IN THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

Case No. 75413/2014

(1) REPORTABLE: ~~YES~~/**NO**

(2) OF INTEREST TO OTHER JUDGES: ~~YES~~/**NO**

(3) REVISED

DATE: **27 September 2024**

SIGNATURE:

In the matter between:

B[...], T[...] obo S[...] N[...] **PLAINTIFF**

And

MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH OF THE MPUMALANGA PROVINCIAL GOVERNMENT **DEFENDANT**

Coram: Millar J

Heard on: 2 ,3,4 & 6 September 2024

Delivered: 27 September 2024 - This judgment was handed down electronically by circulation to the parties' representatives by email, by being uploaded to the *CaseLines* system of the GD and by release to SAFLII. The date and time for hand-down is deemed to be 09H00 on 27 September 2024.

JUDGMENT

MILLAR J

[1] The present action brought by the Plaintiff against the defendant arises out of what is contended by the plaintiff to be the negligent conduct of the medical staff at the Themba Hospital, a facility operated under the aegis of the Defendant. The events in question span the period 15 December 2010 until the birth of the child by caesarean section on 19 December 2010.

[2] Although the action was set down for hearing for a period of 10 days, when the trial commenced, the parties had reached the following agreement:

[2.1] That there would be a separation of the issues of liability and the quantum of damages.

[2.2] The common cause facts upon which the trial on liability would proceed.

[2.3] That save in respect of two issues, the reports of the plaintiff's expert Radiologist, Obstetrician and Gynaecologist, Pediatrician, and Paediatric Neurologist were not in dispute.

[3] When the trial commenced, I ordered the separation of issues in terms of Rule 33(4). The two issues to be decided were the following:

[3.1] Whether the alleged taking of 'isiwasho' or 'imbita' by the Plaintiff to speed up labour had any impact upon her child's subsequent birth injury.

[3.2] Whether the Themba Hospital facilities and relevant budget, including for the period relating to the weekend of 18 and 19 December 2010, was causally related to the delay in the carrying out of the caesarian section for the delivery of the Plaintiff's child.

[4] In consequence of the agreements reached between the parties, only 4 witnesses were called – 2 for the plaintiff and 2 for the Defendant. For the Plaintiff, she testified together with Dr Murray (Obstetrician and Gynaecologist) and for the defendant, Dr Dhlodhlo (the current Senior Clinical Manager of Themba Hospital) and Sister Z. Nkosi (a Nurse who had been on duty at the time in question).

COMMON CAUSE FACTS

[5] The following facts were common cause and were not in dispute between the parties.

[6] The Plaintiff is the biological mother of S[...] L[...] N[...] (hereinafter referred to as *"the minor child"*) who was born on 19 December 2010 at the Themba Hospital, a health facility that falls under the control, management and authority of the Department of Health of the Mpumalanga Provincial Government (herein after referred to as "*the Department"*).

[7] The Department was under a legal duty to provide hospital facilities at the Themba Hospital, such hospital facilities to be reasonable having regard to the relevant budget of the Department.

[8] The nurses who provided nursing care to patients admitted to the Themba Hospital acted in the scope of their employment in providing nursing care and were under a legal duty to provide nursing care to patients according to the standard expected of a reasonable nurse with commensurate experience and practicing in Mpumalanga.

[9] The doctors who provided medical care to patients admitted to the Themba Hospital acted in the scope of their employment in providing medical care and were under a legal duty to provide medical care to patients according to the standard expected of a reasonable doctor with commensurate experience and practicing in Mpumalanga.

[10] The Plaintiff's pregnancy progressed uneventfully and without apparent complications.

[11] The Plaintiff was first admitted to the Themba Hospital at 01h50 on 15 December 2010 at term gestation and was discharged on 16 December 2010 as she was deemed to not to be in labour. The foetal heart rate was normal during this period.

[12] The Plaintiff was again admitted to the Themba Hospital at 00h30 on 18 December 2010 and was again discharged home at around 12h15 that day, as she was deemed to not be in labour.

[13] The Plaintiff returned to the Themba Hospital later on the same day where she was reviewed at 17h45 and was admitted in labour. Two mild contractions in 10 minutes were felt and the foetal heart rate ranged between 130 and 150 beats per minute.

[14] It was documented in the hospital records at 17h45 on 18 December 2010 that the Plaintiff "*said that she took two spoons of Isiwasho today"* and at 18:30 that "*Pt*

admits to taking Imbita to speed up her labour". At 17h45 the foetal heart rate was 130 – 150 beats per minute and two mild contractions in 10 minutes were palpated.

[15] The Plaintiff admits that these entries were recorded in the hospital records but places its meaning and import in dispute.

[16] The Plaintiff progressed through latent labour (cervical dilatation of 3 cm or less) with no obvious concerns and there appears to have been no concern in regards the foetal condition at this time.

[17] The Plaintiff had progressed to active labour (cervical dilatation from 4 cm to full dilatation at 10 cm) by 04h00 on 19 December 2010 at which time the foetal heart rate ranged between 123 and 158 beats per minute and three mild contractions in 10 minutes were felt.

[18] According to the *Guidelines for Maternity Care in South Africa* (2007), during the active phase of labour, *inter alia*, the foetal heart should be monitored half-hourly, listening before, during and after a contraction and the frequency and strength of contractions should be monitored hourly.

[19] The Plaintiff was reviewed by a doctor at 09h30 on 19 December at which time she was 7 cm dilated, it was noted that the progress of labour fell on the action line with moderate contractions, and labour was augmented with Pitocin.

[20] Pitocin is the trade name for oxytocin, which is a synthetic hormone used to increase the strength and frequency of contractions to assist in achieving labour in the setting of poor labour progress where the cause of the slow progress is thought to be due to ineffective uterine contractions.

[21] Because of the risks of oxytocin use, continuous foetal monitoring by way of CTG is imperative. The dose of oxytocin must, furthermore, be titrated against the strength of

contractions. For that reason, careful contraction monitoring is also imperative. Oxytocin should be stopped if tachysystole occurs, or if there is any change in the foetal condition. It should also not be used if the foetus is already showing any signs of compromise as it would exert additional stress on the foetus. A CTG should therefore be performed before oxytocin is commenced.

[22] The Plaintiff was reviewed at 12:00 on 19 December at which time a caesarean section was indicated because of the failure to have progressed despite being on oxytocin at an excessively high dose and without engagement of the foetal head with worsening caput.

[23] The Plaintiff was reviewed at 14:30 on 19 December at which time it was noted that her progress had crossed the action line. The plan was made to perform a caesarean section *"for obstructed labour".* The Plaintiff's urine was blood-stained which is in keeping with obstructed labour (cephalopelvic disproportion). At this time the Plaintiff's labour was already markedly prolonged.

[24] The Plaintiff's baby was delivered at 17h15 on 19 December 2010. The baby was delivered 2 hours and 45 minutes after the decision had been made for caesarean section (at 14:30), and over 5 hours since the caesarean section was indicated. There is no evidence that contractions were tocolysed while awaiting caesarean section or that intrauterine resuscitation was performed.

[25] The caesarean section in the present matter would be classed as a Category 1 caesarean section, which means that there was an immediate threat to the life of the mother or the baby. As such, delivery should have been within 30 minutes of the decision time.

[26] However, various researchers in developed countries have found the 30-minute interval to not be feasible. Studies from South Africa (Le Riche and Hall, *J Trop Paed* 2005, O 'Dwyer and Fawcus, *RCOG World Congress* 2013) have found the average

decision-delivery time to be between 48 and 64 minutes. The *Guidelines for Maternity Care in South Africa* (2007) stipulate that all hospitals should ensure that a caesarean section can be performed within one hour of the decision to operate.

[27] There is no note of the foetal condition at all between the hours of 13h10 and delivery by caesarean section at 17h15, a period of more than 4 hours. This means that the foetal condition during the last 4+ hours of a prolonged labour was thus unknown.

[28] This failure to monitor must be seen in the context of the requirement that a foetus in an uncomplicated labour should be monitored half-hourly, whereas continuous monitoring of the foetus by way of CTG is recommended in complicated labour.

[29] It follows that, with no monitoring, any change in the foetal condition could not and would not have been diagnosed, and no steps could and would therefore have been taken to improve foetal oxygenation by performing intra-uterine resuscitation or by expediting delivery.

[30] However, management aimed at expediting delivery was indicated even if there had been no evidence of foetal distress due to the prolonged nature of the labour.

[31] There are no notes or reference on the partogram to the foetal condition, the progress of labour or the maternal condition being monitored or assessed after 10h00 / 10h30 (i.e., approximately 7 hours before delivery). The failure to perform continuous foetal heart monitoring, especially in circumstances where a very high dose of oxytocin was infused, which increases the risk of reduced oxygen supply to the foetus and resultant foetal distress, means that these warning signs would have been present and would have been observed had proper foetal monitoring been performed.

[32] Furthermore, the last plotting of cervical dilation on the Partogram (at 10h00) was already to the right of the action line, which means that action had to be taken. Once the decision was taken at 14h30 to perform a caesarean section, there is no

evidence that intra-uterine resuscitation was done to improve oxygen delivery to a probably distressed foetus in order to reverse hypoxia and acidosis.

[33] The dates of 18 and 19 December 2010 fell on a weekend and were a Saturday and Sunday, respectively.

[34] The Apgar scores were recorded as 3/10 and 5/10 at 1 and 5 minutes of life, respectively. The baby did not cry at birth and required suctioning, bagging and nasal prong oxygen.

[35] The baby's birth growth parameters (weight, length and head circumference) were normal for a baby born at term and suggest a suitable intra-uterine environment to support normal antenatal growth.

[36] It is accepted that the available evidence supports the premise that the brain injury was caused by hypoxia and that this hypoxia most likely occurred during the course of labour because of the prolonged nature of the advanced stages of labour.

[37] There is no documented evidence of a sentinel event, which is an obstetric emergency which puts the mother's and/or foetus' life at immediate risk and is usually associated with sudden and dramatic cessation of oxygen delivery to the foetus.

[38] The baby was discharged from hospital on 23 December 2010.

[39] The minor child has since been diagnosed with severe mixed-type cerebral palsy (predominantly dystonic / dyskinetic).

[40] The minor child' s co-morbidities include moderate to severe intellectual disability, multiple contractures, relative microcephaly, and severe developmental delay. He is completely dependent on others for activities of daily functioning.

[41] Based on the available clinical notes and hospital records, and the history obtained, the minor child fulfils sufficient criteria for the diagnosis of an early neonatal encephalopathy and, furthermore, the evidence is in keeping with a Grade 2 (moderate) neonatal encephalopathy.

[42] Infection, congenital brain abnormalities, maternal medication, intra-uterine growth restriction, intra-cranial haemorrhage, an inborn error of metabolism, genetic disorders and an acquired metabolic cause have been excluded as possible causes of the child's neurological condition.

[43] Hypoxic-ischemic encephalopathy, or HIE, which is the brain injury caused by oxygen deprivation to the brain, also commonly known as intrapartum or birth asphyxia is the most probable cause of the minor child's neonatal encephalopathy. This is confirmed by the MR images.

THE EVIDENCE

[44] The Plaintiff testified that she had taken 'isiwasho' the day before the birth of the child. She said that in consequence of her having been to the hospital and having been sent home because she was not in labour, she felt that her 'luck' was bad. The iziwasho was taken to change her luck and that the specific preparation she had taken was in fact called 'luck'.

[45] Her evidence was that she had mixed the 'luck' with some water and then taken two teaspoons of the mixture, put them into her mouth and then spat the mixture onto her stomach. The plaintiff was adamant that she had neither drank nor swallowed the mixture. She admitted to telling the nurses at the hospital that she had taken the 2 teaspoons of the isiwasho. However, the plaintiff denied taking 'imbita.' She testified that the former was to bring luck and was not ingested whereas the latter was a herbal mixture which was ingested. They were two different things. She had been told by her mother to take the isiwasho.

[46] The Plaintiff was cross examined at some length on this aspect and on her attendances at the hospital in the days before she was admitted. The Plaintiff testified that she had informed the experts with whom she had consulted, that she had taken the isiwasho.

[47] Dr Murray testified that she had formed her opinion of the matter exclusively upon a review and consideration of the hospital records. She neither consulted with the plaintiff nor examined the child. Dr Murray testified that she was unable to ascertain from the records the nature of the 'isiwasho' or 'imbita' and did not know the composition or the amount of these substances alleged to have been taken save as set out in the hospital records. In the summary of her evidence, delivered to the defendant in terms of Rule 36(9)(b), her evidence on this aspect was as follows:

"

15.1 The Plaintiff presented back the same day, now with painful and pulpable contractions and some evidence of cervical change (in that the cervix had become fully effaced).

15.2 The Plaintiff had reportedly ingested herbal medication to aid in labour progress. Dr Murray will testify that she is not familiar with this particular name, but that she assumes it to be some sort of uterotonic similar to Isihlambezo, which is a herbal mixture commonly taken by Zulu women in South Africa as an aid to labour. It is a potent uterotonic and its use is associated with very rapid labours, foetal distress and heavily meconium-stained liquor. It will be the evidence of Dr Murray that she is unable to comment on the exact nature of this substance or the effect thereof in relation to how much thereof she reportedly took. It does however appear that the attending doctor was familiar with it and was aware that it can cause very strong contractions, uterine rupture being a consequence of this.

15.3 It will be the evidence of Dr Murray that it is fair to state that the Plaintiff had progressed to latent labour by 18:30 on the 18th of December 2010 as there had been more definitive cervical change, with strong contractions.

15.4 ……

15.5 ……

15.6 It is the opinion of Dr Murray that because of the reported ingestion of a probable uterotonic substance, CTG monitoring should have been utilised as far as possible in the present matter".

[48] Dr Murray confirmed her opinion set out in the summary in evidence. She was cross examined at some length as to why she had not deferred an opinion on the effect of the iziwasho / imbita to a specialist herbalist whereas on certain other aspects, she had deferred to a Pediatrician and a Paediatric Neurologist. She fairly conceded that she was not in a position to offer an opinion and that it may have been of assistance to have deferred the question to a specialist herbalist but then went on to explain, as set out in the quote above in paras 15.2 read together with 15.3 and 15.6 in para [47] above why the use of isiwasho / imbita was not relevant in the present matter.

[49] Dr Murray had testified that ordinarily a foetus had sufficient oxygen supply to weather momentary, albeit repeated, periods of oxygen deprivation but that if this continued for too long, the foetus would not be in a position to recover its oxygen supply as it would normally and that this may then lead to ischaemic brain damage and cerebral palsy.

[50] The crux of her evidence was that the case was one of an obstructed birth – the child was too big to be born naturally and that if anything, the reference to iziwasho or imbita in the hospital records, ought to have been a red flag to the medical staff.

[51] Dr Dhlodhlo, the current Clinical Manager of the Themba Hospital was called to testify on behalf of the defendant. Her current position equates with what used to be referred to as “The Superintendent” of a hospital. Although she is herself an Obstetrician by profession, who has worked in a number of hospitals at different levels throughout the government healthcare system, she only began working at the Themba Hospital in 2013, 3 years after the events in question occurred.

[52] Her evidence, like that of Dr Murray, in regard to the Plaintiff’s care and treatment was predicated solely on a consideration of the hospital records to which she had access. Although the defendant did not give notice of its intention to call Dr Dhlodhlo as an expert witness, she testified that as an Obstetrician, she knew about the use of isiwasho and imbita.

[53] Her evidence on this aspect was that these were the same as the ‘isihlambezo’ referred to by Dr Murray in her report and that the consumption thereof by patients to induce labour was particularly problematic because it had the same effect as Pitocin or Oxytocin, medications which were administered to induce labour.

[54] Dr Dhlodhlo testified that when labour was induced, this resulted in stronger and more frequent contractions and that when this occurred, the foetus was momentarily deprived of oxygen.

[55] It was the evidence of Dr Dhlodhlo that since neither the amount nor the frequency with which the isiwasho or imbita taken could be ascertained, it would not be possible, in the context of the present case, to say whether or not the effects of the iziwasho or imbita had worn off before the medical staff had then subsequently administered Pitocin to the Plaintiff.

[56] Dr Dhlodhlo testified that the staff at the Themba Hospital had to do the best they could with what was available to them which included the decision on whether or not to administer Pitocin. On one aspect with regards to the management of patients,

Dr. Dhlodhlo was clear. This was that a reasonable medical practitioner would not do anything that would create an emergency.

[57] She testified that on the weekend of 18 and 19 December 2010, there was only one medical team from the obstetric ward and one theatre available. The single theatre which had one anaesthetist was required to service all the departments of the hospital over the weekend which included the casualty department. This meant that patients had to be triaged for surgery and that they would be taken in for surgery based on the seriousness of their condition. She testified that transfer to another hospital, in the present case, the nearest one being the Rob Ferreira Hospital in Mbombela would have been neither appropriate nor advisable in the plaintiff's case.

[58] Nurse Nkosi testified that she was on duty on 19 December 2010 and that she had attended the plaintiff. She corroborated the evidence of Dr Dhlodhlo as regards the availability of only one medical team and one theatre team on the weekend in question. She testified that there were two other patients that needed to go to surgery before the plaintiff and that the determination in this regard was made as a result of assessment and triaging.

[59] In her evidence she pointed to 2 entries in the hospital records to substantiate this. Her evidence was that given the nurse patient ratio of 1 nurse to 4 patients on the day in question and that the nurses, besides monitoring patients, had other tasks to complete such as taking and fetching patients from theatre, it was simply not possible to have monitored the Plaintiff in the way that it was expected she should have been monitored.

THE LAW

[60] It is not in issue that a failure to meet the professional standards reasonably expected of them by the medical staff at the Themba Hospital would result in the liability of the defendant.

[61] Pertinently two issues arise. The first is whether or not there is a nexus between the conduct of the medical professionals and the damages said to be suffered – factual causation. The second, is the standard by which such conduct is to be assessed.

[62] In *Oppelt v Department of Health, Western Cape,*[1] the test when dealing with a negligent omission, was set out as follows:

> "*While it may be more difficult to prove a causal link in the context of a negligent omission than of a co-mission, Lee explains that the "but-for" test is not all the be-all and end-all of the causation enquiry when dealing with negligent omissions. The starting point, in terms of the but-for test, is to introduce into the facts a hypothetical non-negligent conduct of the Defendant and then ask the question whether the harm would have nonetheless ensued. If, but-for the negligent omission, the harm would not have ensued, the requisite causal link would have been established. The rule is not inflexible. Ultimately, it is a matter of common sense whether the facts establish a sufficiently close link between the harm and the unreasonable omission."*

[63] The but-for test, presently applicable in the consideration of the defences raised is perhaps most cogently explained in *Cork v Kirby Maclean Ltd*[2] when it was expressed as follows:

> *"(I)f you can say that the damage would not have happened BUT FOR a particular fault, then that is in fact the cause of the damage; but if you can say that the damage would have happened just the same, fault or no fault, then the fault is not the cause of the damage."*

---

[1] 2016 (1) SA 325 (CC) at para [48].
[2] [1952] All ER 402 (CA) at 407 quoted with approval in *JA obo DA v MEC for Health, Eastern Cape* 2022 (3) SA 475 (ECB) at para [49].

[64] In *S v Kramer and Another,*[3] the approach to be adopted with regards to the standard to be accepted of professional persons, was framed in the following terms:

> "*. . . Obviously the ordinary reasonable man test of negligence cannot be applied to an activity calling for expertise that an ordinary man does not possess. One cannot judge a surgeon's conduct by asking how diligent paterfamilias would have operated, for either he would not have operated at all (which is most likely) or, if he would have operated (in some rare emergency) he would no doubt have done worse than even the most barbarous surgeon.*
>
> *And so there emerges the reasonable expert – a practitioner like the actor, but possessing no special flair or frailty; the reasonable doctor, the reasonable auditor, the reasonable mechanic. It is he who looks over the actor's shoulder to see if he attains the standard of his peers, for if he does not, he is negligent. That standard it has been held, is not the highest level of competence: it is a degree of skill that is reasonable having regard to 'the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs' (per Innes CJ in Van Wyk v Lewis, 1924 (AD) 438 at 444.)"* [my underlining].

[65] In the present instance it is not the conduct of an ordinary person that is to be considered through the lens of negligence. Here we are concerned with the conduct of professional medical practitioners – nurses and medical doctors. Both are possessed of specialised skill.

[66] In the present case the doctors and nurses at the Themba Hospital made their knowledge and skill available to the plaintiff and other members of the public who sought admission at the hospital. Once the plaintiff was admitted and under their care,

---

[3] 1987 (1) SA 887 (W) at 894F-H. See also *Oppelt supra* at para [69].

they were all duty bound to render those professional medical services with at least a *"general level of skill and diligence"*[4].

DISCUSSION

[67] It is not in dispute that the plaintiff's minor child suffered a brain injury in consequence of oxygen deprivation at the time of his birth.

[68] Whether or not this was caused in the first instance as a result of the actions of the Plaintiff herself in taking isiwasho or imbita or, in the second instance by insufficient resources (nurses and theatres), created an impossibility for the medical staff on duty to provide any more or better care than they did.

[69] I propose dealing with each of these in turn.

[70] Firstly, the records reflect that the Plaintiff disclosed to the nursing staff that she had taken isiwasho. This occurred at 17h45 on 18 December 2010. At 18h00 the records reflect that the nursing staff had disclosed what the plaintiff had told them to the treating doctor. She was subsequently seen by the treating doctor at 18h30. Although she disputed in evidence that she had told the treating doctor that she had taken imbita, the entries in the record reflect that he had been made aware of the fact that she had taken something – either isiwasho or imbita and had then considered it in his management of the plaintiff.

[71] The specific preparation taken by the Plaintiff seems to me to be of no moment once the treating doctor had been made aware that she had taken something to hasten labour. He recognized the risk that this could pose and his notes that the plaintiff was *"high risk for rupture of uterus"* and that she required *"close maternal monitoring"* are indicative of this.

---

[4] *Mitchell v Dickson 1914* AD 519 at 525 as quoted in *Oppelt v Department of Health, Western Cape* supra at para [107].

[72] The risk was recognized, and the Plaintiff monitored. By the following morning, the plaintiff was still not in a position to deliver her child. Monitoring up to that point indicated that notwithstanding the plaintiff not being in a position to deliver the child, both she and the child were otherwise well.

[73] At 09h30 on 19 December 2010 and as a result of the delay in delivery, the plaintiff was administered Pitocin. Dr Murray testified, and it was not disputed, that the dosage given to the Plaintiff was substantially higher than that which was considered to be normal. Monitoring continued and at 10h00 and despite it having been recorded that the plaintiff was "*progressing poorly*", the dosage of Pitocin was increased.

[74] The Plaintiff was seen again at 12h00. The records indicate that the doctor *"promised to see her after c/section."*

[75] By 13h10 there was no change, and the decision was taken to transfer the Plaintiff to the delivery room. This is the last time that the heart rate of the child was recorded. At 14h30 it was accepted, at least the notes record it for the first time, that the plaintiff's labour was obstructed.

[76] The records indicate that at 15h00 the Plaintiff had been prepared for a possible caesarian section and her temperature, blood pressure and pulse were checked. The records also record "*Doctors going to theatre for an emergency c/section."*

[77] The next entry in the hospital records reflects that the Plaintiff was taken to theatre but there is no time recorded when she was taken from the delivery room or when she arrived. The final entry relevant to the present enquiry was made at 17H30 when it was recorded that the Plaintiff's child had been delivered at 17h30 and had to be resuscitated.

[78] The Defendant argued that the two entries made at 12h00 and 15h00 were indicative of other patients having to deliver their children by caesarian section and thus being “in front of the plaintiff in the queue”. These two entries together with the evidence of Dr Dhlodhlo and Nurse Nkosi formed the entire evidentiary fulcrum upon which the Defendant’s contention that it was not liable to the Plaintiff due to insufficient resources was based.

[79] Despite Dr Dhlodhlo testifying that she had regard to the duty rosters of the hospital for the weekend in question, no such rosters were made available to the court. Whether there was only one hospital theatre available at the time with a high demand for its use is something that could easily have been corroborated by the production of such rosters. The Defendant elected instead to proceed on the basis only of Dr Dhlodhlo’s ‘consideration’ of such rosters together with the recollection of Nurse Nkosi of events some thirteen years earlier.

[80] Accepting that there was only one theatre available and a limited number of nurses, the question that remains unanswered is why, despite recognising that the plaintiff was a high-risk patient that required close monitoring, even with the supposed limitation on resources, that she was not more closely monitored.

[81] It is not explained why, despite the fact that both the Plaintiff and the child had been monitored up to 13h10 on 19 December 2010, that all monitoring of the child ceased from that point in time onwards until he was delivered. There were as far as the records reflect, at least sufficient resources until that point.

[82] If there was an impossibility upon the Defendant to have delivered the Plaintiff’s child sooner than he was because of the need to attend to patients whose situation was deemed more serious, there is an onus upon the Defendant to demonstrate that this was so.

[83] Indeed, it is only the Defendant that could demonstrate this.[5] Aside the bare assertion that this was the situation in which the staff at Themba Hospital found themselves in on the day in question, they failed to place any evidence before the court that this was the situation that prevailed.

[84] The reliance on selective entries in the Plaintiff's hospital records is misplaced. If there were other patients or the theatre was occupied, it was incumbent upon the Defendant to demonstrate this by making the duty roster and theatre roster available. Although Dr Dhlodhlo said she had considered the duty roster (nothing was said about the theatre roster), this was not made available to the Plaintiff or the court. The ineluctable inference is that this document (although available) did not support the case of the Defendant.

[85] Another aspect which was never explained and lends credence to the argument by the Plaintiff that the Defendant's reliance on such entries was contrived and self-serving is why notes would be made in the Plaintiff's file that were unrelated to her but to other unidentified patients. Read as a whole, the entries clearly relate to the plaintiff and to no-one else.

[86] In *HN v MEC for Health KZN*[6]*,* in regard to the admissibility of the contents of hospital records, it was held that:

> *"[8] Statements in the medical records that are favourable to the Defendant are hearsay where the author thereof was not called to testify, and hence not admissible. . . No application was made for the admission thereof in evidence in terms of section 3 of the Evidence Law Amendment Act 1988, but even if there was, it would be unlikely to have succeeded as there was no evidence that the author thereof was no longer available to give that evidence . . .*

---

[5] See *Soobramoney v Minister of Health, KwaZulu Natal 1998* (1) SA 765 (CC).
[6] [2018] ZAKZPHC 8 (4 April 2018).

[9] Recordings favourable to the Plaintiff's case in establishing negligence and liability generally, and accordingly damaging to the Defendant's case, made as part of the records kept by the Defendant's servants, are however on a different footing. They constitute admissions by the servants of the Defendant made in the ordinary course of discharging their duties, which are binding against the Defendant. The Defendant's staff are obliged to make these statements by recording the medical position as it unfolds in the records. They have an obligation to speak on behalf of the Defendant and dispute what is recorded, if indeed incorrect."

[87] In the present matter, save for the singular dispute relating to whether or not the plaintiff told the doctor at the Themba Hospital that she had taken imbita, no evidence was led to place any of the other entries in the hospital records in issue. It was in respect of this issue raised by the defendant, that necessitated the calling of both the Plaintiff and Dr Murray as witnesses.

[88] The evidence of the Plaintiff that she neither took imbita nor told the doctor that she had, was not disputed and is accepted. However, even if I am incorrect in accepting the Plaintiff's evidence in this regard, I am fortified in my view for two reasons that the whole question of whether or not she took isiwasho and/or imbita is a red herring.

[89] The first reason is that the claim of the Plaintiff was brought against the Defendant in a purely representative capacity. The plaintiff sues on behalf of her child and her child alone. Her personal estate stands separate and distinct from that of her child. The Plaintiff was never joined as a wrongdoer in her personal capacity[7] and so it does not now afford the Defendant succour to raise as a defence to the claim, that the Plaintiff's conduct was in any way the cause of her child's misfortune.

[90] The second reason arises out of the undisputed entries in the hospital records. The recording of the use of isiwasho (and allegedly imbita) was accompanied by a

[7] *Road Accident Fund v Myhill* 2013 (5) SA 426 (SCA) at para [28]-[29].

caution recorded by the doctor that in consequence of this, the Plaintiff was at high risk for a ruptured uterus and required close monitoring. Throughout the period of monitoring, neither the plaintiff nor the child demonstrated any distress which could be attributable to the isiwasho (or the imbita).

[91]

[92]

[93] It is readily apparent from the records that whatever the effect of the isiwasho (or the imbita) may have been and knowing that it had been taken, the doctors at Themba Hospital then went on to administer Pitocin to the Plaintiff.

[94] Once the Pitocin was administered to the Plaintiff, the effect, if anything of what had been taken before, would have been rendered irrelevant. This is particularly so given the high dosage administered. On this aspect, the evidence of Dr Murray was not disputed.

[95] Despite the recognition that the plaintiff was in obstructed labour and required a caesarian section, inexplicably, and for a 4,5-hour period, monitoring of the foetus ceased. It is self-evident that if the monitoring of the plaintiff and foetus had continued, then distress in the foetus would have been detected earlier and the caesarian section performed earlier[8].

[96] It was agreed between the parties that:

> *"It is accepted that the available evidence supports the premise that the brain injury was caused by hypoxia and that this hypoxia most likely occurred during*

[8] *Buys v MEC for Health and Social Development of the Gauteng Provincial Government* [2015] ZAGPPHC 530 (18 June 2015) at para [79].

the course of labour because of the prolonged nature of the advanced stages of labour."[9]

and that

"There is no documented evidence of a sentinel event, which is an obstetric emergency which puts the mother's and/or foetus' life at immediate risk and is usually associated with sudden and dramatic cessation of oxygen delivery to the foetus. "[10]

[97] It follows that in the absence of any adverse effect on the foetus being established in consequence of the use by the plaintiff of iziwasho (or imbita) or of the Themba Hospital being without the staff or facilities to properly care for the plaintiff and the foetus, that the sole cause of the injury to the foetus (the child once he was a newborn) is the negligent failure on the part of the staff of the Themba Hospital to timeously deliver him when by the exercise of reasonable care, they could and should have done so.

[98] For the reasons I have set out above, I find no merit in the defendant's argument that the taking of iziwasho (or imbita) played any role in the birth injury. Additionally, I find no merit in the argument that due to a lack of resources the staff at the Themba Hospital were unable to provide a minimum standard of care which would have obviated the birth injury. The injury to the plaintiff's child was entirely avoidable.

COSTS

[99] The costs will follow the result. The parties had agreed at a pre-trial conference that they would apply for a separation of issues and that the action would proceed only

---

[9] Paragraph [36] *supra*.
[10] Para [37] *supra*. See also B*urger v Union National South British Insurance Company* 1975 (4) SA 72 (W).

for the determination of liability in the first instance. In preparation, the plaintiff obtained reports from various experts and reserved those experts to come and testify in the trial.

[100] On the first day, the parties were able to reach agreement which obviated the need for the calling of all the experts. In consequence of the agreement however, the plaintiff (in order to meet the specific defences raised by the defendant) was required to call both the plaintiff and Dr Murray as witnesses. Both travelled some distance to be at court and to testify. I found their evidence necessary and of assistance.

[101] It was argued that if liability was established, that given the nature and complexity of the matters in issue together with the importance of the case to the future of the child, that it would be appropriate for the costs of counsel to be awarded on scale C. I have considered the matter of costs holistically and in so doing intend to make the order for costs that I do below.

[102] In the circumstances, it is ordered:

> [100.1] The Defendant is liable for the payment of 100% (one hundred percent) of the proven or agreed damages the Plaintiff's minor child, S[...] L[...] N[...], suffered, which damages flow from the severe brain injury sustained by him during the intrapartum period in consequence of substandard obstetric care and management at the Themba Hospital on the 19 December 2010, and the resultant cerebral palsy (and its *sequelae*) which he suffers from.
>
> [100.2] The Defendant shall pay the Plaintiff's taxed or agreed party-and-party costs of suit on the High Court scale to date which costs include:
>
> > [100.2.1] the costs of counsel as may be taxed which include trial costs for 2, 3, 4 and 6 September 2024 and including for heads of argument, such costs to be paid on Scale C;

[100.2.2] the costs of the undermentioned experts, provided that in respect of Dr Murray these are also to include her costs relating to her attendance and testimony before court:

- Dr Murray
- Dr Lewis
- Dr Alheit
- Burger Radiologists
- Dr Pearce

[100.2.3] the costs and expenses of accommodation and of transporting the Plaintiff and the minor child in attending all medico-legal examinations and consultations for purposes of preparing for the trial relating to the issue of liability, which costs are also to include all the Plaintiffs costs for attending and testifying at the trial.

[100.3] The costs stipulated above shall be paid into the trust account of the Plaintiff's attorney, the details which are:

WIM KRYNAUW ATTORNEYS TRUST ACCOUNT
ABSA – TRUST ACCOUNT
ACC. NR: 4[...]
REF: L WHITTLE-NORTJE / MEC0264

[100.4] The determination of the quantum of damages is postponed *sine die*.

_____

A MILLAR
JUDGE OF THE HIGH COURT
GAUTENG DIVISION, PRETORIA

HEARD ON:	2 – 4 & 6 SEPTEMBER 2024
JUDGMENT DELIVERED ON:	27 SEPTEMBER 2024
COUNSEL FOR THE PLAINTIFF:	ADV. M COETZER
INSTRUCTED BY:	WIM KRYNAUW ATTORNEYS INC.
REFERENCE:	MS. L WHITTLE-NORTJE
COUNSEL FOR THE DEFENDANT:	ADV. G SHAKOANE SC ADV. D MAKHUBELE
INSTRUCTED BY:	MEINTJIES & KHOZA INC.
REFERENCE:	MR. B MEINTJIES