



**IN THE HIGH COURT OF SOUTH AFRICA
(EASTERN CAPE DIVISION, BHISHO)**

Case No: 242/2020

In the matter between:

PB obo IS

PLAINTIFF

and

**MEMBER OF THE EXECUTIVE COUNCIL
RESPONSIBLE FOR HEALTH IN THE EASTERN CAPE**

DEFENDANT

JUDGMENT

Bloem J

[1] The plaintiff, in her personal and representative capacity as mother and natural guardian of her child, IS, claims damages from the defendant, the Member of the Executive Council responsible for Health in the Eastern Cape, arising from harm allegedly suffered by her and her child, IS, when IS was born on 27 July 2008. The plaintiff's claim is that IS has spastic quadriplegic cerebral palsy and microcephaly.¹ The plaintiff's claim is that the injury to IS's brain was caused by the negligence of the medical practitioners and medical personnel (the medical personnel) at the Port Elizabeth Provincial Hospital (the hospital) who treated her on 27 July 2008.

¹ An abnormally small head size secondary to brain damage.

[2] At the commencement of the trial and at the request of the plaintiff, an order was made separating the issue of the defendant's alleged liability from the quantification of the plaintiff's damages, if any, with the trial proceeding on the former and the latter standing over for later determination.

[3] The parties agreed in a pre-trial minute dated 9 August 2023 inter alia that the documents, inclusive of hospital records relevant hereto are what they purport to be and that where a document, in the face of it, purports to have been created by any person, it shall be regarded as having been so created. The defendant discovered all the records kept at the hospital to which reference was made during the leading of evidence at the hearing. In *HN v MEC for Health, KZN*² it was held that recordings favourable to a plaintiff's case in establishing negligence and liability generally, and accordingly damaging to the defendant's case, made as part of the records kept by the defendant's servants, constitute admissions by the defendant's servants made in the ordinary course of discharging their duties, which are binding against the defendant. In the case of a hospital, the medical personnel are obliged to make these statements in the records to reflect the medical position as it unfolds. I respectfully align myself with the position articulated by Koen J in *HN v MEC for Health, KZN*. The plaintiff's expert witnesses were, in the circumstances, entitled to refer to and rely on the hospital records as part of the factual basis for their respective opinions.

[4] The plaintiff testified in support of her case. She also called three medical practitioners to testify. Andrew Redfern qualified as a medical practitioner in 2001, as a paediatrician in 2009 and as a developmental paediatrician in 2013. He is currently a senior lecturer and senior specialist in the Department of Paediatrics and Child Health in the Faculty of Medicine and Health Sciences at the University of Stellenbosch. Dr Redfern assessed IS on 5 September 2019 when he was 11 years old. The purpose of the assessment was to compile a report on the possible cause and timing of the neurodisability with which IS presents. At the time of the assessment, Dr Redfern was in possession of only the Road to Health Booklet, which was handed to the plaintiff when she and IS were discharged from hospital after his birth. After he had assessed IS, he

² *HN v MEC for Health, KZN* [2018] ZAKZPHC 8 paras 6-9.

was also placed in possession of a Magnetic Resonance Imaging (MRI) scan performed on IS on 6 September 2019 and the medico-legal report dated 10 September 2019 compiled by Jan Lotz, a neuroradiologist. The antenatal, maternity case records and neonatal records relating to IS were not available.

[5] Dr Redfern testified that on 5 September 2019, he interviewed the plaintiff and clinically examined IS. He reported that, from the interview, examination and the available documents, he established that the plaintiff presented to the hospital at about 08h00 on 27 July 2008, complaining of intermittent lower abdominal pains since about 07h00. After an assessment and after a cardiotocography (CTG) was performed on the plaintiff, she went into a room. She told him that she was not reassessed until approximately 14h00 when she called a nurse because she was experiencing stronger labour pains. She was advised to walk up and down. She called a nurse at about 15h00. She was taken to the labour ward where she positioned herself on a bed. A nurse advised her to push. IS was born at about 15h40.

[6] The plaintiff informed him that IS did not cry when he was delivered or at any stage in the early neonatal period, and he was placed in an incubator, on oxygen. He was fed through a tube. He was transferred to Dora Nginza Hospital, where he was admitted to the nursery. IS was in an incubator for about a week after delivery. The plaintiff described him as '*weak, just lying, not moving, not crying, doing nothing*'. He started to suck and breastfeed and showed increased movement at about eight days after delivery. He was discharged home during the second week of life.

[7] The plaintiff informed him that she noted that, at three months after birth, IS was less active than babies of a similar age. He sat at about two years of age and crawled at about 6 years. The postnatal records reflected that IS was admitted to Dora Nginza Hospital for pneumonia when he was about three years old. An entry was made in those records reading '*Prolonged labour and birth asphyxia. HIE*' (Hypoxic Ischaemic Encephalopathy). The clinic notes reflected that IS suffered from constipation and feeding issues in the past.

[8] Dr Redfern reported that his physical examination of IS revealed that his clinical findings were in keeping with microcephaly, spastic quadriplegic cerebral palsy and severe physical and intellectual disabilities. He testified that, through the physical examination, he established signs of cerebral palsy affecting all four of IS's limbs and his trunk. His abnormally small head was indicative of impaired growth of the brain caused by damage to it. IS had no dysmorphic features, meaning that IS did not present with features of a genetic syndrome, like Down Syndrome. IS also did not present with other neurological or metabolic conditions that could mimic cerebral palsy. The examination also showed stiffness in IS's muscles. The damage to IS's brain caused his muscles to become stiff. He also presented with risk reflexes, being inadequate control of the muscles and movements. IS had a slight drool. It means that the part of the brain which controls swallowing was damaged. IS was unable to communicate in any meaningful way other than crying. He did not seem to understand anything that was said to him. Dr Redfern testified about the importance of the MRI in the absence of the availability of the maternity case records and the neonatal records. The MRI scan supported his opinion that there was nothing pointing towards an early insult, an infection or a stroke. The MRI scan was consistent with prolonged intrapartum asphyxia.

[9] The fact that IS did not cry at birth, required oxygen and had low Apgar scores³ suggested to Dr Redfern that there was depression at birth. The history of depression at birth and the presence of neonatal encephalopathy after birth point towards the perinatal period (the period around the time of delivery) as the likely period when the brain injury occurred. He reported that the evidence, based on medical research, suggests that, when a neonatal encephalopathy is present after delivery, intrapartum factors can almost always be said to be the main cause of the encephalopathy. His opinion was that the low Apgar scores, the neonatal encephalopathy and the MRI findings collectively make intrapartum asphyxia causing HIE the most likely cause of IS's spastic quadriplegic cerebral palsy.

³ Dr Redfern testified that Apgar scores are recorded by the birth attendants to describe the condition of the baby at birth. Factors considered include the colour of the baby, whether the baby is breathing and at what rate (respiration), the baby's heart rate, whether the baby is crying and how active the baby is (response). In this case IS's Apgar scores were recorded as 5 in the first minute after birth, which is abnormally low; 5 in the fifth minute, which is also low and 6 in the tenth minute, which is also low.

[10] Dr Redfern subjected IS's symptoms to the criteria of the American College of Obstetricians and Gynaecologists (ACOG) and Volpe⁴ for the determination of the occurrence of intrapartum asphyxia. Dr Redfern preferred to rely on the criteria set out by Volpe. Volpe has suggested that intrapartum asphyxia is most likely to have occurred if foetal distress, depression at birth and neurological syndrome after birth (evidence of brain dysfunction) are present. Dr Redfern was of the view that two of those features were present in this case. Based on the then available documents, he was unable to determine whether foetal distress was present. Despite not knowing whether foetal distress was present, Dr Redfern concluded that there was sufficient information to conclude that intrapartum asphyxia causing HIE was the most likely cause of IS's cerebral palsy, because IS was depressed at birth and he presents with brain dysfunction. Dr Redfern stressed that his opinion might be confirmed or refuted if the maternal case records became available.

[11] The maternal case records indeed became available. On 29 July 2023 Dr Redfern was provided with neonatal records; obstetric records, including antenatal and maternal case records; and records from IS's hospital admission in 2011. The antenatal record did not reveal any pre-existing medical condition. The maternal case records showed that, when the plaintiff was examined at 09h40 on 27 July 2008, she was 1-2cm dilated and the foetal heart rate was normal; and a CGT was concluded at about 10h05. The plaintiff had three strong contractions in 10 minutes. The partogram was started at 13h00 when the plaintiff's cervix was 9cm dilated. Meconium⁵ was noted at 13h37. In a separate nursing entry in the maternal case records, the meconium was noted to be thick. The presence of meconium was a sign of foetal distress. When IS was born at 15h37, he was depressed and required resuscitation. It means that IS needed to be assisted with breathing. The plaintiff was given dextrose and oxygen (intrapartum resuscitation), which is indicative that there was concern about the foetal condition.

⁴ JJ Volpe's *Neurology of the Newborn* 6 ed (2018) Philadelphia, PA: Elsevier; is seen by many as the leading textbook on the neurology of babies.

⁵ Meconium is a stool passed by a newborn, usually after birth. When a foetus passes a stool while in utero, it is a sign that the foetus is in distress due to low levels of oxygen because of insufficient blood supply to the foetus.

[12] Dr Redfern concluded that the newly discovered records confirmed the presence of a prolonged moderate neonatal encephalopathy, the most likely cause thereof being HIE. The neonatal encephalopathy was secondary to intrapartum asphyxia. The presence of meconium-stained liquor and low Apgar scores are consistent with his opinion regarding the cause of the neonatal encephalopathy, namely intrapartum asphyxia. There was foetal distress, depression at birth and neonatal encephalopathy, all three criteria set out by Volpe for the determination of the presence of intrapartum birth asphyxia. Dr Redfern reported that the newly discovered records did not provide information that caused him to alter the opinion that he expressed in his original report. To the contrary, those documents confirmed that IS suffered HIE. The newly discovered documents did not suggest that there were any associated or contributing factors present, such as neonatal sepsis chorioamnionitis, nor any other avoidable factors, such as a perinatal sentinel event.

[13] The plaintiff testified that she realised that she was pregnant in November 2007 when she missed her menstrual period. She attended an antenatal clinic in February 2008 when she was four months pregnant. She returned to that clinic on the dates given to her. At no stage was she told that something was wrong with her or the foetus. She did not experience any form of trauma during her pregnancy before her admission to hospital.

[14] At approximately 05h00 on 27 July 2008 she felt lower back pains. She arrived at the hospital at approximately 09h00. The staff attended to her without delay. A CTG was performed. When a vaginal examination was performed, she was informed that her cervix was 2cm dilated. The two nurses who attended to her informed her that it would take some time before the child was born. At approximately midday she called the nurses because the pain became severe. After her vaginal examination, she was told that her cervix was 9cm dilated. The partogram showed that it was 13h00 when her cervix was 9cm dilated. She was told to walk up and down in the passage, which she did. When the pain became more severe, she was taken to the labour ward where a bed was allocated to her. One nurse asked her to open her legs and to push whilst the other nurse used her two hands to push the foetus in the direction of the birth canal. She estimated that exercise to have taken between 3-4 minutes.

[15] When IS was born at 15h40, he was not crying. The nurses called an ambulance.

She saw the nurses inserting nasal pipes and incubating IS. She and IS were taken to Dora Nginza Hospital at approximately 19h00 on that same day. She saw him only at about 03h00 on 28 July 2008 when she was told to go to the nursery. When she arrived at the nursery, she saw a pipe in IS's mouth. That was in addition to the nasal pipes. After changing his nappy, she left IS. She saw him again at 09h00 when a doctor was present. The doctor told her that IS was not the same as other babies and would take time to walk and speak. She and IS were discharged from hospital on 4 August 2008.

[16] The plaintiff testified that before they were transferred to Dora Nginza Hospital, IS did not latch onto her breasts. When she saw him at 03h00 on the day following his birth, she was not asked to breastfeed him. It was only when she met the doctor that he said that IS would be fed through a pipe. IS was taken from the incubator on 3 August 2008 when she was told that she could breastfeed him. He was able to breastfeed. The plaintiff testified that IS cannot crawl. He started bum shuffling after approximately five years. He cannot walk, have a conversation, wash, dress or feed himself.

[17] Constant Ndjapa-Ndamkou is a specialist gynaecologist and obstetrician who qualified as a medical practitioner in 1997, as a gynaecologist and obstetrician in 2013 and obtained various other qualifications, inclusive of a master's degree in obstetrics and gynaecology. He is a lecturer at the Charlotte Maxeke Academic Hospital in the Department of Obstetrics and Gynaecology.

[18] Dr Ndjapa⁶ confirmed that he interviewed the plaintiff and reviewed the Road to Health chart, hospital records as well as the reports prepared by Dr Redfern and Prof Lotz. He did not have the maternal case records in his possession when he compiled his initial report. To enable him to compile that report, he relied on the plaintiff's recollection of events; the entries in the then available hospital records and the presence of neonatal encephalopathy, which strongly suggested that, in his view, that intrapartum asphyxia was the most probable cause associated with IS's birth asphyxia. He was of the opinion that, despite the lack of clinical records, based on the information narrated by

⁶ Although his surname is Ndjapa-Ndamko, I shall refer to him as Dr Ndjapa, as he was referred to by the plaintiff, her counsel and the two medical practitioners. He also referred to himself as Dr Ndjapa.

the plaintiff and the presence of neonatal encephalopathy, IS's current condition was the result of substandard care during the intrapartum period. In his view the harm was preventable.

[19] After he had compiled his initial report, the clinical records, inclusive of the maternity case records, became available. Since the plaintiff was not monitored between approximately 10h00 and 13h00, it is unknown when the plaintiff went into active labour, which commenced when the plaintiff was about 4cm dilated, and why there was rapid dilatation during that period.

[20] The maternal case records also showed that at 13h37 thick meconium-stained liquor was discharged after the plaintiff's membranes ruptured spontaneously. It was recorded on the partogram that meconium-stained liquor was present at 14h00, 14h30 and 15h00. Dr Ndjapa testified that the presence of meconium suggested that the foetus was in distress, causing the plaintiff to be placed on dextrose saline and oxygen. What was very disturbing for Dr Ndjapa was the absence of the recording of foetal heart rate decelerations which were last recorded at 13h30. It therefore means that foetal heart rate deceleration was not excluded after 13h30. The absence of foetal heart rate deceleration recording after 13h30 suggested to Dr Ndjapa that, regard being had to how IS presented at birth, foetal heart abnormality may have been present, but went unnoticed, resulting in birth asphyxia. That would be consistent with the radiological finding of Dr Lotz and the neonatal findings of Dr Redfern. In the circumstances, Dr Ndjapa was of the view that, because there was no monitoring of the plaintiff between 10h00 and 12h50, the foetal heart rate abnormality may have occurred unnoticed over that period, resulting in birth asphyxia. That is the most probable cause of the harm to IS's brain, if regard is had to the presence of meconium which caused foetal distress and the absence of the recording of foetal heart rate deceleration since 13h30. He was of the view that foetal distress was evident at 13h37 with the appearance of meconium, requiring intrapartum resuscitation. He was of the view that, in addition to intrapartum resuscitation, the plaintiff should have been prepared for immediate delivery of her baby by the fastest route, being a caesarean section. Dr Ndjapa was of the view that had the plaintiff undergone intrapartum resuscitation with a view of performing a caesarean section, the outcome of birth asphyxia would in all probability have been prevented.

[21] Prof Lotz qualified as a specialist in radiology in 1980. He testified that the human brain evolved over millions of years. Initially there was only the reptilian brain. The vital centres of life (that is all the aspects that keep humans alive, like breathing, heartbeat and swallowing) are centred in the reptilian brain. The mammalian brain developed around reptilian over millions of years. It controls things like increased smell. The human brain developed around the reptilian and mammalian brain. It helps to make contextual sense of life around us. The reptilian brain, which is surrounded by the mammalian and human brains, is still alive. The human brain is dormant until the child is about three or four years old, when it starts making contextual sense of life. Before, during and after birth the human brain is less important. What is controlling breathing and other vital centres of life during that period is the reptilian brain.

[22] Under normal circumstances the various brains are adequately supplied with blood and accordingly oxygen. If, for one reason or the other, there is a reduced supply of oxygen to the foetus, its automatic redistribution mechanism is activated. Blood supply to certain organs, like the kidneys, liver and skin, will be shunted off and channelled to the reptilian, mammalian and human brains. The reduced supply of oxygen to the foetus will cause foetal distress. When a foetus is in distress, the heart rate is increased and the heart contracts differently during and after contractions. The foetal distress will be removed if the oxygen supply is restored. If the insufficiency or lack of oxygen were to persist, there would be less or no more oxygen to be channelled from other organs to the brains. The blood supply to the human brain will then be shunted off since the human brain is not necessary for life at that stage. The blood supply is then channelled to the reptilian brain. The effect of the human brain being starved of blood and accordingly oxygen is the dismantling of the human brain. That process does not happen suddenly. It is a prolonged process, extending over hours. Once the human brain is damaged through an inadequate or no supply to oxygen, the foetus stops to function as a human and would from then function like a reptile. In such a case the human brain would have been destroyed by the lack of or inadequacy of oxygen, which oxygen was channelled to the reptilian brain to keep it alive.

[23] In this case two images were shown on the MRI scan. On the one, the brain

ventricles were visible. Next to them was the reptilian brain. Outside the reptilian brain were the areas of IS's human brain which had been destroyed. Those were the areas which had been starved of oxygen so that the available oxygen could be channelled to the reptilian brain to keep it alive. The MRI showed an intact reptilian brain and a destroyed human brain. The damage to IS's human brain was the dominant injury.

[24] Prof Lotz's evidence, based on the MRI scan only, is consistent with Drs Redfern and Ndjapa's opinions and reasons therefor. The undisputed independent evidence of Prof Lotz was that the MRI scan showed a mixed pattern of both moderate (prolonged partial) and more severe (terminal) hypoxic ischaemic injury.

[25] I am satisfied that the plaintiff's expert witnesses are sufficiently qualified and have sufficient experience to testify as experts in their respective fields of expertise. Their evidence has been accepted as reliable. In my view, the evidence given by the plaintiff, together with the evidence of her expert witnesses, demonstrated that IS suffered harm because his brain has been destroyed. The damage to IS's brain occurred when it was starved of oxygen over a few hours while in utero. What needs to be determined next are whether the medical personnel at the hospital were negligent and, if so, whether that negligence was causally connected to IS's destroyed brain.

[26] Counsel for the plaintiff relied on the maternal case records as well as the plaintiff's and Dr Ndjapa's evidence for the submission that the medical personnel were negligent. Dr Ndjapa's evidence was that the conduct of the medical personnel fell short of the norm in three respects. The first was that the plaintiff was not properly monitored when she was in labour. Secondly, fundal pressure was applied to assist with IS's delivery. Thirdly, the medical personnel failed to prepare the plaintiff for theatre so that an emergency caesarean section could be performed to have the baby delivered.

[27] The onus was on the plaintiff to prove on a balance of probabilities that the conduct of the medical personnel caused the harm. In that regard Dr Ndjapa testified about the importance of recording whether the recorded heart rate reflected the position before, during or after a contraction. Foetal distress can only be properly determined through an indication of when exactly a deceleration in the foetal heart rate occurs. Foetal heart

decelerations indicate the drop of the foetal heart rate below the baseline by fifteen beats per minute lasting for fifteen seconds. Monitoring decelerations is very important in that, without monitoring and recording them, the foetal condition would be unknown to the attending clinician who would not know if the foetus was coping during labour. That would be the case even if the baseline foetal heart rate is monitored and assessed to be normal. A normal foetal heart rate is between 110 and 160 beats per minute.

[28] In this case the partogram reflected a normal foetal heart baseline when readings were made every half an hour between 13h00 and 15h00 and that there were no decelerations at 13h00 and 13h30. Foetal heart decelerations were not recorded from 13h30 onwards. Dr Ndjapa testified that a normal foetal heart baseline does not mean the absence of decelerations. The failure by the medical personnel to monitor the foetal heart decelerations from 13h30 means that it could not be assessed how the foetus reacted to contractions. Had the medical personnel monitored and recorded the foetal heart rates before, during and after contractions, they would have established when a deceleration in the foetal heart rate occurred and would accordingly have assessed whether the foetus was in distress. As it turned out, the foetus was indeed in severe distress at approximately 13h37 when thick meconium-stained liquor was draining. In this regard it is pointed out that, according to the maternity case records, between approximately 10h00 and 13h00 the plaintiff's labour was not monitored. A CTG was performed between 09h50 and 10h05 but the report turned out to be blank. The probabilities are that the foetus was in distress before 13h37 because the distress caused the foetus to discharge meconium. The foetal distress went unnoticed because of the absence of monitoring and consequently the absence of the recording of the foetal rate decelerations. The foetal heart rate abnormality resulted in birth asphyxia which is in keeping with the evidence of Dr Redfern and the independent conclusions at which Prof Lotz arrived. In the circumstances, the failure to properly monitor the plaintiff during labour constituted negligence on the part of the medical personnel who attended to the plaintiff during labour.

[29] The second ground upon which the plaintiff relied for the contention that the medical personnel were negligent, was the application of fundal pressure. The plaintiff testified that while one nurse told her to push, another one was applying pressure on her abdomen

in the direction of the birth canal to assist with delivery. The medical records reflected that at approximately 13h00, almost two and half hours before delivery, ²/₅ of the foetal head was above the pelvic brim. Since the foetal head was not plotted anywhere on the partogram, except at 13h00, it was unknown where the foetal head was when the nurse applied fundal pressure.

[30] For the nurse who applied fundal pressure to the plaintiff's abdomen (the treating nurse) to be held negligent, the plaintiff was required to show that a reasonable nurse in the position of the treating nurse would have foreseen the reasonable possibility of her or his conduct injuring the foetus and causing harm to it, and if so, the reasonable nurse would have taken reasonable steps to guard against causing harm to the foetus; and the treating nurse failed to take such steps.⁷

[31] In the circumstances of this case, a reasonable nurse, faced with a situation where the position of the head of the foetus was unknown, would have foreseen the reasonable possibility of such conduct injuring the foetus and that such injury would cause harm to the foetus; and that a reasonable nurse would take reasonable steps to guard against conduct injuring and causing harm to the foetus. The treating nurse failed to take reasonable steps to guard against her conduct injuring and causing harm to the foetus. She was, on the *Kruger v Coetzee* test, negligent by applying fundal pressure under these circumstances. Whether her negligent conduct caused harm to the foetus is another issue altogether.

[32] I now deal with the last ground upon which the plaintiff relied for the contention that the medical personnel were negligent. This ground overlaps to a large degree with the lack of proper monitoring of the plaintiff during labour. The maternity case records reflected that at approximately 13h00 the plaintiff's cervix was 9cm dilated. This was after her cervix was 1-2cm dilated at approximately 09h40. The dilation of her cervix progressed faster than normal. The evidence was that, during labour, the cervix dilates at approximately 1cm per hour. No investigation was conducted to establish the reason for the rapid dilation after 13h00, after it had been established that the cervix was 9cm

⁷ *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E-F.

dilated. At 13h37 the thick meconium was noted. The nurses then initiated intrapartum resuscitation. Dr Ndjapa testified that the performance of intrapartum resuscitation was an acknowledgment on the part of the nurses that the foetus was in distress and required assistance. It was for that reason that they gave the plaintiff dextrose (sugar) and oxygen. The oxygen that was given to the plaintiff was to supplement the oxygen supply to the foetus. Dr Ndjapa's evidence was that, because the foetus was in distress at the latest at 13h37 when thick meconium was noted, it should have been relieved from the distress as a matter of urgency. He commended the nurses for having performed intrapartum resuscitation but testified that the intrapartum resuscitation was a means to an end. The purpose of the intrapartum resuscitation was to assist the foetus with oxygen until it was delivered through caesarean section which, according to Dr Ndjapa, was the only option to deliver the baby by the fastest route. In my view, had the medical personnel taken the plaintiff to theatre for an emergency caesarean section to be performed when thick meconium was noticed at 13h37, the outcome of birth asphyxia some two hours after the meconium was noticed, would in all probability have been prevented. The failure of the medical personnel to prepare the plaintiff for theatre for the performance of a caesarean section constituted negligence.

[33] In the circumstances, the plaintiff has demonstrated on a balance of probabilities that the medical personnel were negligent when they did not properly monitor the plaintiff during labour, when fundal pressure was applied to the plaintiff's abdomen and when they failed to prepare the plaintiff for theatre for a caesarean section to be performed. The next enquiry is whether the above negligence caused the outcome.

[34] Causation gives rise to two distinct enquiries, namely factual and legal causation. Factual causation entails a factual enquiry into whether the negligent act or omission caused the harm that gave rise to the claim. If the negligent act or omission did not cause the harm, then that is the end of the matter. If the factual enquiry shows that the harm was caused by the negligent act or omission, a judicial problem arises. That is the second enquiry, where the question is whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether the harm is too remote.

This is termed legal causation.⁸

[35] To determine factual causation in an instance of an act or commission on the part of the defendant, if the *conditio sine qua non* theory or but-for test is used, the conduct is mentally removed to establish whether the relevant consequence would still have resulted. By way of example, in the case where the defendant hit the plaintiff on the mouth, one must mentally remove the hitting to determine whether the plaintiff would have sustained the swollen lip and loss of teeth (the harm). If the plaintiff would have suffered that harm in any event, then the wrongful conduct (the physical use of force) was not the cause of the plaintiff's loss. If the wrongful act is shown not to be a *causa sine quo non* of the plaintiff's harm, then no liability can arise.⁹

[36] In an instance of an omission on the part of the defendant, the but-for test requires that a hypothetical positive act be inserted in the particular set of facts. This means that reasonable conduct by a reasonable defendant would be inserted into the set of facts. By way of example, in the case of an educator who can swim and sees one of his learners has difficulties in a swimming pool during an official school outing, the reasonable conduct by a reasonable defendant would be inserted into the set of facts. Where the learner drowned, the question would be whether his death was caused by the educator's omission to save him. The educator would be liable if a reasonable attempt to save the learner would have prevented his death by drowning. He would not be liable if reasonable attempts to save the learner would in any event not have prevented the learner's death. The rule regarding the application of the test in positive act and omission cases is flexible since there is no magic formula by which a causal nexus is established between the wrongful act or omission and the harm. The existence or absence of the nexus depends on the facts of a particular case.¹⁰

[37] Legal causation involves the question whether the defendant should be held liable. For the defendant to be held liable, there must be a reasonable connection between the act or omission and the harm done. A defendant is not liable for harm that is too remote

⁸ *Lee v Minister for Correctional Services* 2013 (2) SA 144 (CC) para 38.

⁹ *International Shipping Coal (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at 700E-I.

¹⁰ *Lee* fn 8 para 41.

from the conduct. A defendant's negligent conduct which manifests itself in the form of a positive act causing harm to the plaintiff is *prima facie* wrongful. However, a defendant's negligent omission is not regarded as *prima facie* wrongful. The wrongfulness of the negligent omission depends on the existence of a legal duty.¹¹

[38] The determination of the existence of a legal duty in any case involves criteria of public and legal policy consistent with constitutional norms. A negligent omission causing harm will only be regarded as wrongful and therefore actionable if public and legal policy considerations require that such omission should attract legal liability for the resultant damages.¹²

[39] In her plea, the defendant admitted that the medical personnel were under a legal duty of care to ensure the rendering of proper antenatal care, monitoring and management of labour, delivery and postnatal care at the hospital, and that those duties be rendered with such skill, care and diligence that could reasonably be expected of medical personnel in similar circumstances.

[40] Regard being had to the facts of the present matter, I am of the view that the plaintiff has failed to establish on a balance of probabilities that the fundal pressure that the treating nurse applied to her abdomen caused harm to the foetus. That much was conceded by the plaintiff's counsel, who, in their heads or argument, submitted that it was '*impossible to determine the exact consequences of the application of fundal pressure*'. The fact that the treating nurse was negligent when she applied fundal pressure under the circumstances, does not mean that such negligence caused harm to the foetus. Since the plaintiff failed to prove factual causation in respect of the application of fundal pressure to the plaintiff, the need to enquire into legal causation in respect of that ground of negligence falls away.

[41] I will deal with the remaining two grounds of negligence together, namely the lack of adequate monitoring of the plaintiff during labour and the failure to prepare her for a caesarean section to deliver her baby as a matter of urgency. The lack of the plaintiff's

¹¹ *Hawekwa Youth Camp and Another v Byrne* 2010 (6) SA 83 (SCA) para 22.

¹² See also *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) paras 21 and 22.

monitoring between 09h40 and 13h00 has already been pointed out above. Assuming a hypothetical course of lawful conduct be substituted for the omission to properly monitor the plaintiff during labour and the failure to prepare the plaintiff for theatre, namely that the plaintiff was regularly monitored between 09h40 and the time of delivery at approximately 15h37, the medical personnel would have realised that there was foetal distress, as confirmed by the presence of meconium and would have prepared the plaintiff for theatre, including the performance of intrapartum resuscitation. Such hypothetical course of lawful conduct would, in my view, probably have prevented the harm that the foetus suffered. The plaintiff has accordingly succeeded in establishing factual causation. The medical personnel breached the admitted legal duty of care. Public and legal policy considerations require the defendant to be held liable for the negligent failure to treat the plaintiff with the necessary care, which negligence on the part of the medical personnel caused the harm to IS's brain. In the circumstances, the plaintiff has established on a balance of probabilities that the damage to IS's brain was negligently caused by the medical personnel. The defendant should therefore be held liable for such damages as the plaintiff may prove arising from the brain damage that IS sustained during labour on 27 July 2008 as well as the consequences of such brain damage.

[42] The plaintiff was successful. She is entitled to the costs of the action, such costs to be paid by the defendant.

[43] In the result, it is ordered that:

1. The defendant is liable to the plaintiff, in her personal and representative capacity, for such damages as she may be able to prove or agreed arising from the brain damage that IS sustained during labour on 27 July 2008 as well as the consequences of such brain damage.
2. The defendant shall pay the plaintiff's costs to date of this judgment, such costs to include:
 - 2.1. the costs attendant upon the obtaining of the medico-legal reports, addenda thereto and joint minutes, if any, of the expert witnesses in respect of whom notices in terms of rule 36(9) were delivered;

- 2.2. the qualifying and appearance fees of the expert witnesses in respect of whom notices in terms of rule 36(9) were delivered;
 - 2.3. the reasonable and necessary air transport and accommodation costs and expenses of the expert witnesses in respect of whom notices in terms of rule 36(9) were delivered;
 - 2.4. the expenses relating to the transcription of the evidence of Prof Jan Lotz; and
 - 2.5. the reasonable fees of two counsel, where such services were engaged, including the preparation of heads of argument, and expenses in respect of consultation when preparing for trial with expert witnesses in respect of whom notices in terms of rule 36(9) were delivered.
3. The defendant shall pay interest on the plaintiff's taxed or agreed costs of suit at the prescribed statutory rate calculated from a date 14 (fourteen) days after agreement in respect thereof, or a date 14 (fourteen) days after affixing of the taxing master's *allocatur*, to date of payment.

GH BLOEM
JUDGE OF THE HIGH COURT

Appearances

For the plaintiff:	Mr <i>AM Bodlani</i> SC and Ms <i>Z Nxazonke-Mashiya</i> , instructed by Sakhela Inc, East London.
For the defendant:	No appearance.
Date heard:	7, 14,15 and 16 August 2023.
Date of delivery of the judgment:	3 October 2023.