IN THE HIG COURT OF SOUTH AFRICA

(EASTERN CAPE LOCAL DIVISION, MTHATHA)

In the matter between: **CASE NO: 2314/13**

NOXOLO SIFUMBA **PLAINTIFF**

And

MEC FOR HEALTH, EASTERN CAPE **DEFENDANT**

Date heard: 03 August 2015

Date delivered: 07 August 2015

JUDGMENT

BROOKS AJ.:

[1] The plaintiff is an adult woman who is resident at Mtyu Location in Libode, Eastern Cape. On 17 September 2013 she issued summons against the defendant on the basis that he is nominally liable for all wrongful acts committed by persons acting in the course and scope of their employment by the Department of Health, including those employed at St Barnabas Hospital, Libode. A subsequent amendment to the plaintiff's particulars of claim makes it clear that she pursues the claim both in her own capacity and in her capacity as the mother and the natural guardian of her minor child Endinako.

[2] In both her capacities, the plaintiff's claim is for damages. It is based upon allegations that employees of the defendant stationed at St Barnabas Hospital, Libode, breached the terms of an oral agreement concluded by them with the plaintiff to provide her with diligent and adequate medical, surgical, nursing and midwifery treatment, alternatively that the defendant's employees stationed at St Barnabas Hospital, Libode, acted negligently whilst under a legal duty of care to render such services to the plaintiff.

[3] Both causes of action relied upon by the plaintiff arise from the circumstances which arose subsequent to her presentation on 20 December 2010, at approximately 06h00, at St Barnabas Hospital, Libode. The allegations common to both causes of action are that at the material time the plaintiff was in labour prior to the birth of Endinako, that she sought and was denied emergency medical treatment, that the defendant's employees failed to monitor the foetal heart rate at 30 minute intervals, failed to take precautions against foetal distress, failed to detect foetal distress, failed to transfer the plaintiff to another hospital and failed to perform a caesarean section timeously.

[4] The plaintiff alleges further that as a result of her prolonged labour and the failure to perform a caesarean section timeously, Endinako suffered an hypoxic incident which resulted in severe brain damage causing permanent spastic cerebral palsy including elements of epilepsy.

[5] In due course, the plaintiff's action was defended and the defendant filed a plea which denied liability on two bases. The first was a special plea which alleged that the plaintiff had failed to issue a notice as contemplated in sections 3 and 4 of the Institution of Legal Proceedings against Certain Organs of State Act (Act 40 of 2002). The second basis for the denial of liability was, in

essence, an assertion that at all times material to their involvement with the plaintiff, the defendant's employees stationed at St Barnabas Hospital provided diligent and adequate medical care.

[6] When the matter was first called before the court, the parties sought an order by agreement in terms of the provisions of Rule 33 (4) of the Uniform Rules of Court which had the effect of separating the issues pertaining to the liability of the defendant from the issues pertaining to the *quantum* of the plaintiff's damages and postponing the latter *sine die*. Such an order was granted.

[7] At the initial hearing, the parties were also in agreement that all issues arising from the special plea should stand over for determination at the end of that part of the trial in which the issues pertaining to the defendant's liability were determined. This somewhat unusual request was predicated upon a mutual belief that the issues relating to the special plea might be resolved by agreement in due course. The optimism of counsel was rewarded and at the end of the evidence an interlocutory application was moved by Mr Kincaid, who appeared on behalf of the plaintiff together with Mr Sambudla, seeking condonation for the delay on the part of the plaintiff in giving the prerequisite notice to the defendant of her intention to institute an action. The supporting affidavit gave a full explanation of the circumstances surrounding the delay. The interlocutory application was not opposed by Mr Pienaar, who appeared on behalf of the defendant together with Mr Kunju, and condonation was granted.

[8] Subsequent to the close of pleadings, expert notices and reports in support of the plaintiff's claim were provided by Dr Van Toornza, a paediatric neurologist, Dr Ebrahim, an obstetrician, Professor Nolte, who holds a

doctorate in midwifery and is a qualified paediatrician who specialises in neonatology, Professor Andronikou, a radiologist and Professor Coetzee, an anaesthetist.

[9] In support of the defendant's stance expert notices and reports were provided by Dr Booyens, a radiologist, Dr Burgin, an obstetrician and gynaecologist and Dr Kara, a paediatrician.

[10] It is apposite to record at this point that none of the defendant's expert witnesses were called to testify. After the closure of the plaintiff's case, the defendant's case was closed without any evidence being led. In the main, the defendant's attack upon the plaintiff's case was confined to extremely limited cross examination of the plaintiff's expert witnesses during which the essential elements of the professional opinion offered by Dr Kara were put to the plaintiff's expert.

[11] It is apposite also to record that by agreement between the parties a minute produced jointly by the two paediatricians, Dr Van Toorn and Dr Kara, was made available to the court.

[12] Against this background, the following evidence available to the court was either agreed upon between the parties and their experts or emerges as uncontradicted from the plaintiff's medical records, the medico legal reports prepared by the plaintiff's expert witnesses or the evidence given on behalf of the plaintiff:

. the plaintiff's pregnancy with Endinako and his delivery, were not the plaintiff's first pregnancy and delivery;

. the plaintiff presented herself at St Barnabas Hospital, Libode, at 06h00 on 20 December 2010;

. the plaintiff was admitted to hospital at 09h00 on 20 December 2010;

. upon her admission, it was recorded that the onset of labour commenced at 08h00 on 19 December 2010, the plaintiff first presenting at Gateway Clinic and being referred therefrom to St Barnabas Hospital, Libode;

. upon her admission the plaintiff's contractions were already occurring at intervals less than twenty seconds apart;

. the partograph completed by the defendant's employees stationed at St Barnabas Hospital discloses that the progress of the plaintiff's labour and the foetal heart rate were monitored at 10h00 , 11h00, 12h00, 14h00, 15h00, 16h00 and 17h00;

. the clinical notes of St Barnabas Hospital disclose that a drop in the foetal heart rate was identified at 17h00, with a further drop being noted at 18h30;

. at 18h30 a decision was taken to perform a caesarean section;

. Endinako was delivered by caesarean section at 19h50 on 20 December 2010;

. with a birth weight of 4,4kg, Endinako was a large baby;

. a drop in the foetal heart rate is an indication of foetal distress;

. whilst the plaintiff was fully dilated at 16h00, she was first seen by a doctor only at 18h30 and Endinako was delivered only at 19h50, meaning that the plaintiff was fully dilated for close on four hours;

. the foetus had bradycardia since 17h00, but only one further foetal heart rate was recorded, at 18h30, before the delivery was accomplished;

. save for the insertion of an intravenous infusion at 14h00, no foetal resuscitation was commenced;

. immediately upon delivery, Endinako required resuscitation by suction and the administration of oxygen by mask;

. Endinako presents with an asymmetrical spastic quadriplegic type cerebral palsy with microcephaly, cerebral visual impairment and severe intellectual disability;

. the MRI findings in respect of Endinako confirm cystic encephalomalacia and ulegyria. This indicate a likely exposure of Endinako to a severe global hypoxic-ischemic insult. Unless done within the first three weeks of life, an MRI scan does not time such an injury. In circumstances such as those pertaining to Endinako, where the MRI scan is done at a later stage, it is necessary to read the finding on the MRI scan together with the clinical presentation. Whilst hypoxic-ischemic injury is the most common cause of cystic encephalomalacia, the herpes virus or other infections are also possible causes when the MRI scan shows cerebral white matter to be dominantly involved (as in the case of Endinako).

[13] The final element of the common cause facts as reflected in the preceding paragraph encapsulates the essence of the difference of opinion between the plaintiff's paediatrician, Dr Van Toorn, and the defendant's paediatrician, Dr Kara.

[14] On a reading of the MRI scan results in conjuction with the clinical presentation and the records of St Barnabas Hospital pertaining to the monitoring of the plaintiff's labour and the delivery of Endinako, Dr Van Toorn was of the firm opinion that the cystic encephalomalacia was the result of an hypoxic-ischemic insult to the foetus intrapartum. In his opinion, the encephalopathy was due to reduced brain oxygen caused by inadequate blood flow to the brain during the plaintiff's labour.

[15] Dr Vaan Toorn's opinion was based upon the diagnostic observation that all four of the criteria for intrapartum asphyxia nominated by leading literature on the subject [Volpe (Neurology of the Newborn, 4th edition, 2001 WB Saunders Company, page 332)] were met upon an analysis of the medical records pertaining to the plaintiff and Endinako. Firstly, there was clear evidence of foetal distress. Secondly, there was evidence of depression at birth requiring resuscitation by suction and by the administration of oxygen. Thirdly, there was clear evidence of an overt neonatal neurological syndrome during the first hours and days of life in that hypertonicity and seizures were noted. Fourthly, the medical records pertaining to Endinako's later neonatal care at Nelson Mandela Academic Hospital, Mthatha, revealed severe renal compromise, which demonstrated the onset of multi-system involvement within seventy-two hours of birth (the fourth criterion).

[16] Although he never gave evidence, Dr Kara's opinion, which informed the defendant's approach to the matter, was that the cystic encephalomalacia was probably caused by an infection, either maternal or neonatal. In his view, the record of Endinako presenting with a fever, jaundice and grunting within the first few days of life was indicative of

an infection. This opinion was also informed by the unremarkable Apgar score recorded on Endinako's assessment from.

[17] It is convenient at this point to record that on the first day of trial the medical records pertaining to Endinako's subsequent treatment at Nelson Mandela Academic Hospital were made available for the first time to the plaintiff's legal representatives and experts. Two significant aspects emerged therefrom. Firstly, it is readily apparent that any suggestion that the symptoms with which Endinako presented at that hospital were caused by a maternal or neonatal infection can safely be excluded. The outcome of tests and treatment conducted at Nelson Mandela Hospital resolve the query relating to a possible infection and, accordingly, remove the potential factual basis relied upon by Dr Kara in the expression of his opinion. Secondly, the Nelson Mandela Academic Hospital record pertinently record that on admission, Endinako's medical records showed no Apgar score.

[18] There was much debate during the evidence about the anomaly presented by an apparent recordal of an unremarkable Apgar score one minute after Endinako's delivery in circumstances where it is recorded that he required resuscitation by way of suction and the administration of oxygen. Against the background of a recordal of a drop in the foetal heart rate, indicating foetal distress, some hours before the delivery by caesarean section, which culminates unsurprisingly in the need for resuscitation upon delivery, the accuracy of the Apgar score was queried by the plaintiff's experts. In my view, the complete absence of evidence on behalf of the defendant to throw light on the anomaly leaves room for the speculation that the Apgar score was inserted on Endinako's

assessment form at a much later stage and was indeed fictitious. That the medical records from the Nelson Mandela Academic Hospital record specifically that no Apgar score was apparent from Endinako's St Barnabas Hospital records cannot be overlooked. When this is seen in the context of the need to attend to the resuscitation of Endinako upon delivery, the probabilities are overwhelming that no Apgar score was measured and recorded one minute and then five minutes after delivery. In the absence of any explanation which would enable reliance to be placed upon the Apgar scores recorded, and in the absence of evidence from Dr Kara to explain why the fundamental bases for his opinion should be maintained, in my view, his opinion may safely be disregarded.

[19] It follows that the issues in this matter fall to be determined upon the evidence presented on behalf of the plaintiff by her team of medical experts.

[20] In my view, the conclusion that the cystic encephalomalacia manifest in Endinako was caused by an hypoxic-ischamic injury intrapartum is irresistible.

[21] In determining the legal issue of liability in this matter it is noteworthy that choosing between their two pleaded alternatives, the plaintiff's counsel have concentrated on a demonstration that the damage suffered by the plaintiff, in both her capacities, has been caused by the negligence of the defendant's employees. If established by the evidence, the failure of a professional person to adhere to the general level of skill and diligence possessed and exercised at the same time by

the members of the branch of the profession to which he or she belongs would normally constitute negligence[1].

[22] The issue of negligence involves a twofold enquiry. 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's employees fail to take those steps[2].

[23] The trial procedure in medical negligence cases is essentially the same as in other cases[3] .

[24] Any explanation as may be advanced by a defendant forms part of the evidential material to be considered in deciding whether a plaintiff has proved the allegation that the damage was caused by the negligence of the defendant or its employees acting within the course and scope of their employment.[4]

[25] In failing to adduce evidence to show that reasonable care had been exercised by his employees in monitoring the plaintiff 's labour and in making decisions in respect thereof, the defendant took the risk of a judgment being given against him. The task of the court is to decide whether on all of the evidence and the probabilities and the inferences the plaintiff has discharged the *onus* of proof resting upon her on a preponderance of probability.[5]

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[1] VAN WYK V LEWIS 1924 AD 438 AT 444; CECILIA GOLIATH V MEMBER OF THE EXECUTIVE FOR HEALTH, EASTERN CAPE 2015 (2) SA 97 (SCA) PARA [8].
[2] KRUGER V COETZEE 1966 (2) SA 428 (A).
[3] CECILIA GOLIATH V MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, EASTERN CAPE 2015 (2) SA 97 (SCA) PARA [13].
[4] OSBORNE PANAMA SA V SHELL & BP SOUTH AFRICAN PETROLEUM REFINERIES (PTY) LTD 1982 (4) SA 890 (A) AT 897 G-H; NOTE 3 (SUPRA) PARA [17].
[5] NOTE 3 (SUPRA) para [19]

[26] In addressing the standard of care received by the plaintiff upon presentation at St Barnabas Hospital from her perspective as a professor of nursing, Professor Nolte opined that the midwives who cared for the plaintiff during her labour were negligent in that they did not do and record maternal observations two hourly and foetal observations half hourly during labour, they did not diagnose foetal compromise when the foetal heart rate dropped to one hundred beats per minute, they did not record and call a doctor when there was foetal compromise and they did not record and call a doctor when there was a prolonged second stage of labour after the plaintiff was fully dilated.

[27] From his perspective as a specialist obstetrician and gynaecologist, Dr Ebrahim was equally critical of the standard of care applied by the midwives who attended to the plaintiff during labour. In his opinion the frequency of the foetal heart rate monitoring was well below the recommendations for a normal labour. Not only did the nurses not use the correct technique, but they were apparently unconcerned by the critically slow foetal heart rate at 17h00. The plaintiff's labour was not recognised as a slow and dysfunctional labour, when it ought to have been. The exposure of the foetus to strong contractions during what was an abnormally prolonged labour would have caused higher than normal intrauterine pressure and greater foetal head compression, leading to an exponential rise in foetal hypoxia. The appearance of a foetal bradycardia, a drop in the foetal heart rate, at 17h00 should have been recognised as a grave sign of possible foetal compromise warranting urgent investigation and management. At that point, immediate intrapartum resuscitation ought to have commenced by placing the plaintiff on her side, administering oxygen to the plaintiff by

mask, administering a rapid intravenous infusion and medicating to suppress or reduce uterine contractility. At the same time a doctor should have been called urgently.

[28] Observing the same dynamics from his perspective as a neonatologist, Professor Smith regarded the failure to perform intrapartum resuscitation and the failure to expedite delivery by way of a timeous caesarean section as negligent.

[29] It was the unanimous opinion of all the experts who gave evidence on behalf of the plaintiff that the consequences of the poor standard of care rendered to the plaintiff by the defendant's employees at St Barnabas Hospital was an hypoxic-eschemic brain injury sustained by Endinako intrapartum, that such a consequence was foreseeable by trained nursing staff who were accordingly negligent in their failure to monitor the plaintiff's labour and to take available decisions of a responsible and professional nature in the face of the distinct prospect of foetal distress in order to minimise that distress and avoid the inevitable outcome.

[30] In argument, Mr Pienaar submitted on behalf of the defendant that the plaintiff had failed to establish factual causation on a balance of probabilities.

[31] An assessment of causation involves a consideration of two questions, namely:

(a) whether any factual link exists between the defendant's conduct and the harm sustained by the plaintiff, and

(b) whether the defendant should be held legally responsible for the consequences of his conduct[6]. The distinction between the two questions can be explained as follows:[7]

> "The first is a factual one and relates to the question as to whether the negligent act or omission in question caused or materially contributed to… the harm giving rise to the claim. If it did not, then no legal liability can arise and *cadit quaestio.* If it did, then the second problem becomes relevant, viz. whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether, as it said, the harm is too remote."

[32] In the present matter, the conduct on the part of the defendant's employees under scrutiny consists of a number of closely linked omissions (i.e. a failure to identify the plaintiff's labour as unduly prolonged and dysfunctional, a failure to detect foetal distress timeously, a failure to implement intrapartum resuscitation, a failure to summon a doctor timeously and a failure to perform a caesarean section timeously). In such circumstances, the determination of factual causation involves a retrospective analysis of what would probably have happened if the defendant's employees had acted positively and not negligently. This requires one to substitute the omission of the defendant's employees with a lawful positive act. If the hypothetical positive conduct of the defendant's employees would probably have prevented the particular consequences from occurring then the omission was a necessary condition and therefore a cause of the consequences. Conversely, if the consequence would probably still have occurred, the omission was not a necessary condition and cause of the consequence.[8]

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[6] HLOMZA V MINISTER OF SAFETY AND SECURITY 2013 (1) SACR 591 (ECM) PARA [35].
[7] MINISTER OF POLICE V SKOSANA 1977 (1) SA31 (A) at 34F-G.
[8] NOTE 6 (supra) [37]

[33] Mr Pienaar's submission is founded on two bases. The first is an answer by Dr Ebrahim under cross-examination. Having stated in his evidence that he would have expected that the decision to do a caesarean section should have been made at 17h00 and the baby born at about 18h30, he was asked whether such action would have meant that cerebral palsy would have been avoided. Dr Ebrahim's answer was "it's very difficult to say". He explained under re-examination that as an obstetrician he was unable to answer the question and that he was unsure whether a paediatrician would be able to answer that question "because this is something that is impossible to test for…". In my view, nothing turns on this as he is not a paediatrician.

[34] The second basis for Mr Pienaar's submission is found in the evidence of Dr Van Toorn, the plaintiff's paediatrician. He had been asked to express an opinion on the extent of the causal effect of the suboptimal neonatal management on the spastic cerebral palsy and the final manifestation thereof in Endinako. In his reply, he stressed that this would be difficult as there were no studies which looked at both insults. He stated that there was a significant insult during the labour itself and opined that this gave rise to a moderate encephalopathy. There was evidence obtained from the medical records of Nelson Mandela Academic Hospital to suggest that neonatal mismanagement of Endinako's care at St Barnabas Hospital had created the climate for a second hypoxic-ischemic insult, leading to the development of a severe encephalopathy. He confirmed that it was difficult to attribute degrees of causal effect to the two hypoxic-ischemic insults. (Emphasis added).

[35] In my view, it is clear that Dr Van Toorn was not stating that he was unable to attribute any causal effect to the hypoxic-ischemic insult sustained by the foetus intrapartum. The difficulty lay in answering the question posed

in the face of the clear evidence of suboptimal neonatal care and the clear indications that this had resulted in a second hypoxic-ischemic insult. He was unable to indicate the degree to which that second insult had a causal effect upon the condition of Endinako. Accordingly, I do not agree with the submission by Mr Pienaar that Dr Van Toor's evidence concludes that it is impossible to attribute any causal effect on Endinako's condition to the hypoxic- ischemic insult suffered by him intrapartum.

[36] Moreover, the criticism ignores the other expert evidence tendered on behalf of the plaintiff which links the hypoxic-ischemic insult suffered intrapartum as the cause of the cystic encephalomalacia diagnosed on the MRI scan to the exclusion of all other possible causes. The correctness of this diagnosis was agreed with by the defendant's own expert paediatrician, Dr Kara, in the joint minute prepared by him and Dr Van Toorn. Therein he also agreed that the most common cause of this condition is an hypoxic-ischemic insult. The only point of departure between him and Dr Van Toorn was contained in the proposal that the condition may have been caused by an infection. The impossibility of this theory being accurate in the present matter is demonstrated by the hospital records emanating from Nelson Mandela Academic Hospital.

[37] In the circumstances, I am of the view that were one notionally to substitute positive action on the part of the defendant's employees at the critical times identified by the plaintiff's experts for the omissions demonstrated clearly in the evidence, the intrapartum hypoxic-ischemic insult would probably have been prevented and the cystic encephalomalacia would probably not have occurred. In the circumstances the question of factual causation is to be answered in favour of the plaintiff.

[38] The next question is that of a legal causation. The enquiry is whether the omissions of the defendant's employees are linked sufficiently closely or directly to the intrapartum hypoxic-ischemic insult and the onset of cystic encephalomalacia, or whether that outcome is too remote. The test for legal causation is said to be flexible one. Factors such as foreseeability, directness, the absence or presence of a *novus actus interveniens,* legal policy, reasonability, fairness and justice will play a part[9]. It follows that this exercise must be conducted against the background of the evidence under scrutiny. In my view, the evidence given by the plaintiff's medical experts establishes overwhelming that the omissions of the defendant's employees are linked directly to the intrapartum hypoxic-ischemic insult and the resultant cystic encephalomalacia. To the extent that the other factors in the test are to be considered, they too indicate that legal causation in this matter has been established.

[39] As indicated earlier in this judgment, clear evidence emerged of suboptimal neonatal care extended to Endinako at St Barnabas Hospital during the first few days of his life, leading to his admission to Nelson Mandela Academic Hospital and the diagnosis that he had suffered a second hypoxic-ischemic insult neonatally. After the closure of the defendant's case, Mr Kincaid moved for an amendment to the plaintiff's particulars of claim clarifying that she sued in a dual capacity. The same notice of intention to amend contained a paragraph which had as its aim the amplification of the scope of this action to include complaint about the neonatal care of Endinako and to seek redress in respect thereof. The defendant had objected to the proposed amendment which targeted the suboptimal neonatal care and in those circumstances Mr Kincaid indicated that he would not seek the second

[9] 9 NOTE 6 (SUPRA) para [43]

element of the amendment. In my view, in the circumstances no regard can be had to the evidence relating to the neonatal care and the diagnosis of a second hypoxic-ischemic insult having been suffered neonatally. As Endinako remains of tender years, it is still open to the plaintiff to consider the pursuit of any remedies which she may be advised would address her complaints about the suboptimal neonatal care.

[40] It follows that I am of the view that the plaintiff has succeeded in discharging the *onus* of establishing causal negligence on the part of the defendant's employees who monitored her labour and saw to the delivery of Endinako at St Barnabas Hospital. She is entitled to such damages as may be proven or agreed between the parties in due course.

[41] In dealing with the issue of costs, Mr Kincaid seeks the payment of the plaintiff's costs on the scale as between attorney and own client. This request is premised upon the observation that the unacceptably late production of the records from the Nelson Mandela Academic Hospital exposed the lack of merit in the opinion expressed by the defendant's expert, Dr Kara, and demonstrating unequivocally that the defendant had no defence to the claim.

[42] In meeting the argument on behalf of the defendant, Mr Pienaar relied upon the content of the plea, his opening address, his cross-examination of the plaintiff's experts and his closing argument as demonstrative of the fact that the defendant has consistently defended the claim by challenging causation, as was the defendant's entitlement.

[43] In my view, whilst Mr Pienaar may be correct in his identification of a consistency in the defendant's approach, and whilst it is undoubtedly within a

defendant's rights to defend a matter on the basis of a challenge to establish causation where this is appropriate, a closer scrutiny of the defendant's approach in this matter suggests strongly that the litigation was unnecessary.

[44] The defendant's plea, opening address and cross-examination were all based upon an assertion of Dr Kara's opinion that the cystic encephalomalacia may well have been caused by an infection rather than an hypoxic-intrapartum ischemic insult. Once this theory was displaced by the content of the Nelson Mandela Academic Hospital records, the foundation of the defendant's defence disappeared. I have little doubt that it is for this reason that the defendant's case was closed without evidence being led. It is reasonable to assume that had Dr Kara seen the records from the Nelson Mandela Academic Hospital before compiling his expert report, his opinion would have been different. Given the content of the joint minute produced by him with Dr Van Toorn, where the only point of departure between them on the cause of the cystic encephalomalacia is the possibility of an infection, it is reasonable to assume that he and Dr Van Toorn would have been *ad idem ab initio* had all the medical records been made available timeously. In this event, there would not have been the basis from which to challenge causation espoused by the defendant. In the circumstances, one can only conclude that the expensive litigation would have been avoided.

[45] It follows that the defendant falls to be criticised for the manner in which the defendant's case was prepared. The criticism must extend to the conduct of the defendant's case. Once the unacceptably late production of the key medical records on the first day of trial demonstrated that there was no sustainable basis to the defendant's defence, a swift re-evaluation of the defendant's position ought to have occurred. That it did not led to a situation

where valuable time was expended unnecessarily by expert witnesses at a cost to the plaintiff which there is little doubt is unaffordable for her, leading evidence which is challenged only on the basis of a defunct expert opinion, culminating in the closure of the defendant's case without any evidence being led to contradict the plaintiff's evidence. In my view, such a situation calls for the censure of the court, which is appropriately expressed in a punitive costs order which ensures that the plaintiff will not be out of pocket unnecessarily.

[46] In the result, the following order is made:

"1. The defendant is directed to make payment to the plaintiff of such damages as may be proven by the plaintiff on trial or as may be agreed upon between the parties as having been suffered by the plaintiff in both her personal capacity and her representative capacity as mother and natural guardian of the minor child Endinako Sifumba arising out of the intrapartum hypoxic-ischemic insult suffered by Endinako Sifumba;

2. The defendant is further directed to pay the plaintiff's costs of suit on the scale as between attorney and own client, such costs to include:

(a) any reserved costs;

(b) the costs attendant upon the employment of two counsel where such counsel were employed;

(c) the travelling and accommodation expenses of the plaintiff's legal representatives incurred in the consultation with witnesses and in attending court;

(d) the travelling expenses, reservation and appearance fees, if any, together with the costs of the preparation of their reports and qualifying fees, if any, of the following expert witnesses:

(i) Dr Van Toorn;

(ii) Dr Ebrahim;

(iii) Professor Smith;

(iv) Professor Nolte;

(v) Professor Andronikou; and

(vi) Professor Coetzee.

3. The defendant is directed to pay interest on the aforesaid costs, such interest to be calculated at the prescribed rate of interest from a date fourteen (14) days after date of allocatur, or after date of agreement, to date of payment.

RWN BROOKS

JUDGE OF THE HIGH COURT (ACTING)

APPEARANCES:

For the plaintiff: **ADV JC KINCAID and ADV L SAMBUDLA**

Instructed by: **DAYIMANI SAKHELA INC, MTHATHA**

For the Defendant: **ADV BJ PEINAAR SC and ADV V KUNJU**

Instructed by: **STATE ATTORNEY, MTHATHA**