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**IN THE HIGH COURT OF SOUTH AFRICA
(EASTERN CAPE DIVISION, BHISHO)**

CASE NO.: 210/2021

Reportable	Yes / No
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In the matter between:

N[...] T[...]

First plaintiff

O[...] T[...]

Second Plaintiff

herein represented by **SIBUSISO BONGANI
MSITSHANA N.O** as *Curator ad Litem*

and

**THE MEMBER OF THE EXECUTIVE
COUNCIL FOR HEALTH: THE EASTERN
CAPE PROVINCIAL GOVERNMENT**

Defendant

JUDGMENT

MAKAULA J

A. Introduction.

[1] The first plaintiff is N[...] T[...], the mother and the guardian of the second plaintiff, O[...] T[...] (O[...]), who has attained the age of majority. The first plaintiff sued in her personal and representative capacity as the mother of O[...]. Due to O[...]’s brain injury, which resulted in cerebral palsy, a curator *at litem* was appointed for him as per court order dated 20th July 2024. The first plaintiff was substituted for the *curator ad litem* in the amended particulars of claim.

[2] The claim is based on an alleged negligence of the medical and / nursing staff of the defendant interchangeable referred to as defendant’s employees, being alleged to have caused such negligence, resulting in the medical condition O[...] found himself in.

[3] At the start of the trial, the parties agreed to a separation of the issues in terms of Rule 33 (4) of the Uniform Rules of Court. The trial proceeded on the issue of liability only.

B. The Facts.

[4] Apart from the sketchy documentary medical records that were available, the plaintiff called the following witnesses, namely

- 4.1 The first plaintiff, whose testimony was about her pregnancy journey up until the birth of O[...],
- 4.2 Dr Alheit, a radiologist who testified regarding the brain injury suffered by O[...] as visualised on the MRI,
- 4.3 Dr Kara, a pediatrician who gave evidence regarding O[...]’s cerebral palsy and the cause and timing of the brain injury suffered by him,
- 4.4 Dr Murray, a specialist obstetrician and gynecologist who testified with reference to the Maternity Guidelines and standard obstetric practice, giving content to the neglect of the obstetric care and management of the first plaintiff.

N[...] *T[...]*.

[5] I should mention upfront that the first plaintiff’s evidence was not challenged by the defendant. She was 45 years old when she testified. She was neither married nor employed when O[...] was born. She left school in grade 11. She gave birth to O[...] on 8 April 2006.

[6] The first plaintiff testified that she became aware that she was pregnant after she missed her monthly periods. She attended the Central clinic in her hometown, where it was confirmed that she was indeed one month pregnant.

She started the antenatal clinic monthly until she gave birth. All the required tests were continually done, and she was assured that the baby was growing well. She was taken for a scan. She neither smoked nor drank alcohol at the time of her pregnancy.

[7] On 7 April 2006, early in the morning, she felt pain in her lower abdomen and decided to go to the hospital as she was earlier informed that her due date was 5 April 2006. On arrival at the hospital, she met with a nurse in the maternity section and explained to her that she had lower abdominal pains and she thought she was in labour. The nurse told her to go home, saying she must come back only if she sees something coming out of her vagina. She refused, but the nurse rebuked her, saying she was one of those people who knew everything. She obliged.

[8] On arrival at home, the pain persisted and gradually became severe, and she called an ambulance, but in vain. She took a taxi to Frere Hospital. She got to the hospital at about 16h00. She went to the maternity section and informed the nurses that she was in severe labour pains. The same question was asked of her and she responded that nothing was coming out of her vagina. One of the nurses informed her to remain in the waiting room until something comes out of her vagina. She complied and waited until evening. While she was still waiting, a nurse passed by and informed her that she was in pain. The nurse told her to walk around in the corridor. She did so, but that did not help. After some time,

she went back to the nurses to enquire whether they had not forgotten about her. They told her to wait as they were still busy with an emergency. At 19h00, the night shift of nurses took over. She approached them, and they told her to wait. After a while, she felt an urge to urinate. She went to the toilet. As she was sitting on the toilet seat, her water broke. It was green with blood spots. On seeing that, she screamed. A certain lady appeared. That lady called the nurses who arrived and took her to bed and told her to 'push'. She pushed, and the baby was born shortly thereafter. The baby did not cry. They took the baby away, and she saw the baby the following morning at the nursery. He was in an incubator, and a tube was inserted in his nose and mouth. There were patches on his body, which were later explained as electrocardiogram patches. She was told that the child could not feed, and milk had to be expressed in a tube. Even when the child was discharged after seven days, she was given a breast pump to use in feeding him.

[9] She was informed by the nurses that her baby had seizures. When she enquired why, she was advised that 'oxygen did not arrive well in the brain' (sic). As aforesaid, she and the baby were discharged after seven days. After three months, the baby started to have seizures, and she took him to the hospital for treatment. Later, she was told the child would not be normal. She was not cross-examined by the defendant as aforesaid.

Dr Berthold Alheit

[10] Dr Alheit is a retired Diagnostic Radiologist. He testified virtually as he was in France. His expertise is not in dispute. Whilst in practice, he spent 50% of his specialised working life practicing MR, specifically in Neuro MR from 1989 until he retired in 2018. He was a member of the Pediatric Neuro-Radiology Society of South Africa.

[11] Dr Alheit compiled two reports based on the MRI scan of O[...]. The first is dated 19 September 2020, and the second is 11 October 2022. He testified that the difference between the two reports is that in the second report, he added more literature. Otherwise, his findings are the same. He further compiled a slide presentation. He stated in his evidence that the MRI brain of O[...] revealed a hypoxic ischemic brain injury involving the central parts of the brain, namely the Paracentral lobule, Periolandic, Basal Ganglia and Thalamus (PPBGT) structure of the brain. He found that O[...] suffered an insult, which ended up as an injury. He explained what leads to the injury as follows:

“would call the high metabolic rate regions of the brain. So, that is the part of the brain that before the child is born needs the most energy. And it contains the perirolandic region which is an area where the motor and sensory functions of the brain are established. And then the basal ganglia or the central part of the brain, that is where all the vital functions of the human body are controlled. We refer to them as the deep grey nuclei ... These areas because they need energy just before birth, much more than the rest of the brain, these areas are more vulnerable to a lack of oxygen and the lack of blood pressure. And if this occurs if for some reason there is a lack of

oxygen then these regions start suffering and eventually when there is lack of blood pressure that is when the actual injury happens, the cells become acidotic, the metabolism, toxic substances build up in the cells and it damages the cells and then we end up with this injury. Which is due to lack of oxygen and a lack of blood pressure, when the heart fails, and this leads to this injury of the high metabolic regions. We do not know how long it takes to develop but it is likely that to take quite a long time”. (sic). He described the high metabolic regions as “the collective name we use is central regions, and that includes the parietal region and the central basal nuclei ganglia and the thalamus or the deep grey nuclei. So that the whole consortium of high metabolic regions are also called the central regions.” (sic) He described this as his core finding of the brain injury he discovered on O[...].

[12] Dr Alheit opined that if there was a history of an intrapartum sentinel event, then the injury pattern could have been due to an acute, profound hypoxic ischemic event. He described a sentinel event as an acute or abrupt cut-off of oxygen supply, which then leads to an acute injury, for instance, a rupture of the placenta or if the mother suffered heart arrest, profuse bleeding of the baby, etc. He testified that if the fetus is distressed, these areas are vulnerable and become increasingly metabolic acidotic and eventually, when the blood pressure also disappears, then one gets the injury of the same central areas of the brain. He testified that in the absence of a sentinel event, the same brain injury occurs after ongoing hypoxia over a prolonged period in which the fetus is compromised but not injured, and then finally cardiac compromise (ischemia)

occurs, resulting in brain injury. He deferred to a clinical correlation in this instance. He testified that the other experts would place the injured pattern in the appropriate clinical and obstetrical context. He stated that how the injury occurred would come from the obstetrician as well as the pediatrician.

Dr Yatish Kara

[13] Doctor Kara is a pediatrician specialising in neonatal and intensive care pediatrics. Similarly, his credentials as an expert are not in dispute. His brief was to conduct a medico-legal assessment to establish the degree of disability and the causal connection between the delivery and subsequent neurological outcome in respect of O[...]. He examined him, consulted with his mother and compiled a report.

[14] His examination of O[...] revealed that he had spastic quadriplegia cerebral palsy, meaning that he is stiff and weak in all four limbs. He is unable to use his hands, unable to speak and has limited expressive and receptive ability. However, he can hear and see. He has epilepsy and microcephaly, meaning he has a small head or shrunken brain. Due to this condition, he is caregiver dependent.

[15] Dr Kara received and reviewed limited medical records that were made available to him. At birth, O[...] weighed 2.7 kg, had an Apgar score of 3 and 5, and the pediatric records showed that he had a hypoxic ischemic brain injury.

Based on the information he received from the first plaintiff, O[...] could not have sustained the injury during pregnancy antenatal stage because she had no complications. He opined that there was no evidence to suggest that the brain injury occurred after delivery because O[...] was born in a compromised condition. That is because the available records indicated that O[...] was diagnosed with moderate hypoxic ischemic encephalopathy after birth, indicating that the injury occurred at birth. What was made clear to him is that O[...] was critical at birth, he had seizures after 3 months, was on a ventilator and had to be fed through a tube.

[16] Doctor Kara testified that he excluded other causes of encephalopathy because he looked for *'features of infection, features of chromosomal abnormalities, features of metabolic diseases at cetera. And in essence, based on my examination, the availability records and the MRI scan, I could not find any evidence of these conditions ... I would not find an alternative cause for the encephalopathy other than hypoxic ischemic injury, which is what was shown on the MRI scan'*. (sic). He described ischemia as a lack of blood flow to an affected organ, in this case, the brain. He stated that hypoxic ischemic brain injury is low oxygen in the bloodstream, which makes it difficult for the body to transport oxygen to the brain. He stated that based on the interview with the first plaintiff and the limited available records, he could not find a reason to suspect that there was a sentinel event and had it occurred, it would have been

mentioned or recorded. All the available information and criteria, so he stated, on a balance of probabilities, favour an intrapartum hypoxic ischemic injury.

[17] Doctor Kara reviewed extensive literature by renowned experts¹ regarding the timing of the injury. According to him, the studies reveal that 56% of neonatal encephalopathies in term infants are caused by events that occur during labour, and HIE is a cause of 52% newborn encephalopathy. Relying on Volpe, he states that there are three features which are important in considering hypoxic-ischemic injury, namely, (a) evidence of foetal distress and/or foetal risk for hypoxia-ischemia, (b) need for resuscitation at birth and or low Apgar scores, and (c) an overt neurological syndrome in the first hours or day of life. Based on those, he opined that the period of highest risk of hypoxic ischemic injury in pregnancy is during labour.

[18] Doctor Kara stated that in this matter, it is indeterminable what the period is between the commencement of the insult and the onset of the ischemia. That is compounded by the lack of obstetric records. He testified that on the available information, there is no indication or evidence of a sentinel event having occurred during labour. He explained a sentinel event to be *'a ruptured uterus, cord prolapse abruptio placenta, maternal cardiovascular collapse, massive fetomaternal haemorrhage, shoulder dystocia - unknown, but there is no history of placental abruption, cord prolapse or urine rupture or shoulder dystocia'*.

¹ Cowan and Rutherford; Gun and Bennett.

Based on the above, he concluded that “(i)t appears probable despite missing information that there was acute intrapartum hypoxic injury of sufficient severity to cause cerebral palsy”.

Dr Linda Ruth Murray.

[19] Doctor Murray is a specialist obstetrician and a gynaecologist. Her expertise in both fields is not an issue between the parties. She compiled a report on the obstetric management and care provided to O[...]. In producing her report, she had a virtual consultation with the first plaintiff and obtained the background of her pregnancy and the medical history of O[...] since birth. I need not regurgitate what the first plaintiff informed her about her journey through pregnancy until she gave birth, as it is in line with the evidence of the plaintiff. Based on the information she received from the plaintiff, Dr Murray opined that at the time the first plaintiff visited the hospital for the first time, she must have been in latent labour i.e. early stages of labour because the pain continued until ‘*she gave birth 12 to 24 hours later*’, therefore it was not false labour and she should not have been sent home by the nursing staff. She testified that sending the first plaintiff home without having assessed her and the fetal condition indicates substandard care on the part of the defendant’s staff.

[20] Dr Murray referred to Guidelines for Maternity Care in South Africa 2002 and 2007. (The guideline) She stated that the guidelines are set out by the Department of Health as a manual for midwives and doctors, specifically in

Public Health hospitals, as they give recommended practice and management of pregnant women to avoid adverse outcomes and to give a safe level of recommended care, which is usually evidence-based. Had the defendant's staff confirmed her as probably being in latent labour, she would probably have been admitted and managed according to the guidelines which stipulate that the following should be performed at intervals namely; *'the maternal blood pressure and pulse rate should be assessed 2 hourly, the fetal heart rate and contractions should be assessed 2 hourly, cervical dilation should be assessed 4 hourly.'*

[21] Dr Murray stated that labour is divided into three stages. The first stage is that part of labour from the onset until the mother is fully dilated, which is 10cm dilated. The second stage is when the mother is fully dilated, that is, during the time when she will also start pushing or bearing down. This is the most intense part of labour because it culminates in the child being born. The third stage is the delivery of the placenta, and the immediate care of the woman post birth. She stated that what is critical is the examination and monitoring of the foetal well-being throughout labour. She testified that labour becomes progressively stronger, and the risks of foetal compromise increase as the labour becomes stronger. Monitoring of the foetal conditions commences from every two hours in latent labour, to every 30 minutes in active labour and every 5 minutes in the second stage of labour. Even contractions must be assessed every 30 minutes in

active labour. It is important to observe contractions because they result in transient hypoxia, which is tolerated well by a normal foetus. If it is not within normal limits, then it poses a risk of the foetus becoming hypoxic. She stated that every time the uterus contracts, for 30 to 60 seconds, blood through the placenta stops (which means there is no supply of oxygen to the baby), and that is a normal process and a healthy baby and a healthy labour can withstand such short intervals of impaired blood flow because it is part of the normal labour process. She said monitoring is important in cases where labour might be complicated, like where perhaps the labour takes too long, or contractions are too hard or frequent, or the baby does not tolerate that hypoxic stress as labour progresses, with heart rate changes which signify their distress. In that event, the medical staff should assist in the delivery of the baby. She said prolonged contractions lead to brain injury. She stated that since they do not have that ‘magic ball’ which can tell which baby would withstand labour, monitoring becomes key. She said monitoring of the foetal heart rate is crucial. It should be done every 30 minutes. She was of the view that the plaintiff’s labour was unmonitored, unattended, and neglected to an extent that it was fair for her to say she received no medical care at all.

[22] As aforesaid, Dr Murray ruled out that the injury could have occurred antenatally, even though the medical records are scanty. That is so, because the foetus was probably appropriately grown, there were no noted abnormalities, no

congenital abnormalities on MRI, there was no sepsis, no trauma and no pregnancy complications and all that made the likelihood of antenatal injury very low. As aforesaid, she was of the opinion that this matter supports the premise that the brain injury could have been caused by hypoxia and which probably occurred during labour. Amongst other reasons why she said so, is because; (a) the main risk factor for the injury was labour which was unmonitored, unattended and probably neglected, (b) although a healthy foetus will undergo various cardiovascular adaptations aimed at directing blood and oxygen delivery to vital organs such as the brain, if the oxygen debt is ongoing, eventually even a previously healthy foetus will run out of reserves and will progressively deteriorate and decompensate, becoming hypoxic and finally (c) there is no documentation of a sentinel event. As previously stated, she described a sentinel event as a sudden obstetric emergency and catastrophe, which is normally '*a call for help*', that would require a team approach at management and would be readily evident to the mother and would be captured in the Road to Health Card. She confirmed that the available medical records make no mention of a sentinel event occurring during the birth of O[...]. The first plaintiff's history also does not indicate such an event. She reiterated events which are recognised as placental abruption, cord prolapse, etc.

[23] Dr Murray had access to limited pediatric records, which were provided to her. In terms of the records, O[...] was diagnosed with hypoxic ischemic

encephalopathy. That indicated that the baby had been deprived of oxygen, and that manifests as a neurological sign due to damage to the brain and possibly other vital organs from lack of oxygen. As noted by other experts, she also observed that the notes revealed that she had an Apgar score of 3 and 5, which was very low, thus indicating that O[...] had very little sign of life. Even after birth, it remained at 5, meaning that he was in a poor condition. O[...], sometime after birth, was diagnosed with microcephalic spastic cerebral palsy (MSCP), which means that his head did not grow after birth as there was damage to the brain. She described MSCP as a neurological syndrome disease an aftermath of damage to the brain. She described it as mainly caused by spastic hypoxic damage and the spastic type, which is most associated with hypoxic damage. That, to her, was the cause of seizures because the brain injury manifests with neurological signs (the seizures). As aforesaid, Dr Murray concluded, like the other two experts, that the injury to O[...] was solely caused by the medical staff of the second defendant in their neglect to provide the first plaintiff with any form of care and treatment during her labour. She concluded that the first plaintiff received substandard care.

C. The issues.

[24] The issues before me require the determination of negligence and causation. I have to determine: (a) whether the defendant's medical staff was negligent in the medical care and treatment of the first plaintiff during the

labour and delivery of O[...], and (b) whether such negligence caused him hypoxic ischemic brain injury resulting in cerebral palsy.

D. The applicable law and its application on the facts.

[25] Neethling-Potgieter-Visser Law of Delict;² defines negligence; thus, “*The defendant is negligent if the reasonable person in his position would have acted differently; and according to the courts the reasonable person would have acted differently if the unlawful causing of damage was reasonably foreseeable and preventable.*” The test for negligence was stated by Holmes JA in *Kruger v Coetzee*³, and see also *Transnet LTD t/a Metrorail and another v Witter*,⁴ as follows:

“For the purposes of liability *culpa* arises if -

(a) a *diligens 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.

(b) the defendant failed to take such steps.

² 6th edition at page 13.

³ 1966(2) SA 428 (A) p4 30 E-G.

⁴ 2008 (6) SA 549 (SCA) at p553 D-F.

This has been constantly stated by this Court for some 50 years. Requirement (a) (ii) is sometimes overlooked. Whether a *diligens 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. Hence the futility, in general, of seeking guidance from the facts and results of other cases.” (footnotes omitted).

[26] As a rule, a person does not act wrongfully for the purposes of the law of delict if he omits to prevent harm to another person. Thus, the point of departure is that a person is generally not liable where his omission or *omissio* - his failure to act positively to prevent loss factually infringes the interests of another. Liability follows only if the omission was in fact wrongful - and this will be the case only if (in the particular circumstance) a legal duty rests on the defendant to act positively to prevent harm from occurring and he failed to comply with that duty. The question of whether such a duty exists is answered with reference to the flexibility criterion of the legal convictions of the community and legal policy. The test to determine whether the omission conflicted with the convictions of the community is purely objective, in the sense that all the relevant factors of a particular case must be taken into consideration. Such factors have been developed over a considerable period and are indicative of the existence of a legal duty to act positively to prevent harm. A person acts in a *prima facie* wrongful manner when he creates a new source of danger by means of positive conduct (*commissio*) and subsequently fails to eliminate that danger

(omission), with the result that harm is caused to another person. Prior conduct is, however, not a prerequisite for the existence of such a legal duty: other factors may also point to the existence of a legal duty to act positively.⁵

[27] It should be appreciated that it is the established principle of our law that negligent conduct is not actionable unless it is also wrongful. However, an omission will be wrongful only when it occurs in circumstances where the law regards it as such to attract liability. Otherwise stated, it is not wrongful when the law, for reasons of legal policy, affords an immunity against liability for such an omission, whether negligent or not; in these circumstances, the question of fault does not even arise; the defendant enjoys immunity. A negligent omission will be regarded as wrongful and therefore actionable only when the legal convictions of the community impose a legal duty, as opposed to a mere moral duty, to avoid harm to others through positive action.⁶ In certain instances of omission, a special relationship between parties may be an indication that one party has a legal duty towards the other to prevent harm. The existence of a contractual relationship may indicate such a legal duty as, for instance, a relationship between a doctor and patient.

[28] To succeed in their claim, the plaintiffs bore the onus to prove on the balance of probabilities that the defendant was negligent. As reflected in paragraph 25 above, the test is that of a reasonable person in the position of the

⁵ Neethling-Potgieter-Visser, *supra* at pages 57-59.

⁶ Local Transitional Council of Delmas v Boshoff 2005 (5) SA 514 (SCA).

defendant. What a reasonable person is generally in terms of the law is now trite⁷. However, when it comes to experts, the test for negligence is that of the so-called reasonable expert in the field so affected. Dealing with the degree of care expected of a surgeon in *Van Wyk v Lewis*.⁸ Innes JA said the following about the standard of a reasonable surgeon;

“It was pointed out by this Court, in *Mitchell v Dixon* (1914, A.D., at p. 525), that "a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care. And in deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level.”

Similarly, *in casu*, the *onus* is on the applicant to discharge and to establish that the defendant’s employees acted negligently in the treatment meted out to the first plaintiff and O[...] before and after his birth.

[29] In *AN v MEC for Health: Eastern Cape*,⁹ the Court said the following about medical negligence:

“[3] It is worth briefly sketching the legal landscape governing such a claim. ‘[I]n order to be liable for the loss of someone else, the act or omission of the defendant

⁷ Neethling- Potgieter- Visser, *supra* at page 135 and the authorities referred thereto.

⁸ 1924 AD 438 at 444.

⁹ 585/2018) [2019] ZASCA 102; [2019] 4 All SA 1 (SCA) (15 August 2019).

must have been wrongful and negligent and have caused the loss.’ Wrongfulness involves the breach of a legal duty. The legal duty in the present matter arose when the mother was admitted to the hospital in labour. The staff assumed a duty to care for mother and foetus during the birth process without negligence, in other words, as would reasonable staff in their position. More particularly, they had a duty to monitor the condition of mother and foetus and act appropriately on the results. They negligently failed to do so, in breach of that legal duty. Their conduct was thus wrongful. But this, in and of itself, has never been sufficient to found delictual liability. The wrongful conduct must cause the wronged person to suffer loss. The first step in proving this is to prove that the wrongful conduct of the staff caused the baby to suffer brain damage. The appellant accordingly bore an onus to prove this. Wrongfulness should not be conflated with factual causation.” (footnotes omitted)

[30] The defendant, relying on *VN on behalf of PN v The Member of the Executive Council for Health & Social Development*,¹⁰ submitted that the plaintiff, in the absence of medical evidence or the records, must still establish negligence, because medical records constitute a neutral factor. This may be so, but I have evidence from the first plaintiff which has not been gainsaid by the defendant. Her evidence remains unchallenged and constitutes the truth of what occurred to her at the hospital in the morning, afternoon and at night when she eventually gave birth. Decerning from her evidence of how she was treated by the defendant employees (nurses) when she reported in the morning and

¹⁰ (132/2015) [2022] ZAECQBHC 13 (17 June 2022).

afternoon, I am in no doubt that from those instances, the defendant's employees acted negligently in treating her, even at that stage. It is inconceivable that the first plaintiff would have gone the hospital in the morning if she was not feeling labour pains. That is logic and needs no elucidation, especially in the backdrop that she gave birth a few hours thereafter. It was expected of the nurses to have examined the first plaintiff to check whether she was in early labour or not. It was careless and negligent of the nurse to have sent her back home without examining her. This was exacerbated by the defendant's employees' conduct when they failed to attend to her on the second occasion in the afternoon. Even on that occasion, she was left in her own devices until her 'water broke' in the toilet. She was unexpectedly assisted by a fellow patient who happened to be in the bathroom. As testified to by Dr Murray, the nursing staff and doctors are called upon to heed to the Guidelines referred to above. They are, as stipulated step by step by Dr Murray as reflected in paragraph 21 above, the things they should have done when she presented herself in hospital. They neglected to do so.

[31] The facts of this matter are distinguishable from those in VN relied upon by the defendant. Van Zyl DJP in VN summarised the issue; thus,

“The issue raised herein is factual. It concerns mainly the reliability of the plaintiff's evidence against that of Sister Minnaar, that fundal pressure was applied during labour. As counsel for the defendant correctly points out, the issue of fundal pressure

became the touchstone of the plaintiff's case after her expert witnesses effectively had to concede that the monitoring of the first stage of her labour was in order, and that nothing outward had been noticed which could have been indicative of foetal distress." (underlining is mine).

In the instant matter, there was no monitoring at all during her first stage of labour, hence the experts agree that that was grossly negligent and Dr Murray's conclusion that the care she received was substandard. Paragraphs 36, 38, and 39 of VN, relied upon by the defendant, merely regurgitate or set out the legal position as it pertains to the medical negligence cases.

[32] As previously said, Dr Alheit found that the injury to the brain was caused by a lack of oxygen in the brain, which occurred over a prolonged period. In the absence of a sentinel event, the same brain injury occurs after ongoing hypoxia over a prolonged period in which the foetus is compromised but not injured, and then finally cardiac compromise (ischemia) occurs, resulting in the pain injury. However, he referred to an obstetrician or pediatrician. Dr Kara, a pediatrician, based on the pediatric records, which revealed that at birth, O[...] weighed 2,7 kg and had an Apgar score of 3 and 5, and the information he received from the first plaintiff, O[...], could not have sustained the injury during pregnancy nor after delivery. He indubitably concluded that the injury occurred during birth because O[...] was diagnosed with moderate hypoxic ischemic encephalopathy after birth, indicating that the

injury occurred at birth. To confirm his opinion that O[...] was critical at birth, he was placed on a ventilator and was fed through a tube and suffered seizures after three months. As aforesaid, Dr Murray categorically stated that the first plaintiff should not have been sent home without medical examination on the first occasion she visited the hospital. As previously stated in paragraph 30 above, I also found that to defy even logic because the first plaintiff would not have gone to the hospital if she did not feel the medical urge to do so and to only come back again shortly after she had returned home. Dr Murray further relied on the failure by the medical staff to adhere to the guidelines. That is not an assumption by her; it is the word of the plaintiff that she was not attended to until her “*water broke*”, which was hours after she presented with labour symptoms. She ruled out that the injury could have occurred during pregnancy, like the other experts, because of the lack of complications, and no congenital abnormalities on the MRI. She concluded that the injury could have been caused by hypoxia that probably occurred during labour. She said that there was no sentinel event because the first plaintiff would know because *‘that is a sudden emergency and catastrophe which normally is ‘a call for help’ that would require a team approach at management and would be readily evident to the mother and would be captured in the Road to Health Card.’*

[33] The findings of the experts and the evidence of the plaintiff put paid to the argument by the defendant that there is *‘no evidence to draw an inference*

that the defendant's staff was negligent'. Their opinion is based, among others, on the credible and unchallenged evidence of the first plaintiff. Their opinions were unchallenged. The evidence given by the experts is chronologically sound and backed up by facts from the first plaintiff, their expertise and literature by scholars in their respective fields of expertise. I therefore found that the defendant's employees were negligent in treating the first plaintiff and O[...].

[34] The question of damage through conduct, or, in other words, a causal nexus between conduct and damage, is required for a delict. A person cannot be liable if he has not caused any damage. The question of whether there is a causal nexus in a particular case is a question of fact that must always be answered considering the available evidence and relevant probabilities, and that may, in suitable instances, be dealt with first during a trial¹¹. The plaintiffs must establish that the negligence of the defendant's employees was the cause of the damage suffered by them. That must be determined from the conclusions drawn from the relevant facts and the probabilities of this matter. The test or method for determining factual causal connection has always been the *conditio sine qua non*, i.e. an inquiry whether one fact follows the other or also known as the '*but for*' test. The test is not without problems or criticism. In *International Shipping Co (PTY) Ltd. v Bentley*¹², the court formulated the approach as follows:

¹¹ see Neethling-Potgieter-Visser; supra at page 175.

¹² 1990 1 SA 680 (A) page 700.

“The inquiry is a factual one and relates to the question whether the defendants wrongful act was a cause of the plaintiff's loss. This has been referred to as “factual causation”. The inquiry is generally conducted by applying the so-called “but -for- test”, which is designed to determine whether a postulated cause can be identified as a *causa sine qua non* of the loss in question. In order to apply this test, one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This inquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical cause of lawful conduct and the posing of the question as to whether upon such a hypothetical hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss, *aliter*, if it would not so have ensued. If the wrongful conduct is shown in this way not to be it *causa sine qua non* of the loss suffered, then no legal liability can arise”

[35] The learned authors¹³ state that:

“In the case of an omission (omission) the *conditio sine qua non* requires that a hypothetical act be “inserted” into the particular set of facts - this can probably also be regarded as the mental “removal” of the defendant's omission. If hypothetical positive conduct of the defendant could have prevented the damage, it can be said that the defendant's omission was the cause of the damage. This inquiry requires a retrospective analysis of what would probably have happened, based upon the evidence and what could have been expected in the ordinary course of a human endeavour.”

¹³ Neethling- Potgieter-Visser at page 179; see also Lee v Minister for Correctional Services 2013 (2) SA 144 (CC); 2013 (1) SACR 213; 2013 (2) BCLR 129 at para. 40 and 41).

Similarly, the test for causation was dealt with as follows in *Mashongwa v Prasa*.¹⁴

“Lee never sought to replace the pre-existing approach to factual causation. It adopted an approach to causation premised on the flexibility that has always been recognised in the traditional approach. It is particularly apt where the harm that has ensued is closely connected to an omission of a defendant that carries the duty to prevent the harm. Regard being had to all the facts, the question is whether the harm would nevertheless have ensued, even if the omission had not occurred. However, where the traditional but-for test is adequate to establish a causal link it may not be necessary, as in the present case, to resort to the Lee test.”

[36] The submission by the defendant is that there is no evidence that the cause of the injury was foreseeable and preventable, contending that it is not known how the condition the baby was inside the uterus, and prior to his delivery and what the cause was for his condition after or upon delivery. The testimony of the three experts, especially Dr Murray, as dealt with above, talks to the issue now raised and relied upon by the defendant. Dr Murray spoke to the Guidelines which must be applied to every case where there is a woman who is about to give birth. As alluded to, the Guidelines speak to the monitoring of the mother and the foetus from the beginning of labour until the birth of a child, as aforesaid. The Guidelines were produced to make sure that abnormalities during labour are detected early to prevent harm to both mother

¹⁴ [2015] ZACC 36 at para 65.

and baby. Failure to adhere to these Guidelines frequently results in catastrophic health hazards either to the mother or baby, as is the case in this matter. There is ample evidence to sustain the contention that there was no compliance at all with the Guidelines. The birth of O[...] was clinically mismanaged from the time the first plaintiff presented with labour pains and attended the hospital until she gave birth. Had the defendant's employees not omitted to monitor the labour and birth of O[...], the latter would not have suffered the injury, as testified to by the first plaintiff and the doctors, running the risk of repeating myself. Dr Murray testified that if there was monitoring, the medical staff would have picked up in the early stages of labour that there was foetal distress or compromise through the heart rate and would have performed the necessary intervention. Had the medical staff monitored the labour, the probability is that O[...] would not have suffered the brain injury. But, for their conduct, O[...] would not have suffered the injury complained of.

[37] In a matter similar to this, Molemela JA¹⁵, as she then was, said the following:

“Both obstetric experts agreed that the exact time at which foetal distress occurred was impossible to determine due to the absence of clinical notes detailing the last 95 minutes of the respondent's labour. Despite it having been the hospital staff's

¹⁵ MEC for Health, Limpopo v L W M obo D M (502/2021) [2022] ZASCA 146 (26 October 2022).

obligation to monitor the foetal heart rate and to make the necessary clinical notes, which it failed to do, the appellant tried to capitalise on the fact that the exact times at which the foetal heart rate was indicative of foetal distress could not be established. In my opinion, it is fallacious to posit that where a woman in labour has not been monitored by hospital personnel at all during the most critical stage of her labour, the MEC responsible for the relevant hospital should escape liability arising from the negligence of its employees purely on the basis that the exact timing of the hypoxic injury of an acute profound nature cannot be ascertained. To do so would be to ignore uncontested evidence that, on probabilities, shows a link between the negligence and the harm that ensued.” (Emphasis added).

These are equally relevant and find application in this matter. I find that the plaintiff has, on a balance of probabilities, established negligence of the defendant’s staff is the direct cause of the brain injury and the subsequent cerebral palsy O[...] suffered.

E. Costs.

[38] There is no reason that the costs should not follow the results. However, the scale should be B opposed to scale C as proposed by the defendant.

F. Order

[39] Consequently, I make the following order.

1. The defendant is declared to be 100% liable for the proven or agreed damages suffered by the plaintiff as a result of the negligent conduct

of the medical staff at the Frere Hospital, resulting in O[...] suffering brain injury and resultant cerebral palsy.

2. The defendant shall pay the plaintiff's costs of suit (on the High Court scale B) to date hereof, such costs to include:

2.1 The costs of counsel.

2.2 The costs incurred in obtaining the medico-legal reports, addendums and joint minutes, as well as, where necessary, the qualifying attendance reservation and preparation fees of:

- Dr Alheit (Radiologist)
- Dr Kara (Paediatrician)
- Dr Murray (Obstetrician)

3. All reserved costs to date of this order.

4. The defendant shall pay interest on the aforesaid costs at the current prescribed legal rate of interest from the date of allocator or agreement to the date of payment thereof.

M MAKULA
JUDGE OF THE HIGH COURT

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Date heard : 16 May 2024 and 05 March 2025

Judgment delivered : 09 September 2025