



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

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

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DATE: 31/10/2024

Case number: 2014/24051

Date: 31 October 2024

In the matter between:

EN obo SN

PLAINTIFF

and

**THE MEC FOR HEALTH: GAUTENG
PROVINCIAL GOVERNMENT**

DEFENDANT

JUDGMENT

BRAND AJ

Introduction

[1] In this action, of a kind that has become tragically common in this Division,¹ the plaintiff, Ms EN claims damages on behalf of her daughter, SN, from the defendant (the Member of the Executive Council for Health of the Gauteng Provincial Government) for injuries resulting in severe permanent impairment that her daughter sustained on her version during birth, because of the negligence of health care professionals employed by the defendant.

[2] The parties have agreed to separate the issues of liability and quantum, so that before me was only the question of the defendant's liability.

[3] It is common cause that the plaintiff gave birth to her daughter SN at 03:00 on 16 August 2004, in the Chris Hani Baragwanath Hospital (CHBH), under the care of health care professionals (nurses and a medical doctor) employed by the defendant. It is also common cause that SN suffers from cerebral palsy and is severely impaired as a result. Beyond that, the parties diverge.

[4] The plaintiff alleges that her daughter's cerebral palsy resulted from an injury to her brain caused by prolonged and severe foetal distress that occurred during the time from when she was admitted to CHBH on 15 August 2004 at 23:00 until she gave birth the next morning at 03:00; and that this injury was caused by the negligence of the nursing staff attending her in failing to monitor her and her daughter adequately and as required during birth, so that they did not notice the foetal distress and could not intervene until it was too late to prevent the resultant injury.

[5] The defendant denies that the brain injury that caused the cerebral palsy occurred while the plaintiff was in labour and gave birth in CHBH under the care of its nursing staff, instead of at some point before or after that, for another cause than complications during birth. If the plaintiff fails to establish that, her case falls flat – whether or not the defendant's nursing staff were negligent in the care they showed the plaintiff and her unborn child during birth, a causal link between their conduct and the plaintiff's daughter's

¹ See the remarks concerning this of Keightly J in *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* (4314/15) [2019] ZAGPJHC 504; 2020 (2) SA 567 (GJ); [2020] 2 All SA 177 (GJ) (18 December 2019).

injury and impairment cannot be established.

The evidence

[6] This case, as it is so often in matters of this nature,² is complicated by a paucity of evidence.

[7] The only documentary evidence available to this court concerning the plaintiff's pregnancy, labour, the birth of her daughter and the period immediately and shortly after birth is the Road to Health Chart, and the outpatient records concerning SN's treatment that commenced several months after birth at CHBH. There are no contemporaneous records of the birth.

[8] Only one witness gave evidence on the facts: the plaintiff herself. In addition to this, the plaintiff called four expert witnesses (Prof Gericke (a neonatologist and geneticist); Dr Njapa (an obstetrician/gynaecologist); Dr Pearce (a paediatric neurologist); and Prof Nolte (a nursing specialist) and the defendant two (Prof Bolton (a neonatologist); and Prof Smith (a nursing expert)).

[9] The plaintiff gave evidence as follows:

[9.1] Prior to NS, she had given birth to two live children. The first, although born alive died after two months, with no known cause of death. The second is alive and healthy, but her birth was by caesarean section, as she was too large to be delivered vaginally.

[9.2] Five months into her pregnancy with SN, the plaintiff was diagnosed with hypertension at the clinic where she went for checkups. The clinic referred her to CHBH for the further monitoring of her pregnancy, as a precaution.

[9.3] Throughout the antenatal period when she was examined by nurses, she was told that her pregnancy was progressing well. Seven months into the pregnancy she was administered an ultrasound and was told that SN was developing normally. She was not ill and did not suffer any injury during the pregnancy and also did not smoke, drink

² See eg *PG on behalf of TG v The MEC for Health, Gauteng Province* (2014/6003) [2021] ZAGPJHC 351 (19 March 2021) at para [7] *et seq.*

alcohol or use other substances that could have harmed her daughter.

[9.4] On 15 August 2004 around 21:00 her labour pains started. A family member took her to CHBH, where she arrived at 23:00. Upon arrival at 23:00 a nurse examined her. The Plaintiff told this nurse that she had previously given birth through caesarean section. The nurse took her blood pressure, checked her dilation manually, and took a urine sample. She also assessed her daughter's heart rate with a so-called CTG belt that was applied to the plaintiff's stomach. After this examination the nurse told her that all was in order and that she was not yet ready to deliver the baby.

[9.5] A nurse again examined her at 00:00, an hour after the first examination. She was again told that all was in order, but this time also that she had now entered the active phase of labour as her cervix was 5cm dilated.

[9.6] After this, no nurse again came to examine her, until at 02:00 on 16 August, she experienced severe labour pains. When she screamed with pain, a nursing sister came to her aid. After a cursory examination she called a doctor. The doctor also examined her and concluded that her baby must be delivered urgently through a caesarean section.

[9.7] She was taken to theatre, given a spinal anaesthetic injection and her daughter was eventually delivered via caesarean section at 03:00 on 16 August. As she was not fully conscious during the procedure she could not see how the caesarean section was done, but once delivered her daughter was neither breathing nor moving and she was taken away directly after birth.

[9.8] The next time she saw her daughter was only at 17:00 that afternoon, in the neonatal intensive care unit. Her daughter was in an incubator and had an oxygen delivery device in her nose and drips in her arms. She saw her daughter having fits and was told that her daughter was brought to and still was in the neonatal ICU because she did not get enough oxygen during birth.

[9.9] From then her daughter stayed in the neonatal ICU for another approximately 10 days. After this, her daughter remained with her in hospital for more or less a further three weeks before they were discharged. While her daughter was with her in hospital,

she noticed that she did not move. At discharge she was told that she should bring her daughter for physiotherapy sessions, although she was not told why.

[9.10] In the months that followed she noticed that her daughter progressed much more slowly than other children her age and that she was not meeting her developmental milestones. When she later again attended at the hospital, she was told that her daughter had cerebral palsy, but she was not told why.

[10] The plaintiff's evidence is in all material respects corroborated by the evidence given by the experts called on her behalf. Prof Gericke relied on the plaintiff's narrative explanation of the events as rendered in the reports of the other experts and a physical examination of both the plaintiff and SN. Apart from confirming SN's current health status, he gave evidence that an MRI neuroimaging study of SN showed signs of an injury to her brain that was caused by a period of prolonged asphyxia that culminated, when a certain threshold was reached, in a superimposed acute profound event.

[11] He further gave evidence that there were no risk factors that would have predisposed SN to an antenatal cause of the cerebral palsy and that, on the available evidence he could not detect evidence of any sentinel hypoxic event that could have caused the injury that resulted in the cerebral palsy. On this basis he concluded that the injury that caused SN's cerebral palsy most probably occurred during birth, rather than before or after it.

[12] He continued that the risk of SN developing cerebral palsy would have been reduced had there been an earlier delivery intervention and that it could reasonably have been detected earlier that SN was compromised during birth if the CTG monitoring was done more regularly during the hours preceding birth.

[13] Dr Njapa gave evidence on several issues related to the standard of care expected of nursing staff during birth. He first confirmed that a patient presenting as did the plaintiff with a record of one child that was born alive but died two months later of unknown causes; one prior birth by caesarean section; diagnosis of hypertension requiring additional monitoring during pregnancy; and an age of 35 years should have been recognised by the nursing staff attending her at CHBH as a high-risk patient.

[14] He continued that for high-risk patients like the plaintiff, a more stringent monitoring protocol applies during labour leading to birth than for others. The maternity guidelines require that the nurses should have monitored SN's foetal heart rate continuously with the CTG and should further have conducted vaginal examinations and assessments of the foetus every 30 minutes from the time when she was 5 cm dilated, which from the plaintiff's evidence was from 00:00 on 16 August. He further gave evidence that it appears that the examinations and monitoring as required by the maternity guidelines were not done.

[15] Dr Njapa concluded, on the basis that no interventions were made when the plaintiff was examined upon admission at 23:00 and again at 00:00, that both mother and unborn baby were in good health at least until 00:00; but, based on the fact that, upon being assessed at 02:00, she was immediately taken for an emergency caesarean section, that SN suffered such severe distress between 00:00 and 02:00 that a drastic emergency intervention was then required.

[16] He further gave evidence that the fact that examination showed that SN had suffered a partial prolonged hypoxic ischemic brain injury indicated the distress that caused the injury happened over a period of more than 30 minutes.

[17] In light of this, his logical inference is that had the plaintiff and SN been monitored continuously on CTG and otherwise at the required 30-minute intervals, the nursing staff would have detected the distress or insult that caused the brain injury early enough that interventions could have been made to prevent SN's brain injury.

[18] He also stated that, given that SN was delivered in a compromised state (neither breathing nor moving upon birth), the insult that caused the brain injury must have happened before birth – intrapartum – and could not have occurred after birth.

[19] On this basis he concludes:

[19.1] that the nursing staff's failure to monitor the plaintiff and SN during labour and birth as prescribed by the maternity guidelines, constituted substandard care and negligence; and

[19.2] that there is a direct causal relationship between this substandard care and

negligence, and SN's brain injury, that in turn caused her cerebral palsy and impairment.

[20] Dr Pearce, in turn, examined SN. On the basis of this examination, she noted that SN has a severe mixed spastic quadriplegic type cerebral palsy, with a superimposed hemiplegia and a GMFCS IV (Gross Motor Functional Classification Scale IV) with co-morbidities, including profound intellectual disability, probable visual impairment, extensive contractures, epilepsy, microcephaly and global developmental delay. For these reasons SN is completely dependent on others for her daily functioning.

[21] SN's condition was caused by a hypoxic ischemic brain injury which in turn resulted from a partial prolonged insult with a superimposed acute profound pattern of injury. The superimposed acute profound pattern is probably due to the long duration of the hypoxic ischemic insult.

[22] Dr Pearce found no indicators of a congenital or syndromic cause for the brain injury; nor for an infective cause; no congenital brain abnormalities were observed; no evidence was found of intracranial haemorrhage which would indicate a physical injury; and there was no clinical evidence of genetic disorders. Furthermore, SN was found to have a classical nonprogressive neurological disability that affects mostly the motor system. Any inborn metabolism error would most probably have shown significant progression or morbidity, while SN's condition is static, not progressive. Against this background, and based on the so-called ACOG criteria, she concludes that SN suffered an *intrapartum* hypoxic injury, ie she was injured during birth.

[23] The nursing specialist, Prof Nolte, concluded that the nursing staff attending the plaintiff and SN were negligent in that they failed to recognise that the plaintiff was a high-risk patient for whom more intensive monitoring was required, and as a result also failed to monitor the plaintiff on continuous CTG and every 30 minutes as the maternity guidelines require.

[24] Because of these failures they did not detect that SN was in distress during labour and could not intervene at the time it was needed to prevent SN's injury.

[25] Prof Nolte also expressed her scepticism about the relatively high APGAR scores indicated on SN's Road to Health card as these do not correlate with the fact that SN had

to be admitted to the neonatal intensive care unit immediately after birth and stayed on in the hospital after that for a period far exceeding the norm.

[26] The defendant brings no evidence on the facts. Instead, it led only the evidence of two experts, Prof Bolton and Prof Smit.

[27] Prof Bolton agreed with the relevant experts for the plaintiff concerning SN's current health status, the nature of the injury giving rise to that and the probable cause of that injury. However, he did not share their conclusion that the brain injury occurred most likely intrapartum, rather than either before or after birth – on the available evidence his conclusion was that it was not possible to determine when the injury occurred.

[28] He reaches this conclusion on two grounds:

[28.1] First, he points to literature indicating that globally, the majority of cerebral palsy cases are not caused by events during birth. Instead, for a variety of different causes (including maternal medical history, obstetric antecedents and placental pathology) the events that cause cerebral palsy mostly occur peripartum rather than intrapartum. This, to him diminishes the likelihood that SN's injury occurred during birth.

[28.2] He also pointed to the relatively high APGAR scores of 6/10 at 1 minute and 9/10 at 5 and 10 minutes as inconsistent with an injury that occurred during birth.

[28.3] He asserted that the fact that immunisations were administered at 8 days, indicates she then no longer could have been in the ICU as immunisations are administered only to healthy babies.

[29] Prof Rensia Smit, the defendant's nursing expert, focussed on the question whether the attending nursing staff can be said to have been negligent, and to a lesser extent also on whether it was most likely, as the plaintiff maintains, that SN's brain injury occurred intrapartum. In general, her evidence was that it is impossible to say whether either is so, given that the only records available are the non-contemporaneous Road to Health Chart and the outpatient records. Nonetheless, she pointed to several issues that in her view place a question mark over any conclusion of negligence of the nursing staff and over the conclusions of the experts for the plaintiff, that the injury that caused NS's cerebral palsy most probably occurred intrapartum.

[30] These are:

[30.1] There is no documentary evidence that the nursing staff who attended to the plaintiff when she was admitted were appraised of the three factors mentioned above that rendered the plaintiff a high-risk patient. Only if the nursing staff knew of these factors, could they be expected to have applied the stricter monitoring protocol prescribed for such high-risk patients.

[30.2] The fact that, as indicated on the Road to Health Chart, NS received the polio and BCG vaccinations eight days after birth (on 24 August 2004) shows that she could not have been in the Neo-natal ICU for the two weeks that the plaintiff in her evidence referred to. These vaccinations are only given to 'healthy babies' so that NS must have been out of the ICU by then.

[30.3] The monitoring process of mother and foetus during labour and birth takes from 30 to 45 minutes to complete. This means that, had the plaintiff indeed been examined at 00:00 as she stated in evidence, that monitoring cycle would have extended at least to 00:30, so that next monitoring cycle should then have commenced again at 02:00.

The law

[31] The onus is in general on the plaintiff to persuade the court on the basis of credible evidence that her version, that the nursing staff were negligent and that their negligence caused NS's injury and damages, is more probable than other possible versions and in particular more probable than the defendant's version, if any.

[32] Should the plaintiff in this way put up a prima facie case, it is for the defendant, usually likewise on the basis of credible evidence, to rebut that case by persuading the court at the very least that the plaintiff's version is not the most probable. That is, once the plaintiff has established such a prima facie case, this is

'sufficient as to place an evidentiary burden upon [the defendant] to shed some light upon the circumstances attending [the plaintiff's] injury. Failure to do so meant that, on the evidence as it then stood, [the defendant] ran the risk of a finding of negligence against [it]. For, whilst ... the plaintiff, bore the overall onus in the case, [the defendant] nonetheless had a duty to adduce evidence to combat the prima facie case made by [the plaintiff]. It remained for it to advance an

explanatory (though not necessarily exculpatory) account that the injury must have been due to some unpreventable cause, even if the exact cause be unknown.’³

[33] In the ‘very rare medical negligence case in which the defendant[] take[s] the risk of calling no factual evidence, when such evidence is available to [it], of the circumstances surrounding a procedure which led to an unexpected outcome for a patient’,⁴ the defendant, to rebut the plaintiff’s prima facie case, unless it can show that the plaintiff’s version is inherently improbable, can only challenge the credibility of the factual evidence led by the plaintiff and/or the reasonableness of the inferences drawn from that evidence on behalf of the plaintiff.

[34] In cases where a plaintiff cannot put up evidence on an issue because that evidence is peculiarly in the knowledge of the defendant, who does not produce it, less evidence will be sufficient for the plaintiff to establish a prima facie case. Although the overall onus remains with the plaintiff, the defendant then acquires a shifting burden to persuade the court it had taken steps to comply with the expected standards.⁵

[35] For both plaintiff and defendant, inferences must be based on proven facts and arrived at through logical reasoning:⁶

‘Inference must be carefully distinguished from conjecture or speculation. There can be no inference unless there are objective facts from which to infer the other facts from which it is sought to establish. In some cases, the other facts can be inferred with as much practical certainty as if they had been actually observed. In other cases, the inference does not go beyond reasonable probability. But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture.’⁷

[36] The plaintiff need not convince the court that its inference is the only possible to draw from the facts. Instead, it is enough for it to satisfy the court that its inference, from

³ *Meyers v MEC, Department of Health, EC* [2020] ZASCA 3; 2020 (3) SA 337 (SCA) at para [71].

⁴ *Ratcliffe v Plymouth and Torbay Health Authority* [1998] EWCA Civ 2000 (11 February 1998) (*Ratcliffe*).

⁵ *Monteoli v Woolworths (Pty) Ltd* 2000 (4) SA 735 (W) at para [27] (*Monteoli*).

⁶ *PriceWaterhouse Coopers Inc & others v National Potato Cooperative Ltd & another* [2015] ZASCA 2; [2015] 2 All SA 403 (SCA) at para [90]; *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH* 1976 (3) SA 352 (A) at 371F-G.

⁷ *Caswell v Powell Duffryn Associated Collieries Ltd* [1940] AC 152 at 169–170.

among several other possible, is the most readily apparent and acceptable.⁸

[37] What the plaintiff must show to establish the defendant's liability for SN's damages is both fault in the form of negligence and a causal link between that fault and SN's damages. Concerning negligence, the plaintiff must satisfy the court that SN's harm was reasonably foreseeable; that a *diligens paterfamilias* in the position of the defendant's nursing staff would take reasonable steps to prevent the harm occurring; and that the defendant's staff failed to take such steps.⁹

[38] For causality, the plaintiff must show that SN's harm would not have ensued if the defendant's staff's negligent omission had not occurred.¹⁰

Evaluation

[39] The defendant does not claim that the plaintiff's version is inherently improbable so that it may be rejected out of hand. Instead, it disputes the plaintiff's version in two ways:

[39.1] it points to various inconsistencies in the plaintiff's evidence as showing that her recollection cannot be accepted as accurate and her version not as reliable; and

[39.2] it rejects the plaintiff's inferences concerning negligence and causality on the basis that the available facts are too scant to allow inferences to be drawn concerning either.

[40] Crucially, as already mentioned above, the defendant led no factual evidence of its own, leaving the court with only the plaintiff's version of the facts. Indeed, the defendant offers no version of its own as alternative to the plaintiff's – it merely seeks to impugn the plaintiff's version. Partly as a result of this, neither of its challenges to the plaintiff's version can be sustained.

[41] Concerning the reliability of the plaintiff's version of the facts, the defendant highlights various discrepancies between her version as it was provided at different times

⁸ *AA Onderlinge Assuransie-Assosiasie Bpk v De Beer* 1982 (2) SA 603 (A); see also *Cooper & Another NNO v Merchant Trade Finance Ltd* 2000 (3) SA 1009 (SCA); *PG on behalf of TG v The MEC for Health, Gauteng Province* (2014/6003) [2021] ZAGPJHC 351 (19 March 2021).

⁹ *McIntosh v Premier, Kwazulu-Natal and Another* 2008 (6) SA 1 (SCA) at paras [12]-[14].

¹⁰ *Mashongwe v Prasa* 2016 (3) SA 528 (CC) at para [65].

and in different contexts. Apart from various instances in which the plaintiff was tripped up under cross examination (concerning, for example, her own date of birth, the date at which she was discharged from hospital with NS) which are not relevant to the intrapartum period at issue, the defendant's main complaints about the plaintiff's reliability as witness are that:

[41.1] at various stages (when consulting with various of the experts; in her evidence in chief) she gave different times for her arrival at and admission to CHBH – moving between 22:00 and 23:00;

[41.2] to Dr Pearce when consulting with her she said that when she was admitted to the hospital at 22:00, she already had such labour pains that she felt the urge to scream; but to Dr Njapa and in her evidence before court she said that her labour pains were intermittent and mild until 02:00 on 16 August, when it became so bad that she screamed out for help and was assisted; and

[41.3] to Dr Pearce she said that when her baby was placed on her chest after birth, she was not breathing; yet to the court she said that the baby was breathing slowly;

[42] In further support of the submission that the plaintiff's evidence was unreliable, the defendant raised the evidence of Prof Bolton, concerning literature that showed that maternal recall in the intrapartum period was often much different from reality, in that women tend to remember more or less when, where and in what sequence things happened but that the details of labour and delivery may be sketchy.

[43] The efforts of the defendant to impugn the reliability of the plaintiff's evidence by showing its discrepancies in detail and by relying on the expert evidence of Dr Bolton concerning maternal recall are insufficient to warrant either the rejection or even the devaluing of the plaintiff's version of the facts. None of the discrepancies the defendant highlights are material in the sense that they are not only about detail but bring into question the general frame of the plaintiff's version. The general when, where and at what stage of the plaintiff's version of the facts remain intact, despite these discrepancies.

[44] This conclusion is supported rather than refuted by Prof Bolton's evidence concerning maternal recall, namely that while recall of detail is unreliable, recall of the

basic when, where and what sequence of events is usually sound. Indeed, Prof Bolton's evidence concerning this is supported by Dr Pearce, who in her evidence under cross examination also confirmed that the plaintiff's recall was typical of maternal recall of the intrapartum period, which was usually weak on precise detail, but strong on the general 'arc' of events. In the plaintiff's case this entailed that although there may be discrepancies concerning exactly when she arrived, what her baby was doing directly after birth etc, she remained consistent about the fact that she arrived at hospital late evening, was then examined and again around an hour later, was then not examined again for around two hours and was only assisted at 2:00 because she screamed for help; underwent an emergency caesarean section with the baby born at 3:00; and that her baby was not healthy at birth and was almost immediately taken away. Her version of the facts is not impugned by the discrepancies pointed out by the defendant. In the absence of an alternative version being put up by the defendant on the basis of alternative facts, the plaintiff's factual evidence stands.

[45] The defendant's challenge to the inferences the plaintiff draws from the facts likewise fails. These inferences are that:

[45.1] the nursing staff attending to the plaintiff at CHBH were negligent because they either failed to recognise the plaintiff as a high-risk patient and consequently failed to apply the stricter monitoring regime required by the maternity guidelines or recognised her as a high-risk patient but then neglected to monitor her as frequently as required for such a patient;

[45.2] the injury to SN's brain that caused her cerebral palsy resulted from distress she suffered intrapartum; and

[45.3] the nursing staff's negligence caused SN's brain injury and so her impairment, as, had they not been negligent and indeed monitored the plaintiff and SN as required, they would have picked up SN's distress earlier, at a time when it was still possible to avert the harm.

[46] To rebut these inferences the defendant first submits that there are insufficient facts to sustain them, as they rely only on the plaintiff's own evidence. But this avenue is not open to the defendant. It did not allege, and I do not find that the plaintiff's version of

the facts is inherently improbable. In the absence of alternative facts put up by the defendant and with the defendant's attempt to impugn the plaintiff's evidence as unreliable having failed, the plaintiff's version of the facts stands and inference can legitimately be drawn upon it.

[47] The defendant next seeks to challenge the logic of the reasoning through which the plaintiff's experts arrived at their inferences. The two experts for the plaintiff who gave evidence relevant to negligence – Prof Nolte and Dr Njapa – reached their conclusion on the basis of the plaintiff's evidence that:

[47.1] she told the nurses attending her upon admission that she had previously had a birth by caesarean section and her own age (35 years at the time), and that they checked her blood pressure so that they knew or should have known that she was high-risk and should have proceeded to monitor her more regularly as prescribed by the maternity guidelines; and

[47.2] the nurses in fact examined her only upon admission at 23:00, again at 00:00 and then only at 02:00, when the plaintiff and SN were already in severe distress (so that they missed the opportunity to detect the foetal distress at a time when harm could still be prevented).

[48] Prof Smit for the defendant sought to cast doubt on this reasoning by giving evidence that one cycle of the monitoring that applies in cases such as the plaintiff's takes between 30 and 45 minutes to complete so that it would have been impossible for the nursing staff to monitor the plaintiff more frequently than they did. Apart from the fact that Prof Smith's evidence concerning this was in conflict with Dr Njapa's evidence that the CTG monitoring should be continuous while the manual vaginal examination is a quick procedure that could be applied every thirty minutes, the logic of Prof Smit's own reasoning here is in question. Even if one accepts her evidence at its best for the defendant, that the monitoring cycle takes 45 minute to complete, this still means that from 0:45 to 02:00 – 1 hour and 15 minutes – the plaintiff and her unborn baby were not monitored. Indeed, when pressed under cross examination Prof Smit was forced to concede that, if the plaintiff's factual evidence is accepted as correct (as one must) then the nursing staff were indeed negligent.

[49] Accordingly, the plaintiff's version that the nursing staff were negligent must stand. The conclusion to this effect is based on the uncontroverted facts placed before this court that the nursing staff knew or should have known that the plaintiff was a high risk plaintiff; that they knew or should have known that high-risk patients and their unborn babies must be monitored continuously with the CTG belt and examined every 30 minutes manually to detect any problems intrapartum early enough that resulting injury to the unborn baby can be prevented; and that they nonetheless failed to monitor the plaintiff and SN as prescribed. These facts were not successfully controverted or otherwise challenged by the defendant and logically support the conclusion of negligence.

[50] Prof Gericke and Dr Pearce who gave expert evidence on the injury and the time that it occurred based their conclusion that it occurred most likely intrapartum on the facts that:

[50.1] SN's brain injury was a hypoxic ischemic brain injury which in turn resulted from a partial prolonged insult with a superimposed acute profound pattern of injury. The superimposed acute profound pattern is probably due to the long duration of the hypoxic ischemic insult.

[50.2] There are no indicators of other possible causes for the injury than an intrapartum insult: not for a congenital or syndromic cause; nor for an infective cause; no congenital brain abnormalities were observed; no evidence was found of intracranial haemorrhage which would indicate a physical injury; and no clinical evidence of genetic disorders. SN's disability - classically nonprogressive neurological, affecting mostly the motor system – is further static, whereas an inborn metabolism error would most probably have shown significant progression.

[50.3] Apart from the plaintiff's hypertension, that was detected early during her pregnancy and monitored at CHBH once she was referred there for her checkups, no problems were detected during pregnancy and all examinations subsequent to her referral to CHBH showed that the pregnancy was progressing normally.

[50.4] SN suffered distress intrapartum sufficiently serious that upon detection the plaintiff was immediately taken for an emergency caesarean section.

[50.5] SN was not healthy at birth (unresponsive, with difficulty breathing) and was immediately taken to the neo-natal ICU, where she remained at the very least for several days and then remained in hospital for an extended further period before discharge. In the NICU she was observed to have seizures. After discharge, she was regularly taken to the clinic for checkups but was then referred again to CHBH, where the plaintiff was told that she had cerebral palsy.

[51] The challenge the defendant offers to the conclusion that SN was most likely injured intrapartum is twofold. First, Prof Bolton gave evidence that the high APGAR scores indicated on the Road to Health Chart are inconsistent with SN having been unhealthy already at birth. Prof Bolton's reliance on the APGAR scores must be evaluated in the context of Dr Njapa's evidence that APGAR scores, based as they are on experiential observation are unreliable and are often inflated, and the fact that on the plaintiff's uncontroverted evidence, SN was having trouble breathing directly after birth, was immediately taken to NICU, and had seizures there. Indeed, Dr Bolton under cross-examination readily conceded that, if the plaintiff's evidence is correct – as I have now already found it is – the APGAR scores are inaccurate and SN's injury most likely occurred intrapartum.

[52] Second, Prof Bolton referred in evidence to literature in indicating that globally, the large majority of cases of cerebral palsy are caused by events that do not occur intrapartum, but instead before or after birth. This proposition was put to Prof Gericke under cross-examination. Prof Gericke was familiar with the literature referred to and agreed that it showed that globally cerebral palsy is mostly cause by events before or after, rather than during birth. However, he pointed out that the study applied to high income countries unlike South Africa. He referred to other studies in lower income countries, including one in South Africa, that showed the opposite, namely that in such lower income countries the majority of cerebral palsy cases are caused by intrapartum events.

[53] Prof Gericke's opinion places a question mark over the relevance of Prof Bolton's studies to this case and in fact points to the opposite conclusion than that advanced by Prof Bolton. However, it is not necessary to reach any conclusion on the relative weight

of their opinions concerning this. Even were the studies Prof Bolton cites relevant to this case, he advances his opinion without basing it on any proven facts of this case. Accordingly, his opinion on this question, even if sound in the abstract, remains conjecture and speculation concerning SN's injury and the question of what caused it and when.¹¹

[52] Accordingly I accept the inference on behalf of the plaintiff that SN's brain injury most likely occurred intrapartum, as a result of an intrapartum insult.

Conclusion

[53] On the available facts the plaintiff has shown on a balance of probabilities that:

[53.1] the nursing staff attending to her and her unborn baby at CHBH were negligent in failing to monitor the plaintiff and her unborn baby according to the frequency prescribed by the maternal guidelines;

[53.2] SN suffered the injury to her brain that in turn caused her cerebral palsy and impairment intrapartum, due to a partial prolonged hypoxic insult.

[53.3] The nursing staff's negligence in not monitoring mother and baby as prescribed caused SN's injury (and so her condition and impairment) in that, had they not been negligent and had they monitored the plaintiff and SN as prescribed, SN's distress would have been detected earlier, and action would also have been taken earlier to prevent any injury.

[54] Accordingly I hold that the defendant is liable for SN's damages resulting from the injury she suffered to her brain during birth, **and I order that:**

1. The defendant is liable for 100% of the plaintiff's damages, as proven or agreed to, arising from the birth of SN on 16 August 2004.
2. The defendant shall pay the plaintiff's costs.

¹¹ *Caswell v Powell Duffryn Associated Collieries Ltd* [1940] AC 152 at 169–170.



JFD Brand

JUDGE OF THE HIGH COURT
GAUTENG LOCAL DIVISION,
JOHANNESBURG

This judgment was handed down electronically by circulation to the parties' and/or parties' representatives by email and by being uploaded to CaseLines. The date and time for hand-down is deemed to be 10h00 on 31 October 2024.

Dates of hearing: 19 – 27 February 2024

Plaintiff's heads of argument: 4 April 2024

Defendant's heads of argument: 9 April 2024

Date of judgment: 31 October 2024

Appearances:

Counsel for the Plaintiff: Adv D Brown

Instructing Attorneys: Du Plessis Attorneys

Counsel for the Defendant: Adv D Ntsebeza SC; Adv N Mashabela

Instructing Attorneys: State Attorney