IN THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

Case Number: 53151/ 2015

9/12/2016

Reportable: Yes

Of interest to other judges: No

Revised.

In the matter between:

MAKHANYA, SIBUSISWE AUDREY
ON BEHALF OF O. M. PLAINTIFF

And

NETCARE HOSPITALS (PTY) LTD
T/A NETCARE FEMINA HOSPITAL 1st DEFENDANT
DR F. M. MOLOKOANE 2nd DEFENDANT

JUDGMENT

Fabrlclus J

1.

While part of the world celebrated Christmas for various reasons on 25 December 2013, a young boy's life was destroyed by the negligence of medical personnel, either due to

the negligence of the staff of First Defendant, the Netcare Femina Hospital, or the acts or omissions of Dr F. M. Molokoane, an obstetrician, who is the Second Defendant in these proceedings, or both.

2.

The child's mother acts herein in her representative capacity as the mother and natural guardian of the minor son who suffered a permanent and total brain impairment (cerebral palsy), arising during the labour process at the hospital on 25 December 2013. It was agreed that the trial would proceed on the issues of liability only, i. e. negligence and causation, and that the issue of quantum would be determined at a later stage, if Plaintiff proved her case.

3.

After the close of Pleadings, the parties agreed on matters that were common cause between them, and prepared a document setting out these facts which was handed in as exhibit A, and which forms part of the record. Expert reports and joint Minutes of experts were also handed in, and it was agreed that these documents were what they purported to be without the need to call the author, although the correctness thereof was not admitted. It was further agreed that the expert reports would serve as evidence into the record, on the condition that the parties were able to lead evidence and cross-examine the experts should they so wish.

4.

Plaintiff gave evidence and also called the following expert witnesses:

4.1. Dr L. Pistorius, a maternal and foetal specialist;
4.2. Prof Jan Lotz, a paediatric neurological radiologist; and
4.3. Sister Barbara Hanrahan, a nursing specialist.

The qualifications of these witnesses as experts were not placed in dispute, nor was their expertise.

5.

Plaintiff s evidence:

She fell pregnant during March 2013 with her first child. She had attended a private obstetrician, Dr Sulliman for her ante-natal care. There were no ante-natal problems. She had also attended ante-natal classes, where she was educated as to what to expect during the labour process, and had done research herself on this topic over the internet.

6.

On 25 December 2013, she experienced lower abdominal pains in the early hours of the morning. Relying on the knowledge that she had gained from her own research, she did not think that she was then in active labour and went about her normal day-to-day activities, which included making prepared meals for her husband and also going for a walk after lunch. After 1ShOO, the pains increased and she was taken to First Defendant's Femina Hospital in Pretoria. She was admitted, taken to a receiving room in the labour ward, was examined, had contractions, and was told that she was in labour. At about 18h00, Dr Sheik saw her and looked at her file. At that time she had confirmed that she did not want pain medication.

7.

After 20h00, the pain became more intense and she was struggling with the intensity of th1se labour pains. A nursing sister told her that they were busy preparing the delivery room and left. After a while, she returned and told her that she had been unable to contact Dr Sheik. She was taken to the delivery room and when she went to the bathroom she saw blood dripping down her legs. She told the nurse about the bleeding and the pains.

8.

She had very strong labour pains. After 21h00, Second Defendant arrived. She checked dilation and she heard that she told the nurse that she was eight centimetres dilated, that the child's head was a bit high and asked whether her "waters" been broken. The nurse answered in the negative, whereupon Second Defendant proceeded to "break her waters". After a few minutes she told the doctor that she had a strong urge to push, but this was ineffective and she had very little energy.

9.

Second Defendant then asked the nurse to obtain the suction apparatus which the doctor then used three times, and thereafter attempted to use forceps. Thereafter the doctor told the nurses to prepare for a caesarean section. The doctor had also asked the nurse to put her on a drip and whilst the nurses prepared for the caesarean section, the paediatrician arrived. She still had the urge to push at the time and told the nurses so, but in reply she was asked not to do so and to lie on her side. The paediatrician was at the foot of the bed and said to the nurse that he could see the baby's head. The nurse replied that there was a need for a caesarean section, but was then told that the baby had "come ouf'. The nurse turned her around and gave instructions to push further. Eventually the baby was born.

10.

Second Defendant did not explain the risks and nature of the instrumental delivery attempts to her and did not obtain her consent, but told her that the procedure was needed as the baby was suffering from distress, which she accepted.

11.

The evidence of Prof Lotz:

He gave evidence about the images of the MRI taken in August 2014, which still correctly reflected the pattern of injury to the brain at the time of birth. The white areas appearing on the MRI images were areas where cells had died as a result of blood being drawn from the brain and shunted to the basal nuclei. These areas effectively

now consisted of water. The images show extensive white matter destruction over almost all areas of the brain. The corpus callosum is globally destroyed, commensurate with extensive peripheral white matter destruction. The MRI images indicated a global and near-total pattern of injury, which meant that the impairment probably arose over a period of at last three hours before the birth. He was of the opinion that the clinical findings would corroborate this time frame. It is not in dispute that the child was born at 23h40.

12.

Dr L. Pistorius:

He is a foetal and maternal specialist, which was a sub-speciality of obstetrics. He also holds a Ph.D. degree in foetal brain imaging. He was of the view that there were no factors, either ante-natal or post-natal, to show that the child would have been born with a brain impairment, but for the negligence of Defendants. He explained how hypoxia arose. Oxygen from the mother's blood diffuses across the membranes to the foetal tissues. Each and every time the mother experiences a contraction, the blood supply to the foetus is compromised, thus cutting off the oxygen llJ the foetus and hence its brain. The longer the foetus is exposed to this compromise whilst the mother is having contractions, the worst the effects would be the foetus, as it cannot recover in time before the next contraction begins. This "snow-balling effect" sets in and compromises the blood-oxygen supply. The stronger, longer or more frequent any contractions are, the more such blood/ oxygen supply is interrupted to the foetus. During the trial, the Plaintiff sought an amendment to her Particulars of Claim relating to a ground of negligence relied on *vis-a-vis* Second Defendant. This was that "she prescribed the drug Pitocin when it was contra-indicated in the presenting circumstances". There was no objection to this application for amendment and it was granted. In this context Dr Pistorius testified that Pitocin (oxytocin) was an artificial uterine stimulant which amplified the frequency and strength of the contractions in an effort to stimulate such activity and expedite delivery. This drug must be used with caution, because as the uterine activity increases, it effectively has the downside of enhancing the limitation of oxygen to the foetus and retaining C02 in the contraction process. He was of the view that it would have been negligent to have commenced Pitocin was administered at 2

2h05 at the time when Plaintiff was already experiencing strong contractions, her labour was progressing well and she had experienced vaginal bleeding. It should have been stopped immediately when foetal bradycardia of 60 to 80 beats per minute was noted at 22h08, as the on-going administration thereof would have been harmful to the foetus if this was probably precipitating bradycardia. The effects of Pitocin could and should have been reversed with the administration of a counter drug. There was no indication that the Pitocin was stopped, and during this time the foetus would have been subjected to the mechanisms of hypoxia. I will deal with the topic of the Pitocin when I deal with the evidence of the Second Defendant.

13.

As far as instrumental delivery was concerned, he testified that it was not indicated, because a number of pre-requisites were required according to normal standards, and there were no written entries that these pre-requisites were present before commencing the procedure. He gave details as to how ventouse (vacuum) delivery should be attempted according to protocol, and also when and how forceps should be used according to protocol. Again, I will deal with this topic when I analyse the evidence of Second Defendant and the parties' submissions thereon.

14.

He added that after the attempts at instrumental delivery failed, the foetal heart rate continued to show bradycardia (low foetal heart rate below the norm). The relevant records indicated that Plaintiff had been pushing for more than one hour whilst they were waiting for an anaesthetist.

He added that the actions or the omissions of the Second Defendant in attempting the failed instrument deliveries, and then not commencing with a caesarean section delivery immediately, was contrary to protocol, and most probably led to the foetus suffering from hypoxia.

15.

Record keeping:

Dr Pistorius was of the view that First Defendant (obviously through its employees), failed to keep proper records. The partogram was not completed properly. Had it been done, it would have provided the Second Defendant with an overview as to the progress of labour, or the lack thereof, the foetal condition, and any complications that were arising at the time. In response to a question by me, he stated that if it had been completed properly, then a doctor would most probably have been called at an earlier stage, and told that the foetus was in distress. This in turn would have led to an earlier caesarean section, and avoidance of the events that led to the cerebral palsy. All of this would have happened a lot earlier than when Second Defendant arrived at the hospital at 21h45. If dilation had been recorded correctly to show lcm at 16h00, but quick progress thereafter, this could be either reassuring, alternatively it could be an alert that the mother was experiencing over-active uterine contractions. The foetal condition should have been assessed and entered into the program and this could have alerted the staff to foetal distress.

It was also protocol that the foetal heart rate should be assessed every 30 minutes in the active phase of labour, before, during and after contractions. The foetal heart rate is a crucial indicator of foetal condition and is assessed by means of an electronic cardio topography ("CTG"). The condition is determined by taking into account the baseline foetal heart rate, as well as other factors including variability (range between beat-to-beat), decelerations, accelerations and variations. There were no CTG tracings available to indicate foetal heart condition from 21h07 to 23h2 5. This was most probably the most critical time when it should have been done after bradycardia arose. There were only tracings of a foetal heart rate at 16h10, 21h48 and 2 3h25.

Foetal heart rate variability:

Foetal heart rate variability represents the balance between the sympathetic and para-sympathetic nervous system. Lack of variability can be an indication of foetal distress. From 16h10, the continuous cardiograph showed that the foetal heart rate had a lack of

variability. This was admitted on behalf of First Defendant. There was no indication that the cause of variability at the time was investigated. Lack of variability could also be due to foetal sleep pattern, but there was no indication that foetal distress was excluded. This meant, according to Dr Pistorius, that it could not be excluded that foetal distress could have arisen from as early as 16h10.

17.

Apgar scores:

Apgar scores are a subjective assessment of the baby's first response to life. Five factors are graded on a scale of 10 at one minute, five minutes and 10 minutes. In this case the one minute score was 3 /10 and five minute score was 6 /10, indicating that the foetus suffered distress shortly before the birth. The 10 minute score of nine indicated that the baby had responded well to resuscitation.

18.

Blood gas results:

The results of blood gas taken shortly after birth yielded a pH reading of 7.083, which was well below the accepted level of 7.2. The base excess reading of -15.2 similarly was unfavourable. The higher the negative BE value above -12, the worse the condition of the infant. In his view these readings indicated that the baby was suffering from metabolic acidosis, an imbalance which arises from foetal distress in which the body has accumulated too much acid and does not have enough bicarbonate to effectively neutralize the effects thereof. In his view both the pH and base excess levels indicated that the baby had been suffering from foetal distress during the labour process.

19.

Ante-partum haemorrhaging:

Plaintiff was noted to have had blood in her urine at 15h45 at admission. This could

have been due to ante-partum haemorrhaging or due to normal process of dilation. She experienced vaginal bleeding at 20h30. This was still present 45 minutes later when it was reported to Second D1fendant at 21h15. There was no indication that the cause of this was investigated either at 15h45 or at 20h30, or thereafter. The bleeding at 15h45 and 20h30 could be linked, but was probably due to cervical dilation.

Ante-partum haemorrhage was an indication for continuous CTG monitoring. CTG should have commenced and should not have been discontinued. It ceased at about 16h50, but should in any event never be considered as a substitute for clinical observation.

20.

Intra-uterine resuscitation:

He was of the view that Second Defendant should have started intra-uterine resuscitation after the failed instrument deliveries whilst waiting for the caesarean section. In his view it was possible that this resuscitation could reverse what would have been a more serious hypoxic ischaemic encephalopathy ("HIE"). There was no indication in the records of such resuscitation. He also added that it could take up to an hour for a caesarean section to be performed from the time of decision.

21.

The joint Minute between specialist obstetricians:
Dr C. Sevenster and Dr Pistorius:

The date of this joint Minute was 12 October 2016. The joint Minute can in a number of respects not be reconciled with the expert report of Dr Pistorius, and on behalf of Second Defendant, it was put to him and also argued that she did not consider herself bound by the contents of paragraphs 16, 18, 19 and 21 thereof. I mention the following example: in par. 16 of this report it appears that "Dr Molokoane instructed that Su of Pitocin/11t of - lactate be started at 2 2h05". There is no record of any such instruction and a complete lack of evidence as to when Pitocin had been administered, how and

when it had been obtained, and who had initiated this process. Dr Molokoane in fact denied in her evidence that she had given such instruction, and also added that she was not even aware that it had been administered, or was so administered at the time of her arrival. It was also said in par. 18 of this Minute that the Second Defendant made an incorrect choice by not stopping the Pitocin, which was used to increase contractions. Par. 19 contains a conclusion that a Court is called upon to make, and it is an unjustifiable intrusion into the duty of the Court which detracts from the objectivity or good judgment of the particular obstetricians. It said the following: "There is adequate evidence that the hypoxic ischaemic injury to the brain of the baby was a result of the Second Defendanf'. Dr Pistorius conceded during cross-examination that he S>hould not have signed the joint Minute, and that after signing it he attempted to reach agreement with Dr Sevenster to amend it, but the latter refused. He confirmed that his report was accurate and that after preparing his report, he obtained no new information that would have persuaded him to amend it. He therefore did not confirm the joint Minute as being correct. The content of his report can in a number of material respects not be reconciled with the joint Minute.

In par. 54 of his expert report the following was said: "With regard to foetal monitoring and the tracings, it thus appears that the foetus could have been suffering from distress from as early as 16h10 till 16h50; from 20h48 till 21h07 (and perhaps longer, but the tracing ends there), and from 23h2 5 till birth at 23h40. Read in conjunction with other factors dealt with thereafter (MRI and blood gas results), he is of the opinion that the CTG tracings are evident of the fact that the staff and doctor failed to properly monitor the foetal condition and take heed of warning signs of foetal distress, either timeously or at all. Had they reacted sooner, the foetal distress would have been prevented or limited". In par. 43 the following was said: "Late FHR decelerations coupled with lack of variability are indicative of lack of oxygen to the foetus".

In par. 68 the following view was expressed: "Because a decision to expedite the delivery by c/s is made because the foetus is suffering from distress, during this time the foetus could be monitored continuously by CTG. There is no record of foetal monitoring (or of foetal condition) until the CTG tracing which commenced at of 23h25. When tracing be11ins, the foetus is seen to already be suffering from distress (lack of variability and late decelerations), so the question arises as to how long prior to the

tracing havin!J commenced was a distress present. Having regard to the Apgar scores and blood gas results (especially the base excess score), it would seem that the foetus is su1fering from distress for a period before the tracing commenced at 23h25".

22.

"OPINION":

The following was said: "On the evidence available it appears that the management of the Plaintiff's labour was plagued by an on-going chain of unfortunate events which were not properly managed or attended to. There is a possibility that the foetus was suffering from distress from as early as 16h10, yet there is no indication that this was investigated or attended to. Observations noted are at odds with tracings. Each tracing from 20h48 and 2 3h25 shows continued lack of variability, yet there is no indication that this was reacted or attended to. The 20h48 tracing ends during an abnormal pattern and there is no indication as to why the CTG was not continued or what was done to attend to the problem. As 23h25 tracing starts with a similar lack of variability, (and that there is no other tracing in between to indicate the contrary), it is most likely that the FHR pattern was also abnormal during this absent period, yet was not picked up and reacted to. It was inappropriate to have attempted three vacuum extractions contrary to good practice, and then a further attempt at forceps delivery. The birth seems to have not taken place within an hour after the decision to operate. The MRI, blood gas and Apgar scores all corroborate this opinion. The unfavourable outcome could have been prevented with prudent medical care, attention and care, and O.'s impairment can reasonably be directly linked to the negligence of the hospital". In the light of these opinions and others expressed in his expert report, Second Defendant's Counsel Mr P. Delport SC justifiably criticized the witness for arriving at the conclusion with Dr Sevenster as contained in par. 19 that I have quoted.

23.

The joint report also contains the conclusion that the record keeping by the midwife was sub-standard according to the guidelines for maternity care in South Africa. However, given that the birth asphyxia was most likely caused by a prolonged second stage,

aggravated by repeated failure of instrumental delivery, the sub-standard midwifery care is unlikely to have had a significant contributory effect on the final outcome. Another conclusion which is one that Court must make was contained in the last paragraph of this joint Minute, namely "that there is no clear evidence that Netcare Hospital (Pty) Ltd t/a Femina Hospital was negligent". The statement itself is surprising given the opinions offered in resp1ct of record-keeping, and actions relating thereto.

24.

In the context of these paragraphs which do not accord with the conclusions contained in his expert report, Dr Pistorius admitted that when he signed the joint Minute, it was "not his best momenf' as an expert witness.. I will deal with this aspect when I deal with the evidence of the Second Defendant and Counsel's argument.

25.

Sister Hanrahan:

It is not in issue that Sister Hanrahan is a highly qualified expert in nursing with over 30 years' experience in midwifery. She and Sister Els, another expert in nursing who the Second Defendant intended to call as a witness, had met and had compiled a joint Minute of their findings. Their joint Minute is very detailed and *vis-a-vis* the allegations made by the Plaintiff against First Defendant, they agreed as follows:

25.1. The Hospital failed to render good and proper medical service that would be expected to be given to a mother and the unborn foetus during labour and birth;

25.2. The Hospital failed to keep proper records of the ante-natal care and/or of the labour and/or both, which records are vital in order to ensure proper assessment, management and treatment of the mother and foetus;

25.3. The Hospital failed to recognise that she was experiencing complications of prolonged labour and have failed to act accordingly;

25.4. The Hospital failed to manage the Plaintiff having regard to the fact that she was potentially a high-risk patient at term;

25.5. The Hospital failed to timeously enlist the services of a duly qualified person to attend to the management of Plaintiff during labour and delivery, when it appeared that she was experiencing complications;

25.6. The Hospital failed to establish the reasons for the complications or at least should have alerted the doctor thereto with a view to establish the reasons of the complications. There is no record that they did so, and accordingly they failed to act as good practice would require to be done;

25.7. The Hospital failed to notice that the foetus was suffering from intermittent foetal distress from as early as 16h00 on the day of admission, and/or if they did, failed to act accordingly;

25.8. The Hospital failed to record the failed Wrigley's forceps delivery and take action to prepare for a caesarean section;

25.9. The Hospital proceeded to assist Second Defendant with ventuse and forceps delivery procedures without first ensuring that the informed consent of Plaintiff had been obtained, either by First Defendant or the Second Defendant;

25.10. The Hospital failed to monitor the foetal heart rate properly which would have alerted them to the foetal distress, and failed to react to indications that the foetus was suffering from distress.

This Minute is dated 8 October 2016

26.

In her evidence and by way of a summary, Sister Hanrahan stated that the record keeping level of nursing care which could be gleaned from the records, was poor and contrary to the guidelines, the *Regulations to the Nursing Act,* the SA Nursing Council and accepted nursing practice. She also gave evidence about the role of Pitocin, and the importance of CTG tracing. She stated that from 16h10 till 16h35, the tracing showed a lack of variability. This could be an indication of foetal hypoxia. There was no indication as to what was done to establish if this was due to a foetal sleep cycle or foetal distress. A simple stimulation test could be performed to establish this. There was no evidence that this was done or evidence to show that foetal distress was excluded. Vaginal bleeding was reported at 20h30, and there was no record to show what was done to establish the extent and cause thereof.

27.

First Defendant chose to rely on the joint Minutes of the experts and did not call any witnesses. At this stage it is my opinion from the evidenc11 presented that the nurses on duty on that particular day who attended to Plaintiff could have given material evidence as to her condition and the factors that I have referred to, including details of the foetal heart rate, the readings of the CTG and other observations that they made during the critical hours, but did not make a note of. It is clear on the undisputed facts relating to the absence of proper note keeping, that the particular witnesses were not called by the First Defendant, because it knew that such evidence would damage its case by giving such evidence, and by subjecting themselves to cross-examination. A strong negative inference is therefore justified.
See: *Galante v Dickenson 1952 SA 460 (A) at 265.*

28.

Second Defendan's evidence:

Second Defendant only became involved in the management and treatment of Plaintiff and her unborn baby when she received a telephone call from Sister Bekker at 21h15. She testified that the Sister told her that she tried to contact Dr Shaik, but was unable to do so. The patient was bleeding in the active phase of labour. The CTG was reactive. She assumed therefore that it was normal. She asked Sister Bekker whether a caesarean section was necessary and was told that the bleeding was not much, that the CTG tracing was reactive, and that a caesarean section was not necessary. She told Sister Bekker that she would be on her way to see the patient. This part of her evidence was not disputed and, as I have said, Sister Bekker was not called by First Defendant. In the context of this telephone conversation, both Dr Pistorius and Sister Hanrahan testified that "reactive" meant "normal", and Second Defendant then also testified that that is how she understood it. I do not know 1Jn which grounds Sister Bekker informed the doctor that the CTG tracing was normal. Sister Bekker was an experienced nurse. In her expert summary, Sister Hanrahan said that in terms of the *Regulations to the Nursing Act,* which prescribed good record keeping, the *Regulations* also demanded of the duties of a registered nurse that a patient's vital signs be monitored, and that the

duties of a registered midwife also entailed the monitoring of the progress of pregnancy, labour, the vital signs of the mother and child, and the reaction of the mother and child to various conditions. Wilful and negligent omissions were also wrongful in terms of the *Regulations.* In accordance with the exigencies of the circumstances and the seriousness of a patient's condition, a nurse may also not neglect to refer a patient for medical care where such care is beyond the scope of practice of the nurse, and may not delay such referral. The keeping of good medical records was essential for continuity of care, especially when many clinicians are involved in a patient's care and work in shifts. Good record keeping is an integral part of good professional practice. Records should include sufficient detail for someone else to take over a patient's care, seamlessly, from where one has left off. Records that ensure continuity of care will also be adequate for evidential purposes, in the event of a complaint, a claim or disciplinary action. Medical records must therefore be clear, objective, contemporaneous, tamper-proof and original. The timing of each entry is most important.

29.

Second Defendant arrived at the hospital at 21h45. She went to the labour ward, examined Plaintiff, saw that the CTG was reassuring, the abdomen was soft and non-tender, and she tried to exclude causes of the bleeding. The membranes were bulging and Plaintiff was 9cm dilated. She ruptured the membranes and after rupture waited to see that the CTG was still normal. Since Plaintiff was progressing quickly, she went to the nurses' tearoom. The CTG at 22h00 was not printing, but she could see the tracing on the monitor. At about 2 2h10, the patient was bearing down and she was called to the delivery room. She noticed that Plaintiff was pushing and immediately attended to the delivery. Plaintiff had been pushing for several minutes without effect. The foetal heart rate was 60 to 80 beats per minute at that time. She became concerned and decided to expedite delivery. She therefore performed an assisted delivery via vacuum extraction. She did inform Plaintiff that the foetal condition was not well. The vacuum process did not work well and she asked the Sister to arrange a caesarean section. The Sister returned and told her that she could not get hold of an anaesthetist and that she had given the duty to call one to another Sister. At that time the foetal heart was not improving during the delay. She attempted a further vacuum attachment to get the baby delivered. This as also not successful, and she then did her best to attempt a forceps

delivery, which was also unsuccessful. There was also me1ternal exhaustion at that stage. At that stage the foetal heart rate was 120 beats per minute.

She did not prescribe Pitocin and was not aware until a week before the trial commenced that it had been administered. The allegation that she was negligent in one or other manner in this context was not contained in the Particulars of Claim, but this allegation was effected by way of an amendment which was granted during the trial.

She did not look at the available records and would not have handled the patient differently if she had, because the patient was so dose to delivery.

Her instruction to Sister Bekker to prepare for a caesarean section was at around 22h40 and she remained at the Plaintiff's bed side. She added that if she had been presented with a patient in latent labour, and summoned to her bed side and was told of vaginal bleeding and lack variability, she would have started preparing for a caesarean section. She agreed that it was against protocol to have more than two attempts at vacuum extraction where the cup slipped twice, and adherence to protocol was important. She agreed that her own clinical notes were incorrect and not reflecting the interruption after the second cup detachment, but explained that she had only summarized the events at the time. She agreed that her notes in this context were sub-standard. She agreed that save for her notes appearing in the bundle of records, she made no other clinical notes and especially none of her first consultation and examination of the Plaintiff at 21h45. She added that she did perform intra-uterine resuscitation at approximately 2 3h00 after she had abandoned the efforts at assisted delivery, but conceded that no record thereof was made in the notes. She agreed with Dr Pistorius' opinion in this context that intra-uterine resuscitation could improve foetal condition, and if initiated sooner, the better could be the result. She could not explain why nurses would prescribe Pitocin on their own, if they had done so, whilst she was in attendance at the hospital, and agreed with Dr Pistorius that the unauthorized administration of Pitocin by nurses was a serious allegation. She also agreed that at 21h15 when Sister Bekker called her and told her that Plaintiff was experiencing vaginal bleeding, but that a caesarean section was not needed, that it would have been a safer option for her to have started making arrangements to get a team together in the event that a caesarean section would indeed be needed.

30.

Plaintiff's argument:

Even before that however, there were no notes to show that CTG lack of variability was investigated and that foetal distress was excluded at 16h10. In that context the nurses failed to timeously consider alternatives to normal delivery by way of caesarean section when the presenting complications required that this be done from as early as 16h10.

They also failed to monitor the foetal heart rate properly or at all, which would have alerted them to foetal distress, alternatively they failed to react to indications that the foetus was suffering from distress. The foetal heart condition was not monitored every 30 minutes before, during and after contractions as per the nursing guidelines and accepted protocol. Tracings were also not kept of all observations and there was no record as to what the foetal heart condition was from 21h08 until 23h25, save for the brief note of bradycardia at the time of the failed ventuse delivery attempts.

31.

The results of the combined acts and omissions referred to was that they allowed the foetus to become severely asphyxiated and to suffer from hypoxic ischaemic encephalopathy.

32.

The opinions of Dr Pistorius and the detailed comments of the expert nurses that I have referred to in some detail must be obviously considered under this heading as well.

33.

Plaintiff s argument vis-a-vis Second Defendant:

I have mentioned the aspect of Pitocin. In my judgment there is no evidence to show

who ordered the administration of such, when this was done and for which period it had been administered. The allegation that Stcond Defendant had been negligent in this context was not contained in the original grounds l)f negligence relied on in the Particulars of Claim, but was only introduced during the trial at a late stage. It was argued by Plaintiff's Counsel Mr Austen that Second Defendant was not a good witness in that she contradicted herself and in regard to the allegations made in her plea in regard to the sequence of events relating to the ventuse detachments, and exactly when a caesarean section was called for. It was submitted that her denial that she prescribed Pitocin, or knew that it had been administered, as being unlikely on the balance of probabilities. It was argued that she failed in her duties to keep proper records of the indications for ventuse delivery, the core details of the procedure itself, read the hospital file on arrival, record the details of intra-uterine resuscitation, keep notes of her assessment and examination on her arrival at 21h45 and also transgressed protocol by administering three ventuse applications.

34.

I do not agree that the Second Defendant was an untruthful witness. She readily admitted much of the criticism against her conduct and it was certainly not my impression in Court that she intended to give false evidence. Certain of her actions or omissions were indeed subject to criticism, but it was not my impression during her evidence-in-chief or cross-examination that she had lied about the ventuse cup detachments or about the administration of Pitocin, as Plaintiff's Counsel would have it.

35.

It is important to note what Plaintiff's state was, and that of the foetus upon her arrival at 21h15. I have referred to what she did and what she did not do. It is common cause that at 21h15, when regard is had to the evidence relating to the phone call of Sister Bekker, which was never in issue, that Plaintiff had been progressing well and had strong contractions. One of the questions that arises in this context is: why would the doctor then resort to Pitocin? The relevant hospital record with the heading "PARTOGRAPH", indicates that at 22h05 IVI was commenced. The document titled "CONDITION OF PATIENT POST TRANSFER TO DELIVERY ROOM/THEATRE" refers to the

"SECOND STAGE" form. It refers to "Pitocin in ll RV". The signature next to that entry is not of Second Defendant. In the expert report of Sister Els, which led to the joint report by the nurses that I have referred to, it was stated that it was not observed in the record keeping that the Pitocin five units injected into the litre of Renous Lactate infusion line at 2 2h05 was discontinued when foetal distress was observed towards the initiation of emergency foetal resuscitation in-utero. There was no evidence who had ordered the Pitocin, what the process was in obtaining it, and who had injected it into the infusion line at 22h05. It was not recorded in the relevant record keeping that this infusion was discontinued when foetal distress was observed towards the initiation of emergency foetal resuscitation in-utero, as the joint report of the expert nurses state. There is in my view on the available evidence and record keeping insufficient grounds for holding that Second Defendant was not truthful when she said that she did not know at the time of her arrival or thereafter that Pitocin had been injected into the infusion. Also, on her evidence she was in the nurses' tearoom at about 20h00 that evening and was only called to the delivery room at about 22h08.

Dr Pistorius said the following in his expert report in this particular context (par. 66 to 67): "66: It is unclear from the records as to when Molokoane made the decision to operate, but it must have been shortly after the sequence of events which transpired after starting with her examination at 2 2h08. The birth only took place at 23h40 and whilst they were waiting for the anaesthetist to arrive, and so it would appear that they would not have been able to (and did not) perform the procedure within the hour after decision.

67: Having regard to the indications of foetal distress, the possibility of a c/ s should have been considered early and preparations made timeously. An anaesthetist and paediatrician should have been present or on close call from early evening when the CTG tracings were showing possible distress. It was unacceptable that a period (of seemingly an hour) elapsed while waiting for an anaesthetist, when they all knew that the foetus was in distress".

In evidence Dr Pistorius said that the reference to "timeously" in his report referred to

the time between 20h50 and 21hl5, and the preparations referred to by him referred to the nurses.

37.

It is common cause that an anaesthetist did not arrive within an hour and it is also not in issue that he or she had still not arrived at the time of the baby's birth, or at any time thereafter.

38.

The undisputed evidence of Prof Lotz, when being cross-examined by Counsel for Second Defendant was that at 20h30 there should have been indications of foetal distress if proper observations had been made, but at 20h50 there were definite indications of foetal distress. I asked him at that stage what he meant by that and he replied that he meant "get the child out as soon as possible".

39.

Having regard to the functions and duties of Second Defendant it is in my view inexplicable, and certainly no attempt has even been made to explain it, how it could accept patients, who may or who may not, require the services of an anaesthetist, without having sufficient arrangements in place for such to be on stand-by and actually be at the hospital at the very least within an hour's notice. I will return to this topic.

40.

Counsel for Plaintiff argued that it was the undisputed evidence of Prof Lotz that the impairment to the baby's brain was global near-total and would have arisen over a period of at least three hours prior to birth. As I have said, Dr Pistorius was also of the view that an anaesthetist should have been present or on close-call from early evening, and in any event long before Second Defendant arrived at the hospital.

41.

It is of course clear that negligence on the part of a medical practitioner must be causily related to the result. It must be asked whether a reasonably skilled and careful medical practitioner in the position of a particular Respondent would have realised that a serious condition was developing or threatening and, if so, when such practitioner would reasonably have come to realise this. It must then be asked whether there was remedial action which could reasonably have been taken, and whether this practitioner would have known of it, and would have realised that it had to be taken. The resulting question then is whether the remedial action, if taken when the need for it ought to have reasonably have been realised, would have prevented the damage suffered by the particular Plaintiff. Lastly, the question then is whether the particular Respondent failed to take remedial action.

See: ***Blyth v Van den Heever 1980 (1) SA 191 (A) at 220****;*

Kruger v Coetzee 1966 (2) SA 428 A*.*

42.

First Defendant's argument:

The conclusion was that the damages *in casu* were caused exclusively by negligence of the Second Defendant. I will deal with the criticisms levelled against the Second Defendant when I deal with the argument on her behalf.

43.

Second Defendant's argument:

In the summary of admissions and denials that I have referred to, which was handed up as an exhibit, Second Defendant admitted the following relevant allegations:

43.1. That she had a general legal duty subject to the facts that I will mention hereunder;

43.2. She saw Plaintiff at 21h45 after nursing staff contacted her and advised her of vaginal bleeding. She examined Plaintiff and found no complications.

Contractions were strong. The foetus was of average size. CTG was reassuring. Membranes were bulging. Plaintiff was fully dilated and draining clear liquid. She was restless and pushing prematurely;

43.3. She reassessed Plaintiff at 2 2h08, now fully dilated. She was requested to bare down, but there was poor maternal effort. Vacuum was applied three times, but it slipped each time, because of caput. Forceps were then applied, but could not lock to head position. FHR was 60 to 80 bmp and not improving. She then called for an emergency caesarean section in the light of the prolonged second stage and failed instrumental delivery;

43.4. Whilst waiting for the anaesthetist, Plaintiff started bearing down and Second Defendant, assisted by a nurse, delivered the baby with an Apgar score of 3 /10. Resuscitation was taken over by the paediatrician Dr Reddy;

43.5. As far as grounds of negligence against the First Defendant were concerned, Second Defendant referred to the joint Minute of Plaintiff and Second Defendant's nursing experts;

43.6. Dr Shaik was the gynaecologist on call between 16h10 and 16h3 5;

43.7. There was a lack of base line variability according to CTG in respect of the period 21h00 to 23h25;

43.8. The second stage of labour was prolonged;

43.9. There was bradycardia (between 60 to 80 bmp) at full dilation;

43.10. There was 10cm dilation at 22h00 according to the partogram;

43.11. The partogram was incomplete;

43.12. The MRI report of 2 April 2014 was admitted. In respect of the report done jointly by Drs Pistorius and Sevenster, it was said in the same document that the reports could be handed in subject to the reservation that Second Defendant was not a party to the joint Minute, and did not regard herself as being bound by it, whilst at the same time being of the view that the opinions expressed therein did not constitute admissible evidence. There was also no objection to the joint Minute of the nursing experts being handed in subject to the reservation that evidence in that context was necessary to enable a proper understanding thereof by the Court. Second Defendant's view as expressed in the exhibit was further that the hospital had failed to establish the reasons for the complications, or at least should have alerted a doctor thereto with a view to establishing such reasons. There is no record that they did so and accordingly it failed to act as

good practice would require to be done. She also agreed that First Defendant failed to notice that the foetus was suffering from intermittent foetal distress from as early as 16h00 on the day of admission, or, if they did, they failed to act accordingly. It was further said that the hospital failed to record the failed forceps delivery and to take action to prepare for a caesarean section. She added that the hospital failed to monitor the foetal heart rate properly which would have alerted them to foetal distress, and failed to react to indications that the foetus was suffering from such. In regard to aspects of the joint Minute of Drs Pistorius and Sevenster it was pointed out to me by Second Defendant's Counsel that in any event I was not bound by an opinion expressed by an expert, be it during evidence or in a joint Minute. Reference was made in this context to *Van Wyk v Lewis 1924 AD 438 at 447 to 448,* where the following was said by Innes CJ:
"The testimony of experienced members of the (medical) profession is of the greatest value in questions of this kind. But the decision of what is reasonable under the circumstances is for the Court; it will pay high regard to the views of the profession, but it is not bound to adopt them".
In *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another 2001 (3) SA 1188 (SCA) at 1200,* it was said by GJurt that ... "it is perhaps as well to re-emphasize that the question of reasonableness and negligence is one for the Court itself to determine on the basis of the various, and often conflicting, expert opinions presented. As a rule that determination will not involve considerations of credibility, but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the Courts reaching its own conclusion on the issues raised".

44.

I have already referred to Second Defendant's Counsel's submission that I should not regard myself as being bound by paragraphs 16, 18, 19 and 21 of the joint Minute. The differences between the opinions expressed by Drs Pistorius' report and the statements in the joint Minute must detract from his evidence, so it was submitted. The argument was that despite this criticism, his evidence and opinions expressed by him in his report should be accepted insofar as they were supported by evidence given at the trial. A Court's approach to opinions by medical experts has been dealt with in a number of

decisions and many of them were referred to in *SS v Road Accident Fund [2016/ 3 ALL SA 637 {GP) at 664 par. 50.* At the end of the day, the crux is that a Court must assess evidence not by scientific standards, but by the legal standard of the balance of probabilities. In the present context the question is: what acts or omissions most probably led to the child's brain damage?

45.

When did the foetus start experiencing foetal distress? In his report, Dr Pistorius expressed the view that the foetus could have been suffering from foetal distress as early as 16h10 until 16h35. This opinion was based on the 16h10 tracing. He also stated that this tracing showed marked lack of variability from start until about 16h35. This opinion was supported by the evidence given by Prof Lotz, and in his report he stated that the injury pattern suggested a prolonged partial hypoxic ischaemic event. During his evidence he explained this, and stated that this event endured for approximately three hours. As a result of poor record-keeping by First Defendant's nursing staff, one does not know what exactly happened from approximately 17h00 until 20h30. However, based on the CTG tracing that was done from 20h50 to 21h05, and which also showed marked lack of variability, Dr Pistorius said that the foetus suffered from distress from this time. In his evidence he expanded on this and testified that a caesarean section ought to have been performed at this time. It was submitted that if regard was had to the vaginal bleeding that Plaintiff experienced at 20h30, the foetus on the probabilities was suffering from distress at least from this time.

46.

The causal connection between any act or omission by Second Defendant and the result

Regarding the test for negligence I have referred to this in par. 41 above. At the end of the day, a Court must exercise a value judgment in this context. All the facts and circumstances of any particular case must be taken into account. It will, for instance, not be required of a doctor who acts in an emergency situation to exercise the same level of skill as a doctor acting under normal circumstances. In this context I was referred to

Mkhatswa v Minister of Defence 200 (1) SA 1104 SCA, with reference to *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd 2000 (1) SA 827 (SCA),* and the dictum of Scott JA that "It is probably so that there can be no universally applicable formula which will prove to be appropriate in every case". The Court said that whether or not conduct constitutes negligence ultimately depends upon a realistic and sensible judicial approach to all relevant facts and circumstances that bear on the matter at hand. What also needs to be emphasized is that what is required to satisfy any test for negligence is *foresight of reasonable harm.* Foresight of a mere possibility of harm will not suffice.

In considering whether Second Defendant acted negligently I was referred to *Carstens and Pearmain, Foundational Principles of South African Medical Law, Lexis Nexis 2007,* where the following was said at 63 9, par. 9.6.6: "The test of medical negligence, by its very nature and scope, can never be disentangled from the particular facts of circumstances. For this reason it can he stated that the degree of skill and care required of a medical practitioner will be dependent on the circumstances of each case. The alleged medical negligence of a physician cannot be assessed in isolation or "in the air" and should only be considered in conjunction with the objective and proven facts in each case. This principle is often referred to as "concrete negligence". In practical terms, this rule of circumstance refers to the place where the medical intervention is formed (in essence the locality of practice), the facilities available at the hospital or clinic where the operation or intervention is formed, the financial resources of the hospital or clinic, the nature of the medical operation or intervention or medication, the difficult conditions or emergency situations in which the medical intervention or operation takes place, and the particular predispositions, idiosyncrasies and susceptibilities of the patient".

The learned authors give ample authority for this proposition, and I agree with that approach. It is based on 'sound practical reasoning, and is in any event in line with jurisprudential reasoning, namely that value judgments must be made with regard to the particular circumstances of each individual case. This "rule of circumstance" seems to have been acCE!pted by *Zondl JA in Medi-Clinic v Vermeulen 2015 (1) SA 241 SCA at 252 G to H (par. 33)* where the following was said: "In conclusion, a Plaintiff has suffered such terrible consequences that there is a natural feeling that he should be

compensat13d but, as a Denning, LJ correctly remarked in *Rowe v Ministry of Health /1954/ 2 ALL ER 131 (CA) at 139:* "but we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than the good of their patients. Initiative would be stifled and confidence shaken and proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure".

The same approach had already been followed in *Castell v De Greet 1993 (3) SA 501 CPD at 509 h to 510 a.*

47.

I have already referred to Second Defendant's evidence and the call made to her by Sister Bekker at 21h15, whom First Defendant, for completely unknown reasons, did not deem it necessary to call as a witness. The note in the relevant record that Sister Bekker made supports Second Defendant's evidence.

It was submitted that it was important to note that during this conversation Sister Bekker informed her that the CTG tracing was reactive. Both Dr Pistorius and Sister Hanrahan testified that "reactive" means "normal" and Second Defendant testified that that was how she understood it. Sister Bekker also stated that she did not regard caesarean section as necessary. I do not know on which grounds Sister Bekker informed Second Defendant that the CTG tracing was normal. In this context Dr Pistorius said the following in his expert written report: "The progress report at 21h15 ... strangely mentions that the CTG was "reactive", but makes no mention of the lack of variability which had constantly been evident from the tracing which had previously run for 20 minutes, and had only ended some eight minutes before then. There is no tracing on file regarding an observation of foetal condition at 21h15, and no record to elaborate on this finding of an internal "reactive" FH at 21h15, nor is there any other document detailing any other aspect of foetal condition at this time". Sister Hanrahan made the same observation in her report.

48.

It was therefore submitted that there was no reason why Second Defendant could not accept, and rely on, what Sister Bekker told her during the telephonic conversation. Sister Bekker was an experienced nurse and her duties would have been, as I have already said, to make and keep clear and accurate records of all vital signs, reactions and progress of pregnancy. A wilful or negligent omission to keep clear and accurate records of all actions which a nurse performs in connection with a patient is in this instance wrongful.

49.

Second Defendant testified that after she had arrived at tl1e hospital at 21h45, she examined Plaintiff and did her own reading of the CTG machine from the screen. It was common cause that when the doctor arrived at the patient's side, she was already 9cm dilated and had a strong urge to push prematurely. At 2 2h00 she was fully dilated (10cm) and on the point of giving birth. I hav13 referred to her evidence and the fact that after an examination of Plaintiff, she went to the nurses' tea room as she had to wait for a while before delivery could proceed after she had ruptured the membranes. It is not in dispute that she was called back to the patient's side by Sister Bekker at 22h08. Plaintiff was pushing without any result. In-between this pushing, the CTG monitor was put on Plaintiff's stomach. The reading was between 60 to 80 beats per minute. She realised that the foetus was compromised and that delivery had to take place as soon as possible. At that time she was aware that delivery by means of a caesarean section would take at least another hour. She accordingly decided that delivery had to be expedited by means of assisted delivery and informed Plaintiff thereof. I have mentioned the ventuse and forceps procedure. She was told by Sister Bekker that there was a problem in arranging the caesarean section as an anaesthetist was not on site and had to be called. Evidence was that she instructed Sister Bekker to make the arrangements for a caesarean section at approximately 22h40. She denied that she had prescribed Pitocin at any stage, but I must add, that in any event there was no evidence at all what the probable result would have been l1ad she either not prescribed Pitocin, or discontinued its use at some stage. The record indicates that it was introduced at 2 2h05 at a time when Plaintiff was at the point giving birth.

She testified that after attempting to perform an assisted delivery, a CTG tracing was commenced. The foetal heart rate had improved slightly. At one time, although the time is not recorded, it was about 120 beats per minute. Dr Pistorius mentioned this in his report. A print-out of the CTG tracing was available from 23h25. This print-out shows late decelerations and lack of variability, confirming a severely compromised foetus.

Whilst waiting for the anaesthetist, Plaintiff started pushing again and the infant was born at 23h40. Second Defendant testified that by that time the assistant had arrived, but not the anaesthetist. In fact, it is not disputed that the anaesthetist, who was also never identified, never arrived while Second Defendant was at the hospital. It is a fact thereof that Second Defendant could not have performed a caesarean section after 23h00, or at any time after her arrival at 21h45.

50.

It was submitted that Second Defendant's decision to proceed with the vacuum assisted delivery after she observed the foetal bradycardia, was not unreasonable under the circumstances. Both Prof Lotz and Dr Pistorius testified that it was essential to expedite delivery once there were signs of foetal distress. It was submitted that I must bear in mind that when Second Defendant had to decide whether to attempt an assisted delivery or arrange for a caesarean section, she was aware that it would take at least an hour to make arrangements for such. Her evidence in this regard is supported by the undisputed fact that even after 23h40 on that particular night, the anaesthetist had not arrived. In considering the reasonableness of Second Defendant's decision to proceed with the assisted delivery, I was referred to what was said in *Castell v De Greet supra* at 511 to 512 B: "It must not be overlooked that, even if it were to be shown that the Defendant's decision, involving as it did a clinical judgment, turn out to be the incorrect one, it would not necessarily follow that on this account he was negligent. Indeed, a practitioner is not to be held negligent merely because the choice made or the course he took turned out to be the wrong one".

51.

It was submitted that even if Second Defendant could justifiably be criticized for proceeding with the assisted delivery by n1eans of ventuse and forceps, her evidence was that she instructed Sister Bekker to arrange for a caesarean section after the ventuse had slipped twice, It was only alter Sister Bekker reported that there were problems in arranging the procedure that she applied the ventuse for the third time. I have dealt with the attempt to apply forceps. The fact that Second Defendant proceeded with ventuse and forceps delivery procedures when they were not indicated, were pleaded as a separate ground of negligence in the Particulars of Claim.

As I have said, Second Defendant was of the view that the child had to be delivered urgently. She decided upon the assisted delivery procedure whilst at the same time (be it after the second or third attempt) asking Sister Bekker to arrange for an Emergency caesarean. She made a decision on a basis of the particular circumstances, and I do not deem this to be negligent conduct. At the same time, it must be remembered in the context of causation that in any event no anaesthetist was available, either at that time or at any other time that night, and it is clear that even if the ventuse forceps procedure had not been decided upon by Second Defendant, the result would probably have been the same. The child was born at 23h40.

Drs Pistorius and Sevenster were in agreement that the severe foetal bradycardia of 60/ 80 beats per minute, which occurred before the ventuse was applied for the first time, was indicative of severe foetal distress and was, said Dr Pistorius in his report, probably the main reason for the negative outcome. It was therefore submitted that there was no evidence on which I could find that the third attempt with the ventuse, or the forceps, contributed to the negative outcome.

As far as causation was concerned, I was referred to the decision of *Chapeikin v Mini 2016.IDR 1324 (SCA) of 14 July 2016.* The test to be applied to the question of causation is the "but-for", as formulated in *International Shipping Company (Pty) Ltd v Bentley 1990 (1) SA 680 (A) at 700 E to J.* In *ZA v Smith 2015 (4) SA 574 (SCA) at P•1r. 30,* the following was said: "What [the but-for test] essentially lays down is the. enquiry - in the case of an omission ·- as to whether, but for the Defendant's wrongful

and negligent failure to take reasonable steps, the Plaintiff's loss would not have ensued. In this regard this Court has said on more than one occasion that the application of the "but-for test" is not based on mathematics, pure science of philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the back-ground of everyday-life experiences. In applying this common sense, practical test, a Plaintiff therefore has to establish that it is more likely than not that, but for the Defendant's wrongful and negligent conduct, his or her harm would not have ensued. Plaintiff is not required to establish a causal link with certainty..." The Constitutional Court has also recently affirmed the continued relevance of this approach to causation.

See: *Mashongwa v Passangar Rail Agency of South Africa 2016 (3) SA 528 (CC}, par. 65.*

53.

As far as the question of Pitocin was concerned, it was submitted that there was no reason to reject Second Defendant's. It might well be unusual for a nurse to administer Pitocin without instruction from a doctor to do so. In the present case, if regard is had to the criticism expressed by the nursing experts as to the conduct of the nurses, it cannot be assumed that they would have abided by what was customary or not. One did not know which nurse made the note relating to the introduction of Pitocin. One did not know whether the time recorded was recorded contemporaneously. One did not know what effect it had over any period of time, how much was in fact administered, and for how long, and in fact one knew very little, except what appears in the particular note, which in any event contains hearsay evidence.

54.

Regarding other criticisms levelled against the conduct of Second Defendant, it was argued that in the context of intra-uterine resuscitation, she did testify that she started such after the attempts with the ventuse failed. I am not able to find after having listened to Second Defendant's evidence as a whole, that she was untruthful, be it in this context or any other. She explained that when she consulted with her legal advisors for

purposes of a plea, she did not refer to each and every item of criticism levelled against her. but merely gave a summary of the events of the evening. There was also no evidence that mc1re than 1/5 of the foetal head was above the pelvic rim, and the criticism of Ors Pistorius and Sevenster in their joint Minute was never put to her for comment.

55.

It is clear from the reports of Sister Hanrahan and joint Minute of the nursing experts, that there was a failure on the part of First Defendant's nursing staff to keep proper records. It is also abundantly clear that according to the opinions of Dr Pistorius and Prof Lotz, and their evidence, foetal distress occurred during the late afternoon or early evening that day. In any event, it was well before the Second Defendant arrived at Plaintiff's bedside. Had proper observations been made and proper records kept and proper actions taken, a doctor ought to have been called by the nurses well before 21h00, and a caesarean section during that period, would probably have avoided the ultimate result or lessoned the effects of repeated foetal distress.

56.

There is therefore sufficient acceptable medical evidence before me to hold that First Defendant's nursing staff was negligent in the respects that I have discussed in some detail, and upon which the expe1t nurses agree, and that this negligence caused the cerebral palsy eventually suffered by Plaintiff's baby. In fact, all indications are that the foetal distress was present from 16h10, yet the nursing staff took no steps to investigate the lack of variability in the tracing and to obtain advice in regard thereto from an obstetrician. It is common cause that the foetal heart rate should have been monitored every half hour. Yet, it was monitored only on three occasions, namely at 16h50, 20h30 and 21h15. Vaginal bleeding was observed at 20h30, which was not mild according to Plaintiff, but there was no indication that the foetal condition was monitored. In the light of the next tracing that only commenced at 21h15, foetal distress increased as from that time, requiring urgent attention. Dr Pistorius stated in his evidence that Sister Bekker ought to have made arrangements for a caesarean section at least between 20h00 and 21h00. This view was not challenged, and he added that had intra-uterine resuscitation

been applied during this period, the episode of bradycardia would probably have been avoided. Furthermore, the failure on the part of Sister Bekker to inform Second Defendant that three available CTG tracing in fact show lack of variability coupled with bleeding, necessitated a caesarean section, was clearly negligent. I agree with that submission.

57.

In my view therefore, having regard to the evidence on a holistic basis, I find that the negligence of the First Defendant's nursing staff was the sole cause of the cerebral palsy suffered by the baby.

58.

The following order is therefore made:

1. **It is declared that First Defendant is liable to Plaintiff for the proven or agreed upon damages suffered by her in her personal capacity, and in her capacity as guardian and mother on behalf of her minor child O. M.;**
2. **First Defendant is ordered to pay the costs of the action including the costs of Second Defendant;**
3. **The parties are given leave to approach me within 30 days of this order for a more detailed order relating to costs.**

_____

JUDGE H.J FABRICIUS

JUDGE OF THE HIGH COURT GAUTENG DIVISION, PRETORIA

Case number: 53151/ 2015

Counsel for the Plaintiff: Mr G. W. Austin

Instructed by: Gary Austin Inc

Counsel for the 1st Defendant: Adv D. Prinsloo

Instructed by: ODBB Inc

Counsel for the 2nd Defendant: Adv P. P. Delport SC

Instructed by: MacRobert Inc

Date of Hearing: 25 - 2 7 October 8: 31 October 2016

Date of Judgment: 9 December 2016 at 10:00