

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



CASE NO: 36681/2017

- (1) Reportable: No
(2) Of interest to other Judges: No
(3) Revised: Yes

Handwritten signature
Date: 28 September 2021

In the matter between:

EN obo RN

Plaintiff

and

**THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH (GAUTENG)**

Defendant

J U D G M E N T

MAIER-FRAWLEY J:**Introductory background**

1. The plaintiff instituted a claim for delictual damages on behalf of her minor child (NR) (hereinafter referred to as 'baby R') against the MEC as the employer of the nursing and other medical staff at Natalspruit hospital on 24 September 2009. The plaintiff's claim against the MEC was brought on the basis that he was vicariously liable for the negligent conduct of the employees of the defendant who attended to the plaintiff (and her then unborn twins) at the hospital after her admission and/or who attended to baby R after her birth. She claims that this negligence caused and culminated in baby R developing cerebral palsy as a consequence of a hypoxic-ischaemic event that resulted in irreversible brain damage being sustained by baby R.
2. Pursuant to an agreement between the parties' legal representatives, the issue of liability (negligence and causation) was to be tried separately from, and before, the remaining issues in the action. It was implicit in the parties' agreement (and indeed confirmed by the defendant's counsel at the outset of the trial) that if causal negligence on the part of the medical staff was established, it would be reasonable in the given context - in particular, the defendant's admission that the treating medical staff had been under a legal duty of care to treat their patients with professional skill and care - that liability for such damages as the plaintiffs might prove would follow; in other words, that the element of wrongfulness for the purpose of delictual liability would also have been established.
3. In her particulars of claim, the plaintiff pleaded that the defendant owed her and her twins a legal duty of care, which was breached by employees of the defendant who were alleged to have been negligent in several respects, but

which for purposes of the judgment, in the main, *inter alia*, included that they:

- 3.1. Negligently prolonged the plaintiff's labour;
 - 3.2. Failed to perform a caesarean section (c-section) timeously or at all;
 - 3.3. Failed to monitor the foetal heart rates appropriately, timeously or with sufficient frequency and/or at all and/or failed to detect that baby R was in foetal distress;
 - 3.4. Failed to take 'steps to prevent the dangers of multiple gestation';
 - 3.5. gave inadequate care to baby R during and after her birth by: failing to properly monitor both foetuses; failing to give baby R enough oxygen; failing to prevent baby R from suffering from hypothermia and failing to prevent her from suffering a hypoxic ischaemic event during or after her birth, causing her to sustain a brain injury which resulted in her suffering from cerebral palsy;
 - 3.6. negligently unnecessarily administered AZT and Neviraprine to both twins whilst the plaintiff was HIV negative.
4. The defendant opposed the action and filed a plea, *inter alia*:
- 4.1. denying that the employees of the defendant were negligent in any of the respects alleged or at all; and
 - 4.2. pleading that there was no causal connection between the negligence (if any) and the cerebral palsy sustained by baby R. It is noteworthy that no contributory negligence on the part of the plaintiff was raised in the plea.
5. The plaintiff called the following witnesses to testify at the trial:
- 5.1. Mrs 'EN' (plaintiff);
 - 5.2. Dr Mbokota (Obstetrician & Gynaecologist);
 - 5.3. Prof Nolte (Nursing Professional) and

- 5.4. Dr Lefakana (Paediatrician).
6. The defendant called the following witnesses to testify at the trial:
 - 6.1. Dr Ramodike (Attending doctor in the labour ward at Natalspruit hospital on 24 September 2009 who delivered the leading twin, a baby boy and brother of baby R)
 - 6.2. Sr Masakale (Midwife who delivered baby R);
 - 6.3. Dr Manthata-Cruywagen (Obstetrician and Gynaecologist);
 - 6.4. Dr Kganane (Paediatrician) and
 - 6.5. Dr Mogashoa (Paediatric Neurologist).
 7. It was common cause that baby R suffered a central (acute profound pattern) hypoxic ischemic brain injury, as per the joint minute prepared by the radiologists appointed by the parties, although the cause and probable timing of the hypoxic ischemic event (HIE), i.e., whether it occurred before or after her birth on 24 September 2009 or what had precipitated it could not be established by means of an MRI scan.
 8. A summary of relevant factual matrix is the following: The plaintiff discovered she was pregnant with twins when she was about 2 months along in her pregnancy. She consulted a private general practitioner during the first 6 months of her pregnancy where after she attended at the Zonkezizwe clinic for further ongoing care and management of her pregnancy. She suddenly went into pre-term labour on the morning of 24 September 2009, at 32 weeks gestation. She was admitted to the labour ward after being assessed by Dr Ramodike, the attending doctor who was on duty at the labour ward, at 13h10. She was referred for a c-section delivery as the twins were in a breech position. Her pregnancy was considered high risk because she was carrying twins. She was 2cm dilated at that stage, with ruptured membranes, and presented with a history of pregnancy induced hypertension (high blood

pressure). Three other emergency c-sections were prioritized before the plaintiff's c-section. Only one theatre was available to perform emergency c-sections on the day. The plaintiff was assessed and her condition monitored in the labour ward at 13h10; 15h00; 15h30; 18h30. Whilst being prepared to be wheeled to theatre at 19h20, she started bearing down (pushing). The leading baby was starting to show an appearance. Within minutes, the twins were thereupon delivered naturally by way of vaginal birth inside the labour ward. The first twin (baby Boy) was born at 1925 by way of breech delivery whilst baby R was born ten minutes later, at 19H35, by way of vertex delivery. The babies were taken to the nursery section inside the labour ward after birth where they were attended to by a midwife and their condition stabilised. The babies were thereafter assessed by an intern paediatrician (Dr Oakbay) inside the labour ward. He diagnosed them as having moderate respiratory distress and decided to transfer them to the neonatal ward (ward 2) for ongoing monitoring and care. According to the hospital records, baby R was transported in a cold incubator without oxygen to ward 2. Baby R's condition deteriorated after her birth to the point where she had to be vigorously resuscitated by the attending paediatrician (DR Mpoyi) in ward 2. The resuscitation was successful, where after she was admitted to ICU where she remained until discharge from hospital. It is common cause that she was diagnosed with cerebral palsy, having suffered an irreversible brain injury due to a profound hypoxic ischemic event which occurred on 24 September 2009.

9. The expert reports filed of record by both parties were admitted into evidence at the trial as well as the available hospital and medical records on which all experts relied to formulate their respective opinions.
10. Joint minutes were prepared by the parties' appointed gynaecologists; paediatricians; radiologists and nursing professionals (midwives). No

significant disagreements arose between them as regards the brain injury sustained by baby R. The issue for determination by the court was *when* such insult was likely to have occurred, and whether negligence on the part of the attending staff caused baby R to suffer the consequences of such event.

Agreements per experts' joint minutes

11. The midwives agreed, *inter alia*, that the plaintiff pregnancy was a high-risk pregnancy by reason of the fact that it was a twin pregnancy. The midwife/s who cared for the plaintiff during her labour delivered sub-standard care in that they did not do or record maternal and foetal observations, as well as progress of labour in accordance with the Maternity Guidelines (2007), both during the latent and active phases of labour and especially in the case of a mother with a history of pregnancy induced hypertension and premature labour of twins. Only one foetal heartbeat was recorded on the CTG (cardiotocograph), and only one foetal heartbeat was recorded in the hospital notes by the attending midwife at 15h30 and 18h30. Both foetuses should preferably have been monitored with a CTG during labour as required by the Maternity Guidelines (2007). Every effort should have been made to ensure a safe delivery by C-section because of the fact that the twins were premature and because, as later transpired, the leading twin remained in a breech position.

12. The paediatricians agreed, *inter alia*, that the delay in the delivery of the twins by c-section was due to the unavailability of theatre/s. Monitoring at the time showed no abnormalities. Baby R was exposed to hypoxia (cyanosis) and hypothermia during transfer (from the labour ward to the neonatal ward) and her condition deteriorated in the neonatal ward, requiring resuscitation and ICU admission. Hypoxia and hypothermia are possible causes of the HIE (hypoxic ischemic event). These (consequences) are the result of substandard care and negligence.

13. The Obstetricians/Gynaecologists agreed, *inter alia*, that the plaintiff presented late for her first ante-natal care visit (at 28 weeks), when she was diagnosed with 'multiple pregnancy', anaemia and a booking blood pressure of 140/90. She was HIV negative at booking. She attended at the hospital within 6 hours of her membranes rupturing. Discharge of liquor was clear and non-offensive. On admission, she had pre-term labour and premature rupture of membranes and was assessed to be in the latent phase of labour. No speculum examination was done on admission as per standard, but a digital vaginal examination was done that could have increased the risk of intrauterine infection. When the decision to deliver her by emergency c-section was made at 13h10, the theatre was busy with three other cases. It is the responsibility of the clinicians and the hospital management on duty to reprioritize the cases or find an alternative theatre within the hospital. Between 15h30 and 18h30, the plaintiff's blood pressure recordings were 132/61 and 133/69 respectively, which is normal, and her pulse was 97bpm. The plaintiff was wheeled to theatre six and a half hours after the decision to deliver by c-section was made. The two babies did not show any evidence of intrauterine growth restriction or growth discordance.
14. The radiologists agreed, *inter alia*, that the MRI pattern was in keeping with a *hypoxic ischemic brain injury* in a pre-term baby. There were features of central (acute profound pattern) hypoxic ischemic brain injury. The findings of the MRI study suggested that genetic disorders as a cause of baby R's brain damage were unlikely. There was no evidence of current or previous infective or inflammatory disease on the various MTI sequences and inflammatory or infective conditions were unlikely causes of the child's brain damage.

Evidence at trial

Plaintiff (Mother)

15. The plaintiff previously gave birth to three individual children ('singletons') prior to falling pregnant with twins. The births of the singletons were uneventful and without complication. According to the plaintiff, she had the advantage of consulting a private doctor (Dr Hira) during the first six months of her twin pregnancy. She opted for private professional care as the doctor's rooms were situated in close proximity to her workplace, which made it both convenient and beneficial for her to attend thereat. She had no reason to doubt that she was receiving anything other than the best possible care from her doctor. The plaintiff was treated, *inter alia*, for influenza, a persistent urinary tract infection and high blood pressure during the time that she consulted Dr Hira. At the six month mark of her pregnancy, Dr Hira referred her to the Zonkezizwe clinic for ongoing care, including sonar examination to determine the sex of the babies and for her to be registered to enable her to deliver the twins at Natalspruit hospital. She attended at the clinic on two occasions prior to spontaneously going into premature labour. Clinic records showed that she had slightly raised blood pressure on one occasion, for which she was given medication, and that both babies presented in a breech position upon examination.

16. At about 6am on the morning of 24 September 2019, her waters broke, which prompted her to go to the hospital. Upon arrival, she was assessed as being in the early latent phase of pre-term labour (estimated to be approximately 32 weeks' gestation) with ruptured membranes, draining clear liquor. She was then referred for admission to the labour ward. Shortly after arriving at the labour ward, she was further examined by an attending doctor (Dr Ramodikwe). A scan (sonar) performed on her revealed that both babies were in a breech position. She was informed that the babies would have to be delivered by caesarean section (c-section) in theatre, however, as the

theatre was then occupied with other emergency deliveries, she was placed onto a bed in the labour ward for onward monitoring of the progress of her labour. She confirmed that she was monitored at 13h10; 15h30; and 18h30 on 24 September 2019. According to the hospital records, at 15h30, she was prepared for theatre. At 18h30, she was assessed as being in the active phase of labour, being 5cm dilated. The plaintiff testified that at about 19h20, whilst the doctor or nursing staff were preparing to take her to theatre, she suddenly felt the babies bearing down, as if she was about to give birth. She screamed for a doctor to come and help. The doctor saw that a baby was coming out and within minutes, the first twin, a boy, was delivered vaginally inside the labour ward. He came out legs first. The plaintiff heard him give a loud cry where after he was taken away. The second baby, a girl (Baby R) was delivered vaginally shortly thereafter, with a vertex presentation. Baby R did not cry at first, although a short while after the midwife 'did something to her' she gave a faint cry (which was less audible than the baby boy's cry) before being taken away. The plaintiff was informed that the second baby was having difficulty breathing. She did not see the twins again until later in the evening when she saw them being wheeled together in a 'small cot' to ward 2 (neonatal ward) for further care. According to the hospital records, the first baby boy was delivered at 19h25. The second baby girl (baby R) was delivered at 19h35.

17. The following day the Plaintiff saw baby R in the ICU with 'alot of things' attached to her body. She was also on a breathing machine. The baby boy remained in ward 2. According to the plaintiff, she noticed immediate differences between baby R and her brother. The baby boy was more active, able to suckle on his own and was breastfed by the Plaintiff, whereas baby R had difficulty suckling and a syringe had to be used to feed milk to her.

18. It is almost 12 years since the birth of the twins. Baby R was diagnosed with cerebral palsy within a few months after birth. She is still unable to do anything on her own. She does not talk, has to be fed, uses diapers (nappies) and cannot sit or even stand unaided. Her brother (leading baby) has also experienced mental challenges. He attends a special school as he has learning difficulties.
19. During cross-examination, the plaintiff was questioned about the incomplete set of hospital records¹ that were discovered by her at trial. She stated that she obtained the records from Mr Mogadi, whom she believed to be working at the hospital. She paid him R50 for assisting her to obtain same. It was put to the plaintiff that the hospital records had all gone missing from the hospital and that the only records presently available are those which the plaintiff had herself obtained from Mr Mogadi.
20. She readily conceded that she only attended the clinic for the first time when she was 28 weeks pregnant but reiterated that she had enjoyed the benefit of private care prior thereto. She was questioned about whether she was informed as to why she had been referred for caesarean delivery. She testified that she was told that one of the babies was not lying in the correct or proper position. She further testified that at the time when she was being monitored in the labour ward by the midwife/s, they had informed her that 'everything was fine' with the twins and that they (nurses) were happy with their heartbeat. She conceded that the birthing process went smoothly. It was a short and uneventful process even though one baby had been delivered in a breech position. She felt that she was treated properly during her labour although looking back, she feels that the doctors should have taken her for a caesarean procedure earlier that day.

¹ Cross-examination revealed that various pages were missing from the records that were discovered by the plaintiff at trial.

Proffessor AGW Nolte

21. Prof Nolte testified that the plaintiff presented as a high risk pregnancy by virtue of the fact that she was carrying multiples; that one or both babies were breech; that the plaintiff's labour was premature; and that she presented with borderline pregnancy induced hypertension. High blood pressure (pregnancy induced hypertension) and premature labour are known to be possible complications of a twin pregnancy.

22. The first stage of labour is the latent phase which endures until the cervix is 4cm dilated. The active phase of labour commences from when the cervix is 4cm to 10 cm dilated. According to the hospital records, the plaintiff was 5cm dilated at 18h30, by which time she was thus in the active phase of labour. In terms of the Maternity Guidelines (2007),² in the active phase, the foetal heart rate should be recorded every half hour until birth, whereas in the latent phase it should be recorded four hourly in order to detect foetal compromise (if any). This was not done in the plaintiff's case. The hospital records contain a record only one foetal hearbeat (as opposed to two) and it is unclear which foetal heartrate was monitored.³ Both foetal heart rates ought to have been monitored with a continuous CTG when the active stage of labour commenced.

² Prof Nolte explained that the Maternity Guidelines provide standards of care according to which midwives should practice, i.e., they contain guidelines on how to act under certain circumstances or how a patient is to be cared for in various conditions. Any deviation from the guidelines would indicate sub-standard care. If the patient is not assessed according to the prescribed guidelines/standards of care, the nurse would possibly not see if complications were developing in utero.

³ Prof Nolte explained that per the hospital records, at 18h30, the foetal heart rate was recorded as '136-140 bpm' (beats per minute). It is unclear whether such record reflects the fluctuation occurring in the heart rate of one foetus, or the discrepancy between two separate foetal heart rates. The notes ought to record a difference of 10 beats per minute between two foetal heartbeats (in the case of twins) so as to ensure that two separate foetus's are being monitored. In Prof Nolte's view, the note more likely depicted the variation in the heart rate of a single foetus, for if not, the individual heartrates should have been separately recorded in respect of foetus 1 and foetus 2.

23. During the active phase of labour the mother usually experiences more frequent contractions during which the uterus contracts and blood flow to the placenta is temporarily cut off, resulting in oxygen deficiency to the foetus. For that reason, the risk of developing foetal compromise is much higher in the active phase of labour when the foetus is subjected to more frequent bouts of oxygen deficiency. If babies are oxygen compromised, they may not recover sufficiently between contractions. It is thus necessary to assess the foetal heart rate more frequently in the active phase in order to be able to detect foetal compromise. A foetal heart rate of more than 160 beats per minute is an indicator of tachocardia, whilst a foetal heart rate of less than 110 beats per minute is an indicator of bradocardia – both being indicators of possible foetal compromise. Both the foetal heart rate⁴ and the frequency of contractions ought to be monitored to assess abnormal variability in heart beats or abnormal decelerations as these may provide indicators of insufficient foetal oxygen or cord prolapse. If foetal heart rates are not monitored properly it would not be possible to detect foetal distress, however, a normal foetal heart rate assessment does not necessarily indicate non-foetal distress or an absence of foetal compromise.
24. During cross-examination, Prof Nolte conceded that even if the maternity guidelines are not followed so that substandard care is delivered, it does not necessarily follow that the baby will not be born healthy. She accepted that information was lacking in the available medical records to sustain an inference that baby R had suffered from intra-partem or birth asphyxia. Stated differently, she was unable to say whether the non-compliance with the maternity guidelines in the present matter resulted in baby R suffering an injury in the intrapartum period.

⁴ Foetal heart rate can be monitored by means of a CTG or stethoscope.

25. The hospital records reflect that steroids (known as servactin) were administered to the plaintiff round 15h00. Steroids are usually given where the mother is in premature labour to aid in the development of the foetal lungs (or to prevent the lungs collapsing after birth) and to enable the babies to breathe better when they are born. Two doses administered 12 hours apart are required for such medication to take effect. In the plaintiff's case, steroids were administered late (approximately 4 hours before birth) and there was insufficient time for it to take effect. Any premature labour carries the risk that a baby's lungs will not be fully developed at birth and could collapse.

Dr Mbokota (obstetrician/gynaecologist)

26. Dr Mbokota's oral testimony focussed largely on the fact that the hospital notes did not contain a record two separate foetal heartbeats and that the twins were born in non-optimal conditions. He testified that the foetal heart rate of each twin baby should ordinarily be reported. If the medical staff only record the heartbeat of one baby, the condition of the other twin would remain unknown. It is unknown in the present case which twin's heart rate was monitored. The fact that the foetal condition of the baby whose heart rate was reported was good, does not mean that the other baby was also in a good condition.
27. The plaintiff's membranes had ruptured before she arrived at the hospital and her premature labour had commenced. That, in Dr Mbokota's view, was sufficient to constitute an emergency. At 13h10, the plaintiff was correctly assessed as requiring delivery by c-section as both babies were in a breech position at that stage.
28. If babies are born prematurely, the risk of developing respiratory distress is present. Therefore it would have been more ideal for them to have been

delivered in theatre, in a temperature controlled environment, with a paediatrician/neonatalist being present with two midwives in attendance and resuscitation trolleys on hand. In the absence of a paediatrician being present at birth (as was the case with the plaintiff), the best to do would be to administer oxygen by mask to the new-borns; to ensure that their airways are and remain clear; for the babies to be placed in an incubator to ensure they are kept warm; to intubate (if required); and to put up a drip to ensure hydration.

29. According to the hospital notes, the baby boy was breech at the time of delivery whilst baby R had turned and was delivered vertex. Both babies were suctioned after birth and despite having been given oxygen, exhibited moderate respiratory distress after birth. With premature babies having underdeveloped lungs, one would anticipate an element of respiratory distress at birth resulting in them battling to take in sufficient air on their own.
30. The babies were not delivered in ideal circumstances. Dr Mbokota opined that had a caesarean section been performed earlier in the day, the babies would not have been exposed to increased contractions, which result in starving the babies of oxygen.
31. Accepting the radiologists' joint opinion that baby R suffered an acute profound hypoxic ischaemic insult, it means that there was a sudden complete shut down of oxygen to her brain, resulting in neurological damage to the main part of the brain.
32. Since there is nothing in the hospital records to show that both fetuses were properly monitored,⁵ in his opinion, the injury to baby R must have

⁵ According to Dr Mbokota, full foetal monitoring entails recording the foetal heart rate as well as foetal heart rate variability, including the absence or presence of decelerations pursuant to

occurred within 10 to 40 minutes *prior* to birth, due to a deprivation of oxygen supply. He reasoned that because there is nothing in the hospital records to show that both fetuses were properly monitored, therefore foetal distress intra-partem could be ruled out. The baby may have suffered distress and a hypoxic insult and thereafter recovered sufficiently to present with APGAR scores of 8/10 at 5 and 10 minutes after birth.

33. During cross-examination Dr Mbokota stated that the APGAR scores (being 8/10 for both babies at 5 and 10 minutes after birth) indicated that there was no need for vigorous resuscitation after birth. However, in his view, the scores do not tell one what happened to the fetuses' during labour. If the hypoxic event occurred before birth, the baby could still recover to present with Apgar scores of 8/10 but the damage to the brain would already have occurred and the effect of it would continue over time.
34. He conceded the possibility that the hypoxic event could have occurred *after* the birth of baby R, however, he remained adamant that because foetal compromise could not be ruled out intra-partem, it was not likely. He went on to explain that if both fetuses were monitored during labour or if it were known that baby R was in fact monitored during labour, so that foetal distress could be ruled out - despite which her condition deteriorated after birth - *that* would have made it more probable that the injury occurred later.
35. In a twin pregnancy where one or both babies are in a breech position, it is advisable to do a caesarian section before the process of labour advances. There is a known risk of foetal compromise because the babies might not be able to withstand the stress of labour. During contractions, the mother's uterus contracts – it squeezes the baby and the baby does not receive sufficient oxygen and blood supply. After the contraction subsides, a baby

contractions during labour, i.e., whether they are early, late or variable, all of which needs to be recorded.

with sufficient reserves of oxygen would recover, but, if the event occurs close to delivery there would be insufficient time to recover. Therefore, to avoid known risks of complications arising, it would be better to deliver earlier by caesarian section before the process of labour becomes advanced. He therefore opined that had the C-section been performed at the time proposed by the attending doctor (14h00), in his view, the outcome may have been prevented. If the theatre at Natalspruit hospital was occupied with other emergency cases on the day in question, the hospital ought to have made more theatres available. The head of the unit in the labour ward has the responsibility of ensuring that a request is made for additional capacity (theatre) and there is no indication in the hospital records that this was done.

Dr Lefakane (paediatrician)

36. Premature babies often present with respiratory distress symptoms at birth and can develop hyaline membrane disease ('HMD')⁶ due to the underdevelopment of their lungs. At 32 weeks, the lungs of a baby are still underdeveloped. The alveoli (the tiny air sacs in the lungs) are not usually open until 37 weeks maturity which is when a baby's respiratory system is fully developed. Pulmonary surfactant is produced by the lungs when they develop. If HMD is observed due to respiratory distress at birth, whoever is performing resuscitation can provide artificial surfactant to the baby. The hospital records show that artificial surfactant (suvanta) was administered to baby R in ward 2 (neonatal ward). The hospital notes reflect that a doctor was called when baby R was seen gasping. This indicates that she was having difficulty taking in air, something which occurs with respiratory distress. She was effectively resuscitated by means of intubation, bagging (where oxygen is provided through a respiratory bag), and medication in the form of

⁶ Also known as respiratory distress syndrome, a condition that causes babies to need extra oxygen and help breathing. It is a common problem seen in premature babies.

adrenaline (used to assist heart to pump more blood to the lungs) and sevanta were administered. She was diagnosed with bradycardia (low heart rate) which is usually the case with low oxygen levels or hypoxia,⁷ and referred to ICU for further care.

37. Labour ward records indicate that baby R and her brother were born with moderate respiratory distress. Baby R's APGAR score for respiration remained at a score of 1/2 (one out of two) at 1, 5 and 10 minutes after birth. The fact that her overall score was 8/10 at 10 minutes after birth does not alter the fact that she experienced problems with respiration. After birth, both babies were suctioned and given oxygen by mask and per 'head box' (being an incubator that provides oxygen to baby) whilst waiting for the paediatrician to arrive. Records from the neonatal unit (ward 2) indicate that baby R was referred for admission to ward 2 with a diagnosis of 'respiratory distress with subcostal indrawing', meaning that she was having difficulty in breathing and was using accessory muscles located between the ribs to breath. A note recorded (with the time of 22h00 stipulated) indicates that baby R was having severe difficulty in breathing as she was gasping. A progress report (with the time of 22h00 stipulated) recorded that the babies had been transported to the neonatal ward in an incubator without oxygen. The condition of baby R on arrival was noted as being 'critically ill and having gasping respiration. Baby [R] was cyanosed+++⁸ and cold on touch...Baby has been resuscitated in the ward by sister and doctor Oakbay...'.

⁷ *Hypoxia*: A lower-than-normal concentration of oxygen in arterial blood (as opposed to anoxia, a complete lack of blood oxygen). Hypoxia will occur with any interruption of normal respiration. See: <https://www.rxlist.com/hypoxia/definition.htm>

⁸ 'Cyanosed' means that the baby is blue in colour because there is not enough blood flow and oxygen provided in the blood to the baby. 'Cyanosis' is defined as: 'A bluish color of the skin and the mucous membranes due to insufficient oxygen in the blood.' See: <https://www.medicinenet.com/cyanosis/definition.htm#:~:text=Cyanosis%3A%20A%20bluish%20color%20of,when%20exposed%20to%20extreme%20cold>

38. Where a baby presents with respiratory distress, immediate treatment would be to get oxygen into the lungs by bagging. If that does not provide relief, then it should be administered by means of an endotracheal tube for purposes of supplying oxygen directly to the lungs and bypassing any areas of blockage that would be found in the trachea. When a baby is 'cyanosed' it means the baby is blue in colour which indicates insufficient blood supply or insufficient oxygen is provided by the blood to the baby.
39. The hospital notes reflect that Baby R was exposed to hypoxia (not enough oxygen), cyanosis and hyperthermia during the transfer from the labour ward to the neonatal ward. The fact that respiratory distressed babies were transported to the neonatal ward whilst being exposed to low temperatures without oxygen is indicative of sub-standard care. A baby ought to be transferred to a different ward in a warm incubator with oxygen. If the baby shows signs of respiratory distress during transportation, resuscitation should be performed by means of a mask being placed over the baby's nose and mouth connected to an oxygen tank carried on the incubator with oxygen being continually provided until the baby can be fully resuscitated by ventilator, if necessary.
40. Baby R was hypoxic on arrival, when regard is had to the relevant hospital note. Furthermore, there was a known cause of the hypoxia. The exposure to low temperatures leading to hyperthermia (baby being cold to touch and blue) on its own, or in combination with HMD, likely led to the hypoxic event. Both hypoxia and hypothermia are possible causes of the hypoxic ischaemic event (HIE)⁹ suffered by baby R, which in Dr Lekota's opinion, most probably

⁹ Hypoxic ischemic encephalopathy (HIE) is a type of brain dysfunction that occurs when the brain doesn't receive enough oxygen or blood flow for a period of time. Hypoxic means **not enough oxygen**; ischemic means not enough blood flow; and encephalopathy means brain disorder. See: <https://www.ucsfbenioffchildrens.org/conditions/neonatal-hypoxic-ischemic->

occurred in the post-partem period, i.e., after birth. By the time that baby R was gasping, the damage would already have been done. At the time when baby R suffered pulmonary arrest, treatment was both immediate (the attending doctor arrived timeously) and effective (she was successfully resuscitated. Baby R's oxygen saturation levels improved successfully after resuscitation and she was transported to ICU in a reasonably stable condition.

41. There are no hospital records to show what bay R's condition was or what care and treatment Baby R received in the neonatal ward after admission until 22h00 when the record of her decompensation was made.
42. Examination of baby R (who is presently 12 years old) revealed that she presents with spastic quadriplegic cerebral palsy with myoclonic jerks. She is unable to move her joints. Her upper and lower limbs are stiff. She can see and hear, but is unable to speak. She cannot walk or stand and is dependent on others to feed and dress her.

Dr Ramodike (attending doctor during delivery of babies)

43. Dr Ramodike confirmed that she was the only doctor on duty in the labour ward at Natalspruit hospital on 24 September 2009. She worked as a medical officer although she had not yet qualified as a gynaecologist. The labour ward has different sections which are demarcated according to the level of care required by the patient. The plaintiff was admitted in the labour ward at 12h55 and transferred to the high care area shortly after 13h00. Five midwives were on duty in the labour that day. There was only one emergency theatre available. Other theatres are usually reserved for pre-booked elective c-sections. The labour ward was equipped with four CTG

encephalopathy#:~:text=Hypoxic%20ischemic%20encephalopathy%20(HIE)%20is.and%20encephalopathy%20means%20brain%20disorder.

machines. On average, approximately 25 to 30 babies are delivered at the hospital on any given day.

44. Dr Ramodike examined the plaintiff at 13h10. An ultrasound performed revealed that both twin babies were then in a breech position. She decided to refer the plaintiff for a c-section due to the breech presentation in order to avoid compromise during delivery. The plaintiff was in pre-term labour with ruptured membranes. She advised the staff to admit the plaintiff to the high care area and to prepare her for a c-section at 14h00. Bloods were taken from the plaintiff in preparation for theatre due to the risk of blood loss when a c-section is performed. The plaintiff also had a history of hypertension. During her examination, she noted from the CTG printout that the heart rate of only one twin was recorded at 146 beats per minute, however the scan that was performed earlier had detected two foetal heart beats. She testified that she however had no concerns about the condition of the foetuses from the ultrasound performed by her, but confirmed that she had queried as to why only one twin was being traced with the CTG.
45. She saw the plaintiff again at 18h30. The plaintiff's blood results revealed that the plaintiff's haemoglobin levels were low. She ordered two units of blood for theatre. The plaintiff was at that stage in the active phase of labour. As no tracing by CTG was being done at that stage, she requested that CTG tracing be performed in respect of both foetuses. Dr Ramodike testified that she had no concerns about the babies or the mother at that stage. The midwife on duty (Sr Motaung) recorded the foetal heart rate as '136-140' which was within normal limits. Sr Motaung passed away in 2020. Sr Motaung was replaced by the night shift staff (Sr Masakane) at 19h00.
46. At approximately 19h20 Dr Ramodike was called as the plaintiff was bearing down (pushing) when she was supposed to go to theatre. Dr Ramodike

delivered the first twin (boy) who was in a breech position and after his delivery she took him to the nursery room for post-natal management. Ten minutes later, baby R was delivered by Sr Masakane, with Dr Ramodile being in attendance. She had no concerns with the condition of the babies. Their APGAR scores were 7/10 (at 1 minute); 8/10 (at 5 minutes) and 8/10 at ten minutes after birth. Because they were born prematurely, she expected them to have mild to moderate breathing problems at birth. She assessed their respiration efforts at a score of one out of two. This is because breathing ability was present, without severe distress, but because their lungs were under-developed, they could not be given a score of two out of two as with full term babies.

47. Sr Masakane attended to baby R after her delivery. Sr Masekane recorded in the hospital notes that she had suctioned her airways and had administered oxygen by mask while waiting for the paediatrician on duty to assess her further. Two paediatricians were on duty that day: Dr Oakbay (intern paediatrician) and Dr Mpoyi (on duty in the neonatal & ICU section). Dr Oakbay assessed both babies in the labour ward sometime after 20h00.
48. The babies' APGAR scores were reassuring. There were no major concerns. She did not get the impression that baby R had suffered an acute profound hypoxic event intra-partem. She assessed her respiratory effort as 1/2 because of the fact that baby R was premature. In other words, breathing effort was present, just a bit slower, most probably because of premature delivery and underdeveloped lung capacity. There were no indicators of birth asphyxia, such as the baby being 'floppy'; exhibiting an absent heart rate or no respiratory effort at all. Baby R's colour was pale at first but it improved and was pink at 5 minutes after birth. Baby R was also not 'floppy' at birth as would have been the case had she suffered an acute profound intra-partem hypoxic insult; Other indicators of an intra-partem hypoxic event are: a slow

or absent heart rate, or absent respiratory effort, or gasping, floppy muscle tone with no activity, and pale or blue colour (cyanosis) at birth, which was not the case with baby R.

49. Sr Masekala's notes indicate that baby R was given oxygen by mask and through a head box (where the baby is placed in an environment that has continuous oxygen flow) whereafter she was assessed by Dr Oakbay in the labour ward. Dr Oakbay made the call to admit both babies to the neonatal ward. They were admitted to ward 2 later that evening. Dr Oakbay has since returned to his home country and Dr Mpoyi is no longer employed at Natalsrut hospital. It is unknown where either of the doctors are currently based.
50. Dr Ramodike confirmed that there were three other emergency deliveries that occupied the emergency theatre on the relevant day. Patients are prioritized for delivery depending on their condition and need. For example, if a mother is actively bleeding and her life is in danger, she would be prioritized ahead of other c-sections for emergency delivery. If the mother and baby/ies are assessed to be in a stable condition, they will ordinarily have to wait their turn. As far as the plaintiff was concerned, she was regularly monitored until she gave birth. There were no indicators from the mother or babies that required emergency medical intervention. A minimum of three doctors are required to operate one theatre, and a total of 7 people are required in theatre, being a gynaecologist and two assistants; paediatrician and anaesthetist; midwife; and scrub nurse. The hospital did not have sufficient doctors on duty that day for purposes of opening a second theatre. Dr Ramodike herself had been on duty for a continuous period of 24 hours that day.

51. The vaginal delivery of baby R and her brother was quick, uneventful and proceeded without complication. In her view, the fact that the twins were not born by c-section did not make any difference to the birth outcome. The babies were at high risk for HMD by reason of the fact they were premature with under-developed lungs. From the time that the plaintiff started bearing down, the baby boy was born merely five minutes later and baby R was born 10 minutes after her brother.
52. Most premature babies are at risk for developing HMD because of an underdeveloped respiratory system. Although steroids were administered to the plaintiff at 15h00 to enhance foetal lung development, there was insufficient time for it to take effect before delivery. She could not stop the plaintiff's labour as this is contra-indicated where the patient's membranes have ruptured, as in the plaintiff's case.
53. During cross-examination Dr Ramodike conceded that CTG tracing of only one foetus was wholly inadequate, more so because it is unclear whether it was the boy or baby R whose heart rate was being monitored. It would have been preferable for two separate foetal heart rates to have been documented specifically. The only record of CTG tracing in this case is a print-out of one page which is too short to make 'any sort of determination' of the foetal condition. Dr Ramodike did not know whether further CTG tracing was done and if so, whether such records went missing. She diagnosed the plaintiff as being hypertensive because she had presented with high blood pressure on her first antenatal assessment at the clinic and elevated blood pressure a month later on admission to hospital. This in her view was sufficient to warrant a diagnosis of hypertension.
54. Although the foetal heart rate (as recorded) was not alarming, Dr Ramodike conceded that in the absence of proper management of both foetal heart

rates by means of CTG tracing (to rule out foetal distress) she would not have known that the plaintiff's pregnancy and delivery of the plaintiff's twins was not urgent, requiring prioritization of the plaintiff's c-section delivery. She also conceded that she would not know about the foetal condition without a CTG tracing of both foetal heart rates.

55. She admitted that upon examination of the plaintiff at 13h10, she had reference to a CTG tracing report which recorded one foetal heart rate of 146 beats per minute, however, this was an unsatisfactory CTG tracing. At 15h30, the hospital records record a foetal heart rate of 136 beats per minute, however, there are no CTG tracing documents to confirm same and no second foetal heart rate was specifically recorded. Therefore she conceded that it would not have been known if the unmonitored baby was in foetal distress.
56. Finally, in her view, if baby R was taken off oxygen, this could have caused her hypoxia. Cyanosis as a result of having been subjected to cold temperatures could also have caused hypoxia.

Sister Masakele (midwife)

57. Sr Masekela testified that she was employed as an advanced midwife at Natalspruit hospital on 24 September 2009. She commenced night duties in the labour ward at 19h00 on that date. She is the midwife who delivered baby R. She recalled that although baby R was pale at birth, she was not cyanosed. After Baby R was born, Sr Maselele suctioned her airways to remove secretions and administered oxygen per mask. Baby R was exhibiting respiratory distress – her sternum was depressed and she had nasal flaring, therefore she put baby R in a head box to receive oxygen. Baby R had low birth weight which was likely due to low gestational age. After attending to baby R in the nursery, the paediatrician on call (Dr Oakbay) was summoned.

After he assessed the condition of the babies, she (Sr Masekela) completed the required documentation for their admission to the neonatal ward. This took place in the labour ward. The twins were referred to the neonatal ward (ward 2), meaning that both were at that stage not considered fit enough to accompany their mother to her word.

58. When a CTG tracing is done, the machine produces a graph. After the machine has run for approximately 20 minutes, the record is printed and placed inside the mother's file.
59. In this case, an important document known as a 'partograph'¹⁰ is missing from the hospital records. It records the foetal condition and progress of labour and reflects, amongst other things, the foetal hear rate/s and any decelerations pursuant to contractions, and whether they are early or late. The CTG reading is plotted on the partograph by the midwife attending to the patient. The partograph is usually located between pages 9 and 10 (it is a double page) but this document is missing from the discovered hospital records.
60. She testified that the twins were put in a radiant warmer to prevent hyperthermia before being transferred to ward 2. After delivery, baby R was suctioned and placed on oxygen and kept under the warmer. Aside from nasal flaring, both babies were stable. In her experience, premature babies are prone to suffering apneic attacks (a temporary cessation of breathing) due to their underdeveloped lungs and lack of surfactant. Baby R was cared

¹⁰ The *partograph* is a graphical presentation of the progress of labour, and of foetal and maternal condition during labour. It is the best tool to help one detect whether labour is progressing normally or abnormally, and to warn attending professionals as soon as possible if there are signs of foetal distress or if the mother's vital signs deviate from the normal range. See: <https://www.open.edu/openlearncreate/mod/oucontent/view.php?id=272&printable=1>

for by the ward nurse whilst Sr Masakele attended to completion of the APGAR scores. By the time she had completed the necessary paperwork, she observed that both babies were still in a stable condition. She in fact visited the babies three times before their transfer to the neonatal ward. Whilst she was attending to administrative duties, the nurse enrolled in the nursery remained with the babies and they were therefore under constant care from the time of their delivery.

61. In her experience, if a baby suffers asphyxia or hypoxia in the intrapartum period, the baby usually comes out blue, 'floppy', exhibits no effort of spontaneous breathing and no crying, thus requiring vigorous resuscitation. Whilst baby R cried reluctantly after birth and was a bit pale at first, she showed no signs of birth asphyxia. Her colour corrected itself swiftly after she was given oxygen. Baby R received the standard form of resuscitation after birth. It was because mild nasal flaring was present at 5 minutes and 10 minutes after birth that her respiratory efforts were scored at 1/2.
62. Once the paediatrician arrived at the nursery she had nothing further to do with baby R or her brother. She conceded that if the babies were transported in a cold incubator without oxygen, this would be tantamount to sub-standard care.

Dr Manthata-Cruywagen (gynaecologist)

63. The hospital records reflect that the plaintiff's blood was taken on booking into the hospital. Blood results revealed that the plaintiff was anaemic. That meant that the plaintiff's oxygen levels were low because her haemoglobin was low.

64. From the available medical records discovered in the matter, it is not known what caused the rupture of the plaintiff's membranes at 32 weeks into her pregnancy.
65. The copy of the single page CTG tracing that was discovered in the present case appears to be only a section of the full CTG tracing. Foetal heartrate 2 was not showing. The reason for that is unknown
66. At 23 weeks gestation, the baby's lungs are not mature or ready to sustain normal breathing and that is why steroids are administered.
67. In her opinion, baby R likely did not suffer an intrapartum acute profound hypoxic insult. If that had occurred, one would have expected her to have presented as 'flat' and floppy at birth with lower APGAR scores, which was not the case. From an obstetrics point of view, an acute hypoxic ischaemic event happens suddenly, without warning. Known causes of such an event are, amongst others, cord prolapse; abruption of placenta where one would see a retro placental clot; and uterine rupture. In the plaintiff's case, there were no such markers to indicate the occurrence of an intrapartum insult. Even with CTG monitoring up to the time of delivery, one could not predict that, for example, an abruption would happen down the line. CTG monitoring provides a useful tool, but it is not 'the alpha and omega' as an indicator of foetal distress. The CTG scan monitors what is happening presently but it cannot predict what will happen in an hour's time. An acute profound injury is not predictable – it happens suddenly. For example, one cannot predict that a uterus will rupture. In her view, any premature birth carries the risk of a negative outcome as the baby's lungs are not mature, with the further risk of reduced oxygen intake. Such babies have to be put on oxygen to assist in breathing. Any twin pregnancy itself carries a risk of onset of pre-term labour. In the plaintiff's case, she had ongoing uterine infections

during her pregnancy together with anaemia and hypertension, as well as an over-extended uterus (which carried the increased risk of rupturing of the membranes), all of which cumulatively increased the risk of onset of pre-term labour.

68. The plaintiff presented at the antenatal clinic late in the day for assessment and management. In her view, the plaintiff received inadequate antenatal care from the private general practitioner whom she had consulted. Examples were given in evidence of what was not done.¹¹ In the words of Dr Manthatha—Cruywagen, ‘you cannot have poor antenatal care and expect a good outcome in the end – it is like building a house without a foundation.’
69. In her view, the single page CTG printout forming part of the hospital records forms part of an incomplete strip, without the whole strip having been included in the trial bundle. The graph itself reflects one foetal heart rate at 150 beats per minute. The attending doctor (identified as Dr Ramodike) recorded the foetal heart rate as 146 beats per minute. The strip that reflected that heart rate of 146 beats per minute was not included in the discovered hospital records. The printed strip that is contained in the trial bundle reflects that the CTG machine that was being used had dual channel monitoring and therefore it is likely that both twins were being monitored simultaneously. It reflected a foetal heart rate of 150 beats per minute and therefore Dr Ramodike must have picked up a foetal heart rate of 146 beats per minute (as recorded by her in the hospital records) from somewhere else.

¹¹ *Inter alia*, scans that ought to have been performed in the plaintiff's first trimester were not seemingly done; the plaintiff's blood glucose levels were not checked or monitored for purposes of ruling out gestational diabetes, given that the plaintiff presented with a high body mass index; the plaintiff was prescribed the same medication for a persistent urinary tract infection ('UTI') that did not improve over a 6 month period, despite use of anti-biotics, and such persistent UTI would have predisposed the plaintiff to pre-term labour.

70. The witness confirmed that various pages from the hospital records were missing from the Plaintiff's trial bundle of documents. For example, the complete maternity case book was missing from the records provided to court. The maternity case book would ordinarily contain a record of the foetal heart rate/s which are usually written down at 30 minute intervals. It is a composite exercise book which contains a separate section for recording foetal heart rates and contractions. The information is further plotted on a partograph, which forms part of that same book, however, the partograph has not been included in the trial bundle.
71. In her opinion, the fact that the plaintiff delivered the twins vaginally was not problematic. The plaintiff was correctly referred for a c-section delivery because the babies were premature and there was therefore a risk that they might not be able to withstand the stress of labour. Whilst a vaginal delivery of a breech baby is not advisable (depending on the position of the baby's head) in the case of a first time mother, in the plaintiff's case, she had previously given birth to three babies and as matters stand, she was able to deliver vaginally without difficulty. Moreover, the babies weighed more than 1.5 kg at birth and they would therefore likely have been able to sustain the stress of labour.
72. It is known that babies will experience respiratory distress as a natural occurrence of pre-term birth. A c-section delivery earlier in the day would not have changed that outcome, as baby R and her brother would still have been born prematurely with underdeveloped lungs. Baby R's APGAR scores were reassuring at birth. The scores were within acceptable parameters and suggest that baby R had signs of prematurity and not birth asphyxia. This is because birth asphyxic babies usually come out 'flat', which was not the case with baby R.

73. During cross-examination, Dr Manthata-Cruywagen agreed that continuous foetal heart rate monitoring is required during the active phase of labour. It is also important to monitor contractions during this phase of labour and the variability of accelerations and decelerations should be recorded in the notes. However, she pointed out that the notes would not necessarily contain a full record if the heart rates, had been plotted on a partogram. She conceded during questioning that premature birth is not a factor that in and of itself can cause an acute profound hypoxic event. An insufficient supply of oxygen to the brain after birth in a baby experiencing respiratory distress can lead to such an event.

Dr Kganane (Paediatrician)

74. Dr Kganane testified that a full term pregnancy is between 38 and 40 weeks. Baby R was born at 32 weeks gestation and she was therefore 6 to 8 weeks premature. There are known possible complications for a child who is born prematurely. These include: an underdeveloped brain; possibility of periods of non-breathing after birth; risk of respiratory complications such as HMD - before birth, a baby uses blood coming from the placenta to breathe and not the lungs. Surfactant is a substance that the lungs produce once they have matured, which helps the baby to breath after birth. Further known complications include heart problems; anaemia (iron deficiency); haematological problems – premature babies are not born with all the clotting factors; chronic lung disease; and blindness. A premature baby is therefore considered a fragile child.
75. On his understanding of the hospital records, Baby R (and her twin brother) were admitted to the neonatal ward at 8h20 and were from such time under the care and control of the intern paediatrician, Dr Oakbay. Baby R had already been diagnosed with respiratory distress on admission to the neonatal ward. When a baby is born at 32 weeks, he or she is at high risk of

developing HMD. Notes entered at 22h00 in the hospital records reflect that baby R was in fact considered as having HMD. Appropriate treatment for managing a diagnosed condition of respiratory distress and for keeping the baby stable under such circumstances would include: (i) keeping the baby warm with ongoing monitoring of her temperature; (ii) administration of oxygen with saturation levels being monitored; and (iii) administration of fluids via a drip. Whether this was done is unknown as there are no records available to show what treatment baby R received in the period between 20h20 (assumed time of admission to ward 2) and 22h00 (assumed time when baby R decomposed).

76. Baby R and her brother had identical APGAR scores at 1, 5 and 10 minutes after birth. At the 10 minute mark, they had both responded to mild resuscitation efforts and were considered to be stable, albeit being diagnosed with moderate respiratory distress. Both were born under the same circumstances in the labour ward. Yet later in the evening baby R regressed, whilst her brother did not. In Dr Kganane's experience, some premature babies respond better to treatment than others. That is why continuous monitoring of their progress – to see how they respond - is important after birth.
77. In the present case, the premature twin babies had similar birth weight. They came from the same uterine environment and attained the same APGAR scores. The correct approach was to monitor them for two to four hours after birth to see how they were responding and to treat them by keeping them warm; administering correct levels of oxygen and intravenous fluids. Any transfer from one ward to the other would have to take place under the same treatment conditions.

78. According to the neonatal progress note completed by Sr Makhwanya (enrolled nurse), baby R was cyanosed ++ (meaning very blue, denoting a lack of oxygen in her body) and cold on touch, critically ill, and gasping upon arrival at the neonatal ward. She was admitted in that condition. The notes do not specify whether this was *peripheral cyanosis* (classified by bluish discoloration to hands or feet – which is associated with cold temperatures that hampers normal blood flow) or *central cyanosis* (bluish discolouration of the tongue, face and core part of the body, which is associated with inadequate oxygen i.e. baby not taking in enough oxygen because of either a heart or lung problem). The fact that the baby was gasping indicates that this was hypoxia. If it was peripheral, treatment would require keeping the baby warm. If it was central, treatment would include administration of oxygen, especially where the baby was gasping for air. Accepting what the note says, baby R was likely experiencing a lack of oxygen and hypothermia.
79. Another note appearing in the neonatal hospital records (recorded by Dr Mpoyi) appears to have been completed at 22h00 on 24 September 2019. It records that he was called to treat a baby who was gasping.¹² The note that was completed by the enrolled nurse (which also appears to have been completed at 22h00 on the same day) refers to baby R having been admitted in the neonatal ward from the labour ward and arriving in an incubator without oxygen, with the baby's condition described as cyanosed++, cold on touch, and baby being critically ill with gasping respiration. The note also refers to baby R having been resuscitated in the ward by the attending sister and Dr Mpoyi. Both notes appear to have been completed retrospectively (i.e., after the event/s described in the notes). The timelines, however, remain unclear. It is uncertain at what time the baby was resuscitated because it is not clear what happened at what time. In other words, the

¹² This note appears at CaseLines, p 04-43.

notes are not specific as to what happened at what specific time in relation to the baby's arrival, resuscitation and stabilisation. It is unlikely that the enrolled nurse's note was entered on baby R's arrival at ward 2 if it says 22h00. It is also not possible to know what was done between admission and the note recorded at 22h00 in relation to the resuscitation of baby R, as there are no available hospital records for that period.

80. According to the note, on arrival Baby R was gasping and had decompensated. This means that with gasping for air, the baby is breathing fast to take in air/oxygen without having the capacity to expel or expire carbon dioxide.
81. During cross-examination, Dr Kganane agreed that it was not irresponsible for the plaintiff to have obtained prenatal care from a private practitioner, although she believes that treatments offered at the ante-natal clinics are more thorough than that which a general practitioner is ordinarily equipped to provide.
82. In her opinion, the time at which the baby was gasping (timeframe uncertainties aside) was probably the moment when the acute profound hypoxic event that led to the cerebral palsy occurred. Having been diagnosed with respiratory distress after birth, monitoring of baby R's condition for at least a period of 2 to 4 hours after birth was vitally important. Monitoring would include observing whether respiratory efforts are maintained at 1/2 (a score of one out of 2) or whether they showed either improvement or deterioration. Optimal care should be provided by the nursing staff during this period (i.e., keep baby warm, administer oxygen and fluids). If there is a deviation from the standard of care required, a negative outcome would be reasonably foreseeable. As baby R's lungs were known to be underdeveloped

at birth, baby R should have been kept warm and on oxygen, at the very least.

83. In her opinion, it would be reasonably foreseeable that a hypoxic event could occur if a baby who was probably born with HMD due to premature birth and who was known to have respiratory distress, were to be deprived of oxygen.

Dr Mogashoa (paediatric neurologist)

84. Dr Mogashoa testified that an acute profound hypoxic ischemic brain injury entails an injury to the brain which occurs suddenly and where the deep nuclei of the brain are impacted. It results from a short intense lack of oxygen to the brain for a short period of time (between 7 to 15 minutes), and results in irreversible brain damage.
85. In her opinion, the injury sustained by baby R likely did not occur intrapartum. Had it occurred in this period, baby R would have been in a depressed state at birth, requiring more vigorous resuscitation, which was not the case with baby R. A form that was completed for purposes of admission of baby R to the neonatal clinic¹³ reflects that all her primitive reflexes such as grasp, suck and moro (where baby lifts head and drops it and arms come up) were present, which is indicative of brain function. Had she been hypoxic at birth, she would likely have exhibited depressed reflexes. The reason for her transfer to the neonatal ward was stated to be 'respiratory distress with subcostal indrawing'. That means that baby R had difficulty in breathing and was using accessory muscles to breathe. The time at which the paediatrician signed this form is not recorded on this form. According to another form that recorded baby R's admission to ward 2,¹⁴ she was admitted by Dr Oakbay on 24 September 2019 at 20h20. It is unclear

¹³ The form is part of the available hospital records, at Caselines, p04-31.

¹⁴ The admission form is at Caselines, p 04-65.

from the form whether baby R arrived at the neonatal ward (ward 2) at 20h20 or whether Dr Oakbay completed and signed the form for her admission to ward 2 at 20h20.

86. The hospital records also contain a note that was completed by Dr Mpoyi. It records that he that he was called to attend to a gasping baby (baby R) as well as the treatment provided by him to resuscitate her. Whilst the date and time are recorded on the form (being '24/09/19 22h00') it is not known whether he wrote the note at 22h00 (i.e., after the fact) or whether he was conveying that he was called to assist a gasping baby at 22h00. At the time that baby R was gasping for air, her oxygen saturation level was at 58%. After resuscitation, her saturation level increased to 81-85%. Baby R was described as bradycardic, meaning that she had a low pulse rate likely because of a lack of oxygen that led to a hypoxic event. Treatment consisted of intubation, bagging (manual ventilation) and *inter alia*, adrenaline and servanta (artificial surfactant) were administered. Upon further bagging, her oxygen saturation level improved to 92%. This type of vigorous resuscitation would likely have taken between 20 to 30 minutes.
87. In her opinion, babies do not sustain gasping for air for an extended period of time. Gasping is a grossly abnormal occurrence. If the baby was gasping upon physical arrival at ward 2 but only resuscitated at 22h00, she would likely not have survived. Therefore it is more probable that resuscitation occurred shortly after the baby arrived gasping.
88. A progress report that was completed by the enrolled nurse (Sr Makwanya)¹⁵ makes reference to baby R arriving at ward 2 in a critically ill condition, having been transported in a cold incubator without oxygen. She was very cyanosed (denoted by the inscription 'cyanosed ++') and cold on touch. The

¹⁵ This is the note at Caselines, p04-67.

baby was gasping. She was resuscitated in the ward by Dr Mpoyi and the attending sister, and had also been diagnosed by Dr Oakbay with respiratory distress. This note appears to have been completed retrospectively (after the event) and coincides with the time supplied by Dr Mpoyi in his own note, i.e., 22h00. The notes however are unclear in regard to time. It is unclear whether the time indicated, being 22h00, as recorded on the note made by Dr Mpoyi and the note made by Sr Makwanya is the time that baby R was examined or the time at which the notes were completed retrospectively. There are also no available notes during the period between the arrival of baby R at ward 2 and her resuscitation inside ward 2. There is therefore no record of what treatment was given or how her condition was managed. It is known that an acute profound hypoxic event happens suddenly.

89. According to the hospital records, baby R had been stabilised in the labour ward after birth and diagnosed with respiratory distress. A decision was made to transfer her to the neonatal ward. The correct management of a pre-term baby in her condition would be to ensure that the baby is transferred in a warm incubator and given oxygen. On arrival at the neonatal ward, the staff would assess the baby's vital signs and measure the baby, put the baby on a drip to administer fluids, keep the baby under a radiant warmer and administer oxygen. Thereafter the baby should be closely monitored to see if he/she settles down with oxygen supply or if his/her condition deteriorates. Oxygen saturation levels should be closely monitored. If any deterioration in respiration is noticed, the doctor should be notified to intervene. The doctor would assess whether the baby requires surfactant and/or any other intervention.
90. During cross-examination Dr Mogoshoa could not refute the evidence of Sr Masakane to the effect that the twins had been assessed by Dr Oakbay in the labour ward and that the necessary paperwork relating to baby R's transfer

and admission to the neonatal ward had been completed in the labour ward. That means that records wherein the reflexes of baby R were recorded including the reason for her transfer to ward 2 and her weight, height, length and APGAR scores were likely completed in the labour ward. Dr Mogoshoa stated that she did not know, from a perusal of the available hospital records, how long the babies had remained in the nursery before they arrived in ward 2. Nor could she say at what time the babies arrived in ward 2. Sister Makwanya's note regarding the condition of baby R on arrival at ward 2 and the successful resuscitation by Dr Mpoyi in ward 2 (which would have taken 20 to 30 minutes) means that, on an ordinary reading of such note, and accepting that such notes were probably written retrospectively at 22h00, baby R's resuscitation would probably have commenced at 21h30 with her arrival in ward 2 shortly before such time. This is assuming the note was completed directly after the resuscitation ended.

91. Further during cross-examination Dr Mogoshoa conceded that if baby R had been transported in a cold incubator without oxygen so that she was gasping on arrival and in a critically ill condition at that time, then it means that the acute profound hypoxic ischaemic event could have occurred during the transfer. During further questioning on this point, she stated that the injury occurred after birth but she could not say whether it occurred en route to ward 2 or upon arrival in ward 2 – it occurred sometime between the two times. Considering that baby R had been diagnosed by Dr Oakbay as having respiratory distress with subcostal indrawing, *that* was reason enough to ensure that she be kept warm with adequate oxygen supply.
92. The hospital notes reflect that baby R was not bradycardic at birth. She was active and exhibited respiratory effort. According to her APGAR score, (being 1/2 for reflexes) her reflexes were 'down' but not absent. There was thus no need for intensive resuscitation at birth. In her opinion, the injury therefore

did not likely occur before birth. At one minute after birth, Baby R had a normal heart rate and normal muscle tone and at 5 minutes after birth, she had a normal colour. Had she presented with a low heart rate, absent respiratory effort and floppy muscle tone at or shortly after birth (which she did not) this would more likely have signified the occurrence of an intrapartum hypoxic event.

93. In her opinion, there is a window period for monitoring a pre-term baby with respiratory distress, during which period the attending nurses should remain alert to assess improvement or deterioration in respiration. Monitoring would include ensuring that the baby is placed in the best possible environment for improvement, which would include warmth and oxygen supply. Transporting a pre-term baby with respiratory distress in a cold environment, without oxygen, constitutes a deviation from the minimum standard of care required. Premature babies can suddenly stop breathing because their respiratory systems are immature. A baby can stop breathing within 5 minutes without oxygen. That is why it is important to monitor their breathing so that interventions can be put into action (such as immediate resuscitation) should they suddenly stop breathing.
94. Dr Mogashoa testified that transporting a preterm baby who has known respiratory distress in a cold incubator could result in the baby stopping to breathe because her temperature is so low so that she develops hyperthermia, which is a condition associated with neurological impairments.
95. Although Dr Mogashoa was at first reluctant to concede that hypoxia or hypothermia were foreseeable consequences in circumstances where a pre-term baby with known respiratory distress is exposed to a lack of oxygen for 5 minutes or more, including cold temperatures, she did concede that the

lack of oxygen, cyanosis and hyperthermia experienced by baby R (as documented in the hospital records) could have triggered the acute profound hypoxic ischaemic event that led to the brain injury and resultant cerebral palsy.

Discussion

96. The uncontroverted evidence was that an incomplete set of hospital records was produced at trial. The relevant pages that were missing from the records, as identified during cross-examination of various witnesses, are a matter of record. Suffice it to say that these included the partograph and the section in the maternity case book where the foetal heart rates are ordinarily recorded in more detail, including a full and complete print-out of the CTG tracing report (as opposed to the one page extract therefrom as was discovered by the plaintiff). I am not for a moment suggesting that the plaintiff was complicit in withholding relevant documents from the court. On the contrary, I found her to be a credible witness who did not seek to obfuscate the facts. I believe her when she said that she obtained copies of the records discovered by her from a person whom she *bona fide* believed to be an employee at the hospital and that she produced whatever records she had so obtained.
97. The courts have from time to time expressed their dissatisfaction with the defendant's failure to retain and produce hospital records at trials of this nature. More often than not, as in the present case, no explanation is given for the disappearance of the records or why they were not properly preserved, as is statutorily required¹⁶ of the defendant's employees. See: *PG on behalf of TG v The MEC for Health, Gauteng Province* (2014/6003) [2021] ZAGPJHC 351 (19 March 2021) at paras 7-10, where the various cases are

¹⁶ In terms of ss13 and 17 of the National Health Act 61 of 2003, the records of hospitals and clinics are required to be maintained and safely stored and that adequate control of access thereto be put in place.

recapped. In *Khoza*,¹⁷ Spilg J cautioned, *inter alia*, that the failure to produce the original medical records which are under a hospital's control and where there is no acceptable explanation for its disappearance or alleged destruction cannot of its own be used to support an argument that a plaintiff is unable to discharge the burden of proof because no one now knows whether the original records would exonerate the defendant's staff from a claim of negligence.

98. The defendant sought to argue that 'somebody intentionally manipulated' the hospital records by providing only selective pages to the court.¹⁸ The argument developed to the point where the plaintiff was accused of intentionally manipulating the hospital records by failing to incorporate all the relevant pages and medical notes 'which may not have been in the plaintiff's favour.' Such an argument is not sustainable. It is devoid of primary facts to ground it and in any event cynically ignores the duties that are imposed on medical staff to retain and secure the safety of hospital records, as set out in the case law referred to above.
99. In *AN v MEC for Health, Eastern Cape*,¹⁹ the court explained that a sudden, total, persistent interruption to the blood supply [and hence oxygen supply] in the prepartum period is usually caused by a perinatal sentinel event such as placental abruption, uterine rupture, umbilical cord prolapse, shoulder dystocia, maternal collapse or compression of the cord (which totally interrupts blood supply for a period long enough to cause damage) (a total, persistent interruption). Each of these (with the exception of a cord compression) can be verified afterwards because they leave a footprint. In

¹⁷ *Khoza v MEC for Health and Social Development, Gauteng* 2015 (3) SA 266 (GJ) para 47

¹⁸ Evidence was given that the hospital records are contained in an exercise book format, which is stapled together in the middle, with front-to-back recorded pages. Having regard to the numbering at the bottom of the hospital records, it was plain that pages 5 to 9, 11, 14, 15 and 21 were not included in the copies that were produced at trial.

¹⁹ *AN v MEC for Health, Eastern Cape* (585/2018) [2019] ZASCA 102 (15 August 2019), para [16].

the present case, the evidence did not establish that any such markers were present at birth to denote that such sentinel events had occurred. There was also no evidence that cord compression had likely occurred.

100. Prof Nolte confined her evidence to the standard of care provided by the midwives during the plaintiff's labour (intrapartum period). Dr Mbokota too confined his evidence to the intrapartum period. Their views were based on inferences drawn by them from the recording of only one [normal] foetal heart rate by the attending doctor and midwife in the available records (without knowing whether such recorded heart rate pertained to baby R or not) including the absence of evidence depicting the monitoring of the plaintiff's contractions, more specifically, the variability of accelerations and decelerations as well as the insufficient CTG tracings in the hospital records.
101. Dr Mbokota was the lone voice amongst the various experts that postulated that the acute profound hypoxic ischemic insult likely occurred intrapartum, between 30 to 40 minutes prior to baby R's birth. He reasoned that because there were no records of CTG monitoring of the plaintiff's contractions and both foetal heart rates (or specifically the heart rate pertaining to baby R) during both the plaintiff's latent and active phases of labour, it was possible that she (baby R) may have experienced undetected foetal distress in the active phase of labour leading to an intrapartum hypoxic ischemic insult to her brain. He stated that had there been evidence of proper foetal monitoring during labour, then only could it be said that it was possible that the HIE may have occurred after her birth. Such reasoning is flawed in several respects. Firstly, it is speculative. It is based on a postulation that in the absence of records of foetal heart rate monitoring according to the Maternity Guidelines (2007), foetal distress in utero could not be ruled out, without any primary facts having being established to support the reasonable inference that foetal distress had occurred intrapartum.

102. In *A M and Another*,²⁰ the Supreme Court of Appeal had occasion to reiterate the role of experts and how their evidence is to be approached. Wallis JA put it thus:

[17] ...The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.

[20] The need for clarity as to the facts on which an expert's opinion is based has been stressed in a number of cases. In *PriceWaterhouseCoopers v National Potato Co-operative Ltd* the following passage from a Canadian judgment was cited with approval:

'[326] *"Before any weight can be given to an expert's opinion, the facts upon which the opinion is based must be found to exist"*

[327] *"As long as there is some admissible evidence on which the expert's testimony is based it cannot be ignored; but it follows that the more an expert relies on facts not in evidence, the weight given to his opinion will diminish"*.

[328] An opinion based on facts not in evidence has no value for the Court.'

[21] The opinions of expert witnesses involve the drawing of inferences from facts. The inferences must be reasonably capable of being drawn from those facts. If they are tenuous, or far-fetched, they cannot form the foundation for the court to make any finding of fact. Furthermore, in any process of reasoning the drawing of inferences from the facts must be based on admitted or proven facts and not matters of speculation. As Lord Wright said in his speech in *Caswell v Powell Duffryn Associated Collieries Ltd*:

²⁰ *A M and Another v MEC for Health, Western Cape* (1258/2018) [2020] ZASCA 89 (31 July 2020) at paras 17 and 19-21.

‘Inference must be carefully distinguished from conjecture or speculation. There can be no inference unless there are objective facts from which to infer the other facts which it is sought to establish ... But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture.’” (emphasis added)
(footnotes omitted)

103. Secondly, Dr Mbokota’s opinion as to the timing of the HIE was not supported by peer review or scientific research, or for that matter, the opinions of any of the other experts who testified at the trial, all of whom opined²¹ (with the exception of Prof Nolte – such an opinion essentially falling outside the scope of her expertise) that it most likely occurred only after baby R’s birth, based on the primary fact that baby R had been deprived of oxygen for a sustained period and was also exposed to hypothermia during her transfer to ward 2. Thirdly, the APGAR scores of baby R after birth were shown to be incompatible with the inference sought to be drawn by Dr Mbokota.
104. I am therefore constrained to concluded that the HIE did not occur in the intrapartum period but after birth.
105. As to the cause of such event, the uncontroverted evidence was that baby R was diagnosed, upon assessment by the attending paediatrician (Dr Oakbay), with moderate respiratory distress after birth. She had difficulty breathing as evidenced first by nasal flaring and thereafter by subcostal indrawing. As she was born premature with underdeveloped lungs, such condition was to be expected. Her condition after birth ought to have been managed and treated by way of keeping her warm, hydrated and on oxygen whilst being closely

²¹ On the direct evidence of the attending doctor, Dr Ramodike, there were no abnormalities detected or recorded during the intrapartum period. The other expert doctors, (with the exception of Dr Mbokota) all appear to accept the proposition that there was no evidence to support an inference of foetal compromise in the intrapartum period.

monitored for a period of between two and four hours thereafter. Monitoring of her condition was vital for purposes of assessing improvement or any deterioration in her condition. Both paediatricians and other expert witnesses who were called by the defendant were all in agreement that the deprivation of oxygen and cold temperatures to which baby R was exposed were capable of precipitating the HIE and had likely precipitated the HIE. The evidence of the factual witnesses (Dr Ramodike and SR Masakale) was to the effect that the transportation of baby R from the labour ward to ward 2 would have taken between 5 to 15 minutes, depending on the congestion of pedestrian traffic utilizing the relevant elevator at the time. Ward 2 is located on a floor above the floor on which the labour ward is situated. On the evidence of Dr Mogashoa, a deprivation of oxygen for a period of 5 minutes is sufficient to cause a baby to stop breathing. How much more so with a pre-term baby with underdeveloped lungs who is suffering from respiratory distress and is reliant on oxygen support?

106. It is common cause that a combined note was made by the enrolled nurse, Sr Makhwanya, of the condition of baby R upon arrival at ward 2 (i.e., very cyanosed, cold on touch, gasping and critically ill) and of her eventual resuscitation by the paediatrician on call, Dr Mpoyi, who found her gasping upon his arrival. It is clear from Sr Makhwanya's note that she completed same after the resuscitation process was completed, otherwise she would not have been able to make mention thereof in her note. Sr Makhwanya's note indicates that she was not the sister who had assisted Dr Mpoyi in resuscitating baby R. Had there been more than one resuscitation procedure performed on baby R that night, on the probabilities, a reference thereto would have been included in the same note. Only one resuscitation attempt (by Dr Mpoyi) was noted in the hospital records. The experts were in agreement and the evidence established that the notes made by both Dr

Mpoyi and Sr Makhwanya were completed retrospectively at 22h00, that is, after the happening of the events described in the respective notes. Furthermore, the uncontroverted evidence of Sr Masakale was that the documents that were utilized for processing baby R's admission to ward 2 had been completed by her and Dr Oakbay in the labour ward. Having regard to Sr Makhwanya's note and the unrefuted evidence of Dr Lefakane, Dr Kganane and Dr Mogahoa above, it is entirely probable that baby R was resuscitated inside ward 2 after being observed to be in a critically ill condition when arriving at ward 2 (as noted by Sr Makhwanya). The evidence did not establish that baby R had physically arrived at ward 2 at 20h20. Rather, the probabilities were that she arrived after such time. The witnesses testified that it was unclear whether the time of 20h20, as recorded on the neonatal admission form (signed by Dr Oakbay), depicted the time that the form was completed rather than the time that baby R actually arrived and was admitted into ward 2. On the probabilities, as only one resuscitation was recorded as having been performed on baby R, such resuscitation must have occurred later than 20h20 but before 22h00. No *precise* time in respect of baby R's arrival and subsequent resuscitation and stabilisation is capable of being inferred from the hospital records. In any event, the evidence established that had baby R in fact arrived at the neonatal ward at 20h20 in a state of gasping, exhibiting hyperthermia and a lack of oxygen supply, and had the resuscitation only occurred at 22h00, she would likely not have survived. Yet the evidence established that she was successfully resuscitated in time after the sudden deterioration in her condition was observed. When regard is had to the blood report forming part of the hospital records, a blood specimen was taken from baby R in ward 2 at 21h00. Another record, being a feeding chart, indicates that her temperature was 35 degrees [very low] at 21h00, with a further note reading: 'Feeding NPO [nil per mouth], Meconium 5.3 MMO LL' (meaning that she had passed a stool). Whether her

temperature and bloods were taken before or after the resuscitation, remains unclear. In my view, the time at which this would have occurred does not detract from the fact that baby R was resuscitated as a result of her gasping for air at a time when she was hypothermic due to a known and established cause, being the fact that she had been deprived of oxygen and warmth for a sustained period, at least whilst being transferred to ward 2.

107. The proper approach for establishing the existence or otherwise of negligence was formulated by Holmes JA in *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430 E-G where the following was said:

“ For the 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.

...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 upon the particular circumstances of each case. No hard and fast basis can be laid down.”²²

²² See too: *Sea Harvest Corporation (Pty) Ltd and Another v Duncan Dock Cold Storage (Pty) Ltd and Another* [1999] ZASCA 87; 2000 (1) SA 827 at [19], where the following was said:

“It should not be overlooked that in the ultimate analysis the true criterion for determining negligence is whether in the particular circumstances the conduct complained of falls short of the standard of the reasonable person. Dividing the inquiry into various stages, however useful, is no more than an aid or guideline for resolving this issue... It is probably so that there can be no universally applicable formula which will prove to be appropriate in every case... [I]t has been recognised that while the precise or exact manner in which the harm occurs need not be foreseeable, the general manner of its occurrence must indeed be reasonably foreseeable.”

And

Pitser v Eskom [2012] ZASCA 44; JOL [2012] 29007 (SCA) at [24] where the court stated:

“What is or is not reasonably foreseeable in any particular case is a fact bound enquiry...Where questions that fall to be answered are fact bound there is seldom any assistance to be had from other cases that do not share all the same facts.”

108. In my view, it has been shown in evidence that an injury of the type that befell baby R, who was a respiratory distressed premature new-born with underdeveloped lungs, in circumstances where she had been deprived of oxygen and had moreover been exposed to cold temperatures and hypothermia, was both reasonably foreseeable²³ and preventable and that the defendant (represented by the medical professionals who were tasked with caring for baby R) failed to take reasonable steps to guard against an injury happening by ensuring that she was conveyed in a warm incubator, supported with oxygen supply. It could have been prevented by adhering to the basic treatment protocol required during the necessary ongoing monitoring of her condition, as testified to by the various experts, which, at the very least required that she be kept warm and on oxygen, even during her transfer to ward 2.
109. I thus find that those responsible for managing the care and treatment of baby R after birth were negligent in not seeing to it that she was kept warm and supported by means of oxygen supply after birth. It is not in dispute that the defendant is vicariously liable for their conduct.
110. Did the failure to adhere to the necessary treatment protocol cause the HIE and resultant cerebral palsy?
111. Dr Mbokota aside, all expert doctors who testified at trial concurred that a deprivation of oxygen with resultant severe cyanosis and hypothermia could have caused the HIE and resultant brain damage to baby R during her

²³ Stated differently, the staff members who were tasked with caring for baby R after birth for and monitoring her condition ought to have foreseen the possibility of baby R suddenly being harmed or injured through being exposed to a total persistent deprivation of oxygen at a critical time when she was dependant on the aid of oxygen for the management or improvement of her condition.

transfer from the labour ward to the neonatal ward. There can be no doubt that the deprivation of oxygen at a critical time during which baby R was supposed to be nursed for a diagnosed condition (moderate respiratory distress) in accordance with a basic treatment protocol, fell short of the standard of care that was required to be provided to baby R by the attending staff who were responsible for monitoring her condition.

112. In *AN v Mec for Health, Eastern Cape*, *supra*,²⁴ the test for causation was stated as follows:

“The test for factual causation is whether the act of omission of the defendant has been proved to have caused or materially contributed to the harm suffered. Where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach is what caused the harm suffered.”

113. In *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) at [25], the court observed:

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

114. In *Minister of Finance and Others v Gore NO* 2007 (1) SA 111 (SCA) at [33] the SCA held:

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

115. In the present case, the cause of the brain damage sustained by baby R was an *acute profound hypoxic ischaemic insult*”. As was explained in *AN v Mec*

²⁴ Cited in fn 20 above, at para [4].

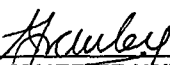
for Health, Eastern Cape, supra, 'acute' means 'sudden' as opposed to developing over time. 'Ischaemia' is a restriction in blood/oxygen supply. Blood supplies oxygen to the brain. A restriction in blood supply leads to a lack of oxygen supply. 'Hypoxia' results from sustained reduction in the supply of oxygen to the brain. This is a form of neurological dysfunction. It is plain that the damage described in the radiologists joint minute was caused by a sudden total sustained lack of oxygen to the brain of baby R.

116. In my view, on a conspectus of the expert testimony, the plaintiff has established that it was the deprivation of oxygen exacerbated by the cold temperatures to which baby R was exposed whilst being transferred to ward 2 which caused her to sustain the HIE injury which ultimately resulted in the cerebral palsy from which she suffers.
117. I am satisfied that the plaintiff has established that the defendant is 100% liable for any damages sustained by her as may be proven or agreed to as a result of the negligence of the defendant's employees which led directly to the resultant injury to baby R. It is not in dispute that the defendant is vicariously liable for their conduct.
118. The general rule is that costs follow the result. I see no reason to depart therefrom.
119. In the circumstances, the following order is granted:

ORDER

1. The defendant is liable for any damages that are proved or agreed to be due to the plaintiff in her capacity as parent and natural guardian of RN;

2. The plaintiff's costs in respect of the determination of the issue of liability are to be borne by the defendant.


A. MAIER-FRAWLEY

JUDGE OF THE HIGH COURT

GAUTENG DIVISION OF THE HIGH COURT, JOHANNESBURG

This judgement was prepared and authored by the Judge whose name is reflected and is handed down electronically by circulation to the Parties/their legal representatives by email and by uploading it to the electronic file of this matter on CaseLines. The date for hand-down is deemed to be 10h00 on Tuesday the 28th September 2021.

Dates of virtual hearing: 12-16 April 2020; & 19-23 April 2021;
& 17 June 2021.
Judgment delivered: 28 September 2021

APPEARANCES:

Counsel for Applicant: Mr BD Molojoa
Attorneys for Applicant: Jerry Nkeli & Associates Inc

Counsel for respondent: Mr DJ Joubert SC
Attorney for Respondent: State Attorney (Johannesburg)