stethoscope to listen to the foetal heart rate. He agreed that the acute profound injury happens fast but stated that the signs were there in this case and the hospital staff did not take the necessary action – hence the injury was not avoidable. The hospital staff should have acted at 22H10 and there was a fair chance that the baby could have been saved.

- [35] He agreed that IUGR is sometimes caused by placenta insufficiency and that IUGR babies need to be managed as high risk. Dr Pheeha should have been worried that the patient has platooned from 32 to 36 weeks. The patient developed hypoxia later in labour and it was caused by the GPH as the blood pressure of the patient was not monitored in terms of the guidelines at intervals of 2 hours since it interferes with the transfer of oxygen from the placenta. The CTG results were pathological at 22H00 since the foetal heart rate would decelerate and only return to normal after 3 minutes
- [36] The child was not given a chance since the caesarean section was not done and or delivery was not induced timeously. Caesarean section was necessary since the delivery was not imminent and the foetus was in distress. The injury was a grade II since the child suffered some seizures at birth. He testified that the blood pressure could stress the baby but the stress of labour is the one that tips the scale. Placenta pathology was not done which could have given more information on intrauterine infections and other diseases. Cord compression is excluded in this case for there were no signs like the foetal heart rate. On the facts of this case the cerebral palsy was caused by foetal distress which was not managed at all during labour. The hospital staff failed to adhere to the guidelines and monitor the plaintiff and its baby frequently and closely as required.
- [37] Dr John Christopher Archer, an obstetrician and gynaecologist of 35 years, testified that he prepared a medical legal report and confirmed signing a joint minute with Dr Chimussoro in this case. He considered a number of articles and prepared an addendum to his report. He testified that this case is clearly a high risk pregnancy which required constant monitoring. Further, he testified that it is inadequate to have one CTG machine when there are 13 patients in the labour ward ready for deliveries. It is not ideal to have 1

midwife for a delivery since the record keeping becomes poor and the midwife cannot be expected to use the stetoscope whilst the patient is pushing at the same time.

[38] The CTG is a screening but not a diagnostic tool which is used to monitor the foetal condition. It is used to detect foetal distress or that a baby is in some kind of trouble. It has not been shown to reduce cerebral palsy and has a false positive of 99.8%. The CTG is reactive when the foetal heart rate is between 110-160 beats per minute and it is classified as a grade II when it shows abnormality but not that gross as the brain of the baby is still intact. The CTG only tells about the foetal heart rate and not the brain of the foetus. The baby is not in a reasonable condition when the CTG is pathological and the foetal heart rate is not responding. The CTG would not pick up a foetus that suffered an intrauterine stroke. The CTG at 21H50 is normal as a category II and is not associated with acidosis or brain injury. Although the foetus suffered large decelerations it was a sign of increasing hypoxia by something and needed action but not necessarily immediate delivery. There was still a need for a diagnostic process to be done before any remedial action could be taken.

[39] He testified that an acute profound injury is so sudden and catastrophic that it cannot be prevented by an intervention including by a caesarean section delivery. He agreed with Dr Chimussoru that if the baby was delivered at 22H00 the baby could have been saved and it was a missed opportunity by the hospital staff which resulted in the care of the plaintiff being substandard. However, he is unconvinced that the substandard care given to the plaintiff was the cause of the injury. IUGR and GPH are associated with the increase in cerebral palsy and foetal distress during labour. This was a small baby and skin peeling confirmed that it was stressed before labour.

The baby could get an injury affecting the brain but not apparent on admission and only the stress of labour will make the baby become hypoxic. The baby was small and the mother had GPH making the pregnancy a high risk necessitating close monitoring and the creation of a birth plan which the hospital staff failed to do. Skin peeling shows that the baby was postdate but the 37 weeks gestation contradicts that.

- [40] He continued to testify that there is a lot of literature supporting the relationship between IUGR and cerebral palsy. If the placenta is not functioning optimally the foetus will not grow optimally and the lower the birth weight of the baby the greater the chance for brain damage. Cord compression reduces blood flow to the foetus causing hypoxia which in turn causes brain damage resulting in cerebral palsy. Because the baby was clearly sick on admission, it is possible that the injury occurred before labour.
- [41] He testified under cross examination that he left clinical practice 3 years ago and that he has been involved in more than 150 similar cases 5 of which were for the plaintiff with one wherein his testimony was rejected by the court. From his reading of the antenatal card there seemed to be nothing wrong with the plaintiff until the point of admission. He agreed that alarm bells should have sounded when she presented with high blood pressure and protein in her urine. She was misdiagnosed on admission as being in latent phase when she was in fact in the active phase of labour. A partogram, which gives full history of the labour, should have been commenced at this stage.
- [42] This was a high risk patient and the foetal heart rate should have been monitored closely and every 30 minutes. Foetal heart rate would alert the staff of any abnormality so that they could act accordingly. It was inappropriate and substandard care to check the blood pressure after 3 hours

after having given the patient medication for the blood pressure. It was not a resource issue to measure blood pressure at 20H49 and not to check on the foetal heart rate but a dereliction of duty and incompetence on the part of the staff.

[43] He agreed that IUGR is a risk factor for hypoxia and needs something to happen for the risk to eventuate and labour is most stressful. The foetal heart rate reacts at many things and the CTG is there to alert staff. He agreed that the baby had not suffered a partial prolonged injury on admission and that IUGR predisposes the baby to injury. He agreed that MRI does not time the injury, that the plaintiff was in active phase on admission and that the hospital staff missed about 9 opportunities to assess the foetus and intervene. Foetal heart rate was non-reassuring and action in the form of intrauterine resuscitation should have been taken at that point at 22H00.

[44] The CTG may look normal but cannot rule out any injury that occurred just before labour. At 22H00 the nursing staff did not know when the plaintiff was going to deliver the baby and at worst she was to deliver at 02H30. He further agreed that a partial prolonged injury is usually followed by the acute profound injury if there is no intervention. When the partial prolonged occurs, the foetal mechanism to protect itself takes over and when it has lost all its defences the acute profound injury occurs. Considering the circumstances of this case, the CTG will function normally when in fact there was an injury before labour, but we do not know when exactly the injury happened.

[45] He continued to testify that if cord compression did not occur then the injury occurred intrapartum. He conceded that he overstepped the mark by putting things which are not supposed to be in his report and saying the plaintiff

must prove on a balance of probabilities that the injury occurred during labour. He agreed that 2 CTGs were functional on the day the plaintiff was admitted. He conceded that the failure of the hospital staff to take action at 22H00 is indefensible. He admitted as a speculative possibility that the injury might have occurred before entering the labour ward.

[46] He conceded that it is speculation to think that there is something wrong with the placenta since no placenta pathology was undertaken. He agreed that the baby was coping within its environment and that mismanagement caused the problem. He reiterated that cord compression can cause the injury before labour but cannot be traced after birth. It is possible for the partial prolonged injury to have occurred before labour due to lack of blood supply to the foetus. It is ideal to have 1 midwife per 2 patients and to make proper notes since they are important. Nothing was affected by the lack of resources in this case.

[47] Dr Makgwadi Stepen Pheeha, a grade 1 medical officer and general practitioner, was on duty on the 7th of August 2014 and was responsible for the general female problems and the maternity ward at Yusuf Dadoo Hospital. He testified that it was strange that the plaintiff was kept waiting to enter the maternity ward from 10H00 until 16H00. Sister Kgengwe, a midwife, was the one who interviewed, assessed and examined patients on that day and contacted the doctor if there were any problems. A nurse checked the vital signs of the plaintiff and called him to prescribe medication for blood pressure. He did a walk about the ward at about 20H00 to see if there were any red flags and there was none. The blood pressure of the plaintiff was checked at 20H49 and it was found to be going down and he decided to allow labour to progress.

- [48] He was informed of the abdominal examination which showed that palpation was 29 and an SF height of 32 and interpreted it with the clinical card which suggested 36 weeks gestation – to mean that the baby was small for the gestational age. This was a growth restricted baby. Such a small baby for gestational age is a concern but not an emergency and he allowed labour to progress because an operation is a danger to the patient. He saw the plaintiff again at 23H20. The plaintiff presented with a mild blood pressure and protein in her urine. Only one sample of urine was tested at the time and needed to do more urine tests before he could consider removing the baby by caesarean section – hence he decided to intervene by prescribing medication.
- [49] He makes notes when he has time and the note at 23H20 related to what happened at 22H30. The plaintiff was 7-8 cm dilated and in the active phase of labour. He did the artificial rupture of the membrane and disputes that he did not see the plaintiff before as he saw her twice that day. He had 13 deliveries to manage on that day and only one CTG machine was working. He had 90 patients to attend to and the sisters were also assisting in terms of the protocol. Sister Ramaboa was responsible for the plaintiff. The CTG at 22H10 was reactive and he considered the foetal heart rate variability at the time and found nothing wrong – hence he allowed labour to progress. After entering the note at 23H20 he waited to observe the labour and the plaintiff delivered within an hour.
- [50] Under cross examination he testified that he remembers certain details of the matter but he could not say where exactly he was at 21H00 on that day and what he was doing. He agreed that a patient with GPH is high risk but he could manage it and he allowed labour to progress as the baby was on its way. Although it was not recorded, he saw the patient at 20H00 because she was in the active phase of labour and needed to be checked 2 hourly. He was

concerned with the palpation of 29 and SF height at 32 gestation showing that the baby did not grow properly but it did not warrant that he should take out the baby. The CTG at 22H10 was reactive and the baby was fine although there were decelerations due to the contractions. He disputed that he was part of the problem that the baby was born with cerebral palsy.

- [51] Dr Ugobor Osamwonyi, the Chief Executive Officer of the hospital, testified on the ideal resources the hospital required and what it had at the time. He testified about the budgets over the years from 2013 and that on the 7th of August 2014 there were 3 CTG machines but 2 thereof were in for repairs. He confirmed that he was in charge of the doctors and that only 1 doctor was allocated to maternity ward at night. He disagreed with the proposition that 2 CTG machines were working on the day. He confirmed that on the 7th August 2014 there were no capacity issues since there was a doctor on duty at the maternity ward.
- [52] Professor Arnold Louise Christianson, a paediatrician and specialist medical geneticist, testified that he compiled a medical legal report in this case. He testified that the HIE scores of 6 on 10 August 2014, 4 on 11 August 2014 and 4 on 12 August 2014 are indicative of HIE grade 1 which usually does not progress to cerebral palsy. HIE 1 is not associated with an abnormal long term outcome and the baby in this case has a hypoxic ischemic cerebral injury of partial prolonged and acute profound type. The baby had a neurological depression at birth and according to his score on day 3 of 6/10 it means that he is graded as HIE 1 which is moderate. It confirms that the injury is not intrapartum for it should have been worse within 72 hours if it was intrapartum.

- [53] He testified that babies with IUGR are at a high risk of developing HIE and cerebral palsy. The injury to the baby must have occurred before labour since it turned out to be HIE 1. The baby was born at 35 weeks 5 days weighing 2060g and that places him under the 3rd centile when using the international birth chart. His head circumference was 34 cm 3 days after birth which makes him a wasted baby.
- [54] He testified under cross examination that he last did general paediatrics in 1992. He conceded that the baby had upper limb jittery but stated that that does not necessarily mean that the baby had seizures. Sometimes it does but babies respond differently to stimulus. He conceded that the apgar score of 3/10 and 5/10 was an assisted score since the baby was resuscitated at birth. He further conceded that the baby had 3 seizures on the first day of life but that it was treated therefor. He disputed that HIE1 have seizures but accepted that the baby had episodes of seizures in its first day of life. This is confirmed by literature in these types of injury including a grade II HIE. He disagreed with Dr Kara and Dr Cooper that the seizures put the grading of the HIE of this baby as grade II. He conceded that the article he referenced to refer to severely affected infants whereas the baby in this case is not severely affected.
- [55] It is a principle of our law that for the plaintiff to succeed with its claim against the defendant it must establish on a balance of probabilities that its version is reliable and can be believed. As indicated above, the experts agreed that the care received by the plaintiff on the 7th to the 8th of August 2014 at the hospital was substandard. What remains for determination is whether the substandard care is the cause of the injury sustained by the S and the resultant damages.

- [56] Advocate Sibuyi SC, counsel for the defendant, submitted that the hospital did not have the capacity or resources to handle the number of patients that presented on the day. The hospital was under staffed and one doctor had to look after 90 patients. There were 13 deliveries to be managed with only 1 CTG machine available. However, Dr Pheeha, who was the doctor assigned to the maternity ward that night did not allude to capacity problems in the hospital except that he was assigned to more than 1 ward on the day. Further, this submission was negated by Dr Ugobor Osamwonyi, the CEO of the hospital, who testified that there were no resource or capacity problems on the day and that one doctor was assigned to strictly attend to the maternity ward.
- [57] It is apparent that there were 2 CTG machines that were working on the day and that the hospital staff was not only obliged to use the CTG scan to monitor the foetal heart rate but could also use the stethoscope to listen to the foetal heart rate. Further, it was agreed by the experts that if the hospital did not have the capacity or resources to handle a complicated labour, it was obliged to refer the patient to a hospital that was better equipped to do so. Dr Pheeha also confirmed in his testimony that the labour of the plaintiff was something he could not handle – hence he did not find it necessary to refer the plaintiff to another institution which was of a higher level than this hospital. I therefore hold the view that the capacity or resources of the hospital were not an issue on the day in question.
- [58] I am unable to agree with the submission by counsel for the defendant that the intrauterine growth restriction suffered by the baby after 32 weeks was caused by the plaintiff either by not eating properly or because she was using drugs or consuming intoxicating liquor. The uncontroverted evidence of the plaintiff is that she ate properly during the pregnancy and has never

consumed intoxicating liquor or taken drugs in her lifetime. This is also borne out by the antenatal clinic record that she was not treated for any sickness during her attendances to the clinic except that she was given medication or vitamin supplements which are normally given to pregnant mothers.

- [59] It is on record that the experts agreed that when the plaintiff presented and was diagnosed with gestational proteinuric hypertension with plus 3 protein in her urine at 17H30 on the 7th of August 2014 and with 3-4 cm dilation, she was supposed to be treated as a high risk pregnancy. Further, that since the palpitation was 29 and the SF height was 32 gestational age on admission, it meant that the baby was growth restricted and small. This necessitated that, although the foetal heart rate was normal at the time, it was supposed to be checked every 30 minutes and the blood pressure of the plaintiff every 2 hours.
- [60] However, the nursing staff did not follow the guidelines and monitor the foetal heart rate and the blood pressure of the plaintiff. The blood pressure of the plaintiff was only checked at 20H49 and the foetal heart rate at 21H49 when the CTG scan was misinterpreted by Dr Pheeha as reactive when it was in fact non-reassuring and pathological and the baby was in distress or in trouble. The experts further concurred that it was for the hospital staff at the time to immediately take action by doing an intrauterine resuscitation of the foetus. Should the intrauterine resuscitation have failed, then they were to decide to immediately take out the baby by caesarean section rather than to allow her labour to continue until she delivered vaginally.
- [61] I am in agreement with Advocate McKelvey for the plaintiff that the hospital staff missed about 13 opportunities within which to take remedial action and

deliver the baby rather than to allow the continuation of her labour. I am appalled by Dr Pheeha's testimony that he did not find anything wrong with the CTG of 21H49 when he interpreted same at 23H20. All the experts agree, except Dr Pheeha, that the 22H00 CTG was non reassuring calling for prompt action from the hospital staff which was not done. Dr Pheeha makes a flimsy excuse that a caesarean section is a danger to the patient – hence he did not find it necessary to put the patient at that risk.

[62] I am therefore in agreement with counsel for the plaintiff that Dr Pheeha was part of the problem in this case. He failed to take charge of the situation when he received the report on the plaintiff at 17H30 that she has hypertension and plus 3 protein in her urine. Instead, he prescribed medication and failed to appreciate that he was dealing with a high risk pregnancy which needed continuous monitoring but only came at 23H20 to examine the patient. Even then, he misinterpreted the CTG scan that was non-reassuring showing that the baby was in distress and in trouble and assessed it as reactive – hence he allowed labour to continue.

[63] The experts agreed that hypertension of the mother causes the lack of blood supply to the uterus and by extension to the foetus. The MRI scan revealed that the brain injury described as partial prolonged and acute profound hypoxic ischaemic injury occurred in a term baby's brain. The MRI demonstrated no features of congenital infection nor the presence of cord compression or placenta insufficiency. I do not agree with Dr Archer's proposition that the injury to the baby might have been caused by cord compression which cannot be traced after birth. Nothing turns in the suggestion that the placenta was not pathologically tested and cannot be conclusively accepted that it was normal under the circumstances. The uncontested evidence is that the placenta was normal and had normal weight.

- [64] Counsel for the defendant contended that the timing of the injury is that it occurred before labour when the hypertension started and caused the partial prolonged injury. However, although Dr Archer suggested this possibility, it flies in the face of the evidence that on admission at 17H30, the CTG revealed that the foetal heart rate was normal. If the foetus had suffered any injury before admission, according to Dr Chimusoro, the CTG would have been pathological and non-reassuring showing that the foetus was in distress. Dr Archer also conceded that if the partial prolonged injury did not occur before labour, then it occurred intrapartum. Further, it is on record that if the injury occurred a week or two before labour, it would have been detected by the ultrasound which was done after the birth of the baby.
- [65] I am unable to comprehend the rational of Dr Archer that the CTG should not be believed for it has a 99.98% false positive. He rubbishes the CTG scan and calls it 'Junk Science'. However, this begs the question why is the CTG scan continually in use in hospitals if it was so unreliable. I accept the view of Dr Chimusoro, which to some extent is the view of Dr Archer, that the CTG is not the final tool for monitoring but one needs to follow up with other tests to ascertain the condition of the patient. I therefore conclude that Dr Archer rubbished the CTG scan as Junk Science in an attempt to bolster the case for the defendant so that the action or inaction of its staff in response to the results of the CTG should not be seen as negligence.
- [66] I am unable to agree with Dr Archer that placenta insufficiency or cord compression could have been the cause of the lack of blood and oxygen supply to the foetus. The uncontroverted evidence before this Court is that the placenta was noted as normal by the hospital staff and therefore the theory of placenta insufficiency falls to be dismissed as speculation. Further,

cord compression was excluded by the MRI scan which has been admitted in evidence by agreement.

[67] In *Bee v Road Accident Fund (093/2017) [2018] ZSCA 52 (29 March 2018)* the Supreme Court of Appeal per Seriti JA stated the following:

“It is trite that an expert witness is required to assist the court and not to usurp the function of the court. Expert witnesses are required to lay a factual basis for their conclusions and explain their reasoning to the court. The court must satisfy itself as to the correctness of the expert’s reasoning.

The facts on which the expert witness expresses an opinion must be capable of being reconciled with all other evidence in the case. For an opinion to be underpinned by proper reasoning, it must be based on correct facts. Incorrect facts militates against proper reasoning and the correct analysis of the facts is paramount for proper reasoning, failing which the court will not be able to properly assess the cogency of that opinion. An expert opinion which lacks proper reasoning is not helpful to the court.

.....If an expert witness cannot convince the court of the reliability of the opinion and his report, the opinion will not be admitted. The joint report of experts is a document which encapsulates the opinions of the experts and it does not lose the characteristic of expert opinion. The joint report must therefore be treated as expert opinion. The fact that it is signed by two or more experts does not alter its characteristic of expert opinion. The principles applicable to expert evidence or reports are also applicable to joint report. The joint report before the court is consequently part of evidential material which the court must consider in order to arrive at a just decision. The court, in such instance, will be entitled to test the reliability of the joint opinion, and if the court finds the joint opinion to be unreliable, the

court will be entitled to reject the joint opinion. The court is entitled to reject the joint report or agreed opinion if the court is of the view that the joint report or opinion is based on incorrect facts, incorrect assumptions or is unconvincing.”

[68] Dr Archer has ignored the facts of this case and tried at all costs to bring in some other theory as a possible cause of the injury to the baby’s brain. The MRI scan has been admitted in evidence, however, Dr Archer still suggest a theory of cord compression as the possible cause of the injury. He insist on placenta insufficiency as the possible cause of the injury to the baby when the placenta was noted as normal and of a normal weight. His contention is that the placenta was not properly or pathologically tested and it can therefore not be conclusively accepted that it was normal. I therefore conclude that Dr Archer’s evidence is not based on the facts of this case and is purely speculative and falls to be dismissed.

[69] It is agreed amongst the experts, the partial prolonged injury occurs when there is insufficient supply of blood and oxygen to the foetus. This will be followed by the acute profound injury if the insufficiency of blood and oxygen supply to the uterus and the foetus continues resulting in the HIE injury to the brain.

It is on record that IUGR does not by itself result in cerebral palsy but it is a risk factor for intrapartum hypoxia and hypoxic brain injury if not properly managed. Further, that a growth restricted baby does not per se become brain damaged but it is predisposed to the danger if not properly monitored as it is weak to withstand the stresses of labour. Generally, babies with growth restriction are born without any complications. I accept the evidence of Drs Kara and Chimusoro that for the growth restricted baby to suffer an injury there must be a sentinel event, which in this case is the labour. I am of the

view therefore that, the ineluctable conclusion is that the baby suffered the HIE in utero and during labour since the foetus was in a reasonable and good condition on admission at 17H30 on the 7th of August 2014.

[70] In *Magqeya v MEC for Health, Eastern Cape* (699/17) [2018] ZASCA 141 (1 October 2018) the Court stated the following:

“Paragraph 39: As I have said, in my view, the radiology report supports the contentions advanced on behalf of Ms Magqeya that what had occurred was an unmonitored and undetected gradual evolution of hypoxia, followed by the acute, catastrophic hypoxic ischaemia. The lack of adequate monitoring and care constitutes in my view negligence. It was common cause (conceded by Professor Buchamann) that this neglect was contrary to the professional guidelines and practice. Such a ‘failure’ of a professional person to adhere to the general level of skill and diligence possessed and exercised at the same time by members of the branch of the profession to which he or she belongs would normally constitute negligence.

Paragraph 40: This court has held that the nursing profession is a distinct profession and nurses are expected to perform their duties with the requisite skill and diligence exercised by members of that profession. The negligent lack of monitoring and care for the extraordinarily long periods, as set out above, resulted in the risk of, inter alia, hypoxia developing unnoticed. Was this, however, adequate for factual causation to have been established on a preponderance of probabilities? For the reasons that follow, I am of the view that the answer should be in the affirmative.”

[71] It was submitted by counsel for the defendant that the acute profound injury happened between 23H20 and 00H10, ie, less than 90 minutes before the

delivery of the baby – hence the hospital staff could not take any intervening action and deliver a healthy baby. It was contended that a sentinel event has occurred in this case, a sudden acute, unexpected profound event which caused sudden great damage.

[72] I do not agree. The facts of this case are distinguishable from those in Maqgeya referred to above where it was accepted that no intervention by the hospital staff could have saved the baby if the acute profound injury occurred 90 minutes before delivery. Firstly, the hospital staff in this case did not know that the plaintiff was due to deliver at 00H10. Secondly, the acute profound injury is accepted as continuum of the partial prolonged injury which could have been detected earlier had adequate monitoring and care been exercised timeously.

[73] It is apparent that the CTG was non-reassuring at 22H00 showing that the baby was in distress but Dr Pheeha misinterpreted the CTG as being reactive and assuring and decided to allow labour to progress. Had there been adequate and proper monitoring and care from the time of admission of the plaintiff, and had Dr Pheeha attended to the plaintiff at 22H00 and interpreted the CTG correctly at that time, he would have initiated procedures to save the baby including delivery by caesarean section. The baby would have been saved and delivered before 23H30 and the outcome would have been different.

[74] As indicated above, the hospital staff misdiagnosed the plaintiff as being in a latent phase of labour on admission when she was in fact in the active phase. Had the hospital staff assessed and diagnosed the plaintiff correctly at the time, and since she was diagnosed with hypertension and plus 3 proteinuric, the partogram would have been commenced and constant

monitoring at intervals of 2 hours for the plaintiff and every 30 minutes checking the foetal heart rate as prescribed by the guidelines would have been implemented. Had monitoring been implemented, the foetal distress would have been timeously detected and the necessary interventions implemented to prevent the injury and or brain damage. It is my respectful view that the actions or inaction of the hospital staff in its care of the plaintiff and its baby on the day was the direct cause of the brain injury sustained by S resulting in cerebral palsy.

[75] In the circumstances, I make the following order:

1. The defendant is liable for 100% of the damages of the plaintiff as proven or agreed in her representative capacity for and on behalf of her minor child, S, resulting from the negligence of the staff at the Yusuf Dadoo Hospital resulting in the minor child suffering from cerebral palsy;
2. The defendant shall pay the costs of suit, including such costs to include:
 - a) The costs attendant upon obtaining the medical legal reports, addendums and joint minutes of the following experts:
 - I. Professor Andronikou;
 - II. Dr Chimusoro;
 - III. Dr Sekawabe;
 - IV. Lesley fletcher;
 - V. Dr Kara.
 - b) The qualifying, attendance, preparation, travelling fees, where applicable, of the aforesaid witnesses.
 - c) The costs consequent upon the employment of counsel.

TWALA M L

JUDGE OF THE HIGH COURT OF SOUTH AFRICA

GAUTENG LOCAL DIVISION

Date of hearing: 15th – 25th April 2019
7th – 22nd October 2019

Date of Judgment: 28th January 2020

For the Plaintiff: Adv. C McKelvey

Instructed by: Nonxuba Inc
Tel: 011 234 1194

For the Defendant: Adv. W Sibuyi SC
Adv. K Siqongana

Instructed by: State Attorney
Tel: 011 330 7778