REPUBLIC OF SOUTH AFRICA

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

CASE NO: 34058/2015
REPORTABLE: NO
OF INTEREST TO OTHER JUDGES: NO
REVISED: YES
09JULY 2022

In the matter between:

N [....] 1 P [....] Z [....] obo N [....] 2 **PLAINTIFF**

and

MEC FOR HEALTH GAUTENG PROVINCE **DEFENDANT**

JUDGMENT

BEZUINDEHOUT, AJ

Introduction,

[1] The plaintiff is the adoptive parent and legal guardian of NZ, a minor male born on 8 August 2005 (the minor child).

[2] The minor child has mixed cerebral palsy, predominantly dystonic with superimposed right hemiparesis, global developmental delay and profound mental retardation.

[3] The plaintiff, in her representative capacity and on behalf of the minor child, has instituted action against the defendant. She alleged that during labour and delivery of the minor child, the management, monitoring and assessment of the biological mother by the Chris Hani Baragwanath Hospital (CHBH) employees, were executed in a negligent manner, and this led to the minor child suffering severe brain damage manifesting as cerebral palsy.

[4] In terms of the joint pre-trail minute, this Court is required to determine the following:

> *1.1.* "*Did the negligent failure of the employees or staff at CHBH to properly monitor the biological mother and foetus during delivery cause the brain injury to the minor child?*
>
> *1.2. Whether the harm to the minor child resulted from the negligence of the CHBH staff and is that causally connected to the minor child's brain damage?*
>
> *1.3. Whether there was a prolong or delayed labour when the minor child was delivered at the hospital?*
>
> *1.4. Whether the minor child suffered perinatal stroke before, during or after birth following substandard care from the hospital?*
>
> *1.5. What caused the subaponeurotic bleed to the minor child?*
>
> *1.6. Whether there was any sentinel event which caused the minor child to suffer from cerebral palsy?*
>
> *1.7. Whether there was any thrombo-embolic and hypo-perfusion or ischemic encephalopathy that could have caused cerebral damage to the minor child?"*

[5] On 25 October 2018, at a pre-trail meeting before Meyer J, the parties agreed to a separation of issues in terms of R 33(4). The trail proceeded on the issue of liability only and the issue of quantum is postponed *sine die*.

[6] The following experts filed reports and joint minutes and safe for Dr Weinstein, they all testified at the trail:

> 1.8. The radiologists were Dr Jogi for the plaintiff and Dr Weinstein for the defendant,
>
> 1.9. The obstetricians were Dr Songabau for the plaintiff and Dr Marishane for the defendant,
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> 1.10. The paediatricians were Dr Lefakane for the plaintiff and Prof Bolton for the defendant, and
>
> 1.11. Dr Manyane who is a neurologist, for the plaintiff and Dr Mogashoa for the defendant who is a paediatric neurologist.

[7] In addition to the experts the Plaintiff, biological mother and Dr Mokhachane also testified at the trail. Dr Mokhachane is a paediatrician but testified as a witness and not as an expert witness.

SUMMARY OF THE EVIDENCE OF THE BIOLOGICAL MOTHER

[8] The biological mother of the minor child was the first witness to testify. According to the biological mother, she realised that she was pregnant in June 2005 and then attended Chiawelo clinic (the clinic) in Soweto. She was physically examined, and a sonar was done, which yielded nothing out of the ordinary. Her period in waiting was uneventful and she did not suffer from any illness or complications.

[9] On 8 August 2005, at around 13h00 the biological mother noticed a blood clot when she went to the bathroom whereupon she called her mother, the plaintiff. The plaintiff left work early and arrived home a bit before 17h00. The biological mother started experiencing labour pains at around 16h00 to 16h30. The plaintiff called an ambulance which arrived at the biological mother's home at approximately 17h00. The ambulance took the biological mother to Chiawelo clinic.

[10] At the clinic, a sister assessed the biological mother and referred her to CHBH as the sister felt the baby was too big and the biological mother was short. At about 17h30 to 18h00 the same paramedics who brought the biological mother to the clinic transported her to CHBH.

[11] At about 19h00 the ambulance arrived at CHBH and the paramedics completed the admission forms. Admission took about half an hour whereafter the biological mother was taken to a cubicle in the labour ward.

[12] According to the biological mother, two student nurses came to attend to her in the cubicle. They wore white uniforms with maroon epaulette. The biological mother could not recall if the nurses introduced themselves, but they had name badges on. She could not remember any of the nurse's names. The nurse's placed a monitor on her midriff to monitor the minor child's heart rate and every now and again, they came to check up on her and her dilation. At some stage the biological mother told the nurses that she wanted the CTG monitor to be removed as it was hurting her, and she felt a need to go to the bathroom. The nurses said they could not remove the monitor as they must monitor the baby's heart rate.

[13] At around 22h00 the nurses noted that she was fully dilated and told the biological mother to push. According to the biological mother, the minor child was still too far, and she could not push the minor child out. A doctor came in, there were a lot of instruments around them, and the doctor used instruments to remove the baby. The

biological mother indicated that she pushed for almost 30 minutes before the minor child was born.

[14] The biological mother furthermore testified that there was no paediatrician present when she gave birth to the minor child. The biological mother in examination in chief gave a description of the doctor that used instruments to deliver the minor child and the most prominent features of the doctor were that the doctor was a female wearing dreadlocks who wore a very specific shoe. She also recalled seeing the doctor afterwards when she attended the CP clinic with the minor child, and this was the same doctor that did a brain scan on the minor child.

[15] One of the nurses showed the minor child to the biological mother, it was a boy. The biological mother described the minor child as looking beautiful, was very light in colour and being a handsome baby, the only thing was that he did not cry. The nurses took the minor child away and “cleaned and stitched her up”. The biological mother was then moved to the mother’s ward. When the biological mother enquired where the minor child was, the nurses told her that he did not cry at birth, and they took him to the ICU.

[16] The next morning, the biological mother went to see the minor child in ICU. He was in an incubator and part of his head was shaved where a drip was inserted, he also had tubes inserted into his nose. The biological mother indicated that she could not interact with the minor child, but she could see that he was breathing. He was sleeping.

[17] The biological mother returned to the ward and while looking for someone to discharge her, bumped into a female doctor who thought the biological mother was looking rather pale. The biological mother however testified that she was not feeling ill or lightheaded and was not experiencing any blood loss. The doctor did a sonar on the biological mother and told her they had to clean her up as the placenta was not removed. They took the biological mother to theatre where the placenta was removed; she did not receive a blood transfusion in the process.

[18] The next day, 10 August 2005, upon her release, the biological mother was told that the minor child was going to remain in ICU, and she must return to the CHBH daily to assist with the care of the minor child until his discharge.

[19] On 11 August 2005, the biological mother attended CHBH, ICU neonatal and saw the minor child's health had improved; she could play with him. The next day she visited him again and this time he was released to the general baby ward.

[20] In the general ward she had difficulty with getting the minor child to suck however she managed and started to breast feed him. Upon the minor child's discharge on 17 August 2005, she was told that the minor child had a problem, and she was told what signs to look out for. She collected his medication and was told that the minor child was not going to function like other babies because he did not cry.

[21] The biological mother indicated that when they went for the first visit at the CP clinic, there was other children who looked really sick, and the minor child did not look like that. There was a red sticker on her file which indicated the seriousness of the CP.

[22] The biological mother was recalled as a witness due to further documents the defendant discovered during the trail. The documentary evidence showed that the biological mother attended the clinic on 7 August 2005 and not 8 August 2005. The biological mother disputed the correctness of the record and insisted that she only attended the clinic at around six in the afternoon on 8 August 2005.

[23] The biological mother queried the information contained on some of the documents more particularly the cell phone number and her identity number which were included in some of the documents. According to the biological mother she did not use the specific cellphone number at that stage and did not have her identity document yet.

[24] The plaintiff have challenged the correctness of the documents in question in a material way and the defendant did not call any witnesses to clarify these issues. I therefore accepted the plaintiff's version.

[25] The defendant identified the doctor that allegedly delivered the minor child using instruments as Dr Mantoa Mokhachane.

SUMMARY OF THE EVIDENCE OF THE PLAINTIFF

[26] The plaintiff is the mother of the biological mother.

[27] The plaintiff testified that she noticed that the biological mother was pregnant in January 2005. She was disgruntled at the biological mother being pregnant at such a young age as she had hoped for the biological mother to further her studies after matric.

[28] The plaintiff stated that the biological mother contacted her at work on 8 August 2005 at about 13h00 and informed her of the clot of blood she noticed. The plaintiff sought permission to leave work early and then made her way home, via taxi. She arrived home round about 17h00. She called an ambulance, and it transported the biological mother to the clinic. Later that evening the biological mother contacted her and told her that she was transferred from the clinic to CHBH.

[29] She went to CHBH to visit the biological mother and the minor child and was told by the nurse that her grandson was not going to function like other babies as he did not cry at birth.

SUMMARY OF THE EVIDENCE OF DR M MOKHACHANE

[30] Dr Mokhachane testified that from 2005 to 2013 she was head of the Kangaroo Mother Care at CHBH and was no longer actively involved in the Neonatal unit. Her involvement with the Neonatal unit was limited to attending meetings, training, and

doing cranial sonars and follow ups on a Thursday. She furthermore testified that as a paediatrician, she does not assist with the delivery of babies and that she has never used forceps.

[31] Dr Mokhachane during cross examination testified that she had no independent recollection of her interaction with the minor child, and the times she would have seen him, as she had attended to so many babies over the years.

[32] During cross examination Dr Mokhachane conceded that the reference to “Dr Mokhachana” in the discharge summary is in all probability a reference to her. She stated that she had no independent recollection of the cranial sonar to which reference is made therein. Dr Mokhachane indicated that if she had attended to a cranial sonar, as is indicated on the discharge summary, it would in all probability have been done just before discharge.

[33] Dr Mokhachane disputed that it was her signature on the discharge summary and that she completed the discharge summary. She indicated that the discharge summary would normally be completed by either the medical officer or the registrar.

[34] Dr Mokhachane indicated that if a baby was born and was not well, he would first be stabilised in the Labour Ward, and then a decision would be taken to either transfer him or her to the Intensive or High Care Units.

[35] Dr Mokhachane also testified that during the period she did the brain sonar, the “brain” sonar probe was stolen, and they had to make do with a normal sonar probe. She explained that a normal sonar probe which is much bigger than the brain sonar probe. The bigger probe interfered with the effectiveness of the sonar as she could not move into small space of the baby’s head to get better images. She also explained that it is not always possible to get clear and detailed images as there is a lot of things that might interfere with the capture of the images. She had no recollection of this matter and could not assist with additional information.

RADIOLOGISTS

[36] In their joint minute, Drs Jogi and Weinstein recorded that there are multiple causes that must be considered to account for the MRI findings.

[37] They noted a left sided MCA territory perinatal stoke with ventral medial thalamic lesions / percheron stroke components. There were also features of prolonged partial hypoxic injury (bi-frontal watershed) in the chronic state of evolution.

[38] The two experts agreed that the multifactorial causes of neonatal encephalopathy, which include perinatal and postnatal aetiologies should be considered, which include thromboembolic disease, sepsis and / or metabolic causes that may account for this, mandating clinical correlation by paediatric and obstetric experts.

[39] As the minor child was age 11 years and 4 months old when the MRI was done, the two doctors recorded that they were unable to identify a more exact time (antenatal, intrapartum or postpartum) mandating clinical correlation.

[40] They also agreed that there were no MRI features of structural genetic abnormalities, and during cross examination Dr Jogi indicated that this finding related specifically to intracranial abnormalities, and that a geneticist still had to confirm the absence of congenital abnormalities.

[41] Under the heading disagreement, the experts recorded that there were none.

[42] During cross examination, Dr Jogi confirmed that Dr Weinstein and he only focussed on the major findings in their joint minute. His individual report contained more findings, which could also have contributed to the outcome of the minor child’s injury. In this regard he was referred to the portion in his report, where he recorded that he noted,

Ventro-medial thalamic lesions, that would be indicative of neonatal hypoglycaemia or intracranial sepsis.

[43] It was also put to Dr Jogi that the discharge sheet records “problems” that was picked up when the 1st cranial sonar was done. On 6 September 2005, a further sonar was done. The 2nd sonar showed the same “problems”, but it was now more definite of where the impact of the injury was, more to the right-hand side than to the left, he agreed with this proposition.

[44] Dr Jogi indicated that he could not exclude stroke from the notes that was made relating to the two cranial sonar’s that was done, as the sonar is very operator dependent, and it might not have picked it up.

[45] In examination in chief, Dr Jogi explained that when they refer to the perinatal period, they refer to the period 22 weeks before birth to 30 days after birth.

NEUROLOGIST

[46] The two doctors filed a joint minute dated 15 August 2017. However, after filing their joint minute the defendant discovered further hospital records, an MRI was done, and the two radiologists filed a new report containing their findings. Dr Lefakane and Professor Bolton filed addendums to their individual reports and an addendum to their joint minute. Dr Marishane also filed an addendum to his report. The two neurologists were not provided with these additional reports, they did not file addendums to their individual reports and did also not file an addendum to their joint minute. This the Plaintiff only discovered while leading the evidence of Dr Manyane.

[47] Not having had regard to the updated reports and documentation, and not having had an opportunity to address the multifactorial aspect of the minor child’s injuries, the plaintiff presented the evidence of Dr Manyane on the old and outdated joint minute.

The defendant similarly presented the evidence of Dr Mogashoa on the old outdate joint minute.

[48] In their joint minute the two doctors came to the following conclusion: “The minor child’s neurological impairments are secondary to intrapartum hypoxia, and this is supported by history, available records and clinical findings.”

[49] Dr Mogashoa however recorded further that although she agreed with the conclusion, the record that was available, was only the discharge summary, and that stated the end product or the final process. Dr Mogashoa recorded that the minor child was delivered by vacuum, but what was not known was the reason for this decision. There were no ANC records, therefore they did not know if there were any pregnancy problems nor were there any labour records, therefore they also did not know how labour was managed. Dr Mogashoa was thus of the opinion that one cannot attribute the intrapartum hypoxia to vacuum delivery, without understanding how the labour process was managed.

[50] The neurologists agreed that the minor child has mixed cerebral palsy, predominantly dystonic with superimposed right hemiparesis, global developmental delay and profound mental retardation

[51] Although the neurologist in their joint minutes recorded that there were no features to suggest a stroke, Dr Manyane in evidence in chief agreed with the radiologists finding of a stroke (though this went outside of the scope of her report). Dr Manyane in her evidence in chief tried to track the stroke with the records at her disposal. In this regard she noted that the clinical notes dated 1 September 2015, indicated that the tone was fine. On 6 September 2015, an ultrasound was done and there it was picked up that the one side was more affected than the other. Clinically they also started to notice thereafter that the minor child’s one side was more affected than the other. According to Dr Manyane, this could be an indication of the stroke. Under cross examination Dr Manyane agreed that without having had regard to all the

addendums, new evidence and MRI results she was not able to properly comment on and apply her mind to the issues.

[52] According to Dr Manyane, the subaponeurotic bleed would occur on the outside of the brain, and the use of forceps would not affect the inside of the brain, unless the skull is crushed.

[53] Dr Mogashoa testified that she did her report prior to the additional hospital documents became available and the MRI and addendum reports were filed by the other experts. She agreed with the finding of a stroke as per the radiologist's joint report but did not submit an addendum report.

[54] A Court will look towards the facts upon which the expert base his or her opinion to determine to what extent the Court can rely thereon. A Court must understand why the expert exclude or disregard certain facts from his opinion before a Court can decide whether it assist the Court, and to what extent it can rely on the opinion. The opinions of the neurologists were not of assistance, as it excluded important new information that came to the fore since the filing of their joint minute and reports, and this new information influenced the views and opinions of the other experts, to which the neurologist would also have paid heed to.

OBSTETRICIANS

DR SONGABAU

[55] Dr Songabau similarly did not file an addendum to his report dealing with the additional documents the defendant discovered in 2017. Although Dr Marishane filed an addendum to his initial report, he and Dr Songabau did not get together to file an addendum to their joint minutes. During his evidence in chief Dr Songabau accepted full responsibility for not filing an addendum to his report and to their joint minute.

[56] During Dr Songabau's evidence in chief the defendant objected to Dr Songabau testifying outside the scope of his report. The plaintiff elected not to proceed with questions outside the scope of Dr Songabau's report instead of amending it.

[57] What was said about expert opinion under the neurologist is equally applicable to Dr Songabau's opinion.

[58] In his report Dr Songabau summarised his view as follows: "*The records informed that the baby did not cry at birth, his APGAR scores were very low, had neonatal seizures, metabolic acidosis, and imaging studies (brain sonar and later MRI brain) This imply strongly that this baby was born severely asphyxiated by an intrapartum insult/cause. I concur with the findings of the other experts that N [....] 2's neurological impairments are secondary to an intrapartum hypoxia following a substandard care from CHBH*."

[59] The substandard care relates to the following:

> 1.12 The CHBH did no heed the referral from the clinic of a primigravida for CPD. No foetal weight estimation was done by CHBH via sonar or clinical pelvimetry;
>
> 1.13 There was a missed opportunity for an emergency caesarean in the presence of a big baby and CPD;
>
> 1.14 The use of student / junior nurses to provide maternity care and delivery to a high-risk labouring patient is not justifiable;
>
> 1.15 No medical doctor assessment until the medical doctor by change rescued the delivery once he entered the labour ward;

1.16 Paediatrician was not alerted to CPD referral so that he can be present at delivery so that he can resuscitate the neonate;

1.17 The use of forceps during the delivery was not warranted as it is regarded as an absolute contra indication;

1.18 The chief reason the baby was transferred to ICU was because it did not cry, which if viewed with the low APGAR scores, neonatal seizures, acidosis, brain scans and MRI is an indication that the baby was born severely asphyxiated by an intrapartum insult/cause; and

1.19 The biological mother was diagnosed PPH with anaemia due to retained product or placenta in the ward, which was removed in theatre.

[60] During the trail Dr Songabau ‘s view of the matter was succinctly summarised by counsel for the defendant and confirmed by Dr Songabau during cross examination. According to Dr Songabau there is a probability of prolonged labour due to a suspected CPD which resulted in a difficult delivery, needing or calling for the use of forceps, and it is uncertain whether the requirements of the use of forceps were complied with which, if done incorrectly, might have caused the injury to the minor child resulting in the brain injury.

[61] Dr Songabau did not agree that the minor child suffered a stroke and if the minor child did suffer a stroke, it was discovered after a long time. According to Dr Songabau if the minor child suffered a stroke in the antenatal or intrapartum period, it would have been noticed clinically at or after birth, and the brain scan would have picked it up as well. Dr Songabau also clarified that he did not disagree with the radiologists finding of a stroke, however he feels it did not happen pre or during delivery. If it happened, it happened after delivery and it was caused by hypoxia, birth asphyxia.

[62] Having regard to the history of the mother and thrombophilia not having been investigated at all over the years, Dr Songabau dismissed the possibility of thrombophilia playing a role in the damage causing event. According to him, thrombophilia is the autosomal dominant trait and if the mother has it, it will transfer to the baby. The biological mother has not been diagnosed with any clotting and has not received any medication for such. On the acquired leg of thrombophilia, he indicated that he has a difficulty in accepting that the minor child would have acquired thrombophilia, but it falls outside his scope of expertise.

[63] With regard to the issue of infection, he dismissed infection as a probability given rise to the damage causing event due to the discharge summary being silent on the minor child having an infection or being treated for an infection. The biological mother did not report any infections and the blood test she had attended to, did not reflect any infections as well.

DR MARISHANE

[64] According to Dr Marishane, the radiologic findings helped the experts to make a finding on where the actual problem is, and the thromboembolic phenomenon that has been diagnosed on the MRI, gave an indication of where the problem with the minor child lies. The fact that there was hypoxia is, according to him, neither here nor there, hypoxia just indicate that there was low oxygen in the blood and hypoxia can be caused by thrombosis. The fact that the baby was born hypoxic does not indicate that he was mismanaged intrapartum. The fact that the minor child had low APGAR scores and was acidotic, did not mean that the subsequent damages to the minor child had an intrapartum cause.

[65] Dr Marishane testified that it is difficult to say when the thromboembolic phenomenon started, it could have been before labour even started, early in labour or during labour. Dr Marishane disputed that there are any clinical signs that can be picked

up immediately after birth that would be a clear indication of a stroke in a new-born baby.

[66] Dr Marishane testified that the stroke caused brain damage, and with cerebral palsy, the signs from a clinical point of view, may delay detection and it is not something they would pick up immediately when a baby is born. Hence the diagnosis of cerebral palsy, is usually delayed for 3 months or more as the signs may manifest only later in life. Dr Marishane testified that he does not know what a doctor would clinically look for in a new-born baby to determine whether that baby has cerebral palsy.

PEADIATRICIANS
DR LEFAKANE

[67] Dr Lefakane and Professor Bolton both filed individual reports, addendums to their reports and a joint minute with an addendum to their joint minute.

[68] According to Dr Lefakane the minor child's brain damage was caused by asphyxia which resulted in HIE 2. The damage could have occurred when the minor child was delivered. Dr Lefakane stated that he does not know between the effort to get the baby out and after the baby was delivered, when it was observed that the child showed signs of HIE 2. According to Dr Lefakane the minor child had asphyxia, HEI 2, subaponeurotic bleed, and convulsions, all these things could have caused the child to have brain damage[1]. Especially the hypoxia can cause a stroke.

[69] Dr Lefakane testified that the minor child's blood gasses showed that he had sever metabolic acidosis. The acidosis supports a finding of hypoxia. Convulsions can cause low oxygen levels, the mother could have struggled to deliver the child, or worked too hard to push the baby out, and this could have affected the oxygen levels, or it took to long for the child to be delivered.

[1] Transcript p 056-218

[70] According to Dr Lefakane a subaponeurotic bleed can cause anaemia and that can gradually add to hypoxia. Dr Lefakane indicated that the effect of birth asphyxia is hypoxia, if it is in the birth canal it is referred to as perinatal hypoxia.

[71] According to Dr Lefakane if a child has less oxygen, it develops hypoxia, and this causes a metabolic delay which affects the brain. Brain damage does not take place immediately. It takes a bit of time to develop depending on which other factor adds to the hypoxia in the child[2].

[72] Dr Lefakane testified that the subaponeurotic bleed could lead to low blood pressure and the minor child having low oxygen levels, and this could lead to hypoxia. According to Dr Lefakane, this could possibly explain why there is birth asphyxia as a diagnosis on the discharge sheet. Thus, besides the blood or oxygen flow being restricted by the delivery as a secondary cause, the subaponeurotic bleed could also have added thereto.

[73] According to Dr Lefakane asphyxia, hypoxia, the subaponeurotic bleed and seizures, all could have caused the minor child to have a stroke. How the HIE 2 happened he could not tell, due to the lack of records. According to Dr Lefakane the most likely cause of the minor child's hypoxia, is birth asphyxia leading to stage 2 HIE, as documented in the discharge summary. According to him HIE 2 relates to brain damage. He could not tell how the brain damage happened due to a lack of records.

[74] On the question of whether the stroke could have caused the brain damage to the child, Dr Lefakane indicated that he would not agree that the stroke alone could have caused the brain damage to the child, stroke in the presence of all the other factors that he can support but not stroke alone.

[75] Dr Lefakane has recorded in his report that there are no documented medical records of risk factors which could have caused the minor child's brain damage other

[2] Transcript p 056-209

than the recorded birth asphyxia. There is also no documentation of infection or metabolic imbalances that could have caused the convulsions.

[76] There were no postnatal records available which could assist with the evaluation of the quality of, and extent of, the resuscitation measures that was taken to reverse the effects of the birth asphyxia.

[77] According to Dr Lefakane the biological mother stated that the minor child did not cry at birth and the recording in the discharge summary of birth asphyxia, HIE 2, acidosis and the low APGAR's lends credence to her statement.

[78] During cross examination Dr Lefakane conceded that having regard to the time periods the biological mother testified to, labour progressed very quickly and that would exclude an inference of CPD.

[79] Dr Lefakane confirmed that Professor Bolton and him agreed with the radiologists finding that there were multiple reasons why one finds that there is neonatal encephalopathy in this matter.

[80] Dr Lefakane indicated that he agreed with Professor Boltons statement in his report that: "presumed periarterial ischemia was present in this child and it may have many causes often unrelated to hypoxia or ischemia."

PROFESSOR BOLTON

[81] Prof Bolton highlighted the fact that there are conflicting APGAR scores if regard is had to the admission record and the discharge sheet. Prof Bolton indicated that what in all probability happened, was that the midwife that delivered the minor child noted her score, whereafter the minor child was taken to ICU, where the two further APGAR scores were recorded. Prof Bolton in his assessment worked from the midwife's first APGAR and the 5-minute APGAR as recorded in the discharge sheet. Prof Bolton

testified that in his view, as the placenta started to dislodge an embolus occurred and within minutes of this happening, the minor child was born, and the minor child looked okay, but he was busy having a stroke and then he deteriorated dramatically thereafter. This would account for the 6/10 APGAR in the first minute and then the greatly reduced 5-minute score.

[82] According to Prof Bolton the injury could not have occurred intra partum, for then the minor child would have been flat, and would not have been shown to the biological mother. In this instance the minor child was shown to the biological mother, and she testified that safe for being very light, he looked fine and was a chubby boy. She testified that he was the most handsome boy, all that was amiss is that she did not hear him cry.

[83] According to Prof Bolton the minor child suffered two strokes. One major one blocking the left middle cerebral artery on the left, and one in the percheron artery.

[84] According to Prof Bolton the most likely and probable explanation is that embolism from the placenta dislodged and made its way to into the arteries of the minor child, and as the minor child was born, or within minutes, the child suffered the strokes.

[85] From MRI alone Prof Bolton cannot tell if it was an embolism or thrombosis.

[86] According to Prof Bolton, stroke in neonatal infants commonly occur after birth. He testified that he had witnessed two strokes that occurred in babies before labour, and they were both associated with congenital infections.

[87] When Prof Bolton was asked what his comment would be that hypoxia caused the stroke, he indicated that if regard is had to the Leeham article he referred to, that he does not think that hypoxia caused the stroke. According to him these are associated factors, it is not to say the one caused the other.

[88] Prof Bolton under cross examination agreed that the minor child suffer a partial prolonged hypoxic injury.

[89] According to Prof Bolton a stroke would cause a sever metabolic acidosis. He testified that they usually do blood test within the 1st hour after birth but may do it repeatedly if the child remains sick.

[90] According to Prof Bolton it is uncertain when the convulsions occurred as the discharge summary did not give an indication as to when it occurred, just that it occurred.

NEGLIGENCE

[91] The case of Kruger v Coetzee 1966 (2) SA 428 (A) established the test for negligence, and has been widely followed, making it the locus classicus on this aspect. The court held as follows at page 430 E - F:

> *"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; and*
>
> *(b) the defendant has failed to take such steps.*
>
> *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 on the particular circumstances of each case. No hard and fast basis can be laid down."

[92] In Mashongwa v PRASA [2015] ZACC 36; 2016 (2) BCLR 204; 2016 (3) SA 528 (CC) para 40 - 38 the Constitutional Court held that: “the standard of a reasonable person was developed in the context of private persons and given the fundamental difference between the State and individuals, it does not follow that what is seen to be reasonable from an individual’s point of view must also be reasonable in the context of organs of state.” Therefore, in cases involving organs of state, the standard to be applied is not that of the reasonable person but that of a reasonable organ of state.

[93I] In Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung MBH the SCA held: [An] expert’s opinion represents his reasoned conclusion based on certain facts or data, which are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert’s bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.

[94] Furthermore, before any weight can be given to an expert’s opinion the facts upon which it is based must be found to exist and an opinion based on facts not in evidence, and I add that are non-existent, has no value for the court. It therefore follows that the credibility and reliability of the factual witness, the plaintiff herein, impacts on the probative value of the expert evidence especially where the expert witness bases his/her opinion on the facts provided by the plaintiff.

EVALUATION OF EVIDENCE

[95] The expert witnesses during their testimony indicated that they accepted the findings of a left sided MCA territory perinatal stoke with ventral medial thalamic lesions

/ percheron stroke components, and the prolonged partial hypoxic injury, as per the radiologist's report.

[96] The experts furthermore agreed with the radiologists finding that the injuries to the minor child were multifactorial.

[97] The experts in evidence in chief, and or during cross examination, testified that based on notes on the discharge summary and the biological mother's evidence, that:

1.1 she was in good health at all material times, did not smoke, drink or take drugs and had no health complaints or complications;

1.2 her family did not have a history of heart ailments;

1.3 her attendances at the clinic were uneventful and nothing concerning was
picked up; and

1.4 her attendance at the gynaecologist in private practice did not yield anything concerning.

[98] The possibility of the HIE injury occurring antenatally can be excluded.

[99] The experts testified and / or conceded that from the records and the MRI, no sentinel event is evident.

[100] The above evidence and concessions must be viewed taking the limited amount of information that has been made available to the experts. They all complained that their task of trying to piece together what caused the minor child's injuries, and when and how these injuries would have occurred, were severely compromised by the

missing records, and having to rely on an MRI done almost 11 years after the injury had occurred.

[101] The experts agreed that the minor child has mixed cerebral palsy, predominantly dystonic with superimposed right hemiparesis, global developmental delay and profound mental retardation

[102] The plaintiff alleged that during labour and delivery of the minor child, the management, monitoring and assessment of the biological mother by CHBH employees were executed in a negligent manner, and this led to the minor child suffering severe brain damage manifesting as cerebral palsy. I will thus deal with the different issues which impacted on the management, monitoring and assessment of the biological mother by the CHBH employees as it emerged during the trail.

CEPHALOPELVIC PELVIC DISPROPORTION (CPD)

[103] Dr Songabau testified that he suspected that the biological mother was referred by the clinic to CHBH for a C-section as they suspected CPD. (In so far as Dr Songabau might have been under the impression that the biological mother told him that she was referred for an emergency C-section, this was denied by the biological mother.)

1.2 The factors which lead Dr Songabau to regard the biological mother as a possible CPD was:

1.2.1 the minor child's weight,

1.2.2 the biological mother's height,

1.2.3 the prolonged birth,

1.2.4 the use of forceps, and

1.2.5 the recorded cranial bleed in the hospital records.

WEIGHT

1.2.6 Dr Marishane testified that the normal birth weight of a baby is between 2.5 and 4 kilogrammes and that a weight of 3.6 kg is within the normal range. To this end he inserted a table into his report reflecting same. It was not placed in dispute during the trail that the minor child's birth weight fell within the normal range.

1.3 HEIGHT

1.3.1 The biological mother is about 1.5 meters tall and was not put in issue.

1.4 BIG BABY

1.4.1 The biological mother testified that the sister at the clinic told her the "baby was too big" and that is why they are referring her to CHBH. What the sister meant by "too big" is unclear as the biological mother testified that the sister listened to the minor child's heart and checked her dilation. The sister did not do a sonar before making her diagnosis (if one can call it that) nor did she examine the biological mother physically to feel the minor child's size and assess the mothers birth canal and so forth.

1.4.2 Dr Songabau testified that if one has to assess whether a "baby is too big" weight is but one factor to be considered. CPD in layman's terms means that the birth canal of the mother when compared to the size of the baby she is carrying, is too small to safely facilitate the baby passing through. Therefore, the size of the mother's pelvis in relation to the baby's head is

amongst others, what they will have regard to. Therefore, if the baby's head is too big to pass though the mother's pelvic area, the baby can be referred to as big without necessarily referring to weight alone.

1.5 PHYSICAL EXAMINATION

1.5.1 Dr Marishane confirmed that he physically examined the biological mother during the consultation he had with her and that he did not pick up any signs of an unusually contracted pelvis during this examination.

1.5.2 In Dr Songabau's expert report he similarly indicated that he physically examined the biological mother and did an ultrasound as well. He noted that the vulva, perineum and uterus were normal.

1.5.3 None of the two doctors thus picked up any physical attributes in the biological mother which would confirm a pelvic disproportion.

1.6 ROAD TO HEALTH CARD

1.6.1 According to Dr Marishane, to confirm a diagnosis of CPD one would have to have regard to the minor child's birth records where his birth measurements were recorded, which records were not available.

1.6.2 According to Dr Lefakane, the Road to Health card is relevant as it contains antenatal information pertaining to the child, and information of the child's physical health from birth onwards.

1.6.3 During cross examination the biological mother confirmed that she still had the Road to Health card in her possession. The Road to Health card was not before Court, and it would appear did not form part of the plaintiff's discovery.

1.6.4 In the report filed by Dr Songabau, he stated that the biological mother had handed him the Road to Health card, and he confirmed same at the hearing. He however did not record the birth measurements contained in this card in his report. It appeared that Dr Songabau was the only expert before Court that had sight of the Road to Health card.

1.6.5 Subsequent to the biological mother and Dr Songabau's testimony, the plaintiff did not make the Road to Health card available for the benefit of the other experts or the Court.

1.6.6 Dr Songabau did not explain why he did not obtain the important information pertaining to the minor child's birth records from the Road to Health card which would have assisted in resolving the issue of suspected CPD.

1.7 ULTRASOUND

1.7.1 Dr Songabau testified that CHBH should have done an ultrasound to exclude CPD after the referral from the clinic and not doing so amounted to negligence.

1.7.2 Dr Marishane and Lefakane disagreed on the use of ultrasound to determine CPD. According to them, there are various factors that would influence the effectiveness of an ultrasound especially towards the end of term. They indicated that the best method to assess whether or not there was a risk of CPD was through physical examination of the mother (using your hands).

1.7.3 Dr Marishane indicated that the assessment by the midwife of a "big" baby at the clinic was a subjective assessment which was not binding

on the staff at CHBH. According to Dr Marishane the midwife receiving the patient at CHBH, will undertake her own assessment of mother and child and act according to what she assesses the situation to be.

1.7.4 The mother was assessed by CHBH, this much is clear from the admissions register where the hight of funds was recorded, the reactive monitor and so forth.

1.7.5 The clinic did not do an ultrasound to diagnose CPD, and made the referral to CHBH just on clinical observations. The note or letter from the clinic to CHBH was not available. The biological mother testified that she took the clinic file and handed it to CHBH, she can therefore not testify to the content of a referral letter or note as she did not brows though it.

1.7.6 From the clinic records that accompanied the biological mother, the sister at CHBH would have been able to analyse the information that was at the disposal of the clinic when they made the referral, and it would guide them on what is expected of them.

1.7.7 Dr Songabau was of the view that CHBH missed an opportunity to perform a C-section due to the clinic referring the biological mother to CHBH as a CPD or possible CPD.

1.7.8 Keeping all the aforesaid in mind, I can find nothing untoward a midwife at CHBH making her own assessment of whether there is a risk of CPD in a patient referred to them from the clinic and only calling on a registrar, inter or medical officer if she deems it necessary. This is the manner in which Prof Bolton described CHBH operated as a training hospital. It is evident from the admission records, which Dr Songabau did not incorporate into an addendum to his report, that the biological mother was assessed by the midwife upon her arrival at CHBH.

1.7.9 The physical evidence does not point towards the biological mother being a CPD and although the clinic has referred the biological mother to CHBH, the biological mother indicated that no mention was made of a C-section by the clinic. Safe for the “big baby” and height of the biological mother, there is nothing that would lend support to the notion that the receiving midwife should have scheduled a C-section upon assessing the biological mother.

1.8 DIFFICULT BIRTH

1.8.1 Dr Songabau testified that the biological mother told him that the delivery was a difficult one. In support of her allegation that the delivery was a difficult one the biological mother mentioned to Dr Songabau that she was very tired when trying to push, a doctor was called to assist with the delivery and instruments were used to help get the minor child out. The biological mother could not recall how many times she tried to push, but stated it was probably around three times, and thereafter the minor child was born.

1.8.2 Dr Marishane testified that primigravida’s does not know what to expect of the labour process, and almost all of them experience it as difficult. According to Dr Marishane, if one has regard to the progression of labour as testified to by the biological mother, her labour progressed rather rapidly for a primigravida, and that would negate the inference that the birth was difficult.

1.8.3 Having regard to the biological mother’s evidence I concur with Dr Marishane’s view that the biological mother did not know what to expect of the labour process and that this appeared to have influenced her perception of the labour process as being difficult which is not supported by the quick progression of labour.

1.9 INSTRUMENTS

1.9.1 Dr Songabau based his view on the issue of prolonged labour on the fact that forceps were used to assist in the delivery of the minor child. According to him the use of forceps was necessary where the mother, as a CPD and primigravida, was struggling to deliver the baby, a doctor had to be called and an instrument used to pull the baby out. The struggle to deliver, the calling and waiting for the doctor and the use of forceps would by necessary implication, caused a delay.

1.9.2 In evidence in chief the biological mother testified that a doctor delivered the minor child, that the doctor used instruments during the delivery and that there was no paediatrician available to assist the minor child. She also gave a description of the doctor who would have used the instruments to deliver the minor child.

1.9.3 The biological mother disputed that sister Mkhoza delivered the minor child and made it clear in evidence in chief that there were only 3 ladies in the room when the minor child was born. The two nurses / sisters and the doctor and it was the doctor that delivered the minor child, not the sister.

1.9.4 During cross examination it was put to her that the doctor she described was identified as Dr Mokhachane, and that she was a paediatrician and that she did not use an instrument to deliver the minor child, in fact she did not deliver the minor child. The biological mother conceded that she could not recall who delivered the minor child and what instruments were used (safe for the scissors).

1.9.5 The biological mother herself stated that a nurse or sister would not use an instrument to deliver a baby.

1.9.6 The biological mother could not describe the instrument that she said was used nor could she describe how it was used. It became evident during cross examination that the biological mother herself did not observe someone using an instrument to assist with the delivery of the minor child. It was noted towards the end of the biological mother's cross examination that she, for the first time indicated that a big instrument was used to remove the minor child. This was after the defendant's counsel put this proposition to her earlier on in cross examination and she responded that she could not describe the instrument.

1.9.7 The biological mother's evidence that a doctor delivered the minor child as opposed to sister Mkhonza and that the said doctor used an instrument to deliver the minor does not stand up to scrutiny and is rejected.

1.10 DELAYED OR PROLONGED DELIVERY

1.10.1 The hospital records reflect that the biological mother was admitted to CHBH at 15h16 on 8 August 2005. However, the biological mother disputed the correctness of this record. According to her she noticed a blood clot at around 13h00 whereafter she called her mother who arrived home on or just after 17h00, she arrived at the clinic at about 17h30 to 18h00 and CHBH at around 19h00[3]. The Plaintiff's evidence corroborated that of the biological mother in so far as the time of the clot and the arrival time of the Plaintiff at home is concerned.

1.10.2 The biological mother testified that she was fully dilated by 22h00 and that she pushed for about 30 minutes before the minor child was born.

[3] P056-21

1.10.3 Although the biological mother testified that she gave birth at 23h00 in evidence in chief, under cross examination when she was referred to the hospital record, she conceded 22h30 to be the correct time of birth.

1.10.4 Dr Songabau explained the stages of labour – the 1st stage is divided into 2 phases, 1st or latent phase is from the onset of labour to 3-4 cm dilation, the 2nd phase is from 3-4 cm to full dilation, the 2nd stage is from full dilation to delivery and the 3rd stage is after delivery.

1.10.5 Given the times as testified to by the biological mother, her 1st phase of labour commenced at 13h00. it is unknown as to when the 1st phase ended as the biological mother was not monitored while she remained at home. The 2nd phase of labour also started off at home and the commencement hour is unknown, however from the biological mother's evidence it ended at 22h00 when she was told that she was fully dilated.

1.10.6 If the standard, as advocated by Dr Songabau, of one hour for one centimetre dilation is applied (without making a finding thereon), the 1st and 2nd phases if combined, does not appeared to be prolonged or delayed. The biological mother's 2nd stage of labour started at 22h00 and by 22h30 the minor child was born. Dr Songabau agreed that half an hour for the 2nd stage is not long and cannot be said to be prolonged or delayed. The 2nd stage of labour was therefore also not prolonged.

1.10.7 The biological mother told Dr Songabau that on admission she was 7 - 8 cm dilated. She arrived at CHBH at 19h00, was admitted at about 19h30.

1.10.8 The biological mother testified that she wanted the nurses to remove the machine as it was causing her pain, but the nurses did not want to remove the machine. She also needed to go to the bathroom, but they said

she must go on the bed, and they came to clean her bed. She indicated that "They kept on saying the baby was too far because I was 8 cm" [4]. The hour at which they said the biological mother was 8 cm dilated is not known.

1.10.9 If the biological mother had been fully dilated at 22h00 the period between 19h30 to 22h00 was two and a half hours. The movement from 7-8 cm to 10 cm dilation in a period of 2.5 hours does not appear to be prolonged, if the one-centimetre dilation per hour standard is applied.

1.10.10 The plaintiff's evidence did not establish that the labour process was prolonged or delayed.

1.11 MOULDING OR CAPUT

1.11.1 Dr Marishane testified that there were no parameters of moulding or caput recorded. Dr Songabau also indicated that due to the lack of records one cannot say if there was moulding or caput.

1.12 2ND CHILD

1.12.1 The plaintiff sought to use the biological mothers second pregnancy and the C-section she had as an additional motivator to indicate that the biological mother was a CPD risk.

1.12.2 However, the biological mother testified that with her second child, she was like with the birth of the minor child, not beforehand scheduled for a C-section. From this one can then deduce that prior to the biological mother going into labour, CPD was not diagnosed.

[4] Transcript p 056-27

1.12.3 The biological mother testified that a C-section was only called for during her second pregnancy when, during labour, the second child did not decent similarly to her first child.

1.12.4 No medical records or reports were obtained from the doctor or hospital that handled the second child's delivery. The experts could not validly compare the two children's deliveries and drawn inferences therefrom due to the lack of hospital and other records.

1.13 NURSES

1.13.1 The hospital records reflect that sister Mkhonza was the person that delivered the minor child. The biological mother disputed the correctness of this record on the basis that a doctor delivered the minor child and not a sister and that only student nurses attended to her during her stay at CHBH.

1.13.2 In her evidence in chief the biological mother testified that the ladies that attended her wore white blouses and that she could see that they were student nurses. The biological mother stated that she distinguished the nurses from the sisters as their epaulette were different. She indicated that the "older one's" had normal epaulette on, where the others had colours like yellow, green and red. The biological mother testified that the nurses which attended to her might have had maroon epaulette on. When it was put to the biological mother, during cross examination, that nurses wore blue epaulettes and that their stripes were white, she indicated that she could not really recall the colour of the epaulette that they wore. The biological mother later testified that she could recall white strips on the epaulette.

1.13.3 Following the biological mother's evidence in chief and during cross examination it became apparent that she could not distinguish between a sister and a nurse, and she had no independent recollection of whether it

was nurses or sisters who attended her on the day in question. The biological mother could not recall whether the nurses or sisters that attended to her were the same set that started out with her and whether they remained together or whether there were others that assisted with the delivery. On her own version there was a lot of movement with nursing staff coming and going. The biological mother testified that she was in pain and confused while in hospital and giving birth. The biological mother used the term sister and nurse interchangeably while giving evidence.

1.13.4 Having regard to the biological mother's evidence in this regard her testimony that only student nurses attended to her and assisted with the birth of the minor child is rejected.

1.14 UPSKILL

1.14.1 Dr Songabau testified that when a patient is transferred from a lower level of care like the clinic, to a higher level of care, like CHBH, the aim is to upload expertise. But in this case the upload was not implemented as the biological mother was only seen by a midwife whose expertise was on the same level as those at the clinic.

1.14.2 Dr Marishane disagreed with Dr Songabau because in the public sphere, the aim of a transfer like the one under discussion, is to ensure that facilities and expertise are available which are not available at the clinic. According to Dr Marishane, a timeous transfer ensures that the facilities and expertise are available to the staff and patient when it is required for the patient's care, and this happened as the referral from the clinic to CHBH was made timeously.

1.14.3 Having regard to the evidence of Prof Bolton with regard to how CHBH as a training hospital functions and the reporting lines of the nurses,

sisters, registrars and medical officer, it appears to be more probable that the aim of referring the biological mother to CHBH was to ensure that there is a timeous transfer from the clinic to CHBH, where facilities and skills would be available that is not available at the clinic. And not for the biological mother to be referred to a medical officer or registrar upon her arrival at CHBH and for an emergency C-section to be performed.

1.14.4 As already indicated the midwife at CHBH would have had the clinic file at her disposal and would have been able to ascertain the reason for the referral and the biological mother's history form the file. She would have been in the best position to assess after examining the biological mother whether there was a need to call for an intern, registrar or medical officer.

1.15 MONITORING

1.15.1 The biological mother testified that the nurses came to check her regularly and monitored her dilation: "They put the machine on me that monitor the child's heartbeat and they kept it on me for 45 minutes to an hour[5]". "The only thing that they did was taking the child's heartbeat and they kept on coming and checking up on me, I think they were like 30 minutes apart and then they were checking the centimetres and what not[6]" and "They took it off after I complained that I had a, my stomach was very irritated, so I needed to go to the ladies[7]. So, they said no, you cannot go to the ladies, and they were speculating that the baby is on its way, and when I told them I was pressed, they said I must go on the bed. But after that time, they still kept me on that machine. I stayed on the machine for a very long time[8]." and

[5] Transcript p 056-24
[6] Transcript p 056-26
[7] Transcript p 056-26
[8] Transcript p 056-26 - 27

"…they prepped me on the machine and they kept on monitoring it….[9]"and "They kept on saying the baby was too far because I was 8 cm[10]."

1.15.2 The biological mother testified that the CTG machine was placed around her midriff when she arrived at the labour ward. While in the labour ward the nurses came to check up on her and measure her dilation regularly. About an hour and a half later, she wanted them to remove the machine. Though she initially indicated that they removed the machine, she corrected herself and indicated that the nurses refused to remove the CTG machine. The reason the sisters refused to remove the CTG machine was that they needed to monitor the minor child's heart rate with it. The biological mother indicated that she had the CTG machine on for a very long time, two hours or it could have been longer. The biological mother did not testify as to when the CTG machine was removed, if at all.

1.15.3 From the biological mother's evidence, it is apparent that there was continuous monitoring with the CTG machine, the nurses checked the child's heartbeat, her contractions, monitored her dilation and did regular check up on her. The biological mother's evidence did not establish substandard care with regard to monitoring of the biological mother and minor child. To the contrary.

1.16 SUBAPONEUROTIC BLEED

1.16.1 The discharge summary noted a subaponeurotic bleed which was treated with Vitamin K and Fresh Frozen Plasma (FFP). The experts agreed that a bleed would normally be treated with Vitamin K and FFP. The discharge summary did not give an indication as to what might have caused

[9] Transcript p 056-107
[10] Transcript p 056-27

the subaponeurotic bleed neither did any of the other hospital records shed any light on this question.

1.16.2 The biological mother did not testify to noticing any subaponeurotic bleed when the minor child was shown to her.

1.16.3 Dr Songabau testified that normally such type of injuries resulted from the use of vacuum or forceps. It can also be from unknown sources.

1.16.4 Dr Marishane in his report recorded that subaponeurotic bleed can occur with the use of forceps to extract a child in a difficult delivery. In his evidence in chief Dr Marishane stated that he does not know what caused the subaponeurotic bleed but a subaponeurotic bleed can be caused by the use of instruments during the delivery or it can occur during normal vaginal delivery as well. The mother pushing too hard, and the scalp being traumatised by the pelvic bones.

1.16.5 The plaintiff's notion that the subaponeurotic bleed was caused by the use of forceps is rejected due to the finding that forceps were not used during the delivery of the minor child.

1.16.6 The plaintiff thus failed to establish what caused the subaponeurotic bleed.

1.17 CRY AT BIRTH

1.17.1 Sister Mkhonza recorded that the minor child cried well at birth. However, the biological mother disputed this. According to her, the minor child did not cry at birth and they kept on tapping him but he did not cry at birth. The biological mother also testified that she did not hear the minor child

cry at birth and when she asked the sisters where the minor child was, they said he was taken to ICU as he did not cry at birth.

1.17.2 The biological mother in examination stated that she did not hear[11] the minor the minor child cry and it might be quite true that she did not hear him cry, that is however not to say that he did not cry.

1.17.3 The biological mother's evidence did not always stand up to scrutiny and appeared to be unreliable. She for instance disputed Dr Songabua's recording that she told him that she stood in a pool of blood and had a blood transfusion on 9 August 2005 and that she did not tell him that she was referred for an emergency C-section and so forth. Her evidence regarding Dr Mokhashana and the use of forceps was problematic so too her evidence regarding the use of student nurses.

1.17.4 Sister Mkhonza did not testify at the trail and Counsel for the Defendant informed the Court that this was due to her not being able to contribute anything further to the proceedings as she had no independent recollection of the event due to the timelapse.

1.17.5 It is highly improbable that sister Mkhonza would record that the minor child cried at birth and then tell the biological mother that the minor child is in ICU because he did not cry at birth. The authenticity of the register was not placed in issue by the plaintiff.

1.18 APGAR SCORES

1.18.1 Sister Mkhonza recorded an APGAR score of 6/10 in the first minute. However, the discharge summary reflects an APGAR score of 2/10 in the first minute and a 5/10 in five minutes. There is no entry for a ten-minute

[11] Transcript P 056-35

score. Prof Bolton explained that normally the ward register would be kept at the mother's bed and the sister would complete that and keep that at the mother's bed and the register would remain in the labour ward after the mother's discharge. This registered would be updated as soon as possible after the birth of the minor child. The minor child was taken to ICU after his birth, and in all probability APGAR scores were recorded for the minor child at ICU as well, as he was no longer under sister Mkhonza's care, and she could thus not record a 5-minute score. And this would explain why there are two one-minute APGAR scores before Court. The discharge summary was completed by someone from ward 66 almost 11 days later, and it is unknown whether this person would have been aware of the APGAR score recorded by sister Mkhonza. The discharge summary is not a document in which contemporaneous notes are made.

1.18.2 The explanation offered by Prof Bolton is logical and appears to be in line with the working practices at CHBH.

1.19 PLACENTA

1.19.1 The biological mother testified that her placenta had to be removed in theatre the day after she gave birth to the minor child. The biological mother disavowed standing in a pool of blood on the morning of 9 August 2005 as described by Dr Songabau in his report. She also disputed having received a blood transfusion as mentioned by Dr Songabau. She also disputed feeling ill on the morning.

1.19.2 According to Dr Songabau not ensuring that the placenta was completely expelled amounts to substandard care. Dr Songabau did not file an updated report hence he did not deal with the hospital record where a note regarding the placenta was made.

1.19.3 According to Dr Marishane, the retained placenta can be an indication of an abnormally adherent placenta, it can be an indication of a satellite placenta, or it could be that it was not the whole placenta that was retained but just portions of the placenta that was retained. According to Dr Marishane, very little to no blood loss might be an indication of hypoglycaemia. Dr Marishane indicated that if the mother did not receive a blood transfusion and that she was not anaemic it supports a finding of hypoglycaemia as a probable cause or contributor to the brain injury.

1.19.4 Dr Lefakane also testified that when a mother struggle to deliver a child or worked too hard to push the baby out this could have affected the oxygen levels of the child.

1.19.5 The biological mother did indeed testify that she was exhausted when she had to push the baby out. This aspect did not receive a lot of attention during the trail as the experts were guided by their reports and joint minutes and was not asked to adjust their views and opinions according to the evidence of the biological mother during the trail.

1.19.6 It is uncertain whether it was the whole placenta that was retained or portion of the placenta or whether there was a satellite placenta that was removed. Taking into account that the biological mother testified that she did not bleed, did not fell ill and did not have a blood transfusion Dr Marishane's view that what was removed might have been a satellite placenta seems more probable.

1.20 DESCRIPTION OF MINOR CHILD

1.20.1 The biological mother testified that the nurse showed the minor child to her after birth. She described the minor child as looking beautiful, a handsome boy. She said he was very light in colour and under cross

examination she testified that she would not know whether the minor child was blue or deprived of oxygen by looking at him as she would not know what to look for or how a child that is blue looked like.

1.20.2 According to Prof Bolton a child with the APGAR scores as contained in the discharge summary would have been “flat” and the biological mother would have noted that immediately as the minor child would have been “floppy”.

DISCUSSION

[104] The experts agreed that the discharge summary indicated that the minor child suffered a subaponeurotic bleed and that such a bleed is normally treated with fresh frozen plasma and vitamin K. The discharge summary recorded the use of fresh frozen plasma and vitamin K. The CHBH employees treated the subaponeurotic bleed appropriately.

[105] The discharge summary recorded that the minor child suffered birth asphyxia. It was not recorded when the birth asphyxia occurred or were noticed. Same goes for the HIE.

[106] It was furthermore recorded on the discharge summary that the minor child suffered a convulsion, this was treated with phenobarbital, there were no recurring convulsions, and no maintenance was required. The experts agreed that phenobarbital was the appropriate treatment for convulsions. It was not recorded when the convulsion occurred. How strong or weak the convulsion was also unknown.

[107] The experts furthermore agreed that the blood gas levels of the minor child as recorded on the discharge summary indicated a severe metabolic acidosis. Dr Lefakane testified that birth asphyxia can cause acidosis and Prof Bolton testified that stroke could also cause acidosis.

[108] It is also not evident what caused the subaponeurotic bleed. Dr Songabau was of the view that it could have been caused by the use of forceps, having excluded the use of forceps, it is unclear what caused the subaponeurotic bleed.

[109] A delayed or prolonged 2nd phase of stage 2 of labour is excluded based on the biological mother's evidence.

[110] The experts were in agreement that from the discharge summary there does not appear to have been any sentinel event.

FINDING

[111] Based on the evidence, the Court finds that:

1.1 There was proper monitoring of the biological mother and foetus during delivery by the staff at CHBH;

1.2 Labour was not unduly prolonged or delayed;

1.3 It cannot be found with sufficient certainty whether the minor child suffered a stroke(s) before, during or after birth and that it followed due to any substandard care from CHBH;

1.4 It cannot be found with sufficient certainty what caused the subaponeurotic bleed;

1.5 The harm to the minor child did not result from any negligence on the part of the CHBH staff.

COSTS

[112] The normal rule is that costs follow the result. In this instance I do not believe that it would be fair on the parties to order the plaintiff to bear the costs of the defendant as she stepped into the shoes of the biological mother once she adopted the minor child, and the biological mother was acting in the best interest of the minor child when she brought the claim.

[113] Safe for any costs order already issued and the interlocutory applications costs each party will be responsible for their own costs.

INTERLOCUTORY APPLICATION

[114] The defendant during the trail brought an interlocutory application sought to discover documents that was not included in their earlier discovery notices. The plaintiff opposed this application.

[115] Having regard to the papers and council's submissions the application was granted. The explanation tendered for the omission to file the discovered documents was acceptable and any prejudice the plaintiff might have suffered could be cured by an appropriate costs order. Furthermore, all the witnesses were in attendance and the parties would have been able to deal with the additional documents without too much upheaval. As this is in essence a children's matter, it is prudent to have all the information before Court which could assist the Court. The matter has been dragging on for many years and finality needs to be achieved at some stage.

[116] The defendant is liable for the costs associated with the interlocutory application, the postponement and hearing of the application. This is to include the costs of two counsel for the plaintiff.

ORDER

The Court therefore orders that:

[1] The action is dismissed.

[2] The defendant is to pay the costs of the interlocutory application, the postponement associated with the postponement and the adjudication of the application.

[3] Each party to bear its own costs.

BEZUIDENHOUT, AJ
ACTING JUDGE OF THE HIGH COURT
GAUTENG DIVISION

This judgment was handed down electronically by circulation to the parties' and/or parties' representatives by email and by being uploaded to CaseLines. The date and time for hand-down is deemed to be 10h00 on 8 July 2022.

Date of delivery:	08 July 2022
Appearances:	
On behalf of the plaintiff:	Adv W Wisani SC
With him:	Adv M Wisani
Instructed by:	PG Makondo Attorneys
On behalf of the defendant:	Adv N Makopo
Instructed by:	State Attorney Johannesburg