IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

17/3/2017

Case Number: 16233/13

DELETE WHICHEVER IS NOT APPLICABLE

(1) REPORTABLE: YES.

(2) OF INTEREST TO OTHER JUDGES: NO.

(3) REVISED.

17/3/2017 .....
DATE SIGNATURE

In the matter between:

LIZ-MARIE BOOYSE	1st PLAINTIFF
JACOB JAKOBUS JONKER	2nd PLAINTIFF

and

MEC FOR HEALTH AND SOCIAL DEVELOPMENT OF GAUTENG PROVINCIAL GOVERNMENT	DEFENDANT

Coram: HUGHES J

JUDGMENT

HUGHES J

Introduction

[1] Johannes Jacobus Jonker (Johannes), a minor boy, was born on 8 February 2010. His mother, Liz-Marie Booyse (Ms Booyse), sues for damages in her personal and representative capacity, as the first plaintiff. Jacob Jacobus Jonker (Mr Jonker), the second plaintiff and father of Johannes, also sues in his personal capacity for damages against the defendant, being the MEC for Health and Social Development, Gauteng Provincial Government (MEC).

[2] The claim for damages of the two plaintiff's arise from, the alleged negligence of the members of the medical staff of the defendant, in the hospitalisation and labour procedure during the birth of Johannes, at the Tshwane District Hospital (the hospital) on 8 February 2010.

[3] The defendant acknowledged that at the relevant time members of the medical staff of the hospital were in its employ, were acting in the course and scope of their employment, were under a legal duty to render medical treatment and exercise the degree of skill and care, which could reasonably be expected of medical staff in the prevailing circumstances.

[4] On 7 February 2010 Ms Booyse, who was 39 weeks pregnant and experiencing lower abdominal pains attended at the hospital at 04h00. A vaginal examination of Ms Booyse was conducted by the nursing staff on duty and it was established that she was not in labour but was in fact experiencing 'false labour'. The foetal heart of unborn Johannes was observed to be reactive and Ms Booyse was discharged and sent home.

[5] On the following day, Ms Booyse returned to the hospital as the abdominal pains had become worse and she had developed vaginal bleeding. She alleges that she returned at around 17h00 and/or 18h00 and was examined by the same nursing sister who attended to her on 7 February 2010.

[6] Johannes was born at 23h05 through normal vaginal delivery. It was recorded that he was born 'flat' and in a compromised condition without spontaneous breathing and Apgar scores of 4/10 at 1 minute, 5/10 at 5 minutes and 5/10 at 10

minutes. Johannes experienced seizures shortly after birth and was transferred on 9 February 2010 to Steve Biko Academic Hospital neonatal ICU, where he was diagnosed with neonatal hypoxia and respiratory distress.

[7] His condition was recorded as being that of grade 3 hypoxic ischemic encephalopathy (HIE) with seizures, he required intubation and mechanical ventilation until 15 February 2010 he was discharged into the plaintiffs care on 15 March 2010 and upon discharge it was recorded that he had suffered birth asphyxia and HIE.

[8] The defendant disputes liability for the damages suffered by the plaintiffs'. I have been tasked to deal with the issue of liability and the issue of quantum is to be held over. Consequently, a separation of liability and quantum was duly granted in terms of rule 33 (4) of the Uniform Rules of Court.

The Pleadings

[9] The plaintiffs pleaded that their claims arose from the wrongful and negligent breach of the contractual and legal duty of care owed to them, by one or more or all of the medical staff who were responsible for or engaged in the first plaintiff and Johannes's treatment at the hospital. The plaintiffs' allege that the medical staff were negligent in one or more of the following respects:

'8.1 They failed to properly assess the first plaintiff's condition on 7 February 2010, they failed to admit the first plaintiff when admission was indicated;
8.2 they failed to properly monitor the condition of the first plaintiff and Johannes, and to administer appropriate medical treatment;
8.3 they failed to properly and correctly plot the first plaintiff's progress of labour on a partogram;
8.4 they failed to deliver and/or to arrange that Johannes be delivered by means of caesarean section when it was indicted that there was foetal distress, as they should have done;
8.5 they failed to institute CTG monitoring of the foetal heart rate of Johannes immediately after the first plaintiff's admission to the Tshwane District Hospital;

8.6 they failed to act immediately and appropriately to the observed clinical signs of foetal distress reflected on the CTG tracing that was obtained;
8.7 they failed to continuously monitor the maternal condition and the foetal condition after oxytocin was administered to the first plaintiff as is indicated under the circumstances;
8.8 they failed to resuscitate Johannes immediately and appropriately after birth and/or failed to seek assistance from the appropriate expert in the resuscitation of Johannes.'

[10] In the plea the defendant denied the allegations of negligence set out above and in the alternative averred that if it was found to be negligent such negligent conduct was not causally linked and/or related to the condition of Johannes. The defendant went on further to stated that the denial of the negligence is amplified by the fact that in the intrapartum period the medical staff exercised the required degree of skill and care to look after the first plaintiff and manage the birth of Johannes.

The Evidence

Admission on 7 February 2010

[11] It is common cause that Ms Booyse was admitted at the hospital on 7 February 2010 and it is uncontested that it was in the early hours of the morning. The hospital records indicate that on that day the first plaintiff was attended to by Sister Mafolo. Ms Booyse was examined and a cardiotocograph monitor (CTG) was used to monitor the foetal heart rate. The results indicated that the foetal heart rate was normal, reactive and that the foetus was non-hypoxic. The incident experienced by Ms Booyse was categorised as 'false labour' as her cervix was still closed. The medical experts, employed to assist in this case, concluded that the management on that specific day was appropriate and the first plaintiff was correctly discharged.

Admission on 8 February 2010

[12] Mrs and Mr Grobler, the first plaintiff's mother and stepfather, testified on behalf of the plaintiffs'. Both stated that on 8 February 2010 Mrs Grobler together with the second plaintiff transported Ms Booyse to the hospital at 18h30. Mrs Grobler

testified that she knew the time as the television series *7 de Laan,* which they watch daily during the week, had just commenced. Mr Grobler testified that on that day he watch the series on his own as Mrs Grobler had left for the hospital.

[13] Mrs Grobler described her daily routine when her husband return from work at about 16h45. She stated that they would chat of the day's events and that they usually ate together at 18h00. On this particular day she served Mr Grobler dinner on his own, left her dinner in the microwave, and proceeded to take Ms Booyse to the hospital as she complained of severe stomach cramps.

[14] Mrs Grobler further testified that it took them 20 to 25 minutes from their home to the hospital and that it was dusk on their arrival. In a quest to corroborate Mrs Grobler's testimony that it was dusk on their arrival at the hospital, the plaintiffs' handed into court an official document titled, 'Times of Sunrise, Sunset and Local Apparent Noon on every day of the Year, at any place in South Africa', published with the approval of the Minister of Justice as signified by Government Notice No. 1739, and dated 8th November 1957. This document reflects that as at 8 February 2010 the calculated time of sunset would be 6:53pm, differently 18h53.

[15] Against the back drop of the Grobler's evidence the particulars of claim of the plaintiffs' state that the arrival time at the hospital on 8 February 2010 was *'between 17h00 and 18h00'.* In addition, Dr M M Lippert, a Paediatrician/ Paediatric Neurologist, who documented a medical legal report dated 28 June 2012, states that it was reported to him by Mrs Grobler and Ms Booyse that they had arrived at the hospital between 17h00 and 18h00. It was also documented in the medical report of Professor H S Cronje, a Specialist Obstetrician and Gynaecologist, dated 7 November 2012, that Ms Booyse and Mrs Grobler, stated to their attorney that their arrival time at the hospital was 17h00 and 18h00, respectively. Dr E J Langenegger, a Specialist Gynaecologist and Obstetrician states, in his medical legal report, that from the patient history provided by the attorney, Ms Booyse reported that she arrived at the hospital shortly after 19h00. However, the nurse's notes, as documented by Sister Mafolo, reflect that the admission of the first plaintiff was at 21h30.

[16] Mrs Grobler gives a detailed account of what she witnessed and what transpired in the hospital during the labour procedure of Ms Booyse. It is to my mind imperative that I consider this evidence in determining the time of admission on 8 February 2010. I will return to the admission time later in the judgment.

Mrs Grobler's evidence

[17] Mrs Grobler's testimony was that they arrived at the hospital at 18h55 as they had left the house at 18h30. It took them 25 minutes to drive from her home to the hospital.

[18] On their arrival at the hospital, they reached the nurses station in the Labour Ward at about 19h00. They informed the nurse on duty, whose name they do not know, that Ms Booyse was experiencing lower abdominal pains and presented her with Ms Booyse's antenatal card. They were certain that this nurse was not Sister Mafolo, as Sister Mafolo had attended on Ms Booyse the previous day when she presented with a 'false labour'.

[19] Ms Booyse was taken to a bed in the waiting room, the curtain was drawn and an examination was conducted. Thereafter the nurse took them to a delivery room where the first plaintiff was made to undress, put on the hospital gown and lie on the bed. Mrs Grobler testified that the nurse then left them in that delivery room for about two hours.

[20] After she had returned from smoking outside at 21h15, a nurse entered the delivery room at about 21h20 or 21h25. She examined the first plaintiff and advised that she was 8cm dilated. Mrs Grobler states that when the first plaintiff was fully dilated, the nurse ruptured Ms Booyse's membranes artificially at 21h30. This nurse, Mrs Grobler states was, Sister Mafolo.

[21] At 21h40, Sister Mafolo inserted an intravenous line IV drip and explained that this *'would help the pains to come on'*. At this stage there was another nurse assisting the sister. Her testimony is that for a short time the CTG monitor was placed on the first plaintiff's belly.

[22] During the course of the labour process, she stated that her daughter was lying on her back on the bed. Ms Booyse was fully dilated and she was instructed to push, as she did so one of the nurses stood behind her and pressed on her stomach each time she pushed. The episiotomy was cut by the first nurse who attended on them and at 23h05 Johannes was born face down, showing no signs of life. Mrs Grobler states further that one of the nurses even lifted the leg of the baby and dropped it saying *'this is a lifeless baby'.*

[23] She further testified, that after the birth of the baby, no assistance was rendered to the baby, which resulted in an exchange of words taking place between her and the nurses. She contends that the doctor must have heard this, as he rushed and took the baby into another room, with the nurse following on his heels. After a few minutes she left the delivery room and found them in a nearby room. The doctor advised that he had stabilised the baby, had requested an ambulance and were awaiting same to transfer the baby to Steve Biko ICU. This attending doctor was none other than Doctor Ngali.

[24] Ms Booyse remained in the delivery room until about 02h30. She was then cleaned up, stitched and transferred to the Postnatal Ward. It is common cause that Johannes was discharged from Steve Biko hospital on 15 March 2010.

Dr Langenegger's evidence

[25] Amongst, Dr Langenegger's numerous qualifications and expertise, one of these being training mid-wives, interns, students, registrars and fellows in Essential Skills in Managing Obstetric Emergencies (ESMO). In addition, he is also one of the developers of this national skills training program.

[26] As stated above he provided a medical report on the process of the birth of Johannes. He had before him the medical records of the hospital, medical history of Ms Booyse obtained from her attorney, the pleadings, reports from other experts and joint minutes of other experts.

[27] The doctor testified that from the hospital progress report of the first plaintiff it was recorded that she was POG1 which is indicative of her first pregnancy and approximately 40 weeks pregnant. She had attended on the hospital, on 7 February 2010, complaining of abdominal pains however there were no contractions. A vaginal examination concluded that her cervix was still closed, the CTG reading of the foetus indicated that it was reactive and the baseline foetal heart rate was normal. He explained that *'the advantage of the CTG ...it can show us that the baby is in a good non-hypoxic condition'*. In the first plaintiff's case the heart rate was 130 to 140 beats a minute which is normal with acceleration and no decelerations. He concluded that on 7 February 2010 Ms Booyse experienced 'false labour' as the baby was not in distress, there was a normal CTG reading and there was no rapture of membranes. She was thus correctly discharged and sent home.

[28] Dr Langenegger testified that from his experience of the practice in such state hospital, the procedure and standard of care is designed that there is continuous monitoring of mother and foetus in the labour ward. If any abnormality occurs, the protocol is that the nurse on duty must call the doctor, as there is usually a doctor on call for the obstetric area.

[29] He further testified that Sister Mafolo who took charge of the patient at 21h05 should have conducted a CTG on admission of Ms Booyse and not 35 minutes thereafter as indicated by her nursing notes. The advantage in doing so, he states, was to establish if the foetus is stable or not, if it is stable the sister has more time, but if the CTG indicates problems then the emergency procedures will kick in. Thus, it is imperative that on arrival of the patient, the process would be abdominal examination, CTG and then vaginal examination, which process was incidentally not followed by Sister Mafolo.

[30] From the nurse's notes the circumstances prevalent were that the foetal heart beat was 122 beats per minute and that there were decelerations. He noted that the decelerations recorded were concerning and the *'action must be to initiate resuscitation and call the doctor to decide whether there was foetal distress or not'*. This procedure was not followed by Sister Mafolo.

[31] The doctor testified that with the indicators mentioned above there was *'a good chance that the baby having hypoxia, decrease oxygen delivery or decrease in the blood flow to the tissues, showing signs that the foetus was in distress'.* The procedure to be followed this case was for the sister to turn the mother on her left side, give her oxygen, put up a Ringers Lactate drip, do a vaginal examination and call the doctor as an emergency. This procedure was not followed by Sister Mafolo.

[32] The doctor expressed concern, why the sister had raptured the membranes (according to the nurse's notes), whilst the patient was only 8 centimetres dilated with decelerations without calling the doctor first, as the patient was not fully dilated. He stated that by the nurse rapturing the membranes when there were already problems that being the deceleration, made the problem even worse.

[33] However, when Sister Mafolo testified, she denied rapturing the membranes. She explained that the notes were not clear that membranes had in fact raptured on their own. This however was not put to the doctor during cross examination, in order that he be granted an opportunity to respond.

[34] He was asked to comment on Mrs Grobler's testimony that she was informed by the nurse that the drip put up for Ms Booyse was to make the labour go faster, he replied:

'...So for instance if the contractions are not adequate then if a drug called oxytocin is added inside the drip then that can stimulate the contractions, but I did not see anything from the notes that oxytocin was administered into the drip...So sorry I know that a drip was put up but I do not know what the reason was...So I think the drip was probably inserted to, maybe the mother looked dehydrated, to hydrate her'

[35] From the notes the doctor testified that he could not reason if the Ringers Lactate drip had oxytocin or not. He explained that a drip was usually put in circumstances, *'for instance if there is foetal distress...if the patient is dehydrated...if the patient has poor bearing down efforts.'* In this instance, he said, it is not documented by Sister Mafolo for what purpose she put up the drip. In the case of a lactate drip, the doctor explained, that this will increase the maternal cardiac output,

as it expands the blood volume, and it also assists to rehydrate the patient as it contains electrolytes.

[36] He continued explaining that the drug oxytocin would only be added to the drip if the contractions were not strong enough as it stimulates contractions.

[37] By mere deducting, the doctor established that Ms Booyse would have been 4 to 6cm dilated at 19h00, if she was, as record by Sister Mafolo, 8cm dilated at 21h30. He stated that from the MRI reading conducted on the baby after birth demonstrated partial prolonged as well as profound perinatal hypoxia. Thus, the process of hypoxemia had probably commenced between 19h00 and 21h00. He added that the foetus, as it was a healthy foetus, would have been able to compensate and cope with the hypoxia during that period and had an earlier CTG been conducted it would have been picked up that the foetus was in distress. Intrapartum resuscitation could have commenced and delivery expedited avoiding the acute profound hypoxic injury which was the major cause of the brain damage suffered by Johannes.

[38] Dr Langenegger was adamant that the CTG should not have been stopped by Sister Mafolo at 22h10, as she did, having observed the abnormalities that she did. He stated that at 21h50 from the CTG, which was in the suspicious-category 2 / non reassuring, a doctor should have been called to assess the CTG. Between 22h00 and 22h10 the CTG showed late decelerations, slow to return to the baseline and decreased baseline variability which is an indication of an abnormal or pathological pattern. The doctor contends further, that by then there was a 60% chance that there was foetal distress, associated with decrease oxygen delivery to the baby and the brain. He noted that there was no recording of the foetal heart rate between 22h00 and 22h20. The patient is now full dilated, type 3 CTG was thus not documented, and there was no attempt to intrauterine foetal resuscitation, that is turning the mother on her side, administering oxygen, calling the doctor and relaxing the uterus.

[39] He was also critical of the sister's failure to record on the partogram, regular and relevant, the foetus and mother's vital signs. The partogram, he explained, is

designed for the attending midwife/nurse to regularly monitor and record these vital signs in order to pick up any abnormalities and deal with emergencies.

[40] As a result of the substandard foetal monitoring, the doctor testified that an opportunity was missed, in his view at 22h20, for a ventouse vacuum extraction to be conducted. This is so, he contends, because the patient was fully dilated and the head was 1/5 above pelvis, this was an opportune time to expedite the delivery by calling a doctor.

[41] If the attending doctor was of the view that it was not safe to perform the ventouse, there was still an opportunity to administer a tocolytic agent to reduce the contractions to '*buy time*' to prepare for a caesarean section.

[42] The doctor testified that an assisted delivery in the prevailing circumstances by way of ventouse could have been done within 15 to 20 minutes, as the patient met the safe criteria for a ventouse to be conducted, meaning the baby would have been born around 22h30 to 22h40, thus decreasing the exposure to hypoxia and hypoxic ischemic injuries.

[43] As regards the caesarean section delivery the reasonable expected time to arrange, suppress the contractions and provide intrauterine resuscitation to improve the condition of the foetus, would have taken 45 minutes, meaning the birth would take place at 22h45.

[44] He further testified that it would not have mattered whether Ms Booyse came in at 21h00 or earlier as the substandard maternal and foetal monitoring created the catalyst of problems that followed which resulted in the damage coursed to the foetus.

[45] Dr Langenegger also qualified himself as being able to express an opinion on conditions of neonates, as he had read in that field and was qualified to do so, as a registered foetal specialist.

[46] Dr Langenegger contended that the manner in which the foetus was resuscitated after delivery was incorrectly conducted. The doctor explained that the process is to firstly clear the airways by sucking away the mucous or fluid from the

lungs, then establish breathing if necessary by assisted ventilation using the ambubag, observe circulation and heart function which will be reflected in the oxygen saturation of the blood. This he said was what was termed as the A, B, and C of resuscitation. He emphasised that the suctioning of the fluid from the lungs must be done before bagging with the ambubag which is connected to the oxygen.

[47] In this instance, the nurse's notes reflect that the baby was bagged with an ambubag, the suction was clear then nasal prongs were placed. The doctor testified that it should have been the suction first and then the ambubag. Be that as it may, in this instance, he states, the ambubag was removed far too soon and replaced with the nasal prongs in a case where the baby was already experiencing difficulty maintaining regular and spontaneous breathing. By replacing the ambubag with the nasal prongs would have resulted in the baby getting into further distress as this would result in oxygen saturation falling, which was counter-productive.

[48] The baby at that time had a saturation score of 90% indicating oxygen saturation in the blood was decreased. The normal percentage for oxygen saturation is between 97 to 98 %. The Apgar scores explained the doctor was an indication of the heart rate, respiration, muscle tone and reflexes of the baby after birth. Thus, when one examines the baby after birth against all the indicators of the Apgar score in a vaginal birth the best score is a 9 or 10, whilst in a caesarean section birth it would be 6 or 7.

[49] In this instance, 1 minute after resuscitation the Apgar scores of Johannes was 4/10 at 5 minutes, 5/10 at 10 minutes and it remained at 5/10. If the Apgar score is under 7 then this is an indicator of hypoxia. In this instance 10 minutes after resuscitation the baby remained at 5/10 indicative of inadequate respiratory effort. When asked if a baby with scores such as Johannes could then be termed a *'lifeless baby'* he responded by saying: *'Yes I am saying it looks like a floppy doll so it can have it being lifeless, that is a word that you can use.'*

[50] The relevance of the aforesaid, the doctor explained, was that at 10 minute the baby still had inadequate respiratory efforts, struggling to breath, and thus was a candidate to be incubated. The nasal prongs should not have replaced the ambubag.

Professor E Buchmann's evidence

[51] Professor Buchmann is an Associate Professor at the University of Witwatersrand, in the Obstetrics and Gynaecology department. The professor based his medical legal report on the clinical notes from the hospital, and the reports of Dr W Edridge and Professor H Cronje.

[52] He also concurred that the 'false labour' assessment of Ms Booyse on 7 February 2010 was reasonable and most probable in the circumstances. On an examination of the nurse's notes he confirmed that the conclusion reached by Sister Mafolo of 'false labour' on this day was in keeping with the absence of labour contractions and a closed cervix found with Ms Booyse.

[53] In cross-examination he testified that the factors that were present in this case necessitated calling a doctor. His testimony was as set out below:

'*They certainly should have called a doctor, no matter what their level of experience as a midwife was a... about...after that first late deceleration at 22h05 and depending on their expertise they may well have needed to call a doctor at 21h47 when there was another early deceleration of variable. No doubt if a doctor had been called, there may have been opportunities to intervene.*'

[54] His testimony is confirmed in his report where he states under 'Quality of care in labour and delivery' :

*'In view of LB being a low –risk, it was reasonable for the nursing staff to attend her, and not call a doctor. All findings, including the early decelerations, were reassuring until 22:02, from this time there appear to have been late decelerations. These decelerations suggest that significant fetal (*foetal*) hypoxemia may have started at this point, but further CTG recordings after 22:10 were either not done or are not available. There are no notes of fetal (*foetal*) heart rates between 22:10 and 23:05. Therefore the possibility of severe feta (*foetal*) hypoxaemia occurring between 22:10 and 23:05 is difficult to exclude, even in the absence of obvious sentinel event.'*

[55] The Professor contends that by 22h07 and no later than that, one would have to call a doctor, by any standard of expertise of the midwife and experience because of the second deceleration.

[56] The Professors testimony is that a ventouse delivery or a caesarean section delivery would have resulted in early delivery and a decrease exposure duration to hypoxia. In essence he concurs with Dr Langenegger.

[57] From the Professor's evidence in chief, he states that at the time Sister Mafolo got Ms Booyse to lie on her side and a vaginal examination was conducted at 23h20, that examination should have been conducted by a doctor. A doctor would have requested that the patient be placed on her side with a drip to be then inserted. If the foetal distress did not improved then he would have decided to do either a caesarean section delivery or a vacuum or ventouse delivery. The vacuum may have been possible.

[58] The Professor had this to say in his report with regards to when the insult could have occurred:

'Late decelerations has stopped became noticeable at 22:10, but then the tracing was stopped or subsequently tracing records are lost. If intrapartum fetal (foetal) *hypoxemia (lack of oxygen) is considered to be the cause of LB's baby's neurological condition, then the hypoxemic insult would had occur in 55 minutes between 22:10 and 23:05 the latter being when delivery occurred...All findings including the early decelerations, were reassuring until 22:02, from this this time there appear to have been late decelerations .These decelerations suggest that a significant fetal* (foetal) *hypoxemia may have started at this point, but further CTG recordings after 22:10 were earlier not done or are not available.'*

[59] The Professor concluded that from the record the nursing staff did not monitor the baby after 22:10, even though there were late decelerations of the heart rate at that time. It was also concluded from the note that the nursing staff did not call a doctor to attend to the patient when there appeared to be evidence of foetal hypoxemia at 22:10. The nursing stuff missed this opportunity to intervene to prevent the foetal damage that inevitably ensured.

[60] In conclusion, in the Professor's report he states that the CTG tracing was normal from 21:40 to 22:02. That there was a possible episode of severe foetal hypoxemia in labour after 22:10.

Dr S K Ngali's evidence

[61] This doctor was called from the casualty ward to assist with Ms Booyse's baby, Johannes. He testified that:
'I came in being called to come and assess the baby, then transfer the baby.'
The startling fact is that he did not record any clinical notes of what he did when he resuscitated baby Johannes, except for a note to transfer the child to Steve Biko Hospital.

Sister Mafolo's evidence

[62] Sister Mafolo has advance midwifery and has been employed as a professional nurse at the hospital since 2007. She confirmed having attended to Ms Booyse on both 7 and 8 February 2010. On the first date it was a case of 'false labour' whilst on the second date, the patient was in labour and the baby was delivered. Sister Mafolo contends that she only attended on the first plaintiff at around 21h00 on 8 February 2010.

[63] She testified that she did not have an independent recollection of this specific birth as it was a while ago. She did concede that her documented nursing notes may have been written in the early hour of the following day after the events had taken place. This would then be 9 February 2010 as the birth took place on 8 February 2010.

[64] She stated that she delivered the baby of the first plaintiff with the assistance of another nurse. She was adamant that she was not the one that ruptured the membranes of Ms Booyse and that the membranes ruptured on their own.

[65] She confirmed that she did not conduct the CTG on admission as is required and did so at 21h40 some forty minutes after she admitted Ms Booyse. When she was conducting the CTG, she noted the decelerations as being suspicious in the first

ten minutes, which changed to normal in the next ten minutes and then the decelerations reverted to abnormal again at 22h00. At 22h10 she testified that she removed the band and stopped the CTG. She examined the first plaintiff, found her to be fully dilated and failed to resume with the CTG monitoring.

[66] She stated that she did not call the attending doctor throughout the birth of the baby of Ms Booyse. She also concede that she did not monitor and write down the foetal and maternal heart rate, maternal pulse or the strength or frequency of the contractions. She further concede that she did not conduct the resuscitation process correctly.

[67] She concurred that the management of the patient and foetus was of substandard quality and unacceptable, that she failed to adhere to the standard practise and procedure, in that, she failed to call a doctor in order to assist in assessing the condition of the foetus. She acknowledged that she did not engage intrauterine foetal resuscitation when required, failed to monitor the mother and foetus and *'messed up'* the resuscitation of the baby. She was adament that during this entire procedure she had not administered oxytocin in the drip put up for Ms Booyse.

The Joint minutes of Dr Lippert, a Paediatrician/ Paediatric Neurologist, and Prof Cooper, a Paediatrician,

[68] This minute concluded that the brain MRI scan showed pictures consistent with the consequence of acute profound birth asphyxia. They concluded that the pathway from asphyxia insult to severe cerebral palsy is well evident in Johannes.

The Joint minute of Dr A B Weinstein and Dr MNJ Van Rensburg

[69] The conclusion reached by these radiologist with regards to the MRI examination of the brain of Johannes indicated the following:

'The MRI changes are in keeping with Hypoxic-Ischemic damage to the brain of a Full Term infant sustained in the perinatal period. The distribution pattern suggests

this to have been of a mixed nature, primarily of an acute profound type, but elements of the partial prolonged damage are also demonstrated.'

The Joint minute of Dr Langenegger and Professor Buchmann

[70] The import of these minutes is set out below:

- The Antenatal period was probably uncomplicated.
- The management during the first admission on 7/02/2010 was appropriate. The patient was probably in false labour. The CTG around 05:00 on 7/02/2010 was reactive and indicated a non-hypoxic foetus.
- It was recorded that labour started at 15h30. The counselling advice by the nurse on 7/02/2010 would have been: *Patients are instructed to return to go to hospital when experiencing progressive contractions.*
- The patient's membranes raptured at 21h30 and the amniotic fluid was clear. At 21h40 the decelerations were recorded. It was standard practise for the midwife to call the doctor but this was not done and is thus substandard care.
- The CTG was only for the period 21h40 to 22h10 and nothing thereafter, thus it was discontinued.
- The overall picture is one of substandard maternal and foetal monitoring.
- Of importance is the fact that the 30 minute CTG recorded 4-5 contractions per 10 minutes and was thus suspicious and borders on pathological, after 22h00 to 22h10.
- In these circumstances the standard practise was to turn the patient on her side and call the doctor, which was not done.
- At 22h30, this time was agreed by the experts as the time was incorrectly recorded, on the partogram there was full dilation and the head above pelvis was 1/5th.
- Both experts agree that with the decelerations, *this was a missed opportunity for the nurse to call the doctor to assess the patient and consider whether a ventouse delivery could be attempted. A ventouse delivery would have resulted in earlier delivery and decrease exposure duration to hypoxia. There was also a missed opportunity for the doctor to order a caesarean section for*

foetal distress, ...if it was possible to perform a ventouse assisted delivery then the delivery would have been 35 minutes earlier according to Dr Langenegger and 15 minutes according to Prof Buchmann.

- Both experts agree that if the patient arrived at 19h00 and the patient was only attended to at 21h30 then it amounts to substandard maternal and foetal monitoring, with missed opportunities to diagnose probable foetal distress. The substandard care probably contributed to the poor outcome.
- Dr Langenegger persist that if the patient was admitted at 21h30 it was still as case of foetal monitoring and obstetric care was substandard and better care may have resulted in earlier intervention and a fully or partially prevented HIE.
- Professor Buchmann's opinion was that if the patient arrived at 21h30 her delay in seeking attention during labour deprived the nurses and doctors of detecting foetal distress early and therefore may have contributed substantially to the infant's poor outcome.

Analysis and Evaluation

[71] The case of the plaintiffs' is that the medical staff at the hospital which Ms Booyse attended on 7 and 8 February 2010, acting in the course and scope of their employment with the defendant, were under a legal duty to render proper and appropriate medical treatment to her and Johannes. In doing so they were to exercise the degree of skill and care reasonably required and expected of medical staff in the prevailing conditions.

[72] The defendant contends that even though it could be accepted that the conduct of Sister Mafolo was wrongful in this case and, that the plaintiff's suffered damages due to the substandard foetal and maternal monitoring and care, the plaintiffs' had failed to show that such substandard care was in fact negligent and the cause of the damages they suffered.

Negligence

[73] The duty to prove the negligent conduct mentioned above lies with the plaintiffs', as is stated by the general rule, he who alleges must prove. In addressing

negligence it is most insightful to quote the Supreme Court of Appeal judgment of *McIntosh v Premier, KwaZulu-Natal & Another* 2008 (6) SA 1 (SCA) at para [12] where Scott JA observed:

'The second inquiry is whether there was fault, in this case negligence. As is apparent from the much-quoted dictum of Holmes JA in *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E-F, the issue of negligence itself involves a twofold inquiry. The first is: was the harm reasonably foreseeable? The second is: would the *diligens paterfamilias* take reasonable steps to guard against such occurrence and did the defendant fail to take those steps? The answer to the second inquiry is frequently expressed in terms of a duty. The foreseeability requirement is more often than not assumed and the inquiry is said to be simply whether the defendant had a duty to take one or other step, such as drive in a particular way or perform some or other positive act, and, if so, whether the failure on the part of the defendant to do so amounted to a breach of that duty. But the word "duty", and sometimes even the expression "legal duty", in this context, must not be confused with the concept of "legal duty" in the context of wrongfulness which, as has been indicated, is distinct from the issue of negligence. I mention this because this confusion was not only apparent in the arguments presented to us in this case but is frequently encountered in reported cases. The use of the expression "duty of care" is similarly a source of confusion. In English law "duty of care" is used to denote both what in South African law would be the second leg of the inquiry into negligence and legal duty in the context of wrongfulness. As Brand JA observed in *Trustees, Two Oceans Aquarium Trust* at 144F, "duty of care" in English law "straddles both elements of wrongfulness and negligence".'

[74] This is a matter that ought to be decided on the evidence and the probabilities and with that in mind I am mindful of what was stated in *Van Wyk v Lewis* 1924 AD 438 at 444, this being, the failure of a trained person to follow the general level of reasonable skill and diligence possessed and exercised like other trained persons in their field to which they belong would ordinarily constitute negligence. As stated by Brand JA in *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) at para [15] the test remains always whether the trained or skilled person exercised reasonable skill and care or whether or not his/her conduct fell below the standard of a reasonable competent trained or skilled person in his/her specific field.

[75] Before moving on to address the two enquiries to establish if the plaintiffs have proven that there was in fact negligence, I need to address the approach to be adopted by a presiding officer when dealing with evidence of an expert.

Expert evidence witness

[76] The nature of expert's evidence and how it should be assessed was affirmed in *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft Für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A.D) at 371G-372A:

"(See Klue and Another v Provincial Administration, Cape. 1966 (2) S.A. 561 (E) at p.563). *' As I see it, an expert's opinion represent his reasoned conclusion based on certain facts and data which are either common cause, or established by his own evidence or that of other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert. Even bearing in mind that the addressee of the summary is properly also an expert, I am of the opinion that the addressee may not be able to evaluate the opinion, so as to enable him to advise the party consulting thereon, if he is not informed in the summary of "the reasons" for the opinion. Having regard to the above meaning of the word "reasons" in the context of the sub-rule as a whole and the purpose thereof, I am of the opinion that the summary must at least state the sum and substance of the facts and data which lead to the reasoned conclusion (i.e., the opinion). Where the process of reasoning is not simply a matter of ordinary logic, but involves, for example, the application of scientific principles, it will ordinarily also be necessary to set out the reasoning process in summarized form. The addressee should then be in a position to evaluate the opinion, and be in a position to advise the party consulting him whether the opinion can be controverted and, if so, what evidence is required to do so."*

[77] *Coopers* at 371A-C, further states that the facts or data for the opinion reached by the expert witness must appear in the reasons for his or her opinion or conclusions. These facts or data would include, but are not limited to, experiments, investigations and information obtained from text books and scientific knowledge.

[78] In this case, there are various reports from experts in different medical fields, in addition experts in the same fields of expertise have come together and compiled joint minutes for that specific discipline. By agreement the expert's reports and the joint minutes form part of the evidence. The only two experts that were called to testify as their opinions differed in some respects were Dr Langenegger and Professor Buchmann. In essence these two experts testimony confirmed that contained in their expert reports and the joint minute.

[79] By virtue of the expert's special knowledge and skills, the experts are clearly in a better position to draw inferences from the facts of the trial. This is especially so in circumstances where the court is not capable of forming an opinion unassisted by the experts report, opinion and testimony. In these circumstances the experts were helpful to the court.

Negligence Enquiry

[80] In this instance, applying the test set out above, the first enquiry is whether the harm to the first plaintiff and her son was reasonably foreseeable and, secondly whether there was a duty upon the sister to take reasonable steps in the circumstances. The approach adopted in conducting the enquiry was stated by Holmes JA in *Sardi v Standard and General Insurance Co Ltd* 1977 (3) SA 776 (A) at 780C-H, that it is inappropriate to resort to piecemeal processes of reasoning and to split up the enquiry regarding proof of negligence into two stages. He emphasized that there is only one enquiry, namely whether the plaintiff, having regard to all of the evidence in the case, has discharged the onus of proving, on a balance of probabilities, the negligence averred against the defendant.

[81] On an examination of the evidence before me, in establishing whether Ms Booyse's admission was at 19h00 as per Mrs Grobler or at 21h30 as per Sister Mafolo, I look to the factors which pertain to the active labour. These indicate that the standard of care and monitoring of the mom and foetus were substandard. A point well emphasised by both Dr Langenegger and Professor Buchmann in their joint minute.

[82] I must add that Professor Buchmann's view was that:
'...if the admission was found to be later the first plaintiff was to blame for the defendant's staff not having time to observe her prior to her being 8 cm dilated'.

[83] The damage to the foetus is documented as having occurred at Full term, as clearly highlighted by the joint minute of the radiologist Dr Van Rensburg and Dr Weinstein. In addition, the indicators are that it was primarily an acute profound insult, but there were elements of partial prolonged damage. The obstetrics expert's state that MRI indicates that the acute insult would have occurred within an hour before delivery took place at 23h05, whilst the partial prolonged insult would have commenced during active labour. Which on the nurse's notes was reflected from 21h40.

[84] Having sketched the above picture, with a 40 week gestational admission, having attended on the previous day with 'false labour', in my view, when the first plaintiff was admitted for the second time on 8 February 2010, warning bells should have been ringing for those attending on the first plaintiff.

[85] What is telling is that, when Sister Mafolo examined the patient at 21h30, the patient was then 8 cm dilated and her membranes had raptured, but still Sister Mafolo did not follow protocol, to at least do the CTG on admission which we are well aware was done only at 21h40. In addition, when the CTG was done decelerations are noted. Protocol dictates that the nurse/midwife calls for the attending doctor as there is now an indicator of foetal distress. Sister Mafolo did not do so.

[86] Sister Mafolo was supposed to turn the patient on her side to assist the foetus in distress and call the doctor as there was decelerations noted. This was not done. The CTG recording was conducted from 21h40 to 22h10 and then stopped and thereafter no foetal or maternal monitoring was conducted until delivery. Yet again the conduct of Sister Mafolo was not in tune with acceptable procedures and protocol.

[87] By 22h10 the decelerations were now pathological the nurse should have called the doctor on duty to assess the patient in order to attempt other means of delivery either by ventouse or caesarean. The Sister failed to do so and this was yet another missed window opportunity.

[88] Both experts concluded that the signs of foetal distress were there since Sister Mafolo took control of the patient, however she still failed to follow protocol. In my view with all these facts before me, the foetal distress from all the indicators was foreseeable and could have been avoided had Sister Mafolo followed protocol.

[89] The worst blunder, was the resuscitation of Johannes after birth. This procedure was conducted incorrectly and in my view made matters worse or worsen the condition of the baby. Instead of suction first, to extract the fluids in the lungs of the baby, then bag with ambubag to assist the lungs to breath, the Sister bagged with the ambubag whilst there was still fluid in the lungs and suctioned thereafter. On suctioning, clear fluid was drained from the lungs a clear indicator that there was

fluid in the lungs. To add injury to insult the Sister placed nasal prongs when she should have continued with the ambubag as the oxygen saturation of the baby was only 94%, as opposed to the required 97 to 99%.

[90] There is a concession that the maternal and foetal monitoring and care was substandard. We also have an admission by Sister Mafolo that the resuscitation was a *'mess up'*. These factors together with the evidence and the probabilities lead to the only conclusion that can be reached, that had proper protocol and procedures been followed, the result presented could have been avoided.

[91] There was no reason whatsoever for Sister Mafolo and the medical staff involved in the labour procedure to not follow protocol. Obviously, Sister Mafolo and the medical staff on duty, their conduct and duty to the patient amounts to a serious deviation from the general level of skill and diligence they ought to have and exercise, as members of the nursing profession.

[92] It was established and concurred by the defendant's expert that the procedures adopted were conducted in a substandard manner. This means that the sister and staff's conduct was below the standard of a reasonably competent nurse responsible for the maternal and foetal monitoring and care. The result being that Sister Mafolo and the medical staff of the defendant who had a duty of care towards the plaintiffs' failed in their duty to do so and as such the conduct ascribed is negligence.

Was oxytocin administered?

[93] Firstly I must state that this drug would be administer in the drip, in this case, the Ringers Lactate drip. The drug oxytocin is a Syntocinon and is administered to stimulate the contractions as was mentioned *supra.*

[94] According to both experts, Dr Langenegger and Professor Buchmann, their testimony was that they could not observe from the nurse's notes whether the drug was administered to the patient. However, Dr Langenegger in his medical legal report stated that the drug was administered during advance labour. He does not substantiate why he comes to this conclusion though. If one then looks at his

testimony he clearly states that the drug is not documented and he cannot say if the drug was administered or not. He then goes on to testify that if one looks at the fact cumulatively then the only conclusion that one can reach is that the drug oxytocin was indeed administered.

[95] I do not agree. From the nurse's notes one thing that can be appreciated even as sketchy as they are, Sister Mafolo took time out to write down what drugs where administered. The medical experts did not doubt this at all and as such I do not find any evidence that points in the direction that Sister Mafolo had in fact administered the drug.

[96] In the circumstances I find that the drug oxytocin was not administered by Sister Mafolo as she had testified.

Was the admission of Ms Booyse at 19h00 or 21h30 on 8 February 2010?

[97] Mrs Grobler testified as to when they all left her home. She also gave the distance from her home to the hospital and the period of time it took them to get to the hospital. I also take into consideration that the plaintiffs were at the hospital during the early hours of the morning of 7 February 2010 when a false labour was recorded.

[98] In addition, Mr Grobler corroborated Mrs Grobler's evidence regarding the time they had left home and both relied on the fact that it was just as *7de Laan* commenced.

[99] Sister Mafolo recorded in her nurse's notes that at 21h30 Ms Booyse was 8 cm dilated and draining clear liquid, contractions were strong when she received the patient from admission.

[100] Adv. Soni SC, for the defendant, argued that the nurse's notes should be accepted as reflecting the time of admission, as being 21h30. He submitted that, Mrs Grobler should be taken as a single witness due to the fact that Mr Grobler could not remember some of the soapie's like *Days* that would have been screened before *7de Laan*. On the other hand Adv. Maritz SC, for the plaintiffs', contended that the nurse's notes were not reliable, as Sister Mafolo testified that the notes were not

written at the same time of the occurrences but rather sometime after the events had taken place.

[101] In addition, there is the evidence of Mrs Grobler that they were taken to a waiting area of the labour ward. In this area they were attended to by a nurse other than Sister Mafolo, whom it is common cause attended upon them in the delivery room. Even though challenged, Mrs Grobler stood firm, the defendant could not dispute that the nurse who assist Sister Mafolo was in fact the same nurse who had attended on Ms Booyse when she arrived in the waiting area of the labour ward on 8 February 2010.

[102] Another factor worth consideration, is the fact that the nurse who attend to Ms Booyse before Sister Mafolo conducted a brief examination and advised her that she was not fully dilated. Thereafter she was left on the bed and after sometime a CTG band was placed over her tummy and a drip inserted. The events tie in with Sister Mafolo's testimony that she conducted a CTG and put up a Ringers Lactate drip after receiving the patient from admissions. In my view, in these circumstances it is more probable that the events that occurred with Sister Mafolo were a continuation from whence the first nurse left off.

[103] Why do I say so? It was not disputed that two nurse attend on the first plaintiff during the labour procures, that being an additional nurse with Sister Mafolo. I am also mindful of all the pertinent errors made in the nurse's notes by Sister Mafolo. I do not propose to tabulate all of these errors as they are far too many. I am also mindful of the fact that Sister Mafolo recorded the notes after the events took place. This, in my view, is an indicator that she failed to complete the notes as is prescribed by procedure and protocol, as and when the event arose and this yet again amounts to Sister Mafolo not complying with procedure and protocol.

[104] The defendant's counsel argued that Mrs Grobler was a single witness, I am of the view that Sister Mafolo is in fact the single witness, whose evidence should be treated with caution as she had nothing but the nurse's notes to corroborate her version, which notes where questionable to say the least.

[105] In my view, the nurse's notes don't come to Sister Mafolo's aid but rather highlight her transgressions from the applicable procedures and protocols. The probabilities of the admission time on 8 February 2010, in my view, favour Mrs Grobler's evidence, even though accounts of the admission at the hospital are recorded as being between 18h00 and 19h00. This is clearly not in the region of 21h30, as per the nurse's notes. Adv. Soni, commenced by putting to the witnesses, that the admission time was 21h00 and then he changed the admission time to be 21h30. Frankly, it so clear to me that in fact he did not know the admission time of Ms Booyse at all.

[106] In addition to that stated above, there is still the issue of the evidence of Ms Booyse being a *prima gravida* and 8cm dilated at 21h30. According to Dr Langenegger the plaintiff would have been 4 to 6 cm dilated at 19h00 in active labour. This ties in with the first nurse's examination of Ms Booyse where she advised that she was not fully dilated. Both obstetrical experts confirmed that this was a probability.

[107] Having regard to the evidence and the probabilities I am convinced that the admission time was 19h00 as testified by Mrs Grobler.

Conclusion on negligence.

[108] The only conclusion I am able to reach is that the plaintiff's' have proven that Sister Mafolo and the medical staff of defendant would have/could have and must have, foreseen that her action would have caused harm and a loss.

[109] The conduct of Sister Mafolo is indicative that there was non-compliance with the procedures and protocol, for the numerous reasons set out above of the various transgressions.

[110] Most of which is related to the failure of Sister Mafolo and medical staff in adhering to procedures and protocol. In doing so the medical staff inclusive of Sister Mafoloand doctor Ngali were negligent in the circumstance.

Causation

[111] In *Za v Smith* 2015 (4) SA 574 (SCA) at para [30] Brand JA referred to the well-known case in determining factual causation :

"[30]...for determining factual causation was the ell-known but-for test as formulated, eg by Corbett CJ in *International Shipping Co (Pty) Ltd v Bentley* **1990 (1) SA 680** (A) at 700E-H. What it essentially lays down is the enquiry – in the case of an omission – as to whether, but for the defendant's wrongful and negligent failure to take reasonable steps, the plaintiff's loss would not have ensued. In this regard this court has said on more than one occasion that the 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 minds of ordinary people work, against the background of everyday-life experiences. In applying this common sense, practical test, a plaintiff therefore has to establish that it is more likely than not that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this causal link with certainty (see eg *Minister of Safety & Security v Van Duivenboden* **2002 (6) SA 431** (SCA) para 25; *Minister of Finance v Gore NO* **[2006] ZASCA 98**; **2007 (1) SA 111** (SCA) para 33. See also *Lee v Minister of Correctional Services* **[2012] ZASCA 30**; **2013 (2) SA 144** (CC) para 41.)"

[112] Adv. Soni contended that the plaintiffs' needed to show that the substandard care was negligent and was the cause of the damages of the plaintiffs'. He accepted that Sister Mafolo's conduct was wrongful in that her conduct consists of an omission in failing to call the doctor. He contended that the view of Prof Buchmann was to be accepted and even so it has not been established that there is a connection between the negligent omission and the harm suffered.

[113] The view expressed by Prof Buchmann is that the defendant places reliance upon the fact that had a doctor been called and a decision was taken to do either the ventouse or the caesarean, the ventouse would have hastened delivery by 15 minutes, whilst the caesarean would be longer, as it would have had to be performed at Steve Biko Hospital.

[114] Dr Langenegger testified, if a doctor had been called and a ventouse delivery conducted, the delivery would have been 35 minutes earlier, whilst if a caesarean was to be performed, both he and the Professor agreed that the reasonable expected decision delivery interval would be 45-60 minutes.

[115] What I find strange is that Adv. Soni disregards all the other omissions by Sister Mafolo and places reliance on just one. He forgets, that even if the admission is taken as 21h30, the first omission was that Sister Mafolo did not conduct the CTG on admission as protocol dictates. Foetal distress would have been observed by way of the decelerations and a doctor was supposed to have been called then to assess the patient, delivery could have been initiated earlier. A further omission was that she failed to turn the mother on her side having noted the decelerations to assist the foetus.

[116] There is also the pathological reading from 21h30 to 22h10 of the CTG which yet again required remedial steps to be taken, the CTG was not supposed to be discontinued and the doctor should have been called. Dr Langenegger testimony was that had the delivery been initiated earlier, the profound hypoxic event could have been avoided. This evidence was not challenged.

[117] Taking into account my findings that the admission occurred at 19h00, the patient would have been dilated at least 4 to 6 cm even though no CTG was conducted on her admission, working backwards from her dilation of 8 cm at 21h30. During that 2 hour period whilst she was on the bed, had a CTG been conducted at 19h00 on admission, and she was monitored as per protocol, then the delivery could have been engaged much earlier and the hypoxic event avoided.

[118] On an examination of the evidence and the probabilities had there been proper maternal and foetal monitoring from admission at 19h00, then the delivery could have been earlier and the hypoxic event avoided. Further, had there been proper maternal and foetal monitoring from 21h30 to 22h10 yet again delivery could have been earlier and the hypoxic event avoided. The failure to follow protocol and the failures I have mention in the preceding paragraphs is the cause of the loss in these circumstances. In addition to the factual loss, there is also a legal loss for the medical staff had a legal duty toward the patient, to monitor both the mother and foetus in a proper manner according to protocol and the procedures, and they failed to do so.

Costs

[119] The costs are to follow the result and are to be on the scale of party and party. The costs are to include the employment of two counsel, the qualifying fees of the experts and the fees of the experts in attendance.

[120] Consequently, in the result the following order is made:

[a] The order attached marked as "X" is made an order of Court.

W. Hughes
Judge of the High Court Gauteng, Pretoria

Appearances:

For the Plaintiff: N G D Maritz SC
: M M Lingenfelder

Instructed by : Adele Van Der Walt INC

For the Defendant: V Soni SC
: A Mofokeng
Instructed by : State Attorney
Date delivered : 17 March 2017

"X" 16/3/17

Case Number: 16233/13

In the matter between:

LIZ-MARIE BOOYSE	1st PLAINTIFF
JACOB JAKOBUS JONKER	2nd PLAINTIFF
and	
MEC FOR HEALTH AND SOCIAL DEVELOPMENT OF GAUTENG PROVINCIAL GOVERNMENT	DEFENDANT

Draft order "x"

The following order is made:

[1] The defendant is ordered to pay 100% of the plaintiffs' proven or agreed damages in their personal capacities and in their representatives capacities as the biological parents and natural guardians of their minor son, JOHANNES JACOBUS JONKER ("Johannes"), who was born on 8 February 2010, arising from the perinatal hypoxic ischemia suffered by him on 8 February 2010 and the resultant grade 3 hypoxic ischaemic encephalopathy and cerebral palsy.

[2] The defendant is ordered to pay the plaintiffs' taxed or agreed costs on the High Court scale up to date of this order, which costs will be on a party and party scale. These costs will include, but will not be limited to:

2.1 The reasonable costs consequent upon the obtaining of the medico legal reports and the reasonable qualifying fees (if any) of:

2.1.1 Dr M Van Rensburg, neuro- radiologist;

2.1.2 Dr M.M. Lippert, paediatric neurologist;
2.1.3 Professor H S Cronje, gynaecologist;
2.1.4 Prof A Nolte, qualified nurse;
2.1.5 Dr E Langenegger, gynaecologist.

Of whom the plaintiffs have given notice in terms of the provisions of Rule 36(9) (a) and (b).

[2.2] The costs consequent upon the employment of senior and junior counsel.

[3] All costs incurred on party and party scale in respect of the postponement of the hearing which was set down for 1 June 2015, including the costs of the reservation of expert witnesses of whom notice has been given in terms of the provisions Rule 36 (9) (a) and (b), and the costs consequent upon the employment of senior and junior counsel.

BY THE COURT

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THE REGISTRAAR

17/03/2017