Reportable:	**NO**
Circulate to Judges:	**NO**
Circulate to Magistrates:	**NO**
Circulate to Regional Magistrates:	**NO**

IN THE HIGH COURT OF SOUTH AFRICA
NORTH WEST DIVISION, MAHIKENG

CASE NO:2058/2019

In the matter between:-

LPM obo LM Plaintiff

and

THE MEC FOR HEALTH:
NORTH WEST PROVINCIAL GOVERNMENT Defendant

***Coram*:** **Mfenyana J**

This judgment was handed down electronically by circulation to the parties' representatives *via* email. The date and time for hand-down is deemed to be **31 March 2026**.

ORDER

a. The defendant is liable for payment of 100% of the plaintiff's proven or agreed damages, in her representative capacity as the mother and natural guardian of LM, born on 31 August 2013, consequent upon the hypoxic-ischaemic brain injury, manifesting as cerebral palsy, which the minor child suffered as a result of the negligent conduct of the medical and nursing personnel at the Klerksdorp Hospital on 31 August 2013.

b. The issue of quantum is postponed *sine die*.

c. The defendant is ordered to pay the plaintiff's taxed or agreed costs in respect of the determination of the issue of liability on an attorney and client scale, taxed on the high court scale, within 14 days of taxation or agreement, including:

    i. The qualifying preparation and reservation costs, travel and accommodation, attendance of the plaintiff's witnesses at court, as well as their costs in respect of consultations, the preparation of their reports, addenda, and joint expert minutes, if any.
    ii. The plaintiff's costs of attendance at medico-legal examinations and related costs.
    iii. The costs consequent on the employment of counsel.

JUDGMENT

Mfenyana J

Introduction

[1] The plaintiff instituted proceedings against the defendant on behalf of her minor child, LM ("the minor child"), for damages arising from a brain injury suffered by the minor child during birth at the Klerksdorp Hospital (the hospital).

[2] The plaintiff alleges that the defendant owed her a duty of care to ensure that its employees provided medical treatment with the diligence reasonably expected of qualified medical practitioners and nursing staff. She further alleges that the hospital staff, acting within the course and scope of their employment with the defendant, were negligent in various respects in their treatment of her and the minor child. The plaintiff, therefore, contends that the defendant breached its duty of care towards her, which also extended to the minor child.

[3] The defendant disputes the plaintiff's claim and seeks its dismissal.

[4] On 24 October 2023, following application and subsequent agreement between the parties, I granted an order separating the issues of merits and quantum. The matter thus proceeded only on the issue of merits, with the issue quantum postponed *sine die.*

Preliminary issues

[5] From the beginning, the trial of this matter was marred by delays, irregularities and a change of tack orchestrated by the defendant. This situation persisted throughout the trial until its conclusion and remained unchanged despite several postponements in the matter.

[6] Before the commencement of the trial, joint minutes were filed in respect of various experts. Notably, with regard to the obstetrician-gynaecologists, two sets of joint minutes had been filed, one between Dr Songabau for the plaintiff

and Dr Manthata-Cruywagen for the defendant, and subsequently between Dr Songabau for the plaintiff and Dr Mtsi for the defendant.

[7] When the trial commenced on 24 October 2023, Ms Sidzumo, counsel for the defendant, informed the court that the defendant was not seeing eye to eye with Dr Manthata-Cruywagen due to payment arrangements between them, which led to the defendant abandoning Dr Manthata-Cruywagen's report together with the joint minute she had compiled with Dr Songabau. This appears to be the reason why the defendant enlisted the services of Dr Mtsi, who duly engaged with the plaintiff's expert and compiled another joint minute as already noted.

[8] The defendant, thus, brought an application from the bar seeking to reintroduce Dr Manthata-Cruywagen's report as well as the joint minute between her and Dr Songabau.

[9] The plaintiff opposed the application, citing prejudice as it had prepared its case and arranged its affairs on the basis that the defendant would not be proceeding on the basis of Dr Manthata-Cruywagen's report and the joint minute she compiled with Dr Songabau. Mr Patel argued on behalf of the plaintiff that the plaintiff had consequently consulted on that basis, disregarding these reports and would need to reconsult with its witnesses to accommodate the new developments, should the court be inclined to grant the application.

[10] For the purpose of fully ventilating the issues, I granted the application. It was in the interests of justice for me to do so. In doing so, I took into account the timing of the application and the fact that the defendant had ample opportunity

before the hearing date to make all necessary arrangements to avoid a postponement. I accordingly postponed the matter and ordered the defendant to pay the costs occasioned by the postponement.

[11] When the matter resumed, nine months later the defendant's goal post had shifted. This time, Ms Sidzumo submitted that Dr Manthata- Cruywagen, (on occasion of whose report the matter had been postponed on the previous occasion) was not available and was not cooperating with the defendant. However, despite having engaged Dr Mtsi on the same aspects, the defendant preferred the angle taken by Dr Manthata- Cruywagen as it put a different spin on the matter, counsel submitted. She asked that the court should subpoena Dr Manthata-Cruywagen.

[12] On the other hand, Mr Patel, counsel for the plaintiff, argued that in the circumstances described by the defendant, Dr Manthata-Cruywagen's report and the associated joint minute should be excluded. He argued that the defendant's conduct was deliberate and contemptuous as it was open to the defendant to subpoena Dr Manthata-Cruywagen if it so wished.

[13] Having considered the submissions by both counsel, I ruled that the matter should proceed.

[14] It further appears from the record that on 6 June 2024, the court granted an order following an application by the plaintiff seeking to compel the respondent to instruct Dr Manthata-Cruywagen to attend to the obstetrician-gynaecologist joint minute.

Factual matrix

[15] The plaintiff, a 19-year-old pregnant woman, was admitted to Klerksdorp Hospital on 28 August 2013 after being transferred from the Orkney Clinic (the clinic) with lower abdominal pain. At about 00h05 on 31 August 2013, she delivered the minor child vaginally. She avers that she underwent prolonged labour in circumstances where a caesarean section (C-section) was indicated, resulting in the minor child's diagnosis of cerebral palsy due to birth asphyxia.

[16] It is common cause that the minor child was diagnosed with cerebral palsy and mental retardation consequent upon suffering a hypoxic-ischaemic insult due to birth asphyxia and/ or hypoxia. He also has epilepsy and presents with developmental delays, speech deficits and behavioural problems.

[17] Expert reports were filed on behalf of both parties, and in specific instances, which I deal with hereunder, joint minutes were prepared by the parties' corresponding experts on key findings, including the pattern of the injury and the probable time of injury.

[18] The remaining disputes relate to the care of the plaintiff and the minor child and whether the medical staff of the defendant were in any way negligent during the labour process.

[19] As it has become prevalent in matters of this nature, clinical records and other relevant documents are in short supply.

[20] The following experts prepared joint minutes:

20.1. Radiologists- Prof Andronikou (for the plaintiff) and Dr Kamolane (for the defendant).

20.2. Midwives – Ms Zondo(for the plaintiff) and Prof. du Plessis(for the defendant).

20.3. Obstetrician- Gynaecologists- Dr Songabau (for the plaintiff) and Dr Manthata-Cruywagen (for the defendant);

20.4. Obstetrician- Gynaecologists – Dr Songabau (for the plaintiff) and Dr Mtsi (for the defendant.

20.5. Paediatricians – Dr Kara (for the plaintiff) and Dr Lombard (for the defendant).

Joint Minute of the radiologists – (Prof Adronikou and Dr Kamolane)

[21] In their joint minute, the radiologists agree on most aspects of the injury suffered by the minor child. In addition, Dr Kamolane noted abnormalities in the Peri-Rolandic area of the brain. They conclude that the Magnetic Resonance Imaging (MRI) scan performed on the minor child on 27 September 2019 demonstrates features of a prior basal-ganglia-thalamus injury, in a brain of term maturity, consistent with a perinatal acute profound hypoxic ischaemic brain injury in a term infant, which, at the time the scan was performed, was in the chronic stage of evolution. The MRI further records that there were no definitive features of a congenital infection or malformation.

[22] The significance of the agreement between the radiologists is that the pattern observed in the brain of the minor child at the age of 6 indicates that the minor

child suffered a severe, sudden lack of oxygen and blood flow to the brain around the time of birth.

Joint minute of the midwives (Ms Zondo and Prof. du Plessis)

[23] The midwives agree that the plaintiff could be categorised as a moderate risk patient due to lack of antenatal attendance, maternal anaemia, a urinary tract infection, and a sexually transmitted disease on admission to the hospital.

[24] They also agree that the plaintiff was transferred to the hospital without delay and was correctly referred to higher levels of care on observation of tachycardia.

[25] They agree that the plaintiff's latent phase of labour was excessively prolonged, and her assessment and monitoring were not done in accordance with the protocol.

[26] They further agree that labour was accelerated by administering oxytocin, and the second stage of labour was not prolonged, but presented with difficulties, including the hyperflexion of the legs (which is not standard practice with vaginal delivery) and lack of maternal effort.

[27] The midwives further note that the minor child was born with low Apgar scores.

[28] No documentation was available for the immediate neonatal period, and no progress reports, completion of the latent phase observation chart or

assessment and progress of labour were provided. They deferred the care and management of the neonate after birth to the paediatrician.

[29] The midwives disagree on whether fetal problems were observed during the prolonged latent phase of labour, with Ms Zondo noting the lack of accurate documentation and Prof du Plessis noting that on admission, the fetal heart rate was normal and labour was allowed to continue, which would not have happened if the fetal condition was compromised.

[30] The second point of disagreement is whether the fetal heart rate remained without suspicion until the commencement of the second stage of labour. Ms Zondo does not agree, while Prof du Plessis opines that the fetal heart rate as plotted in the partograph at 23h00 on 30 August 2013 was normal at 142 beats per minute (bpm), just half an hour before the commencement of the second stage of labour.

[31] Finally, Ms Zondo notes that the plaintiff's account indicates that some practices by the nursing and medical staff amounted to 'obstetric violence' and caused her trauma during childbirth, an issue Prof du Plessis declined to comment on.

Joint minute of the paediatricians(Dr Kara and Dr Lombard)

[32] Drs Kara and Lombard reached agreement on all aspects. In particular, they agree that the minor child has dystonic cerebral palsy and impaired cognitive function. She is partially ambulant and did not have any dysmorphic or syndromic features.

[33] Importantly, the paediatricians agree that there were no antenatal risk factors for a hypoxic ischaemic injury**.** They further agree that there was fetal tachycardia at approximately 22h00 on 28 August 2013, and antibiotics were commenced. At 22h45, the CTG was described as 'reactive' and later confirmed by a doctor at 00h45 on 29 August 2013.

[34] They also agree that there is no record of a sentinel hypoxic-ischaemic event during the plaintiff's labour, and that the minor child was delivered vaginally at term, with an episiotomy on 31 August 2013 at 00h05. She was floppy, unresponsive and gasping, with Apgar scores of 3/10 and 5/10. She was resuscitated at birth and put on oxygen therapy. His weight, length and head circumference were in keeping with an appropriate gestation for a term baby.

[35] Regarding the timing of the injury, both paediatricians opine and agree that the injury was probably intrapartum, due to the (i) augmentation of labour, (ii) substandard fetal monitoring as agreed by the obstetricians, (iii) fetal distress on 30 August 2013, (iv) low Apgar scores and resuscitation at birth, and (v) neonatal encephalopathy (with no record of any other cause of such outcome due to inadequate records).

[36] Significantly, the paediatricians agree that the presence of a central pattern of hypoxic-ischaemic injury and hypoglycaemia, as found in the minor child, when combined with the neonatal encephalopathy, has an over 80% probability of being due to intrapartum hypoxic-ischaemia.

Joint minute between the obstetrician-gynaecologists (Dr Songabau and Dr Mtsi)

[37] In their joint minute, Drs Mtsi and Songabau agree on various aspects of the plaintiff's pregnancy and labour as detailed hereunder:

Antenatal care

37.1. They agree that on probabilities, the plaintiff was a healthy 19-year-old, in her first pregnancy, with no obvious pre-pregnancy or medical risk factors; her blood test results were normal. She was assessed as a low-risk patient to attend antenatal care and deliver at the local clinic. The pregnancy progressed well and without complications up to full-term gestation; blood pressure and haemoglobin were normal. With reference to the Guidelines for Maternity Care in South Africa, 2007(Maternity Guidelines), they both conclude that the plaintiff's antenatal care was satisfactory.

Intra-partum care

37.2. At approximately 22h00, on examination at the clinic, a yellowish vaginal discharge was noted, 'show' was present, and the cervix was 1 cm dilated. The plaintiff was diagnosed to be in the latent phase of labour with fetal tachycardia at 173- 177bpm. Membranes were intact, and there was no caput or moulding. The vaginal infection was treated with antibiotics, and she was given Ringer's Lactate and the doctor on call (Dr Maie) was notified to review the patient. At 22h50, the tachycardia had persisted, and the fetal heart rate

was at 163-165 bpm, prompting the nursing staff to notify the doctor on call. However, Dr Maie could not be reached, and the nurses transferred the plaintiff by ambulance to Klerksdorp Hospital for fetal tachycardia in the latent phase of labour.

37.3. The plaintiff was admitted to Klerksdorp Hospital at 23h45, and an hour later she was seen by a doctor, who confirmed that she was in the latent phase of labour, with the cervix 2 cm dilated. The CTG was reactive. The latent phase of labour continued from 22h00 on 28 August 2013, as noted by the nurses at the clinic and later confirmed by the attending doctor at the hospital, until 19h00 on 30 August 2013. The obstetricians agree that there was poor assessment and suboptimal fetal and maternal monitoring, which increased the likelihood of an adverse perinatal outcome.

37.4. The doctors note that the fetal tachycardia, which, according to the available CTG tracings, persisted for seven minutes at 19h20 on 29 August 2013, was non-reassuring and pathological on 30 August 2013, sustained for 15 minutes, with no accelerations and no decelerations. No contractions were recorded. Notably, the obstetricians agree that fetal tachycardia, with reduced variability, is a non-reassuring sign which warrants delivery, as these abnormalities are indicative of fetal distress. They further agree that the care given to the plaintiff in this regard was substandard and the plaintiff ought to have been indicated for intrauterine resuscitation and an emergency C-section, which was not done.

37.5. They further note that there are contradictions between the fetal heart rate shown in the CTG tracings and that recorded by the nurses. There was also no continuous CTG monitoring while the plaintiff was on augmentation of labour. According to the obstetricians, these factors directly increase the probability of an adverse perinatal outcome.

37.6. The doctors note that the minor child developed early onset of neonatal encephalopathy within 24 hours of delivery, which may be a marker of intrapartum fetal hypoxia. The obstetricians deferred to the paediatrician for issues relating to HIE and birth asphyxia.

37.7. Both doctors agree that there was no sentinel event to justify the poor outcome of the minor child.

[38] The obstetricians further agree that in the active phase of labour, the plaintiff also experienced substandard care for various other reasons, including the inappropriate administration of oxytocin, as augmentation of labour was contraindicated in the presence of fetal distress; misdiagnosis of cephalopelvic disproportion(CPD), failure by the doctor on call to timeously review the patient and indicate a C-section by 16h00 on 30 August 2013, lack of continuous CTG monitoring during augmentation of labour, lack of senior supervision as the doctor remotely managed the patient and remotely ordered Pitocin, which itself caused more injury to the hypoxic foetus. The doctors added that this amounts to malpractice and negligence.

[39] In conclusion, the obstetricians agree that the management of the minor child

was complicated by several other factors, including poor record keeping, substandard care at Klerksdorp hospital with the latent phase of labour prolonged by 46 hours, with persistent fetal tachycardia and slow progress of labour; poor intrapartum fetal and maternal monitoring, inappropriate use of the partogram, misdiagnosis and incorrect interpretation of CTG tracings suggestive of fetal distress, failure to intervene in the presence of persistent fetal tachycardia and indicate intrauterine resuscitation and emergency C-section.

[40] Regarding the timing of the injury, the obstetricians opine that the injury may have occurred during the second phase of labour, shortly before delivery. This, they agree is evidenced by various factors such as the description of the minor child after birth as well as the neonatal course, the diagnosis of severe birth asphyxia and Meconium Aspiration Syndrome, the fact that the minor child had seizures within 24 hours of life and the radiological findings which are all in keeping with moderate to severe hypoxic ischaemic encephalopathy which occurred secondary to progressive and sustained intrapartum hypoxia. They, however, concede that the timing of the injury cannot be stated with certainty, as the MRI cannot confirm it.

[41] The doctors further note that if the combined experts agree that the brain injury was preventable and was likely caused by intrapartum hypoxia, the substandard management of the plaintiff's labour would be implicated, which was the reason why the onset of fetal distress was missed and not in accordance with the Maternity Guidelines.

Report of Dr Manthata-Cruywagen and the joint minute between Dr Songabau and Dr Manthata-Cruywagen

[42] Whilst the report of Dr Manthata- Cruywagen forms part of the court record, it is, *stricto sensu*, not properly before the court, as there was no compliance with Rule 38(2) for its admission into evidence. It therefore lacks evidentiary value and thus cannot be considered. Furthermore, Dr Manthata- Cruywagen was not called to testify.

[43] The same goes for the areas of disagreement between Dr Manthata-Cruywagen, as raised in the joint minute. As she was not called to testify, her opinions as expressed in the joint minute remain inadmissible hearsay.

Evidence on behalf of the plaintiff

[44] Dr Songabau, the obstetrician-gynaecologist and Ms Zondo, the midwife, were also called to testify.

[45] To a large extent, Dr Songabau confirmed his findings and the agreements reached in the joint minute with Dr Mtsi.

[46] During cross-examination, he was questioned at length about his conclusion that the yellowish vaginal discharge on the plaintiff was non-specific and had no effect on the outcome of the minor child, which he maintained. He stated that it is a common symptom and in the absence of other components, such as a urinary tract infection, offensive smell and itchiness being noted, it has no

effect on the outcome of the minor child. He added that an intervention was made when the plaintiff was placed on antibiotics.

[47] In relation to his evidence that there was no proper monitoring and record-keeping, it was put to Dr Songabau that the staff took their work so seriously that they even noted seemingly insignificant observations, such as the yellowish discharge. He answered that staff did not always document the progress of labour and the baby's condition as required, and further testified that there was a discrepancy between the CTG and the partogram.

[48] Dr Songabau was further questioned about his erroneous reference to the plaintiff as a 15-year-old primigravida, which he conceded. It was then suggested that, given this basic mistake, his report might be riddled with further errors.

[49] Importantly, Dr Songabau testified that once it had been identified that there were contractions but dilatation was stationary; augmentation of labour should have been done at that stage, which in the present case was at approximately 19h00 on 30 August 2013. As such, the intervention at that stage was late. He maintained that the plaintiff's failure to attend antenatal care was immaterial, given the absence of co-morbidities. Responding to the evidence that the plaintiff was anaemic when she finally attended antenatal care, Dr Songabau stated that anaemia has no bearing on the well-being of the baby.

[50] Ms Zondo's testimony related to the management of the plaintiff's labour and poor record-keeping, which she stated was not available to prompt the

midwives. She also testified to the areas of disagreement with Prof du Plessis. Ms Zondo stated that there is no indication that labour was allowed to proceed because the fetal heart rate was normal, as there was no accurate recording.

[51] Regarding whether the fetal heart rate did not remain without suspicion until the second stage of labour, Ms Zondo testified that there was no adequate plotting for the entire time, and there was no plotting of the partogram from 18h00 on 29 August 2013 to 11h00 on 30 August 2013.

[52] Lastly, she testified that according to the patient narrative, the practices used by the nurses constitute obstetric violence practices. She, however, conceded that she did not interview the plaintiff.

Defendant's case

[53] On resumption of the matter, following a lengthy postponement, Mr Patel placed on record that his instructing attorney had received a telephone call from the defendant's attorneys that the defendant was conceding liability and was awaiting a response in respect of a proposed draft order transmitted to the defendant's attorneys.

[54] Ms Sidzumo informed the court that she held no instructions to concede liability, but merely not to continue with her cross-examination of Dr Songabau, who was under cross-examination on the previous occasion, and not to cross-examine any of the plaintiff's witnesses. She further placed on record that the defendant would not be calling any witnesses. She disagreed with Mr Patel that her discontinuation of cross-examination would render the matter uncontested

and susceptible to judgment by default.

[55] In its plea, the defendant pleads that the plaintiff was not in labour at the time of her admission and that her condition did not warrant a C-section. The defendant further pleads that the plaintiff was admitted with an infection, characterised by a yellowish vaginal discharge. The defendant further pleads that the plaintiff and her unborn child were monitored, and the plaintiff was advised regularly of the progress of labour. The defendant states that the plaintiff was in labour for 22 hours, from 01h30 on 30 August 2013 until delivery on 31 August 2013 and denies that the plaintiff's labour was prolonged.

[56] Notably, the defendant pleads that the outcome of the minor child was due to the plaintiff's failure to employ sufficient maternal effort during the active phase of labour; her failure to attend antenatal care until 28 weeks of gestation, at which point it was already very late, and this could have put the minor child's health at risk.

[57] In the alternative, the defendant pleads contributory negligence on the part of the plaintiff in failing to employ sufficient maternal effort and failing to attend antenatal classes and in having an infection and thus exposing the minor child.

[58] I understand the defendant's case, as can be gleaned from its plea, to be that the plaintiff was monitored appropriately, that labour was not prolonged, that a C- section was not warranted, and the outcome of the minor child was due to lack of maternal effort.

Status and purpose of the joint minutes prepared by the plaintiff's and defendant's experts

[59] In *Hal obo MML v MEC for Health, Free State*[1], the Supreme Court of Appeal (SCA) underscored the importance of joint minutes as follows: "It is trite that, where experts agree on a matter of fact in a joint minute, the parties are bound by that agreement and may not, without more, deviate from it without proper explanation and consideration of prejudice".

[60] In *Bee v Road Accident Fund*[2], the court held that where experts in the same field reach agreement, a litigant cannot be expected to adduce evidence on the agreed matters, and unless a trial court is dissatisfied with the agreement and the parties had been notified of the need to adduce evidence, it would be bound to accept the issues as agreed by the experts.

[61] Where medical certainty is virtually impossible, a court assessing expert evidence must decide whether, and to what extent, the opinions are supported by logical reasoning. It must be satisfied that the expert has weighed comparative risks and benefits and reached a 'defensible conclusion'.

[62] I cannot find any compelling reason, nor is there any suggestion that the agreement, which form the "total body of evidence" in this matter should be disregarded. They, therefore, remain binding on the parties. As decreed in *Bee*, those experts are not required to testify on the agreed issues unless such

[1] 2022 (3) SA 571 (SCA) para 49.
[2] 2018 (4) SA 366 (SCA).

clarification is required by the court.

[63] Where there are conflicting expert opinions, "the court must determine which, if any, of the opinions to accept, based on the reasoning and reliability of the expert witnesses. The court must determine whether and to what extent an opinion is founded on logical reasoning. An expert's function is to assist the court, not to be partisan. Objectivity is the central prerequisite (see *Michael & Another v Linksfield Park Clinic (Pty) Ltd & Another* **2001 (3) SA 1188** (SCA) paras 37-39; *Jacobs & Another v Transnet Ltd t/a Metrorail & Another* 2015 (1) 139 (SCA) paras 14-15). The expert must not assume the role of advocate. If the expert's evidence is to assist the court he or she must be neutral. The expert should state the facts or assumptions from which his or her reasoning proceeds (*PriceWaterhouseCoopers Inc & Others v National Potato Co-Operative Ltd & Another* **[2015] 2 All SA 403** (SCA) paras 97-99)."[3] … "The expert must demonstrate to the court that he or she has relevant knowledge and experience to offer opinion evidence. If such knowledge and experience is shown, the expert can draw on the general body of knowledge and understanding of the relevant expertise."[4]

[64] The only points of contestation were between the midwives on limited aspects relating to the fetal heart rate and whether the plaintiff experienced obstetric violence practices during labour.

[3] *AD and another v MEC for Health and Social Development, Western Cape Provincial Government* [2016] ZAWCHC 116 para 39.
[4] Ibid para 42.

Plaintiff's submissions

[65] In its submissions, the plaintiff contends that the harm suffered by the minor child is clearly demonstrated by the radiologists' findings that the child sustained an acute, profound hypoxic-ischaemic brain injury. Counsel submits on behalf of the plaintiff that the evidence of wrongful conduct and causation on the defendant's part is overwhelming, demonstrated, *inter alia*, by the medical staff's failure to interpret the CTG tracings, which, according to the obstetricians, were suggestive of fetal distress.

[66] Counsel further submitted that the failure to summon a doctor after 8 hours of labour, as stipulated in the Maternity Guidelines, allowing the latent phase of labour to be excessively prolonged, also proves the defendant's negligence. In addition, disregarding the doctor's instruction at 17h00 on 30 August 2013 to perform a C-section was the final blow.

[67] Concerning causation, the plaintiff relies on the decision of the Constitutional Court in *NVM obo KM v Tembisa Hospital & Another*[5] for the proposition that 'probable causation and risk reduction are closely linked', and that 'an increase in risk is the probable cause of the harm'. The evidence in this matter has established an increase in risk as the probable cause of harm to the minor child. Thus, there is evidence of direct, and not merely probable causation occasioned by an increase in risk, the plaintiff further argued.

[5] [2022] ZACC 11.

[68] Counsel added that the experts agree that the substandard fetal and maternal monitoring increased the risk of signs of fetal distress being missed, and the misdiagnosis of CTG tracings further increased the probability of an adverse outcome. Moreover, they agree that the inappropriate use of the partogram increased the likelihood of injury due to birth asphyxia.

[69] In summing up, the plaintiff cited *Ntsele v MEC for Health, Gauteng Provincial Government*[6], submitting that on the probabilities, the facts justify an inference that the minor child's injury resulted from the negligence of the defendant's employees. Absent countervailing evidence disproving negligence, the only logical and reasonable inference to be drawn from the defendant's failure to provide an exculpatory explanation is that its employees were negligent in not providing the plaintiff the treatment she was lawfully entitled to in line with the skill and diligence expected of medical professionals, the submission went.

Defendant's submissions

[70] In the heads of argument, it is submitted that the plaintiff has not established that the conduct of the hospital staff was wrongful, negligent and caused the harm to the minor child, as wrongfulness is not sufficient for delictual liability. The defendant further avers that the plaintiff has failed to prove that the hospital staff did not have the necessary skill and that the defendant did not ensure that the hospital staff treated the plaintiff and her unborn child with the skill, care and diligence reasonably expected of medical practitioners in similar circumstances.

[6] [2013] 2 All SA 356.

[71] It is further submitted that the plaintiff has not proved that the alleged prolonged labour caused the minor child's brain injury, or that a caesarean section would have produced different and favourable results that would have prevented the sudden injury. The defendant further avers that the plaintiff has also failed to establish a contravention of the Constitution, as alleged in the particulars of claim.

[72] In what appears to be a reliance on the judgment of the SCA in *AN v MEC for Health, Eastern Cape(AN)*[7], counsel submits that the two matters are similar. No attempt is made to indicate what those similarities are. It is, however, evident from the facts of both matters, looked at side by side, that there are more distinguishing factors than there are similarities. Save for the lack of monitoring and, to some extent, the nature of the injury, I could not find any other similarities. Importantly, the sole issue for determination in *AN* was whether the lack of monitoring caused the brain injury to the minor child. The experts also agreed that there was a sentinel event.

[73] In the present case, the experts agree that there was no sentinel event to justify a hypoxic-ischaemic injury. The experts attribute the adverse outcome to a host of acts and omissions in the care of the plaintiff and the minor child, including the following: excessively prolonged latent phase of labour, which ran into days; sustained fetal tachycardia, misdiagnosis of fetal distress and CPD; augmentation of labour when it was contraindicated; failure to refer for intrauterine resuscitation and emergency C-section.

[7] [2019] ZASCA 102; [2019] 4 All SA 1 (SCA).

[74] The defendant further contends that because the plaintiff did not testify, there are gaps in the factual narrative relating to various issues, such as the yellowish discharge, her monitoring by the hospital staff and why she was not monitored. In this regard, the defendant relies on *Tshishonga v Minister of Justice and Constitutional Development and Another*[8], that an adverse inference must be drawn from her failure to testify, and there was an intimation that she would be called as a witness[9].

[75] The defendant also assails that the plaintiff's failure to call the radiologist to testify. While conceding that there was agreement between the parties' respective radiologists, the defendant falls short of explaining why it did not call its radiologist to testify on the aspects it wished to bring before the court. There is, therefore, no merit to this contention.

[76] The remainder of the defendant's heads of argument concerns the evidence of the two witnesses who testified for the plaintiff. As regards Dr Songabau, the defendant argues that his evidence on the monitoring of the plaintiff and the minor child is misleading, as it suggests there was no monitoring, whereas his addendum report states that the monitoring was poor. Counsel submits that, according to the observation chart (which forms part of the record), monitoring occurred from 05h00 on 29 August 2013 to 11h00 on 30 August 2013, and again from 13h00 on 30 August 2013 until delivery. The fetal heart rate on admission was recorded at 133 to 143 and 173 to 177.

[8] [2006] ZALC 104; [2007] 4 BLLR 327 (LC); 2007 (4) SA 135 (LC); (2007) 28 ILJ 195 (LC).
[9] *M. v MEC for Health, Eastern Cape* [2018] ZASCA 141.

[77] She further submits that Dr Songabau was untruthful because he downplayed the importance of antenatal care and the yellowish discharge observed on the plaintiff on her arrival at the hospital. Counsel then undertakes a linguistic analysis of the terms ‘poor’ and ‘substandard’ monitoring.

[78] To the extent that these submissions contradict the agreement between the experts, they are of no consequence and fall to be disregarded.

[79] The defendant argues that, because Ms Zondo did not interview the plaintiff, her evidence that the plaintiff experienced obstetric violence practices is hearsay, since the plaintiff did not testify.

[80] Curiously, counsel for the defendant questions why the plaintiff’s witnesses did not testify about the augmentation of labour, which the defendant classifies as a ‘positive step’. This is bizarre, if not detrimental to the defendant’s case. Both Drs Mtsi and Songabau, in their joint minute, agree that the augmentation of labour constituted substandard care as it was contraindicated in the presence of foetal distress and misdiagnosis of CPD.

Discussion

[81] The key question in this matter is whether the medical and nursing staff at Klerksdorp hospital were negligent in their care and treatment of the plaintiff and her minor child, and if so, whether such negligence contributed in any way to the outcome of the minor child.

[82] The onus of proving negligence rests with the plaintiff, who must prove on a

balance of probabilities that the defendant had a legal duty that it breached. This would satisfy both the requirements of unlawfulness and negligence. In *Kruger v Coetzee*[10], the Appellate Division set out the test for negligence 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) and the defendant failed to take such steps."

[83] This was later confirmed in *Botes v van Deventer*[11], another decision of the SCA, where the court held that the nature of damages that might occur need not be precisely foreseeable, as long as it can be foreseen that the plaintiff will suffer damages.

[84] If sufficient evidence exists giving rise to an inference of negligence on the part of one or more of the medical and/or nursing staff of the defendant, it is not necessary to prove that the inference is the only reasonable inference. What is required is for the plaintiff to satisfy the court that the inference is the most readily apparent and acceptable inference from a number of possible inferences.[12] In respect of professionals such as doctors and nurses, they are required to adhere to the level of skill and diligence exercised by members of

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[10] 1966 (2) SA 428 (A).

[11] 1966 (3) SA 182 (AD).

[12] *AA Onderlings Assuransie- Assosiasie Bpk v De Beer* 1982 (2) SA 603 (A).

the profession to which they belong, failing which they would be negligent.'[13]

[85] With regard to causation, the inquiry centres on two questions: first, whether the harm would have occurred "but for" the defendant's wrongful conduct; and second, whether the wrongful act is sufficiently, closely, and directly linked to the loss. "A plaintiff is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics."[14]

[86] When applied to the facts of this case, the general consensus among the experts is that the injury probably occurred intrapartum shortly before delivery. The plaintiff was in labour from 22h00 on 28 August 2013 until 00h05 on 31 August 2013; the hospital staff did not adequately monitor the plaintiff and the foetal condition. They essentially left the plaintiff to her own devices. Having diagnosed her with foetal tachycardia, the doctor on call did not review her condition as the doctor did not arrive despite being called by the nurses. They incorrectly interpreted the CTG tracings and failed to diagnose fetal distress. Consequently, they administered oxytocin when it was contraindicated; they failed to diagnose or exclude CPD. They failed to indicate the plaintiff for intrauterine resuscitation and an emergency C-section.

[13] *Van Wyk v Lewis* 1924 AD 438.
[14] *Minister of Safety and Security v van Duivenboden* [2002] ZASCA 79; 2002 (6) SA 431 (SCA) at para 25; See also: *Oppelt v Department of Health* 2016 (1) SA 325 (CC) para 45.

[87] The submission by the defendant that (for a limited time), the fetal heart rate was within normal range, on its own, is not an indication of a good outcome as suggested by the defendant. This submission does not consider the variability, accelerations and decelerations, and maternal contractions. A reasonable professional in the position of the staff at Klerksdorp hospital could not have assumed this as sufficient to guarantee the minor child's well-being. A reasonable person in the position of the defendant's employees would have foreseen the possibility of harm occurring and would have taken steps to avoid such harm. The defendant's employees failed to take such steps.

[88] Concerning the issues identified by the defendant as potential gaps owing to the failure of the plaintiff to testify, these are medical issues for which the plaintiff bears no expertise. In the circumstances of this case, they were, in my view, adequately addressed by the objective medical evidence and documentation as well as the agreements in the joint minutes.

[89] As far as the differing views between the midwives are concerned, the question is whether either of the two versions is supported by any evidence. Ms Zondo's version is that there were no records and that she could not merely assume that there were no fetal problems observed. Prof. du Plessis, on the other hand, bases her assumption on the fact that labour was allowed to progress.

[90] There is no evidence to suggest that labour was allowed to proceed based on the foetal heart rate.

[91] On the second disagreement, Prof du Plessis's assumption is based on a

recording of the fetal heart rate done half an hour before the commencement of the second stage of labour, which was within the normal range. She can therefore not vouch with certainty that this remained the case until the commencement of the second stage of labour, particularly in light of the various incidents pointed out by Ms Zondo before the commencement of the second stage of labour, where there is no record of the fetal heart rate.

[92] Regarding Ms Zondo's evidence about obstetric violence practices, this is based on the patient narrative, which forms part of the record. The defendant did not dispute this evidence and elected to abstain from comment. Ms Zondo was also not cross-examined on this issue or any part of her evidence. The undisputed version of the plaintiff's expert should therefore prevail.

[93] In my view, the issue of whether the plaintiff's failure to attend antenatal care contributed to the outcome of the minor child is specifically excluded by the agreement between the paediatricians that there were no antenatal risk factors for a hypoxic ischaemic injury. This is confirmed by the agreement of the obstetrician-gynaecologists. Similarly, the suggestion of a sentinel event mentioned for the first time in the heads of argument does not accord with the overall agreements between the experts. Importantly, the paediatricians and obstetrician-gynaecologists specifically agree that there was no sentinel event to justify the poor outcome of the minor child.

[94] From the evidence in this matter, it is clear that there were warning signs which were sustained for some time and were not heeded by the staff at Klerksdorp hospital. There were several missed opportunities for timely diagnosis and

intervention. All these factors, taken as a whole, lend credence to the conclusion that the brain injury to the minor child was probably a result of the negligence of the employees of the defendant at Klerksdorp hospital.

Costs

[95] Costs fall within the court's discretion, to be exercised judiciously. The plaintiff contends that a punitive cost on the attorney and client scale is warranted, as the matter could have been finalised expeditiously if the defendant had timeously placed Dr Manthata-Cruywagen in possession of the CTG tracings when preparing her initial report.

[96] In this regard, the defendant argues that it was entitled to defend the matter as the initial report by Dr Manthata-Cruywagen provided a defence which it could not proceed with due to matters beyond its control. Nothing could be further from the truth. Despite being in possession of Dr Manthata- Cruywagen's report, the defendant enlisted the services of Dr Mtsi, who compiled a report with Dr Songabau. There is no reason why the defendant could not have proceeded on that basis, bearing in mind that both Dr Manthata-Cruywagen and Dr Mtsi were appointed by the defendant.

[97] The defendant's conduct throughout these proceedings has been shocking to say the least, and warrants a punitive costs order to signal the court's disapproval. As confirmed in Public Protector v South African Reserve Bank, attorney-and-client costs are justified where a party's conduct is vexatious, fraudulent, or amounts to an abuse of process. Here, the defendant's conduct

reflected a lack of *bona fides* and preparedness, and, to some extent, an ill-conceived and constantly shifting stratagem to frustrate the process.

[98] In addition, although the defendant's own experts agreed with the plaintiff's experts on the key findings, the defendant persisted with its defence, which to this day remains unclear. After a lengthy postponement, occasioned by the defendant's unreadiness, it was still not ready to proceed when the matter resumed. A further adjournment after Dr Songabau's evidence likewise did not spur the defendant to prepare, and it effectively chose not to participate meaningfully in the trial.

[99] Given these factors, including the complexity of the matter and the resources required to dispose of it, I am inclined to agree that a punitive costs order is warranted.

Order

[100] In the result, I make the following order:

a. The defendant is liable for payment of 100% of the plaintiff's proven or agreed damages, in her representative capacity as the mother and natural guardian of LM, born on 31 August 2013, consequent upon the hypoxic-ischaemic brain injury, manifesting as cerebral palsy, which the minor child suffered as a result of the negligent conduct of the medical and nursing personnel at the Klerksdorp Hospital on 31 August 2013.

b. The issue of quantum is postponed *sine die*.

c. The defendant is ordered to pay the plaintiff's taxed or agreed costs in respect of the determination of the issue of liability on an attorney and client scale, taxed on the high court scale, within 14 days of taxation or agreement, including:

    i. The qualifying preparation and reservation costs, travel and accommodation of the plaintiff's expert witnesses, as well as their costs in respect of consultations, the preparation of their reports, addenda, and joint expert minutes, if any.
    ii. The plaintiff's costs of attendance at medico-legal examinations and related costs.
    iii. The costs consequent on the employment of counsel.

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S MFENYANA
Judge of the High Court
North West Division, Mahikeng

APPEARANCES

For the plaintiff
Counsel: M Patel
Instructed by M.G. Mali Attorneys Inc.

For the defendant
Counsel: WN Sidzumo
Instructed by State Attorney Mahikeng

Date reserved: 20 August 2025
Date of judgment: 31 March 2026