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**REPUBLIC OF SOUTH AFRICA**

**IN THE HIGH COURT OF SOUTH AFRICA  
GAUTENG DIVISION, PRETORIA**

**CASE Number: A70/2021**

**COURT A QUO CASE NO: 69859/2017**

REPORTABLE: NO

OF INTEREST TO OTHER JUDGES: NO

REVISED: YES

In the matter between:-

**THE MEC FOR HEALTH & SOCIAL DEVELOPMENT OF      APPELLANT  
GAUTENG PROVINCIAL GOVERNMENT**

and

**TEBOGO EVAH MACHETE      RESPONDENT**

**JUDGMENT**

[1] This is an appeal against an order granted by the Gauteng Division of the High Court, Pretoria (per TLHAPI J) (court *a quo*) in favour of the respondent, who as the Plaintiff, had instituted a medical negligence claim against the Member of the Executive Council for Health and Social Development, Gauteng (the MEC). The respondent's claim is on behalf of her minor child, L [...] (the minor), who had suffered cerebral palsy as a result of a hypoxic ischemic event that occurred during the birth process. The court *a quo*, having been called upon to decide the matter on the issue of liability only, found in favour of the respondent – that the respondent had

succeeded in proving negligence and causation on the part of the employees of the MEC (the staff). Therefore, the court *a quo* found that the MEC was vicariously liable to compensate the respondent, because the staff at Mamelodi Hospital had dispensed medical care to the respondent within the course and scope of their employment. Aggrieved by this decision, the MEC lodged an appeal, which appeal was dismissed with costs by the court *a quo*. The MEC then launched an application for leave to appeal to the Supreme Court of Appeal (SCA). The SCA ordered as follows:

1. *Condonation as applied for is granted. The applicant for condonation to pay the costs of the application.*
2. *Leave to appeal is granted to the Full Court of the Gauteng Division of the High Court, Pretoria.*
3. *The costs order of the court a quo in dismissing the application for leave to appeal is set aside AND the costs of the application for leave to appeal in this court and the court a quo are costs in the appeal. If the applicant does not proceed with the appeal, the applicant is to pay these costs.*

[2] The basis of the appeal is that the court *a quo* erred in fact and law, misdirected itself and committed several irregularities. The respondent on the other hand relies on a breach of a legal duty of care towards her by the medical and nursing staff acting within the course and scope of their employment.

### **Background Facts**

[3] The common cause facts are that the respondent who was a primigravida was admitted at gestational term (38 weeks) at approximately midnight on 16/17 May 2009 at Mamelodi Hospital. The respondent gave birth by normal vaginal delivery. The respondent was fully dilated at 11h00 on 17 May 2009. There is a dispute between the appellant and the respondent as to whether the normal vaginal delivery occurred at 11h45 on 17 May 2009. The respondent submission is, however, that

whether the delivery had been at 11h45 on 14h00; there had been a failure to appropriately or at all monitor the labour process of the respondent leading to the birth complication of the minor.

[4] On admission a CTG scan was used to document the heart of the foetus. The foetal heartbeat was checked and recorded at 08h00 and 10h00 on 17 May 2009 and no abnormalities that needed any intervention were detected at that state. The practice is to monitor a patient during the labour with a CTG monitor (a cardiotocograph, an instrument measuring the foetal heartrate and contractions of the mother and recorded on a paper tracing). It is also common cause that according to the guidelines foetal heartrate has to be checked and recorded half hourly in the active stage of labour.

[5] It is common cause that the minor, when born, was compromised. The minor suffered from an acute profound hypoxic ischemic brain injury as recorded by both parties' expert Radiologists' joint minutes which were accepted by both parties and the court *a quo* as evidence. On 18 May 2009, on referral of Dr Sigwadi, a paediatric registrar who testified for the respondent, the minor was transferred to the Steve Biko Academic Hospital (SBAH) for further management.

[6] The respondent's case is that the hospital failed to notice that she was experiencing some form of complications during labour and thereafter get other suitably qualified personnel (a doctor) to attend to her case. She contends that the failure of the staff to adequately monitor her, in line with the recommended intervals and then take the necessary steps, led to the minor developing cerebral palsy. According to her, the failure to monitor her progress in accordance with the National Maternal guidelines published in 2007 (2007 guidelines) constituted a negligent omission that resulted in the foetus suffering a hypoxic ischemic encephalopathy of an acute profound nature. According to the respondent, if the 2007 guidelines had been followed in monitoring her labour, a change in the condition of the foetus would have been observed in time and the delivery would have been expedited with the necessary expertise, which actions would have prevented the brain injury. It was alleged that a caesarean section was not performed within an hour of the decision to operate being taken contrary to the 2007 guidelines. Therefore, the hospital staff had

acted negligently by failing to expedite delivery of the foetus when the circumstances warranted it.

[7] The appellant on the other hand contended that the hospital staff had acted with the necessary skill, care and diligence as could have reasonably been expected of persons in similar circumstances. It was also alleged that the hospital staff had not been negligent in their treatment of the respondent. Of utmost importance, the appellant denies that there is any causal link between the negligent omission alleged by the respondent and the brain injury suffered by the minor. The issue then is whether the respondent has proven the elements of negligence and causation on a balance of probabilities. That is, was the CTG scan taken at 10h00 on 17 May 2009 suspicious enough to warrant monitoring. In addition, whether the failure to monitor the respondent between 08h00 and 10h00 taken with the failure to deliver the minor within an hour of the decision to perform a caesarean section, constituted negligence which caused the minor's cerebral palsy. Relying on the expert evidence of Dr Sigwadi and Prof Cronje, the court *a quo* found that negligence and causation were proven on a balance of probabilities. The result was that the court *a quo* found in the respondent's favour.

### **Issues to be decided**

[8] Therefore, the issues for determination are whether the staff were negligent in the treatment of the respondent, and if so, whether such negligence was the cause of the minor's hypoxic ischemic injury and the resultant cerebral palsy.

### **Joint minutes**

[9] The joint minutes of the following experts can be summarised as follows:

*-Neonatologist: Prof PA Cooper (for appellant) and Prof VA Davies (for respondent)*

[10] They agree that the minor presents with moderate to severe neonatal encephalopathy (NE) (new term used for HIE [hypoxic ischemic encephalopathy])

with convulsions initially difficult to control. They agree that this was most probably due to intrapartum hypoxia-ischemia, having excluded other causes. They agree that baby L [...]’s subsequent neurological handicap is consistent with a brain injury sustained as a term infant. They also agree that the care and management of the minor after admission to the neonatal ICU. at SBAH was appropriate.

*-Paediatric neurologists: Dr Hauptfleisch (for appellant) and Dr MM Lippert (for respondent)*

[11] They agree that the minor suffers from a severe form of cerebral palsy, is quadriplegic, chiefly spastic form with abundant complications including joint contractures and chronic epilepsy. Even with the absence of certain evidence due to missing documents or it not having been documented, they are in agreement “therefore no reasonable doubt that the child’s condition, as is now, is the result of an intrapartum asphyxia event in the face of missing components of action taken by the hospital staff or recording them”.

*-Obstetricians: Dr Koll (for appellant) and Prof Cronje (for respondent)*

[12] They agreed that the respondent was admitted at around midnight on 16/17 May 2009 in the latent phase of labour. Shortly after admission the foetal heartrate was monitored electronically by CTG and there were minor abnormalities which were not indicative of a shortage of oxygen to the baby (foetal distress). The foetal heartrate was recorded at 04h00, 08h00 and 10h00 by the nursing staff.

[13] A doctor was called in the second stage of labour due to poor maternal effort; however, could not come immediately as he was busy in theatre. She was fully dilated at 11h00 (10cm) and baby was born normal, head first.

[14] The baby suffered from cerebral palsy and radiological studies pointed out the shortage of oxygen before, during or after delivery and they agree and are of the opinion that it probably occurred just before delivery.

*-Nursing experts: Sister R Smit (for appellant) and Dr Candice Harris (for respondent)*

[15] The nursing experts are critical of the standard of care given by the nursing staff at the time of admission at Mamelodi hospital. They agreed that the respondent had a normal pregnancy. At admission, they agree that reasonable midwifery and labour assessment was performed. The latent phase of labour progressed normally.

[16] They agree that during the active phase of labour it is reasonable to expect the midwife to assess the foetal heartrate every 30 minutes. It was an omission that the foetal heartrate was not assessed and documented between 08h00 and 10h00.

*-Radiologists: Dr Tracy Westgarth-Taylor (for appellant) and Dr Ranchod (for respondent)*

[17] The radiologist agree that the MRI dated 31 January 2019 indicates features consistent with chronic sequelae of an acute profound hypoxic ischemic brain injury, but the scan was unable to determine when the injury took place.

[18] In paragraph 28 of her judgment the learned judge in the court *a quo* deals with the joint expert reports or minutes, makes reference to the authorities in this regard, and correctly concludes as follows:

“the parties have therefore, agreed that they are bound by the joint minutes.”

### **Negligence**

[19] In order to satisfy the existence or otherwise of negligence, the approach is that as laid down in ***Kruger v Coetzee* [1966 (2) SA 428 (A) at 430 E-H]** HOLMES JA sets it out as follows:

“For the purposes of liability, *culpa* arises if –

(a) a *diligent paterfamilias* in the position of the Defendant –

(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and

(ii) would take reasonable steps to guard against such occurrence; and

(b) the Defendant failed to take such steps.”

[20] Therefore, the test rests on two legs namely, reasonable foreseeability and the reasonable preventability of damage. The facts and circumstances of each and every case would determine what was reasonably foreseeable in each matter. The appellant’s staff are required to act with the necessary care, skill and diligence of members of their profession when doing their work. What this court is being asked to do is to determine whether in these circumstances, persons similarly qualified as the appellant’s staff would have acted otherwise; i.e. would they have reasonably foreseen the possibility of harm to the respondent and taken such steps as were necessary to prevent the harm from materialising.

### **Causation**

[21] The test for factual causation is whether or not an act or omission of the defendant has been proven to have caused or materially contributed to the harm suffered. In **ZA v Smith [2015 (4) SA 574 (SCA)]**, at paragraph 30, the court states as follows:

*“the criterion applied by the court a quo for determining factual causation was the well-known but-for-test as formulated e.g. by CORBETT CJ in **International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA A at (1989) ZASCA (138) at 70E-H**. What it 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 or philosophy. It is a matter of common sense, based on the practical way in which the minds of ordinary people work, against the background 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 that, but for the defendant's wrongful and negligent conduct, his or her harm would not have ensued. The plaintiff is not required to establish this causal link with certainty."*

[22] Therefore, it is not enough to prove that the appellant's staff breached the legal duty of care and that the respondent suffered harm, it must still be proven that the breach is what caused the harm suffered (***AN obo EN v Member of the Executive Council for Health Eastern Cape* [2019] ZASCA 102 [2019] 4 All SA 1 (SCA) para 4**). In this instance, a determination has to be made whether the injury sustained by the minor would have been avoided if the hospital staff had properly monitored the respondent and foetus and acted in line with the results of such monitoring. If yes, then there would be factual causation.

### **The evidence**

[23] Apart from the admitted joint minutes, the court heard evidence from the respondent, the respondent's father – Mr Machete; and respondent's expert witness Dr Segwadi and Prof Cronje. For the appellant, the following witnesses testified; Sisters Mogale and Komote and the expert witness, Dr Koll. The SCA in ***Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädling bekämpfung MBH* [1976 (3) SA 352 (A) at 371 F-G]** stated as follows:

*"An expert's opinion represents his reasoned conclusion based on certain facts or data which, are either common cause, or established by his own evidence or that of some other competent witness. Except possibly where it is not controverted, an expert's bald statement of his opinion is not of any real assistance. Proper evaluation of the opinion can only be undertaken if the process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds are disclosed by process of reasoning which led to the conclusion, including the premises from which the reasoning proceeds are disclosed by the experts."*



[24] The functions of an expert witness were enunciated in ***McGregor and Another v MEC Health Western Cape* ([2020] ZASCA 89 para 17)**. “The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inference and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.

### **Missing neonatal records**

[25] The paediatric/neonatal file of the minor was not available. The appellant contends throughout that such a file does not exist. Sister Mogale on behalf of the appellant, testified that there is no separate file opened for a newborn at the labour ward, but she does not know what happens at the neonatal/paediatric ward where the new born was taken after birth. Dr Sigwadi, for the respondent, testified that the information she completed on the application for transfer to SBAH was obtained from the neonatal/paediatric file, which information is not in the respondent’s obstetrical file kept at the maternity section.

[26] In this regard, the court *a quo* relied on what was stated in ***Khoza v MEC for Health and Social Development* [2015 (3) SA 266 (GJ) at paragraph [35]]**, referring to section 13 and 17 of the National Health Act (Act 16 of 2003) that requires not only that the records of hospitals and clinics be maintained and safely stored, but also that adequate controls of access are put in place:

*Section 13: obligation to keep records “the person in charge of health establishment must ensure that health records containing such information*

*as may be prescribed is created and maintained at that health establishment.*

*Section 17: protection of health records “the person in charge of health records must set up control measures to prevent unauthorised access to such records”.*

[27] In finding for the respondent, the court *a quo* stated as follows:

*“44 In my view and all probabilities the foetal distress was as a result of insufficient monitoring.”*

### **Liability**

[28] At the outset, it must be stated that while there is conflicting information on whether the delivery occurred at 11h45 or at approximately 14h00, both appellant and respondent’s information in this regard is inconclusive. The issue is, however, irrelevant for purposes of determining this appeal as Prof Cronje on behalf of the respondent testified that it was the failure to conduct frequent monitoring with the CTG between 08h00 and 10h00 that resulted in the nursing staff not picking up the foetal distress. Prof Cronje testified as follows:

*“The important point is whether delivery was 11:45 or at 14:00 to monitoring was insufficient and fetal distress was not detected prior to delivery. There must have been fetal distress because the baby was born with severe birth asphyxia which there is just no other explanation, so there was fetal distress before delivery it does not really matter when the deliver occurred and it was not detected.*

*If the delivery was at 14:00 the additional factor is that the...the second sate was...stage was most probably prolonged which is still a burdening of... another burdening factor but the absence of proper monitoring is the key factor in that led to a baby as we saw the file this morning and this is so sad to me.” (Record 005-65)*

[29] Although the respondent testified that she gave birth at approximately 14h00, she also indicated that she was back in the ward at 14h00. Sister Mogale testified that she was back in the ward at 14h00. Sister Mogale testified that the birth was at 11h45 and recorded much later which is why Dr Sigwadi misunderstood the entries on the transfer letter to SBAH. Dr Koll on the other hand, relied on Sister Mogale's entries as to time of birth. The respondent was fully dilated at 11h00. This is when the second stage of labour starts

[30] During the appeal, it became clear that the respondent's case is based on the failure of the nursing staff to adequately monitor the respondent, i.e. not in line with the guidelines, thereby rendering substandard care. The respondent was admitted at midnight on 16/17 May 2009. Upon such admission the foetal heartrate was normal. A CTG scan was used to document the heartrate of the. foetus. In support, Prof Cronje mentions as follows:

*"Practice is to monitor a patient during labour with a CTG monitor it is a cardiotocograph, an instrument measuring the foetal heart rate and contractions of the mother and recorded on a paper tracing." (Record 005-28)*

[31] There were variable decelerations on the CTG scan at 00h23 and 00h37 and these, Prof Cronje concluded as follows:

*"So there are two of these variable decelerations the one at Block 7971 at 00H23, is that correct? --- That is correct.*

*And then there is a second one where do you identify that/ --- The second one is in Block 7972 right at the end close to the number there 120 just before 120, and you will see it drops down to almost 90.*

*I detected it as being as 00H37 would that be correct? --- That is correct.*

*Now this one has a deeper decelerations as the previous one, is that correct? ---That is correct.*

*All right, this does not necessarily indicate a shortage of oxygen to the foetus, is that correct? --- Not on the on the long-term it is just a moment of oxygen shortage but it does not indicate foetal distress. Foetal distress is a pathological condition of not enough oxygen.*

*Now that is what I want to get to. What do you do when you as a midwife or a medical practitioner see these two even if they can call slight abnormalities, what would you do? --- Well slight I agree that these are slight abnormalities and they are warning signs red lights that tell the Staff that this baby must be monitored very accurately because there is a risk that these variable decelerations can become worse, and it can happen within a very short period of time, so a baby like this has to be monitored very closely throughout labour.” (Record 005-36 to 005-37)*

[32] The foetal heartbeat was checked and recorded at 08h00 and 10h00 with no abnormalities that required any intervention being detected. It is so that in terms of the maternal guidelines of 2007, the foetal heartrate should have been checked and recorded every 30 minutes. Therefore, there should have been readings for 8h30, 9h00, 9h30 and 10h30. Both parties accepted that the focus in terms of the failure to monitor on the part of the nursing staff is at this period; because from 11h00 when the respondent was fully dilated, there was continued activity around her:

*“--- It is very unlikely that a patient that is fully dilated will walk particularly after a very good progress in the first stage because that progress is indicative of strong contractions.*

*Now you had indicated to the Court over the period from 06:00 in the morning until delivery whether it was 11:45 or whether it was 14:00 there had only been two monitoring at 08:00 and 10:00 is that.... [Intervene]. --- That is correct.*

*Does that not pose the problem that there is a failure to properly monitor when it is required? --- That is correct I think the main problem in this case was the absence of adequate monitoring of the fetal heart. The evidence*

*points towards insufficient oxygen to the baby before delivery and that should have been picked up if the monitoring was adequate.*

*The stages of monitoring at 08:00 and 10:00 is just a few seconds of ... can I call it of observation at that stage but from 06:00 to 11:45 or 06:00 to 14:00 only a few seconds are then taken into consideration is that correct? --- That is correct.*

*Do you consider this conduct in any way in an obstetrical or nursing... aspect as acceptable only monitored twice? --- It is... it is completely unacceptable I think that is why we encourage woman to come to a facility for their deliver and this is probably the most important aspect and that is the proper monitoring of the fetal heart". (Record 005 -56 to 005-57)*

[33] The suggestion from Prof Cronje is that the minor suffered a hypoxic ischemic injury of a prolonged type. He bases his opinion on the acceptance that the respondent delivered the minor at 14h00 and therefore the second stage of labour was prolonged eating into the foetus' reserves in terms of oxygen supply. Further that had there been proper monitoring, the foetal heartrate would have necessitated that the hospital staff take preventative action. However, Prof Cronje concedes under cross-examination that first stage of labour was normal and if the insult had occurred within 45 minutes of the second stage, it could not have been prevented:

*"If there were any problems are you then saying this could be in the second stage of labour because in the first stage of labour... the first stage of labour was normal? --- The progress of labour was normal in the first stage.*

*The... the insult if any... you exclude occurrence in the first stage is that correct?--- No it is not correct the insult could have occurred in the first stage already, I already said that with a baby of this size 3.7 it was a healthy normal baby no disease.*

*Now what methods or way are there to determine the timing of the insult. --- Monitoring that is all". (Record 005-79 to 005 – 80)*

[34] He also agrees that the recorded monitoring up to 10h00 did not call for a caesarean section:

*“The recording as they stand and as you correctly point out... did not call for a caesarean section for example at that stage. --- That is correct”.  
(CaseLines Record 005 – 91)*

[35] Further Dr Koll testified as follows as to the possibility of having performed a caesarean section:

*“It is correct that if they did a Caesarean section at 7 to 8cm it would have been prevented the acute injury, but I cannot see any indication why a Caesarean section should have been done at 7 to 8cm, if the baby was distressed at 7 to 8cm and was born some hours later, there would be a partial prolonged injury or a mixed injury, there would not be a pure acute profound injury, because the injury occurred late in labour, but there was no indication, no reason to do a Caesarean section at 7 to 8cm, the labour was progressing adequately and we know that the baby was not distressed at that time, because there is no partial prolonged injury”. (Record 008 – 71)*

[36] In contrast the radiologists’ joint minute brain injury records the brain injury he as being of an acute profound type. The joint minutes were accepted as evidence by both parties and even though the radiologists could not state when the insult on the foetus took place, the MRI pattern confirms an injury which is an acute profound type. This, as submitted by the applicant, is direct evidence. In his evidence, Prof Cronje on behalf of the respondent admits as such:

*“In other words MRI wise nothing abnormal was found with the brain, is that correct? --- That is correct, yes. Could I just explain? The most important things are congenital abnormalities for example a water head or a brain that does not develop all those things were absent in this case.*

*And those things were absent. Then in the neonatology period they established by way of blood tests and of a lumbar puncture performed that*

*there was no septicaemia no sepsis and also no meningitis. --- That is right, that is correct.*

*In other words as the Paediatric Neurologists conveyed in their report if I can just get to that I will read it to you as well. The Paediatrician Neurologist Doctor M.N. Lippett and Doctor M.K. [indistinct] recorded as follows on Pages 5 to 6.*

*‘Radiological evidence scan supports the exclusive pathology of perinatal asphyxia of severe extent.’*

*Doctor Hobflish did not consider it but he did disagree with Doctor Lippett in the evaluation of that document. Then the Neonatologists came to the conclusion in Paragraphs 5 on Page 2 of the joint minutes.*

*‘Davis, and Professor Cooper agree that neonatal encephalopathy that is what it is called it was previously call HIE also confirmed by Doctor Sigwale was most probably due to intrapartum hypoxia ischemia, and only black gas would have been informative in confirming this this but was apparently not done.*

*Other causes of [indistinct] such as intracranial bleeding or structural brain abnormalities were excluded by [indistinct] while tests excluded meningitis and septicaemia, do you agree with that? --- I agree with that, yes”. (Record 005 – 26 to 005 – 27)*

[37] Even during argument, the respondent submitted that because the radiologists were unable to tell when the insult on the foetus took place, their argument that it was a prolonged type brain injury should prevail as evidenced by Prof Cronje and Dr Sigwadi referencing a prolonged second stage of labour.

*“Whether there was a prolonged second stage or not the critical factor here was insufficient oxygen before delivery which was not detected because of*

*insufficient monitoring. That is the crucial factor whether there was a prolonged second stage or not.*

*Yes. --- If there was a prolonged stage it just strengthens my whole argument but my argument still stands even if there was not a prolonged second stage.” (Record 005 -96)*

[38] This argument on the facts and the joint minute of the radiologists cannot hold because the MRI scan points to a brain injury of an acute profound type which Prof Cronje describes as follows:

*“Professor what is a... what is acute profound injury? --- That is an incident in the late second stage of labour where there is an acute shortage of oxygen. Usually within about ten to... on the most say 20 minutes before delivery”. (Record 006 – 16)*

[39] There remains for the respondent to prove that the conduct of the nursing staff complained of was responsible for the harm suffered by the minor. Even if there is acceptance that the nursing staff failed to monitor the foetal heartrate every 30 minutes as prescribed by the maternal guidelines, such failure has no causal connection with what occurred after 10h00. The results of the monitoring at 08h00 and 10h00 did not warrant any intervention. Dr Koll concludes from the documentation that as at 10h00, *“we had a reasonable documentation of a healthy baby...”* (Record 008 – 61)

[40] And if there had been evidence of foetal distress at 10h00, there would have been a partial prolonged or mixed pattern injury.

*“So my conclusion was that the management and recording of observations at Mamelodi Hospital during the latent phase of labour did not meet the guidelines, the foetal heart was however recorded as normal, in the notes at 10:00 a.m. and clear lycol, which is also an indicator that foetal wellbeing was documented at 10:00. So in my opinion we had a reasonable documentation of a healthy baby at 10:00.*



*There no record of recording the foetal heart between 10:00 and 11:45 and it should have been recorded at 10:30 and again at 11:00, when full dilatation was noted. And if there had been evidence of foetal distress at 10h00, there would be a partial prolonged or mixed pattern injury evidence of foetal distress at 10:00, then there would be a partial prolonged or a mixed pattern". (Record 008 – 61)*

[41] This emphasises under cross-examination

*"That's exactly the point of Professor Cronje. He says over a period of time the reserves had just been drained of this child, it's a big healthy baby and then there was clear brain damage caused because of no more reserves and the prolonged stage of labour... --- That would have been correct if there was evidence of a partial prolonged injury on the MRI, there was no evidence of a partial prolonged – it was an acute event that happened suddenly as described in an acute hypoxic brain injury in this article". (Record 009 – 28)*

[42] Most importantly, given that this matter concerns an acute profound type injury that occurred immediately before delivery and not a partial prolonged injury, the failure to monitor at that time is irrelevant. In that regard, Prof Cronje testified as follows:

*"Now as you explained it Professor this acute... type of injury is the type of... or guess under circumstances for example where one cannot have an opportunity to do a caesarean section. --- Yes that is usually too late for a caesarean section, an acute profound injury or event is usually very late in the second stage and instead of a caesarean section it is usually possible to do an assisted delivery with an instrument.*

*I see. So in short Professor one can correctly say that in that case because of the sudden nature of this thing... it is not preventable or options of preventing it are indeed limited. --- I think if you look at the circumstantial*

*evidence of this case the Hypoxia or the fetal distress must have lasted longer than we understand under acute profound". (Record 006 – 18)*

[43] Dr Koll confirmed as much:

*"But the connection, the event isn't there. If they had missed fetal distress because of their failure to monitor, this baby would have had a mixed pattern or a partial prolonged pattern without – with the monitoring as it is, I would have very definitely said, you know, there's no case". (Record 006 – 18)*

[44] It follows that the appeal must succeed. The following order is made:

1. The appeal is upheld.
2. The order of the high court is set aside and replaced with the following:

The plaintiff's claim is dismissed with costs.

MA LUKHAIMANE  
ACTING JUDGE OF THE HIGH COURT  
GAUTENG DIVISION, PRETORIA

I agree

AJ MOTH  
ACTING JUDGE OF THE HIGH COURT  
GAUTENG DIVISION, PRETORIA

I agree, and it is so ordered

CJ VAN DER WESTHUIZEN  
JUDGE OF THE HIGH COURT  
GAUTENG DIVISION, PRETORIA

*Heard on:* 19 October 2022

*For the Applicant:* SS Maakane, SC

*Instructed by:* The State Attorney

*For the Defendants:* AN Tshabalala

*Instructed by:* Adele Van Der Walt Inc Attorneys

*Date of Judgment:* 20 January 2023