

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

CASE NO. : 21/2015

Date of hearing: 01 November 2018

Date delivered: 15 October 2019

In the matter between:

L[...] T[...] obo S[...] T[...]

Plaintiff

And

**MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH, EASTERN PROVINCE CAPE**

Defendant

JUDGMENT

MAJIKI J:

[1] The plaintiff instituted a claim based on vicarious liability against the defendant for a sum of 32 million rands. The claim is for damages she contends are attributable to the negligent conduct of the defendant's employees. She sues both in her personal and representative capacity as the mother and natural guardian of her male minor child, S[...]. She contends that, as a result of the plaintiff's prolonged and obstructed labour, S[...] was born with hypoxic encephalopathy of the partial

prolonged variety giving rise to cerebral palsy. The action is defended by the defendant.

[2] The plaintiff in her particulars of claim alleged various grounds of negligence by the defendant's medical staff, including, failure to recognise the plaintiff as a high risk patient; failure to properly examine and monitor the plaintiff and the condition of her foetus and administer proper medical care to prevent development of fetal distress and or cerebral damage when they should have done so.

[3] The defendant denied that S[...] was born with hypoxic ischaemic encephalopathy or that the defendant's employees were negligent in any way in their care, treating and managing of the plaintiff and S[...]. The defendant pleaded that if minor omissions happened to be found in relation to the compliance with prescribed procedures, regarding the care and monitoring of the two, such had no adverse effect on the birth process of S[...] and had no causal connection to S[...]’s medical condition.

[4] During the hearing, it was not in dispute between the parties that the magnetic resonance imaging (MRI) scan showed that S[...] has cerebral palsy due to suffering of a global insult to the brain due to hypoxic ischemic injury of a partial prolonged nature with features compatible with super imposed hypoglycaemia at term.

[5] The issue is whether S[...] sustained a hypoxic ischemic encephalopathy (HIE) or injury, *intra partum*. If he did, whether the injury is causally connected to any of the proven negligence due to the defendant's employees, within the course and scope of their employment with the defendant.

EVIDENCE

[6] The plaintiff testified that she was a primigravida of 18 years, having been born on 02 July 1994. She felt labour pains, she proceeded to Siphetu hospital (Siphetu) where she arrived after midnight. She initially said she was admitted on 29 November 2012 but the medical records reveal that she was admitted on 30 November 2012. She was admitted and assessed just after 00h50. She was in

early labour, with 2 centimetres dilation. At 14h00 on 1 December 2012 she was in active labour with 4 centimetres dilation. At 17h00, she was again examined, vaginally. S[...]’s fetal heart rate was not checked. After realisation that she had obstructed labour, she was then transferred to Madzikane Kazulu Memorial hospital (Madzikane) for a caesarean section.

[7] On 2 December 2012 at 08:00 she was given an anaesthetic which rendered her to be unconscious. Dr. Ximbi performed a caesarean section and delivered Sifundo. She later woke up at a recovery ward, she was not fully conscious. She observed that S[...] had swollen head. He was spanked and he gave a soft cry. She went back to sleep.

[8] She saw S[...] again at 12h00. His neck was pulling towards one side. He winked with one eye, one hand was clenched, and another had a wound at the back. He was pink. She stayed with S[...] from then henceforth until their discharge to Siphetu the next day. Sifundo could not breastfeed, he did not suckle. Her breast too, could not produce milk. She fed Sifundo her own juice by using the lid of a bottle. The nurses did not give her formula milk. S[...] cried hard when she stopped feeding him.

[9] The doctor would come, look at S[...], and would not say there was anything wrong with him.

[10] Upon their discharge they went back to Siphetu. Her breast could still not produce milk. A nurse gave her a bottle and said if she expressed the breast, the milk would eventually come out. S[...] could not sustain a sleep for more than 30 minutes, he cried a lot. His neck was no longer twisting. S[...]’s eye was no longer winking and his fist was no longer clenched. S[...] could only breastfeed after three (3) days of birth, at Siphetu and he was able to suckle. She conceded that, whilst kept in hospital, it was her who was being treated.

[11] She said they were discharged on 8 December 2012, the discharge summary indicated that the date of discharge was 7 December 2012. She stayed with S[...] for

a month and handed him to his paternal grandmother after that. She said she was saddened by S[...]’s condition.

[12] She disputed that at 16h00 on 03 December 2012 S[...] was sucking and breastfeeding well as recorded in the medical records. She disputed that she ever told the experts she consulted that S[....] was fed nasogastrically, when he was unable to suckle. Grace Hughes, and Dr Hulley referred to this in their reports and said they got that information from her. She also denied that she told Grace Hughes that S[...]’s neck was wrapped with umbilical chord. She denied that she ever mentioned to Dr Reddy, the paediatrician anything about hearing that Sifundo had a seizure. S[....] never experienced a seizure. She further denied that she had said she only saw S[...] a day after birth. She further denied that she delivered S[...] at 06h00, as Dr Reddy had recorded. She said she told Dr. Reddy S[...] gave a cry at birth and not an audible cry as Dr Reddy had noted.

[13] Her evidence in cross examination changed in various respects. That included the following aspects, she said she did not see everything at the recovery ward. She also introduced the fact that upon their discharge from Siphetu, at home and until she gave the child to his grandmother, his one fist was still clenched, and the neck was twisting towards one side. She however, conceded that she did not inform the medical staff that Sifundo was not well. She still said she had forgotten to testify about the fact that she had told the nurses, upon their discharge that Sifundo, was not well, his eye was winking, his neck was twisting and he was not breastfeeding. With regard to S[...] not breastfeeding, a nurse told her that she should wait, the breast might still produce milk. She said she had forgotten some of the things she testified about in her evidence in chief, the previous day, in particular that she had said the neck was no longer twisting and the hand was not clinched. She said she also forgot some of the things that had happened at home. She could not provide an answer as to why she told Dr Reddy said she had caesar at 06h00. She conceded that she told Dr Reddy she arrived at Madzikane hospital on 29 December 2012. She said she was confused about the dates. She also said she had forgotten to testify about what she had told Dr Hulley that she was put on a drip. She said at theatre the nurses kept her awake despite having testified earlier that she was unconscious once sedated. When it was suggested to her that her version kept

on changing because she was not telling the truth she said she had no answer to that.

[14] Even though she said S[...] had problems, she could not dispute what was recorded in the medical records about Sifundo's condition. The medical records indicated amongst others, that S[...] was born with Apgar scores of 9/10, 10/10 and 10/10 at 1, 5 and 10 minutes respectively, he was suckling and sucking well.

[15] The next witness, a paediatric neurologist, Professor van Toorn, testified that he examined S[...] in 2016, when he was four (4) years old. He had severe developmental delay. He did not walk, see or hear properly. He had mild degree of cerebral palsy. He confirmed that S[...] had caput at birth. The labour was prolonged to about five (5) hours instead of the expected twenty (20) minutes to two (2) hours after the cervix had fully dilated. In the summary of labour in the medical records the part that indicates fetal distress is circled. The fetal heart was not monitored in accordance with the Guidelines for Maternity Care in South Africa (the guidelines). The fetal heart should have been monitored every half an hour before, during and after a contraction for low risk babies. If fetal distress was picked up early, interventions like, giving mother oxygen, lying her on the side, suppression of contractions or quick delivery could be done. He said based on the MRI and literature, there was support that S[...] had HIE which occurred *intra partum* which culminated into cerebral palsy. MRI revealed damage of white matter at the back. That indicated lack of oxygen and blood sugar. He said the stiffness, indicated by pulling of the neck and clenched fist suggested compromise but there was no indication of compromise after birth.

[16] Under cross examination Professor van Toorn made some concessions relating to whether it could be concluded that HIE in S[...] could be said to have occurred *intra partum*. Firstly, that there had to be abnormalities in the brain on neurological examination within the first few days of life, in the first week, before injury could be said to have occurred *intra partum*. The classical signs of the abnormalities would include, abnormal breathing, comatose, eye fixation, low muscle

tone, seizures, reflexes, no cry or lots of cry, posturing, non-feeding and etc. Secondly, he said he agreed with well accepted Volpe's theory on the aspect that three features had to be present in order to indicate the probability that the injury occurred *intra partum*. Fetal distress is a risk factor, depending on when it was diagnosed. The other two features are depression at birth and overt neonatal neurological syndrome. The depression at birth entails absence of a loud cry, low Apgar scores and neonate requiring resuscitation and being taken away from the mother. With regard to suction, he agreed that suction was not resuscitation.

[17] It was suggested to him by Mr Zilwa, counsel for the defendant that according to the medical records the Apgar scores were good. Further, according to the facts based on parts of the plaintiff's version and the medical notes, they indicate that S[...] was not depressed at birth. He agreed that no seizure was recorded and the plaintiff denied telling Dr Reddy about seizure. He also agreed that a baby with seizure would not be left with the mother to be fed juice. He said the pulling of the neck to one side together with other medical findings, would be indicative of depression. Brain stem was not shown to be damaged in the scan, therefore no swallowing problems would be expected on S[...]. If what the plaintiff testified to, including being left with S[...], S[...] having cried loud, and fed juice together with clinical notes, were true, that meant that not all of Volpe requirements were met, two were not, that is, the depression and overt neurological syndrome.

[18] In the light of that, Professor van Toorn conceded that only the fetal distress requirement was met. Therefore, it could not be said that the injury was *intra partum*. He said his views that appeared on page 100, second and third paragraphs of his report took a wide picture in totality, where he outlined factors favouring and those against intra partum hypoxic ischemic injury. He stated that he was not able to believe the plaintiff and the accuracy of medical notes. However, he agreed that the discharge of S[...] on the second day supported the contention that S[...] was in good clinical state.

[19] The paternal grandmother of S[...] testified. Her evidence mainly, was in respect of S[...]’s condition on their alleged first meeting and when she took him over from the plaintiff. She said she lived with Sifundo from when he was one

month old. She said she saw S[...] two days after he was discharged from Siphetu. He cried a lot, he had a clenched fist and his neck was twisted on one side. He had a small bleeding wound at the back of head. Later, she also said she only saw S[...] for the first time when he was a month old. This is in line with what the experts she consulted in the matter recorded. She also confirmed that she told them so.

[20] She said when S[...] grew up, he developed challenges and could not speak, crawl or sit still at the age other children normally do. Later, he developed fits and by then walked with a limp.

[21] She denied that she had told the occupational therapist and the physiotherapist that the plaintiff had told her that Sifundo was born with the umbilical chord wrapped around his neck. She said the plaintiff had told her that Sifundo only managed to breastfeed at home, after their discharge at Siphetu, not after three (3) days as the plaintiff testified. She was also unable to give a clear answer of what the real position was, in relation to the twisting of Sifundo's neck. When she was told that the plaintiff had said it had stopped whilst still in hospital, she stated that she was the one who stayed with Sifundo. Furthermore, she said, even though she could not dispute what the plaintiff had said, as the person who stayed with S [...], she maintained that his neck was still twisting. She said maybe it had started twisting again.

[22] Dr Hulley testified. He had prepared two medical reports in the matter. One report he prepared before he had sight of hospital medical records and another after that. He corroborated the plaintiff's evidence about admission and the first two assessments. He said at 14h00 the level of head above pelvic brim was 4/5. That according to him was an indication of likelihood of pelvic disproportion. It was not diagnosed for a period of up to 31 hours. The head had still not dropped after 13 hours. There were adequate contractions exceeding 20 seconds in 10 minutes. The plaintiff's labour progress was poor and prolonged. The fetal heart was not monitored in compliance with the guidelines, from 02h00 to 06h30. Her blood pressure went up to 164/93. That should have been a reason to refer her to a higher level hospital, sooner.

[23] He also complained about deletions and or alterations in the medical records, he said it was difficult to make out what was written. He said he did not accept that the Apgar scores recorded in the medical records were correct. He said he did not believe the veracity of medical records.

[24] In his evidence in chief he was of the view that there was no explanation for the injury other than substandard management at the hospital. He said if S[...] had been delivered in 6 to 8 hours earlier than 08h02 when S[...] was delivered, with proper management, cerebral palsy would have been avoided.

[25] Dr Hulley made a number of concessions during cross examination which he agreed had an effect of compromising his report. These included the conclusions he made, based on the information he said he was told by the plaintiff. The plaintiff had said she had no knowledge of most of those, in her testimony in court. The plaintiff was his only source for saying S[...] had poor reflexes after birth, if she testified differently in court his conclusions in that regard could not stand. He reversed his conclusion that referred to nasogastric feeding, in the light of the plaintiff's testimony that S[...] was with her in hospital. He said he had assumed that S[...] was at the nursery. He said all his assumptions in the first report were based on wrong facts, those conclusions ought to be thrown away. He also said he could not have made correct conclusions about S[...]’s seizure at three (3) months old. S[...] was not with the plaintiff, from whom he obtained the said information. He was with his grandmother. The grandmother had told court that S[...] seizures started at one (1) year.

[26] The plaintiff's neonatologist expert, a professor at Tyberburg hospital, Prof Smith, testified that the plaintiff was given substandard care at the defendants' hospitals. Prof Smith was of the view that HIE occurred *intra partum*. The twisting of the neck and the blinking of the eye were signs of encephalopathy. There was a delay in the transfer of the plaintiff for purposes of performing a caesarean birth. The nursing staff ought to have realised much earlier that the plaintiff's progress of labour was poor. They failed to monitor and examine the plaintiff, two hourly, as recommended in the guidelines.

[27] During cross examination Prof Smith appeared to be dismissive of the recorded Apgar scores. In his report he had indicated that he omitted to include the 10 minute Apgar score, because he did not believe that it was true. It later transpired that he had recorded that score and therefore there was no basis for him to place evidence supporting that he had ignored the said score. Despite the inconsistencies in the plaintiff's evidence, Prof Smith sought to put his reliance on her evidence than the medical records. He said his opinion depended on the history. In his view, there were no factual records, however, he acknowledged that the present records depict a picture of a well baby.

[28] He said if the plaintiff's evidence was not to be believed, and there was no neonatal encephalopathy, there was no basis for inferring that HIE occurred *intra partum*. If the baby cried loudly hours after birth, such was not consistent with a depressed baby. He conceded that his criticism about S[...]s vital signs that were recorded after birth, was not justified, in the light of the maternity case record in exhibit C. He conceded that when considering the entire picture it could not be established that HIE occurred *intra partum*.

[29] Professor Andronikou, the paediatric radiologist testified. He had prepared a report in the matter. He had also provided electronic images that spoke to the basis of his report. He and the defendant's radiologist expert, Professor Lotz had prepared a joint minute. They agreed in all respects of radiological aspects in the matter. The summary of their agreed findings are as follows:

- The distribution of cortical and subcortical volume loss and signal abnormality in watershed regions of the brain (predominantly posterior) and sparing the deep nuclei (except for the thalamic pulvinars) is in keeping with partial prolonged type hypoxic ischemic injury that occurred in a term neonate.
- The changes in a thalamic pulvinas, posterior limbs of the internal capsules and occipital lobes are also in keeping with super added hypoglycaemia.

[30] He explained that on probabilities, most hypoxic injuries that happen at term are supposed to be perinatal. This meant, immediately before, during or after delivery. He said according to the literature, there is no mention of ulegyria beyond neonatal period. He went on to say, like all science, there is an upper limit and lower limit, therefore there could be no cut off period per se'. He said he could not give a date of when the injury occurred. However, the distribution which is the watershed indicated that the brain was mature. Sifundo's injury therefore most likely happened within the first couple of months of life.

[31] Before delving on the evidence that relates to quantum, the judgment will first deal with the defendant's case on the merits. The defendant's first witness was Dr Korateng, a specialist obstetrician and gynaecologist. He had prepared two reports, the first report was based on the interview he had with the plaintiff and the information contained in the road to health chart. He prepared the next report after he had received the maternity case record. His evidence dealt with treatment of the plaintiff during the progress of labour and ante-natal care.

[32] He testified that upon the plaintiff's admission at Siphetu on 1 December 2012 at 00:15 she was examined. She had mild contractions of one contraction per 10 minutes, in less than 20 seconds. The fetal heart rate was normal at 142 beats per minute, which was within the normal range, that of between 110 beats to 160 beats per minute. Her blood pressure was 145/85, she was given 500ml of aldomet. In Dr Korateng's view that was not so necessary, her hypertension was very mild. The cervix was 2 centimetres dilated. If a patient is in latent phase, that is, has dilated up to 4cm, she could even be sent home, the progress of labour could even take up to a week.

[33] The next examination was at 14h00 on 1 December 2012, the blood pressure was normal at 130/80; the fetal heart rate was 138 beats per minute; the pulse was normal at 77 beats per minute; the presenting part was 4/5 above pelvic brim and there was no caput or moulding. The contractions lasted more than 20 seconds at one contraction per 10 minutes. They were now moderately strong and the cervix was 4cm dilated. The plaintiff was in active phase of labour.

Her assessment should have been 2 hourly from then onwards. The next examination was at 20h00. The cervix was 7 centimetres dilated. The presenting part had descended to 3/5 above the pelvic brim. The fetal heart rate was 140 beats per minute. The 2 hour monitoring instruction was given. Despite the poor monitoring, the assessment showed no cause for concern. The next assessment was on 2 December 2012 at 02h00. Her cervix was 9cm dilated. The fetal heart rate was 136 beat per minute, her membranes had ruptured. There was no caput, moulding or level of presenting part indicated.

[34] At 04h00 the cervix had fully dilated. The fetal heart rate was 135 beats per minute. Her blood pressure was 145/94, it gave no reason to worry. She was given dextrose (water with sugar). An arrangement was made by the doctor to transfer the plaintiff to Madzikane. There was a cephalopelvic disproportion (CPD) problem with her. Liquor was clean, there was + + caput, and + + moulding. She was given 20ml of nifedipine to slow down the contractions. CPD can be accurately diagnosed in the later stages of labour. + + + caput with severe + + + moulding could be indicative of CPD, especially if the head is not descending as it should. In his view, there was no delay in the transfer of the plaintiff to Madzikane. It is acceptable to allow two hours of labour after full dilation if there are no fetal compromises. If the fetal heart rate is normal, there is no meconium stained liquor and maternal the pelvic is adequate. The plaintiff was referred as soon as she was fully dilated, the doctor did not wait for two hours.

[35] According to Dr Korateng after the plaintiff entered the second stage labour, and could not deliver the baby in two hours, caesarean section ought to have been performed. However, the plaintiff took about two hours to travel to Madzikane and found the doctor busy with another caesar at 06h30.

[36] He said he did not agree with Dr Hulley's opinion that the plaintiff should have been referred earlier for caesarean section because of her small structure. The shoe size and maternal height have been found not to be predictors of CPD. For that contention he relied on the British Medical Journal clinic research of August 1988. On 1 December 2012 at 08h00 when the cervix was 7cm dilated,

the assessment indicated that the head had descended from 4/5 to 3/5. The head had descended throughout with no caput or moulding, but suddenly the baby's head did not come out. According to Dr Korateng that to him was more indicative of failure of the baby's head to rotate so that it presented the right diameters to the mother's pelvis, than CPD.

[37] He said there was abnormality of + + + caput in the first neonatal examination. The ticks in other sections of the examination check list of the neonate indicated that S[...] was not compromised upon delivery. S[...]’s colour was pink, he had nasal flaring that was nursed in an oxygen tent. He could not explain why there was still circling for fetal distress. At 22h00 S[...] was sucking well. On 3 December 2013 he had normal reflexes, sucking well, breastfeeding and eliminating well. His condition was like that until his discharge.

[38] In the final analysis, Dr Korateng was of the view that, according to the records, the progress of the plaintiff's labour was not delayed. There was substandard care in as far as her monitoring was concerned. However, the records of the neonate did not support the occurrence of neonatal and encephalopathy which could give rise to S[...]’s cerebral palsy. The MR1 scan did not indicate the onset of the hypoxic insult. When the scan indicates that the insult occurred at term, that covers a broadband of period of between 37 and 41 weeks of pregnancy. He found no *intra partum* cause for the development of cerebral palsy in Sifundo.

[39] Under cross-examination he conceded the guidelines were not complied with. When the plaintiff had entered the active phase of labour, the maternal condition had to be monitored, the mother had to be examined, four hourly and the fetal heart rate two hourly, during latent stage, that was not done. The blood pressure was not taken hourly, the temperature four hourly, urine volume and test, two hourly and foetal heart rate $\frac{1}{2}$ hourly before, during and after contraction. He explained what was recorded in the medical records as “from three o'clock, draining clear liquor, cervix fully dilated, head at minus two stations”. He said it meant that the biparietal diameter of the head, not the head, was two centimetres. He preferred the reference to 3/5, 4/5 descent because not

everyone could tell at what station was the head through vaginal examination. Such meant that the head was high but not very high.

[40] He agreed that the entries relating to the descent of the head at Siphetu recorded as 4/5 and 3/5 at 21h00 were different to those done later at Madzikane by Dr Ximbi, who recorded 4/5. Also, at Siphetu they did not plot the findings in the portogram. Around twenty hours the portogram had 2/5 and 1/5 above brim. He said that did point out to poor monitoring.

[41] He conceded further that according to the guidelines, the period from 00:55 is prolonged. He clarified that, despite the fact that the guidelines state that the latent phase of labour is prolonged, when it exceeds eight hours, they as medical officers did not just proceed and perform a caesarean section. They considered every factor first, the fetal condition, the presence of meconium, etc. and only then would they make a decision. Furthermore, a guideline is a guideline and in his view the guidelines required review, for example, they did not differentiate the patients, a primigravida is never viewed in the same way as multigravida.

[42] According to him, the defendant's staff did the right thing by waiting on the natural process of labour, during the latent stage of labour in the plaintiff's circumstances. It may not always be necessary to interfere with the natural process. Non-interference did not necessarily lead to death or result in children with cerebral palsy. Where the patient had not been sent home but remained in hospital, the medical staff had to monitor the patient and the foetus, so as to see whether she was going into the active phase of labour and also to exclude fetal non-reassuring condition. He had no reason to say the progress of labour was not good at 20h00 on 1 December 2012 because dilation had progressed from 4 centimetres at 14h00 to 7 centimetres.

[43] He conceded that according to the guidelines, which he reiterated, he had reservations with, the poor progress in active phase of labour started at 20h00 on 1 December 2012. Even though he agreed that by 21h00 action ought to have been taken, he qualified that by saying action meant a lot of things in obstetrics.

[44] Furthermore, the fact that S[...] had nasal flare and was put on oxygen tent could have been due to a number of reasons which affected his breathing. It might have been due to neonatal hypothermia or hyaline membrane. Hypothermia is the dropping of the baby's temperature due to exposure to low temperature. Also, a baby had to be given oxygen if the throat had been cleared and it reacted normally. Oxygen ensures that the baby is kept warm. Presence of the said conditions did not necessary imply that a baby could not have pink colour and normal muscle tone.

[45] He said, considering that, the Apgar scores were 9/10; 10/10; the reflexes were normal; the neonate was not lethargic, he was breathing normally and sucking, those did not indicate a baby who suffered from neonatal encephalopathy. He conceded to the suggestion that, because the record of the examination at birth had ticks that also referred to S[...] as a female, that could be indicative of the fact that the examination was not done properly, but that the nurse ticked the parts of the medical notes routinely. He however, said when one considered the recordings in their totality, he was able to conclude still, that S[...] was normal after birth.

[46] Mr Wessels, counsel for the plaintiff took him through medical records. On the raised issues, he summarily stated that, the blood stained urine in the catheter could have been as a result of trauma caused when the catheter passed uterine passage, amongst others. After diagnosis of non-reassuring fetal condition, caesar ought to have been performed in an hour, with conditions permitting, for example if there was more than one theatre in the facility; it would be used when another one was still in use. At Madzikane there was no need to administer oxygen when the plaintiff awaited caesar. She was given a nefedipine at Siphetu before her transfer. She was transferred for CPD, there was no fetal distress. What was written as, "HTC repeated, nonreactive", according to him, could only refer to CTG. The statement meant that it was not showing acceleration or deceleration, maybe the baby was sleeping or sucking its thumb. The circling of fetal distress upon the examination of the neonate was inconsistent with the rest of clinical notes in the records, including the Apgar

scores. Abnormal fetal heart alone, could not be indicative of foetal distress. Other parameters had to be checked, like, the presence of academia, meconium stained liquor, lethargic baby etc. There were no signs for fetal distress. There are many CPD's without foetal distress. So as there are 90% of cerebral palsy cases that are not due to *intrapartum* events.

[47] The next defendant's witness was Dr Kara, a paediatrician. He has been in private practice at St Augustine hospital in Durban since 1997. Before he prepared his final report he said he consulted with S[...]s grandmother, examined S[...], considered maternity case records and experts Dr Hulley and Ms Brainbridges' reports. His final report is part of the record.

[48] He testified that the summary of labour reflected that S[...]s delivery was uneventful. There were three versions of Apgar scores but, all indicate that the baby Apgar scores were good. The only problem that was noted in the first examination of the neonate was + + + caput. There was no resuscitation done, the condition of the plaintiff and the baby were satisfactory. The clearance of the airways by suction of the lungs was a matter of routine which would, usually not signify the existence of a problem. The presence of fetal distress was a risk factor the medical staff should have been alerted to, and look for signs of neonatal encephalopathy. According to him, if the infant's colour was pink, the medical staff might not have even needed oxygen. There was limited information furnished in that regard. The nasal flaring indicated transient respiratory distress, which in itself did not necessitate administration of oxygen. If the hospital had facilities, they would have needed to check oxygen saturations with a monitor. If the saturation was low, only then would oxygen be administered to the infant. It was common after delivery for babies to have fast breathing because during births with caesarean section, their chests did not get squeezed to expel fluids. The respiration would improve in less than 24 hours, on its own. Sifundo was with the mother around 12h00, that was indicative of the fact that Sifundo's being on oxygen was transient. Noteworthy, S[...] was given two vaccines on 2 December 2012. Vaccines are not administered on unwell babies. Before vaccination, one had to be satisfied with the baby's condition.

[49] The fact that at 16h00 on 3 December 2013 S[...] was sucking, swallowing and had normal reflexes, indicated that S[...] was well. He was referred to Siphetu on 4 December 2013. At Siphetu the indicators in the reports depicted that S[....] was well until his final discharge with the plaintiff.

[50] S[...] had convulsions after a year. On 19 December 2013, he had fever and flaring nostrils. S[...]’s grandmother said it was his first fit. Even though S[...]’s road to health chart was not the best of them, it still mentioned no abnormal developmental concerns to him.

[51] It was at the three day hospitalisation for fever related fits that it was noticed that S[...] was developmentally delayed. He said Si[...]’s grandmother’s history was not reliable. She said she first saw S[...] at one month and later said at two months. She had said S[....] was fed with a bottle, a cup and a spoon. He was sucking well.

[52] According to Dr Kara in S[...]’s case, there is no evidence of neonatal encephalopathy. For the injury to be said it occurred *intra partum* presence of encephalopathy is an essential factor. It is not manifested by just an abnormal cry or slight movement or head nodding, it is an overt syndrome. There must be a moderately severe encephalopathy lasting several days. Volpe’s features were not satisfied, which must all be present simultaneously in order to say the injury occurred *intrapartum*.

[53] In cross examination he said he agreed with Dr Campbell’s report which suggested moderate, severe septic cerebral palsy. He however, said Dr Campbell was generous on life expectancy. He said he missed the part about severe spastic quadriplegic cerebral palsy, if it was the case S[...] would not have been ambulant. He said he probably signed the joint minute which was drawn by Dr Campbell without noticing the reference to severe spastic quadriplegic cerebral palsy. What Dr. Kara said in this regard has to be viewed mindful of the plaintiff’s paediatric neurologist’s evidence that Sifundo had mild degree of cerebral palsy.

[54] He said no one could tell when the injury occurred. The timing of the injury could only be based on probabilities. If there was no moderate severe encephalopathy, lasting several days, everything fell away, there was no link of injury *intra partum*.

[55] About the recording of the examination at birth, he said he would not rely on the ticks only. He would worry if Professors van Toorn and Smith would base their view that, there was no thorough examination, on the incorrect tick of genitalia only. Dr Kara said he would consider all relevant factors in order to make conclusions about S[...]’s condition. He disagreed with Professors Van Toorn and Smith opinions, according to him S[...] was well at birth. He specifically explained that if injury had occurred during labour or after delivery S[...] would have been severely compromised and required intensive support. Regarding the abrasion in S[...]’s neck he said it was common in caesarean births for babies to be cut in the process.

[56] Dr Ximbi testified, he said he was a senior medical officer and was the plaintiff’s receiving doctor at Madzikane hospital. He delivered S[...] by caesarean section. He wrote the clinical notes about the plaintiff’s delivery. He delivered S[...] without delay or difficulty. The delivery took 10 minutes. He scored the Apgars of 9/10; 10/10. The first two scores were done at one and five minutes at theatre. The first one was done after he had taken out the baby and had palpated it. The second one is usually done without touching the baby. The last score was done after the baby would have been taken to the nursery. It might have taken longer than 10 minutes to do the last score. He first finished everything before he went to the nursery. The receiving sister also scored the Apgars at one minute of their receiving of the baby. Sifundo did not need resuscitation. Both the plaintiff and S[...]’s conditions were satisfactory. He did not complete the summary of labour indicating the time of delivery as 08:28. He also did not complete the section referring to first examination of the neonate.

[57] Regarding the note “bleeding to both” he explained that the plaintiff bled, mothers bleed vaginally after giving birth. That could have referred to S[...] as having been bleeding as well, he could not be certain. However, it made sense

that the second bleeding still referred to the plaintiff, that she also bled where she was sutured, if not sutured properly.

[58] His view was that the plaintiff was probably mistaken in believing that S[...] was sick at birth. He would not have referred a sick baby to neonatal department. Furthermore, he would not have sent S[...] back to Siphetu. He was well and stable. If he manifested neurological problems, that was definitely not the case at birth. S[...] came out live with all reflexes, crying, with good colour and skin tone. At that stage, nothing suggested neonatal encephalopathy.

[59] Under cross examination he said he did not complete the note which recorded the delivery time as 08h04. That was the note of the nurse at theatre. However, he had delivered within three to four minutes several times before. He conceded that there were no notes in obstetric and anaesthetic portions of the record. Nonetheless, elsewhere in the records it appeared that the plaintiff was given 2millilitres marcain under spinal. That paralysis lasts about six to eight hours. He said + + + caput did not necessarily indicate fetal neurological compromise.

[60] Furthermore, he said all babies that come out had to undergo suction to clear the airway. He was asked to explain how he scored Apgars and it was suggested that his scoring was inaccurate. He explained that the scoring is subjective according to the discretion of the scoring clinician. However, overall there is conversion as to whether the scoring depicts normal or abnormal picture. As for recording everything including, whether meconium was stained or not, HCT, fetal distress etc. he said it was important to record in full. Where the Apgar scores are good, it may not be so necessary to state the fetal distress.

[61] Ms Thuleka Ranana also testified . She said on 1 December 2012 at 19h00 she reported for duty, at 19h00. She worked as a professional nurse and midwife at Siphetu. She recorded the notes in the maternity case record on 01 December 2012 at 20h00. She took over from sister Mpisane. Sister Mpisane subsequently testified during trial. In assessment 2 she recorded :

- The plaintiff's BP was good at $128/70$; temperature was normal at 36.4; pulse was normal at 76 urine had no abnormalities detected; the fetal heart was normal at 140 beats per minute; dilation was 7centemetres; the fetal head was 3/5 above pelvic brim.

She also noted that the plaintiff and the fetal observation was to be done 2 hourly.

[62] Her second assessment was at 02h00. She had altered the date and time of assessment. She said she made a mistake because she was working hard and it was late. There were two midwives in the shift, assisted by two assistant nurses. She wrote the time where she ought to have written the date. The plaintiff was 9 centimetres dilated. She had moderate to strong contractions. The membranes had ruptured spontaneously and drawing clear liquor. The fetal heart rate was 136 beats per minute.

[63] She conceded that the plaintiff was not assessed in accordance with the guidelines. She said she could only do her own first assessment at 20h00 as it took her an hour from 19h00 to take reports. She was also busy with another patient, she could not do her 2 hourly assessments on the plaintiff, she only assessed her at 02h00. After that she did the next assessment after 2hours, at 04h00. She also conceded the latent stage was prolonged when it exceeded 8 hours. When she said progress of labour was good at 20h00, she had looked at the fetal heart, it was good. She did not comment on the suggestion that the progress labour was not good between 14h00 and 20h00. The plaintiff had dilated from 4 centimetres to 7 centimetres. Nevertheless, the court had heard from Dr Korateng that there was no cause for concern at that time. Mrs Ranana conceded that at 02h00 the progress of 2 centimetres was poor. At 04h00 the plaintiff was fully dilated, she called for the medical officer to assess.

[64] Noncedo Mpisane testified that she was a midwife at Siphetu hospital, She was on duty on 1 December 2012. She did not record the progress of labour because the plaintiff was in active phase. She assessed the plaintiff at 14h00 and completed assessment 1. Fetal heart was 138 beats per minute. There was no caput or moulding. The plaintiff was 4 centimetres dilated. Contractions were less than 20 seconds in 10 minutes. The fetal head was 4/5 above the pelvic brim.

The plaintiff's BP was 130/88, the pulse was 77 and the urine had no abnormalities detected. According to her there was nothing alarming with the plaintiff's and the baby's conditions. She was the person who started to plot the partogram .

[65] She testified further that on 3 December 2012 the plaintiff returned to Siphetu. She recorded the notes at 16h00. It was day one after the operation on the plaintiff. The operation was clean, with no visible blood. Her feet were slightly swollen. The catheter was drawing well. The plan was to continue her with antibiotics. S[...] was sucking and swallowing, the reflexes were normal. Breastfeeding was to continue. She denied that when the plaintiff arrived, S[...] could not breastfeed or there was no milk coming out, or he could not suckle such that the plaintiff fed her juice. She said the plaintiff could not be able to source juice on her own because she was not able to walk. Her clothes would have been kept at the kit room, she would not keep juice. She would have toiletries, only, with her.

[66] She said she made the notes stating that S[...] was feeding and passed urine. If a baby could not feed sufficiently that baby would not urinate. The further record that S[...]’s elimination was good showed the medical staff’s continuation of care. She stated that she was not satisfied with the further records in the partogram. She also could not read the alterations made thereon.

[67] Nombulelo Bonga also testified. She said that in December 2012 she worked as a professional nurse and midwife at Madzikane. She recorded the puerperium notes on 2 December 2012 at 22h00. Her observation showed that both the plaintiff’s condition and that of S[...] was well. When she took over the duties, she had seen the Apgar scores and the doctor’s notes. She explained her notes in detail, she said she took them as she was next to S[...]. If there was anything abnormal, she would have noted it and referred the matter to a medical officer for immediate attention. She said she did not write the note about S[...] being nursed in oxygen tent. Even though it was not indicated, which ought to have been recorded, as to when S[...] was removed from the oxygen tent, he could not have been in the oxygen tent and at the same time still have the plaintiff

at puerperium. S[...] was already with the plaintiff. The guidelines allowed them to use oxygen tent, its measurement is regulated according to the weight of the baby. It is usually given to boost the baby if the mother was in labour for a long time. However, S[...] was born normal, there would have been no need to be much concerned.

[68] Various other experts were called by the plaintiff. Mr Erving, a forensic document examiner testified. He examined the original maternity case record of the plaintiff. He pointed out various alterations, difference in handwriting and adjustments on the notes in the maternity case record. During the hearing he conceded that he failed to comment on spelling alterations. He also conceded that some alternations were minor corrections that indicated ordinary mistakes.

[69] The alterations on the notes at Siphetu after the plaintiff was re-admitted with S[...] were later explained by the author, Mrs Ranana in her testimony.

[70] The speech therapist Ms Singh testified. She has been in private practice since 2007. She said she did an additional course on swallowing. According to Ms Singh, S[...] has dysphagia which was not capable of improving but which required lifelong management. According to her when Sifundo was asleep there was saliva that went to his chest and could cause choking. His lips could not close properly and the saliva drooled. She said she did not cover the aspect of breastfeeding and the fact that S[...] could suckle from day three of birth. She said she was not aware of S[...]’s brain and swallowing abilities after birth. S[...] was not underweight but had difficulty in eating and drinking with consistency.

[71] Mr Gregory Shapiro, an industrial psychologist testified. He had an interview with the plaintiff and had had regard to medical reports and various other experts’ reports. He also signed the joint minute with the defendant’s industrial psychologist, Ms Bobat. Their conclusions differed in the following aspects;

- Ms Bobat did not include tertiary qualification scenario. S[...] had a paternal sibling who has a diploma.

[72] They both looked at S[...]’s career path with and without injury. S[...] would have passed grade 12, if he was not injured. They agreed that S[...] would have retired at the age of 65 years. They agreed to use Kogh’s salary survey, 2017. S[...] would never enter labour market. Under cross examination he said the family background was given small consideration when assessing how the injured would have fared. It was not a strong predictor for him. Their focus was on available infrastructure to determine the academic progression of a minor child.

[73] Grace Hughes a physiotherapist testified that she examined S[...] at the age of 3^{1/2} years. She also consulted with the plaintiff and S[...]’s grandmother. She also had regard to the road to health chart. According to her, S[...] will remain disabled and will require ongoing use of positioning and sitting aids, in order to improve his quality of life. He presented muscle tone abnormalities. He had diminished trunk strength and endurance and had difficulties crossing the midline. His gross motor development was equivalent to a child of about two years old. Under cross examination she conceded that, due to the contradictory information the plaintiff and the grandmother gave to her and to court, her report would be affected, however her assessment based on her observations would not be altered.

[74] Ms Mandy Reed, a dietician also testified. She said she based his report on her assessment and the report he got from the plaintiff. She was under the impression that she was S[...]’s caregiver. She also saw other reports of some of the plaintiff’s experts. She opined that S[...]’s drooling would make it difficult for him to feed on solid foods. He would not be able to feed with consistency and take in the quality of the food. During their consultation he did not feed or see S[...] feeding. She expressed doubts as to the credibility of what the plaintiff told court that S[...] could eat solid foods. She said the recommendations of the defendant’s dietician co-incided with his. Ms Reed just added one blood test per year and a daily mineral supplement.

[75] Mr Dione Rodemeyer a mobility consultant testified. He said his report was meant to quantify Sifundo’s present and future external mobility requirements

which would provide a reasonable quality of life. It was based on reports of medical experts, physiotherapist, occupational therapist and nursing professionals. He did not personally assess S[...]. S[...] would always require a vehicular transport and had to be accompanied.

[76] He recommended that S[...] needed a dedicated run about car. According to him S[...]'s private transport would compare equitably with public or hired transport. Public transport would always have to cater for costs of the person to accompany S[...]. It could be more than double the normal costs, considering the additional costs of the refreshments of the person to accompany S[...].

[77] He conceded that in his report he did not include that public transport arrangement could be made for S[...]'s travels. He said he based his calculations on previous calculations he had done. He said his calculations tended to be on point regarding S[...]'s reality of the distances he would travel and frequency of the need to travel. He, however, conceded that he did not know the proximity of S[...]'s home to the main road.

[78] Ms Sue Anderson, a paediatric general ICU nurse's report was admitted by consent between the parties. She gave an estimation of costs of equipment S[...] would need for his disability, its maintenance, personnel to attend to the equipment and costs for his therapy sessions. Her estimations were taken into account in the actuarial calculations.

[79] Mr Rob Campbell the physical rehabilitation expert had prepared a report on S[...]. He consulted with the plaintiff and S[...]'s grandmother in 2016. He also examined S[...]. He also went through Prof Andonikou, Ms Brainbridge and Dr Hulleys' reports. In their joint minute with Dr Kara they recorded that Sifundo's clinical features is associated with a reduction in his life expectancy. His life expectancy is 73 – 75% of that of his population peers or an additional 47 years from his then 4 years of age. There were certain considerations that he said he had made based on the history that was narrated by S[...]'s grandmother which turned out to be different to what she said in court and to other experts, like Grace Hughes. For example, he had said Sifundo was unable to speak even a single

word and that he walked with a limp and could stand independently. It was established that in actual fact S[...] could say a few words and was able to walk and run but required support to improve his stability. With regard to S[...]’s medical costs, some fell by the wayside, those that remained were taken into account in the actuarial calculations.

[80] Ms Jane Brainbridge an occupational therapist testified that she assessed S[...] at 2 years of age. She opined about S[...]’s physical and cognitive abilities. Furthermore, she testified about the effect the disabilities might have on his functional performance of activities of daily living. She then submitted costs of what S[...]’s future treatment would entail. When she observed S[...] she found him to be motorically reliant on assistance for dressing. His cognitive, speech and physical delays could not be accommodated in a mainstream school. Better options for remedial schools for him would be in East London and Durban. He had not received therapy before. He was on level IV on the eating and drinking ability classification scale. He was on level IV on the manual ability classification scale. He needed a care giver for 24 hours. He would need transport to his therapy sessions. Ms Brainbridge’s evidence and her joint minute with Ms Mzila was included in the actuarial calculations.

[81] The plaintiff’s actuarial calculations were admitted. The defendant asked for higher contingencies of up to 50% because the plaintiff must have overstated S[...]’s condition and stated that he is septic quadriplegic.

[82] In order to establish a claim against the defendant, the plaintiff must have proved that S[...]’s injury occurred *intrapartum*. Further, that the injury must have been caused by the negligence of the defendant’s employees. It is trite that this involves a factual enquiry as to whether the negligent act or omission caused the harm that is the basis of the claim. If it did not the claim fails. If it did, whether the negligent act or omission is sufficiently, closely or directly linked to the harm for legal liability to ensue. The submission on behalf of the plaintiff in this regard was that, the court had to evaluate the evidence and decide whether as a matter of inference or otherwise, on a balance of probabilities, indeed the defendant’s employees were negligent and that negligence caused S[...]’s injury.

[83] With regard to the inference the court has to draw, in **AA Onderlinge Assuransie Assosiasie BPK v De Beer** 1982 (2) SA 603 A at 614 h – 615 B it was held to be that of discharging the onus to convince the court that the inference the plaintiff advocated is the most readily apparent and acceptable inference from a number of inferences.

[84] The plaintiff sought to rely on **Lee v Minister of Correctional Services** 2013 (2) SA 144 (CC) in its submission that defendant's employees caused S[...]’s injury. It was submitted on behalf of the plaintiff that because of the defendant's conceded failures to adequately monitor the plaintiff's labour, in accordance with prescribed methods, including, the defective record keeping mode, therefore the timing of the probable hypoxia of the foetus would not be able to be identified. In Lee's case, *supra*, the plaintiff had contracted tuberculosis (TB) whilst in prison. The source of the infection could not be identified. The court had to determine whether the systemic failure to take preventive and precautionary measures by the department of correctional services caused the plaintiff to be infected with TB. The plaintiff had no TB infection upon incarceration. He was diagnosed with TB after three years of his incarceration.

[85] In my view, the facts in Lee's case are distinguishable to the present case. Therein, the statement of agreed factual findings indicated that the plaintiff did not have TB infection when he was incarcerated; the responsible authorities were, pertinently, aware of the risk of inmates contracting TB; the congestion and confinement of inmates to close contact for as much as 23 hours every day provided ideal conditions for transmission; and the responsible authorities relied on a system of inmates self-reporting symptoms of TB, among others. It was established hypothetically as to what the prison authorities ought to have done to prevent the TB infection. Even though it well could not have been total elimination of risk. An inference was therefore made that a non negligent system reduced the risk of general contagion. Therefore, individual contagion with a non negligent system, would be less likely than in a negligent system. I had not been pointed to facts similar to those in the present case. It is known that S[...] suffered

acute profound hypoxic ischaemic injury of a partial prolonged nature with features compatible with super imposed hypoglycaemia at term. It still requires to be established that the signs that S[....] had neonatal encephalopathy at birth were present in order to determine that his injury occurred *intra partum*. Furthermore, that had it not been for the defendant's employees poor monitoring, the risk would not have ensued or it would have been prevented to some extent. Finally, in **AN v MEC for Health, Eastern Cape** [2019] (4) ALLSA (1) (SCA) at paragraphs 7 – 8 the court stated that Lee's case seemed to embrace a flexible approach to causation only where the specific incident or source of infection cannot be identified. The court then applied the traditional but for test because the source of harm was known, it was acute profound hypoxic ischaemic insult caused by complete lack of oxygen to the brain for a sustained period.

[86] It was submitted further on behalf of the plaintiff that even if the court applied the traditional "but for" test, the plaintiff has proved that the damages causally flow from the negligence of the defendant. In order to determine this the courts have repeatedly explained what that factual enquiry involves. In **International Shipping Co (Pty) Ltd v Bentley** 1990 (1) SA 680 A at 700 F-G Corbett CJ, explained the but for as follows:

"In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis [the] plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; *aliter*, if it would not so have ensued. If the wrongful act is shown in this way not to be a *causa sine qua non* of the loss suffered, then no legal liability can arise ..."

[87] All the experts called on the merits by both parties agree that if there were no clear signs or neonatal syndrome, the brain injury could not be attributed to *intra partum* asphyxia. The neonatal neurological examination exhibited by the infant within the few days of birth, for example, fits, seizures, changes in muscle

tone, tendon reflexes, abnormal breathing, fisting etc., The question that requires an answer in S[...]’s case would therefore be whether, his condition after birth meets the criteria and features for an inference of an *intra partum* cause.

[88] The available evidence on the condition of S[...] after birth and few days thereafter, is the following:

- Evidence of the plaintiff;
- Clinical notes on the medical record and the staff who attended the plaintiff and S[...];
- Evidence of S[...]’s grandmother.

With regard to the clinical notes, it has submitted on behalf of the plaintiff that, it has not been shown that there was no encephalopathy found, following, a thorough and proper examination by a knowledgeable person. Encephalopathy was present after birth as testified to by the plaintiff and S[...]’s grandmother but it was not recorded by a competent trained person after a thorough examination.

[89] This submission presents a problem, there are specific clinical notes that indicate the record of the state of S[...] on the aspects that relate to the presence or absence of encephalopathy. I would have to reject those recordings to find that encephalopathy was not recorded. There is criticism against Apgars recorded by Dr Ximbi, However, the experts agreed that Apgars, alone, cannot be used to assess presence or absence of HIE, Dr Ximbi explained as to when he took the Apgars. At theatre, he was criticised that he could not have tested sucking and grasping reflexes. Furthermore, that would be so because those are not part of the standard Apgar test. Even if I would accept this, Dr Ximbi gave further explanation about the condition of S[...] after delivery. He even said, if he was not well, he would have referred him. S[....] manifested no neurological problems. There has not been a basis that has been suggested which sought to cast doubt about Dr Ximbi’s professional abilities in this regard.

[90] There were notes about the examination of the neonate at Madzikane. A criticism was directed at the ticks on S[...] as having both genitals. The author,

sister Mzinyane was said to have retired and that she could not be traced. However, when I have regard to other factors, as Dr Kara suggested in his testimony, such as the detailed record sister Mzinyane made, other notes recorded in their totality, a day after birth, S[...] having been kept with the plaintiff in the ward, the notes by sister Bonga who testified, that S[...] was pink, active, sucking well, retaining with good elimination and the fact that Dr Ximbi discharged S[...] to Siphetu, I have no reason to doubt the notes made by sister Mzinyane as well.

[91] Furthermore, there were further notes upon readmission of the plaintiff and S[...] at Siphetu. The authors of the notes testified. They were qualified midwives, with vast experience in the caring of neonates. They confirmed the records they noted. I would not find basis to reject their evidence, in particular with regard to S[...]’s condition. Their evidence was clear and not biased. Three days after birth S[...] could suckle, he was breastfeeding, he was swallowing with normal reflexes and his elimination was good. That testimony related to the observations at Siphetu, another hospital which was not the delivery hospital, Madzikane.

[92] The evidence of the plaintiff on the other hand contradicts these clinical notes with regard to the condition of S[...]. That brings me to the need to examine the quality of her evidence. She said the fetal heart was not checked at Siphetu. When I view her evidence in totality, I consider that as probably having been her failed attempt to mimic her experts, that the monitoring was substandard. She testified to the pulling of the neck, the blinking eye, the clenched fist and inability to feed from 12h00 on the date of birth, until after three days. She said S[...] was feeding on juice with a lid before day three. After three days all those symptoms had subsided. S[...] was crying a lot. She had no knowledge of the nasogastric feeding, the seizure, the loud cry at birth, Dr. Reddy referred to and of S[...] having been at the nursery, as referred to by her experts. She changed to say the neck and the fist problems in Sifundo were present in S[...] at home.

[93] The plaintiff's evidence on the symptoms of S[...] being unwell after birth was very inconsistent. Her own expert said the infant could not feed on juice, otherwise he would have fallen ill. The symptoms according to her were manifested at 12h00, they subsided and resurfaced at home after discharge, eight days after birth. S[...]’s grandmother’s evidence in this regard was different with that of the plaintiff’s. She said she saw the symptoms two days after the plaintiff and S[...] were discharged from Siphetu. However, she also said in court and to some experts, she saw S[...] when she was a month old. She also said the plaintiff had said S[...] could only breastfeed at home not after three days, in hospital.

[94] The plaintiff was clearly not able to stand by her evidence under cross examination. She would be dump and not be able to explain the problems in her evidence. S[...]’s grandmother fared better. However, the essence of her evidence on S[...]’s state after birth was destroyed by her having said she first saw S[...] when he was one month old. The plaintiff and S[...]’s grandmother’s evidence on this aspect did not assist the court. I find no reason why both hospitals would not record any of what the said two witnesses said at all. The nurse allegedly gave the plaintiff a bottle to express milk. Why would she fail to note that S[...] could not suckle but was bottle fed, at her instance.

[95] I now turn to consider the evidence of Prof. van Toorn. He said there was a mild degree of cerebral palsy. Sifundo had normal weight and head circumference. The pattern of the injury suggested that the brain was starved of oxygen and sugar. That was caused by prolonged labour. Babies with that pattern of injury usually have complications during the birth process, especially when there was prolonged labour. They were born suppressed with neonatal encephalopathy. Nasal flaring suggested respiratory distress. The pulling and stiffness of the neck were abnormal signs which could even suggest a seizure, those support that HIE occurred *intra partum*. He found no basis for the contention that there was compromise or risk of brain damage before onset of labour.

[96] Even if I would accept that S[...] was unwell, it is not in dispute that he was kept with the plaintiff, throughout the duration of his stay in both hospitals. Prof van Toorn also said, that S[...] had no classical signs of abnormalities and no overt neurological syndrome, that implied that there was no indication of compromise after birth. I find it hard to believe that if S[...] needed proper neurological examination, the blinking eye, the stiff neck, etc. which the plaintiff saw as a layman, none of the medical staff was able to observe or respond to her when she reported those. Furthermore, all relevant experts agreed that Volpe remains a renowned authority in this area and not all three authoritative features Volpe refers to were satisfied. Eventhough, Prof van Toorn qualified this by stating that Volpe did not incorporate MRI scan findings. Having looked at everything in totality, I am not persuaded that Prof van Toorn put forward enough basis on evidence, to support the probability of the injury having been *intrapartum*.

[97] Prof Smith said the combination of S[...]’s nature of injury was found in babies who had lacked energy stores, glucose sugar. That occurred during protracted exposure to hypoxic ischemia in uterine over hours and/or in the immediate period in the first week after birth. The type of injury was sustained over several hours. That would be consistent with long poor progress of labour. The Apgar score at 10 minutes could not physiologically link with the fact that S[...] was in respiratory distress when he came back from theatre. He also said that the nursing of S[...] in an oxygen tent and his having a nasal flaring suggested some form of respiratory distress. He said there was no record of the concentration of oxygen given. According to the notes, S[...]’s breathing was scored at 1 at one minute of life. The breathing was said to be 2 at five minutes. However, on the table he looked at, S[...]’s breathing was still abnormal. He therefore could not attach any value to the Apgar scores in the maternal notes. He was of the view that the manner in which S[...]’s breathing was said to have recovered on its own, without putting a bag mask, would be a cause of concern in itself. It would have required a follow up immediately.

[98] In Prof Smith’s view, the ticks on both genitals on the neonatal assessment; the lack of record of pulse, breathing rates, temperature, sugar

levels and etc. suggested that there was no evidence that S[...] was properly assessed. He said considering that, S[...] was later diagnosed with a smaller than expected head; there was prolonged latent and active stages of labour; there was poor monitoring; there was lack of management of fetal distress, there was delayed adjusting of respiration and the nature of his injury, those support *intrapartum* hypoxic ischemia and hypoglycaemia. Had proper care been administered the outcome of labour would probably have been prevented and there would have been no need to nurse S[...] on oxygen tent. Furthermore, the features described by the plaintiff to him were consistent with encephalopathy.

[99] Prof Smith put more reliance on the history he was given by plaintiff than the medical records. When advised of the plaintiff's testimony in court, he conceded that, if the plaintiff was not to be believed, there would have been no basis to suggest that S[...] had neonatal encephalopathy. Consequently it could not be said that the injury occurred *intrapartum*. The medical records depicted that S[...] was well. There was no dispute in the fact that S[...] was kept with the plaintiff. The plaintiff herself said he was crying loud. According to Prof. Smith if S[...] had cried loudly after birth, he could not have been depressed. He said this picture did not suggest an injury *intra partum*. He conceded that many babies who initially had breathing difficulties which get resolved, end up without encephalopathy. In my view, Prof Smith's analysis of the nature of the injury and the poor monitoring would not be viewed as sufficient to support an *intrapartum* injury, if S[...] had no encephalopathy, at birth. As regards lack of proper examination, Dr Ximbi positively testified that S[...] manifested no neurological problems at birth. Nasal flaring had been said to be indicative of transient respiratory distress which did not need oxygen. The evidence showed that S[...] did not need to be cared for at nursery.

[100] Dr Hulley's main complaint which he opined resulted in S[...]’s condition was prolonged labour. The head had not dropped in 13 hours. The plaintiff had adequate contractions. Her BP was 164/93. She ought to have been referred for delivery sooner. Dr Hulley withdrew a number of his findings when advised of the plaintiff's testimony about S[...]’s condition after birth. He also said that despite

the substandard care, without neonatal neurological syndrome the brain injury could not be attributed to *intrapartum* events.

[101] The only evidence led on behalf of the plaintiff which would have assisted in the timing of the injury in this matter would have been that of the plaintiff, during her time at the defendant's hospitals. Her evidence would then have to be contrasted with the medical records and the testimony of the defendant's medical staff, during labour and after the birth of S[...]. The plaintiff consulted with various experts and gave them a version which differed with her evidence in chief and in cross examination. There are aspects in her version as given to the experts that are very concerning, for example, that S[...] was fed nasogastrically and that she only saw him the next day. I am unable to accept the plaintiff's evidence in as far as it differs with the defendant's version. Her version to the experts which turned out not to be true affected the opinions of those experts to a great extent. They had to concede that if her version was not accepted Sifundo injury could not be found to have occurred *intrapartum*.

[102] As for S[...]’s grandmother’s evidence, I accept it in as far as it relates to the time S[...] was one month old. That was what she also confirmed she told the experts she consulted. Her evidence that she saw S[...] two days after his discharge from Siphetu and her description of his condition is self-contradictory. It also contradicts the plaintiff’s evidence in chief about S[...]’s condition after discharge from Siphetu. It is also not consistent with two versions she gave to Dr Kara that she stayed with S[...] when he was one and again two months old.

[103] The defendant’s employees’ evidence did not have contradictions. They would easily concede to the substandard care and monitoring of the plaintiff and S[...]. They also conceded the problems with the partogram. Even though they could explain some of the contributory difficulties, such as being short staffed but that was not in an attempt to justify their noncompliance with the regulations. Their evidence was satisfactory in relation to the entries in the medical records. Their evidence in support of the medical notes, is accepted that S[...] had no neurological syndrome and was not depressed at birth.

[104] The evidence established that the plaintiff was fully dilated only at 04h00. When the arrangement for her transfer was made, she was given nifedine, there were no fetal compromise indications. Dr Korateng had testified that despite the failure to adhere to the guidelines, regarding fetal heart monitoring, the assessment at 20h00 on 1 December showed no cause of concern. He also said two hours lapse after full dilation was acceptable. When CPD was realised the plaintiff was transferred immediately. The 1½ hours in Madzikane was because the operating doctor was busy at theatre. The travelling to Madzikane took 2 hours. Dr Korateng said after diagnosis of non reasoning fetal heart condition under normal circumstances, caesar had to be performed in an hour. There was no fetal distress upon transfer. Despite the fact that Dr Ximbi level descent of the head was not consistent with the records at Siphetu, I accept that considering the results of the assessments, that there was no caput or moulding, there was clear liquor, therefore there were no early obvious indications of CPD. S[...] was given two vaccines after birth which would not be done when the neonate was unwell. According to Dr Kara abnormal cry and nodding of the head did not satisfy the requirement of presence of encephalopathy after birth. S[...] never required intensive support. When Prof. Smith suggested that if care had been administered the outcome would probably have been prevented, he supported that by saying that if S[...] was well he would not have needed oxygen tent. However, he also said not all babies with breathing problems end up with encephalopathy at birth. I accept what the defendants' experts said, that considering S[...]’s condition in totality, there probably was no need to even administer oxygen in him.

[105] In conclusion, despite the defendant’s medical personnel’s negligence in the care of the plaintiff and S[...], in the light of the insurmountable problems in the plaintiff’s case, I am of the view that the plaintiff has failed to establish that S[...]’s injury had occurred *intrapartum* and therefore is causally linked to the defendant’s personnel’s omissions.

In the result,

The plaintiff's action is hereby dismissed with costs.

B MAJIKI

JUDGE OF THE HIGH COURT

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