

REPUBLIC OF SOUTH AFRICA



IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, JOHANNESBURG

Case Number: 58672/2021

(1)	REPORTABLE: NO
(2)	OF INTEREST TO OTHER JUDGES: YES
(3)	REVISED: YES
22/05/2025	
DATE	SIGNATURE

In the matter between:

YM ON BEHALF OF LM

PLAINTIFF

and

**MEMBER OF THE EXECUTIVE COUNCIL, HEALTH,
GAUTENG PROVINCE**

DEFENDANT

JUDGMENT

PJ DU PLESSIS AJ

DELICT and CAUSATION - Liability only - Delict - Whether defendants employees delivered sub-standard care and was negligent in performing or failing to perform their duties - Causation - Whether the respondents employees sub-standard care resulted in the minor child suffering a hypoxic-ischemic incident due to birth asphyxia sustaining severe brain injury.

INTRODUCTION

- [1] This is a delictual claim wherein the plaintiff is alleging negligence due to sub-standard care on the side of the Thembisa Hospital staff, resulting in her minor child sustaining a brain injury. The requirements for a successful claim in delict are well-established. A plaintiff must prove positive conduct or an omission, causation, wrongfulness, fault and harm¹.
- [2] The defendant contends that causation was not proved by the plaintiff because as a mother with HIV there were various risk factors in existence and highlighted by the experts that were not excluded in evidence and therefore she didn't discharge the onus resting upon her. They submit absolution from the instance must be granted due to the two mutually destructive versions before court.
- [3] The parties agreed at pre-trial that the matter would proceed on liability only, with the court to determine specific questions² regarding the defendant's employees' alleged negligence and the causation of the minor child's brain injury.

BACKGROUND

- [4] In 2018 YM³ was 23 years of age. She started with morning sickness and did a home pregnancy test which turned out to be positive. She then attended the Mayibuye clinic for the first time on 13 July 2017 where her first pregnancy was confirmed. On information she supplied gestation was estimated at 15 weeks. She had HIV and was on ARV treatment.
- [5] She continued her visits to the Clinic and on 12 January 2018 she was given a letter by the clinic sisters to report to the Thembisa Hospital on 19 January 2018 if the baby wasn't born yet. On her own evidence she did not attend the hospital as advised, only doing so on 21 January 2018. This visit was never recorded

¹ Par 51 - NVM obo VKM v Tembisa Hospital and Another (CCT 202/20) [2022] ZACC 11; 2022 (6) BCLR 707 (CC) (25 March 2022) – Minority judgment: Majiedt J

² Discussed below in detail

³ Plaintiff on behalf of her minor child

anywhere, but YM insisted she gave the nurse her card and the letter from the Clinic, but after the nurse determined she was not in labour she sent her home.

- [6] She then felt lower abdominal pains at 14h00 on Saturday 3 February 2018 and by 16h00 an ambulance was summoned for her. She was taken to Thembisa hospital and admitted to casualties where she was monitored spending a substantial period of time in the waiting room awaiting a bed.
- [7] She was seen by a doctor in the early hours of Sunday 4 February 2018. She was diagnosed and treated for vaginitis (inflammation or infection of the vagina) and assessed as post-date (beyond 40 weeks of gestation). The foetus's heart rate was normal according to the CTG (Cardiotocography, electronic foetal monitoring method recording baby's heart rate and mother's uterine contractions – used during labour to monitor foetal wellbeing and detect potential signs of distress) and she was then admitted to the labour ward for induction of labour.
- [8] The induction was not carried out, a decision which the probabilities in evidence suggests was related to her HIV status and the fear of transmission possibilities between mother and baby.
- [9] In the late hours of the evening when according to plaintiffs evidence she had excruciating pain and had requested a C-section several times a CTG was done between 22H13 and 22H38 which showed poor variability with a heart rate of 180 bpm (poor variability is when there are minimal or no fluctuations in the foetal heart rate indicating a potential issue as the brain or central nervous system control this function, and when the heart stops compensating, dropping below the base-line it is an indication the foetus is running out of oxygen). There was a follow up done at 22h45 also with poor variability but at 150bpm more in line with normal which is between 110-160bpm. It is here, with these CTG's, especially the follow up one, where the first foetal distress was observed according to the experts.
- [10] She was returned to the ward and monitored and in the morning she reported to the nursing staff the baby was no longer kicking. She described herself as tired and dizzy and when the doctor saw her on Monday 5 February 2018 around

10h00 she was informed the baby is not well and she was referred for an emergency C-section. LM was born at 12h53.

- [11] When LM was born, YM never heard her cry and didn't see her as she was taken to the ICU. She was told her baby was exhausted, distressed and not breathing. She only saw baby LM the next day in the ICU at around 17h00.
- [12] She described in her evidence that LM was on a machine. She looked if she had convulsions. She was naked and had a hat on her head. There were drips and she had pipes in her nose. She was told it was necessary as the machine LM was on was helping her to breathe and she couldn't breathe without it. Ulanda was discharged from hospital after 4 days and LM after 10 days.
- [13] She was later told LM is Cerebral Palsy (CP), but no one ever told her what it is. She describes LM's problems as having a small head, not walking or talking normally and her right side is not working properly. The clinic sisters at four months old told her there was something wrong with LM and she was referred to hospital where LM was receiving speech, physical and occupational therapy. She used to take LM monthly, but it seems it isn't always possible for her to do so as a single parent who must care for her special needs child.
- [14] The rest of the evidence consisted of expert witnesses' viva voce evidence and Exhibits A - C3 which were expert witnesses' opinions, agreed upon and submitted with consent, as they were not called. These were Exhibit:
- A - Report by Prof Anna Nolte report (6 Pages)
- B - Joint minutes between Dr L Muthelo and Prof Nolte (2 Pages)
- C1 - Joint minutes Dr's T Kamolane and S Dlangamandla (1 Page)
- C2 - MRI Brain Dr T Kamolane (3 Pages)
- C3 - MRI Brain Dr Dlangamandla (2 Pages)
- [15] The plaintiff called in support of her case Dr Meshack Mbokata (Specialist Obstetrician and Gynaecologist) and Dr Nosipho Maponya (Specialist Paediatrician) and the Defendant called Dr Magdalena Susanna van der Merwe

(Specialist Obstetrician and Gynaecologist) and Professor Keith Duncan Bolton (Specialist Paediatrician)

- [16] It is observed that all these specialist were basing their expert opinions on what they could note from the Hospital records. None of them were actually present during the period of admission to hospital of YM or at the birth of LM and none of them actually saw or treated them. The experts, whose credentials and expertise was never questioned, all worked from the premise that if it was not written in the hospital notes, it was probably not done.

SUMMARY OF THE EXPERT OPINIONS AND THEIR ANALYSIS

- [17] I do not intend doing an in-depth analysis of each witnesses evidence as it was mostly of expert nature. I will only allude to relevant portions when deemed important to do so in this judgment. This because essentially, the plaintiff argues that LM's condition was primarily due to negligent intrapartum care⁴, while the defendant emphasises the role of multifactorial causes, particularly neonatal anaemia, and the limitations and constraints of medical practice in Government institutions, which they submitted were not sub-standard in the context of this case.
- [18] What did the respective expert's evidence amount to? The **NURSING** experts of the parties Prof. Nolte (Plaintiff) and Dr Muthelo (Defendant) expressed their views in Exhibit "B" which was handed in by consent.
- [19] Important from the nursing experts is that both agree YM was post-date upon her admission to hospital and there was no intrauterine resuscitation⁵ (IUFR) measures taken at any stage until LM's birth. Even though there was disagreement, it would also seem that the CTG monitoring was too infrequent, measured against the prescribed and applicable guidelines.

They also agreed that YM's pregnancy was normal and the foetus grew as expected, despite her HIV+ status. She was post-date, and didn't follow advice

⁴ Refers to healthcare provided to a women and her baby from the onset of labour, through childbirth and immediately after birth to her and the baby

⁵ IUFR is a set of procedures aimed at improving oxygen delivery to the placenta and umbilical blood flow to reverse foetal hypoxia and acidosis when foetal distress is suspected.

to report at the hospital, as per the letter given to her. They agreed the midwives provided substandard care by not initiating intrauterine resuscitation for foetal distress and by failing to maintain accurate records.

They disagree in that Professor Nolte argues that the midwives failed to adhere to the 2016 Maternity Guidelines by not performing continuous CTG monitoring for foetal compromise and by not promptly responding to, or reporting a foetal heart rate of 163 bpm at 05:30. Dr Muthelo disagreed that there was only one foetal heart rate recording, stating that there is evidence of monitoring at both 05:30 (163 bpm) and 09:37 (150 bpm). This is however a disagreement on what happened on the Monday morning of LM's birth and not Sunday evening, where all experts agree there was clear foetal distress.

[20] Looking at Exhibit C 1 the joint minute of the two Radiologist experts, Dr.T.K Kamolane and Dr S.D. Dlangamandla both agree that the MRI brain scan shows findings consistent with chronic hypoxic ischemic brain injury in a term infant, specifically a pattern of partial prolonged hypoxic ischemic brain, making genetic disorders and TORCH infections unlikely causes. They however indicate that a further review of clinical and obstetrical records is needed to determine the cause and timing of this injury.

[21] Important to note is that TORCH infections⁶ as well as genetic disorders are unlikely to have caused LM's current CP status. Both Radiologists diagnosed Chronic hypoxic ischemic brain injury (HIE) which is long-term brain damage resulting from the brain not receiving enough oxygen and blood flow for a period of time. They diagnosed a pattern of partial prolonged hypoxic ischemic brain, which is a specific pattern of brain injury seen on MRI in individuals who experienced a less severe, but sustained lack of oxygen and blood flow to the brain.

⁶ A group of diseases (Toxoplasmosis, Other, Rubella, Cytomegalovirus, Herpes Simplex Virus) that can pass from a pregnant mother to her baby, potentially causing serious health issues like birth defects and developmental delays

- [22] The viva voce evidence of the two **Obstetrician-Gynaecologists** Dr M. Mbokota and Dr M.S. van der Merwe can be summarised as follows:
- [23] Dr Mbokota's view is that YM presented as post-dates with a concerning low symphysis fundal height, although the initial foetal heart rate was normal. He stated that a "tip of finger" cervical dilation suggests the start of labour. The midwife's finding of "tip of finger" cervical dilation, at 18h00 on 3 February 2018 upon admission is an indication that labour had started. He believes the latent phase should not exceed 8 hours. Postnatally, the baby presented with MAS, HIE, PPHN, and anaemia, likely linked to hypoxia. An abnormal RI (Resistive Index)⁷ on admission indicated potential placental issues, but without testing results of the placenta, sent for analysis but never received back, this is unascertainable.
- [24] Dr van der Merwe's view is that Cerebral Palsy is a multifactorial condition. She highlighted the uncertainty surrounding the gestational age and expressed doubt that the Plaintiff was in established labour upon admission due to the lack of progressive cervical changes. She states from the hospital notes the first definitive sign of labour was at 09h37 on the 5th of February 2018, when the cervix was 2 cm dilated and the membranes had ruptured. She considered a vaginal infection in a post-term pregnancy unlikely to induce labour and state induction probably didn't happen for fear of HIV transmission between mother and baby. Relying on newer guidelines, she downplayed the significance of a prolonged latent phase as she deemed the Cardiotocography (CTG) a poor tool for assessing foetal well-being. She was of the opinion that the cause and timing of the minor child's anaemia is unclear. Critically, she stated that the severe neonatal anaemia in this case would likely have negatively impacted the outcome regardless of earlier interventions for foetal distress. She acknowledged the presence of foetal distress from 22h13 on 04 February 2018, the delayed decision and execution of the Caesarean section, and the 11-hour period of foetal non-monitoring as substandard care.

⁷ RI is a calculated value used in Doppler ultrasound to assess blood flow resistance in a vessel

- [25] The **Obstetrician-Gynaecologist** experts agree on the presence of foetal distress from 22h13 on 04 February 2018, the substandard delays in proceeding with the Caesarean section and the lack of adequate foetal monitoring. They also agreed on the postnatal presence of anaemia and the abnormal RI value.
- [26] Their main disagreement lies in their interpretation of when labour commenced. Dr Mbokota relied on the initial "tip of finger" cervical dilation, while Dr van der Merwe emphasised the absence of progressive cervical changes and raised the possibility of infection influencing the initial finding. They also differed on the significance of the latent phase and, most importantly, on the issue of causation. Dr van der Merwe attributing a significant role to the severe neonatal anaemia in the eventual outcome, a factor Dr Mbokota touched on, but did not emphasise as a potentially overriding cause.
- [27] The two expert paediatricians who testified was Dr Maponya (Plaintiff) and Prof. Bolton (Defendant).
- [28] Dr Nosipho Maponya, presented expert testimony centred on the assertion that LM's, neurological injuries stemmed primarily from intrapartum hypoxia. Her analysis focus on the substandard care rendered according to her at birth, specifically the documented absence of essential resuscitation equipment and adequately trained personnel who could assist Dr Naidoo, who as one person did a two person job. Dr Maponya holds the view that this deficiency directly and significantly worsened any pre-existing or developing hypoxic insult.
- [29] Her core argument is a clear causal pathway: a failure in basic, life-saving care at birth led to or worsened the lack of oxygen (hypoxia), which in turn manifested as Hypoxic Ischemic Encephalopathy (HIE), Persistent Pulmonary Hypertension of the New-born (PPHN), and ultimately the observed developmental delays. She opines that the child's anaemia was a consequence of this hypoxic event, evidenced by the low initial haemoglobin levels, rather than a primary etiological factor. While acknowledging Foetal-Maternal Haemorrhage (FMH) as a potential cause of anaemia in other contexts, she found no evidence of its occurrence in LM's case. She downplayed the role of the mother's HIV status, focusing instead on the immediate impact of the birth asphyxia.

- [30] She made several significant statements to bolster the Plaintiff's allegations of negligence. They are that there was a fundamental breach of the duty of care owed to a vulnerable new-born. That the prolonged 11-hour gap in foetal CTG monitoring and the 2.5-hour delay in performing the Caesarean section fell below the acceptable standard of care.
- [31] Although she agreed with Professor Bolton's concept of Neonatal Encephalopathy (NE)⁸ as a "gateway" her emphasis fell on the link between the hypoxic-ischemic insult and the resulting encephalopathy, and that probably the MAS and PPHN caused the long-term neurological damage to LM. She remained resolute that her conclusion of hypoxic injury based on the clinical picture was correct even though it was not in line with the so called ACOG⁹ (American College of Obstetricians and Gynaecologists) criteria Dr Bolton was relying on.
- [32] Her testimony was a powerful and direct argument for causation rooted in demonstrable negligence focusing on the failure to provide basic medical necessities in the immediate postnatal period, a time of critical vulnerability for LM, who was already compromised. The absence of working suction, a bag-mask, oxygen, and an incubator at the moment of birth, according to her, represents a significant departure from the expected standard of care. This failure, in her expert opinion, directly impeded effective resuscitation and worsened any preceding hypoxic insult.
- [33] Her assertion is that the anaemia was a consequence of hypoxia and directly contradicts Dr Bolton's argument that the anaemia was due to FHM.
- [34] The strength of Dr. Maponya's evidence provides a compelling argument for a direct and significant causal link between the substandard postnatal care and the child's hypoxic brain injury. Her testimony is consistent and directly addresses the core elements of a delictual claim: duty of care, breach of that duty, causation, and harm. The factual evidence placed before court supports her account of staff

⁸ It's a broad term indicating a problem with the new-born baby's brain and nervous system (neurological function) in the first few days of life.

⁹ In the context of new-born's **hypoxic-ischemic encephalopathy (HIE)** and its potential link to cerebral palsy, refer to a set of clinical and laboratory findings that increase the likelihood that a new-born's neurological impairment was caused by an acute intrapartum hypoxic event.

and equipment shortages in an emergency hospital theatre and probable mismanagement of LM's condition as a result thereof at an extremely critical time directly after her birth.

- [35] Professor Keith Duncan Bolton, presents a viewpoint emphasising the multi-factorial causes of Cerebral Palsy (CP). He suggests that CP in this case is likely the result of a complex interplay of proximal (at birth) and distal (before or after birth) risk factors, rather than a singular negligent event. He identifies **Neonatal Encephalopathy (NE)** as a key intermediary stage in the development of CP, noting its presence in LM. A central point of his view is the significant role of severe anaemia, likely caused by foetal-maternal haemorrhage (FMH) ¹⁰ occurring shortly before birth, as a major proximal risk factor. He also highlights maternal HIV and post-datism as distal risk factors predisposing LM to NE and CP.
- [36] In evidence he downplayed the direct causal link between the delayed Caesarean section and CP, attributing the delay partly to systemic staffing and overcrowding issues experienced in State Hospitals. His view is that the value of CTG in preventing CP is limited. Whilst acknowledging initial equipment issues, he believes resuscitation was ultimately adequate. His main conclusion is that multiple risk factors, both pre-existing and peri-partum¹¹, contributed to LM's CP.
- [37] The contradictions in his evidence arise from his agreement on a "sentinel event" near birth potentially contributing to acute brain injury and anaemia, which can be seen as downplaying the multifactorial aspect he insisted was present. Additionally, while deeming resuscitation adequate, he acknowledges (evident from his notes) the frustration caused to Dr Naidoo by the lack of equipment during this emergency, suggesting a potential negative impact.
- [38] The key concessions he made include acknowledging that a component of brain injury occurred intrapartum, agreeing on the likely timing of the acute profound

¹⁰ Refers to the **leakage or transfer of foetal blood cells into the mother's bloodstream** during pregnancy, labour, or delivery.

¹¹ The period preceding or following child birth usually events that occurred during the last month of gestation or the first few months after delivery, with reference to the mother.

injury and severe anaemia in the last 30 minutes of labour, and conceding that the damage caused the NE.

[39] He defers to obstetricians on whether detectable damage constituted substandard care. He agrees NE is a common pathway to CP and the importance of preventing NE. He confirms that post-datism causes complications, HIV in mother's increases meconium aspiration risk, and that the brain damage likely occurred around birth. Also that PPHN is a postnatal risk, and the lack of resuscitation equipment and delays in cooling possibly worsened the existing condition, which was actually a medical catch twenty two situation. He acknowledges the difference between association¹² and causation¹³ from the expert reports he relied on, regarding HIV and NE, but maintains that CP is not a simplistic single-event outcome. This as the Plaintiff's counsel put it to him that his expert reports only shows associations and not actual causation.

[40] In essence, Professor Bolton's evidence aims to establish that while acknowledging some substandard care and intrapartum events, the child's CP is best understood within a framework of multiple contributing factors, with a strong emphasis on pre-existing and likely unavoidable factors like severe anaemia due to probable FMH, alongside distal risks. He argues against attributing CP solely or directly to specific acts of negligence during labour.

ARGUMENTS BY PLAINTIFF AND DEFENDANT

PLAINTIFFS ARGUMENTS

[41] The Plaintiff argues that the clear sequence of events – the documented foetal distress, the prolonged failure to act, the condition of the baby at birth, and the subsequent diagnosis of hypoxic ischemic brain injury – strongly suggests that the hospital staff's negligence directly caused the child's cerebral palsy. They submit the Defendant's alternative explanations as speculative and unsupported by the presented evidence.

¹² Possible link, but not conclusive

¹³ Actual relationship between cause and effect

- [42] The Plaintiff submits that the hospital staff were negligent in their management of the Plaintiff's labour and the foetal distress experienced by her baby. They contend that foreseeable harm was not acted upon when foetal distress was detected at 22h13 on 4 February 2018, a clear sign of danger. Despite this, no immediate or adequate intervention was taken for approximately 14 hours until the emergency C-section at 12h53 on 5 February 2018. This constitutes sub-standard care and a breach of guidelines, specifically in the failure to continuously monitor the foetus with a CTG, initiate intrauterine resuscitation, and perform an emergency C-section within the guideline of one hour after the diagnosis of foetal distress.
- [43] Consequently, the Plaintiff argues that the prolonged period of foetal distress and the subsequent hypoxia and ischemia are the most probable cause of the child's neonatal encephalopathy and resulting cerebral palsy. They firmly reject the Defendant's alternative causation theories, such as the child's HIV exposure or an unspecified infection causing the brain injury, as speculative, unsupported by the evidence, and contradicted by their own expert's concessions regarding the timing and cause of the anaemia.
- [44] The Plaintiff supports their arguments with the following common cause facts and concessions made. The plaintiff's admission to hospital, without being in active labour, and having been in good health (both she and the foetus) since her Mayibuye clinic days up until 22h13 on 4 February 2018, forms the factual basis. All experts agreed that the first signs of foetal distress appeared at the aforementioned time and date. This occurred after YM was admitted for an induction of labour, which never happened. When foetal distress was diagnosed (22h13 on 4 February 2018), the maternity guidelines required continuous CTG monitoring, which did not occur. There was spontaneous rupture of membranes with meconium-stained liquor, further indicating foetal distress before the emergency C-section was ordered. The guidelines stipulate emergency C-sections must happen within an hour; however, the order was given around 10h00 and the baby was born at 12h53 – almost three hours later – without a proper explanation for the delay.

[45] Further, there was a concession by Dr van der Merwe that the acute profound injury likely occurred in the last 30 minutes and probably caused the anaemia. The Plaintiff argues that the lack of oxygen and suctioning equipment in the theatre was negligent and caused a crisis, evident in LM's condition at birth: being floppy, not crying, cyanosed, meconium aspirated, and in respiratory distress. This also delayed her transfer to the NICU. The Plaintiff submits that these events led to the diagnosis of a mixed pattern hypoxic ischemic brain injury and neonatal encephalopathy, ultimately resulting in cerebral palsy.

[46] The plaintiff's critique on Prof. Bolton's evidence was that his theories regarding HIV exposure and anaemia as primary causes are not supported by the cited studies, the facts of this case and are contradicted by his own concession about the timing of the anaemia. They emphasize the distinction between association and causation in scientific studies which they said he tried to elevate to probabilities in this matter, whilst only being possibilities if further research is conducted.

[47] The Plaintiff quoted various pieces of case law to establish the legal principles of negligence and causation, to argue that the hospital staff's conduct fell below the required standard of care and to support the inference of negligence based on the evidence. They also provided case law to counter the Defendant's potential alternative explanations, and to emphasize the importance of basing expert opinions on proven facts and not studies with association which are possibilities, but not probabilities in this matter

DEFENDANTS ARGUMENTS

[48] The Defendant argues that the child's cerebral palsy is likely the result of a complex interplay of various risk factors, some potentially pre-existing. Their evidence was aimed to demonstrate that the outcome in LM's circumstances cannot be solely and directly attributed to negligent actions or omissions by the hospital staff during the final stages of labour. They highlight the uncertainties in the Plaintiff's history and the presence of other plausible contributing factors to counter the Plaintiff's claim of direct causation due to negligence.

- [49] The Defendant's main arguments are that Cerebral Palsy (CP) is a complex condition with multiple potential antenatal, intrapartum, and postpartum contributing factors, making it difficult to pinpoint a single cause. They contend that, despite some shortcomings, the clinical notes provide a generally good picture of the management of the Plaintiff's pregnancy and labour. They submit it cannot be definitively stated that baby LM's condition is purely due to a failure of staff at Tembisa Hospital to provide adequate care during labour and delivery. They also argue that the significant delay between the diagnosis of foetal distress and delivery on 5 February 2018 might have been unavoidable in an overcrowded health system with limited resources and the need to prioritise patients.
- [50] Furthermore, the Defendant highlights several factors that complicate the causation argument: the Plaintiff's uncertainty about her last menstrual period, making accurate gestational age determination difficult; the Plaintiff's greenish/yellowish vaginal discharge indicating an infection, which could have implications for the cervix and potentially contribute to complications for LM; and the initial resistance index (RI) of 0.8 at term being high, suggesting potential pre-existing issues with blood flow to the baby (intrauterine growth restriction). They submit that labour only definitively started at 09h37 on 5 February 2018 with cervical changes (2cm dilation) and spontaneous rupture of membranes, arguing that earlier signs were not conclusive of active labour. Therefore, it cannot be said that labour was delayed, as the spontaneous rupture of membranes on the morning of 5 February 2018 was the clear sign of labour onset.
- [51] Regarding causation, the Defendant submits that the anaemia LM was born with was not caused by the foetal distress experienced during labour, but by factors such as the mother's HIV status, potential post-datism, and the abnormal resistance index, which could have predisposed the baby to hypoxia. They maintain that LM's condition can be attributed to a combination of pre-existing factors and events that are not solely attributable to negligence during the final stages of labour.
- [52] The Defendant largely supports their view with the evidence of their experts, who testified that CP is complex and multifactorial. They contend that the hospital

notes show reasonable management was provided within a difficult, overcrowded hospital setting. They highlight the plaintiff's uncertainty regarding the gestational age due to her unclear menstrual history, and that the greenish discharge was a sign of potential infection. The elevated resistance index at term, they argue, was potentially indicative of a pre-existing issue. Furthermore, they submit that YM's labour observations, which require cervical changes and regular contractions, were not consistently documented to definitively state when active labour started, except when the membranes ruptured, which is a clear sign of labour onset. Dr van der Merwe specifically indicated that the foetal distress did not cause the anaemia, attributing it to a pre-existing risk factor like HIV.

- [53] The Defendant further submits that Drs Mbokota and Maponya, the Plaintiff's own experts, conceded several crucial points: that HIV was a risk factor for hypoxia and that an HIV infection could contribute to brain damage; and that a vaginal infection could predispose LM to hypoxia. Dr Mbokota also agreed that a prolonged gestational period carries risks for the baby, including placental insufficiency and meconium-stained liquor, and Dr Maponya concurred that post-datism poses a risk. They highlight that the initial RI of 0.8 was agreed to be abnormal, suggesting potential intrauterine growth restriction. Crucially, the Defendant points out that Dr Mbokota agreed the baby's anaemia was not caused by foetal distress, and Dr Maponya also stated that hypoxic ischemia does not cause anaemia. Furthermore, Dr Maponya agreed that several factors, including severe congenital anaemia, maternal HIV, meconium-stained liquor, meconium aspiration, PPHN, post-datism, and neonatal infection, could have contributed to the brain damage.

ANALYSIS

- [54] I find to properly understand the views of the Plaintiff and Defendant it must be broken down in very understandable language. This especially for my benefit as the Judge who must rule on the presented very intricate medical facts with mostly experts expressing their medical opinions that are nuanced, sometimes conceded and sometimes based on inference (association) not necessarily supported by the facts of this matter.

- [55] My understanding therefore of the Plaintiff's case is that LM has cerebral palsy because the hospital staff were negligent before and during YM's labour, and throughout the delivery process until after birth.
- [56] The Plaintiff contends that the hospital staff ignored clear signs of danger, specifically foetal distress, for an unacceptably long period (14 hours and 40 minutes), and failed to deliver LM timeously. Furthermore, no interventions were undertaken to initiate intrauterine resuscitation when distress was noted or in the period preceding surgery, thereby causing her to be born hypoxic (lacking blood flow and oxygen to the brain).
- [57] The Plaintiff further asserts that the hospital staff did not have the necessary equipment ready when LM was born in distress, having aspirated meconium¹⁴ and required immediate assistance. This alleged lack of proper care, it is argued, directly caused LM to suffer birth asphyxia¹⁵ resulting in a hypoxic ischemic incident and severe brain damage.
- [58] The Plaintiff's emphasis is therefore on the asphyxia (lack of oxygen in the blood) causing a hypoxic-ischemic incident, damaging LM's brain due to insufficient oxygen and blood flow. This situation was worsened by the fact that she was birthed in distress and that insufficient emergency resuscitation equipment was available to prevent or mitigate further damage. The Plaintiff believes the chronological timeline of events and the established facts of this case strongly support their claim, rendering any excuses or alternative causes for LM's condition untenable given the evidence.
- [59] The defendant says CP is a complicated condition with many possible causes, and it is not fair to blame everything that happened in hospital and in the delivery room on a single event. Whilst there might have been some things the hospital staff could have done better and faster, the staff were doing their best in trying circumstances.

¹⁴ Baby's first stool and a clear sign of distress

¹⁵ Lack of oxygen or an excess of carbon dioxide in the body causing breathing difficulties

[60] The Defendant emphasises that, based on the hospital notes, LM presented with other significant indicators of factors contributing to CP, visible before, during, and after birth. These included YM's post-datism, her HIV status, and vaginal infection, along with the medications used for their treatment and their possible effect on LM. The severe anaemia (indicated by a low RI at admission) is also highlighted. Due to the presence of these various other factors, the Defendant submits that the Plaintiff has not discharged the onus of proving that the staff's actions directly caused the CP.

FINDINGS ON THE FACTS

[61] I conclude from the expert evidence presented that YM was post term when she was eventually admitted to hospital. Her pregnancy was normal apart from her being HIV positive.

[62] LM has confirmed permanent brain damage (Chronic hypoxic ischemic brain injury) that was caused by insufficient blood flow and or oxygen reaching her brain.

[63] I accept that clear labour was only diagnosed at 09h37 on 5 February 2018, but that at that time there was already clear signs of foetal distress noticed at 22h13 on 4 February 2018 which was not acted upon or properly monitored by CTG. This noted distress was agreed upon by all the experts and lasted for 14 hours and 40 minutes for LM.

[64] An emergency C-section was ordered at 10h00 on 5 February 2018, and despite admitted medical guidelines that it should have been performed within an hour, LM was only born at 12h53, two hours and fifty three minutes later.

[65] At birth, LM was in severe distress. Dr Naidoo, who, even according to Dr Bolton, performed a sterling 'one-person job meant for two,' did not have the basic resuscitation equipment available. This situation likely exacerbated LM's already poor hypoxic condition.

[66] I accept, even though there was only reluctant agreement, that a sentinel event occurred 30 minutes before LM's birth and that she was probably delivered just in time to prevent a stillbirth.

APPLICATION OF LAW TO FACTS: NEGLIGENCE

[67] In answering the five questions formulated for answer I find as follows: On question 1 - **Whether or not the defendant's employees who cared for the plaintiff during her admission and treatment in hospital delivered sub-standard care as alleged by the plaintiff?**

[68] The answer is an unequivocal, YES. My acceptance of a prolonged latent phase, foetal compromise not acted upon, multiple missed opportunities for intervention, and the baby's compromised condition at birth, are all deviations from accepted medical practice, and establishes that the defendant's employees delivered sub-standard care as alleged.

[69] On the prolonged latent phase issue, my finding is based on the fact that YM was admitted for induction, which never took place. Although a plausible explanation was given for this omission, it is clear from her individual situation — considering her post-datism, HIV status, possible labour, vaginal infection, and her complaints (that went unheeded) from Sunday evening (4 February) to Monday morning (5 February), when an emergency C-section was eventually ordered — that she required, and indeed almost demanded, much more attention and care from the medical staff than was provided.

[70] On question 2 - **Whether or not the defendant's employees negligently prolonged the plaintiff's labour?** The answer is YES. YM was in clear foetal distress from 22h13 on 4 February 2018, as agreed to by all the experts. This distress was not acted upon definitively. This inaction led to a subsequent delay in calling for the emergency C-section, which procedure was also executed beyond the acceptable guidelines. This indicates that the defendant's employees negligently prolonged the plaintiff's labour, thereby allowing a significant and unacceptable period of foetal compromise to occur.

- [71] On question 3 - **Whether or not the defendant's employees were negligent by failing to timeously recommend an emergency Caesarean Section (C-Section) and perform one without undue delay?** The answer is YES. The experts agreed upon, clear signs of foetal distress at 22h13 on 4 February 2018 warranted a timely recommendation and execution of an emergency C-section. The significant delay until the baby's birth at 12h53 on 5 February 2018, almost three hours after the decision for the C-section taken at 10h00, and nearly fifteen hours after the initial signs of distress, directly contravenes medical guidelines and constitutes clear negligence.
- [72] On question 4 - **Whether or not the failure to provide intrauterine resuscitation (IUF) after having diagnosed foetal distress and while awaiting a Caesarean Section was negligent?** The answer is YES. Following the diagnosis of foetal distress at 22h13 on 4 February 2018, the failure to implement intrauterine resuscitation measures during the prolonged waiting period until the emergency C-section, which was only performed much later, constitutes a deviation from the accepted standard of procedure and care and is therefore negligent.
- [73] On question 5 - **Whether or not the failure to heed warning signs indicated foetal compromise and take appropriate measures to avoid harm to the baby was negligent?** The answer is YES. The clear signs of foetal distress noted at 22h13 on 4 February 2018 were critical warning signs of foetal compromise. The failure to act upon these signs for an extended period, including the delay in performing the emergency C-section and the omission of intrauterine resuscitation, demonstrates a negligent failure to heed these warnings and take appropriate measures to avoid harm to the baby.
- [74] Negligence is therefore apparent in respect to all the questions posed. There was a clear duty of care on Thembisa Hospital and its medical staff. Various deviations from accepted medical practice were either apparent or admitted. Therefore, answering all the questions *supra* with a 'YES' is unavoidable.

APPLICATION OF LAW TO FACTS: CAUSATION

- [75] A delictual claim requires more than just negligence. Causation must also be proved. Causation, in medical terms, is established where there is a direct link between the healthcare provider's negligent actions or omissions and the patient's resulting harm. It's not simply about showing a mistake was made; it's about proving that the mistake made caused the harm.
- [76] In this matter, therefore, the plaintiff needs to show, on a balance of probabilities, that the hospital employees' negligent actions — such as failing to properly attend to YM's specific circumstances and complaints, not properly monitoring, reporting, and taking definitive action on the foetal distress noted, and delaying the emergency C-section — actually caused the baby's brain injury. The plaintiff argues that but for the negligence, the baby would not have suffered the hypoxic event leading to cerebral palsy, and that this outcome was a foreseeable consequence of the negligent medical care.
- [77] This is where the argument of the defendant lies. They agree that some aspects of care could have been better, and even seek to exculpate their staff in parts. Professor Bolton agrees there were some issues with the care provided, but he argues that despite these, LM still had several pre-existing vulnerabilities [post-datism, potential impact of maternal HIV, and significantly, severe anaemia likely from Foetal-Maternal Haemorrhage (FMH)] that made her susceptible to Neonatal Encephalopathy (NE) and Cerebral Palsy (CP). He maintains that these factors are the more significant contributors to LM's outcome. He remains adamant that CP is a complex condition with multiple potential pathways, and attributing it solely to the alleged (and now found by the court) negligence is an oversimplification.
- [78] There has been a lot of confusion lately in court arguments and judgments where factual causation is at issue, regarding whether the so called "but for" or Lee test would be applicable. It must be realised that it is actually only one test wherein flexibility under Lee¹⁶ is recognised against the rigidity of "but for"¹⁷. The underlying principle of factual causation remains, but the way the question is

¹⁶ Focuses on the contribution of the negligence to the harm by way of increased risk or lost opportunity.

¹⁷ But for the Defendant's negligent conduct, would the harm to the Plaintiff have occurred?

framed and the factors considered in answering it can differ depending on the complexity of the causal chain and whether the situation falls under the standard "but-for" test (still preferred) or the *Lee* exception.

[79] In *Lee* the Constitutional Court differed from the lower courts (CPD and SCA) by moving away from a strict "but-for" test and adopting a more flexible approach to factual causation. This approach took into account the systemic nature of the defendant's failures, the state's constitutional duties, and the need to prevent injustice in cases involving vulnerable individuals. The Constitutional Court was willing to find causation present, where the lower courts were not, because they adopted a wider and more constitutionally aligned view of what causation means.

[80] *Lee* would be applicable in cases where the harm that ensued was closely connected to an omission by a party who carries a duty of care to prevent the harm. It focuses on whether the defendant's conduct (the series of omissions) played a substantial role in bringing about the harm. In cases involving multiple contributing factors and a series of omissions, the court would ask: **"Did the conduct of the party with the duty of care significantly help cause the harm even if it's difficult to say the harm wouldn't have occurred?"** This question embodies the core of the *Lee* test. It acknowledges situations with multiple contributing factors where pinpointing a single "but-for" cause is problematic.

[81] The "but for" test enquires whether the harm was inevitable to the plaintiff regardless of the defendant's actions. If the answer is "yes," it suggests the defendant's breach was not a factual cause under this traditional test. The question to be asked is: **"Would the harm likely have happened anyway, even if the defendant had done what they were supposed to do?"**

[82] In *Mashongwa v PRASA*¹⁸ paragraph 65, Mogoeng CJ, states that following in the Constitutional Court's judgment of *Lee v Minister for Correctional Services*¹⁹.

[65] *"It seems to me that the approach adopted in Lee is particularly apt **where the harm that has ensued is closely***

¹⁸ 2016 (3) SA 528 (CC)

¹⁹ 2013 (2) SA 144 (CC)

connected to an omission of a defendant that carries the duty to prevent the harm. In those circumstances, the question one asks in the context of factual causation is **whether the harm would probably have ensued even if the defendant had complied with its duty.** However, where the traditional but-for test is adequate to establish a causal link, it may not be necessary to resort to the Lee test."

[83] The question(s) posed in paragraph 3 supra relating to causation is:

1. Whether the negligence as alleged by the plaintiff above resulted in the Plaintiff's minor child suffering a (HIE) hypoxic-ischemic incident (Brain injury due to lack of oxygen) due to birth asphyxia (Lack of oxygen in the blood) causing her to sustain severe brain damage?

OR

2. Whether the cause of the minor's brain injury is the following according to Prof. Bolton:
 - 2.1 Severe Congenital Anemia – CDA- (blood disorder where significant lower than normal levels of red blood cells, lead to severe deficiency in oxygen transport through the body)
 - 2.2 Maternal HIV infection
 - 2.3 Meconium stained liquor (MSL – Amniotic fluid with greenish / brown colour, due to the presence of meconium, which is the baby's first stool) and meconium aspiration syndrome (MAS – When a newborn breathes into their lungs during or shortly after birth meconium)

2.4 Persistent Pulmonary Hypertension (PPHN – Condition where a new-born's circulation system doesn't adapt to life outside the womb, causing the blood vessels in the lungs to remain constricted, with resultant reduced blood flow to the lungs and low oxygen levels in baby's blood)

2.5 Post Datism (A pregnancy that has extended more than 14 days past the 40 weeks of gestation – expected delivery date)

2.6 Neonatal infection (disease or virus contracted by a new-born from before birth – in utero- to within the first 28 days of life)

[84] The causation question presented for answer is a one, OR, the other option. I however intend to deal with both (even if just cursory) before indicating my conclusion.

[85] On question 1, and on the probabilities, the answer is YES. Dr Maponya and the other evidence adduced by the plaintiff rely directly on the timeline of events to link the substandard care to the outcome. Her testimony indicates there were clear signs of prolonged foetal distress that were not adequately acted upon. There was a significant delay in performing the emergency C-section. Crucially, in this latent phase from distress being noted to the C-section, there was no indication that intrauterine resuscitation was performed.

[86] The baby's severely compromised condition at birth—indicative of asphyxia (floppy, not crying, cyanosed, meconium aspirated, respiratory distress)—along with the lack of essential resuscitation equipment and personnel immediately after birth, all further exacerbated LM's hypoxic state. The resultant diagnosis of hypoxic-ischemic brain injury (HIE) is, therefore, the direct consequence of insufficient oxygen and blood flow to the brain, which, I find, was caused solely by the attending staff's negligence. I agree with this assessment.

- [87] The questions in 2.1 – 2.6 relate to Professor Bolton’s assertion that LM’s HIE was multifactorial. He argues that several pre-existing and peri-partum factors likely contributed to the Neonatal Encephalopathy (NE) and Cerebral Palsy (CP), suggesting that the CP was likely the result of a complex interplay of these factors rather than solely due to the alleged negligence during the final stages of labour.
- [88] The factors he listed, which correlate with the questions, are: **Severe Congenital Anaemia**, which he argued could have impaired oxygen transport; **Maternal HIV infection**, identified as a distal risk factor; **Meconium Stained Liquor and Aspiration**, which he acknowledged as a sign of foetal distress and a respiratory complication if aspirated at birth, affecting the lungs; **Persistent Pulmonary Hypertension (PPHN)**, which he noted as a postnatal condition affecting oxygenation where a baby fails to adjust to its new surroundings after birth; **Post-Datism**, which he cited as a risk associated with prolonged gestation; and **Neonatal infection**.
- [89] Regarding the latter, Professor Bolton indicated it must be assumed, due to the medication used in treating LM in ICU, that she had some kind of infection, as these infections can be caused by various pathogens, including bacteria, viruses, fungi, and parasites, to which new-borns are particularly vulnerable due to their immature immune systems.
- [90] The problem with Professor Bolton, and for that matter the other experts who testified *viva voce* for the defendant, is that they all tried to offer alternative possible risk factors that ***could have*** independently or cumulatively contributed to LM’s brain injury. Crucially, Professor Bolton’s evidence, on which the above questions require answers, was not always based on the available facts of this matter.
- [91] Professor Bolton conceded two very important aspects: first, that there is a difference between association and causation – as discussed in paragraph 39 *supra* – given that the expert material he relied upon showed more association than causation in relation to LM’s specific facts. Second, he conceded that a component of LM’s brain injury occurred intrapartum, agreeing on the likely timing of the acute profound injury and severe anaemia in the last 30 minutes of

labour, and further conceding that this damage caused the Neonatal Encephalopathy (NE)

- [92] This concession is significant because it acknowledges that a critical harmful event occurred during the delivery process itself, aligning with the plaintiff's argument that negligence during this time contributed to the brain injury. While Professor Bolton still maintained his multi-factorial argument, acknowledging a direct injury occurring so close to birth weakens his stance that the CP was solely or primarily due to pre-existing or unavoidable factors. This is indicative that the negligent management during those crucial final minutes contributed to and exacerbated LM's acute injury.
- [93] Professor Bolton's view that Foetal-Maternal Haemorrhage (FMH) likely occurred shortly before birth, causing the severe anaemia, is unsupported by evidence as no blood was drawn from YM to confirm this contention. Furthermore, while the placenta (due to the low RI) was sent for analysis, the results were never received to confirm placental issues. Crucially, on the evidence presented, there was no real indication of excessive blood visible during the birthing process that would explain the severe anaemia LM had at birth.
- [94] Professor Bolton was particularly defensive regarding the equipment available, or rather unavailable, in the emergency operating theatre. He sought to argue that despite the absence of certain equipment, proper help was still afforded by the Paediatrician who assisted LM. However, the absence of this essential equipment in an emergency situation such as this is, under the circumstances, untenable.
- [95] In conclusion on the aspect of causation, I find that Dr Maponya's evidence provides a direct causal link between the alleged negligence (especially the delay in intervention and lack of resuscitation) and the hypoxic-ischemic injury. This finding stands against Professor Bolton's mostly unsupported offering of a broader multiple risk hypothesis that could have caused the brain injury.

LEGAL POSITION

- [96] The legal principles governing negligence, causation ('but for' test), inferential reasoning, and the duty of care owed by medical professionals are well-established in our law.
- [97] I considered the standard of care as in *Kruger v Coetzee*²⁰, foreseeability *Mukheiber v Raath*²¹, the drawing of inferences where factual evidence is absent or disputed *Minister of Safety and Security v Van Duivenboden*²², and the rejection of implausible alternative explanations *Ratcliffe v Plymouth and Torbay Health Authority*²³ in coming to my findings.
- [98] In *Standard Chartered Bank of Canada v Nedperm Bank Limited*²⁴, it was clarified that for liability to result, the precise nature or extent of the loss or the exact manner of harm need not be foreseeable. It is sufficient if the general nature of the harm and the general manner of its occurrence were reasonably foreseeable. This principle is relevant in LM's case, suggesting that even if the exact severity of her CP was not predictable, the harm resulting from untreated foetal distress was indeed reasonably foreseeable.
- [99] In *Minister of Safety and Security v Van Duivenboden*, the court addressed causation, affirming that a plaintiff does not need to establish the causal link with certainty, but only that the wrongful conduct was *probably* a cause of the loss. This principle was pivotal in the courts assessment whether the hospital staffs negligence was the probable cause of the child's brain injury.
- [100] The Constitutional Court in *Minister of Finance and Others v Gore NO*²⁵ further elaborated on factual causation, emphasizing a common-sense, practical approach rather than a purely scientific or philosophical one. A common-sense assessment of this cases timeline of events and the lack of timely intervention points strongly to the hospital staffs omissions as the cause of the injury to LM.

²⁰ 1966 (2) SA 428 (A)

²¹ 1999 (3) SA 1065 (SCA)

²² 2002 (6) SA 431 (SCA)

²³ 1998 PLNR 146

²⁴ 1994 (4) SA 747 (A)

²⁵ 2007 (1) SA 111 (SCA)

FINDING

[101] Having meticulously considered the evidence presented and applied the established legal principles, I find that the Plaintiff has successfully discharged the onus of proving, on a balance of probabilities, that all the requisite elements of a delictual claim for medical negligence have been met. The Defendant's employees acted negligently, failing to uphold the expected standard of care, and their negligence directly caused LM's hypoxic-ischemic brain injury and subsequent cerebral palsy. Therefore, liability for the damages suffered by LM lies squarely with the Defendant.

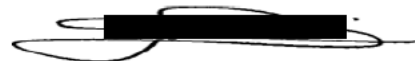
COSTS

[102] The Plaintiff was of the opinion that attorney client cost should be awarded due to the defendants "unpleaded putative defence". The Defendant submitted the action should be dismissed with costs of two counsel.

[103] I am of the opinion that both parties executed their mandates appropriately and honourably. Costs shall follow the cause to be paid by the defendant.

ORDER

- 1 The Defendant is found to be 100% liable for the hypoxic-ischemic brain injury sustained by the minor child LM, arising from the negligent medical care provided by the Defendant's employees, and the determination of the quantum of damages is postponed *sine die*.
- 2 The Defendant shall pay the cost of this action.



PJ DU PLESSIS
ACTING JUDGE OF THE HIGH COURT
JOHANNESBURG

For the Applicant:

Advocate D Brown assisted by Ms
N. Radebe (Attorney) instructed by
Jerry Nkeli & Associates Inc.

For the Respondent:

Advocate(s) MM Gwala SC & HL
Kelaotswe instructed by The State
Attorney

Dates heard: 3-7; 10-14 March 2025

Judgment finalised: 20 May 2025

Judgment delivered after redaction and
revision: 22 May 2025