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

CASE NO: 42380/2014

DATE: 25TH AUGUST 2022

REPORTABLE: **NO**

OF INTEREST TO OTHER JUDGES: **NO**

REVISED:

In the matter between:

L [....] 1: M [....] P [....] **NO**, for and on behalf of:

L [....] 2: L [....] 3 K [....]

Plaintiff

And

**THE M E C FOR HEALTH AND SOCIAL DEVELOPMENT,
GAUTENG PROVINCIAL GOVERNMENT**

Defendant

Coram: Adams J

Heard: 11, 13, 14, 15, 18, 19, 20, 22 February 2019, 27, 28, 29 March 2019,
23, 24 July 2019, 20, 22 January 2020, 23 March 2020, 18, 19, 20, 22 January 2021,
26 February 2021 and 25 February 2022

Delivered: 25 August 2022 – This judgment was handed down electronically by circulation to the parties' representatives by email, by being

uploaded to *CaseLines* and by release to SAFLII. The date and time for hand-down is deemed to be 12:30 on 25 August 2022.

Summary: Trial – Delict – medical negligence – damages – liability in respect of a minor born with brain damage who now suffers from cerebral palsy – whether hospital staff negligent – if so, whether such negligence caused the damage – negligence and causation established – MEC liable.

ORDER

(1) It is declared that the defendant is liable for 100% of the damages that are proven or agreed to be due to the plaintiff in her capacity as parent and natural guardian of her minor child arising from his brain injury.

(2) The defendant shall pay the plaintiff's costs of the determination of this issue relating to his liability.

JUDGMENT

Adams J:

[1]. On 25 June 2005, at about 08:30, a baby boy, weighing 3190 grams, was born by caesarean section to the plaintiff at the Chris Hani Baragwanath Academic Hospital ('CHBAH' or simply 'the hospital'). This had been her second pregnancy and prior to giving birth she had presented herself at the CHBAH antenatal clinic on 7 March 2005 and thereafter attended same regularly from that date to the day on which her son was born. According to her 'antenatal card', the plaintiff had visited the antenatal clinic on 7 March, 26 April and 19 May 2005. During that time, she was diagnosed as being HIV positive and on or about 30 May 2005 she was prescribed and started on anti-retroviral therapy. But for the diagnosis of HIV Positive, the plaintiff was otherwise in good health and the pregnancy progressed well. By sheer coincidence, the plaintiff participated in a clinical trial and research project by doctors and scientists from the University of the Witwatersrand, and data relating to the plaintiff was collected and retained by the scientists in relation to the period from about March to after the birth of the baby during June 2005. The clinical trial was

conducted under the title: 'Prevention of Perinatal Sepsis Trial' (Pops), which, needless to say, assisted the matter from the point of view of access to and availability of records, reports and related documentary evidence.

[2]. At 07:20 on 24 June 2005, when she was thirty-nine weeks pregnant, the plaintiff was admitted to the maternity section of the CHBAH, after her membranes had ruptured reportedly at about 03:00 that morning. She presented with complaints of lower abdominal pains. On her admission, the foetal movement was recorded as 'good' and the physical examination of the plaintiff herself presented with 'no abnormalities detected'. So, for example, her blood pressure was recorded as 120/70. The contractions at that stage were reported as mild and the Cervix dilatation was recorded as 2 cm.

[3]. Fast forward to twenty-four hours later, when an emergency caesarean section was performed at about 08:30 on 25 June 2005 because of and after 'no progress during labour' and after two attempts at vacuum extraction failed. Plaintiff's baby was delivered by caesarean section, which was performed some seven hours after the procedure had been booked by the medical and nursing staff. The baby had suffered a hypoxic ischemic injury ('HIE') during the birth process, which resulted in cerebral palsy. The post-delivery clinical notes recorded *inter alia* that the baby had suffered birth asphyxia.

[4]. In this action, the plaintiff – in her personal capacity and as the mother and natural guardian of her minor son, who is presently seventeen years old – sues the defendant. The CHBAH falls under the auspices of the defendant, who is responsible in law for any injury caused by the negligence of staff employed there. The plaintiff alleges that the hospital staff had been negligent during the birth of her child and that this negligence caused the hypoxic ischemic injury ('HIE') and its sequelae. As a result, she claims damages on her own behalf and on behalf of her son.

[5]. It is the case of the plaintiff that the nursing and medical staff at the hospital were negligent in that they failed to assess the plaintiff's labour properly, sufficiently and/or adequately after her admission to the hospital and therefore failed to detect cephalopelvic disproportion, which occurs when there is a mismatch between the

size of the foetal head and the size of the maternal pelvis, resulting in 'failure to progress' in labour for mechanical reasons. The plaintiff further alleges that the employees of the defendant failed to monitor the progress of her labour and the foetal well-being with sufficient regularity during labour. This resulted, so the plaintiff contends, in a failure to detect that the foetus was in foetal distress during plaintiff's labour after admission to the hospital. The plaintiff furthermore avers that the hospital failed to timeously take appropriate and effective action to prevent further distress to the foetus or to prevent the foetus from suffering any harm. Lastly, it is the case of the plaintiff that doctors and nurses at the hospital negligently failed to timeously deliver the baby by caesarean section when they realised that the labour was not progressing as it was supposed to and that the foetus was in distress.

[6]. The defendant denies liability. The medical and nursing staff of the hospital, so the defendant alleges, did not act negligently. It is the case of the defendant that the child did not sustain an injury while the plaintiff was in labour or when the child was delivered. All things considered and having regard to the evidence led during the trial, the defendant seems to accept that the care given to the plaintiff, the management of her labour and the delivery of the child can best be described as substandard. It is however the case of the defendant that there was no causal connection between the negligence, the injury suffered by the child and the sequela in the form of *inter alia* cerebral palsy. The defendant hypothesised that there were a number of possible causes of the child's condition and the adverse outcome following his birth. Importantly, the defendant contended that: (1) the HIE, which the child suffered, was the result of the plaintiff's HIV infection and the in-utero exposure of the child to the effects of the HIV infection; and (2) The HIE could possibly have resulted from some or the other form of infection or sepsis. So, for instance, the defendant's expert witnesses attempted to implicate a specific infection, namely clinical *chorioamnionitis*, which is undetectable without a histological examination of the placenta, as a possible cause of the HIE which the child had suffered. In this condition, bacteria infect the chorion and amnion (the membranes that surround the foetus) and the amniotic fluid (in which the foetus floats). This can lead to infections in both the mother and foetus.

[7]. The defendant accordingly denied the version of the plaintiff that the HIE, which caused the child's cerebral palsy, was not caused by such infections but by an intrapartum insult causally connected to the substandard care dished out by the hospital staff during labour and the birth of the child.

[8]. Therefore, the issues before me are whether the plaintiff proved that the hospital staff were negligent and, if so proved, whether that negligence caused or contributed to the injury suffered by the plaintiff's child. The plaintiff bears the onus of proof on these issues. It bears remembering that the required standard is proof on a balance of probabilities.

[9]. I interpose here to mention that at the commencement of the trial, the parties agreed that it would be convenient to separate the issues of liability from that of the quantum of the plaintiff's claim. An order to that effect was granted in terms of uniform rule of court 33(4) and the matter proceeded to trial only on the issues of negligence and liability. The quantum of the plaintiff's claim was postponed *sine die*.

[10]. The foregoing issues are to be decided against the factual backdrop as set out in the paragraphs which follow. The facts are extracted from the evidence of the plaintiff herself – she was the only factual witness, as well as from the clinical notes and hospital records, on which was based the reams and reams of expert testimony on behalf of both the plaintiff and the defendant. The following expert witnesses gave evidence in support of the plaintiff's case: Dr Burgin (Obstetrician Gynaecologist); Dr Lefakane (Paediatrician); Dr Manyane (Paediatric Neurologist) and Dr Tracy Westgarth (Radiologist).

[11]. The parties had also agreed that a joint minute of a pre-trial conference between their respective radiologists (Dr Westgarth for the plaintiff and Dr Weinstein for the defendant) was to be accepted into evidence without the said experts having to give evidence. The agreement between the parties was that the contents of the minute were to be accepted as fact.

[12]. The defendant called the following expert witnesses: Dr Weinstein (Radiologist); Professor K D Bolton (Paediatrician); Dr Mtsi (Obstetrician Gynaecologist); and Dr V M Mogashoa (Paediatric Neurologist).

[13]. It is not necessary for me to deal in detail with the expert testimony on behalf of either of the parties. The reason for that is that a substantial portion of the expert testimony was rendered redundant and superfluous when, late in the trial, further clinical notes and additional hospital records became available from the clinical trials which had been conducted by Wits University. Those documents addressed a number of issues raised by the experts as well as disagreements between opposing experts, and in fact resolved some of those disagreements. So, for example, the evidence of a Dr Cutland, a scientific coordinator from Wits University, who was part of the clinical trial and whose evidence introduced the additional documents, ruled out, in my view, an infection or, for that matter, sepsis, as a possible cause of the injury sustained by the plaintiff's unborn child. In that regard, the evidence of Dr Cutland was as follows:

'But this mom did not have clinical features of sepsis.'

[14]. As already indicated, the evidence on behalf of the defendant, on my reading, suggests that he and his expert witnesses accepted and conceded that the care received from the hospital during the birth of her son was substandard and that would, on first principles, make the hospital negligent. Even if my understanding of the defendant's evidence in that regard is wrong, it does not really make any difference, because the uncontested and unchallenged evidence supports a conclusion that such care was in fact objectively speaking substandard. Those facts are as follows.

[15]. The plaintiff was a '*Para Gravida 2*' at the time of the birth of the child on 25 June 2005. This means that, on admission to the hospital, the plaintiff was a high risk patient for two reasons. Firstly, she was HIV positive, which is a risk factor for hypoxia. Secondly, she had a previous caesarean section during 1997. Both of the foregoing signalled the need for careful monitoring, *inter alia*, by way of a cardiotocograph (CTG). This measures foetal heart patterns. If the foetus is not

supplied with sufficient oxygen, abnormal heart rates result. There are various warning signs of impending foetal hypoxic distress. Where these are present, the medical staff need to take action.

[16]. During the four visits she attended at the antenatal clinic from March to May 2005, the plaintiff was noted not to have any current pregnancy complications. She did not have gestational diabetes, hypertension, asthma, cardiac problems and anaemia. No antibiotics were given during her pregnancy. A positive RVD test was recorded and HIV therapy was initiated with *Nevirapine* on 24 June 2005. Six vaginal examinations were done between labour and delivery. No evidence of intra-amniotic infection was recorded. Importantly, no foul-smelling vaginal discharge, maternal tachycardia (>100 bpm), foetal tachycardia (>160 bpm) and maternal leucocytosis (white blood cells > 12x10⁹/l) were noted and the WR/RPR test was negative.

[17]. An artificial rupture of membranes ('ROM') was performed at 19:00 on 24 June 2005 and meconium stained liquor was noted. A prolonged second stage was recorded. An emergency caesarean section was performed, seven hours after it was booked, and the baby was delivered at 08:30 on 25 June 2005. The APGAR scores were 5/10 in 1 min and 8/10 in 5 min and no resuscitation was done. The infant was admitted to the Neonatal Intensive Care Unit ('NICU') of the hospital. The post-delivery notes relating to the infant made reference to the following adverse events: 'Birth asphyxia with ABG – pH = 7.18 and BE = -21.2, low APGARS, coffee ground aspirate for which stomach washout was done, seizures and developing *Phenobarbitone* toxicity. *Phenobarbitone* was withdrawn and the symptoms resolved'. As regards the central nervous system ('CNS'), the baby's symptoms were recorded as irritability, lethargy and seizures. The symptoms were treated with oxygen, antibiotics and anticonvulsants.

[18]. This narrative, in my view, evidences conclusively that the care by the maternity staff at the hospital was substandard. This is evidenced by the infant's delivery being attempted with vacuum extraction twice for prolonged labour and foetal distress. The failure to deliver the infant led to a booking of a C/Section and may have initiated brain trauma. And the substandard care persisted with the plaintiff enduring a delay of seven hours before the C/Section was performed. Moreover, the

duration of the labour was more than twenty-four hours – it was therefore extremely prolonged, especially the first phase of active labour. In this phase the cervix of a *Para Gravida 2*, such as the plaintiff, would dilate from 4cm at the rate of 1 cm per hour up to 10cm, after which point the second phase of labour would commence and the baby would be delivered.

[19]. If the dilatation started at 08h00 on 24 June 2005 and progressed at the normal rate of 1cm per hour, the plaintiff should have been fully dilated by 18:00. This did not happen and there should have been cause for concern and required urgent intervention. The doctor should have been called immediately at 19:40 and the baby should have been monitored every thirty minutes in view of the problems which were manifesting, viz slow descent and slow progress of dilatation.

[20]. None of this happened. So, as indicated above, the standard of care received by the plaintiff was below par, *nay* far below par. What is more is that there is no indication from the hospital records from 20:00 to 01:15 of any attempt to determine why the dilatation was slow and had in fact stopped at 8cm. Between 12:00 and 15:10 on 24 June 2005 there is no foetal heart rate monitoring or maternal monitoring.

[21]. Therefore, in my view, there can be little doubt that the hospital was negligent. The question remaining though is whether, on the evidence led during the trial, it can be said that such negligence caused the insult to the brain of the unborn child and the resultant injury. In that regard, the following facts are instructive.

[22]. The infant was delivered in meconium stained liquor (MSL) and, as a result, may have aspirated MSL. The aspiration could have caused hypoxia and metabolic acidosis both of which manifested as lethargy, low Apgars and seizures as recorded above. Birth Asphyxia is recorded as a diagnosis and probably happened when the infant did not receive enough oxygen. The hypoxia and metabolic acidosis may cause HIE or brain damage. The HIE needs hypothermia treatment to alleviate brain damage.

[23]. In that regard, the evidence of Dr Cutland is important as it shows that there was no infection present save for the HIV in the mother and that this did not have any effect on the child at all. Her evidence also provides the blood gas results which shows that there was acidosis in the child at birth indicating an intrapartum cause of the brain injury.

[24]. The child also presented significant caput (swelling of the skull or fontanelle). The child remained in the hospital from 25 June until 16 July 2005 when he was discharged into the care of his mother and sent home. The child presented with feeding difficulties during his admission in the NICU and further stay in hospital and suffered convulsions and seizures in keeping with the consequences of asphyxia or hypoxic ischaemia on the neonatal brain and consistent with the sequela of neonatal encephalopathy. The child subsequently developed epilepsy which is indicative of an encephalopathy and was treated with the drug Epilim. The clinical record also indicates that the child also developed Epilim toxicity. The child now suffers from mixed spastic cerebral palsy and microcephaly with profound intellectual disability. Also, a mixed picture of asymmetric spastic quadriplegia and dystonia.

[25]. The MRI brain scan dated 30 June 2017 demonstrates features consistent with chronic sequela of a partial prolonged hypoxic ischemic brain injury coupled with evidence of an acute profound injury or neonatal strokes. There are no stigmata of intracranial syndromic disorder and there are no features to suggest complicated intracranial sepsis (infection). The implication of this is that the child does not suffer from a brain injury which was caused by HIV infection or AIDS, inflammatory infections such as meningitis, syphilis, or any other TORCH infections. TORCH stands for toxoplasmosis, rubella, cytomegalovirus, herpes and other agents and TORCH infections are the term given to a group of infectious diseases that can be passed to a baby during pregnancy, at delivery or after birth.

[26]. The child itself is not HIV infected and the mother and child had been given a single dose of Nevirapine to prevent mother to child transmission of the HIV virus as was the practice at the time. Importantly, there is no recorded evidence to suggest that a HIE in the antepartum as well as postpartum period. Clinically no genetic

predisposing familial or antenatal factors could be identified. There are no obvious congenital genetic / syndromic causes for the child's neurological deficits.

[27]. The plaintiff has one other child, who was also delivered by caesarean section but is healthy and does not suffer from any of the health and neurologic deficits which her other child has. As already indicated, during her pregnancy, the plaintiff attended at the antenatal clinic every month where she was vaginally examined by the nurses. They also took readings of her blood pressure, weighed her and checked the health of the foetus. On each occasion, so the plaintiff testified, she was informed by the nursing sisters that the baby was doing fine and the pregnancy was progressing well.

[28]. The foregoing, in my view, excludes as a possible cause any of the defendant's hypotheses, notably that the HIE could possibly have been caused as a result of an infection or the HIV Positive status of the plaintiff. That then brings me back to the substandard treatment received by the plaintiff from the hospital after her admission.

[29]. As has already been indicated, the plaintiff was admitted to the hospital at 07:20 on 24 June 2005. She was seen to and attended on by a nursing sister, who checked her cervical dilatation, did a CTG and then took the plaintiff to a bed in a room where she left her for approximately five hours without any further examination. Her evidence was furthermore that, when next she was examined at about 15:10, the nurse only did a manual check of her dilatation and then left again without saying anything to her about the dilatation. She was again seen thereafter at 19:40. No CTG was done, and no foetal examination or monitoring was done, and, so the plaintiff testified, she was not examined again until approximately 01:00 on 25 June 2005 when a doctor arrived and told her that she was to be taken to the labour ward where he would deliver the baby.

[30]. The doctor did not examine her, but she was placed on a stretcher and prepared for theatre by the nurse. She however remained waiting for a few hours until approximately 06:00 when an attempt was made to monitor the foetus. This did not succeed as the CTG belt could not be found. At approximately 07:20 she was

found to be fully dilated and therefore taken into the theatre for delivery. In the theatre she was told to push, and the doctor attempted to deliver the baby using a vacuum extractor. He attempted to deliver the baby twice using the vacuum but failed on both occasions although he also gave the plaintiff an episiotomy.

[31]. She was then given an epidural injection and the baby was delivered by caesarean section at approximately 09:30 on 25 June 2005. The child was shown to her after delivery, and she noted that the child did not cry. The child was taken away by the nurse to the neonatal intensive care unit where she saw the child after three days. She noted that the child had a pipe in his nostril, and she was informed that the child had suffered epileptic seizures while in the ICU. She was also informed that the child was cup fed and she noted that he could not breast feed and his suck reflex was weak. Plaintiff was discharged from hospital after three days, but the child stayed in hospital for a further two weeks during which period she visited him every day. The doctor informed her that the child had suffered brain damage and that he would be slower than other children and that his condition would not change. In addition, she was informed that his head would not grow like other children's heads and he needed to be cup fed as he could not suck.

[32]. Her child, so the plaintiff testified, has not achieved the appropriate age milestones and she was informed at the clinic that he suffered from cerebral palsy when she took him for treatment.

[33]. The evidence confirmed that there is no record of foetal or maternal monitoring between 03h30 and 06h00 on 25 June 2005 and is unable to explain why that is so given the fact that at this point the Plaintiff and foetus needed to be monitored continuously while waiting for the caesarean section to be performed. It is not possible to determine from the hospital records what the condition of the foetus was between 06h00 and 07h20 on that day.

[34]. In the circumstances and having regard to these facts, the contention by the defendant's experts, notably Dr Mtsi, who was of the view that the plaintiff had suffered an inflammatory infection (chorioamnionitis), and that this infection had caused a placental pathology which in turn resulted in a deficiency in blood perfusion

and therefore a HIE, can and should be rejected. Dr Mtsi's view was based almost exclusively on her *ex post facto* diagnosis of chorioamnionitis based, in turn, on the fact that on 13 June 2005, the plaintiff had a body temperature of 38 degrees Celsius. Apart from this isolated elevated body temperature on one day, the plaintiff did not display any other symptoms of chorioamnionitis. She was also not able to explain the mechanism by which the chorioamnionitis would cause the injury which the child suffered.

[35]. As corrected submitted by Mr Brown, who appeared on behalf of the plaintiff, that should be the end of that hypothesis. It is more likely that the injury the child suffered resulted from an accumulation of the following factors: the cephalopelvic disproportion (the foetus was stuck in the plaintiff's pelvis for a period of more than twelve hours); there was evidence of thick meconium passage indicating foetal distress; the child showed excessive *caput* (swelling of the brain due to excessive pressure of the uterine contractions on the child's head); and the prolonged labour – all of which point a finger at the medical and nursing staff at the hospital.

[36]. It bears repeating that, according to the uncontested and unchallenged evidence of Dr Cutland, the records indicated that the blood gas analysis done on the child at birth, indicated that the child was acidotic thereby confining the HIE to the intrapartum phase. In addition, the records also demonstrated conclusively that the plaintiff's vital statistics such as body temperature, blood pressure, etc, were normal on the date of birth of the child. Moreover, as was conceded by Dr Bolton, the study undertaken by Dr Cutland's team looked specifically for sepsis in the plaintiff and none was found. That then rules out sepsis as a possible cause of the injury to the brain of the plaintiff's child.

The Law and its application *in casu*

[37]. Mr Brown referred me to *Minister of Safety and Security v Van Duivenboden*¹, in which the SCA held as follows at para 25:

¹ *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA), [2002] ZASCA 79;

‘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.’

[38]. Furthermore, in *Minister of Finance and Others v Gore NO²*, the SCA commented as follows at para 33:

‘Application of the “but for” test is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the ordinary person’s mind works against the background of everyday life experiences.’

[39]. Applying these principles to the present matter, leads me to the conclusion that the negligent conduct on the part of the hospital in the form of the substandard care received by the plaintiff of its staff, caused the HIE and led to the cerebral palsy. That is a common sense logical conclusion to be drawn from the facts in the matter. On the flipside of the coin is the contention by the defendant, which, so Mr Brown contended, amounted to no more than speculation. In that regard, I was referred to *Ratcliffe v Plymouth and Torbay Health Authority³*, in which Lord Justice Brooke made the point that:

‘... surrounding a procedure which led to an unexpected outcome for a patient. If such a case should arise, the judge should not be diverted away from the inference of negligence dictated by the plaintiff’s evidence by mere theoretical possibilities of how that outcome might have occurred without negligence: the defendants’ hypothesis must have the ring of plausibility about it. It is likely to be a very rare medical negligence case in which the defendants take the risk of calling no factual evidence, when such evidence is available to them, of the circumstances.’

² *Minister of Finance and Others v Gore NO 2007 (1) SA 111 (SCA)*, [2006] ZASCA 98;

³ *Ratcliffe v Plymouth and Torbay Health Authority* [1998] EWCA Civ 2000 at paragraph 48;

[40]. I find myself in agreement with these submissions.

[41]. As regards the issue of negligence, Mr Brown referred the Court to *Vallaro obo Barnard v MEC*⁴, in which it was held, with reference to *McIntosh v Premier, Kwazulu-Natal and Another*⁵, that:

‘The second inquiry is whether there was fault, in this case negligence. As is apparent from the much-quoted dictum of Holmes JA in *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E-F, the issue of negligence itself involves a twofold inquiry. The first is: was the harm reasonably foreseeable? The second is: would the *diligens paterfamilias* take reasonable steps to guard against such occurrence and did the defendant fail to take those steps? The answer to the second inquiry is frequently expressed in terms of a duty. The foreseeability requirement is more often than not assumed, and the inquiry is said to be simply whether the defendant had a duty to take one or other step, such as drive in a particular way or perform some or other positive act, and, if so, whether the failure on the part of the defendant to do so amounted to a breach of that duty. But the word “duty”, and sometimes even the expression “legal duty”, in this context, must not be confused with the concept of “legal duty” in the context of wrongfulness which, as has been indicated, is distinct from the issue of negligence.

The crucial question, therefore, is the reasonableness or otherwise of the respondents’ conduct. This is the second leg of the negligence inquiry. Generally speaking, the answer to the inquiry depends on a consideration of all the relevant circumstances and involves a value judgment which is to be made by balancing various competing considerations including such factors as the degree or extent of the risk created by the actor’s conduct, the gravity of the possible consequences and the burden of eliminating the risk of harm.
...

⁴ *Vallaro obo Barnard v MEC* Appeal Case No A 5009/16, Gauteng Local Division (Full Court);

⁵ *McIntosh v Premier, Kwazulu-Natal and Another* 2006 (6) SA 1 (SCA);

[42]. There can be little doubt, when applying these principles to the present matter, that the defendant's employees were negligent. The obstetric records indicate that the progress of labour was impeded by cephalopelvic disproportion, the baby's head was too big to pass through the plaintiff's pelvis. This problem was aggravated when the hospital staff attempted to extract the baby by using a vacuum extractor to pull the baby through the plaintiff's pelvic gap. The baby's head became impacted (stuck) in the pelvis and had to be dislodged by way of a caesarean section and then delivered. This delay in the labour process caused the baby to become hypoxic, its head was subjected to excessive pressure evidenced by excessive caput (swelling) and moulding. The combination of delay in labour and excessive pressure on the head led to foetal distress and HIE.

[43]. This insult and injury resulted from a failure properly monitor the plaintiff's labour, to detect foetal distress, to intervene timeously and to assist appropriately with the delivery of the child. If the birth was properly managed, the stressful situation facing the foetus could and should have been recognised and reacted upon. This is the very definition of negligence.

[44]. Moreover, a direct causal link between the negligence of the defendant and the adverse outcome has been established. If there was proper monitoring and assistance, foetal distress would have been detected and appropriate assistance would have been given with the delivery by a timeous caesarean section to prevent the HIE insult, which resulted in the cerebral palsy.

[45]. Accordingly, the relief sought by the plaintiff should be granted.

Costs

[46]. The general rule in matters of costs is that the successful party should be given his costs, and this rule should not be departed from except where there are good grounds for doing so, such as misconduct on the part of the successful party or other exceptional circumstances.

[47]. I can think of no reason why I should deviate from this general rule.

[48]. I therefore intend awarding costs against the defendant in favour of the plaintiff.

Order

[49]. Accordingly, I make the following order: -

(1) It is declared that the defendant is liable for 100% of the damages that are proven or agreed to be due to the plaintiff in her capacity as parent and natural guardian of her minor child arising from his brain injury.

(2) The defendant shall pay the plaintiff's costs of the determination of this issue relating to his liability.

L R ADAMS

Judge of the High Court of South Africa

Gauteng Division, Johannesburg

HEARD ON: 11, 13, 14, 15, 18, 19, 20, 22 February 2019,
27, 28, 29 March 2019, 23, 24 July 2019, 20, 22
January 2020, 23 March 2020, 18, 19, 20, 22
January 2021, 26 February 2021 and 25
February 2022.

JUDGMENT DATE: 25th August 2022

FOR THE PLAINTIFF: Advocate Desmond Brown

INSTRUCTED BY: P P Milazi Incorporated, Fleurhof, Roodepoort

FOR THE DEFENDANT: Adv Roshnee Mansingh

INSTRUCTED BY: The State Attorney, Johannesburg