

REPUBLIC OF SOUTH AFRICA
IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, JOHANNESBURG

Case No.: 2014/32526

REPORTABLE: No
OF INTEREST TO OTHER JUDGES: No
27 June 2022

In the matter between:

MASHELE, MERRY JANE

Plaintiff

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR
HEALTH OF THE GAUTENG PROVINCIAL DEPARTMENT

Defendant

JUDGMENT

This judgment was handed down electronically by circulation to the parties' legal representatives by email and is deemed to be handed down upon such circulation.

Gilbert AJ:

1. The plaintiff was admitted to the Tembisa Hospital during the late afternoon of 27 November 2012. She was in the latent phase of labour at the time, having been admitted to a clinic earlier that day. The plaintiff would enter into the active phase of labour by at least 03h30 the next morning and would later that morning, on 28 November 2012, at 11h10 give birth to a daughter by way of vaginal delivery.

2. It is common cause that the minor child sustained at least a moderate-severe degree of brain damage (encephalopathy)¹ and that this resulted in profound global developmental delay, microcephaly and mixed cerebral palsy (“the condition”). It is also common cause that this brain damage was caused by an acute profound hypoxic ischaemic injury. Put simplistically, the minor child suffered from brain damage arising from reduced oxygen supply to her brain. A hypoxic ischaemic injury (“HII”) is so described, hypoxic referring to insufficient concentrations of oxygen in the blood and ischaemic referring to insufficient blood flow to the brain.

3. What the parties do not agree upon is when this brain-damaging hypoxic ischaemic injury occurred. The plaintiff’s case as was advanced during the trial was that hypoxic ischaemic injuries that are sufficient to cause the condition happened both before and after the minor child’s birth, i.e., that the minor had the misfortune of suffering at least two hypoxic ischaemic injuries, each of which was sufficient to cause the condition, and which cumulatively most definitely caused the condition. The defendant contends that the only hypoxic ischaemic injury that took place was the injury that took several hours after birth when the minor child was in the hospital’s neonatal intensive care unit (“NICU”), and that it cannot be held liable for that injury.

4. The plaintiff’s case of successive hypoxic ischaemic injuries, as conducted during the course of the trial before me, brings a dimension to the matter of considerable consequence, as will be seen later in this judgment.

5. The plaintiff claims damages in her representative capacity as the mother and natural guardian of the minor child arising from the condition brought about by the hypoxic ischaemic injuries that she maintains were sustained by the minor child before and after her birth as a result of the negligence of the hospital’s medical and/or nursing staff (“the medical personnel”).

¹ The joint minute of the paediatricians/neonatologists at para 12 records that the minor child developed neonatal Grade II to III encephalopathy, i.e., of a moderate-severe degree.

6. The parties agreed that there should be a separation of the issue of liability from the quantum of any damages, as is usual in these matters. At the commencement of the trial, I granted a separation of issues provisionally in the sense that I requested the parties to frame an agreed formulation of the separation. They subsequently did so, and so as per their agreed formulation, the issue of liability, inclusive of negligence and causation, is separated in terms of Uniform Rule 33(4) of the Uniform Rules of Court and will be determined first and separately, with the issue of quantum being postponed.

7. It is trite that for the plaintiff to succeed in her claim on behalf of the minor child, she must prove wrongfulness, fault, causation and harm.² Before the trial commenced, the parties filed a joint practice note in which they recorded that the defendant accepted that the plaintiff as the mother of the minor child had *locus standi* to pursue the claim, that the defendant was the responsible entity liable for the damages if proven and that it, including the medical personnel, had a duty of care towards the plaintiff and her minor child. The issue of harm (damages) has been postponed. Accordingly, the two elements of the delictual claim before me for decision are those of negligence (fault) and causation.

8. Only one factual witness would be led, that was the plaintiff herself, who described the onset of labour before she attended the clinic, the latent phase of her labour while at the clinic, her admission to the hospital during the late afternoon of 27 November 2012 because of the prolonged latent phase of the labour, what happened at the hospital both before and after the birth of the child at 11h10 the next day, 28 November 2012, and of her and then later the daughter's discharge from the hospital.

9. I set out a summary of this factual evidence first, not only because the plaintiff was the only factual witness but also because it provides a useful overview to appreciate the plaintiff's case that there were hypoxic ischaemic injuries both before and after birth.

² See, for example, *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC) at para 34.

A SUMMARY OF THE PLAINTIFF'S EVIDENCE

10. This was the mother's first pregnancy.

11. The plaintiff (the mother) gave evidence that she had neither consumed alcohol nor smoked during pregnancy and was generally in good personal health. She was not a sickly person, and to the best of her knowledge was not suffering from any medical condition before she gave birth. The plaintiff testified that she was not informed by the clinic that she was suffering from any medical condition. Why this is important is because the defendant contends that the plaintiff was suffering from pneumonia at the time and that she had passed this on to her baby *in utero* and therefore that the common cause acute profound hypoxic ischaemic injury to the minor child was attributable to this congenital pneumonia. Although there were recordings by the attending doctor of pneumonia and severe pneumonia in the hospital records in respect of the minor child after her birth (which will be considered in some detail later in this judgment), the plaintiff under cross-examination persisted that she had no recollection of being informed by any medical personnel that she was suffering from pneumonia.

12. The plaintiff testified that on the morning of 27 November 2012, while she was bathing in the morning, she noticed a discharge from between her legs. As that was in any event the day for her next scheduled clinic check-up for her pregnancy, she took a taxi to the clinic that morning. Upon arrival, the plaintiff testifies, she was placed upon a bed and a "*belt placed over her belly*" and that something was connected to her arm. This 'belt' is a CTG (cardiotocograph), which is used to measure the foetal heart rate.

13. The plaintiff testified that at the clinic she felt unwell and was suffering from pain.

14. The plaintiff stayed at the clinic for the whole day until she was told late that afternoon that her baby "*was not coming*" and that she was to be taken to Tembisa Hospital by ambulance. The plaintiff was uncertain of the timeframe but believed this to be around 17h00.

15. The plaintiff testifies that upon her arrival at Tembisa Hospital, she was taken into a waiting area and given a gown. She changed into the gown and waited her turn.

16. When it was her turn, she was moved to another room where other ladies were in bed, giving birth.

17. After an indeterminate time, as her water had not broken, a “*lady*” inserted a “*long thing*” into her, in what the plaintiff thought was a successful attempt to break her water as she did feel liquid running down her legs. Upon cross-examination, it was unclear whether this attempt succeeded. The recordal in the clinical notes for 27 November 2012 at 22h30 is that the “*attempt to rupture*” was not successful (at 006-142).

18. During examination-in-chief, she said that this “*lady*” was a nurse as she did not remember seeing a doctor at that time at the hospital. Under cross-examination the plaintiff stated that the person who inserted the “*long thing*” into her may have been a doctor or a nurse.

19. The plaintiff continued under examination-in-chief to testify that after the “*long thing*” was inserted into her, her waters broke. By then, the plaintiff describes, her pain was unbearable and she was informed by the nursing staff that she was ready to give birth. She was told to push when the pain comes. The plaintiff testifies that she did this once, but the baby ‘did not come’. When she did this a second time, the baby was born.

20. The plaintiff testifies that her daughter did not cry when she was born. The plaintiff testifies that she was quickly shown the baby, before the baby was taken away.

21. The plaintiff then testified that she was “*stitched up*” and placed on a bench to wait.

22. The plaintiff testifies that she was then later taken to her baby, which she described as 'just lying there', not crying. While she was looking at her baby, a doctor arrived, and he was "mad" because oxygen to the baby had not been 'turned on'. The plaintiff testifies that the baby was then taken away and she was told again to sit in a waiting area. It would emerge from the hospital records that this was the baby being taken away to the NICU.

23. During cross-examination, the plaintiff would be challenged that this instance of her seeing her baby on 28 November 2012 (after birth but before admission to the NICU) did not take place, and essentially that it was fabricated. The cross-examination was along the lines that this instance of her seeing her child was not recorded in the hospital records and that the witness' recollection thereof was so vague that it essentially was not credible. The plaintiff was referred to an affidavit to which she had deposed on 6 July 2016 in support of an application for condonation for the late filing of the requisite notice in terms of the Institution of Legal Proceedings Against Certain Organs of State, Act 2002 in which she had stated under oath that "*upon being born the minor child was immediately separated from me and taken to the Intensive Care Unit*" and that "*I was first able to see the minor child on the day following her delivery*". It was put to her that this was inconsistent with her testimony before me of her seeing her baby later that day, on 28 November 2012, before seeing the baby in the NICU. It was also put to the plaintiff during cross-examination that this instance of seeing her baby after her birth but before admission to the NICU was not part of the patient history given by her to at least two of the experts consulted in the matter for purposes of giving expert evidence.

24. The plaintiff testified that she was taken later to see the baby in NICU, after she had been "stitched", where her daughter had been attached to various "machines", with "*tubes and plugs on her*". The plaintiff said that she was told that this was necessary because her baby did not cry when she was born. When asked on the timeframe, her testimony was that as she did not have her cell phone with her, she was uncertain about the time these various activities took place.

25. The baby remained in the hospital, and the plaintiff was discharged. The plaintiff had to return each day to feed her baby (as the plaintiff was not permitted to stay with her baby in the hospital as there were no beds available), having expressed breast milk into a cup to enable the baby to feed as the baby could not breastfeed.

26. The plaintiff repeated during her evidence that during her time at the hospital she did not suffer from any flu-like symptoms or have a fever.

27. The cross-examination of the plaintiff focused on certain of her evidence. The defendant sought to establish from the plaintiff that the “*belt*” (CTG) that had been placed upon her at the hospital had been on her “*the whole day*”, i.e. until she gave birth to her daughter at 11h10 on 28 November 2012. Presumably the defendant was seeking to elicit evidence that the foetus was being monitored throughout, including until birth. The plaintiff was referred to the history that she had given to her medical experts, Prof Solomons (a paediatric neurologist) and in particular paragraph 3.2.1 at 008-12 where the following is recorded:

“The mother recalls that a cardiotocograph (CTG) was placed and kept on the mother for the whole day”.

28. The plaintiff did, to some extent, confirm this although it did not appear to me that the plaintiff was particularly clear on this.

29. The relevance of this evidence is that the plaintiff’s case is that there had been insufficient foetal monitoring of the unborn child during the active phase of labour, which had commenced by a least 03h30 on 28 November 2012 until the birth of the minor child at 11h10. A partogram (a standardised document on which labour observations are recorded) at page 006-148 shows that during the active phase of labour recordings of foetal monitoring had taken place on four occasions, between 03h30 and 08h30. In particular, the partogram shows a recordal of a CTG reading at 03h30, 05h30, 07h30, and 08h30, but not thereafter. There are accordingly no CTG recordings on the partogram in the three or so hours immediately preceding birth i.e. from 08h30 to 11h10.

30. The plaintiff's expert, Prof Smith (a neonatologist) would subsequently in his evidence be critical of this for two reasons, namely that the relevant published guidelines required a CTG reading every half an hour during the active phase of labour and, secondly, there did not appear to be any readings at all in the crucial hours preceding birth, i.e. from 08h30 to 11h10.

31. On this, Prof Smith was challenged that it did not necessarily follow that because there were no CTG readings recorded on the partogram during the period 08h30 to 11h10, that in fact no monitoring had taken place during that period. The defendant's argument was that the inadequate recordal of the CTG readings did not mean that there was insufficient or negligent monitoring of the foetus during that period. Prof Smith's response was that in the absence of complete records, he could take the matter no further.

32. A second challenge of the plaintiff's evidence in cross-examination was that it had been a doctor that had ruptured her waters rather than a nurse and that accordingly a doctor had been present at that time. Upon being pressed on this issue, the plaintiff conceded that she was unsure whether there may or may not have been a doctor present at the time. It was put to the plaintiff that in paragraph 3.2.2 of her medical history given by her to Prof Solomons (at 008-12) that she had said that "*later that evening a doctor mechanically ruptured the membranes*". Ultimately the plaintiff's evidence was unclear on this issue.

33. The plaintiff was considerably cross-examined on the second instance of her seeing her baby that day, 28 November 2012 (i.e., after it was born but before admission to the NICU). It appears common cause that immediately after birth the plaintiff was shown her baby, which did not cry. It is also common cause that later that day the plaintiff saw her baby in the NICU. What is not common cause is whether between these two instances of the plaintiff seeing her baby on 28 November 2012 there was a further instance of her seeing her baby. The plaintiff contends that about an hour later, after she had been "*stitched up*" and left to sit on a bench, she was called to a room where she saw her baby "*just lying there*", not crying, naked and on top of a "*green thing*". This is the instance described above.

When pressed in cross-examination, the plaintiff testified that there did appear to be tubes going into the baby's nose that were connected to an oxygen tank and that it was because this oxygen tank was not open that the doctor that appeared while she was there looking at the baby was "*mad*" (a reference to being angry because the oxygen to the baby had not been opened). The plaintiff testified under cross-examination that the medical personnel in response to the doctor's anger appeared to then "*panic*", she was asked to again return to the waiting area, and she did not know what had then become of the baby. The plaintiff testified that after waiting for some time, she made enquiries and then later was taken to see her baby, which by then was in the NICU.

34. A further ground of substantial challenge of the plaintiff's evidence under cross-examination was whether the plaintiff had been informed by the doctors that her daughter had pneumonia at birth. The medical records refer to various instances of the attending doctor informing her that the child had pneumonia, but the plaintiff testified that she did not recall being informed of that. The plaintiff said that all she was told was that the baby did not cry when she was born, and that she needed machines to help the flow of oxygen to the brain.

35. For example, the nurses' contemporaneous progress report show a note at 12h00 on 29 November 2012 that the "*parents counselled on condition and prognosis by Dr Phudu*" (at 006-110). The witness was again not entirely clear as to whether she could recollect this but repeated that all she was told and that she could remember is that her baby did not have oxygen going to the brain.

36. To similar effect is an entry in the attending doctor's "Progress Note" (at 006-50) for 28 November 2012 at somewhere between 19h00 and 21h30 where the following is recorded in manuscript "*Mother has been counselled. She reports that child didn't cry immediately after birth. Mother explained about birth asphyxia and severe cong [congenital] pneumonia*". Again, the plaintiff in response in cross-examination said that she did not recall being told of pneumonia as a diagnosis. To similar effect, in relation to a doctor's note on 29 November 2012 at 11h25 (at 006-46) that the "*parents were counselled on condition and prognosis*" and a further

doctor's note on 6 December 2012 that "*mother counselled about the condition*" (at 006-35).

37. Although the plaintiff testified that after her daughter was discharged that she was referred to a cerebral palsy clinic, she testified that there were no subsequent problems with her baby in relation to pneumonia. In response to this in cross-examination the plaintiff was challenged with a subsequent radiologist report of 28 September 2013, i.e. some 10 months later where it appears that the baby had been taken to radiologists who concluded that "*findings are in keeping with broncho pneumonia*" (Caselines 006-9). The plaintiff testified that she did not remember her baby coughing in August 2013, but she did remember that her baby "could not suck" and was having difficulty feeding and that her mother (the plaintiff's mother), who was assisting her in looking after the baby, may have arranged for this consultation. The plaintiff was challenged that this demonstrated her baby was sick (because of pneumonia) and that her previous statement that the baby was not sick was incorrect.

38. Much of the cross-examination was directed, it would appear to me, to challenge the credibility of the plaintiff as a witness in that her version was vague and was inconsistent with the medical records.

39. It is so that the plaintiff's evidence was unclear in various respects, but this can be justifiably ascribed to the events going back nearly ten years and to what was undoubtedly a traumatic experience. I do not find that I can make a finding that the plaintiff was dishonest and that her evidence should be rejected. But it was unsatisfactory in its vagueness and the witness' oft recourse to saying that "*she could not remember*" or being unable to remember when pressed.

40. The appropriate approach is that identified in *Gestmin SGPS S.A. v Credit Suisse (UK) Limited and Credit Suisse Securities (Europe) Limited*,³ an English decision of the High Court of Justice Queen's Bench Division Commercial Court, in which Leggatt J considered the difficulties encountered with evidence based on a

³ [2013] EWHC 3560 (Comm)

witness' recollection of events, and the unreliability of human memory. Leggatt J held, in this regard,⁴ that:

"The process of civil litigation itself subjects the memories of witnesses to powerful biases. The nature of litigation is such that witnesses often have a stake in a particular version of events. This is obvious where the witness is a party or has a tie of loyalty (such as an employment relationship) to a party to the proceedings. Other, more subtle influences include allegiances created by the process of preparing a witness statement and of coming to court to give evidence for one side in the dispute. A desire to assist, or at least not to prejudice, the party who has called the witness or that party's lawyers, as well as a natural desire to give a good impression in a public forum, can be significant motivating forces."

41. Leggatt J considered the process of preparation for trial and its impact on human memory. He concluded:⁵

"In the light of these considerations, the best approach for a judge to adopt in the trial of a commercial case⁶ is, in my view, to place little if any reliance at all on witnesses' recollections of what was said in meetings and conversations, and to base factual findings on inferences drawn from the documentary evidence and known or probable facts. This does not mean that oral testimony serves no useful purpose - though its utility is often disproportionate to its length. But its value lies largely, as I see it, in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness

⁴ At para 19.

has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth”.

42. It may be that I would have to place more reliance upon the contemporaneous medical and other records, allowing for what appears to be the common cause deficiency of those records (an aspect that I deal with in more detail later in this judgment), than on the plaintiff's version.

THE EXPERT WITNESSES AND THE MEDICAL RECORDS

43. The plaintiff called the following expert witnesses:

- 43.1. Prof Smith (neonatologist);
- 43.2. Dr Hofmeyr (specialist obstetrician / gynaecologist);
- 43.3. Dr Gericke (specialist paediatrician / geneticist);
- 43.4. Prof Andronikou (radiologist); and
- 43.5. Professor Nolte (nursing specialist).

44. The defendant called two expert witnesses:

- 44.1. Prof Cooper (neonatologist); and
- 44.2. Dr Marishane (specialist obstetrician / gynaecologist).

45. Joint minutes were prepared as between the respective experts, i.e. as between:

- 45.1. the neonatologists, Prof Smith and his counterpart Prof Cooper;

⁵ At para 22.

⁶ Subsequently applied in a personal injury case in *AB v Pro-Nation Ltd* [2016] EWHC 1022 (QB).

45.2. the specialist obstetricians / gynaecologists, Dr Hofmeyr and her counterpart Dr Marishane;

45.3. the radiologists, Prof Andronikou and his counterpart Dr Weinstein;

45.4. Dr Gericke (specialist paediatrician / geneticist) and Prof Bolton (specialist paediatrician);

45.5. the nursing specialists, Prof Nolte and his counterpart Dr Du Plessis; and

45.6. the paediatric neurologists, Prof Solomons for the plaintiff and Dr Mogashoa for the defendant.

46. A comparison of the experts who prepared joint minutes (following upon their expert summaries) with the experts who testified in the trial shows that neither of the paediatric neurologists for the parties testified nor did any of the defendant's experts other than Prof Cooper and Dr Marishane.

47. Certain agreed issues between the respective experts had been recorded in some of the joint minutes, as well as in certain instances their disagreements. This is particularly so in respect of the joint minutes of Professors Smith and Cooper, of Prof Solomon and Dr Mogashoa and of Prof Andronikou and Dr Weinstein. In other instances, the joint minutes were less useful, in some instances being little more than excerpts from the respective experts' reports and in other instances no more than recordals of what had been stated in medical records, without what appears to be any meaningful engagement between the experts on the issues.

48. Before the commencement of the trial, the defendant was invited by the plaintiff to accept the agreements concluded between the opposing experts, as envisaged in the judgment of *Bee v Road Accident Fund* 2018 (4) SA 366 (SCA).⁷

⁷ At paras 64 to 74.

Where the parties engage experts who investigate the facts, and where those experts meet and agree upon those facts, a litigant may not repudiate that agreement “*unless it does so clearly and, at the very latest, at the outset of the trial*”.⁸

49. The defendant’s response to this invitation as recorded in the most recent joint practice note was “[t]he Defendant does not repudiate the agreements reached by the experts but, the Plaintiff still has to prove the foundational facts and the basis of opinions expressed by the expert”.

50. I am not certain as what this response is intended to convey but as it transpired during the trial, no attempts were made by either of the parties to repudiate or move from the agreements as were recorded in the joint minutes (save for the plaintiff in one respect, as appears below).

51. The plaintiff sought shortly before the commencement of the trial before me to deliver a supplementary summary by her paediatric neurologist, Prof Solomons, to which the defendant objected on the basis that it was late and prejudicial. In light of the objection, the plaintiff elected to abandon reliance on that supplementary report. What the plaintiff did do instead was to place on record that whereas previously its expert, Prof Solomons, had disagreed with certain views that had been expressed by his counterpart, Dr Mogashoa, and as recorded in paragraphs 6 and 7 of their joint minute, Prof Solomons was now in agreement with those views, save in a minor respect.⁹ Previously contested evidence now was uncontested.

52. Prof Solomons had previously expressed his expert view that an HII had only occurred intrapartum and that postnatal HII was excluded. The change brought about by the concessions made on record in relation to the opinion of Dr Mogashoa was that now the plaintiff accepted that in addition to her contention that there was

⁸ Rogers AJA in *Bee* para 64 citing Sutherland J in *Thomas v BD Sarens (Pty) Ltd* [2012] ZAGPJHC 161 at para 11.

⁹ That minor aspect was a continued disagreement that there had been no meconium staining of liquor.

intrapartum HII, that there were also two subsequent episodes of hypoxia, particularly in the NICU. The defendant persisted that the only HIIs were postnatal.

53. This shift in the plaintiff's case from her pleaded case of an intrapartum HII towards embracing a case based upon the common cause HII that took place postpartum in the NICU would be of significance, as will be seen later in this judgment.

54. As a matter of terminology, I was informed by counsel, a distinction needs to be drawn between an "*insult*" and an "*injury*". An injury may result from an insult, but an insult will not necessarily give rise to an injury.¹⁰ Therefore, the defendant contends, that although there may have been both intrapartum and postpartum insults, those insults did not result in injury (and more particularly brain-damaging injury), until the sentinel event that occurred in the NICU on 28 November 2012 around 19h00. On the other hand, as the plaintiff's case developed, she contended that there were brain-damaging injuries (and not just insults) both before and after birth.

55. As stated, only one factual witness was led, namely the plaintiff herself. While some of the expert evidence was based upon her factual evidence, particularly her case history as conveyed to the experts, most of the expert evidence was expression of opinion based upon what was recorded in the medical records, predominantly a series of what was intended to be contemporaneous notes made by the medical personnel at the hospital who attended upon the plaintiff and her new-born child, particularly the attending doctors and nurses.

56. The doctors' and nurses' contemporaneous progress notes were extensively referred to by the experts in their testimony. It appears that these notes are contemporaneous in the loose sense that they were made more or less around the recorded times in the notes but self-evidently what is described as having occurred at a specific time relates to a period more or less around the recorded time, as many of the notes are, for example, at half-hourly increments.

¹⁰ I note that this distinction was made by an expert in *AN v MEC, Eastern Cape* below in para 56.

57. Early in the trial I enquired whether further factual witnesses would be led, envisaging that one or other of the parties would call the medical personnel who actually attended upon the plaintiff at the clinic and then upon the plaintiff and her baby at the hospital, during both the intrapartum and postpartum periods, and who had made the contemporaneous notes. As stated above, the defendant had recorded that it still required the foundational facts upon which the plaintiff's experts relied to be proven.

58. These nurses and doctors' notes on which much reliance would be placed by the experts in expressing their opinions identified the authors of those notes, such as the attending doctors.

59. In response to my query, I was informed by counsel that no further factual witnesses would be called, including any of the attending doctors or nurses.

60. Ordinarily, the litigants' legal teams will have engaged with each other during trial preparation to consider and reach agreement on what is colloquially described as the status of the documents, dealing with such issues as authenticity of the documents¹¹ and generally the status of those documents for purposes of the trial. I therefore raised with the parties at the commencement of the trial what the status of the medical records was, especially the doctors' and nurses' notes given that these doctors and nurses as the authors of their manuscript notes would not be called. As it did not appear that the parties had engaged with each other squarely on this issue, I at their counsels' request stood down the matter to enable them to engage on the issue.

61. The parties then agreed as follows in relation to the status of the hospital, medical and related documents, which I set out verbatim:¹²

¹¹ See Uniform Rule 37(6)(k).

¹² Caselines section 020:1.

61.1. the documents are what they purport to be and that it is not necessary that the content of the entries in the documents must be confirmed in evidence by the authors of the entries;

61.2. the authenticity of the documentation is accepted, and copies thereof can be used in court;

61.3. the experts employed by both the parties will be at liberty to express their opinions in evidence, as set out in their respective reports and joint minutes, regarding the interpretation of the contemporaneous notes contained in the said documents.

62. The following features of this agreement between the parties are notable:

62.1. the parties accept the documents for what they are and in particular do not dispute the authenticity of the documents. This distinguishes the status of these documents from, for example, those in the Supreme Court of Appeal decision of *AM obo KM v MEC for Health, Eastern Cape*¹³ to which the defendant's counsel referred, where in that matter the documents had been falsified in certain respects and where certain objections had been pertinently made to the correctness and authenticity of those records;

62.2. the parties have agreed to admit what is effectively hearsay evidence. This is clear from their agreement that *"it is not necessary that the contents of the entries in the documents must be confirmed in evidence by the authors of the entries"*. This is reinforced by their recordal that the experts would be permitted to express their opinions regarding the interpretation of the contemporaneous notes contained in the documents.

¹³ [2018] ZASCA 141 (1 October 2018).

63. The medical records, and especially the contemporaneous notes by the medical personnel who are not called to testify, would constitute hearsay evidence and would ordinarily be inadmissible as the probative value of that evidence depends upon the credibility of a person other than the person giving such evidence. In this instance, the probative value would be dependent upon the authors of the notes, who would not be called.¹⁴

64. The parties may agree to admit what would otherwise be inadmissible hearsay evidence. Section 3(1)(a) of the Law of Evidence Amendment Act, 45 of 1988 provides as an exception to the inadmissibility of hearsay evidence where *“each party against whom the evidence is to be adduced agrees to admission thereof as evidence at such proceedings”*.

65. Apart from the parties having formally agreed on the admissibility of hearsay evidence, neither party during the course of the trial raised any concern that much of the evidence upon which their experts relied in expressing their opinions was hearsay evidence.

66. While the parties' agreement to admit otherwise inadmissible hearsay evidence addresses the admissibility of that evidence, the separate issue of the probative value of that evidence remains. As will appear below, in several instances there was a lively debate between the respective experts pertaining to what was to be made of what the author of a particular contemporaneous note intended to convey. To put it simply, experts were offering differing views as to what they thought another person had meant when that other person had written a particular note. It is self-evident that the probative value of evidence led by an expert as to what another person (who in their own right were probably also experts) may have meant when he/she recorded something is questionable.

67. On the other hand, many of the entries in the medical records were uncontentious, such as the recordal of various medical test results and so the

¹⁴ *AM obo KM v MEC for Health, Eastern Cape* above at para 13.

experts readily accepted the correctness of those entries and then proffered their experts' views on what was to be made of those uncontentious entries.

68. I do not propose dealing in detail with the evidence of the experts but shall rather refer to such evidence as is necessary for purposes of this judgment.

69. Where I refer to the views expressed by the experts in their expert reports and/or joint minutes, this is not to be taken as being a reference exclusively to that report and/or joint minute (i.e. to the document) as the source of the evidence). The experts who testified did confirm under oath their reports and joint minutes, save where they otherwise indicated. In other instances, I have had regard to the agreements reached by the experts in their joint minute.¹⁵

70. I shall deal first with the hypoxic ischaemic injuries (the HII) that that took place postpartum in the NICU as those, in my view, are determinative of the defendant's liability.

THE POSTNATAL HYPOXIC ISCHAEMIC EVENTS IN THE NICU

71. Following the minor child's birth on 28 November 2012 at 11h10, she was admitted to the ward,¹⁶ having *inter alia* low Apgar scores.

72. At 13h00, while in the ward, the minor child, having been diagnosed at that stage with birth asphyxia¹⁷ and aspiration pneumonia, was "*still quite distressed*".¹⁸ The attending doctor's note records that there was no bed available "*at the moment*" in the NICU but a baby in the NICU was to be extubated, i.e. a bed in the NICU would soon become available.

¹⁵ *Bee v Road Accident Fund* above, at 386C: "*Unless the trial court itself were for any reason dissatisfied with the agreement and alerted the parties to the need to adduce evidence on the agreed material, the trial court would, I think, be bound, and certainly entitled, to accept the matters agreed by the experts.*"

¹⁶ It is unclear precisely which ward, but it was clearly not the NICU.

¹⁷ Abbreviated on occasion in the notes as "BA".

¹⁸ Doctor's progress notes at 006-54.

73. The nursing notes for 13h30 record *inter alia* that the minor child's condition continued to be distressed (skin colour cyanosed, floppy, foaming and nose flaring), that urgent chest x-rays were needed and if there was no improvement the baby was to be transferred to the NICU.¹⁹

74. The attending doctor's note for 14h00 records a still distressed baby, who was "*still gasping*" and had desaturated in oxygen levels to less than 70%.²⁰ The baby was "*manually bagged with Neopuff*", which was explained in evidence as a form of manually assisted breathing. Notably there is a recordal of "*thick pussy secretions*", which Prof Cooper for the defendant would opine is consistent only with infection. The baby is also recorded as being intubated²¹ by the attending doctor. A continuation of the note²² records that there are "*thick and mucoid [mucus-containing] bloodstained*" secretions, and there appears to be a suggestion of "*aspirated liquor*".

75. By 14h30 it appears from the notes that the minor child had not improved as she was transferred from the ward to the NICU and placed upon mechanical ventilation. Chest X-rays were taken.²³ At that stage, the attending doctor's diagnosis remained birth asphyxia and "*aspiration pneumonia*".²⁴

76. By 15h00 the attending doctor had evidently examined the X-rays as he recorded in his notes that they showed "*severe changes and hyperinflation*".²⁵ His note continues "*NB mother has been explained about severe pneumonia / Birth asphyxia*".

77. This diagnosis requires some elaboration.

¹⁹ Nurse's progress notes at 006-118.

²⁰ Doctor's progress notes at 006-54.

²¹ Intubation is the insertion of a tube into the trachea for the purposes of assisted ventilation.

²² At 006-53.

²³ Doctor's progress note at Caselines 006-53.

²⁴ See the heading on the doctor's notes at 006-52.

²⁵ Doctor's progress note at Caselines 006-53.

78. The plaintiff's contention is that the minor child's condition was caused by birth asphyxia, more particularly from hypoxia (inadequate oxygen to the brain) caused by prolonged labour. This birth asphyxia was, according to the plaintiff, of such a severity as to result in a hypoxic ischaemic injury (HII) sufficient to result in the condition, in contrast to a hypoxic ischaemic insult that may not have brain-damaging consequences.

79. The plaintiff contends that by the time the minor child was admitted to the NICU she had already suffered an HII of sufficient severity to have resulted in irreversible brain damage (and the condition as described). The plaintiff contends that this HII had taken place already during labour (intrapartum).

80. The defendant's case was that although the minor child may have suffered from a hypoxic ischaemic insult (in contrast to a hypoxic ischaemic injury) during labour, that insult may at most may have resulted in 'some' damage but not sufficient to have caused a hypoxic ischaemic injury of sufficient severity to result in the condition.

81. The defendant further disputed that any hypoxic damage to the foetus had been caused by prolonged birth (and so disputed that there had been birth asphyxia insofar as that is intended to be a reference to birth asphyxia caused by prolonged birth²⁶) but that if there was such damage it had been caused by congenital pneumonia (i.e., pneumonia contracted by the foetus *in utero* from the mother). The defendant's argument continued that its medical personnel could not be found negligent in relation to damage caused by congenital pneumonia as that damage was not preventable.

²⁶ Dr Marishane in testifying as an expert special obstetrician and gynaecologist for the defendant expressed reservations as to the use of the term "birth asphyxia" as it was somewhat of a generic term that may have differing shades of meaning. My understanding of the use of the term by the parties in these proceedings, particularly the plaintiff, was that it was a diagnosis of hypoxia (lack of oxygen to the brain) brought about by the consequences of prolonged labour and birth, rather than brought about by some other cause such congenital pneumonia.

82. It is therefore not surprising that much was made in the experts' evidence of this recorded diagnosis by the attending doctor, at that stage, at 15h00, of "severe pneumonia / Birth asphyxia".

83. It was understood by the experts that it was around that point that the attending doctor, in addition to birth asphyxia, diagnosed congenital pneumonia, in contrast to his earlier diagnosis recorded in his notes²⁷ of aspirant pneumonia.²⁸

84. The approach taken by the plaintiff was to dispute the attending doctor's diagnosis of severe congenital pneumonia, asserting through her experts both in their expert summaries and joint minutes, and during the trial that it was a misdiagnosis.

85. The defendant on the other hand advanced the case that the attending doctor's diagnosis of congenital pneumonia was correct, and that this inflammatory disease of the lungs was to blame for the hypoxic injury to the minor child, and that its medical personnel could not be blamed for damage caused by the disease.²⁹

86. I am therefore required to decide on the probabilities whether the diagnosis of congenital pneumonia was correct, insofar as it is relevant to the issue of liability.

87. The experts appear agreed that the attending doctor in recording his diagnosis had done so having had examined the minor child's chest x-rays, as

²⁷ See the header to the doctor's notes for 13h00 and 14h00 on 28 November 2012, at 006-54, 006.53.

²⁸ Aspirant pneumonia is lung infection caused by the foetus breathing in (aspirating) liquid (such as meconium-bearing amniotic fluid) rather than infection contracted from the mother as is the case with congenital pneumonia.

²⁹ Neethling Potgieter Visser *Law of Delict* 6th edition LexisNexis (2010) at p 25 fn 4 makes the point that delictual liability requires a "damage-causing event" which is "a factual situation (consisting of a human act and surrounding circumstances) giving rise to damage". Damage caused by a disease that is not a result of negligence cannot give rise to delictual liability. Hence the defendant's case that the damage was caused by pneumonia. The plaintiff does not seek to demonstrate that the defendant's negligence was responsible for the foetus contracting pneumonia. To the contrary, the plaintiff disputes the diagnosis of pneumonia altogether.

recorded in the note of 15h00. The experts disputed whether the attending doctor had correctly interpreted those x-rays, and particularly whether those x-rays supported a diagnosis of congenital pneumonia. Prof Smith for the plaintiff testified that the attending doctor had misinterpreted the x-rays and so had misdiagnosed congenital pneumonia. Prof Cooper for the defendant disagreed that the attending doctor had misdiagnosed.³⁰

88. Useful would have been the expert witnesses, particularly the radiologists, expressing their expert opinions on the x-rays. But the x-rays were not adduced into evidence, without any real explanation given for their absence. The attending doctor, although readily identifiable, was not called to give evidence on the issue. Instead the expert witnesses Prof Smith for the plaintiff and Prof Cooper for the defendant were left to testify as to what the attending doctor may have meant when he recorded that the x-rays showed “*severe changes and hyperinflation*”.

89. Prof Smith for the plaintiff in his testimony expressed uncertainty as to what the attending doctor meant when he recorded “*severe changes*”. In contrast, Prof Cooper testified that healthy lungs would show black on x-rays in contrast to diseased or compromised lungs that would show white streaks on x-rays, and so that what the attending doctor meant when he recorded “*severe changes*” was changes from black to white, consistent with lung infection.

90. Prof Cooper explained that meconium is essentially dark fecal material produced by the foetus before birth, which can find its way into the amniotic fluid, and that this can be inhaled (aspirated) by the baby around the time of delivery. This could then cause aspirant pneumonia, and which would show on chest x-rays. As described above, until that stage the attending doctor’s diagnosis had been that of aspirant pneumonia, along with birth asphyxia.

91. But, Prof Cooper testified, as there was no evidence of meconium-stained secretions, meconium aspiration (i.e. aspiration pneumonia) could not have been the

³⁰ See Smith’s paragraph 17.5 at 009-15 and Cooper’s corresponding Cooper paragraph 17.5 at 009-17.

cause of the whitened lungs reflected on the x-rays. And so Prof Cooper concluded that in his expert opinion that “*severe lower respiratory tract infection (pneumonia) is the only credible diagnosis*”, that is a diagnosis of congenital pneumonia.

92. This opinion of Prof Cooper is recorded several times in the joint minute of Profs Smith and Cooper,³¹ disagreeing with Prof Smith’s opinion that the attending doctor’s narration of “*severe changes and hyperinflation*” was “*a picture unlike that seen with pneumonia and more likely to be found with aspiration and air-trapping and/or with the application of excessive levels of positive end-expiratory pressure (PEEP, set on a ventilator)*”.³²

93. Prof Cooper then continued to explain that the attending doctor’s observation of hyperinflation of the lungs is noteworthy. Prof Cooper explained that hyperinflation is effectively an over-inflation of the lungs, which is typically caused by the oxygen being pumped into the baby’s lungs mechanically, and the secretions caused by the pneumonia infection then preventing efficient exhalation, resulting in over-inflation. Prof Cooper therefore opined that this is consistent with a diagnosis of pneumonia.

94. Prof Cooper further testified that in his view this also demonstrated that the attending doctor had significant experience in interpreting x-rays as it took considerable experience to be able to detect hyperinflation, and so credence must be given to that doctor’s diagnosis. This, Prof Cooper reasoned, countered Prof Smith’s opinion that the attending doctor may have misinterpreted the x-rays as being indicative of congenital pneumonia.³³

95. Prof Smith proffered his expert view that a misdiagnosis of pneumonia in newborns is not unusual as there were studies evidencing the probable over-diagnosis of neonatal pneumonia.³⁴ While Prof Cooper agreed that congenital pneumonia may be over-diagnosed, he stood firm that in the absence of meconium-

³¹ Such as in paras 17.5, 17.7 and 17.11 at Caselines 009-17, 18.

³² Para 17.5 at 009-15.

³³ Joint minute para 17.7 at Caselines 006-16.

³⁴ Joint minute para 17.11 at Caselines 009-16.

stained liquor, if severe changes are seen on a chest x-ray in a term infant severe pneumonia is the only credible diagnosis.³⁵

96. A difficulty is that two experts (Professors Smith and Cooper) are disagreeing on what to make of another person's recordal (the attending doctor's recordal) of what that other person observed and concluded when examining the x-rays. The probative value of this evidence is dependent upon the credibility of the attending doctor. The hearsay nature of this evidence is plainly evident. Although the parties have agreed to admit hearsay evidence, and have expressly agreed that both parties are at liberty to express their opinions in evidence regarding their interpretation of the contemporaneous notes of the doctors and nurses, this kind of evidence has limited probative value in enabling a court to reach a finding,

97. Nonetheless this is part of the playing field upon which the parties have deliberately chosen to litigate their dispute, as appears from their recordal as to the status of the contemporaneous notes, and so I take account of this evidence in assessing where the probabilities lie.

98. The Supreme Court of Appeal in the oft-cited *Michael and another v Linksfield Park Clinic (Pty) Ltd and another* 2001 (3) SA 1188 (SCA) cautioned³⁶ that a court is not to decide a case by simply expressing a preference for a particular expert's view where there are conflicting views on either side, both capable of logical support. Rather the opinions should be assessed as to whether they are founded on logical reasoning,³⁷ and then for the court to make a finding, on a review of all of the evidence, where the balance of probabilities lie.³⁸

99. Making allowance for the hearsay nature of the evidence and its limited probative value, I find the reasoning of Prof Cooper on this issue more persuasive. His explanation was more thorough than that of Prof Smith, such as accounting for

³⁵ Joint minute para 17.11 at Caselines 009-18.

³⁶ Para 26.

³⁷ *Michael* para 36.

³⁸ *Oppelt* para 11 at 332G.

the exclusion of aspirant pneumonia because of the absence of meconium-stained liquor. Ultimately from the evidence led in the trial there was no dispute that there was an absence of meconium-stained liquor,³⁹ although the experts differed on what to make of that.

100. Further, as already described, Prof Smith reasoned that what was described by the attending doctor was *“more likely to be found with aspiration and air-trapping and/or with the application of excessive levels of positive end-expiratory pressure (PEEP), set on a ventilator”*. “Air-trapping” is nonetheless consistent with a diagnosis of pneumonia, for the reasons described by Prof Cooper as to how pneumonia can cause over-inflation by compromising exhalation following mechanical pumping of air into the baby’s lungs. There is evidence of mechanical pumping of air preceding the taking of the x-rays, as appears from the attending doctor’s note at 14h00 that there was manual pumping with a Neopuff before admission to the NICU.⁴⁰ In contrast, the over-ventilation described by Prof Smith as the result of settings on a ventilator (Prof Smith expressly refers to a ventilator) could only have occurred once the baby was placed on the ventilator in the NICU, which was only at 14h30 when it appears that the x-rays were taken. On the probabilities, it is more likely that the hyperinflation was caused at an earlier stage, such as in the manner described by Prof Cooper.

101. This diagnosis of congenital pneumonia from the x-rays is supported by further evidence. The common cause evidence is that from birth the medical personnel observed thick pussy, mucoid (i.e. containing mucus) bloodstained secretions.⁴¹ I have already referred to the attending doctor’s notes recording this following the admission of the minor child to the ward.

102. The defendant’s experts testified that this was indicative of congenital pneumonia. Prof Cooper was emphatic in this evidence that pussy secretions can only be caused by infection, in this instance congenital pneumonia.

³⁹ Although the plaintiff did not admit an absence of meconium-stained liquor, there was no recordal of meconium-stained liquor in the medical records.

⁴⁰ At 006-54.

⁴¹ To be distinguished from meconium-stained secretions.

103. Prof Smith's opinion was that the excessive lung secretions were indicative of moderate to moderate-severe asphyxia where the autonomic nervous system had been affected by hypoxia and that the bloodstaining of the secretions is explained by *"left ventricular dysfunction causing lung odema"*.⁴² Prof Smith continued that *"the recording of copious creamy, blood-stained and/or mucoid secretions"* was consistent with autonomic nervous system (dis)function and *"not necessarily in keeping with secretions relating to possible pneumonia"*⁴³.

104. Prof Cooper strongly disagreed in his expert view, opining that had there already been moderate to moderate-severe asphyxia where the autonomic nervous system was affected by hypoxia and with lung oedema, as opined by Prof Smith, this would have caused secretions that would have been clear and watery, and not thick, mucoid and bloodstained.

105. I find Prof Cooper's reasoning more persuasive, especially that the presence of pus in the secretions as demonstrative of infection, in this instance congenital pneumonia. Prof Cooper's reasoning accounts for the multiple narrations on the notes of thick, mucoid and bloodstained in a persuasive manner with reference to pus-causing infection. In contrast, Prof Smith's explanation is more in the nature of seeking to "explain away" the mucoid secretions by a hypothesis of what might, rather than what probably did, have caused them.

106. The plaintiff argued, and reasoned, that because the plaintiff as the mother had displayed no symptoms of being infected with pneumonia, both before and after the birth, that she was not suffering from pneumonia and so could not pass on congenital pneumonia infection to her baby. The defendant's experts on the other hand point out that it is not at all unusual for a mother to be asymptomatic, i.e. not show any signs of pneumonia yet still have pneumonia and then transmit that infection to the foetus. Prof Cooper referred to an American study in Dallas where up to 43% of babies diagnosed with congenital pneumonia in a test case had mothers who were asymptomatic. In my view the absence of any symptoms in the mother is

⁴² Joint minute para 18 at 009-18, 19.

⁴³ Joint minute para 19 at 009-19, 20.

not in and of itself sufficient to outweigh the other evidence that is indicative of the baby having congenital pneumonia.

107. The plaintiff's experts, especially Prof Smith, proffered views as to why each of the indications of pneumonia may be explained by something other than pneumonia (for example, that the thick mucoid bloodstained secretions were caused by a compromised autonomic nervous system brought about by hypoxia and lung oedema, and that the X-rays may have been misdiagnosed as pneumonia). I prefer, where the test to be applied is that of the balance of probabilities, the line of reasoning that where multiple indications points to a particular outcome (in this instance congenital pneumonia), that such outcome has been established on the probabilities, rather than finding that because each indication can be explained away when viewed individually, this precludes the finding of the outcome to which those factors point cumulatively. But even if the approach is adopted that the indications can also support, when considered cumulatively, a diagnosis of birth asphyxia caused by prolonged labour, I find, for the reasons set out above, the evidence of Prof Cooper to be more persuasive on this point, and that the indications, on the probabilities, are more consistent with a diagnosis of congenital pneumonia, than not.

108. Therefore, on a balance of probabilities, I find that the diagnosis of congenital pneumonia is established.

109. Returning to the chronology established by the attending doctor's notes, his note of 15h00 goes on to record improved levels of oxygen saturation at 93%, which I understand from the evidence not overly concerning.

110. After this entry by the attending doctor at 15h00, there is no other entry, whether in the nurses' notes or the doctors' notes for a period of some three hours. The next entry by a nurse is at 18h00⁴⁴ and by the attending doctor at 18h30.⁴⁵

⁴⁴ Caselines 006-107.

⁴⁵ Caselines 006-52.

111. Prof Smith explained that it is not unusual for the attending doctor not to have made more frequent notes because an attending doctor would not necessarily make notes on an hourly or more frequent basis as he may be attending to as many as eight patients and so absent a noteworthy incident, might only make a note some three or four times in a 24-hour period. This can be contrasted to the nurses, where close monitoring of the baby is required in an intensive care unit.

112. Prof Cooper accepted that close monitoring by nurses was required in the NICU. Prof Cooper continued though that the absence of any note by the nurses in the nursing notes was not necessarily indicative of a failure to closely monitor the baby. This is because in an intensive care unit there were other records available, such as the ICU charts which would record various measurements and the like on an hourly, if not more frequent basis. But those charts are missing and so there is no recorded evidence whether or not there was close monitoring of the baby over that 3-hour period by the nursing staff.

113. While it is so that the absence of records or even of inadequate note-taking does not demonstrate that the baby herself was not adequately monitored (save insofar as adequate note-taking or record-keeping itself is considered as part of adequate monitoring), it is also not proof that there was close monitoring. Given the statutory obligation of the defendant to ensure there was proper retention of the medical records,⁴⁶ this deficiency in documentation and record-keeping cannot rebound to the detriment of the plaintiff when making a legal (as contrasted to a strictly logical) assessment on the probabilities. This is especially so where no explanation was proffered, such as by a factual witness, of what became of the documents. It cannot be in the interests of justice to reason that a plaintiff is unable to discharge the onus of proof on a particular issue such as negligence because no one knows whether the missing documents that the defendant was obliged to maintain may exonerate the defendant from negligence.⁴⁷ It may also be that depending on the circumstance an adverse inference is to be drawn against the

⁴⁶ See sections 13 and 17 of the National Health Act, 2003 as discussed by Spilg J in *Khoza v MEC for Health and Social Development, Gauteng* 2015 (3) SA 266 (GJ), para 34 to 36.

⁴⁷ *Khoza v MEC* above para 47 at 279D.

party that should have but did not adduce the documents, namely that the documents if produced would have supported the adversary's position.⁴⁸

114. To continue with the narrative, the attending doctor's note at 18h30⁴⁹ reads "*restless child. Pulled out tube. Full of clots. Desaturation to 70. Reintubated with [illegible] 3.5*". The note continues, including with what appears to be a request for repeat X-rays.

115. The nurse's earlier note marked 18h00⁵⁰ confirms that "*baby extubate[d] herself*" and that the attending doctor was called immediately, and whereafter the baby was re-intubated.

116. It is unclear upon a reading of both the doctor's and nurse's note precisely when the baby extubated, i.e. when she "*pulled out [her] tube*". But what can be gathered from a reading of the notes together is that the extubation had occurred by at least 18h30, and probably at some point after 18h00.

117. When Prof Cooper was pressed whether it could be ascertained from the notes how the long the baby had been extubated before it was discovered, he agreed that this could not be ascertained from the notes. He however opined that this could not have been for too long because the saturation levels immediately after the baby was reintubated at 18h30 were at 70, which although low, were not such as to cause brain damage and that this demonstrated that the baby could not have been extubated for too long.

118. Although the plaintiff's counsel contend in their heads of argument that this extubation was a hypoxic ischaemic injury of its own, I do not find that on the available evidence that this incident of self-extubation is a self-standing and independent cause of hypoxia sufficient to cause the condition.

⁴⁸ *Khoza v MEC* above para 47 at 279E.

⁴⁹ Caselines 006-52.

⁵⁰ Caselines 006-107.

119. What was common cause between the parties in relation to this narrated self-extubation is that the tube had become blocked through thick blood-clotted secretions, which had caused the baby to struggle to breathe and that in her resultant restless movements she ended up “*pulling out*” the tube. This then raises the question that but for the baby’s struggles to breathe, and so stay alive, whether any medical personnel would have noticed her struggles.

120. The defendant proffers the thesis that the absence of any notes for the three-hour period from 15h00 to 18h00 does not prove that there had not been close monitoring of the baby in the NICU and that it may be that it was because of that close monitoring the nurses noticed that the baby had extubated, and so could take urgent steps to re-intubate the baby by calling for the attending doctor to do so.

121. The plaintiff’s thesis on the other hand is that if it had not been for the baby’s struggles to breathe and stay alive, her breathing difficulties and more particularly the blocked tube would have gone unnoticed.

122. I will return to these competing theses shortly.

123. I move on to what the parties accepted was a sentinel (catastrophic) event at 19h00. The attending doctor’s notes⁵¹ showed that he was called to the NICU as saturation levels had fallen below 70 and, importantly, there had been a bradycardia and a need for cardiac massage.

124. The parties were agreed that this was a sentinel (or catastrophic) event. It is this sentinel event that the defendant asserts was a hypoxic ischaemic event of sufficient severity to cause the “acute profound” HII reflected on the MRI scans and to result in the brain-damaging condition. The defendant’s case is that this is the condition-causing injury, and it cannot be held responsible for that injury.

125. The attending doctor’s notes at 19h30 continue that the endotracheal tube remained in place but there was no air entry and no chest movement with bagging.

⁵¹ Caselines 006-52, 53.

The tube was then removed and found to be blocked with thick secretions. The baby was then re-intubated, presumably the tube having been cleared or replaced.

126. It appears from the notes that it was these recorded thick secretions that had blocked the endotracheal tube, which prevented the baby from receiving oxygen and which resulted in the bradycardia and, on the defendant's version, the brain-damaging HII.

127. The plaintiff's case, at least by the time the trial commenced and as became more evident as the trial progressed – about which I say more later – was that this blockage of the endotracheal tube by secretions while the baby was in the NUCI – was caused by the medical personnel's wrongful conduct in failing to take adequate steps to prevent (or mitigate) the risk of the blockage where they had been forewarned since the baby's birth that the baby was expelling thick secretions, and so much so that the baby had self-extubated some 30 to 60 minutes earlier (somewhere between 18h00 and 18h30) because of thick secretions blocking the endotracheal tube.

128. On the defendant's version, it is the blocked endotracheal tube incident that caused the injury that led to the condition. The defendant disavows that its negligence caused the blocked tube.

129. Cameron J in *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC)⁵² reiterated that the long-standing test for negligence continues to apply in the field of medical negligence:

"[106] In our law Kruger⁵³ embodies the classic test. There are two steps. The first is foreseeability — would a reasonable person in the position of the defendant foresee the reasonable possibility of injuring another and causing loss? The second is preventability — would that person take reasonable steps to guard against the injury happening?"

⁵² At 106 to 107 (footnotes omitted).

⁵³ *Kruger v Coetzee* 1966 (2) SA 428 (A)

[107] *The key point is that negligence must be evaluated in light of all the circumstances. And, because the test is defendant-specific ('in the position of the defendant'), the standard is upgraded for medical professionals. The question, for them, is whether a reasonable medical professional would have foreseen the damage and taken steps to avoid it. In Mitchell v Dixon⁵⁴ the then Appellate Division noted that this standard does not expect the impossible of medical personnel:*

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

[108] *This means that we must not ask: what would exceptionally competent and exceptionally knowledgeable doctors have done? We must ask: 'what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible'. Practically, we must also ask: was the medical professional's approach consonant with a reasonable and responsible body of medical opinion? This test always depends on the facts. With a medical specialist, the standard is that of the reasonable specialist."*

130. The classic *Kruger v Coetzee* test is set out more fully set out in *Politis NO v Member of the Executive Council for Health, Limpopo*.⁵⁵

"[49] ... The test for negligence set out in Kruger v Coetzee 1966 (2) SA 428 (A) at 430E-G, could thus never be met. It reads as follows:

⁵⁴ 1914 AD 519 at 525

⁵⁵ [2017] ZASCA 86 (2 June 2017), as cited by Van der Linde J in *Khoza v MEC: Health and Social Development* 2017 JDR 1912 (GJ), para 6.

'For purposes of liability culpa arises if –

(a) a diligens paterfamilias in the position of the defendant –

(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and

(ii) would take reasonable steps to guard against such occurrence; and

(b) the defendant failed to take such steps.

This has been constantly stated by this Court for some 50 years. Requirement (a)(ii) is sometimes overlooked. Whether a diligens paterfamilias in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend on the particular circumstances of each case."

131. It would be during the evidence-in-chief of the plaintiff's expert neonatologist Prof Smith, who was called as the plaintiff's second witness after the plaintiff herself had testified, that he proffered his view towards the end of his examination in-chief that the blocked endotracheal tube was "*reasonably preventable*". The defendant's counsel did not raise any objection that this proffered opinion in examination-in-chief may fall outside the ambit of his expert report and the neonatologists' joint minute and of what had been pleaded by the plaintiff. Rather the defendant's counsel in cross-examination sought to explore this issue further and elicited the following evidence from Prof Smith.

132. The question was put to Prof Smith in cross-examination how he would have managed the tube to prevent it from being blocked. Prof Smith answered that once the baby was intubated and the air humidified, an order should have been issued by the attending doctor to the nursing staff in the NICU to regularly suction the tube. The frequency of such suctioning is dependent upon the secretions. The defendant's

counsel continued to probe this issue in her cross-examination, eliciting the evidence from Prof Smith that in this instance given the history of thick mucoid secretions that the suctioning protocol should have been every 10 to 15 minutes, at least from the time that the baby had self-extubated at around 18h30. Prof Smith therefore under cross-examination reaffirmed his expert opinion given during evidence-in-chief that the blockage of the tube was “*reasonably predictable and reasonably preventable*”.

133. The defendant’s counsel continued to explore this issue when leading her first witness, being the defendant’s expert neonatologist, Prof Cooper. The question was put to Prof Cooper whether the sentinel event that took place at 19h00 was preventable. Prof Cooper explained that this was not preventable because the endotracheal tube which is placed into the trachea can only go down so far into the respiratory system because if it goes too low it will cause trauma to the soft tissue. Prof Cooper reasoned that the suction could not go down low enough to where the congenital pneumonia had infected the cells which were causing the secretions. If I understand this reasoning correctly, Prof Cooper is explaining that suctioning of the secretions could not take place at source but only once the secretions had made their way up the respiratory system to where the endotracheal tube could safely reach.

134. Prof Cooper was further asked by defendant’s counsel in examination-in-chief how often suctioning should take place. He answered that this depends on the secretions but if there are lots of secretions, then every 10 to 15 minutes. In this respect he agreed with the evidence of Prof Smith that regular suctioning was required every 10 to 15 minutes and that “*in this matter, no question that the baby needed frequent suctioning*”.

135. Prof Cooper continued to reason in his examination-in-chief that the tube as extubated at 18h30 was found to be blocked and then again the tube was found to be blocked at 19h00, when the sentinel event took place. This accords with the attending doctor's notes. Prof Cooper continued that during this half-an-hour period, using a suction frequency of every 10 to 15 minutes, there should have been at least two additional episodes of suctioning of the tube to prevent blockage.

136. Prof Cooper continued that all this would be doing is unblocking the endotracheal tube, but the secretions would continue to come from lower down in the respiratory system where the pneumonia infection was, and that this continuous upward movement of secretions could not be prevented.

137. Importantly, Prof Cooper then continued that while nothing can be done about this continued upward movement of secretions from source, *"you can only do something about this once in the tube"*.

138. This immediately begs the question how often was suctioning then done as Prof Cooper agrees that this is something that could have been done to clear the tube and that it should be done every 10 to 15 minutes.

139. Prof Cooper stated that as the NICU charts were missing, it could not be ascertained how often this suctioning had been done.

140. Prof Cooper in his reasoning in his evidence-in-chief then goes on to make the following assumption:

"I am assuming that they [the nurses] must have been doing suction because firstly they know there were lots of secretions and secondly as they just had had a major event".

141. Prof Cooper therefore continued that he *"refused to accept that they were not suctioning the baby"*, and that blocked tubes are a recognised event in NICU and the smaller the tubes the more likely it will be blocked.

142. But, as Prof Cooper himself correctly characterises, this is an assumption. Prof Cooper assumes that the nursing staff must have been doing such suctioning but there is no evidence that they actually did so. Whether the medical personnel failed to do so, on a balance of probabilities, is a central issue to be decided in establishing whether the defendant was negligent, and cannot simply be answered by an assumption in favour of the defendant.

143. It is hardly surprising that this issue as canvassed in examination-in-chief would be taken up by the plaintiff's counsel in the cross-examination of Prof Cooper. During cross-examination Prof Cooper confirmed that there should have been at least two episodes of suctioning in the half-an-hour period between 18h30 when the self-extubated tube was found to be blocked and the sentinel event at 19h00. Prof Cooper persisted that he would be very surprised if it did not happen as any reasonable nurse would be suctioning as required. Prof Cooper agreed that intensified monitoring was required, and that very vigorous attention was necessary towards unblocking the baby's airway.

144. Prof Cooper testified in response to the question put to him whether he agreed that if this was not done, this would show gross substandard care, that he did so agree, more particularly if the suctioning of the endotracheal tube was not done.

145. Prof Cooper also agreed that since birth there was evidence of thick secretions, and that suctioning was taking place to assist the baby in her breathing.

146. Where Prof Cooper did not agree with the propositions being put to him in cross-examination was that he would not accept that the nurses had not undertaken that suctioning. But, as set out above, this is an assumption.

147. Applying the classic *Kruger v Coetzee* test, on the first leg I find that on the probabilities reasonable medical personnel in the position of the attending doctor and the NICU nursing staff would have foreseen the reasonable possibility that a failure to regularly suction the endotracheal tube may lead to a blocked tube, and so to the condition-causing HII.

148. There were warning signs from the minute the baby was born that she was struggling and was in distress and required close monitoring.⁵⁶ Thick secretions were present from birth, and by 15h00 the attending doctor had made a diagnosis of congenital pneumonia. The attending doctor, and the nurses in the NICU, knew that the minor child was suffering from congenital pneumonia (in addition to birth asphyxia) and was expelling thick pussy secretions.

149. It is clear from the evidence that the baby was from the time of her first difficult breath at 11h10 signalling her distress and calling for assistance. She persisted in signalling her distress for several hours from 11h10 to 14h30 when she was admitted to the NICU. Then when again presenting with breathing difficulties caused by the blocked tube, it was only her struggles that dislodged the tube. By that stage, it should have been plainly clear to the nursing staff that the baby required close monitoring and tube-suctioning, and that should they not do so, the tube may be became blocked again with thick secretions.

150. In my view there was more than a reasonable possibility that the tube may again become blocked, and cause an HII. The self-extubation incident of less than 30 to 60 minutes earlier caused by just such a blocked tube was a stark warning that this may happen.

151. Turning to the second leg of the *Kruger v Coetzee* test, would reasonable medical personnel in the position of the attending doctor and NICU nurses have taken steps to prevent, or at least reasonably guard against, the endotracheal tube becoming blocked. This, in my view, has been satisfied on the probabilities.

152. Prof Smith testified that a suctioning protocol should have been issued, i.e. that the attending doctor should have issued an instruction to the nursing staff in the NICU as to the frequency of the suctioning. There is no evidence that such a

⁵⁶ This appears from the multiple narrations in the attending doctors and nurses' notes such as that the baby did not cry at birth, had (relatively) low Apgar scores, was "gasping", was pink in colour when on oxygen but blue when not on oxygen, needed to be assisted in breaching with nasal prongs, and was floppy.

protocol was issued, and therefore that the nurses were told that they needed to undertake such suctioning. No issue of protocol is recorded in either the attending doctor's or nurse's notes, and neither the attending doctor nor any other factual witness was called by the defendant to explain whether a protocol had been issued, and if so, why it had not been recorded in the notes. It would have been expected that the issue of such a protocol would have been recorded both in the doctor's progress notes and the nursing progress notes if it had been issued.

153. It may even be that in the absence of the doctors having issued such a suction protocol, the nurses may not have been aware that they were to engage in frequent suctioning of the baby's endotracheal tube.

154. But what is clear is that both the neonatologists Professors Smith and Cooper were agreed that the baby needed to be closely monitored, particularly after the self-extubation incident, and that vigorous suctioning was required at 10 to 15 minute intervals.

155. It is in relation to the third leg of the classic *Kruger v Coetzee* test that the parties differed, namely whether the defendant's medical personnel took the reasonable steps of closely monitoring the baby, checking for a blocked endotracheal tube and undertaking regular suctioning at 10 to 15 minutes, and especially in the period between the self-extubation incident and the sentinel event somewhere between 30 to 60 minutes later.

156. As I have described above, Prof Cooper's evidence was a resolute refusal to accept that the nursing staff had not done this. But a resolute refusal to accept that the nurses had not done so is not evidence of any probative value, assuming it is evidence at all. Prof Cooper is an expert witness called after the event – he is not a factual witness who can testify first-hand to what happened that day, and during that period between 18h00 to 19h00, in the Tembisa Hospital. It did not even appear from his evidence that he could testify as to what the position generally is in the NICU of the Tembisa Hospital.

157. The defendant did not call the factual witnesses who could have testified as to what had happened in the NICU, and particularly during the fateful hour or so. This would have included the attending doctor and the nurses on duty, although they were identifiable. The defendant did not give an explanation why those witnesses were not called, or even whether they were unavailable.

158. As stated, there is no evidence that close monitoring of the baby took place. An argument that the absence of medical records can redound to the benefit of the defendant because if those records were consulted it may show that such accurate monitoring did take place is in my view to be rejected, for the reasons given by Spilg J in *Khoza v MEC for Health*.⁵⁷ It may equally be that those missing records, if found, will prove that there was no close monitoring. As already found, the rest of the evidence shows on the probabilities that there was a failure to closely monitor the baby. The possibility that the missing records might show otherwise is not sufficient to counter the probabilities going the other way.

159. The need for the defendant to call factual witnesses is even more acute where there is a paucity of records, either because records that were kept have gone missing (such as NICU charts) or because of inadequate record (note) taking. As Van der Linde J put it in *Khoza*:⁵⁸

“I do not see the distinction in principle between a case where a defendant who is obliged to do so, discovers hospital records, comprehensive and complete as it happens, fully to tell what had occurred while the patient was under its care, and the case where a defendant discovers hospital records, completely lacking in any relevant respect, completely obscuring what had occurred while the patient was under its care. In the former case, the plaintiff is able properly and fully to instruct his or her experts; in the latter case not so. How can it be that the defendant who fails to comply with accepted standards of record-keeping, is allowed to benefit from its own

⁵⁷ Above (2015 (3) SA 266 (GJ)).

⁵⁸ Above (2017 JDR 1912) para 25.

remissness by declining to call viva voce evidence to supplement the inadequate record?"

160. Just as Van der Linde J could not in *Khoza*,⁵⁹ I cannot avoid the words of Lord Justice Brooke⁶⁰, quoted by Ponnann JA in *Goliath v Member for the Executive Council for Health, Eastern Cape* 2015 (2) SA 97 (SCA):⁶¹

"It is likely to be a very rare medical negligence case in which the defendants take the risk of calling no factual evidence, when such evidence is available to them, of the circumstances surrounding a procedure which led to an unexpected outcome for a patient. If such a case should arise, the judge should not be diverted away from the inference of negligence dictated by the plaintiff's evidence by mere theoretical possibilities of how that outcome might have occurred without negligence: the defendants' hypothesis must have the ring of plausibility about it."

161. Van der Linde J continued:⁶²

"[29] The proposition can also be put this way: the fact of the unexpected and unusual event of cerebral palsy following an otherwise uneventful labour and birth, does not of itself justify the inference of negligence; but it does place a duty on the defendant to call the witnesses who were there and can therefore likely explain what happened, if it wishes to avoid the risk of a finding being made that in all the circumstances of the case, the staff were more probably than not causally negligent in relation to the resultant consequence.

⁵⁹ Above, para 28.

⁶⁰ In *Ratcliffe v Plymouth and Torbay Health Authority* [1998] EWCA Civ 2000 (11 February 1998), para 48.

⁶¹ Para 17.

⁶² At para 29. My emphasis.

[30] Here the plaintiff was, by all accounts, of healthy state of mind and body as she went into the procedure. She subjected herself to a procedure that is a common occurrence in hospitals and clinics across the country. No-one expected a cerebral palsied baby to be born. The records that the hospital in fact kept, were way sub-standard. It justifies the inference, absence an explanation, that the plaintiff was as poorly monitored [as]⁶³ the records that were kept. These circumstances called for an explanation, in my view; and in the absence of an explanation, on all the evidence that was presented to the court, the defendant's staff failed properly to monitor the plaintiff's progress through labour and in delivery."

162. In my view, the present case is a *fortiori*: here the medical personnel in the NICU were forewarned of the baby's precarious position and that the endotracheal tube may become blocked and that the baby required close monitoring and the tube frequent suctioning, having been so signalled since birth and by the stark warning of the self-extubation shortly before the sentinel event.

163. I have previously referred to the two competing theses in relation to whether it was the baby's struggles that had alerted the nursing staff to the self-extubation rather than any close observation of the baby at the time. The plaintiff's thesis is that it was the baby's struggles that alerted the nurses to her breathing difficulties rather than any close observation by the nursing staff, which is consistent with a finding of negligence. The NICU was working at full capacity: it is common cause that the NICU was full as the baby had to wait some 90 minutes before being able to be admitted to the NICU once a need to admit her had been identified. The probabilities are that the nurses were working at full stretch. This explains why it was only when the baby was struggling to breath to such an extent that she pulled out her tube that the nurses reacted. It also lends support to a finding on the probabilities that once the baby had been re-intubated, and particularly in the absence of any evidence of a suctioning protocol having been issued by the attending doctor, that the nurses then

⁶³ The judgment reads 'and' but this appears to be a typographical error as otherwise it does not make grammatical sense.

did not again attend to the baby, including to closely monitor her, and so did not perform any suctioning as required over the next half an hour or so before the sentinel event.

164. In my view, the probabilities are that the medical staff had failed to take the necessary reasonable steps to prevent the condition-causing HII.

165. The test for negligence has been satisfied, on the available evidence, and particularly in the absence of any exculpatory documentary evidence or any exculpatory evidence from factual witnesses evidently available to the defendant but not called.

166. I now turn to whether that negligence factually and legally caused the HII constituted by the sentinel event at 19h00 on 28 November 2012.

167. The SCA in *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA)⁶⁴ held in relation to factual causation that:

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

168. And in *Minister of Finance and Others v Gore* NO 2007 (1) SA 111 (SCA), the SCA held⁶⁵ that:

“Application of the ‘but-for’ test is not based upon mathematics, pure science or philosophy. It is a matter of common sense, on the practical way in which the ordinary person’s mind works against the background of everyday-life experiences.”

⁶⁴ At para 25.

⁶⁵ At para 33.

169. While it might be that the tube would have become blocked even if there had been frequent suctioning, and that as a matter of pure logic, it cannot be said that but for the absence of suctioning there would not have been a sentinel event as the secretions might have been so copious that it would have blocked the tube regardless, I am not required to engage in an exercise of metaphysics or strict logic in evaluating these issues but rather on a common sense basis and in applying probabilities.

170. Applying a common-sense basis and on the probabilities. I am satisfied that factual causation has been established. 'But for' the omission of the medical personnel, particularly over the 30 to 60 minutes from the self-extubation incident to the sentinel event at approximately 19h00, to closely monitor the baby, to issue a suctioning protocol, and to then execute that suctioning protocol, the endotracheal tube probably would not have become blocked and the HII would have probably been avoided.

171. I am also satisfied that the legal requirements for legal causation have also been satisfied. The negligent conduct is sufficiently closely or directly linked to the loss for legal liability to ensue i.e. it is not too remote.⁶⁶ There are no considerations of policy that militate against a finding that negligent conduct in an NICU of a hospital leading to a blocked endotracheal tube which in turn causes an HII of sufficient severity to result in severe cerebral palsy should not be visited with legal liability on the basis that the negligent conduct is too remote from the harm so caused.

172. I therefore find that the defendant has established causative negligence on the part of the medical personnel for whom the defendant is responsible.

173. What requires some consideration is whether it is open for the plaintiff to succeed in demonstrating causative negligence in relation to the postpartum HII that took place in the NICU, in contrast to an intrapartum HII. The plaintiff in her particulars of claim pleaded that the minor child suffered the HII "*[a]s a result of the prolonged labour, a lack of attention and medical care as may be reasonably*

⁶⁶ *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (AD) at 700I.

required in the circumstances, and in particular to timeously perform a Caesarean Section to deliver the Minor".⁶⁷ The grounds of negligence relied upon, although pleaded somewhat generically, relate to labour and delivery and in particular the performance of a caesarean section.

174. By the time the trial started, the plaintiff's case had progressed from those pleadings in that in both the plaintiff's opening address, both written and oral, the hypoxic ischaemic injuries that she relied upon had expanded to both "*before and after birth*". At the commencement of his opening address, the plaintiff's senior counsel specifically pointed out that the plaintiff sought to establish negligence at two stages, being intrapartum and postpartum. The plaintiff's counsel set out the respects in which the plaintiff contended that there had been intrapartum negligence and then continued to describe the contended for postpartum negligence. This included specific reference to the sentinel event that took place at 19h00 in the NICU when the endotracheal tube was blocked. This reliance on postpartum causative negligence continues in the plaintiff's heads of argument.

175. Throughout there was no objection from the defendant's counsel that the plaintiff was going beyond the pleaded case or that the defendant was being taken by surprise.

176. This expansion by the plaintiff of its case was already evident in the plaintiff's expert, Dr Solomons, making common cause at commencement of the trial with the defendant's expert and his counterpart, Dr Mogashoa, that there was evidence of a postpartum HII, as discussed above.

177. I have also described how the defendant's counsel fully explored this expanded case, first in the cross-examination of the plaintiff's witnesses, and in particular the neonatologist Prof Smith, and then in leading the defendant's expert neonatologist, Prof Cooper.

⁶⁷ Particulars of claim para 7 at 002-5.

178. I do not recall any objection by the defendant throughout the trial at this expansion of the plaintiff's case, whether in the opening address of the plaintiff, or during the evidence of the plaintiff's witnesses, or during the defendant's opening address, or during the examination of the defendant's witnesses or even in closing argument.

179. Scant regard was had by either of the parties to the pleadings. I cannot recall any particular reference to the pleadings throughout the trial, whether by way of seeking to constrain the case to those pleadings or otherwise.

180. Given the cursory regard had by the parties to the pleadings, it appears that a departure of the case from the pleadings, whatever inconvenience it may have had for the court, did not concern either of the parties, and in particular the defendant.

181. As oft-cited from *Robinson v Randfontein Estates Gold Mine Co Ltd* 1925 AD 173:⁶⁸

"The object of pleading is to define the issues; and parties will be kept strictly to their pleas where any departure would cause prejudice or prevent fully enquiry. But within those limits the court has a discretion for pleadings are made for the court not the court for the pleadings".

182. The SCA in *EC Chenia and Sons CC v Lamé and Van Blerk* 2006 (4) SA 574 (SCA) pointed out that the question as to whether to permit a party to go beyond its pleaded case was one of prejudice.⁶⁹ One of the factors to be considered is whether there was any objection raised at the trial to a case going beyond the pleadings. As appears from *EC Chenia*:⁷⁰

"If counsel really believed that this evidence was irrelevant and thus inadmissible because it was not covered by the pleadings, he should have objected there and then. The plaintiff could then have tried to persuade

⁶⁸ At 198.

⁶⁹ At para 13.

⁷⁰ At para 15.

the trial court that the evidence was indeed covered by the pleadings or, otherwise, sought an amendment. A party cannot be allowed to lull its opponent into a false sense of security by allowing evidence in the trial without objection and then argue at the end of the trial, or on appeal, that such evidence should be ignored because it was inadmissible. It seems to me that when the defendant's counsel decided not to challenge both the admissibility and substance of Da Silva's evidence, he took a calculated risk and any possible prejudice resulting from such failure must be ascribed to the realisation of that risk and not to the plaintiff's departure from its pleadings".

183. A person can further be prejudiced by a case that goes beyond the pleading if that expanded issue is not investigated fully. Where the issue is fully canvassed in evidence and the parties have had ample opportunity to deal with the point when it arose out of the evidence, that the issue may not have been pleaded need not stand in the way of a determination being made on that issue.⁷¹

184. *Moody v Crossman* 1969 (3) SA 121 (N) was an instance where the relevant issues may not have been sufficiently raised in the pleadings. The court found⁷² that this notwithstanding, *"however, extrinsic evidence was led without objection in the court a quo and this was canvassed and sought to be countered both in cross-examination and counter-availing evidence. In these circumstances, the issues between the parties must be taken to have been enlarged to include those canvassed in the court a quo"*.

185. The court then referred to the following dictum of the then Appellate Division in *Shill v Milner* 1937 AD 101:⁷³

"This preliminary portion of Mr Ramsbottom's argument consists largely of an examination of the ipsissima verba of the pleadings. While listening

⁷¹ See, for example, *John Williams Motors Ltd v Minister of Defence* 1966 (3) SA 27 (A) at 32C-D.

⁷² At para 122 E.

⁷³ At p105.

to him, however, I could not but ask myself what the substantial issue was between the parties in the court below. The importance of pleadings should not be unduly magnified. 'The object of pleading is to define the issues; and parties will be kept strictly to their pleas where any departure would cause prejudice or would prevent full enquiry. But within these limits the court has a discretion. For pleadings are made for the court, not the court for the pleadings. Where a party has made every facility to place all the facts before the trial Court and the investigation into all the circumstances has been as thorough and as patient as in this instance, there is no justification for interference by an appellate tribunal merely because the pleading of the opponent had not been as explicit as it might have been.' Robinson v Randfontein Estates Gold Mine Co Ltd 1925(AD 198. In another case, Wynberg Municipality v Dreyer 1920 AD 443, an attempt was made to confine the issue on appeal strictly to the pleadings, but it was pointed out by Innes, C.J., that the issue had been widened in the court below, by both parties. 'The position should have been regularised of course,' he said, 'by an amendment of the pleadings; but the defendant cannot now claim to confine the issue within limits which he assisted to enlarge'."

186. The present case can be distinguished from that in the very recent decision of the Constitutional Court in *TM obo MM v MEC for the Executive Council for Health and Social Development, Gauteng*⁷⁴ where both the Constitutional Court as well as the majority and minority judgments in the Supreme Court of Appeal found that the issue of wrongfulness had not been raised on the pleadings.⁷⁵ In fact, wrongfulness was not a disputed issue on the pleadings.⁷⁶ In both the High Court and the Supreme Court of Appeal the debate was whether there was negligence and causation.

⁷⁴ [2022] ZACC 18 (30 May 2022). The majority and minority decisions of the Supreme Court of Appeal are *The MEC for Health & Social Development, Gauteng v TM obo MM* [2021] ZASCA 110 (10 August 2021).

⁷⁵ See, for example, the SCA majority decision at para 58 to 68.

⁷⁶ There had been a stated case, where the issues to be adjudicated were negligence and causation: see para 13 of the minority decision in the SCA.

Wrongfulness was assumed and was not an issue before those courts.⁷⁷ And so, the Constitutional Court found, it was impermissible for that undisputed issue of wrongfulness to be relied upon during the course of an appeal to the Constitutional Court as a constitutional issue engaging that court's jurisdiction.⁷⁸ The Constitutional Court therefore declined to grant leave to appeal. In the present instance, the issue of causative negligence had at all times been the live issue between the parties, both on the pleadings and during the course of the trial.

187. Considering the manner in which the trial was conducted, which included the parties' scant regard to the pleadings, the consistent failure of the defendant to object to the expansion of the plaintiff's case to rely on postpartum HII, the defendant's thorough cross-examination of the plaintiff's expert neonatologist on the issue, the defendant's own leading of evidence in-chief on the issue and the defendant having already foreshadowed that such expansion might arise in already stating in the expert summary of Prof Cooper that no negligence can be ascribed to the postpartum HII,⁷⁹ it is open for a finding to be made of causative negligence arising from the postpartum HII, as I have done.

THE ASSERTED INTRAPARTUM HYPOXIC ISCHAEMIC EVENT

188. Having found that the defendant is liable in damages to the plaintiff arising from the hypoxic ischaemic injury that took place postpartum in the NICU, it is unnecessary to deal with the plaintiff's further asserted (and pleaded) case that a HII sufficient to result in the condition had already been sustained intrapartum. Nonetheless, to the extent that it may be of significance and as it affects the costs of some of the experts, I deal with certain aspects thereof.

189. It is necessary for the plaintiff to prove on a balance of probabilities that there is a causal nexus between the conduct relied upon (whether by way of commission or omission) and the damage. Whether or not this causal nexus has been

⁷⁷ See Constitutional Court judgment para 51.

⁷⁸ See Constitutional Court judgment para 51 and 52.

⁷⁹ Paragraphs 22.2 and 22.3 of the joint minute at 009-21, 22.

established in a particular case is a question of fact that must be answered in light of the oral evidence and the relevant probabilities.

190. In deciding the issue of causation, it is necessary first to determine whether there is a factual causal nexus between the act (or omission) and the harmful consequences, and then if such factual causation is established, to consider whether legal causation has been established.

191. The exercise of considering factual causation is to ascertain whether the defendant's act or omission caused or materially contributed to the harm suffered.⁸⁰

192. Our courts in seeking to answer this enquiry apply the so-called 'but-for' test, which is described in *International Shipping* as:

“designed to determine whether a postulated cause can be identified as a causa sine qua non of the loss in question”⁸¹ and that “in order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such a hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss: aliter, if it would not so have ensued. If a wrongful act is shown in this way not to be a causa sine qua non of the loss suffered, then no legal liability can arise. On the other hand, demonstration that the wrongful act was a causa sine qua non of the loss does not necessarily result in legal liability. The second enquiry then arises, viz, whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is

⁸⁰ *AN on behalf of EN v MEC for Health, Eastern Cape* [2019] ZASCA 102 (15 August 2019), para 4.

⁸¹ At 700F. My emphasis.

basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes called 'legal causation'".⁸²

193. From this it is clear, and in any event, it is a matter of logic, that before consideration can be given as to whether causation has been established (whether factual or legal) it is necessary to identify the loss-causing event as only then is it possible to, for example, make the hypothetical enquiry as to probably what would have happened but for the wrongful conduct of the defendant.

194. In this instance, it is common cause that the condition occurred as a result of an acute-profound hypoxic ischaemic injury. What is not common cause is whether that acute-profound HII had already occurred intrapartum.

195. The plaintiff's case is that this acute-profound HII occurred during the intrapartum period, and so that by the time the subsequent injury-causing HII event (or events, as the case may be) occurred postpartum in the NICU, sufficient brain damage had already been caused to result in the condition. The defendant on the other hand contends that although 'some' hypoxic injury may have taken place intrapartum, it was not sufficient to constitute an acute-profound HII resulting in the condition, and that therefore the plaintiff has not proven that an acute-profound HII occurred intrapartum.

196. In the circumstances, it is first necessary for the plaintiff to prove on the probabilities that an acute-profound HII occurred intrapartum, as only once that is established can further questions be considered such as whether the wrongful act, which the plaintiff asserts, caused that loss, and does meet the requirements for causation.

197. The respective radiologists, Prof Andronikou and Dr Weinstein agree that "*the MRI demonstrates acute-profound HII that occurred in a term brain probably in the perinatal time period*".⁸³ Dr Weinstein goes further to state in the joint minute that in

⁸² At 700F-I.

⁸³ Joint Minute at 009-1.

his view the HII was mixed, i.e. that it was predominantly an acute-profound HII but had aspects of a prolonged HII.

198. While the plaintiff called its expert radiologist, Prof Andronikou, the defendant did not do the same in relation to its expert radiologist, Dr Weinstein.

199. Prof Andronikou testified that the assumption must not be made when considering whether a HII is an acute-profound HII that it can only occur over minutes (in contrast to a longer period), notwithstanding what is generally understood by an injury being “*acute*”. Prof Andronikou testified that an acute-profound HII could occur even if there was no sentinel (catastrophic) event and that it can occur over a few hours, rather than only a matter of minutes (but admittedly not days). Prof Andronikou testified that he no longer uses the descriptive adjective “*acute-profound*” in his expert reports and joint minutes⁸⁴ as it does result in confusion and the incorrect attribution to an acute-profound HII of a period of causation that is of minutes, where in his view that was not necessarily always so.

200. Although Prof Andronikou was challenged in cross-examination that his recent understanding of the use of the description “*acute-profound*” is not supported by Dr Weinstein, and is also contrary to the Supreme Court of Appeal’s view as what constitutes an acute-profound HII,⁸⁵ the defendant failed to call her expert radiologist, Dr Weinstein to proffer his opinion in rebuttal of that of Prof Andronikou.

201. That a court may have decided in a particular instance based upon a particular set of facts as to what constituted an ‘acute-profound’ HII in that matter does not mean that that court’s finding of what constitutes an acute-profound HII in that matter is then definitive for all matters going forward. Such a finding is a factual finding rather than a legal finding, and as the legal adage goes, each case depends on its own facts.

⁸⁴ When preparing the expert reports and minutes in this matter, in 2014 and 2016, Prof Andronikou still was using the description “acute-profound”.

⁸⁵ It is unclear to which judgment/s the defendant’s counsel was referring.

202. When, for example, in *AN v MEC, Eastern Cape*⁸⁶ Gorven AJA for the majority stated that “[a]cute means sudden, as opposed to developing over a period of time”⁸⁷ and that “[a]n acute profound event means a sudden, not progressive, event” in contrast to “[a] partial prolonged event”,⁸⁸ that was done with reference to the evidence placed before the court in that matter, including the expert opinion evidence.⁸⁹

203. As there are advances in medical research, what the medical profession may have considered to be an acute-profound injury can change, becoming potentially more expansive, or more restrictive. In this instance, Prof Andronikou explains himself that in his view a more expansive view must be adopted as to what would constitute an acute-profound HII sufficient to result in the condition and this includes damage that is caused over a period of a few hours rather than abruptly over a few minutes.

204. Prof Smith, the neonatologist for the plaintiff, adopted Prof Andronikou’s more expansive use of what is to be understood as an acute-profound HII and that this was occurred intrapartum and more particularly during the time 08h30 to 11h10 when no CTG monitoring of the foetus was taking place.

205. Prof Cooper, who is a neonatologist and not a radiologist, disagreed, persisting that an acute-profound HII follows a period of prolonged bradycardia of approximately 10 to 45 minutes, and not over the lengthy period suggested by Profs Andronikou and Smith and that, his reasoning continues, the only time when this could have happened was during the sentinel event described in the NICU as taking place at 19h00. In other words, the defendant persists that an acute-profound HII could not have occurred intrapartum as there was no sentinel or catastrophic event during that period that could account for an acute-profound HII.

⁸⁶ Above.

⁸⁷ Para 9.

⁸⁸ Para 13.

⁸⁹ In *AN v MEC, Eastern Cape* there was no dispute that there had been, intrapartum, a sudden, sustained total interruption of blood supply to the fetal brain (i.e., a sentinel event), whatever the nomenclature: see para 8, 9 and 17.

206. I am prepared to accept for present purposes, on the evidence before me and in the absence of the defendant adducing expert radiologist opinion in rebuttal of the expert opinion of the plaintiff's expert radiologist Prof Andronikou (whose expert evidence was sufficiently cogent that I cannot reject it as being logically flawed in reasoning or otherwise unsound),⁹⁰ that an acute-profound HII can occur over a lengthier period and that therefore it was possible for an acute-profound HII to have occurred during the unmonitored hours of the active phase of labour without the occurrence of a recognised sentinel event.

207. But having accepted for present purposes that this is so, this does not answer the anterior question, whether as a matter of probability, an acute-profound HII did in fact occur during that period of 08h30 to 11h10 on 28 November 2012 when there was no CTG monitoring of the foetus.

208. As a matter of fact, it is common cause between the parties that an acute-profound HII did occur by at least the sentinel event that took place in the NICU later that day after birth at 19h00. It is for the plaintiff in asserting a condition-causing HII intrapartum to prove that an acute-profound HII had already taken place before then, and more particularly, as pleaded in its particulars of claim, intrapartum.

209. Upon an assessment of the evidence, I am unable to find that on the probabilities it was more likely than not that an acute-profound HII had already occurred intrapartum. It might have occurred during the unmonitored hours immediately preceding the minor child's birth but then it also might have happened after the child was born but before her admission to the NICU. The plaintiff herself contended that after the child was born but before her admission to the NICU the medical personnel failed to properly and adequately resuscitate the minor child, who was clearly in distress from when she was born. And then there is also the possibility

⁹⁰ It appeared during the evidence of Prof. Andronikou that this issue of what constitutes an 'acute profound' HII is apparently a topical issue, with apparently conflicting views between experts and with what was said in relation to the topic in *AN v MEC, Eastern Cape* above as also *AM obo KM v MEC, Eastern Cape* above. It was therefore with some surprise that the defendant did not call the evidence of its expert radiologist Dr Weinstein to proffer his expertise this apparently topical issue, and so I was left only with the expert opinion of Prof. Andronikou.

that there was no acute-profound HII at all until the sentinel event in the NICU at 19h00.

210. It will be recalled that the primary case advanced by the plaintiff was that the acute-profound HII took place intrapartum, specifically asserting that postnatal hypoxic ischaemic injury was excluded. It would appear that it was the plaintiff's intention, at least initially, to call Prof Solomons to advance his opinion as to why the acute-profound HII took place intrapartum, and so prove this part of her case.

211. But Prof Solomons was not called, and so this evidence was not led. This may be explained by the adaption by the plaintiff of her position at the commencement of the trial to accept that there also was a postnatal HII.⁹¹ Although the parties accept that they are bound by the agreement expressed in the joint minute of the paediatric neurologists, Prof Solomons and his counterpart, Dr Mogashoa, as a consequence of Prof Solomons not being called, there is a paucity of evidence on whether the acute-profound occurred intrapartum rather than at some time thereafter.

212. Prof Solomons, in paragraph 7 of the joint minute records his opinion that "*the available evidence indicates that Kurhula's hypoxic ischaemic injury occurred in the intrapartum period*". His counterpart, Dr Mogashoa, disagreed.⁹²

213. Recourse to Prof Solomons' expert summary dated August 2016 in advancing his opinion why he was of the view that the HII occurred intrapartum does so with reference to two sets of criteria which he identifies for purposes of defining whether an acute intrapartum hypoxic event is sufficient to cause cerebral palsy. These are criteria he refers to as having been established by Volpe JJ, *Neurology of the*

⁹¹ See the subsequent concessions by the plaintiff's expert paediatric neurologist, Prof Solomons, in respect of paragraphs 6 and 7 of the joint minute, at 009-2 and 009-3.

⁹² Joint Minutes 009-3.

*Newborn*⁹³ and also those of the American College of Obstetrics and Gynaecology 2014 [“ACOG”]⁹⁴.

214. On applying the Volpe and ACOG criteria, he proffers his expert opinion that three out of the four criteria for intrapartum asphyxia insult are established.

215. The difficulty though, as set out above, is that Prof Solomons was not called to give his evidence in this regard, including to confirm his expert opinion proffered in his report and to afford the defendant an opportunity to test that expert opinion. The only evidence placed before me in this regard by Prof Solomons is that which is in the form of the issues as were agreed between Prof Solomons and his counterpart, Dr Mogashoa, in their joint minute. Those agreements do not include agreement on the hypoxic ischaemic injury having been caused intrapartum. To the contrary, Dr Mogashoa was of the view that the HII may have been caused by the postpartum incident in the NICU. It bears repeating that Prof Solomons’ initial view, and which remained his view until commencement of trial, is that a postnatal HII was excluded and the amendment of his view at the commencement of trial that he now agreed with Dr Mogashoa that there was a postnatal HII still leaves unresolved whether there was also an intrapartum HII.

216. In this regard, something can also be said about the reliance by the plaintiff’s experts on an Apgar score at 5 minutes at 6/10 as being indicative of an intrapartum HII.

217. The experts, who agreed that one of the AGOC criteria in assessing whether there had been an acute peripartum asphyxia incident, is as follows:

“Apgar score of less than 5 at 5 minutes and 10 minutes

1. Low Apgar scores at 5 minutes and 10 minutes clearly confer an increased relative risk of cerebral palsy. The degree of Apgar abnormality

⁹³ 4th Edition, 2001. WB Saunders Company.

⁹⁴ Neonatal Encephalopathy and Neurological Outcome, 2nd Edition. Report of The American College of Obstetricians and Gynaecologists Task Force on Neonatal Encephalopathy, 2014.

at 5 and 10 minutes correlates with the risk of cerebral palsy. However, most infants with low Apgar scores will not develop cerebral palsy.

2. There are many potential causes for low Apgar scores. If the Apgar score at 5 minutes is greater than or equal to 7, it is unlikely that peripartum hypoxia-ischemia played a major role in causing neonatal encephalopathy.”⁹⁵

218. It is common cause that the minor child had Apgar scores at birth recorded as 6/10 and 6/10 at 1 and 5 minutes respectively. The plaintiff’s experts interpreted this as satisfying the Apgar criterion as indicative of acute peripartum asphyxia. On the other hand, the defendant’s experts disagreed.

219. I must confess some difficulty in applying this criterion. While it is clear, in applying this criterion, that if the Apgar score is 5 or less, this is indicative of an acute-profound HII. It is also clear, in applying this criterion, that where the Apgar score is greater than or equal to 7, then it is unlikely that hypoxia ischaemia played a major role in causing the condition. But what of an Apgar score of 6/10 in applying the criterion? It is not clear to me what is to be made of such a score in applying this criterion, as is evidenced by the differing views of the experts as to whether this criterion was in fact met or not.

220. In the circumstances, at most, I find the application of this criterion indecisive.

221. In the absence of evidence that such indications as there may have been that certain of the remaining Volpe and/or ACOG criteria may have been satisfied (such as the need for resuscitation of the baby after birth not being attributable to the baby suffering from congenital pneumonia, as I have already found to be the case), adds to my inability to find on the probabilities that the acute-profound HII did occur intrapartum. As stated, this probably was going to be explored by the plaintiff more fully in the expert evidence of Dr Solomons, and perhaps his counterpart Dr Mogashoa for the defendant, but neither of these witnesses were called.

⁹⁵ Extracted from the report of Prof Cooper at 008-198.

222. In the circumstances, I am unable to find, on the probabilities, that an acute-profound HII occurred intrapartum sufficient to result in the condition. It is insufficient for there to have been some damage intrapartum as the case advanced by the plaintiff is that such injury as took place during the intrapartum period was sufficient to cause the condition. It is therefore irrelevant whether the defendant concedes that some damage was caused intrapartum but where the concession is not that such damage is sufficient to result in the condition.

223. As the plaintiff has failed to prove that there was acute-profound HII intrapartum, it follows that a consideration of what conduct or omission by the defendant's medical personnel may have caused that HII event and whether the defendant's medical personnel were at fault for that conduct is not only unnecessary but also unsound. Those further enquiries, such as causative negligence, must take place with reference to the loss-causing event and an analysis of those issues without reference to that event would be pointless.

CONCLUSION

224. The defendant is accordingly liable for such damages as the plaintiff may have suffered arising from the hypoxic ischaemic injury that took place postpartum in the NICU.

225. As the plaintiff succeeded, she is entitled to her costs.

226. The defendant did not raise any serious objection to the costs relating to the plaintiff's experts, including the qualifying and reservation fees of those experts, if any. As appears above, Prof Solomons did not testify and insofar as reservation costs are concerned, the trial was conducted virtually, which naturally provides more scope for the experts to mitigate such inroads as their required testimony may otherwise have made in relation to their practices. These are issues that the taxing master will take into account.

227. The evidence of the plaintiff's experts Dr Hofmeyr and Prof Nolte did not relate to the postpartum HII, but in seeking to establish causative negligence

intrapartum. As the plaintiff failed to establish the latter, the costs of the plaintiff's experts Dr Hofmeyr and Prof Nolte are disallowed.

228. The plaintiff included in her heads of argument various prayers in relation to the payment of taxed costs, more particularly in relation to the timing thereof and interest thereon should those costs not be paid. As full argument was not addressed to me as to why such prayers would be necessary where ordinarily these are not issues that are specifically addressed in the court order, I prefer not to make such orders.

229. The Deputy Judge President allocated ten days to this trial. As it turned out, through the efforts of both the plaintiff's and defendant's counsel, the evidence was completed within six days, and with argument taking place a few days later after the preparation of heads of argument. I express my gratitude to the parties and their legal teams in ensuring that the trial was completed within the allocated period.

230. An order is accordingly made as follows:

230.1. The defendant is liable for payment of 100% of the plaintiff's proven or agreed damages, in her representative capacity on behalf of the minor child, arising from the minor child's irreversible hypoxic ischaemic brain injury and neonatal hypoxic ischaemic encephalopathy, manifesting as resultant profound global mental delay, microcephaly and mixed cerebral palsy, suffered as a result of the negligence of the Tembisa Hospital on 28 November 2012.

230.2. The defendant is ordered to pay the plaintiff's costs in respect of the determination of the issue of liability, such costs to include:

230.2.1. the reasonable costs of obtaining the medico-legal reports of the following experts:

230.2.1.1. Dr Gericke – specialist paediatrician;

230.2.1.2. Dr Andronikou – specialist radiologist;

230.2.1.3. Dr Regan Solomons – paediatric neurologist;

230.2.1.4. Prof Smith – neonatologist.

230.2.2. the reasonable qualifying and reservation fees of these experts, if any;

230.2.3. the reasonable fees of these experts in respect of their preparation for and holding of joint expert meetings with their respective counterparts, if any, including the costs in respect of drafting and finalising joint minutes emanating from such meetings;

230.2.4. the costs consequent upon the employment of two counsel, where so employed.

230.3. The plaintiff's costs shall be paid into the trust account of the plaintiff's attorneys, MED Attorneys, details of which are as follows:

Mokoduo Erasmus Davidson Attorneys Trust Account

First National Bank, Rosebank Branch

Account Number: [...]

Branch Code: [...]

Gilbert AJ

Date of hearing: 16-20 May 2022
23 May 2022
26 May 2022

Date of judgment: 27 June 2022

Counsel for the Plaintiff: GJ Strydom SC and A Viljoen
Instructed by: MED Attorneys, Johannesburg

Counsel for the Defendant: N Makopo
Instructed by: The State Attorney