IN THE HIGH COURT OF SOUTH AFRICA,
FREE STATE DIVISION, BLOEMFONTEIN

Reportable: NO
Of Interest to other Judges: NO
Circulate to Magistrates: NO
Case No: 2786/2020

In the matter between:

N[...] C[...] M[...] obo Plaintiff
R[...] M[...]

and

THE MEMBER OF THE EXECUTIVE COUNCIL FOR Defendant
HEALTH OF THE FREE STATE PROVINCE GOVERNMENT

HEARD ON: 29 August 2024

JUDGMENT BY: MHLAMBI, J

DELIVERED ON: 30 January 2025

[1] The plaintiff sued for damages in her representative capacity as the mother of her minor child, R[...], following the former's admission to the Defendant's Pelonomi Hospital on 27 July 2013 for the assessment, management and monitoring of her labour and the condition of her unborn baby and delivery of the baby, R[...]. The claim is based on the negligence of the medical and

nursing staff of the hospital, which resulted in R[...] sustaining a hypoxic brain injury during the intrapartum period, which left her with cerebral palsy.

[2] The merits and quantum have been separated, and the matter is to be adjudicated on liability only. It is common cause that there are two central issues to be determined, namely, negligence and causation. The question is whether there was negligence on the part of the defendant's medical and nursing staff in the monitoring and management of the plaintiff's labour and the delivery of her baby; and, if so, did such negligence cause or contribute to R[...]'s brain damage.

[3] In the particulars of claim, the plaintiff averred that as a result of the failure to monitor her labour and foetal well-being appropriately with sufficient regularity, or at all; the prolonged labour and/or failure to expedite delivery, R[...] was diagnosed as suffering from cerebral palsy due to asphyxia during the plaintiff's labour and/or R[...]'s delivery and/or birth. The complication was that R[...] suffered a hypoxic-ischaemic incident due to perinatal asphyxia, causing her to sustain severe brain damage. As a result, she suffered from cerebral palsy, mental retardation and epilepsy.

[4] The defendant pleaded that at all relevant times, the defendant acted reasonably, and the nursing personnel and medical practitioners at the hospital involved in the medical management and treatment of the minor acted with the necessary care, skill and diligence as is reasonably expected in similar circumstances. The nursing personnel and medical practitioners have been appointed as suitably qualified and experienced to deal with a patient's labour, such as the plaintiff who gave birth by normal vaginal delivery at the hospital.

[5] The following exhibits were handed in during the course of the trial:

5.1. Exhibit 1: Plaintiff's opening address;

5.2 Exhibit 2: Statement of relevant facts emanating from the medical records;

5.3 Exhibit 3: Adverse Outcome and Risk reporting document Pelonomi Hospital-completed by Sister TJ Dasheka;

5.4 Exhibit 4: Article-Intrapartum Basal Ganglia-Thalamic pattern injury and radiologically termed “acute profound hypoxic ischemic brain injury” are not synonymous-by Smith et al;

5.5 Exhibit 5: Enlarged partogram;

5.6 Exhibit 6: Dr Meshack Mbokota;

5.7 Exhibit 7: Curriculum Vitae-Prof Peter Allan Cooper.

The statement of relevant facts

[6] The relevant facts emanated from the plaintiff’s medical records and the birth of her baby, as well as R[...]’s hospital records from the time of her birth until discharge. According to her antenatal record, the plaintiff was a 15-year-old teenager in her first pregnancy who initiated antenatal care at a local clinic on 5 February 2013. At each visit, maternal vitals were normal, urine was clear, foetal movements were felt, and the foetal heart was heard. No obvious concerns or complications were recorded in the antenatal period.

Labour and delivery

6.1 The plaintiff attended the hospital on 27 July 2024 and was first seen at 16h20 and assessed by a doctor at 16h27. A vaginal examination was done, and her cervix was found to be 5cm dilated, and the foetal head was 2/5 above the pelvic brim. Membranes were bulging. Good foetal movements were reported. The foetal heart was audible and was recorded at 148 beats per minute. A Partogram was started at 16h20 on the same day, and the above information was plotted on the alert line. The foetal heart was ticked as having a normal rate with good variability and no decelerations.

6.1.1. She was reassessed at 18h20, two hours later, and her cervix was 7cm dilated, and the membranes were bulging. The findings were also plotted on the Partogram. The foetal heart rate was within the normal range with good variability and without decelerations. The membranes were intact, with no caput or moulding. According to the entries plotted on the Partogram, the foetus was monitored at 19h20, an hour later. The heart rate was within normal limits with good variability and no decelerations. The plaintiff was reviewed at 20h20 when further plotting was made on the Partogram. Her cervix was 9cm dilated, and the clear liquor (amniotic fluid) was draining. No caput or moulding was noted. The foetal head was 2/5 above the pelvic brim.

6.1.2. The partogram reflected a last entry regarding the foetal condition, where the baseline was recorded as normal with good variability. The defendant contended that this entry was recorded at 21h20, creating a factual dispute between the parties regarding the time the last entry of the foetal condition was made on the partogram.

6.1.3. A written note made at 22h10 on 27 July 2013 in the Clinical Notes section indicated that the plaintiff delivered while standing in the toilet, and the baby was found fallen on the floor of the toilet and already separated from the mother. According to the Summary Labour form, the plaintiff was fully dilated at 22h10 when bearing down began. She delivered by way of a normal vaginal delivery on the floor while standing in the toilet (bathroom) in the labour ward at 22h10 on 27 July 2013. It was accepted that the respective obstetric experts, Dr Murray for the plaintiff and Dr Mbokota for the defendant, would convey in evidence their particular interpretation of the medical records as to “Summary of Labour”, Clinical Notes” of the delivery and “Assessment of the Newborn”.

The Neonatal period

6.2. The Summary Labour form indicated that R[...]'s APGAR scores were recorded as 3/10 and 5/10 at one and five minutes of life, respectively. The APGAR scores were awarded as follows:

6.2.1 At 1 minute-3/10, scores were awarded for the heart rate [2], respiration/breathing [0], muscle tone [0], response to stimulation/reflexes [0] and colour [2];

6.2.2 At 5 minutes-5/10, scores were awarded for the heart rate [2], respiration/breathing [0], muscle tone [0], response to stimulation/reflexes [0], and colour [2]. The umbilical cord was normal, the placenta was normal and complete, and the membranes were complete. The Clinical records show that at 22h10, when the `baby was found on the toilet floor, she was taken to the admission room for resuscitation. She was floppy with a heart rate of 120 beats per minute, with no breathing, no reflexes and oxygen administered immediately. The paediatrician on call arrived immediately at 22h15 to attend to the baby. At 22h30, the baby was intubated and waited for a bed in the High Care unit.

6.2.3 According to the "Assessment of the Newborn" form, the baby was born at 22h10, and the resuscitation started at 22h10 and was completed by 22h30. Her heart rate was 120 beats per minute, with no breathing. The CPAP (continuous positive airway pressure) was given, and the baby was floppy with hypoxic-ischaemic encephalopathy (HIE) grade 2. On the First Examination Tick List, the following sick features were ticked: The baby was lethargic with haematoma, large fontanelles, pallor (paleness), a slow respiratory rate, absent cry, and she was hypotonic or in a state of abnormally low muscle tone. She was described as critically ill and was intubated. According to the Daily

Clinical Notes, the paediatrician was called after the baby was born and arrived +/- 5 minutes after delivery.

[7] Despite the common cause facts, the parties hold opposing views on the injury-causing incident. The Plaintiff's experts contend that there was a lack of oxygen to R[...]'s brain over a prolonged period during the last hours of the Plaintiff's labour that was not detected because the patient monitoring system was substandard and that it was this lack of oxygen (hypoxia) that caused the brain injury. The Defendant's view was that hypoxia set in after delivery when the baby was on the floor. Its experts contended that vessel spasms of the umbilical cord caused the lack of oxygen after delivery.[1] The other opinion was that the hypoxia was caused by the fall on the floor in the toilet.[2]

[8] The parties also disagreed on the period during which the foetus was monitored. Based on the recording and plotting in the Partogram,[3] the plaintiff maintained that the foetus was last monitored at 19h20, whereas the defendant persisted that the last time it was monitored was at 21h20.

The evidence

[9] The plaintiff testified on her behalf and called three expert witnesses: Dr Murray, the gynaecologist and obstetrician; Dr Lewis, the paediatrician; and Dr Pearce, the paediatric neurologist. The defendant called Sister Dasheka, Dr leroko, Dr Mbokota, the obstetrician and Professor Cooper, the neonatologist. Save for the experts, the plaintiff, Sister Dasheka and Dr Leroko were the only factual witnesses.

[10] D Lewis confirmed his summary of evidence in Bundle "C" and confirmed his signature on the Joint Minute with Professor Cooper in Bundle "E". He testified that the baby was delivered in a compromised condition. The nursing care was

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[1] Dr Mbokota-infra.
[2] Prof Cooper-infra.
[3] A graphic record of the course of labour that inter alia plots cervical dilation, foetal heart, duration of labour and vital signs and provides for alert and actions lines to prompt intervention if the curve deviates from the expected.

inadequate as an adolescent in advanced labour should not have been allowed to go to the toilet alone. There is no exact record of how long it took the midwives to react once the baby was born. The baby's condition was abnormal following her delivery. She was described as lethargic, pale, her breathing rate slow, her cry was absent, and her muscle tone was hypotonic. She was shocked and had signs of a neonatal encephalopathy/ neurological syndrome. In his opinion, her condition was not due to the unassisted delivery but was more likely to have been related to intrapartum hypoxia-ischemia, acidosis and hypotension. Had the foetus not been hypoxic before delivery, the baby would have cried and not required resuscitation after delivery. Babies requiring resuscitation are usually compromised in utero.

[11] The plaintiff testified that, before the birth of R[...], she was in the first stage, room 1, five metres from the toilet. Opposite this room and along the passage was a kitchen and a place where nurses sat. Before R[...] was born, there were no family members in the room. She went to the toilet to answer nature's call. No one told her not to leave the room. There were no nurses or staff members in the room when she left. She had no black belt around her stomach when she went to the toilet.

[12] She sat on the toilet seat to relieve herself, but nothing happened. She stood up and went to the hand basin. She then felt something touching her thighs. She shouted for help, and the baby fell on the floor. The baby did not cry. She was frightened and shocked by what touched her thighs. The nurses came and took the baby away. She was also taken to the bed and asked why she went to the toilet. She said there was no one to tell, and the nurses were not at the place where they sat.

[13] In cross-examination, she testified that she was examined on arrival at the hospital. She was then taken to the room and given hospital clothes. No examination was done on her private parts, and no stethoscope was used. She left her aunt and sisters behind and was walked to the first stage room by the nursing sister, who told her that she should breathe in and out whenever she felt pain and should not make noise. She could not remember what

examinations were done to check the baby's health, but she did not make a mistake about the black belt. There was no machine next to her with paper to print a graph.

[14] The nursing sister who assessed her in the room examined her private parts and told her that the baby was far from being born, and she left. While she was in the room, she was checked two or three times. It was untrue that Dr Leroko examined her at 20h20. No male doctor examined her vaginally. She denied that she was briefed not to leave the room. She also denied Sister Dasheka came alone to the toilet as two nursing sisters did. She did not know how long she shouted before the baby fell to the floor, but it was a long time. It was winter and cold. She did not pick up the baby as she did not know what to do. The baby never moved.

[15] Dr Murray's evidence is that the plaintiff presented to the hospital at term gestation in active labour, which is that part of labour from 4 cm cervical dilation until full dilation (10 cm). According to the Guidelines for Maternity Care in South Africa (2007), during the active phase of labour, the following should be done:

15.1 The maternal blood pressure and heart rate should be monitored hourly, the temperature should be monitored 4-hourly and the urine volume should be measured and tested 2-hourly.

15.2 The foetal heart rate should be monitored half-hourly' listening before, during and after a contraction.

15.3 The liquor (amniotic fluid) should be observed every 2 hours if membranes have ruptured.

15.4 The frequency and strength of contractions should be monitored hourly.

15.5 The cervical dilation, level of the presenting part, and caput and moulding must be assessed 2-hourly.

[16] She testified that plotting the findings on the alert line of the Partogram was correct. This essential obstetric labour tool serves as a graphical record of the maternal and foetal condition during labour and the progress of the labour itself. Failure to use a Partogram during labour constitutes substandard care. The first plot in active labour must be plotted on the alert line, which is a pre-drawn line on the Partogram corresponding to a rate of cervical dilatation of 1 cm per minute. This is done because a primigravid woman is expected to labour at a rate (cervical dilatation) of at least 1 cm per hour. By plotting all cervical findings on the Partogram over time, the progress of labour can be assessed to determine whether it is satisfactory. This assists in timeous recognition of poor labour progress and minimises the risk of adverse outcomes during labour.

[17] Foetal monitoring is performed by listening to the foetal heart either with a foetal stethoscope or a Doptone device before, during and after contraction, every 4 hours in latent labour and every 30 minutes in active labour, and plotting the finding on the Partogram. It is important because, during contractions, placental perfusion falls, meaning less oxygenated maternal blood is available in the intervillous space in the placenta for transfer to the foetus. The foetus, therefore, suffers brief hypoxic bouts during labour.

[18] The plaintiff was a young teenager and, thus, very vulnerable. She was most likely poorly prepared for labour. No notes suggested that she had any labour support with her, such as a partner or family member. She would have required empathetic care and pain relief, at least in the form of Pethidine and Aterax, which help to alleviate pain and anxiety.

[19] At 18h20, the documented foetal heart parameters were normal, implying that the foetal condition was reassuring. According to the entries plotted on the Partogram, the foetus was next monitored at 19h20, and the heart rate was within normal limits with good variability and no decelerations (even though the foetus was not monitored half-hourly as required.) The next review was at

20h20, and the findings were plotted on the Partogram.[4] The foetal heart and variability were normal. The plaintiff's cervix was 9cm dilated, and clear liquor (amniotic fluid) was draining. No caput or moulding was noted, and the foetal head was 2/5ths above the pelvic brim. The foetus had not been monitored for an hour. The next written note was made in the Clinical Notes at 22h10, that the plaintiff had delivered in the toilet while standing.

[20] According to Dr Murray, on a consideration of the entries recorded on pages 4 and 5 of the birth file, read with the entries plotted on the Partogram, there was no evidence that the plaintiff received any further assessments after 20h20. That meant that approximately two hours of labour went unmonitored. This denoted severe substandard care and management during the riskiest part of labour, which is the most stressful period for the foetus. The plaintiff was making good progress in labour, and her cervix was 9 cm dilated at 20h20. It should have been obvious to the attending nursing staff that she would soon be fully dilated (10 cm) and entering the second stage of labour when she should not have been left alone. The foetal heart rate should be carefully monitored by continuous CTG or intermittent auscultation every 5 minutes (during the second stage), and delivery should be expedited in the face of concerns.

[21] She opined that the plaintiff's unassisted delivery in the toilet was entirely due to a lack of medical care and monitoring during the last approximately two hours of labour. Had she been attended to, it would have been apparent that delivery was imminent. When a mother in an advanced stage of labour needs a toilet, it is often a sign that delivery is imminent as the pressure of the foetal head in the pelvis feels like the need to pass stool. Any midwife or nurse would know this. The birth in the toilet was not surprising as the plaintiff had been making good progress and would have been expected to deliver between 21h00 and 22h00 if progress continued, according to the Partogram.

[22] Dr Pearce confirmed her report and agreed with Dr Murray's evidence. In cross-examination, it was put to her that the hypoxic-ischemic event was only

[4] Exhibit 5 on page 8 of the birth file.

after 21h20 and before 22h10 when the baby was discovered on the floor. She responded that it would have been a long enough period if the court had accepted the version that at 21h20, the child was fine.

[23] Sister Dasheka testified that she was a professional nurse employed for 35 years at the Pelonomi Hospital and has since retired. After school, she started nursing in 1989, doing a four-year course at Pelonomi Hospital in Bloemfontein. She registered in 1993 as a registered nurse and continued with training as a midwife. She has been working in the maternity ward at the Pelonomi Hospital since 1994. On 27 July 2013, she was on night duty when R[...] was delivered. As a chief professional nurse, she was in charge of the three nurses on duty that night.

[24] She is the author of Exhibit 3, which she completed on the day of delivery, and it stated the following:

"The abovementioned patient by the name of Ms N[…] C[...] M[...] Pm number: 347579, 15 years old was admitted in admission room at about 18h20 by the day staff personnel. Being in labour, vaginal examination was due at 20h20. The patient was lying in the first stage room one during report taking at 18:50 on the 27.07.2013. At 22h05 on 27.072013, I was busy attending to the delivery of the other patient in the second first stage room. Immediately after clamping and cutting off the umbilical cord and handing over of the baby to the mother to show her that baby and the sex of the baby, I heard people outside the corridor screaming, immediately, I took the baby I was busy with to the incubator that was next to the patient and went outside to see what is happening as the screaming was in the direction of the toilet next to the first stage room. When I opened the toilet door I found Ms N[…] C[...] M[...] was standing opening her thighs and baby on the floor already separated from the mother. I took the baby and rush immediately to the MECO in admission room and called for help while attending to the baby. Her heartrate was 120 bpm, no breathing, no reflexes and the baby was floppy. Dr Charles, the paediatrician who was on call informed telephonically about the incident and came immediately to attend to the baby. At 22h30 baby was intubated by Dr. A Makhupane, the Registrar

paediatrician and baby admitted to the high care unit for further management. Signature: TS Dasheka Date: CPN 27/07/2013."

[25] She recorded in the Clinical notes at 22h10 that:

"Patient delivered while standing in the toilet and baby fell down on the floor in the toilet and already separated from the mother, baby taken to the admission room to the MECO for resuscitation, baby was floppy, heartrate was 120, no breathing, no reflexes and oxygen administered immediately and the paediatrician on call called. He came immediately to attend to the baby. At 22h15 heartrate was 120, breathing 0, pink, no reflexes and still floppy. At 22h30 baby was intubated and wating for the bed in high care."[5]

[26] She testified that she recorded the summary of labour of the second stage and at 22h10 the patient was fully dilated. Bearing down began at 22h10 and the time of delivery was at 22h10. It was a normal vaginal delivery. The complications she recorded as the mother having delivered the baby on the floor whilst standing in the toilet (bathroom) in the labour ward. Her Apgar assessment was at 1 minute, with a score of 3/10, and at 5 minutes, it was 5/10. The last recording on the Partogram is hers at 22h10, where she wrote "Delivered at 22h10" and signed her name and time of 22h10. The recording before her on the Partogram was done by a student at 21h20; before that, the recording was by Dr Leroko at 20h20. In response to questions, despite the documented information, she denied that the delivery time was 22h10. She did not know what time the baby was born.

[27] Dr Thabang Leroko testified that his involvement with the plaintiff was as a third-year registrar in obstetrics and gynaecology at the Pelonomi Hospital on the day of the delivery on 27 July 2013. Since he obtained his primary medical degree, he has been employed by the Department of Health, Free State, and he is now a qualified obstetrician and gynaecologist.

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[5] Bundle F: p20.

[28] He testified that he recorded the Partogram at 20h20. As to his involvement, he conveyed that it is common practice for a doctor to assess the patient on admission and do a full assessment. However, the monitoring and progress of labour thereafter are mainly made by the midwives. This does not prevent a doctor from following the labour progress and may even be involved in the baby's delivery.

[29] He did a physical and vaginal examination of the patient. He recorded the status of the foetus, which had no moulding or caput. The membranes, by then, had raptured, and the liquor (amniotic fluid) was clear. There was no meconium in the amniotic fluid because if meconium was present, it might suggest foetal distress. He did not record any foetal condition regarding the baseline and variability, as there was no CTG connected. The progress of labour was that there was a 9 cm dilation, and the descent of the head was recorded.

[30] He explained the importance of the block for management at the foot of the Partogram and its necessity for recording comments referring to the assessment time, problems identified, and the plan to follow. There were two recordings done at 16h20 with no problems identified, and it was during the active phase of labour, the management indicated that the patient should be allowed to progress. At 18h20, the management conveyed that monitoring should be done according to maternal guidelines. There was no problem for him to record in the management block.

[31] Dr Mbokota testified as the Defendant's obstetric expert and to his expert medico-legal report of 22 January 2024 and the joint minute completed with Dr Murray. In his Summary of Labour,[6] he conveyed that:

"2.5.5. Duration of labour:

2.5.5.1. 1st stage: 6 hours and 20-minutes (from 16h00 to 22h10).

[6] Bundle D15.

2.5.5.2. 2nd stage: 10-minutes

2.5.5.3. 3rd stage: 5-minutes"

[32] He stated that the *"Fetal condition in the active phase is assessed every ½-hours and in this case, it was at most assessed and recorded 2-hourly between 16h20 and 18h20, hourly between 18h20 and 21h20; this was substandard, however there was no fetal compromise recorded."*[7] Though the clinical records indicated that she was fully dilated at 22h10, that could not be confirmed as the plaintiff was found having delivered in the toilet. She was, therefore, fully dilated before 22h10. The fact that she seemed not to have reported to the staff when she had the urge to bear down and went to the toilet by herself made it impossible for the 2nd stage to be monitored. The duration of the 2nd stage is not known.

[33] In summary, he opined that the baby suffered injury as it hit the floor, and the placenta separated before the cord was cut, resulting in blood loss to the baby. The plaintiff's delivery in the toilet without supervision seemed to be the event that resulted in the acute hypoxic episode with subsequent acute, profound hypoxic-ischaemic brain injury.

[34] Prof Cooper testified on behalf of the defendant and referred to his expert report and the joint minute he did with Dr Lewis. In his opinion, the plaintiff's pregnancy was a high risk given her very young age, but the pregnancy seemed otherwise uncomplicated, and she was appropriately booked for hospital delivery. There was no record of an assessment of the cervical dilatation after it was assessed at 20h20 or the foetal heart rate after 21h20. He deferred to the expert obstetric opinion regarding managing the pregnancy, labour and delivery. R[...] was born in the toilet, and the birth was unmonitored. She required active resuscitation and only manifested with spontaneous respiration after 30 minutes. This was in keeping with a severe preceding hypoxic ischaemic episode.

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[7] Bundle D19.

[35] In his opinion, and this case, the exact time of the first blood gas was not recorded, but the sequence of the notes after birth suggests that it was done well within the hour after birth. The severe metabolic component of the blood gas was an indication that there was a severe preceding hypoxic-ischaemic insult, either during labour or the events around the time of birth or both. In this case, he concluded that there was significant asymmetrical intrauterine growth restriction, putting R[...] at risk for tolerating the normal stress of labour poorly. Based on the Apgar scores, the need for active resuscitation at birth, the prolonged time to spontaneous respiration after birth, the severe metabolic acidosis on the first blood gas, and the subsequent development of severe neonatal encephalopathy, it was probable that there was a severe peripartum hypoxic-ischemic episode. However, whether this occurred during labour, during the unmonitored delivery in the toilet, or a combination of the two was unclear.

The parties' contentions

[36] On the totality of the evidence, the plaintiff submitted that:

36.1 she had succeeded in proving on a balance of probability that the medical and nursing staff at the defendant's hospital failed to employ reasonable skill and care in the treatment, management, and monitoring of the plaintiff and her foetus/baby, that the possibility of an injury in these circumstances was unquestionably foreseen, that reasonable steps could and should have been taken to avoid an injury to the plaintiff's foetus/baby and that the medical staff failed to take such steps. In the circumstances, the conduct of the medical staff at the hospital was negligent, and

36.2 the defendant's medical and nursing staff's negligence was the probable cause of the intrapartum hypoxic-ischaemic insult to R[...]'s brain, which she suffered and which resulted in her being left with permanent severe brain damage manifesting as, *inter alia*, mixed

cerebral palsy, microcephaly, global developmental delay, and moderate intellectual disability.

[37] The defendant contended that:

37.1 No causal link existed between the criticism of the substandard management by the nursing personnel or even the medical practitioners involved before 21 h20 when the last recording was made, indicating a normal baseline and good variability, obviously by using a CTG as monitoring instrument;

37.2 The plaintiff's insistence that the reading recorded at 21h20 merely indicated a name and signature and nothing more and that the last indication of a normal baseline and good variability appeared at 20h50 was improbable. The only inference to be drawn, as the only inference that is probable, is that the recording at 21 h20 was only recorded on the incorrect vertical line and should have been recorded one vertical line to the right to correlate with the reading at 21h20 clearly showing then a normal baseline and good variability.

37.3 Similarly, the only probable inference to be drawn is that there was a sentinel event, as convincingly testified to by Prof Cooper, which sentinel event occurred after 21h20 and before the discovery of the baby at 22h10 by Sister Dasheka.

37.4. That, as from the time of delivery, with the baby falling on the floor in the bathroom next to the stage room where the Plaintiff was kept, an extended time lapsed before the discovery of the Plaintiff and the baby on the floor by Sister Dasheka at 22h10, causing the ischemic hypoxia to develop. There is no reason to believe that there was, before 21h20, any hypoxic ischemia present.

Discussion

[38] The question that arises in the light of the conflicting views is which evidence should be accepted as credible. Both parties placed much emphasis on the plotting made on the Partogram, with good reason. An analysis of the contents of the Partogram establishes the following:

38.1 There are no dots plotted on 27/07/13 at 20h20, but at 20h50, indicating the foetal condition.

38.2 There are dos plotted on 27/07/13 at 21h20 to describe the foetal condition.

38.3 After 18h20, there are no notes made in the block for management.

38.4 Three dots were plotted on the vertical line in the block for the maternal condition (relating to the B.P. and pulse), at the top of which line is a signature and the word student written next to it.

38.4 The top block of the Partogram relating to the Foetal condition is divided into half-hour segments, and each vertical segment represents 30 minutes. The first dot was made at 16h20 and the last at 20h50.

[39] In their evidence, Sister Dasheka, Drs Leroko, and Mbokota conceded the substandard management by the nursing personnel. Sister Dasheka and Dr. Leroko testified that they did not make the last dots on the Partogram. According to Dr Leroko, no CTG was available at the time. He did not, therefore, assess the foetal heart. All three conceded that if the first black dot was accepted as being done at 16h20, the last dot was made at 20h50, not 21h20.

[40] However, Dr Mbokota regards such negligence as "*negligence in the air*". It is not clear why Dr Mbokota conveyed in his updated report and evidence that *"despite the substandard monitoring, the last foetal condition recorded around 21h20 was normal; thus, the substandard monitoring had not resulted in fetal distress being missed during labour until around 21h20 when she was last*

assessed. There was, therefore, no record of fetal compromise during her labour until around 21h20. We cannot know what fetal condition was after 21h20 as there was no record of it."

[41] The defendant's version is that a student plotted dots on the Partogram at 21h20. The plaintiff pointed out that Dasheka testified that when students in the maternity ward perform their duties, they do so under supervision except when a student takes a patient's blood pressure. She did not know whether the assessment at 21:20 was done under supervision. Significantly, when one considers the entry at 21:20, this entry pertains only to the Plaintiff's blood pressure. The author of this entry (the student) did not testify to confirm the disputed entry and that the foetal condition was assessed at the alleged time. There is thus no direct evidence to support the Defendant's version. I agree with this submission that, in the absence of evidence showing that a particular nurse or supervised student nurse made a plotting at 21h20 relating to the baby's foetal condition, any reference thereto would be mere conjecture.

[42] The defendant's case is based on this aspect, and the defendant needed to lead evidence to support its case. Failure to do so is fatal. The defendant's expert witnesses' reports (Dr Mbokota and Professor Cooper) are based on the recording at 21h20. The defendant's contention that the only probable inference to be drawn is that the recording at 21h20 was recorded on the incorrect vertical line and should have been recorded one vertical line to the right to correlate with the reading at 21h20, showing a normal baseline and good variability, is meritless and torpedoes the evidence of the defendant's expert witnesses.[8]

Negligence

[43] The test for negligence was formulated in *Kruger v Coetzee* as follows:

"For the purposes of liability, culpa, arises if-

[8] H.N v MEC for Health KZN (1287/2014[2018] ZAKZPHC 8 (4 April 2018].

(a) a diligent paterfamilias in the position of the defendant-

(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and

(ii) would take reasonable steps to guard against such occurrence; and

(b) the defendant failed to take such steps.

…

Whether a diligent paterfamilias in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend upon the particular circumstances of each case. No hard and fast basis can be laid down."

[44] In *Oppelt v Department of Health, Western Cape*,[9] the Court stated that, in simple terms, negligence refers to the blameworthy conduct of a person who has acted unlawfully. Regarding medical negligence, the question is how a reasonable medical practitioner would have acted in the particular circumstances. The negligence of medical practitioners is assessed against the standards of the medical profession at the time. These principles apply equally to the negligence of professional nurses whose negligence must be determined against the reasonable standards of professional midwives applicable at the time.

Causation

[45] In D*e Klerk v Minister of Police*,[10] it was stated that causation was a factual and legal component. Factual causation relates to whether the act or omission caused or materially contributed to the harm. The 'but-for' test or *conditio sine qua non* is ordinarily applied to determine factual causation. If, but for a

[9] 2016 (1) SA 325 (CC).
[10] 2021 (4) SA 585 (CC) at para 24.

wrongdoer's conduct, the harm would probably not have been suffered by a claimant, then the conduct factually caused the harm. Legal causation is concerned with the remoteness of damage. This entails enquiring whether the wrongful act is sufficiently closely linked to the harm for legal liability to ensue. Generally, a wrongdoer is not liable for harm that is too remote from the conduct concerned or harm that was not foreseeable.[11]

[46] In JA obo DA v MEC for Health, Eastern Cape,[12] the court suggested that the test for factual causation need not be applied rigidly and does not require that it be determined with scientific precision. It referred to the passage in Cork v Kirby MacLean Ltd where Lord Denning explained it as follows:

"[I]f you can say that the damage would not have happened BUT FOR a particular fault, then that is in fact the cause of the damage; but if you can say that the damage would have happened just the same, fault or no fault, then the fault is not the cause of the damage."[13]

[47] In Oppelt,[14] it was held that the "but for" test required flexibility and a common sense approach when the issue of causation has to be decided on the grounds of a negligent omission and stated that "*Ultimately, it is a matter of common sense whether the facts establish a sufficiently close link between the harm and the unreasonable omission."*

Conclusion

[48] The question arises: Did the defendant act reasonably, or did the defendant's medical and nursing personnel act with the necessary care, skill, and diligence as reasonably expected in the circumstances? In my view, the answer is no. Save for Sister Dasheka's evidence, especially surrounding the student nurse, there is no evidence that the plaintiff was attended to by either the medical or nursing staff between 20h20 and 22h10. Both Drs Leroko and Mbokoto support

[11] Para 25.
[12] 2022 (3) SA 465 (ECD).
[13] [1952] All ER 402 CA at 407.
[14] Supra.

the evidence of Dr Murray that the failure to check the foetal condition half-hourly was substandard.

[49] The defendant, relying on *Imperial Marine Company v Deiulemar Companqnia Di Navigazione Spa,*[15] contended that the evidence presented by Dr Mbokota and Professor Cooper fell within the test of achieving logical reasoning. In that case, it was stated that in a trial action, it is fundamental that the opinion of an expert must be based on facts that are established by the evidence. The court assesses the opinions of the experts based on whether .and to what extent their views are founded on logical reasoning. As indicated above, the defendant's expert evidence is not based on facts established by the evidence. Consequently, their views cannot be founded on logical reasoning.

[50] I find the evidence presented by the plaintiff and her witnesses credible, convincing, and reliable. I accept the report and the evidence of Dr Murray as against that of Dr Mbokoto, whose findings are, in my view, based on speculation and are illogical. I find the evidence of the plaintiff's expert witnesses to be sound and founded on logical reasoning. What is clear from the evidence is that the nurses failed to provide the necessary care and attention to the plaintiff at a critical time of her pregnancy. The defendant failed to employ the services of suitably qualified, experienced and properly equipped medical and nursing staff who could assess, monitor and manage the plaintiff's labour and expedite the proper delivery of the baby when and if required.

[51] The medical and nursing staff did not act with the necessary care, skill, and diligence as is reasonably expected to guard against harm to the foetus and prevent the baby, R[...], from suffering a hypoxic-ischaemic incident which caused her to sustain severe brain damage that led to her suffering from cerebral palsy. I am satisfied that the negligence of the defendant's employees led to R[...]'s cerebral palsy.

Costs

[15] 2012 (1) SA 58 (CA).

[52] The plaintiff, as the successful party, is entitled to the costs.

[53] I, therefore, make the following order:

Order:

1. The Defendant is liable for payment of 100% (one hundred percent) of the proven or agreed damages the Plaintiff's minor daughter, R[...], suffered, which damages flow from the severe brain injury sustained by R[...] during the intrapartum period in consequence of substandard obstetric care and management at the Pelonomi Hospital on the 27th of July 2013, and the resultant cerebral palsy (and its sequelae) which she suffers from.

2. The Defendant shall pay the Plaintiff's taxed or agreed party-and-party costs of suit on the High Court scale up to finalisation of the issue of liability, which costs shall include (but not necessarily be limited to):

    2.1 the costs occasioned by the employment of counsel by the Plaintiff, including the trial costs for the appearances on the 30th and 31st of January 2024, 6th and 7th of February 2024, 22nd, 23rd, 24th and 26th of April 2024, and the 6th of August 2024, and including the cost of preparation for, and attendance of all pre-trial conferences that were held and attended by him, as well as the drafting and settling of the pre-trial agendas and minutes, such costs to be paid on Scale C;

    2.2 the Plaintiff's costs of obtaining the medico-legal reports of the Plaintiff's experts and joint minutes relating to the issue of liability, including the cost of counsel on Scale C of drafting the Plaintiff's expert summaries in respect of the issue of liability of whom notice has been given in terms of Rule 36(9)(a) and (b);

    2.3 the cost of preparation, qualifying and reservation fees, and fees for testifying, in respect of the liability trial of Drs Lewis, Murray and Pearce, including their reasonable traveling and accommodation expenses, and including the cost of consultations by the Plaintiff's legal representatives

with these experts, and the costs of these experts in preparing for and holding joint meetings with their respective counterparts, and preparing joint minutes;

2.4 the costs of the MRI investigation of R[...]'s brain performed by Burger Radiologists for purposes of the report of Dr Alheit, expert radiologist;

2.5 the costs consequent upon the drafting of heads of argument; and

2.6 the costs and expenses of accommodation and of transporting the Plaintiff and the minor child in attending all medico-legal examinations and consultations by the Plaintiff's and the Defendant's experts, (where applicable), for purposes of preparing their reports for the trial relating to the issue of liability, subject to the discretion of the Taxing Master.

3. The costs stipulated above shall be paid into the trust account of the Plaintiff's attorney, the details which are:

WIM KRYNAUW ATTORNEYS TRUST ACCOUNT
ABSA – TRUST ACCOUNT
ACC. NR: 4[…]
REF: J FRANCIS / MEC1383

5. The following provisions shall apply regarding the determination and payment of the Plaintiff's abovementioned taxed costs:

5.1 the Plaintiff's attorney shall serve the notice of taxation on the Defendant's attorneys of record;

5.2 the Plaintiff's attorney shall allow the Defendant 30 (thirty) calendar days to make payment of the taxed costs from date of settlement or taxation thereof;

5.3 should payment not be made in accordance with paragraph 5.2 above, the Plaintiff shall be entitled to recover interest at the applicable legal rate of interest on the taxed or agreed costs calculated as from 31 days from the date of affixing of the Taxing Master's *allocatur* or date of settlement of the issue of costs, to date of final payment.

MHLAMBI, J

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