



**IN THE HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, PRETORIA)**

Case No: 16223/2013

In the matter between:

GERTRUIDA SUSANNA BUYS

Plaintiff

and

**MEC FOR HEALTH AND SOCIAL DEVELOPMENT
OF THE GAUTENG PROVINCIAL GOVERNMENT**

Defendant

- | | |
|-----|-------------------------------------|
| (1) | REPORTABLE: YES / NO |
| (2) | OF INTEREST TO OTHER JUDGES: YES/NO |
| (3) | REVISED. |

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DATE

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SIGNATURE

JUDGMENT

D S FOURIE, J:

[1] This is a claim for payment of damages instituted by the plaintiff both in her personal and representative capacity as the mother of a minor child. Prior to the child's birth the plaintiff was admitted to the Tshwane District Hospital for medical care to assist with the delivery of the baby. It is common cause that the child suffered a hypoxic ischemic encephalopathy during labour as a result whereof he sustained severe and permanent brain damage. As a result of this injury the plaintiff also suffered damages in her

personal capacity. It is common cause that her damages are inextricably linked to the damages suffered by the child and therefore both claims shall be dealt with as one.

[2] The following facts are common cause between the parties:

- plaintiff's *locus standi* to claim payment both in her personal and representative capacity;
- Tshwane District Hospital is a public hospital which falls under the authority and control of the Department of Health for the Gauteng Province;
- at all times relevant the medical staff of the said hospital acted in the course and scope of their employment with the defendant;
- on 8 February 2010 the plaintiff, who was between 42/43 weeks of gestation, was admitted to the hospital for medical care to assist with the delivery of the child;
- the child suffered a hypoxic ischemic encephalopathy during labour as a result whereof he sustained severe and permanent brain damage rendering him a cerebral quadriplegic.

[3] It has also been conceded by the defendant that if the plaintiff would be able to prove that members of the medical staff were negligent as alleged and that such negligence caused the injuries sustained by the plaintiff and the child, it should be accepted that such conduct was wrongful. Consequently, the issues to be determined relating to the merits are negligence and causation. Before considering these issues, I shall first refer to the pleadings and thereafter provide a summary of the evidence.

PLEADINGS

[4] In paragraph 6.4 of the particulars of claim it is alleged that the defendant's employees were negligent in one or more or all of the following respects:

- they failed to monitor the plaintiff's labour appropriately or at all;
- they administered an inappropriate dosage of Pitocin to the plaintiff during labour;
- they failed to summon, timeously or at all, a suitable qualified medical practitioner when it was necessary to do so;
- they failed to allow the plaintiff to undergo a caesarean section when they could and should have done so;

- they failed to foresee and/or to prevent the possibility of the child going into foetal distress during labour when they could and should have done so;
- they failed to act timeously and correctly after becoming aware that the child was in distress during labour; and
- they failed to provide professional services to the plaintiff and her child, with the necessary skill, care and diligence as could reasonably be expected.

[5] It is also alleged that as a result of the negligent conduct of the medical staff the child was born with a severe and permanent brain injury causing the plaintiff and the child to suffer damages. In the amended plea these allegations are denied and it is pleaded that the defendant provided the plaintiff and the child professional medical services with the necessary skill, care and diligence as could be reasonably expected of a hospital, nurses and doctors.

EVIDENCE FOR THE PLAINTIFF

DR VAN RENSBURG

[6] Dr Van Rensburg is a radiologist. On 7 December 2012 he prepared a report with regard to a MRI scan of the child's brain. When he

took the MRI scan, it appeared that there were no congenital developmental abnormalities of the brain. He concluded that the overall appearance is consistent with an acute profound hypoxic ischemic insult of the brain of a full term infant in the perinatal period. The “perinatal period” is generally considered to be ten days to a week before and after birth. He explained that an “acute profound hypoxic ischemic insult” is a process whereby the oxygen supply to the brain is limited in a very severe manner.

[7] He also pointed out extensive white matter volume loss of the brain suggesting the additional presence of a partial prolonged hypoxic ischemic insult. The overall appearance suggests a combined type insult, consisting of an acute profound and a partial prolonged insult in the perinatal period. According to him the acute profound and partial prolonged insult are not two separate episodes as they could have occurred at the same time or during the same period.

PROF CRONJE

[8] The next witness was Prof Cronje. He is an obstetrician and gynaecologist and was for 22 years the Head of the Department of Obstetrics and Gynaecology at the University of the Free State. He is also the main editor of a text book in obstetrics that is used by all the universities in South Africa. He was also personally involved in practical obstetrics for many years.

[9] He prepared two medico-legal reports with regard to the child. He testified that when the plaintiff was admitted to the hospital she was definitely in the category of a risk pregnancy. This was caused by two risk factors, high gestation (42/43 weeks) and the position of the baby which was, according to the clinical notes, an occipital posterior. This, according to the witness, was an unfavourable position. It tends to cause prolonged labour; there is an increase in incidents of obstructive labour; and there is also an increase in incidents of small decelerations on the cardio-tocograph.

[10] According to him a reasonable medical practitioner would be able to detect that particular position of a baby. That is done either by way of abdominal palpation or a vaginal examination. According to him every nurse and every medical student is well trained in determining the position of a baby's head during labour. That can be determined already in the first stage of labour.

[11] According to this witness a high risk patient should be monitored very closely. Obstetric protocol dictates that a patient should be observed every 20 to 30 minutes while she is in labour. The usual practice is every 30 minutes, but in a high risk case it should be every 20 minutes. According to the clinical notes it appears that four cardio-tocographs were taken during the period 23:00 until 08:55 which, according to the witness, was insufficient for a patient that was 42 weeks pregnant. It also indicates that these examinations were done sporadically and not continuously.

[12] The witness also observed that between 04:45 and 06:00 a period of one hour and fifteen minutes passed without other observations recorded which is not acceptable protocol. The witness pointed out that, according to the clinical notes, at 04:45 the plaintiff had already dilated 6 cm and at 06:00 it was 8 cm which he considered to be good progress of labour. A fully dilated patient is 10 cm which means that the plaintiff made progress of 2 cm per hour. He would therefore have expected the plaintiff to be fully dilated between 07:00 and 08:00 if the progress was normal.

[13] With reference to the clinical notes it was then pointed out that there are no entries between 06:30 and 08:00. The next entry was made at 08:15 which means that only then was the plaintiff assessed again by the medical staff. According to the witness the period between 06:00 and 08:15 would have been a critical stage of labour. The later in labour the stronger the contractions will be which will increase the risk that the baby will not receive sufficient oxygen. Having regard to the fact that this was her second pregnancy, a patient usually dilates faster and therefore the witness was of the view that "it is very possible that she was fully dilated by 07:00".

[14] With regard to the entry made at 08:15 the witness pointed out that the plaintiff was fully dilated with "head at 3/5 above the brim" which means that 3/5 of the baby's head was at that stage still above the pelvis. He then said the following in this regard:

"So, if you have a patient with a normal obstetrical history of a previous delivery, she is now fully dilated with 3/5 head above the pelvis, that is a warning sign. It is too high, something must be wrong ... this head was actually not engaged at this stage, at 08:15, because there was more head, 3/5, more than 50% of the head was above the pelvis, and that is very abnormal in the second stage of labour ..."

[15] When asked, if the medical staff had followed proper protocol, would they have been able to detect the position of the head at 3/5 earlier than 08:15, his answer was "definitely". He then explained the concept of obstructive labour as follows:

"So, the power is there from above, but there is no progress. That is an absolute diagnosis, an absolute reliable diagnosis of obstructive labour ... if we accept that she was already fully dilated say at 07:00, 07:30, and now it is 08:15, it is an hour later, and the head is still 3/5 above the pelvis, to me it means that head remained there. So, this is already to me obstructive labour."

[16] The witness was then asked if that is the case, what is the normal protocol to follow and his answer was: "obstructive labour, with the head so high, is a caesarean section". According to him it usually takes about ½ hour to get a patient in the theatre. The next entry was made at 08:30 indicating "contractions not adequate". According to the witness this means, at that stage, there was poor progress in labour. When there is increased resistance, contractions also increase in power and also slightly in frequency,

but when the resistance is not overcome then it is almost as if the uterus tends to give up.

[17] According to the clinical notes there is another entry, also made at 08:30, which indicates that the plaintiff was fully dilated and the "head visible". The witness pointed out that for a head to go down from 3/5 above the pelvis to nothing above the pelvis within 15 minutes is almost impossible. According to him it is very unlikely for this to have happened and therefore it should not be an indication that the head is completely in the pelvis and the baby now ready to be born. The witness was then referred to the midwife's notes dated "09/02/2010 08:55" where it is stated *inter alia* that "vaginal examination done cervix fully dilated head still high posterior position". The witness indicated that at that particular point the position of the baby had not changed, as he was still high posterior. He gave the following explanation in this regard:

"This was written at 08:55, so I am not quite sure that was the point of delivery. This must be between I would say 08:50 and the time of delivery but the head was still high here with the posterior position. Now that perfectly fits to everything what we have said up to now, this is obstructive labour."

[18] The next entry relates to the birth of the child. It was made at 08:55. It reads: "Alive baby boy cord and hand presentation". According to the witness this means that when the head came out there was a hand and a cord next to the head. He then said the following in this regard:

"So now the picture becomes clear. He has a posterior position, you have a hand next to the head which increases the diameter that must pass through the pelvis and there was a cord. Now if that cord is compressed it will cause even less oxygen to the baby, so you can accept that this baby was severely hypoxic during the process of delivery and that is particularly between I would say around about 08:30 and 09:00 when the baby was born ... now if you think that half an hour earlier there was still 2 to 3/5 of the head above the pelvis for a period of time and now the head was forced through with a cord next to it, it is no wonder that this baby has brain damage due to insufficient oxygen. This is bad obstetric practice, I cannot emphasise it more, this is really bad obstetric practice. That is to force a baby through a pelvis where it should not have happened. A caesarean section should have been done before that."

[19] The witness was then referred to the concluding part of his medico-legal report dated 15 November 2012 where he pointed out the following: there was poor monitoring of the plaintiff with very poor documentation; the standard protocol for the management of a patient in labour was not followed which increased the risk for foetal distress passing unnoticed. Of importance is the allowance of a prolonged second stage of labour. The diagnosis of poor progress during labour (first and second stage) and the diagnosis of foetal distress fall entirely within the practice of midwives and general practitioners. A timely caesarean section should have been performed.

[20] The witness was finally referred to a joint report prepared and signed by himself and Dr Marishane (Exhibit 7). One of the issues was the

question whether a caesarean section would have prevented the asphyxia and brain damage? According to the minute Dr Marishane's opinion is that the caesarean section done in the second stage of labour with the information at his disposal would not have resulted in a different outcome. According to the witness Dr Marishane's view on this issue was that since the second stage lasted only 25 minutes, there was not sufficient time to do a timely caesarean section because it takes about half an hour to prepare the theatre and to get the baby out. The witness' response was that a caesarean section performed an hour or more before delivery, when the head was still high, would have made a difference by preventing hypoxia or by decreasing the risk for hypoxia. In this regard he also pointed out that when a second stage lasts more than 30 to 60 minutes with a second baby and the head remaining high, a caesarean section is indicated.

[21] In cross-examination the witness was asked to explain how he calculated the period of two to two and a half hours. He responded by saying that at 06:00 the plaintiff was 8 cm dilated and having regard to the clinical notes she made good progress up to 8 cm, i.e. more or less two centimetres per hour. If this rate of dilatation continues, one would expect her to be fully dilated by 07:00. That means that she made good progress up to about 8 cm and then for two and a half hours there was no progress. He then used the expression "no progress after good progress" which is indicative of an arrest pattern the treatment for which is a caesarean section. With reference to his first report he also observed that the clinical notes "are so poor, as they were,

I have to construct a picture in my mind of how things actually developed, and I must give a reflection of that. That is what I tried to do in this document.”

[22] He was also referred to the entry which had been made at 08:15 indicating that the foetal condition at that stage was 125 (heart) beats per minute. The witness conceded that it was still within normal limits, but said that he would like to see more information. According to him this is an incomplete report, taking into account that the patient was already 42 weeks plus pregnant and that there was a major delay in progress between 06:00 and 08:15. He then pointed out that “not to record completely on the foetal heart, the whole pattern, all those parameters, I think that is to me, gross negligence”. Later on he also pointed out the absence of notes indicating what the contraction pattern was as well as what was found during a vaginal examination. According to him “this is very poor recordkeeping”.

[23] When the witness was referred to the entry “head visible” at 08:30 the witness explained that although the head was showing, it was still above the pelvis, at least 2/5, which is abnormal and a sign of severe moulding which fits in with cephalopelvic disproportion. When he was also referred to the foetal condition at 08:30 indicating “the heart rate is normal she must continue to bear down”, the witness responded as follows:

"If we take into account the fact that there was a cord prolapsed next to the baby's head and the baby's head was already visible at 08:30 ... there must have been cord compression ... and if there is

cord compression, the foetal heart must have been grossly abnormal, grossly, there is no other way ... the baby will not receive oxygen and the foetal heart will drop. The birth asphyxia of this child is proof of that. So how can you say that the foetal heart was normal? I do not see it on the notes."

PROF DE WIT

[24] Prof De Wit is a neonatologist and employed by the Steve Biko Academic Hospital for the past 20 years. She also prepared a medico-legal report with regard to the child in question. She testified that on 9 February 2010 the baby was referred from the Tshwane District Hospital to the Steve Biko Academic Hospital. The reason being that the referring doctor was concerned about the condition of the baby as a result of certain complications that had arisen.

[25] She testified that on admission the baby showed certain clinical signs that could fit in with a baby that suffered a lack of oxygen during or before the process of birth. In her report dated 4 April 2014 (Exhibit 4) she made the following observation:

"The nursing documentation from TDH of the labour and delivery is very incomplete, almost impossible to read and confusing. In my opinion the diagnosis of abnormal presentation in labour of a compound head, arm and cord presentation was missed and this could have played an important role in the outcome of Baby Buys. An expert obstetrician needs to assess this evidence and evaluate

if there was any opportunity to act differently to prevent this tragedy.”

BUYS

[26] Ms Buys is the plaintiff in this matter. She testified that she was [.....] years old when she fell pregnant. She went to the Tshwane District Hospital on 8 February 2010. She was then examined and sent for a sonar. After that she was told to go home, as it was thought she was then only 40 weeks pregnant. She went home but did not feel well. Later that night she returned to the hospital.

[27] After her admission the medical staff monitored her labour pains and they also performed a vaginal examination. It was then approximately 23:30 on 8 February 2010. Her mother accompanied her to the hospital and was sitting in a waiting area outside the ward. The next morning, more or less when the day staff arrived, she was taken to the delivery room. Two student nurses arrived and examined her. One of them examined her internally and said that she was fully dilated whilst the other one started to prepare for the actual delivery. Later on the other members of the medical staff also arrived to assist her.

[28] At some stage one of the nurses noticed that she was getting exhausted and said they would have to give her an induction. She was also told to prepare herself and to push as hard as she could. As she became totally exhausted, she was unable to push any more. A drip was then

inserted and some time later two or three doctors also arrived who first performed an examination and then discovered that the child was in danger. Two or three doctors or nurses then started pushing "on top of my abdomen to push the baby down so that it can go down into the birth canal". When the child was born, she could only hear talking amongst the medical staff that the child struggled with breathing and that he was having seizures.

[29] A day after her child was born she prepared a written report (10 February 2010) in her own handwriting (Exhibit 9). She recorded the events as follows:

"Omtrent 05:00 is ek in die kraamteater in weer geondersoek vandaar af was daar niemand by my in die teater nie behalwe my ma toe breek my water vir 'n tweede keer dit was omtrent toe so 06h00 of 06h30 gewees. Net toe die dagskof opkom toe begin my drukpyne toe sê ek vir my ma dat sy iemand moet kry, sy kry toe twee studentverpleegsters wat daar verbygeloop het. Hulle het my gemeet en gesê ek is ten volle ontsluit en reg om te druk, toe was daar geen dokter nog by my gewees nie. Ek was toe al so moeg en seer gewees. Omtrent so 07h30 - 08h00 het hulle 'n hoofverpleegster gekry en 'n dokter want ek het gesukkel hulle sit toe eers vir my 'n induksiedrup in om die geboorte aan te help, die hoofverpleegster vra toe of dit my eerste kind is, ek sê toe nee dit is my tweede, sy vra toe of ek probleme met die eerste gehad het toe sê ek ja hy het nie gesak nie en hulle moes hom uitsuig. Intussen het daar nog dokters bygekom, een sê toe 'o so jy het jou reggemaak ons gaan dit ook doen ek sê vir jou jy sal druk'. Omtrent so 08h30 het hulle weer die monitor opgesit en die baba gemonitor toe hulle sien die baba is in gevaar toe het twee of drie

verpleegsters of dokters op my maag gedruk om die baba af te druk en 'n ander het sy hande ingedruk om die baba uit te trek en my reg rondom laat skeur ek het gevoel hoe skeer ek reg rondom. Toe die baba gebore is kon ek hoor dat daar fout is want ek het gehoor hoe sukkel hulle om hom te kry om asem te haal, my baba is omtrent 09h05 gebore.”

[30] In cross-examination it was put to her that part of her evidence in chief differed from her written statement. She responded by saying that she was only answering questions and if she had left out anything it was because it did not “reflect on the question that was asked”. It was also put to her that student nurses are not allowed to examine patients. Her response was that the two ladies to whom she was referring to had jackets on indicating “University of Pretoria”. She also explained that one of the student nurses also said that she had already been fully dilated whereafter she was instructed by them to bear down and push. When they discovered that there were problems, one of them went to call more experienced medical staff to come and assist. She later conceded that she might have been confused “by nurses and doctors because there is no 100% indication whether it is a nurse or whether it is a doctor”.

[31] It was then put to her that the sister or midwife who was in charge did not utter the words “jy sal druk” as alleged by the plaintiff. She gave the following response:

"Your honour, if I may just say, I mean I was the one that was in labour, I was the one that was there and if words like that were said to me it is very difficult or very unlikely that I would forget in a day or two, that type of words that were uttered to me it is, I will not forget it."

[32] It was also put to her that the evidence for the defendant will be that she was fully dilated only at 08:15, not earlier than that. She responded by saying that the two student nurses who her mother had called came in. The one examined her internally and said that she was fully dilated. Whether this was recorded, she was unable to say.

BUYS SR

[33] Ms Buys senior is the mother of the plaintiff. She confirmed that she accompanied the plaintiff to the Tshwane District Hospital. At some stage during the morning the plaintiff informed her that she must start pushing. At that stage the nurses were coming on duty. She then found two nurses in the passage. They assisted the plaintiff and requested her to leave the room.

EVIDENCE FOR THE DEFENDANT

SISTER MAFOLO

[34] Sister Mafolo is a professional nurse specialising in advance midwifery and employed by the Gauteng Department of Health. She was on night duty on 8 February 2010. She testified that when a patient arrives she goes to the waiting room first where she is examined. She met the plaintiff when she was transferred to the delivery room. She explained that when a patient is transferred to the delivery room she will be in the active phase of labour. She will be monitored every 30 minutes and will not be left alone. The patient will also be examined vaginally every two hours to determine how far the cervix has dilated. When it appears that a patient is not making progress, action should be taken and that patient should then be transferred.

[35] The witness confirmed that she had made the entry in Exhibit 1 on 9 February 2010 at 06:00. The entry indicates "strong contractions" and "8 cm dilated". She also explained that the patient's file will remain with the patient when the day staff comes on duty. The night staff hands over their responsibilities to the day staff between 06:45 and 07:00. The witness also referred to various entries which had been made in the clinical notes and she explained the import thereof.

[36] In cross-examination she admitted that a proper and accurate recording of observations is part of nursing protocol. She also admitted that

when the plaintiff had arrived at her ward she was aware that the plaintiff was already post-term and that this was her second pregnancy. When she was asked whether she had been aware of the fact that the position of the baby was ROA (right occipital anterior) she first replied in the negative. She was then referred to an entry under the heading “antenatal admissions only doctors and midwives notes” where it is indicated that the position of the baby is ROA. Her response was that “I think they determined that on delivery that it is facing upwards”.

[37] She testified that she had also examined the plaintiff at 06:00. When she was asked whether she had also determined the position of the baby, she replied that she did a foetal heart monitoring on the back of the baby but did not record it. She conceded that the position of a baby is a critical point in the delivery process. She also said that she did not classify the plaintiff as a high risk patient. The witness then explained that when a patient is transferred to the delivery room the medical staff do their own CTG tracing on admission. When she was asked why did they do their own CTG tracing her answer was it is protocol, “every patient has to be done CTG”. She testified that she also performed a CTG tracing on the plaintiff after her examination at 06:00, but was unable to indicate the results thereof in the clinical notes or hospital records. She conceded that the CTG tracing is very important because the purpose thereof is to determine the heart rate of a foetus and also whether the foetus is in distress or not.

[38] The witness was then referred to the labour Partogram in Exhibit 1. She conceded that the correct protocol is to record the vital signs of a normal patient every 30 minutes during delivery. She conceded that between 06:00 and 08:15 no other time recordings had been made. She also conceded that if the plotting of observations are not accurately kept on the Partogram it would be very difficult for the nursing staff to trace the progress of a patient and in particular that of the plaintiff. She was unable to deny that the plaintiff could have been fully dilated at 07:00 or 07:30.

[39] In conclusion the witness conceded in cross-examination that the nursing documentation with regard to the plaintiff is very incomplete and confusing. She also conceded that it could be assumed, having regard to the absence of proper protocol, that the plaintiff was never observed during the period 06:30 to 08:00.

SISTER RABALAO

[40] The next witness was Sister Rabalao. She is a professional nurse who is presently doing her Master's Degree in Mother and Child Health and Advanced Midwifery. She came on duty at 07:00 on 9 February 2010 and was in charge of the Labour and Delivery Department in the hospital. According to her student nurses are not allowed to do vaginal examinations, except in the presence of a midwife. She said that she can remember this case very well.

[41] She recorded the entry in the hospital records at 08:15. According to her Nurse Ramafo did the vaginal examination, but she was not certain about the result. The witness was then called to assist. It was also difficult for the witness to do a vaginal examination because when she put her finger into the vagina she found caput and molding with regard to the child's head. She also did not know what the position was of the baby's head. She then called the doctors to come and assist. She explained that when she had made the entry at 08:15 the space above that was left open because she realised the other nurse "did not document anything".

[42] The reason why she requested the assistance of two doctors was because of the caput and molding of the baby's head and because she did not know what the position of the head was. The senior doctor arrived at 08:30. He then informed her that the baby's head was down whereupon he started to deliver the baby. He encouraged the plaintiff to bear down and according to the hospital records the baby was delivered at 08:55 with "cord and hand presentation". The witness testified that she did not detect this before the baby was born as "there was caput and the head was still high". She further testified that there was no indication of this presentation in the child's heartbeat or that a caesarean section was necessary. She confirmed that she is the author of the midwife's delivery notes in the hospital record. According to these notes the plaintiff was reviewed at 08:30, the head remained at 2/5 and the foetal heart rate was 125 beats per minute.

[43] In cross-examination she confirmed that on 9 February 2010 there were two student nurses on duty. She was unable to state whether or not Ms Barnard, one of the student nurses, was with the plaintiff between 07:00 and 07:30. The witness also explained that with progress of labour a vaginal examination is done every two hours whereas the vital signs and foetal heart rate are done every half hour. She confirmed, according to the hospital records, that at 08:15 the foetal heart rate was 125 beats per minute. She also explained that each line on the document represents 30 minutes and therefore the time is not always recorded when the vital signs are taken and the foetal heartbeat monitored. That (the time) can be inferred from the pattern of lines as each line represents 30 minutes.

[44] She was also cross-examined about the handing over of a patient by the night staff to the day staff. She explained that one has to know the status of your patient with regard to gestational age and the progress of labour. The person who received the plaintiff from the night staff was Sister Ramafoko. She then conceded that information with regard to the status of the plaintiff was not recorded by Sister Ramafoko in the clinical notes and that her failure to have done so, is not normal practice.

[45] When she was asked whether it would be normal for this child to have a heart rate of 128 beats per minute at 08:30 if he was born with a hand and cord presentation, she replied as follows:

"Yes, it can be, less ... because with this case, with this Ms Buys, when the head is still high, there is no compression of the cord and she became fully dilated and the head was still high, so there was no cord compression, until she started bearing down. This is where the problem starts ... According to me, I managed the patient according to the guidelines. If the head is at two over five, it is not an indication for caesarean section. You have to do your intervention first."

DR MAHUBA

[46] Dr Mahuba is a medical doctor employed by the Department of Health, Gauteng. During 2010 he was Chief Medical Officer at the Tshwane District Hospital. On 9 February 2010 at approximately 08:30 he was called to assist at the delivery room.

[47] With regard to the entry made at 08:30 he was asked whether there is any indication that the baby was in trouble. He responded as follows:

"While if we look at the heartbeat of the child it is 128 beats per minute with her cervix fully dilated and head visible at the perineum we cannot really make a judgment on a single reading, but a heartbeat of 128 is normal."

He also said, if the head is visible at the perineum, it would be quicker and advisable to have a normal delivery at that stage rather than to do a caesarean section.

[48] In cross-examination the witness explained what a prolonged second stage of labour is. According to him, from a second birth onwards, it would be prolonged if it lasts more than 40 minutes. He testified that the most important part of that period is the starting point of calculation. He then explained that “the starting point for the counting is the full dilation of the cervix.”

DR COTWALL

[49] The next witness was Dr Cotwall. She testified that during February 2010 she was employed as a medical officer at the Tshwane District Hospital. At that stage she was a general practitioner who had 7 to 8 years experience. On the day in question she was a member of the day staff working at the Labour Ward.

[50] She testified that according to the hospital records it appears that on the day in question she was called by Sister Rabalao to come and assist at the delivery room. She testified that according to the notes she was called between 08:15 and 08:30. She and a junior doctor then assessed the plaintiff. As they were unsure, or not in agreement of what should happen, the next step was to call a senior doctor to come and assist further. When she was asked to explain the disagreement, she replied by saying: “How this baby should be born”.

[51] A senior doctor, Dr Mahoma was then requested to come and assist. He progressed to deliver the baby normally. The witness confirmed that in a referral letter written by her she refers to a "prolonged second stage" which was more than 30 minutes. She also said that abdominal compression is not part of their protocol and was not a practice at the Tshwane District Hospital when she was there.

[52] In cross-examination she conceded that there was a problem with the delivery of the child. When she was asked to explain she said the following:

"Because when someone is fully dilated, we want to deliver the baby and we want the head on the pelvis or on the brim to be delivered. So, she was fully dilated and the head was far from where it should be ...

So she (the mother) was in trouble. Can we say that? --- Yes, we can say that Your Lordship.

And the foetus --- could it be in trouble too? Can we say that? --- I went from the CTGs ... at that moment from the notes it does not say that the baby was in trouble at that stage."

[53] She was then cross-examined about the disagreement. She said the following in this regard:

"I am so sorry that I do not have such a good memory, but it was possibly ... and I am saying 'possibly', because I do not ... one of

us ... one of us possibly wanted to take her for a caesar and the other one possibly wanted to deliver. So we were not agreeing, but I am not ... I do not ... cannot tell you exactly what happened ...”.

DR MARISHANE

[54] Dr Marishane is a specialist obstetrician and gynaecologist in private practice. He is also a lecturer at the medical school of Medunsa. He prepared a medico-legal report, two addenda thereto and also had a meeting with Professor Cronje whereafter they prepared a joint minute (Exhibit “7”).

[55] With reference to the hospital records the witness explained that immediately after a baby is born and to improve the contractions of the womb to stop bleeding, they will give 20 units of Pitocin. According to his understanding the reference to “P” in the records was intended to refer to a plan to put 20 units of Pitocin in one litre of Ringers Lactate.

[56] He was then referred to the entry at 08:30 where it is recorded “cervix fully dilated, head visible”. When asked whether it would be advisable, at that stage, to do a caesarean section, he responded as follows:

“No, at that stage, unless you know, you have abnormalities and the fact that the head is there, or in the case of twin pregnancy or ... Siamese twins and you think, you know we are going to have a

problem delivering those babies, but if it is a singleton baby ... coming out through the vagina, you cannot push the baby back. You want to deliver this baby. I mean this baby wants to come out, you have to deliver the baby. The head is down there at the perelium, all you need to do is to encourage the patient to push the baby out. That is, that will be the plan, that will be the management."

[57] The witness was also of the view that there was not a prolonged second stage of labour. He motivated his opinion as follows:

"Especially if there was progress and the patient was being monitored, the baby was, if the baby was well and one would not say that this is really a prolonged stage. You must remember that prolonged stage of labour in itself is not a problem. It does not cause any problem as long as the baby is fine. If the baby is fine, the pelvis adequate, if you have prolonged second stage, it is for you to find out why am I having a prolonged second stage and then manage that. ... So you need to basically make a diagnosis why am I having a prolonged stage. So, prolonged stage in itself doesn't cause a problem. It is a risk factor and the two must be distinguished."

[58] With reference to the joint minute the witness then confirmed that, in his view and with the information at his disposal, if a caesarean section had been done during the second stage of labour, it would not have resulted in a different outcome. He motivated his opinion as follows:

"I adhere to that. The patient was in the second stage from 08:15, at least from what we gleaned here, it seems she was fully dilated

then and there is nowhere we found that they were saying that there is evidence of foetal distress or foetal hypoxia and the labour process itself appears to have been progressing well. So, the caesarean section at that stage, there is no indication to have done a caesarean section, at least with the facts at hand."

[59] In cross-examination the witness was referred to the Partogram and asked whether, in his view, it was completed satisfactory. His response was that it was satisfactory, but there are some omissions or areas that were not completed. He was referring to the time and then said the Partogram was completed "at 06:00, it should be an hour, you know to the next block but at the next block it is 08:15 ...". He also said that the foetal heart rate should have been completed at least every 30 minutes, but after 06:15 until 08:15 the foetal heart rate is not completed. He also conceded that the position of a baby during the process of labour is, generally speaking, a risk factor.

[60] The witness was then referred to the CTG results. According to him the accelerations with regard to the child's heart rate indicated that "the baby is not fine". When he was asked what the hospital should have done on 8 February 2010, he responded as follows:

"What I will have advised would be turn the patient to the side, give the patient some fluids, run a CTG for a longer period and see what happens if the CTG does not change, you still have you know an unreactive CTG, then you do a Caesar."

He pointed out that according to his interpretation it was assumed that the CTG was done “at 10h00 pm” (i.e. at 22h00) on 8 February 2010. According to him this reading indicates a problem.

[61] The witness also conceded that according to the joint minute it appears there was agreement that in all probability the CTG scans did not relate to the plaintiff, because they were not sure whether it refers to her or not. According to him, in any event, the pattern of the CTG was not indicating that there was foetal hypoxia during the first half of the first stage of labour.

[62] He then pointed out certain possible scenarios of what could have caused the condition in which the baby was born. According to him it is possible that the plaintiff could have had complete cord compression even before she came to hospital. However, he conceded that this is an assumption not supported by any evidence. When it was put to him that it is common cause the injury occurred during labour, he gave the following answer: “I think I cannot say yes or no, the likelihood is that it occurred during labour.”

[63] Thereafter the following discussion took place during cross-examination:

“So if we follow your course of protocol at 22h12 or 22h40 would then place her in a natural position, would place on a CTG monitoring continually and if necessary depending on what the

tracing interpretation observation was you would do the C-section
--- Yes.

Why would you do that, if you do not really know what the outcome be, why would one then do a C-section. I agree with you, I fully agree with you, why would you do that? --- It is because I will be worried that this baby's cord is being compressed and as the labour progresses that compression can get worse, do you understand. You have, you know, the baby is compressing on the cord, the contractions are getting stronger and stronger. The compression appears to be partial now but if it continues it may be complete ... so I will do a caesarean."

The witness then also added that if he was managing the patient he would probably have taken action earlier – a caesarean section if it was indicated.

[64] Later during cross-examination the witness was referred to the period between 04h00 and 08h15 and according to him there was acceptable progress in labour during this period. He was also of the view that at 2/5's the head is engaged and according to him "in this case head is already beyond the ischial spines, the midpoint of the pelvis, so the head is there. That is why I am saying there is no yellow light."

STUDENT NURSE BARNARD

[65] The next witness was Ms Barnard. She testified that during February 2010 she was a student nurse in her fourth year at the hospital in question. According to her a student nurse was not allowed to examine a patient on her

own. Normal procedure was that a senior sister or a sister would supervise the student nurse. If the student nurse also performs a procedure on a patient, she must record it and the sister will countersign the entry.

[66] During cross-examination and with reference to the hospital records she conceded that she had performed a procedure (delivery of the placenta), but it was not countersigned by a sister. She also explained that if another student nurse had also been on duty on the day in question, “then you would go around and help where you can and to learn”. According to her a student nurse wears the attire of the university which, in this case, is a navy blue scrup on which is engraved “Student Nurse, University of Pretoria and the name badge”.

SISTER RAMAFOKO

[67] Sister Ramafoko is a registered nurse who was employed at the hospital in the labour ward. She qualified as a registered nurse on 1 January 2010. On 9 February 2010 she was stationed at the delivery rooms and was delegated to work in the labour ward. She was on duty from 07:00 until 19:00. She could not remember what transpired on 9 February 2010.

DISCUSSION

[68] It was contended on behalf of the plaintiff that the medical staff of the hospital were negligent in that they failed to monitor the labour progress of

the plaintiff properly as a result whereof a prolonged second stage of labour set in which was not timeously noticed. It was also submitted that if the medical staff had monitored the plaintiff's condition properly, they would have been able to notice that the plaintiff's labour was prolonged and that they could and should have taken action timeously by performing a caesarean section. If a caesarean section was performed timeously, it could have prevented the injuries referred to earlier.

[69] It was contended on behalf of the defendant that in this case the emphasis is on the conduct of the nursing staff. It was then conceded that the absence of proper entries between 06:00 and 08:15 is below the general level of skill, care and diligence exercised by members of the nursing profession. However, it was argued that there is no proof that such conduct caused the injuries sustained by the plaintiff and her child. It was argued that the compound birth presentation of the plaintiff, more particularly the cord compression, was the direct cause of the birth asphyxia.

NEGLIGENCE

[70] The question of negligence involves a twofold enquiry: first, was the harm reasonable foreseeable? Second, would the *diligens paterfamilias* have taken reasonable steps to guard against such occurrence and did the defendant fail to take those steps? (McIntosh v Premier, KwaZulu-Natal & Another 2008 (6) SA 1 (SCA) par 12.) The failure of a professional person to adhere to the general level of skill and diligence possessed and exercised at

the time by other members of the profession to which he or she belongs would normally constitute negligence (Van Wyk v Lewis 1924 AD 438 at 444 and Goliath v The Member of the Executive Council for Health in the Province of the Eastern Cape 2015 (2) SA p 97 (SCA) par 8). This does not mean that a professional person is expected to bring to bear upon the case entrusted to him/her the highest possible degree of professional skill, but he or she is bound to employ reasonable skill and care (Mitchell v Dixon 1914 AD 519 at 525). The test remains always whether the practitioner exercised reasonable skill and care or, put differently, whether or not his conduct fell below the standard of a reasonable competent practitioner in his field (Castell v De Greeff 1993 (3) SA 501 (C) at 512A-B and approved in Buthelezi v Ndaba 2013 (5) SA 437 (SCA) par 15).

[71] Generally speaking, the answer to the question of negligence depends upon a consideration of all the relevant facts and circumstances. The following dictum of Holmes JA in Sardi v Standard & General Insurance Co Ltd 1977 (3) SA 776 (A) at 780 G-H is apposite in this regard:

"At the end of the case, the Court has to decide whether, on all of the evidence and the probabilities and the inferences, the plaintiff has discharged the onus of proof on the pleadings on a preponderance of probability, just as the Court would do in any other case concerning negligence. In this final analysis, the Court does not adopt the piecemeal approach of (a), first drawing the inference of negligence from the occurrence itself, and regarding this as a prima facie case; and then (b), deciding whether this has been rebutted by the defendant's explanation."

[72] Before considering the evidence, it is not only appropriate but also necessary to say something about the credibility and reliability of the witnesses. Counsel for the plaintiff criticised the demeanour of some of the defendant's witnesses and also questioned their reliability to some extent. An assessment of the credibility and reliability of a witness has to take into account the general context, the witness' intelligence, memory and the ability to express him or herself properly. It is a well-known fact that sometimes witnesses do make mistakes. One should therefore distinguish between *bona fide* errors and intentional untruths. I have had the opportunity to observe the demeanour of all the witnesses and to listen carefully to their evidence and I have no reason to conclude that any one of them was untruthful. There is, in my view, no reason to make a finding against any witness with regard to his or her credibility or reliability. This is a matter that should be decided on the evidence and probabilities.

[73] The first question to be considered relates to foreseeability. Was the injury suffered by mother and child foreseeable? It is common cause that on 8 February 2010 the plaintiff was already between 42/43 weeks of gestation and according to the clinical notes (antenatal admissions) the position of the baby was ROA (right occipital anterior). According to the evidence of Professor Cronje this was an unfavourable position as it tends to cause prolonged labour as well as an increase in incidents of obstructive labour. Sister Mafolo who was on night duty on 8 February 2010 conceded that the position of a baby is a critical point in the delivery process. She

performed a CTG tracing on the plaintiff after her examination at 06:00, but was unable to indicate the results thereof in the clinical notes. She conceded that the CTG tracing is very important because the purpose thereof is to determine the heart rate of a foetus and also whether the foetus is in distress or not. Dr Marishane also conceded with reference to the Partogram that there are some omissions. According to him the foetal heart rate should have been completed at least every 30 minutes, but after 06:15 until 08:15 the foetal heart rate is not indicated. Sister Mafolo conceded that if the recording of observations are not accurately performed, it would be very difficult for the nursing staff to trace the progress of a patient and in particular that of the plaintiff. Taking into account all the evidence in this regard, there can be no doubt that if standard protocol for the management of a patient in labour is not followed, such failure could cause injury or even death. I therefore conclude that the injury suffered by the plaintiff and her child was foreseeable.

[74] The second leg of the enquiry relates to the reasonableness or otherwise of the nursing staff's conduct. Generally speaking, the answer to this enquiry depends on a consideration of all the relevant facts and circumstances. It involves a value judgment which is to be made by balancing various competing considerations, including such factors as the degree or extent of the risk created by the conduct of the person concerned, the gravity of the possible consequences and the burden of eliminating the

risk of harm (as per Scott JA in Cape Metropolitan Council v Graham 2001 (1) SA 1197 (SCA) at 1203, par 7).

[75] The plaintiff testified that the next morning (9 February 2010), more or less when the day staff arrived, she was taken to the delivery room. Two student nurses arrived and examined her. One of them examined her internally and said that she was fully dilated whilst the other one started to prepare for the actual delivery. This should have happened more or less between 06:45 and 07:00 as this is the time when the night staff hands over their responsibilities to the day staff. According to the evidence of Prof Cronje the period between 06:00 and 08:15 would have been a critical stage of labour. At 04:45 the plaintiff had already dilated 6 cm and at 06:00 it was 8 cm, which he considered to be good progress of labour. He said a fully dilated patient is 10 cm which means that the plaintiff made progress of 2 cm per hour. He would therefore have expected the plaintiff to be fully dilated between 07:00 and 08:00 if the progress was normal. He also testified that, having regard to the fact that this was her second pregnancy, such a patient usually dilates faster and therefore he was of the view that "it is very possible that she was fully dilated by 07:00".

[76] This expert opinion corroborates the factual evidence given by the plaintiff that she was examined by a student nurse who informed her that she was fully dilated. This happened the next morning more or less when the day staff arrived, after she had been taken to the delivery room. Sister Mafolo was unable to deny that the plaintiff could have been fully dilated at 07:00 or

07:30. Having regard to the evidence in this regard, I am of the view that it is more probable than not that the plaintiff was already fully dilated between 07:00 and 07:30, although this had not been recorded in the clinical notes or hospital records.

[77] What is the relevance of this? According to the evidence of the plaintiff she, at some stage after she had been examined by the student nurse, was getting exhausted. According to her contemporary report which she prepared the day thereafter, she recorded the following:

"Ek was toe al so moeg en seer gewees. Omtrent so 07:30-08:00 het hulle 'n hoofverpleegster gekry en 'n dokter want ek het gesukkel hulle sit toe eers vir my 'n induksiedrup in om die geboorte aan te help ..."

Prof Cronje testified that the later in labour the stronger the contractions will be which will increase the risk that the baby will not receive sufficient oxygen. With regard to the entry made at 08:15 he pointed out that the plaintiff was then (already) fully dilated with "head at 3/5 above the brim" which means that more than 50% of the baby's head was at that stage still above the pelvis. According to him something must have been wrong as the head was actually not engaged at this stage. He testified that this means there was poor progress in labour and this is an absolute reliable diagnosis of obstructive labour. His evidence was also that if the medical staff had followed proper protocol, they would have been able to detect the position of the head at 3/5 earlier than 08:15.

[78] Sister Mafolo testified that she had performed a CTG tracing on the plaintiff after her examination at 06:00, but was unable to indicate the results thereof in the clinical notes or hospital records. It therefore appears that it was only at approximately 08:15 that it was realised by the medical staff there was a problem. That is why Sister Mafolo had decided to call sister Rabalao to assist. The opinion of Dr Marishane that at 08:30 a caesarean section was not indicated was properly qualified by him referring to “at that stage” (i.e. at 08:30), the absence of abnormalities and the fact that the head was already visible. However, the objective evidence, if it had properly been recorded, would by then already have indicated that there was poor progress as the plaintiff was by then already fully dilated for approximately 1 hour. The objective evidence indicates that there was a problem and according to Prof Cronje this problem was obstructive labour.

[79] Having regard to all the evidence and the probabilities I am of the view that if proper protocol was followed the medical staff should and would have been able to detect this problem at an earlier stage and not as late as 08:15. This means that when Dr Cotwall and Dr Mahuba were called it was already too late and there is no evidence to suggest that when they came on the scene, they also acted negligently. There is no acceptable explanation why proper protocol was not followed earlier by the nursing staff. No doubt, this amounts to a serious deviation from the general level of skill and diligence possessed and exercised by members of the nursing profession. Put differently, this conduct fell below the standard of a reasonably competent

nurse who is supposed to monitor a patient and record his or her findings properly. Therefore, in my view, the person who was responsible to have done so, but failed in his or her duties to do so, was negligent.

CAUSATION

[80] The next question to be considered is whether such negligence caused the injuries sustained by the plaintiff and her minor child. As far as causation is concerned, the following dictum in International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA 680 (A) at 700E-G is apposite:

"As has previously been pointed out by this Court, in the law of delict causation involves two distinct enquiries. The first is a factual one and relates to the question as to whether the defendant's wrongful act was a cause of the plaintiff's loss. This has been referred to as 'factual causation'. The enquiry as to factual causation is generally conducted by applying the so-called 'but-for' test, which is designed to determine whether a postulated cause can be identified as a causa sine qua non of the loss in question. 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 cause of lawful conduct and the posing of the question as to whether upon such an hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; aliter, if it would not so have ensued. If 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. On the other hand, demonstration that the wrongful act was a causa sine qua non of the loss does not necessarily result in legal liability. The second enquiry then arises, viz whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes called 'legal causation'."

[81] With reference to this dictum, it was contended on behalf of the defendant that the cause of the birth asphyxia is the compression of the cord. There was no blood flow or very little blood flow through the cord some time after 08:30, meaning that the baby received almost no oxygen during that period of time and that is why the birth asphyxia occurred. It was further submitted that the birth asphyxia would in any event have occurred, even if the entries between 06:00 and 08:15 had been made. This is so when one takes into account the fact that there was no foetal distress observed thereafter. Therefore, so it was submitted, the lack of entries is not the factual cause of injuries sustained by the plaintiff and her child.

[82] Sister Rabalao testified that she came on duty at 07:00 and was in charge of the labour and delivery department. She examined the plaintiff and recorded her findings to the effect that at 08:15 the plaintiff was bearing down with each contraction and the foetal heart rate was 125 beats per minute. She also recorded that the cervix had fully dilated and the head was at 2/5 above the brim and there was also moulding and caput. It further appears that when Dr Mahuma arrived at about 08:30, the head was almost visible

and the foetal condition (heart rate) of the child was 128 beats per minute. The child was born at approximately 08:55 and had a cord and hand presentation. Dr Marishane's evidence was to the effect that there were no signs of complications and there were no indications that a caesarean section should have been performed. He also testified that if a caesarean section had been done during the second stage of labour, it would not have resulted in a different outcome.

[83] According to the evidence of Prof Cronje the baby had a posterior position, a hand next to the head which increased the diameter that must pass through the pelvis and there was also a cord. He testified that if that cord is compressed, it will cause less oxygen for the baby and therefore one can accept that this baby was severely hypoxic during the process of delivery, more particularly during about 08:30 to 09:00 when he was born. When he was referred to a normal heart rate of 128 beats per minute at 08:30, he responded as follows:

"If we take into account the fact that there was a cord prolapsed next to the baby's head and the baby's head was already visible at 08:30 ... there must have been cord compression ... and if there is cord compression, the foetal heart must have been grossly abnormal, grossly, there is no other way ... the baby will not receive oxygen and the foetal heart will drop. The birth asphyxia of this child is proof of that."

[84] This witness was also of the view that if a caesarean section had been performed an hour or more before delivery, when the head was still high, that would have made a difference by preventing hypoxia or by decreasing the risk of hypoxia. He also pointed out that when the second stage lasts more than 30 to 60 minutes with a second baby and the head remains high, a caesarean section is indicated. It was also the evidence of Sister Mafolo that when it appears that a patient is not making progress, action should be taken and the patient should then be transferred.

[85] When Dr Marishane was referred to the CTG results in cross-examination, he was of the view that the accelerations with regard to the child's heart rate indicated that "the baby is not fine". When he was asked what should have been done on the 8th of February 2010, he explained that he would have done a CTG for a longer period and if there was no change (an unreactive CTG) he would have performed a caesarean section. When he was asked why would he have done a caesarean section if he did not really know what the outcome would have been, he said the following:

"It is because I will be worried that this baby's cord is being compressed and as the labour progresses that compression can get worse ... so I will do a caesarean."

[86] What are the probabilities? It appears to be common cause, particularly with reference to the evidence of Dr Mahuba, that if the second stage (from a second birth onwards) continues for more than 40 minutes after

the cervix is fully dilated (to 10 cm) it is regarded as a prolonged second stage. Dr Marishane's opinion that the second stage lasted only 25 minutes during which the cord prolapse and compression occurred appears to be questionable for the following reasons: First, according to his evidence the plaintiff was in second stage from 08:15. This means that his starting point to determine the duration of the second stage is 08:15. His view is founded on the entry which was made at 08:15 indicating the plaintiff was fully dilated. However, this does not mean that the plaintiff only then became fully dilated for the first time. I have already concluded, having regard to the incomplete hospital records, the evidence and the probabilities that the plaintiff was already fully dilated between 07:00 and 07:30. Second, there is also the evidence of Dr Cotwall who expressed the view in her referral letter that there was a prolonged second stage and that of Prof Cronje who was also referring to a prolonged second stage of labour. In short, having regard to all the evidence, if the plaintiff was fully dilated by approximately 07:30 and the baby was born by approximately 08:55, no doubt there was indeed a prolonged second stage of labour (i.e. much longer than 40 minutes).

[87] What is the probable cause of this prolonged second stage of labour? According to the evidence of Dr Marishane a prolonged second stage of labour in itself is not a problem, but a diagnosis should be made to determine the probable cause thereof. Prof Cronje pointed out that according to the entry made at 08:15 the head was at 3/5 above the brim which means that more than 50% of the baby's head was at that stage still above the pelvis.

According to him that was a warning sign that something was wrong. This, according to him, is a reliable diagnosis of obstructive labour. He explained it as follows:

"So, the power is there from above, but there is no progress. That is an absolute diagnosis, an absolute reliable diagnosis of obstructive labour ... if we accept that she was already fully dilated say at 07:00, 07:30 and now it is 08:15, it is an hour later, and the head is still 3/5 above the pelvis, to me it means that head remained there."

[88] The next entry which was made at 08:55 indicates that the child was born with a cord and hand presentation. According to the evidence of Prof Cronje this completes the picture. The child had a posterior position, a hand next to the head which increased the diameter of the head that must pass through the pelvis and there was also a cord. No doubt, the obstructive labour was caused by this increased diameter of the baby's head which had to be forced through a pelvis when it should not have happened.

[89] According to the evidence of Sister Rabalao it was not possible to detect this cord and hand presentation before the baby was born as "there was caput and the head was still high". She also testified that there was no indication of this presentation in the child's heartbeat or that a caesarean section was necessary. Is there a factual foundation to support this conclusion? As a matter of fact there is none. The hospital records are incomplete, confusing and unreliable. It is common cause the child suffered

a hypoxic ischemic encephalopathy during labour and according to the uncontested evidence of Prof Cronje the foetal heart “must have been grossly abnormal”. Having regard to this evidence and the fact that the child suffered a hypoxic ischemic encephalopathy during labour I have to conclude that, on the probabilities, this abnormality in the foetal heart rate was either not noticed or it was incorrectly interpreted and recorded.

[90] Prof Cronje also pointed out that if proper protocol had been followed, the nursing staff would have been able to detect the position of the head at 3/5 earlier than 08:15. He also testified that the diagnosis of poor progress during labour and the diagnosis of foetal distress as a result of obstructive labour fall entirely within the practice of midwives and general practitioners. This evidence was not contradicted and should therefore be accepted. Having regard to all the evidence referred to above I have to conclude that the only probable reason why this diagnosis was not made timeously, is because proper protocol was not followed earlier.

[91] Prof Cronje also testified that if a caesarean section had been performed an hour or more before delivery, when the head was still high, it would have made a difference by preventing hypoxia or by decreasing the risk for hypoxia. What is important about this evidence, is the qualification “when the head was still high”. That is before the baby’s head, with head and cord presentation, was forced through the pelvis. I have already concluded that the plaintiff must have been fully dilated between 07:00 and 07:30. After 40 minutes calculated from that time the medical staff should have realised

there is a prolonged second stage of labour which should have been a warning sign already at that early stage. According to the evidence of Prof Cronje at 08:15 the medical staff should also have realised that there was obstructive labour. He finally observed that if the cord is compressed it would cause less oxygen to the baby “so you can accept that this baby was severely hypoxic during the process of delivery and that is particularly between I would say around 08:30 and 09:00 when the baby was born”. With reference to the CTG results, Dr Marishane was also of the view that he would have performed a caesarean section already at an early stage “because I will be worried that this baby’s cord is being compressed and as the labour progresses that compression can get worse”.

[92] Having regard to all this evidence, I have to conclude that, on the probabilities, if an earlier intervention was performed, when the head was still high and before cord compression took place during the birth process, it would have prevented these injuries to mother and child. Put differently, the failure to follow protocol, to monitor the labour process properly, and to perform a caesarean section timeously, are all, taken together, the *causa sine qua non* of the loss in question. This negligence is not only the factual cause of the plaintiff’s loss, but also the legal causation thereof. It all happened in a hospital, over a fairly long period and in the presence of suitably qualified medical staff who failed to perform their duties in a proper manner. It should therefore also follow that the loss suffered by the plaintiff and her child is not too remote.

QUANTUM

[93] I was informed that the legal representatives of both parties had the opportunity to discuss quantum, but counsel for the defendant was unable to obtain instructions to agree on an amount. However, both counsel were prepared to make submissions in an attempt to shorten the proceedings by not leading any evidence. It is against this background that a document (electronic email dated 3 December 2014) was handed to me by counsel for the plaintiff. Counsel for the defendant did not object thereto and informed me that “this figure will be a just compensation, but I do not have instructions to agree on it.” I was informed that the quantum of both claims (plaintiff and the minor child) is R9,631,520.00, computed as follows:

- R198,520.00 for the plaintiff in her personal capacity;
- R9,433,000.00 for the plaintiff in her representative capacity.

I was given to understand by both counsel that the abovementioned amounts should be regarded as fair and reasonable. I have no reason to doubt the reliability of their submissions and shall therefore accept that these amounts reflect the quantum accurately.

[94] I was also informed that the amount of R9,433,000.00 consists of three components: R83,000.00 for future loss of earnings, R850,000.00 for general damages and R8,500,000.00 for future medical expenses. Both counsel were in agreement that only the amount of R8,500,000.00 for future medical expenses is still subject to a general contingency deduction which should be determined by the court.

[95] It is common cause that the minor child who was born on 9 February 2010 has a life expectancy of only 12,5 years. Both counsel were satisfied that the possibility of inflationary increases with regard to medical costs has already been taken into account by the actuaries. Having regard to these facts, counsel for the plaintiff submitted that a contingency deduction of 10% would be fair and reasonable, whereas counsel for the defendant submitted that it should be 25%.

[96] Contingencies are the hazards of life that normally beset the lives and circumstances of ordinary people (AA Mutual Ins Co v Van Jaarsveld (1), The Quantum of Damages, Vol II 360 at 367) and should therefore, by its very nature, be a process of subjective impression or estimation rather than objective calculation (Shield Ins Co Ltd v Booysen 1979 (3) SA 953 (A) at 965 G-H). Contingencies for which allowance should be made, would usually include the following:

- the possibility of errors in the estimation of life expectation;

- the possibility of illness which would have occurred in any event;
- inflation or deflation of the value of money in future; and
- other risks of life, such as accidents or even death, which would have become a reality, sooner or later, in any event.

[97] In the present matter it seems to be common cause that the claim for future medical expenses relates to the minor child only. He has a limited life expectancy of only about 12,5 years. He sustained severe and permanent brain damage rendering him a cerebral quadriplegic. It is obvious that he will never be able to take care of himself. It has also been conceded by counsel for the defendant (rightly so in my view) that most of the items pertaining to future medical expenses will probably be utilised. Put differently, it is more probable than not that these expenses will have to be incurred on his behalf. On the other hand, the possibility of him becoming seriously ill or that his life will come to an end sooner as expected, should also be taken into account. Having regard to all these circumstances, I am of the view that a contingency deduction of 15% should be applied. That will reduce the amount of R8,500,000.00 to R7,225,000.00. It brings the total amount of both claims to R8,356,520.00 computed as follows:

- for plaintiff in her personal capacity R198,520.00;

- for the plaintiff in her representative capacity: R83,000.00 for loss of earnings; R850,000.00 for general damages and R7,225,000.00 for future medical expenses.

[98] The last issue raised during argument relates to the payment of these future medical expenses. It was argued on behalf of the defendant that the defendant would be entitled to an order to pay the service providers directly instead of an order for a monetary compensation payable to the plaintiff. It was contended that the quantum of damages to be awarded is in the discretion of the Court and an order for payment directly to the service providers would place the plaintiff and the child in a position similar to that in which they would have been, but for their injuries. The argument goes further to say there is no common law requirement that such a purpose must be achieved by the payment of money to a plaintiff only.

[99] I do not agree with these submissions. First, a plaintiff who claims damages for personal injuries, including payment of future medical expenses, has only a single, indivisible cause of action (Casely v Minister of Defence 1973 (1) SA 630 (A) at 642C). The purpose is to restore the *status quo ante* by means of an award *ex nunc* and not *in futura*, although future medical expenses will only be incurred in future. Second, to determine the quantum of damages for future medical expenses one has to resort to a calculation expressed in monetary values. The alternative suggested by the defendant also assumes a “payment” to be made directly to the persons who would provide such services. Even if such an order were to be granted, it would not

(in the absence of a statutory provision) be binding on a third party and that would render a successful plaintiff still liable for payment to a service provider without having been compensated by the defendant. I can see no reason why a plaintiff should be put at the mercy of a defendant as far as future payments to service providers are concerned. What if such defendant fails to make those payments? For these reasons I am of the view there is no merit in this argument.

ORDER: In the result I make the following order: The draft order attached hereto and marked "X" is made an order of Court.

D S FOURIE
JUDGE OF THE HIGH COURT
PRETORIA

Date: 18 June 2015