IN THE HIGH COURT OF SOUTH AFRICA [Not Reportable]

[EASTERN CAPE LOCAL DIVISION, MTHATHA]

CASE NO: 2998/2018

Heard on: 27/08/2020

Delivered on: 26/01/2021

In the matter between:

L[....] D[....] obo A[....] D[....] Plaintiff

and

MEMBER OF THE EXECUTIVE COUNCIL
RESPONSIBLE FOR THE DEPARTMENT OF
HEALTH Defendant

JUDGMENT

NHLANGULELA DJP

[1] The plaintiff is L[....] D[....], a woman, who claims payment of damages against the MEC for Health, doing so in her name and in a representative capacity, which arose out of an alleged medical negligence committed by the nurses and medical staff that caused brain damage suffered by her child whilst she was admitted at Butterworth Hospital on September 2016.

[2] This judgment seeks to address the issue of liability only, the determination of the issue of *quantum* of damages for the injuries sustained having been separated from the merits in accordance with the agreement of the parties that I converted into an order of the court.

[3] To obtain a judgment holding the defendant liable to pay damages the plaintiff must prove on a balance of probabilities that the act(s) or omission(s) of the defendant is wrongful and negligent, and have caused the loss. See: *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 SCA at para [12] when the following was stated:

> "Negligence, as it is understood in our law, is not inherently unlawful – it is unlawful, and thus actionable, only if it occurs in circumstances that the law recognizes as making it unlawful. Where the negligence manifests itself in a positive act that causes physical harm it is presumed to be unlawful, but that is not so in the case of a negligent omission. A negligent omission is unlawful only if it occurs in circumstances that the law regards as sufficient to give rise to a legal duty to avoid negligently causing harm. It is important to keep that concept quite separate from the concept of fault. Where the law recognises the existence of a legal duty it does not follow that an omission will necessarily attract liability – it will attract liability only if the omission was also culpable as determined by the application of the separate test that has consistently been applied by this court in *Kruger v Coetzee*, namely, whether a reasonable person in the position of the defendant would not only have foreseen the harm but would also have acted to avert it. While the enquiry as to the existence or otherwise of a legal duty might be conceptually anterior to the question of fault (for the very enquiry is whether fault is capable of being legally recognised), nevertheless, in order to avoid conflating these two separate elements of liability it might often be helpful to assume that the omission was negligent when asking whether, as a matter of legal policy, the omission ought to be actionable."

[4] Expert witnesses testified. Dr Linda R Murray, the obstetrician and gynaecologist was called to testify on behalf of the plaintiff. A paediatrician, Dr Yatish Kara also testified on behalf of the plaintiff. The defendant called Dr Chris Archer to testify on its behalf. Dr Osei is a general practitioner who attended to

the plaintiff's labour at Butterworth Hospital (BH) on 20 September 2020. Dr Archer is an obstetrician and gynaecologist. He together with Dr Murray compiled a joint minute, which formed part of the evidence. The defendant also called Dr Osei Amankwah to testify. The plaintiff herself also testified.

[5] The medico-legal reports, which were compiled by the expert witnesses mentioned above formed part of the evidence. The Road To Health Chart and Maternity Case Records that had been supplied by BH concerning the plaintiff's progress during labour were also used.

[6] The evidence adduced at the trial reflects the following common cause facts: The plaintiff was approximately 15 years of age when she discovered in April 2016 that she was pregnant. She experienced pregnancy for the first time. Antenatally, she visited Mkoloza Clinic, a village clinic situated in the district of Willowvale. Her attendances there were uneventful. In May 2016, she pursued medical check-ups at Willowvale Health Centre (the WHC). On 17 September 2016, she experienced abdominal pains. The WHC established that the plaintiff had reached 39 weeks of gestation. She was caused to sleep for the night and discharged on the next day. On 19 September 2016, the labour pains intensified so much so that the plaintiff had to go back to WHC. She was in her first stage of labour. At 12h30 when she presented with 1 cm cervical dilatation; mild contractions at 1:10 minutes; the foetal head presented at 3/5 above the pelvic brim and had the cephalo-pelvic disproportion (The CPD). The nurse decided that the presence CPD required that the plaintiff be transferred to the BH for caesarean section to be performed. The BH is a level 1 Hospital, which is appropriately equipped to handle such labour. In preparing the plaintiff for the Hospital the nurse inserted the plaintiff with a drip and a catheter. At 16h30, whilst on a long waiting time for transfer, the foetal heart rate (FHR) was assessed at 142-146 bpm. The FHR had not been assessed at 12h30. The next FHR assessment, at 16h30, recorded a score of 142-146 bpm. At 18h00 the partogram was commenced. At 20h30 the FHR was again assessed at 142-146 bpm and the cervical dilatation had

increased to 3 cm. The ambulance finally arrived at 22h30. It delivered the plaintiff to BH at 23h00.

[7] The first examination of the plaintiff's labour by the Hospital nurse took place on 20 September 2016 at 01h25, in approximately two hours of waiting period. On Dr Tongo's instructions, the nurse gave plaintiff 1 gram of aldomet pill for a mildly raised blood pressure. The FHR was assessed at 132 bpm; and the cervix was measured at 2-3 cm dilatation. At 05h40 the cervix was 3 cm dilated. The nurse decided that the labour should be allowed to progress. At 11h50 the plaintiff was still 3 cm dilated; she had mild contractions, and the FHR was assessed at 150-152 bpm. The plaintiff was seen by Dr Osei for the first time at 19h10. Before that consultation at 18h03, the plaintiff was 4 cm dilated. That is, she had finally reached the Active Stage in approximately 17 hours. The FHR was assessed at 163-167 bpm; and the foetal head was presented at 4/5 above the pelvic brim. Dr Osei prescribed ampicillin, antibiotics and cathadine for the plaintiff. Having examined the plaintiff he found that the presenting part was still 4/5; FHR was 160 bpm; and the cervix was 4 cm dilated. The doctor decided that the plaintiff should be referred to the theatre for caesarean section (category 1) due to foetal tachycardia and CPD. The doctor made the comment that the FHR had been "persistently elevated since admission at 01h25."

[8] The caesarean section was commenced at 21h36 and completed at 21h44 when the plaintiff's child was delivered. The child was born with respiratory difficulties that necessitated resuscitation by a bag and mask oxygen ventilation and IV fluid. The respiratory difficulty was caused by the complexities of foetal tachycardia. At that stage the Apgars of the child were scored as 4/10 and 7/10 in 1 and 5 minutes after birth respectively. The child did not cry at birth. At 21h50 the child was referred to the neonatal unit where he was kept for 2-3 days. Whilst the child was kept in the neonatal unit, the plaintiff remained waiting in the maternity ward for the child to be returned to her.

[9] The plaintiff, L[....] D[....], was 20 years of age when she testified. She told the Court that on 19 September 2016 she experienced labour pains and went to Willowvale Clinic. She got there at 11h00. She was received by the nurse who referred her to maternity ward where her blood pressure was assessed, given a drip, and a belt was put around her abdomen. At 15h00 another nurse examined her on the abdomen using a belt, the nurse inserted fingers into her private parts. That nurse told her that she cannot give birth in a natural way because her "bones" were too small; and that she would later on be transferred to Butterworth Hospital for caesarean section. She only arrived at the Hospital in the middle of the night. She was examined at intervals, given a drip and abdomen checked by means of a belt. On 20 September 2016 and at about 17h00 the doctor palpated her stomach, measured her pulse and informed her that she would be referred to the theatre for caesarean section. She was later on, at about 18h30 moved to the theatre. She was unconscious when the operation was done. She got the news after 2h00 that the child was delivered, but had been referred to the nursery. The child was returned to her on the third day when she observed that he was put on a drip, his body had some wires plugged thereon and that he was feeding on a pipe. The child looked tired and his eyes hardly opening. On the fourth day, she observed that the child was fitting. After discharge, on 03 October 2016, and whilst cup-feeding the child she noticed that the child could not suck. At age four months, the plaintiff reported to the Clinic that the child was sliding backward when sitting. She also reported that the child was unable to squat and walk.

[10] The evidence adduced by the plaintiff was not disputed. It is accepted as it stands.

[11] On 01 June 2018 and the plaintiff's child was subjected to MRI scan which proved that the child had suffered brain damage at term maturity. The Joint Minute compiled by Professor Andronikus and Dr T. Westgarth Taylor on 19 September 2019, reads, as reproduced herein-below:

Joint Minutes Dr. T Westgarth-Taylor and Prof. S Andronikou **Date:19 September 2019**

Regarding the MRI scan (01/06/2018) performed for the child Aluthando Dumezweni (DOB 20/09/2016) at age 1 years 9 months

Westgarth-Taylor	**Andronikou**	**Agreement**
Bilateral abnormal signal	Bilateral, symmetric abnormal high signal on T2/FLAIR	Agree
- Peri-Rolandic (with cortical tinning	- Peri-Rolandic	Agree
- Parietal lobe extension	- Corona Radiata and PLICs	Partial agreement
- Posterior peri-ventricular		
- Dorsal putaminal (cystic change and volume loss)	- Putamina (with cavitation in the posterior portions)	Agree
- Ventrolateral thalamic	- Ventro-lateral thalami	Agree
- Hippocampi (atrophy)		
Focal thinning posterior body of corpus callosum	The corpus callosum is thin at /around the isthmus.	Agree
	localized expansion of the lateral ventricles at the site of the corticospinal tracts, indicating volume loss of these tracts	
Comment: Previous acute-profound hypoxic ischaemic injury in a term infant	**Comment:** Chronic evolution of a global insult due to acute profound hypoxic ischaemic injury,	Agree

The radiologists agree that the MRI demonstrates a previous acute-profound hypoxic ischaemic injury in a brain of term maturity

Dr. Tracy Westgarth-Taylor
MBChB FCRad (Diag)
Date: 26/09/2019

Prof. Savvas Andronikou
MBBCh, FCRad (Diag)(SA), FRCR (Lond), PhD (UCT) PhD (Wits)
Date:

[12] The expert witnesses who testified on behalf of the parties agreed with the findings of the radiologist that the cause of cerebral palsy was the acute profound hypoxic ischaemic injury in the brain of plaintiff's child. As a result, the parties saw no need to call the radiologist into the witness-box. What the findings of the

radiologist do not tell is the time when the brain injury occurred. However, the evidence adduced by expert witnesses was that the brain injury could not have occurred antenatally or post-natally. They all agreed that the brain injury, on the probabilities, most likely occurred during the course of labour. The report of the radiologists also does not tell what exactly caused the brain damage. The case pleaded on behalf of the plaintiff is that the brain injury was caused by a failure on the part of the nursing staff and doctors of BH to monitor the plaintiff's labour properly. On the other hand, the thrust of the case pleaded on behalf of the defendant is that the medical practitioners and nursing staff of BH rendered medical care, treatment and advice to the plaintiff with care and diligence as could reasonably be expected of medical practitioners and nursing staff in similar circumstances.

[13] Dr Linda Murray testified that the diagnosis made at WHC that the plaintiff's pelvic was inadequate was a correct medical ground for the decision made that the plaintiff had to be transferred to the BH to carry out the caesarean section. She went into the Latent Phase of labour whilst still waiting, for a long period of 8 to 9 hours, at a place that would not have prepared her for theatre. According to Dr Murray the decision taken at the Hospital at 05h40 that the plaintiff's labour ought to be allowed to continue on the face of existing CPD and foetal tachycardia pointed to the fact that the medical staff did not understand their roles in monitoring of labour; and especially that they had an obligation not to prolong the Latent Phase to a period beyond 8 hours. She stated that Dr Osei's finding that the plaintiff had a persistently elevated foetal heart rate from 19 to 20 September 2016 at 146 bpm, 160 bpm and 167 bpm was a matter of concern. She noted that the failure to assess labour on 20 September 2016 between 05h40 and to record about progress of labour during the Latent Phase on the partogram put the nursing staff in a position of breaching the provisions of the Guidelines for maternity case. She stated that the delay of more than an hour from the time of taking of the decision to refer the plaintiff to theatre at 19h10 for caesarean section would only have increased the risk of foetal distress. Ms Murray stated that

apgars of 4/10 and 7/10 in 1 and 5 minutes after birth indicated foetal distress that was experienced by the plaintiff due to sub-standard monitoring during labour.

[14] Ms Murray's opinions are that CPD should have raised a concern of obstructed labour that compromised the foetal condition. She stated that the delay to theatre on the face of probably foetal distress and obstructed labour, exposed the foetus to ongoing risk of hypoxic ischaemic injury; sepsis that is supported by plaintiff's taking of ampicillin, antibiotics and cathadine at 18h40; and intrauterine hypoxia that might have been caused by longstanding foetal tachycardia that had developed over a period of more than 15 hours. However, the true condition of the foetus during the last two to three hours of labour before caesar was performed is unknown. She opined that would have been safe for the foetus to be put on continued CTG monitoring due to existing FHR abnormalities and the fact that the plaintiff's labour was an obstructed one. According to the witness, monitoring of labour should have been of a high standard due to the risks of brain injury that the foetus was subjected to.

[15] Dr Murray and Dr Archer wrote a joint minute in which they agreed that it was unlikely that the antenatal period contributed to cerebral palsy that the plaintiff's child is suffering from. They also agreed that the Latent Phase of Labour was prolonged over 15 hours; the Hospital medical staff did not make any comment about the maternal and foetal conditions that obtained during labour; caesarean section was inexplicably delayed; plaintiff's labour was obstructed; tachycardia had been in existence for approximately 18 hours prior to delivery, meaning that there were warning signs that the foetal condition may have been non-optimal and emergency delivery by way of caesarean section was a necessary life-saving remedy. However, Dr Archer disagreed with the opinion that the Latent Phase lasting more than eight hours contributed to foetal distress in any way. The independent opinion of Dr Archer is that for a delayed caesarean section associated with hypoxic ischaemic brain injury to be a cause of cerebral palsy one would have expected to see evidence of a partial prolonged injury pattern on the

MRI scan. Since the MRI pictures depict an acute profound hypoxic ischaemic insult that occurred somewhere during the peripartum period between 36 weeks gestation and one month post-delivery, the Hospital staff and doctors cannot be held liable for the adverse foetal outcome.

[16] However, Dr Archer conceded under cross examination that foetal brain injury was more likely to eventuate on account of CPD having been diagnosed that required an emergency caesarean section to be performed; persisting abnormal FHR scores; the inexplicable decision made at 05h40 that the labour should progress on the face of existing CTG abnormalities; the cervix having been 4 cm dilated at 18h03; the baby's head having been still at 4/5 above the spine at 18h03; and the labour not having progress in more than 15 hours. All these factors were compounded by the failure to refer the plaintiff to theatre within one hour to prevent ongoing foetal distress. Dr Archer stated categorically under cross examination that "… the care at Butterworth Hospital was disgraceful", meaning that care of labour was not applied by the medical staff of BH.

[17] Dr Archer's opinion regarding the time when the brain injury could have occurred at labour is based on medical literature, which says that the acute profound hypoxic ischaemic injury in the absence of a sentinel event, as diagnosed by the radiologists, occurs at 45-50 minutes before birth. Since such injury occurs without prior warning it is impossible to prevent it. He concluded that for such reasons the defendant cannot be held liable for the damage that was caused by an unpreventable insult to the brain of the plaintiff's child during birth. The witness placed reliance on the textbook by Professor Joseph Volpe entitled: "*Neurology of the Newborn";* 6th Edition. The witness lays emphasis on the evidence that the MRI results do not support the existence of foetal heart rate pattern to warrant the conclusion that the foetal heart rate abnormalities referred to in this case (the tachycardia) compromised the child's neurological functioning.

[18] The task given to Dr Kara was to advise on the causal connection between the delivery of plaintiff's child and subsequent neurological occurrence. His

opinion is that the injury noted on the MRI scan occurred during the labour most likely during the period of care provided by BH medical staff. He bases this on certain reasons. As the main reason, the witness stated that the brain injury in this case was preventable, and it could have been prevented only if the hospital nurses and doctors had initiated appropriate foetal monitoring and acted upon the signs of concern. According to him the lack of monitoring increased the probability of an acute profound hypoxic ischaemic event that was a gradual build-up of foetal compromise until a tipping period was reached.

[19] Dr Kara took into account the fact that there is no evidence that would expose the plaintiff to hypoxic ischaemic encephalopathy during the antenatal stage. He together with Dr Murray and Dr Archer agreed that the MRI scan points to the occurrence of the child's cerebral palsy due to either intra-partem events. He stated that the child has a cerebral palsy with a dominant dyskinetic feature (signifying trouble controlling muscle movement) which is medically associated with intrapartum events. For this statement he relies on *Janet Rennie et al*: "Outcome after intrapartum hypoxic ischaemic at term", 2007. He also refers to the textbook of Professor Volpe, *supra*, at p 512 where it is stated that, *inter alia*, foetal distress and neonatal neurological syndrome in the first hour or day of life are *sine qua non* for attributing subsequent brain injury to intrapartum insult. A third feature, depression at birth, is not proved in this case. Dr Kara opined that regard being had to foetal tachycardia, which together with CPD, the prolonged Latent Phase and the history given by the plaintiff hypoxic ischaemic encephalopathy developed due to suboptimal management of labour that resulted in cerebral palsy. He stated further that the need for resuscitation of the child at birth, and the confirmed low apgar scores at birth that were followed by apgar scores of 4 and 7 in 1 and 10 minutes after resuscitation, timed the occurrence of hypoxic ischaemic insult to the period of labour.

[20] To the extent that Dr Archer did not take into account the fact that the apgar scores of 7/10 in 5 minutes are improved scores that were recorded after the

resuscitation of the child, I do not accept his opinion as contained in his report, and re-iterated in his evidence, that:

> "7.4 The five minutes Apgar score in this case should be viewed as reassuring and not as an indication of an infant recently subjected to severe foetal distress. It therefore also does not provide support for a diagnosis of neonatal encephalopathy in the hours and days following delivery."

[21] The fact that Dr Kara, not Dr Archer, is a paediatrician reinforces my decision to prefer the opinions expressed by Dr Kara regarding the condition of the child during the neonatal period. In any event, Dr Archer and Dr Murray agreed to defer paediatric aspects of their evidence to a paediatrician for confirmation.

[22] The upshot of the evidence adduced by Dr Archer is this. Whereas he concedes that the standard of care and management of plaintiff's labour by the nurses and medical staff at BH was substandard, he nevertheless contends that they cannot be held liable for damages suffered by plaintiff and her child because the MRI finding that the acute profound hypoxic ischaemic event, not partial prolonged hypoxic ischaemic event is the cause of cerebral palsy.

[23] For the defendant to be held liable for the conduct or omission committed by its employees it must be proved that the employees caused the event to develop and that notwithstanding they failed to take steps to prevent it from occurring. In deciding these issues, the court is guided by the case of *Lee v Minister For Correctional Services* 2013 (2) SA 144 (CC) at para [41] where Nkabinde J said the following:

> "However, in the case of an omission the but-for test requires that a hypothetical positive act be inserted in the particular set of facts, the so-called mental removal of the defendant's omission. This means that reasonable conduct of the defendant would be inserted into the set of facts. However, as will be shown in detail later, the rule regarding the application of the test in positive acts and omission cases is not inflexible. There are cases in which the strict application of the rule would result in an injustice, hence a requirement for flexibility."

[24] On the issue of causative negligence it was submitted on behalf of the plaintiff that had the employees of the defendant performed caesarean section within a reasonable time and/or monitored the progress of labour properly and appreciating that the foetus had CPD that exposed it to distress the child would have been born by way of caesarean section during the course of the day, on 19 September 2016, before 18h03. Further, it was submitted that had caesarean section been ordered at 18h03 and performed within an hour as required by the Guidelines, then the child would have been delivered before the acute profound injury was suffered during the last 40-50 minutes before birth.

[25] This Court has been urged by *Mr Wessels SC*, for the plaintiff to apply flexible approach to factual causation in the case of negligent omission as stated in the case of *Lee, supra.*

[26] It was submitted by *Mr Joubert SC*, for the defendant, that the evidence adduced in this case does not confirm that any medical intervention at a specific time would or could have prevented the occurrence of hypoxic ischaemic insult. The upshot of this submission is that the cause of cerebral palsy is an acute profound hypoxic ischaemic insult, a catastrophic event that occurs suddenly and it is unforseeable (without a warning sign). Counsel's argument is that the suggestion advanced in the evidence on behalf of the plaintiff that warning signs of severe foetal distress emerged which if met by appropriate medical intervention between 19h10 and 19h45 would or could have prevented the development of hypoxic ischaemic encephalopathy was pure speculation. In amplification of these submissions a reference was made to a passage in *State v Brochris Investments (Pty) Limited and Another* 1988 (1) SA 862 AD at 861G-H. The passage reads:

> "In considering the question whether a particular occurrence was foreseeable, and should therefore have been guarded against, one must guard what was, in *S v Mini* 1963 (3) SA 188 A at 196 E-F, called 'the insidious subconscious influence of *ex post facto* knowledge.' Negligence is not established by showing merely that the occurrence happened (unless the case is one where *res ipsa loguitur)*, or by showing, after it happened, how it could have been prevented. The *diligens paterfamilias* does not have prophetic

> foresight. In *dictum in Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co Ltd (The Wagon Mound)* 1961 AC 388 (PC) at 424 ([1961)] All ER 404 at 414 G-H) applies, namely: "After the event, even a fool is wise. But it is not the hindsight of a fool; it is the foresight of the reasonable man which alone can determine responsibility."

[27] It needs to be stated that the flexible approach to the but-for test as espoused in the case of *Lee* finds application in this case. The facts of this case suggest to me that this Court does not need to have prophetic foresight. Neither does the Court need to speculate what would happen to the plaintiff and the foetus had caesarean section been carried out between 19h10 and 19h45. The court is enjoined to have regard to the evidence placed before it and apply medical opinions as expressed in such evidence. The negligence, or otherwise, of the nurses and medical staff at BH must be measured; in an objective manner, against the medical standards that are applicable in a similar Level 1 Hospitals of the Republic.

[28] It seems to me that the real dispute in this case lies in the differing interpretation of the joint minutes of the radiologists. The expert witnesses from the opposing sides do not read the MRI scan as disclosing brain injury of the same type. The impasse is dealt with below.

[29] The difference of opinions between Dr Kara and Dr Murray on the one hand and Dr Archer on the other requires examination of the mechanisms giving rise to acute profound and partial prolonged hypoxic ischaemic events. Based on medical sources, these events were described in *AN obo EN v Member of the Executive Council For Health* [2019] 4 All SA 1 (SCA) at para [14] in the following terms:

> "The mechanisms giving rise to these two types of brain damage are uncontroversial. Professor Van Toorn, Head of Paediatric Neurology at Tygerberg Childrens' Hospital and Stellenbosch University, was called by the appellant. He gave clear and uncontroverted evidence on this issue. During labour, the blood to the brain is supplied from the placenta along the umbilical cord (the cord). If there is an inadequate supply of oxygen, the brain

> shunts the limited blood from the peripheries to the deep grey matter. This is designed to protect the deep grey matter which is the most vulnerable matter due to its higher metabolic rate. When shunting takes place, damage occurs to the white matter of the brain. This means that if there is some blood supply, but it is inadequate, damage occurs to the white matter. If there is no blood supply at all, none is available to shunt to the deep grey matter. In that instance, only the grey matter will be damaged. The MRI scan shows only damage to the grey matter in the present case. No damage to white matter was evident."

[30] In his evidence Dr Kara interpreted the MRI scan as being descriptive of brain injury of a mixed type in that: "the internal capsule, the peri-rolandic area and the periventricular are areas of white matter injury." This piece of medical evidence, which is cogent, was not gainsaid by any other evidence adduced in this case. Therefore, I am driven to the conclusion that the brain damage started in the area of the white matter and ended in the grey matter. Dr Kara testified further that in the absence of brainstem injury, as is the case here, the brain injury to the cerebral cortex, basal ganglia and thalamus would probably have occurred due to severe and relatively prolonged hypoxia ischaemia. The evidence of Dr Murray fits well into the context of mixed type cerebral palsy.

[31] The question whether the insult to the brain could have been prevented, or not, can only be answered based on the facts that are relevant to the monitoring of labour. Since sentinel event does not exist in this case and the hypoxic ischaemic insult developed during the period of labour. The events of labour make it palpably clear that warning signs did emerge, at the very least soon after discovering: (i) at WHC that the labour had CPD; (ii) at BH at 01h20, that the plaintiff's labour had CPD; the labour had reached the Latent Phase, which was even prolonged; (iii) at 18h03, that the FHR of 163-167 was abnormal; (iv) and at 19h10, that foetal tachycardia had been allowed to persist. In the circumstances, the contention advanced on behalf of the defendant that warning signs of hypoxic ischaemic event was not foreseeable and, therefore, unpreventable is not sustainable.

[32] All the three expert witnesses argued that the conduct of BH staff, coupled with what they omitted to do, was in breach of labour management protocols contained in the National Maternal Guidelines (the guidelines) published in 2007.

[33] In the result the following order shall issue:

1. The *merits* and *quantum* are hereby separated in terms of Rule 33 (4).

2. The determination of *quantum* is postponed sine die.

3. The defendant is held liable for the plaintiff's agreed or proven damages arising from the cerebral palsy suffered by the minor child, A[....] D[....].

4. The defendant shall pay the plaintiff's costs relating to the *merits*, together with all reserved costs, if any, which costs shall include:

4.1 the travelling expenses, reservation and appearance fees, if any, together with the costs of the preparation of their reports and qualifying fees, if any, of the following expert witnesses:

4.1.1 Prof Andronikou - Radiologist

4.1.2 Dr Linda Murray - Obstetrician

4.1.3 Dr Kara - Paediatrician

4.1.4 Lesley Fletcher - Nursing expert

5. The defendant shall pay interest on the aforesaid costs at the current prescribed legal rate of interest from date of allocator or agreement to date of payment thereof.

Z. M. NHLANGULELA

DEPUTY JUDGE PRESIDENT OF THE HIGH COURT

MTHATHA

Counsel for the plaintiff	:	Adv. J.J. Wessels SC
Instructed by	:	Nonxuba Inc c/o POTELWA INC MTHATHA.
Counsel for the defendant	:	Adv. D.J. Joubert SC
Instructed by	:	The Office of the State Attorney MTHATHA.