REPUBLIC OF SOUTH AFRICA

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

Case number: 17077/2012

(1) REPORTABLE: YES / NO
(2) OF INTEREST TO OTHER JUDGES: YES/NO
(3) REVISED.

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DATE SIGNATURE

In the matter between:

VUYUSILE EUNICE LUSHABA Plaintiff

And

THE MEC FOR HEALTH, GAUTENG Defendant

JUDGMENT

ROBINSON AJ

I. **INTRODUCTION**

1. At around 12h00 on 30 June 2000 the plaintiff, then a young woman of 23 years and 36 weeks pregnant, presented herself at the maternity obstetrics unit (MOU) at the Charlotte Maxeke Johannesburg Academic Hospital (previously known as Johannesburg General Hospital). Since 10h00 that morning she had been

experiencing dizziness and constant pain in her abdomen. The pain was non – intermittent, meaning that it could not be explained away as labour contractions. Upon admission it was noted that she was pale.

2. These symptoms are indicative of abruptio placentae, a condition that occurs when the placenta separates (or begins to separate) from the uterine wall. It is an extremely dangerous condition. It leads to "*deprivation of the fetus of oxygen and can lead to cerebral palsy.*"[1] When diagnosed, and unless vaginal delivery is possible, a caesarean section should be performed immediately. Indeed, the situation is a medical emergency and should be dealt with as such. The sooner the baby is delivered, the less the risk of his exposure to deprivation of oxygen.
3. The foetal heart rate at 12h00 was recorded at 150 beats a minute, albeit that the beat was irregular. Dr Arend van den Heever, the expert witness called by the plaintiff, testified that this indicated that, at 12h00, the supply of oxygen was still adequate. The irregularity of the heart rate, so he said, is an indication of the baby's attempts to overcome the insult caused by the abruption. Should the heart rate remain low, the brain is deprived of oxygen to such an extent that permanent damage sets in. As it happened, the heart rate at 13h45 was at 100 beats a minute, indicating bradycardia, which means that the heart is beating abnormally slow, such that the foetus is at risk of dying.
4. The plaintiff was only attended to in any meaningful manner at 13h45, when Dr Jeebodh emerged from theatre where she had performed another operation, tore aside the curtain around the plaintiff, herself pushed the trolley into the operating theatre to perform that which ought to have been set in motion with the same urgency with the plaintiff's arrival at the hospital at 12h00. By that time it was too

[1] Summary of expert opinion of Dr Mashamba

late. The mother was saved but Menzi, the child, is severely disabled, suffering from spastic quadriplegic cerebral palsy. He can neither sit nor walk.

5. It was common cause between the experts that abruptio placentae can lead to cerebral palsy. Indeed, defendant's expert, Dr Mashamba, notes in the concluding remarks in his report:

> With such serious complications following Abruptio placenta the outcome of Menzi is strongly associated with the complication that the mother had just before delivery.

6. In these circumstances the plaintiff claims that the defendant was negligent in not providing her with adequate medical care upon her arrival. The delay, so the plaintiff claims, in performing the caesarean, was negligent, permitted the progression of abruptio that cut off Menzi's supply of oxygen, and which in turn led to the cerebral palsy. The defendant denies negligence. Its plea amounts, in essence, to a bare denial.

II. **THE ISSUES**

7. At the commencement of trial Mr Pillay, who appeared for the plaintiff, informed me that only negligence was in issue. I took that to mean that negligence and causation would have to be proven. Liability had by agreement been split from quantum and, at the request of counsel, I made an order to that effect pursuant to rule 33(4). Accordingly the only issue before me was whether the defendant's negligence caused or materially contributed to Menzi's condition.
8. It is common cause that the plaintiff is the mother of the child Menzi, born on 30 June 2000; that Menzi was born with cerebral palsy; that the plaintiff had received her treatment or the lack thereof at the Charlotte Maxeke hospital and that the defendant would be liable were the plaintiff to discharge the onus on her.

9. At a later stage both counsel confirmed, to questions I put to them, that the hospital records on which Drs van den Heever and Mashamba relied, were to be accepted with their contents as true and correct, without the need to prove them. This meant that the facts enumerated by Dr van den Heever on pages 31 – 32 of the extract from his report appearing in the plaintiff's so – called "liability bundle" can be accepted as correct. Dr van den Heever compiled these from the hospital records also appearing in that bundle.
10. I mention at this stage that the defendant failed entirely to respond to the plaintiff's various requests for further particulars. It also failed to respond to a court order by Makume J of 13 August 2013, that it should respond to the questions detailed in that order. No explanation was provided at the trial for this failure.
11. In addition, the defendant only filed its expert report on Friday 3 October 2014, being the Friday before the week in which the trial was to commence. This, despite the fact that this action had been instituted on 15 May 2012 and had been set down for trial in September 2013. I return to these matters at a later stage in this judgment.
12. The late submission of the defendant's expert report meant that further delays were occasioned during the week of the trial, in that the matter had to be stood down for a joint minute to be prepared between Drs van den Heever and Mashamba during the course of 7 and 8 October 2014. The matter came to trial on 9 and 10 October 2014.
13. The joint minute, undated, but signed by both the experts, records the following agreements:

13.1. patient has lower abdominal pain and dizziness since 10h00 and admitted at 12h00;

13.2. abruption could have started after 10h00;

13.3. on admission: low blood pressure 70/40, pale, dizzy;

13.4. FHR 150 bpm although irregular;

13.5. cervix was closed and no bleeding, multiple as, uneffaced;

13.6. no CTG's available? Done

13.7. nothing happened between 12h00 & 13h00;

13.8. 13h00 admitted to labour ward 162 – possibility of abruption mentioned, treatment : analgesics. Review in 4hrs: UNACCEPTABLE;

13.9. at 13h45 definite diagnosis of abruption made: FHR bradycardia on ultrasound and retro placental clot;

13.10. caesarean done without wasting time after the diagnosis was made.

14. The conclusion to which the doctors agreed was noted as follows:

> Lower abdominal pain, lower blood pressure, dizziness is abruptio placenta until proven otherwise even without PV bleeding. CAESAREAN should have been done ASAP after 12h00 most likely with a better outcome.

15. The one area of disagreement between the doctors focused on the degree of likelihood of the better outcome featured in the conclusion. Whereas dr van den Heever thought that the early delivery was guaranteed to have had a better outcome and that it was likely to have avoided cerebral palsy; dr Mashamba was of the view that there could be no guarantee of a better outcome.

16. Because of the agreement of both parties around the use of hospital records, the following facts are common cause:

16.1. the plaintiff, born on 22 October 1976, was a 23 – year old Gravida 2 Para 1 (1 previous preterm delivery) when she was admitted to the hospital on 30 June 2000 at 12h00;

16.2. she complained of lower abdominal pain and dizziness since 10h00 that morning. She had no vaginal bleeding;

16.3. the plaintiff was found to be pale with a blood pressure of 70/40 mm Hg., approximately 36 weeks pregnant (dates unsure) with a normal temperature and a pulse rate of 64 per minute;

16.4. the foetal heart rate was 150 beats per minute and irregular. No CTG recordings are available;

16.5. the cervix was closed and uneffaced;

16.6. she was referred to the labour ward (162);

16.7. she was again examined at 13h00 when she was found to have strong contractions with an irritable uterus. The cervix was 3cm dilated, moderately effaced and centralizing;

16.8. a provisional diagnosis of abruptio placentae was made and she was admitted to the labour ward. It was noted that she was to be reassessed in 4 hours;

16.9. at 13h45 a doctor was again called to see the plaintiff when she started bleeding vaginally with a tense uterus;

16.10. an ultrasound was done and a massive retro placental clot was seen with a slow foetal heart;

16.11. the definite firm diagnosis of abruptio placentae was made and an immediate caesarean section (“caesarean”) was planned;

16.12. she was immediately transferred to theatre;

16.13. the plaintiff signed consent for the caesarean at 14h10;

16.14. the caesarean under general anaesthesia was commenced at 14h15, with Menzi delivered at 14h20, weighing 2860 grams with Apgar scores of 4,6, and 8/10 after 1,5 and 10 minutes respectively. The estimated blood loss was 1400 ml with a 50% separation of the placenta present at delivery of the placenta;

16.15. Menzi was transferred for further management due to grunting and sternal recession;

16.16. the post – operative course of the plaintiff was uneventful;

16.17. the baby suffered severe metabolic acidosis with Hypoxic Ischaemic Encephalopathy Grade II. Convulsions were noted with episodes of apnoea;

16.18. a cranial ultrasound scan on 7 July 2000 was suggestive of early atrophy;

16.19. the end result was a boy with cerebral palsy with epilepsy on treatment.

17. The medical records on which the expert opinions were based are contained at pages 5 – 7 of the liability bundle and these facts, extracted from those records, are recorded in the report of dr van den Heever.

III. **THE EVIDENCE**

18. Three witnesses testified. These are, for the plaintiff, dr Arend van den Heever and for the defendant, drs Jeebodh and Mashamba.

(i) **Dr Arend van den Heever**

19. The defendant admitted dr van den Heever as an expert witness, as a result of which his curriculum vitae was not canvassed in any detail. He practises as a gynaecologist at the Durbanville Medi – Clinic in the Western Cape. His fields of practise include obstetrics and gynaecology. He graduated in 1975 and has been in practise since 1985. He is the co – author of a few chapters in a textbook on gynaecology and has attended to around 10 000 births.
20. Dr van den Heever is the author of the report, an extract of which appears at pages 31 – 33 of the liability bundle. This was marked exhibit 1.
21. Dr van den Heever stated that, when he saw Menzi the first time on Tuesday, 7 October 2014, he recognised the symptoms of spastic quadriplegic cerebral palsy. The term 'spastic' refers to the spasm experienced by the child, whilst the term 'quadriplegic' refers the fact that all four limbs are affected. Cerebral palsy is a condition resulting from a deprivation of oxygen to the brain of the unborn child during pregnancy. The condition leading to cerebral palsy usually occurs in late pregnancy or whilst in labour. 95% of these cases occur intra partum. Cerebral palsy is associated with brain damage. Brain development is impaired and the child cannot walk because of spasms. The growth milestones such as sitting, crawling and walking are absent. Additionally the ability to talk and have a conversation is not developed.
22. Menzi had an abnormally low Apgar score upon birth. An Apgar score is allocated to a new born child to ascertain the state in which he was born. Any Apgar score below 7/10 is regarded as low. Menzi's scores were 4 after 1 minute; 6 after 6 minutes and 8 after 10 minutes. The initial score is an important indicator. Artificial resuscitation means had his score improving. He was

unresponsive directly after delivery. He was a child born in a so – called “flat” condition.

23. The term abruptio placentae, also known as abruption, refers to the separation of the placenta from the uterine wall. The placenta is a disk which functions as the interface between the mother and baby. The placenta is attached to the wall of the uterus through which oxygen and nutrients pass and through which waste is removed. The placenta must be attached to the uterus properly for this transfer to occur optimally. Separation between the placenta and the uterine wall means that the transfer of oxygen and nutrients is compromised.
24. The symptoms of low blood pressure; lower abdominal pain; paleness and dizziness in a pregnant woman mean that, unless and until excluded, abruption must be assumed to be present. The constant pain the plaintiff was experiencing is as opposed to the intermittent pain which is indicative that labour is in place. The constant pain signifies an accumulation of blood between the placenta and the uterine wall.
    24.1. In a case of abruption the abdomen is hard and tense.
    24.2. The blood clot in the uterus releases a substance called thrombin, which irritates the uterus so that it becomes tense. The medical notes at 13h00 show that the uterus was irritable. It becomes tense and hard upon contraction.
25. The absence of vaginal bleeding meant that the haemorrhage was still concealed at the time the plaintiff presented at the hospital at 12h00. The blood will eventually seep out through the cervix but the fact that it had not done so at 12h00 indicated that the abruption was still in its initial stage.

26. The paleness is significant as indicating a loss of blood. This is detected in a person of darker skin (such as the plaintiff) by inspecting the mucosal surfaces such as the tongue and conjunctiva, which is ascertained by looking in to the eye by pulling down the lower eyelid.
27. The dizziness is ascribable to the low blood pressure, which indicates that the diffusion of blood to the mother's brain is not optimal. The plaintiff's blood pressure at 12h00 was extremely low. This is characteristic of blood loss. The body has a wonderful mechanism of compensating for this clinical situation, which was confirmed by the blood pressure of 100/60 at 13h00. This recovery, without intervention, is the response of a healthy woman. The intravenous infusion (drip) was put up only much later.
28. The drip is important. Good obstetric principles dictate that any woman in labour or with pain should receive an intravenous infusion to have an open entrance into her vascular system for intravenous administration of whatever fluids and medication may be necessary. Dr van den Heever was of the opinion that a low blood pressure of 70/40 warranted the administration of an intravenous infusion immediately to increase the volume of fluids in the vessels. Should the volume fall too low the veins collapse and it could be very difficult and even impossible to insert a needle into such collapsed vein. A substance called ringers lactate, which is an intravenous colloid fluid, is used to expand the intravascular volume. With this blood pressure reading the low drip was essential upon admission. It is mandatory and not open to debate. However, the drip was first inserted at 13h45 when the abruption was confirmed. At the same time, a catheter should be inserted in the bladder prior to the caesarean. This is done to prevent danger to the bladder during the caesarean.

29. There is no doubt that abruption constitutes a medical emergency.

30. Abruptio placentae is an extremely serious condition. It could be lethal to both mother and unborn child.

    30.1. In the case of the mother it would, if left untreated, lead to massive blood loss. When the placenta separates from the uterine wall, the uterus cannot contract to stop the bleeding because of the baby's presence therein. Such contraction can only occur after the birth of the baby.

    30.2. Whilst the baby is inside the uterus, the blood accumulates between the uterine wall and the placenta.

    30.3. In the case of total separation between the placenta and the uterine wall, there is no oxygen transfer and the baby dies.

31. Where partial separation occurs, the harm to the baby is directly proportional to the amount of oxygen still delivered to the baby. That is determined by the FHR (the foetal heart rate). Less oxygen will lower the heart rate. With a FHR of 150 b/m at 12h00, there could not have been a significant separation of the placenta. The heart beat was too strong for that. It was well within the normal range of 110 – 170 beats per minute. The range could also be put at 120 – 160 beats per minute. In either case the heart rate was within normal limits.

32. No CTG records were available which means, according to the medical rule that that which is not recorded did not occur, that no CTG (cardiotography) readings were taken. The Medical Protection Society prescribes as regards acceptable note keeping that, if it is not written down (i.e. recorded), it did not happen.

    32.1. A cardio tacograph makes a graphic representation of the baby's heartbeat.

32.2. It is obtained by strapping a transducer around the mother's stomach which reads the foetal heartbeat.

32.3. The CTG should be strapped around the mother as soon as possible after admission, especially where she presents with low blood pressure and abdominal pain.

33. Abruption is diagnosed, amongst others through the cardio tacograph. Should a pathognomonic pattern be displayed, it would be an indication of abruption. A CTG is standard protocol to obtain an indication of foetal well being. Considering the urgency of the plaintiff's situation, she should have been prioritised to have access to such a machine. It was mandatory that it should have been applied. The ideal is to have this machine in place until birth. The absence of the CTG scan equates to negligence, according to dr van den Heever. An ultrasound could be of assistance, but it is not infallible. For example, the placenta and a clot may have a similar appearance on the ultrasound. The ultrasound will not show the pathognomonic results. One would be looking for clots because blood loss in the uterus is characteristic of abruption.

34. Dr van den Heever could not comment on what the medical notes mean by identifying the heart beat as irregular, apart from the explanation he had provided for the attempts made by the foetus to survive. Variability in the heart rate is usually a sign of foetal well being. The unborn baby has two neurological systems opposing each other. This is the sympathetic system that increases the heart rate as well as the para sympathetic system that lowers the heart rate. These two are in constant opposing action which creates a variability. The more pronounced the variability, the higher the indicators of foetal well being. Dr van den Heever added a caveat by saying that what was meant by irregular could only properly be known

by a CTG reading. According to the notes there was no indication of bradycardia upon admission.

35. Abruption is not an event, it is a process. It causes a worsening position over a period of time. These processes follow different rates of progression in individual patients. In the case of the plaintiff, the abruption was at 50% at the time of the caesarean, thereby indicating that hers was of the slower kind. Had the abruption been at 50% at 13h45, it clearly could not have been at 50% at 12h00.
36. Just before the caesarean was performed, bradycardia was diagnosed in the foetus. This indicates significant oxygen deprivation.
37. Asked about the causes and indicators of abruption, dr van den Heever identified high blood pressure as the most important predictor of abruption. Cocaine use and obesity are other indicators, neither of which applies to the plaintiff. The plaintiff's antenatal records are not available, save for two normal blood pressure readings during her pregnancy.
38. Dr van den Heever praised the efforts of Dr Jeebodh from the moment she stepped in. From that moment no time was wasted. It takes, in his experience, at least 25 – 35 minutes to prepare for a caesarean and the speed with which she produced the baby was admirable.
39. Dr van den Heever had, however, no doubt that, at 12h00, a diagnosis of abruption should have been excluded. The ultrasound or CTG would have taken a few minutes whereafter a caesarean should have been performed immediately. The cervix was still closed. Had the plaintiff been dilated one could have done a vaginal delivery because that would be quicker than going to theatre. That was not possible at 12h00 as delivery was not imminent. The cervix was 3cm dilated,

which is not close to delivery, which occurs at 10cm dilation. The accepted practise is 1cm/hour. Vaginal delivery was, accordingly, no option.

40. Because abruption is a medical emergency, the speed of response in these cases is a determinative factor in the neonatal outcome. The sooner the baby is delivered, the less its exposure to the deprivation of oxygen. It follows that there is a need to intervene instantly.
41. Referring to paragraph 8 in the history portion of his report, dr van den Heever described the reaction at 13h00 as entirely unacceptable. It made no sense to note a reassessment in four hours of what constituted an emergency.
42. Under cross examination dr van den Heever pointed out that there are no notes between12h00 and 13h00. This means that no action was taken to look for a cause for the low blood pressure and the patient's symptoms. The diagnosis was confirmed at 13h45. The speed of intervention governs the neonatal outcome. The sooner this baby was delivered, the better the outcome would have been.
43. Counsel for the defendant attempted to introduce issues relating to capacity at the hospital. This, despite the fact that no such defence was raised on the defendant's plea. Mr Pillay objected to these questions on the ground that no issue was raised in the pleadings that capacity was stretched to the point that proper medical care could not be provided. I ruled in his favour. It appears to me that the issues between the parties would have been different, had such plea been raised. In any event, dr van den Heever commented that, whilst he could not look at anything beyond the records available to him, and whilst he knew what it was like in an academic hospital, prioritisation must take place. A case like this should have had priority above anything else.

44. When asked about the CTG and the method of taking the FHR, dr van den Heever stated that a stethoscope was not a substitute for a CTG as it could not measure a continuous heart rate. If a machine was not available they should have got one to see what the condition of the baby was.

45. Mr Lengane for the defendant made much of paragraph 9 on p32 of the report of dr van den Heever. In this paragraph the doctor quotes from Williams' Obstetrics which reads as follows:

> Concealed hemorrhage carries much greater maternal and fetal hazards. This is not only because of possible consumptive coagulopathy, but also because the extent of the haemorrhage is not readily appreciated, and the diagnosis typically is delayed (Chang and co – workers, 2001). Abruption severity often depends on how quickly the woman is seen following symptom onset. With delay, the likelihood of extensive separation causing fetal death is increased remarkably. The frequency with which placental abruption is diagnosed varies because of different criteria, but the reported frequency averages 1 in 200 deliveries.

46. Counsel for the defendant sought to deduce from this quotation that a diagnosis of abruption could not be expected. Dr van den Heever did not concur. According to him, the fact that the plaintiff experienced pain should have raised the suspicion of concealed haemorrhage. It is the delay of that suspicion that is the problem. If there is undue delay there is foetal compromise. The signs were there to have called for investigation, to minimise the delay.

47. It appears evident to me that, rather than condone the failure to diagnose abruption timeously, Williams is warning about the risk that it not be done because of concealed haemorrhage. Alertness when symptoms pointing to concealed haemorrhage, such as pain in the abdomen is, accordingly, called for.

48. When asked whether Williams Obstetrics prescribes the time that should not be allowed to lapse, dr van den Heever answered that it did not. Williams Obstetrics is a text book for students to make them aware of the importance of early diagnosis.

48.1. According to the book the speed of response is an important factor in neonatal outcome.

48.2. The sooner one responds to a patient with these symptoms the better the outcome for the baby.

48.3. The response should be within 5 minutes.

49. Dr van den Heever pointed out that the notes do not reflect that a provisional diagnosis was made in the MOU. With a patient with these clinical signs, she should have been transferred as an emergency within minutes to the labour ward. There was no excuse for delay even if MOU is far from the labour ward. We have no notes between 12h00 and 13h00 and thus it appears that nothing was done.

50. Asked which reports he read dr van den Heever answered that he compiled his report according to clinical notes presented to him by the plaintiff's attorneys. These notes demonstrate 50% separation found during the caesarean, found at 14h20. This has no relevance to the admission at 12h00.

51. Mr Lengane put it to dr van den Heever that the 50% separation told him that the progression of separation was of the slow type. Dr van den Heever agreed with that statement.

52. He also agreed with the statement that that the symptoms of lower abdominal pains, dizziness and paleness ought to have alerted the hospital to possibility of separation.

53. It was impossible to say when the separation started, but, to have reached 50% during the caesarean, it could not have been 50% when the foetal heartbeat was 150 at 12h00. It was bradychardia at 14h15, it was slow, which corresponded to the 50% separation which was present during the caesarean, the foetal heart rate was very slow. In contrast, at 12h00 on admission the foetal heart rate was

150/minute. Thus, the abruption could not have been 50% at that stage, it might have been 1% or 2% with concealed haemorrhage that caused the pain. With a normal heart rate at 12h00 there was no significant separation that could have caused brain damage.

54. Had a caesarean been done sooner rather than later, the neonatal outcome would have been better.

55. Dr van den Heever stated that, whilst he could not say that Menzi would not have been born with cerebral palsy had the plaintiff been attended to at 12h00, he considered it "very very unlikely" that he would have been so born. Most likely Menzi would have born normally.

56. Mr Lengane put to dr van den Heever that, as a result of the taking of the blood pressure, the staff at the MAU referred the plaintiff to the labour ward. She was seen at 13h00 by Dr Manga who called the obstetrician. When she was first called, the registrar was in the process of delivering a baby.

57. It was also put to dr van den Heever that Dr Mashamba as an expert would testify that the 50% separation discovered during the caesarean does not indicate that it was less than 50% at 12h00. Dr van den Heever was unable to agree with that statement. He based his statement thereon that heart beat was still 150 per minute at 12h00. It could not be 150 with 50% separation. In any event, abruption is a progressive state. There would logically be a change between 12h00 and 14h20.

58. Asked about the causes of the abruption, dr van den Heever identified a few predictive factors. Due to the fact that we do not have ante – natal notes, one cannot say whether Mrs Lushaba had them, one of the more important factors is high blood pressure. However, in two instances at 25 and 30 weeks, the blood pressure was perfectly normal. At 30 weeks she weighed 62 kilograms. She was

not overweight. Hypertension is more commonplace in overweight patients. Other factors include cocaine use; folic acid deficiency, a whole table of deficiencies and anaemia as well as trauma on the abdomen. Some abruptions can happen spontaneously. In any event, dr van den Heever considered the causes of the plaintiff's condition irrelevant. She presented at the hospital with a condition and ought to have been treated for that condition with the appropriate urgency.

59. When asked why it was that he attributed fault to the delay of the hospital staff and excluded the other causes, dr van den Heever answered that it was so obvious there was no doubt that there was delay in delivering the baby once the plaintiff presented to hospital. With those symptoms it is abruptio placentae until proven otherwise. Nothing was done between 12h00 – 13h45.
60. It was irrelevant whether she had suffered trauma or what had caused the abruption to set in. The plaintiff had a developing abruption on admission. Her presenting complaints had to be regarded in a serious light. It was abruption until proven otherwise. Yet nothing was done to exclude it.
61. To a question asked by me dr van den Heever confirmed that, where he testified about the correlation between less oxygen and the low heart rate, he was testifying as an expert.
62. The plaintiff closed her case after the evidence of dr van den Heever.

(ii) **Dr Jeebodh**

63. The defendant's first witness was dr Jeebodh. She qualified as an obstetrician/gynaecologist in 2003 and is a maternal sub – specialist. She was the doctor that delivered the baby and performed the caesarean. At the time she was a registrar, training to be an obstetrician/gynaecologist. She now longer works at the Charlotte Maxenke hospital. She saw the plaintiff for first time at 13h45.

64. She came to know about the presence of the plaintiff in the labour ward when Dr Manga, being the doctor who assessed the plaintiff in the admissions ward at 13h00 (area 162) contacted her to say there was a case. At that time dr Jeebodh was busy in theatre. Dr Manga admitted the plaintiff to the labour ward, where an ultra sound facility is located. Dr Jeebodh performed the ultrasound because the intern (dr Manga) suspected an abrupted placenta. Dr Manga could not detect a foetal heart. Dr Jeebodh could only leave the theatre after her patient was stable. On doing an ultrasound she confirmed there was an abruption, whereupon she stabilised the plaintiff and booked her for a caesarean. Stabilisation involved inserting a drip.
65. There are two floors between the MOU and the labour ward. One is on the 8th floor and the other on the 6th floor.
66. Under cross-examination dr Jeebodh agreed that, when she first saw the plaintiff, no drip, no catheter and no CTG were attached to her. Dr Jeebodh did not see a CTG reading upon arrival. She was sure that she would have looked for a CTG reading. She agreed that the absence of such a reading and the fact that she did the ultrasound suggested there was none.
67. Dr Manga was at that stage a fully admitted doctor. Dr Manga now operates a holistic care centre in Muldersdrift in South Africa.
68. Dr Jeebodh confirmed that she considered the situation an emergency. Bradycardia had set in. The baby is the second patient and a heart rate below 110 is a big concern. She was concerned about the baby's demise. Bradycardia shows that the baby was at pre – terminal stage.

(iii) **Dr Mashamba**

69. Dr Mashamba, called as an expert witness by the defendant, testified that he has been a specialist in obstetrics and gynaecology since 2000. He has, apart from his MBCHB, also a diploma in obstetrics, a master's degree in the medicine of obstetrics and gynaecology, and has completed an advanced course in the management of diabetics in pregnancy. He became a principal specialist in 2004. He lectures at the Medunsa campus, is a member of the maternal death committee of South Africa which enquiries into maternal deaths and has contributed to guidelines on maternity care. In addition he is a member of internal organisations such as the International Aids society; the European Society of Human Reproduction and the American Society of Reproductive Medicine.
70. Dr Mashamba agreed that everything in the joint minute except the conclusion at the bottom reflected his agreement with dr van den Heever. His opinion was based on the hospital records, which he saw after he had compiled his report. He disagreed with dr van den Heever in that a diagnosis of abruptio placentae which could have occurred any time after 10h00 may not have made a difference regardless of when the intervention was made. The abruption could have set in any time from 10h00.
71. The plaintiff was not in the hospital's labour ward at 12h00. At that stage she was in the MOU from where she was referred to a higher level of care as she was found to have problems.
72. It is apparent from the notes at p5 of the liability bundle that, on arrival at the maternity ward, a history was taken from the plaintiff about the problems she was experiencing. The following were noted:

    72.1. the baby lay longitudinally;

72.2. the FHR of 150 but being irregular;

72.3. the blood pressure of 70/40;

72.4. a vaginal examination with notes that the cervix was uneffaced and the foetal head moderately applied to cervix;

72.5. the reference to 162, meaning she was referred to a higher level of care, being the admissions ward, where the plaintiff was seen by a doctor who was an intern.

73. The duration of these initial observations would depend on the experience of the person taking the history, and what that person decides to note as significant. One expects a good history to be taken, which takes long because one must also make a diagnosis and then write notes. Even if one were experienced, this would take at least 15 minutes, then 5 minutes to write the notes.

74. The maternity ward referred the plaintiff to a higher level of management because her blood pressure was low and she was dizzy. Had it been just the pain, they would have thought she was in labour. The low blood pressure indicates that there was little blood going to the essential organs. One would need to consider what could be the cause of the low blood supply going to the mother. A blood pressure of 70/40 indicates a compromised supply of blood to mother and foetus. The condition is called hypotension, with the mother trying to prioritise her life first, preferring the brain and the heart of the mother. The uterus is not a preferred organ, thereby affecting the baby in the uterus.

75. In response to dr vd Heever's opinion that, because there was a delay in performing a caesarean, the baby was harmed, dr Mashamba referred to literature such as that of Baha Sibai which states that, where an in hospital patient complains and a caesarean is done within 20 minutes, the baby will be saved. The

outcome is not guaranteed where the complaint starts outside hospital. The majority of these babies are not born alive. In this regard dr Mashamba mentioned Mustafa Abbasi. There is a 50/50 chance between being born alive or born dead. The majority born alive are born with cerebral palsy. The literature did not form part of dr Mashamba's report nor was it available to him in the witness box.

76. When asked to explain his statement that early delivery does not guarantee different outcome, dr Mashamba pointed to the commencement of the symptoms 2 hours before the plaintiff arrived at the maternity ward.

77. In response to whether he would consider that there was some form of negligence that the plaintiff was operated on so late after she arrived, he answered that the facts on record do not reflect what was actually done. He thought that changes to the plaintiff's blood pressure should mean that something must have been done to improve her condition. At the same time he admitted that, in the absence of documentation, he could not say that it was done. He agreed that medical practise is to the effect that that which is not documented is not done.

78. The basic principle of obstetrics and midwifery is that the mother should be saved first. She must be stabilised for the caesarean otherwise both mother and child will be killed. Dr Mashamba insisted that, though not documented, the improvement in blood pressure meant something was done. When asked whether he agreed with the medical standard that that which was not written was not done, he stated that he did agree. It was not indicated by the intern that there was a plan for a caesarean.

79. When referred to note [7] of the joint minute which records an agreement that the records reflect nothing happened between 12h00 and 13h00, dr Mashamba

answered that he and dr van den Heever were referring to the period after the plaintiff was examined and to her shocked state. The doctors were looking at things that could have been done to save the mother. There was no evidence of resuscitation.

80. As regards the heart rate, dr Mashamba was of the view that irregular heart rate meant that the foetus was affected.

81. In cross-examination Mr Pillay asked dr Mashamba why dr Jeebodh considered it necessary to act with such haste. To that dr Mashamba responded that, if one makes the diagnosis, one acts accordingly. Dr Jeebodh is the one who made the diagnosis. He did not explain why dr Manga's recognition of the possibility of abruption ought not to have been heeded, nor why it should not have been made or heeded at 12h00.

82. Dr Mashamba nevertheless agreed that abruption is an emergency.

83. Dr Mashamba appeared to qualify his recorded agreement about the plaintiff's symptoms and what had to be done when the symptoms were noted. He testified that, at the time his agreement was noted, he was not aware that the plaintiff commenced her interaction with the hospital on the fateful day at the MOU. He did not state why he thought this was relevant apart from stating that it could not be claimed that a caesarean should have been done urgently, considering that she started off in the MOU. When he agreed to the joint minute and at the time he did his export report, he had not had sight of the hospital records. It is now clear from p6 of the liability index that the plaintiff came from the MOU. He did not explain why that removed the objective urgency of the condition.

84. Dr Mashamba agreed that the conclusion to be drawn from the plaintiff's symptoms, which included low blood pressure and lower abdominal pain, must most likely be taken to be abruption until proven otherwise.

85. When asked what should be done upon presentation of a patient with these symptoms, he answered that a drip should be put in. That appeared at odds with his agreement that a caesarean should have been done as soon as possible after 12h00.

86. When pressed on whether Dr Manga missed an essential part of the treatment by not putting in a drip and not following guidelines, dr Mashamba suggested, rather strangely I thought, that he did not know whether dr Manga had read the guidelines. He appeared reluctant to comment on whether she was negligent. In addition he appeared reluctant to comment on whether it was appropriate to recommend deferral of the treatment for four hours in these circumstances, as dr Manga had done. He felt that her 4-hour deferral was appropriate considering her diagnosis of LPL, meaning latent phase of labour. He then suggested that the situation was not an emergency and could not be considered one unless one had made a diagnosis. This too appeared at odds with his noted agreement in the joint minute as well as the contents of his report. Abruption, being an objective condition, presents an emergency regardless of whether diagnoses are made. The urgency does not commence only once the diagnosis is made.

87. Dr Mashamba appeared to suggest that dr Manga had acted appropriately by deferring the review of the latent phase of labour review to after 4 hours and by recording that abruption should be ruled out. She called a senior. It was unfortunate that the senior came late.

88. Mr Pillay pointed out that an intern, such as dr Manga was, is a qualified medical practitioner.

89. Dr Mashamba thought dr Manga had acted appropriately on what she found. With the transfer to ward 162, the first professional to see the plaintiff was dr Manga, the intern, being a doctor in training. Whether dr Manga could perform a caesarean would depend on how long she had been there. The guideline is that the interns rotate between the two sections for 4 months. In those 4 months they cannot do a caesarean unless under supervision.

90. When pressed on this by Mr Pillay, who pointed out that dr Manga would know the history and that alarm bells should have rung, he responded that, when a patient is referred, a doctor would need to confirm the evidence on which she is referred. Dr Mashamba had difficulty answering Mr Pillay's question about whether the 4-hour referral for review was acceptable. It was pointed out to him that his stance in the witness box contradicted his agreement to paragraph 8 of the joint minute, which recorded as unacceptable the referral for review in 4 hours. To this he answered that the referral based on a diagnosis of latent phase pregnancy was acceptable but not if there is abruption. It was pointed out to him that his assessment of the conduct as unacceptable was without reservations and conditions.

91. Dr Mashamba agreed that the absence of a CTG reading was of concern. A CTG is essential to determine foetal health. CTG machines are routinely used in public hospitals.

92. He agreed that the baseline FHR of 150 was within normal limits.

93. He understood the notation of the heart rate as irregular to mean that there is deceleration in the heart rate. This to dr Mashamba indicated problems, but he did

not specify those. He agreed with dr van den Heever that the baby's system was two – fold as a result of which variation is to be expected. One has two forces in opposite directions. When one records abnormalities there is deceleration. Once there is a problem, when there is a decrease, then you say it is abnormal. Both these opposing systems are at work continuously in unborn baby. Normal reaction is that sympathetic nervous system is activated when there are problems. The normal rate of foetal heart rate is110 – 160. Mr Pillay put it to dr Mashamba that, in the absence of low/high numbers, a conclusion cannot be drawn over the seriousness of the deceleration. In answer dr Mashamba persisted that the presence of deceleration indicates an abnormality. He did, however, not identify the effect of that abnormality.

94. When pressed to indicate why the intern was content to review the position in 4 hours, dr Mashamba avoided the question. He could not contest that vaginal delivery was not going to occur within the next hour and that it could not be waited for. Mr Pillay then put it to him that, if this were abruption, one could not wait for vaginal delivery and that that was why dr Jeebodh rushed the plaintiff to the operating theatre with such haste. In this case at 13h00 the only possibility was caesarean, Mr Pillay put to dr Mashamba. To that dr Mashamba answered as follows:

    94.1. I do not agree with what you are saying. There are things you look at.

    94.2. The patient was rushed for Caesarean without making sure the mother is well resuscitated and I am against that.

    94.3. I would not say you make a diagnosis and go to caesarean. First blood must be ordered and only act should the mother be stable.

    94.4. You do not say there is abruption and then act.

Dr Mashamba thought there was no need for urgency at 13h00. It was acceptable for dr Manga to await the registrar and not take any steps towards inserting a catheter or a drip even. He did not consider that the plaintiff presented any worrying signs. I could not reconcile his answer with his previous agreement that the plaintiff's symptoms were indicative of abruption which he agreed constitutes an emergency.

95. When I asked dr Mashamba whether a doctor such as dr Manga was entitled to remain inactive in the circumstances of this case and what her duties and responsibilities would be, he provided me with no clear answer, such that I still do not know what the position would be.

96. When it was put to him that the only area of disagreement was around the likelihood of a better outcome, dr Mashamba gave the impression that the doctors were considering the position of the plaintiff. As Mr Pillay pointed out, that could not have been, considering that the plaintiff came out of the caesarean with no difficulties and this case is not concerned with her condition.

97. Dr Mashamba was evasive when pressed about the conclusion which he agreed with dr van den Heever, namely that the caesarean should have been done as soon as possible after 12h00 with most likely a better outcome. He acknowledged that, once a diagnosis of abruptio was made, the caesarean should be done as soon as possible, in the interests of both mother and child. He acknowledged that this was a concealed abruption. The problem was in underestimating the danger. The diagnosis was not made at 12h00. Dr Mashamba then appeared to qualify his agreement that the caesarean should have been done as soon as possible after 12h00 on the basis that he did not know that the diagnosis had not been made and that he and dr van den Heever thought the plaintiff was in the hospital. He did not

explain why that made a difference to his opinion and was evasive on the point. He seemed to be of the view that paperwork would justify the delay.

98. Nevertheless, dr Mashamba confirmed that it was still his view that the caesarean should be done as soon as possible and that, with symptoms such as the plaintiff presented, the assumption is that it is abruption until proven otherwise.

99. Dr Mashamba eventually acknowledged that, when he wrote the report, he was concerned with the child and that the conclusion in the joint minutes concerning the better outcome concerned the child, albeit with no guarantees. He agreed that the abruption was underway at 12h00. We do not know how far it had progressed by that stage, as the separation occurs over time. He agreed that it was important to do the caesarean without delay because the speed of intervention is a decisive factor for outcome of the foetus.

(iv) **Observations regarding the Witnesses**

100. Dr van den Heever was a good witness. His evidence was rendered in a professional, ordered and comprehensible manner. At no stage did I form the opinion that he was tailoring his evidence in favour of the plaintiff. He came across as fair and reliable. Likewise with Dr Jeebodh. One formed the impression, in both their cases, that they were skilled and dedicated professionals. I have no difficulty in accepting the evidence of these two witnesses.

101. The same cannot, regrettably, be said of Dr Mashamba. It was often impossible to get a straight answer out of him. He was evasive, refused to commit himself and attempted to avoid the logical consequences of both his expert report and the joint minute. He contradicted himself. It is difficult to

avoid the impression of bias on his part and in this regard I must agree with Mr Pillay that dr Mashamba did appear biased in favour of the defendant.[2]

(v) **Conclusions from the Evidence**

102. All three doctors agreed that abruption is an extremely serious condition, such that speed in dealing with it is of the essence. There was no suggestion that, once abruption had been diagnosed, a doctor could proceed at his/her leisure because disaster was inevitable and nothing could be done to save the baby and/or mother in any event. Dr Mashamba could not seriously dispute that the speed of intervention would have an effect on the neonatal outcome and in the end he agreed that it would be so. This outcome includes not only the life of the baby, it includes the quality of life of the baby. Seen in this light it is of no consequence that the plaintiff was first seen in the MOU. She presented with an extreme emergency and ought to have been treated as such.

103. There was no challenge to the evidence of dr van den Heever that a heart rate of 150 bpm excluded a serious breach in the flow of oxygen thereby, on the probabilities, indicating that the baby had not incurred brain damage at 12h00. Logically, had the caesarean been performed at or shortly after 12h00, the brain damage would most likely have been averted. Dr van den Heever was not cross examined on this point. Dr Mashamba did not deal with the effect of the strength of the heart rate. There is no doubt that brain damage had set in by 13h45 with the heart rate at 100 bpm and the foetus at death's door. The evidence of dr Mashamba that the notation of an irregular heart rate meant that there was foetal distress is at best inconclusive. He did not specify what the

[2] See, as regards the duties of expert witnesses *Schneider NO and others v Aspeling and another* 2010 (5) SA 203 (WCC)

outcome, nature or result of such distress would be. He did not deal with dr van den Heever's evidence that the strength of the heart rate excluded any significant loss of oxygen. He could not know what the deceleration (if indeed it were that) would be, as only one heart rate of 150 bpm was taken. Indeed, dr Mashamba did not state an opinion about the effect of the irregularity in the heartbeat, as he interpreted it. In the absence of an indication of peaks and troughs his interpretation of deceleration appears illogical.

104. Dr van den Heever testified that the fact that, at 14h20, the abruption was at 50%, meant that it could not have been such at 12h00. Abruption is a progressive condition. Although dr Mashamba agreed with the latter statement, he challenged the earlier one but did not explain how a progressing condition could at 14h20 be where it was at 12h00 At 14h20, at 50% abruption, the heart rate was at 100 bpm. It follows that it could not have been at 50% with a heart rate of 150 bpm. On this point I accept the evidence of dr van den Heever. It is consistent with logic.

105. Read together, these two facts, namely the strength of the heart rate at 12h00, and the logical inference that the abruption must have been at less than 50% at 12h00, at least such to enable a heart rate of 150 bpm, mean that the foetus was, on the probabilities, still being sufficiently supplied with oxygen at 12h00. As dr van den Heever testified, if the heart rate remains low, the brain is deprived of oxygen to such an extent that permanent brain damage occurs. At 12h00 the heart rate was not low and, on the probabilities, brain damage had not occurred.

106. Both experts agreed that the symptoms with which the plaintiff presented must be taken to be indicative of abruption, until proven otherwise, even without

vaginal bleeding. Medical practitioners can be taken to be aware of the warning in Williams Obstetrics of the danger of a delayed diagnosis in the case of concealed haemorrhage, with its attendant risks.

107. Both the experts agreed that the caesarean should have been done as soon as possible after 12h00. They are agreed that, most likely, this would have ensured a better outcome.

108. There is, accordingly, almost complete agreement between all three doctors about the medical standard to apply in a case of abruption. Where a vaginal delivery is not imminent a caesarean should be performed without delay to minimise, if not avoid, harm to mother and child. No question of two schools of thought on the proper treatment of the patient arises as it did in *Medi – Clinic Limited v Vermeulen*,[3] a judgment Mr Lengane referred me to.

IV. **NEGLIGENCE/CAUSATION**

109. Corbett JA put the question to be answered in a case such as this as follows:

> … did negligence on the part of respondent cause or materially contribute to this condition in the sense that respondent by the exercise of reasonable professional care and skill could have prevented it from developing[4]

(i) **Negligence**

110. A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill but he is bound to employ reasonable skill and care.[5]

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[3] [2014] ZASCA 150 (26 September 2014)
[4] *Blyth v van den Heever* [1980] 1 All SA 148 (A) at p150
[5] *Mitchell v Dixon* 1914 AD 519 at 525

111. In determining what is reasonable, the court will have 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.[6]

112. This test has been refined by the addition of the reservation that the members of the relevant branch should be responsible or, as has been stated, a standard of practice recognised as proper by a competent reasonable body of opinion or a respectable body of professional opinion.[7]

113. As has been stated in *Kruger v Coetzee*[8]*:*

> For the purposes of liability *culpa* arises if –
>
> (a) a *diligens 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.

114. As regards the duty of a hospital in circumstances such as these, our courts have held as follows:

> Because the Hospital accepted the plaintiff on the 26th June as a patient (it is immaterial whether as a paying or non-paying patient) its staff owed him a duty to attend to and treat him with due and proper care and skill. That duty on the part of Cornelius and Fourie in plastering his arm on the 26th June, and Dr. Wolf in attending to him on the 28th June, was to exercise that degree of care and skill which the reasonable plasterman and general medical practitioner respectively would ordinarily have exercised in South Africa under similar circumstances (*van Wyk* v. *Lewis*, Page 541 of [1963] 3 All SA 534 (W) 1924 A.D. 438 at pp. 444, 456; *Esterhuizen* v. *Administrator of Transvaal*, 1957 (3) S.A. 710 (T) at p. 723 C to E, 726 A to C). Any breach of that duty would constitute negligence. [9]

115. And in *Ntsele* it was stated as follows as regards the staff at Baragwanath hospital concerning the birth of a child:

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[6] *Van Wyk v Lewis* 1924 AD 438 at 444
[7] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 (QB) at 122B – C; *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771 (HL) at 778d – g and 779d-g
[8] 1966 (2) SA 428 (A) at 430E
[9] *Dube v Administrator, Transvaal* [1963] 3 All SA 534 (W) at p541

> The defendant's employees had a duty of care to accord the plaintiff and Ayanda obstetric and paediatric care with the reasonable skill and diligence prevailing in the medical profession in order to ensure the safe delivery of Ayanda.[10]

116. Lord Denning put the obligation thus:[11]

> If a man goes to a doctor because he is ill, no one doubts that the doctor must exercise reasonable care and skill in his treatment of him, and that is so whether the doctor is paid for his services or not. If, however, the doctor is unable to treat the man himself and sends him to hospital, are not the hospital authorities then under a duty of care in their treatment of him? I think they are. Clearly, if he is a paying patient, paying them directly for their treatment of him, they must take reasonable care of him, and why should it make any difference if he does not pay them directly, but only indirectly through the rates which he pays to the local authority or through insurance contributions which he makes in order to get the treatment? I see no difference at all. Even if he is so poor that he can pay nothing, and the hospital treats him out of charity, still the hospital authorities are under a duty to take reasonable care of him just as the doctor is who treats him without asking a fee. In my opinion, authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the selfsame duty as the humblest doctor. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves. They have no ears to listen through the stethoscope, and no hands to hold the knife. They must do it by the staff which they employ, and, if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him. What possible difference in law, I ask, can there be between hospital authorities who accept a patient for treatment and railway or shipping authorities who accept a passenger for carriage? None whatever. Once they undertake the task, they come under a duty to use care in the doing of it, and that is so whether they do it for reward or not.

117. Where a hospital accepts a person for treatment, it has a duty towards that person to provide the treatment according to the standards enumerated above. The plaintiff had no control or influence over the staff employed at the Charlotte Maxeke hospital. She was entitled to an appropriate level of care and it is the ultimate duty of the defendant to ensure that the hospital provides such care.[12]

118. Measured against these tests, there can be little doubt that the defendant was negligent. An emergency was met with indifference. That, of itself, is negligent.

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[10] *Ntsele v MEC for Health, Gauteng Provincial Government* [2013] 2 All SA 356 (GSJ) at p364
[11] *Cassidy v Ministry of Health (Fahrni, Third Party)* [1951] 1 All ER 574 at pp584 - 585
[12] *Cassidy v Ministry of Health (Fahrni, Third Party)* supra at p588

118.1. The exercise of reasonable care and skill would, at or very shortly after 12h00, have (1) led to a diagnosis of abruption or possible abruption and (2) a realisation of the urgency of having a caesarean performed and (3) the performance of that caesarean. Dr van den Heever says he would have had the plaintiff on the way to a caesarean within 5 minutes of her consulting him. Dr Jeebodh had the plaintiff on the way to the operating theatre almost immediately upon her first encounter with the plaintiff.

118.2. In these circumstances the hospital ought to have taken steps to perform the caesarean immediately upon noting the symptoms at 12h00. This was an extremely serious emergency that took precedence over all else.

118.3. Plaintiff's referral to the labour ward ought to have happened as a matter of urgency and the caesarean ought to have happened as a matter of urgency.

119. The medical opinion agrees that, had that been done, there would most likely have been a better outcome for Menzi.

120. Although the plaintiff presented herself at the hospital at 12h00 with symptoms indicative of a medical emergency, the defendant's staff proceeded at great leisure and with indifference until 13h45. Startlingly, nothing was done to prevent a very foreseeable tragedy between 12h00 and 13h45. This, against the background of agreement from all three medical witnesses that the caesarean ought to have been done as soon as possible after 12h00 because abruption presents a medical emergency. Against this background, the failure by dr Manga to insert a drip or catheter as well as the failure to apply a CTG

are further instances of negligence along the theme of defendant's indifference between 12h00 and 13h45 to the fate of the plaintiff and her unborn child.

121. In failing to perform a caesarean on the plaintiff shortly after 12h00 the defendant breached its duty of care towards the plaintiff and Menzi. It also acted negligently in not employing reasonable skill and care in its dealings with them.

(ii) **Causation**

122. Did the negligence, being the failure/omission to perform the caesarean timeously, cause the cerebral palsy?

123. As regards the test for causation, the Constitutional Court in *Lee* provides the following guidance:

> [56] Even if one accepts that the substitution approach is better suited to factual causation, the preceding discussion shows that there is no requirement that a plaintiff must adduce further evidence to prove, on a balance of probabilities, what the lawful, non-negligent conduct of the defendant should have been. All that is required is "the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such a hypothesis the plaintiff's loss would have ensued or not". What is required is postulating hypothetical lawful, non-negligent conduct, not actual proof of that conduct. The law recognises science in requiring proof of factual causation of harm before liability for that harm is legally imposed on a defendant, but the method of proof in a court room is not the method of scientific proof. The law does not require proof equivalent to a control sample in scientific investigation.
>
> [57] Postulating hypothetical lawful, non-negligent conduct on the part of a defendant is thus a mental exercise in order to evaluate whether probable factual causation has been shown on the evidence presented to court. It is not a matter of adducing evidence, as the Supreme Court of Appeal appears to have found. I accept that the postulate must be grounded on the facts of the case, but that is not the same as saying that there is a burden on the plaintiff to adduce specific evidence in relation thereto.
>
> [58] What was required, if the substitution exercise was indeed appropriate to determine factual causation, was to determine hypothetically what the responsible authorities ought to have done to prevent potential TB infection, and **to ask whether that conduct had a better chance** of preventing infection than the conditions which actually existed during Mr Lee's incarceration. Substitution and elimination in applying the but-for test is no more than a mental evaluative tool to assess the evidence on record. In my view, this hypothetical exercise shows that probable causation has been proved.

> [59] That there is a duty on Correctional Services authorities to provide adequate health care services, as part of the constitutional right of all prisoners to "conditions of detention that are consistent with human dignity," is beyond dispute. It is not in dispute that in relation to Pollsmoor the responsible authorities were aware that there was an appreciable risk of infection and contagion of TB in crowded living circumstances. **Being aware of that risk they had a duty to take reasonable measures to reduce the risk of contagion.**
>
> [60] Although I accept that a reasonably adequate system may not have "altogether eliminated the risk of contagion", I do not think that the practical impossibility of total elimination is a reason for finding that there was no duty at least to reduce the risk of contagion. It seems to me that if a non-negligent system reduced the risk of general contagion, it follows – or at least there is nothing inevitable in logic or common sense to prevent the further inference being made – that specific individual contagion within a non-negligent system would be **less likely** than in a negligent system. It would be enough, I think, to satisfy probable factual causation **where the evidence establishes that the plaintiff found himself in the kind of situation where the risk of contagion would have been reduced by proper systemic measures.** [own emphasis]

124. The hypothetical non – negligent conduct in this situation is not difficult to postulate. The caesarean section ought to have been performed without delay at 12h00. On that all three doctors who testified are agreed. They are also agreed that such a course of conduct had a better chance of preventing the negative outcome than the conduct adopted by the defendant, namely waiting 2 hours before performing the operation and permitting Menzi to proceed towards a brain damaged state, trapped inside the uterus.

125. Undoubtedly the plaintiff found herself in the kind of situation where the risk of her baby being born with cerebral palsy would have been reduced by a caesarean section being performed without delay after 12h00. Sufficient oxygen was still being delivered for the baby at that time to indicate that, on the probabilities, he was at that stage not brain damaged. Being aware of the risk of brain damage, the hospital was under a duty to take reasonable measures to reduce the risk of brain damage, or cerebral palsy. Following the

reasoning in *Lee*,[13] Menzi would be less likely to be born with cerebral palsy, had the caesarean been performed without delay.

126. By permitting the abruption to progress as it did the hospital caused or contributed materially to Menzi's cerebral palsy.[14] In these circumstances the necessary reasonable connection between the breach and the harm done exists.

V. **COSTS**

127. At the outset of this judgment I referred to the defendant's lack of responsiveness to requests by the plaintiff to reduce the issues in this matter, as well as to court orders that it do so. I also referred to the late filing of the summary of its expert witness, which necessitated a delay and unnecessary costs. Plaintiff's counsel and attorney are all three from Durban and dr van den Heever is from Cape Town. The time of four professionals was wasted for two days because the joint minute between the experts could only be prepared during the course of the week in which the matter ought to have been ready to proceed to trial.

128. The joint minute raises questions around the defendant's reasons for proceeding with its defence. The experts both agree that a caesarean at or shortly after 12h00 would most likely have caused a better outcome for Menzi. Dr Mashamba's attempts to avoid the logical inference of negligence from the failure to so perform the caesarean were not impressive. Dr Mashamba was not willing to guarantee a better outcome, but that is not the test in this case,

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[13] *Lee v Minister for Correctional Services (Treatment Action Campaign and others as amici curiae)* 2013 (2) BCLR 129 (CC)

[14] *Blyth v van den Heever* supra and see *Bonnington Castings Limited v Wardlaw* [1956] 1 All ER 615, [1956] AC 613, [1956] 2 WLR 707, HL

which is whether, on a balance of probabilities, there would most likely have been a better outcome for Menzi.

129. In my view it was incumbent on the defendant to have considered these matters and to have considered them as soon as possible after receipt of the summons. It could not give reasonable consideration to the issues in circumstances where it (i) failed to reply to any request for further particulars and admissions (ii) only obtained its expert report the Friday before the week in which the trial was set down for hearing. Indifferent to the plaintiff's medical needs, the defendant was indifferent to the conduct of litigation.

130. The defendant should only litigate in the public interest.[15] Any decision of the head of the department relating to litigation should be reasonable and rational.[16] When the defendant does litigate, it should conduct itself in such a manner as to avoid unnecessary delays and cost orders. In my view mature and timeous consideration of the claim ought to have led the defendant (at minimum) not to contest the allegation of negligence, thereby reducing the issues in dispute. The defendant's persistent denial of negligence raises concerns that it persists in not appreciating its obligation towards the public it is meant to serve. In heads of argument submitted following the end of the viva voce evidence and argument, defendant's counsel submitted that negligence had not been established and that he had therefore no need of concerning himself with causation. Defendant's persistence that a caesarean should not be performed as a matter of urgency in the case of a heavily pregnant woman with symptoms from which abruption must be deduced; that

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[15] compare *Hughes Aircraft Systems International v Airservices Australia* (1997) 76 FCR151; *Motswai v Road Accident Fund* (2010/17220) [2012] ZAGPJHC 248; 2013 (3) SA 8 (GSJ); *Tsabangu g Road Accident Fund* case no 49589/2009 Gauteng Local Division (Johannesburg)

[16] *Pharmaceutical Manufacturers Association of SA: in re Ex Partr President of the Republic of South Africa* 2000 (2) SA 674 (CC)

she could validly be left essentially unattended for around 2 hours; speaks of a disquieting indifference towards its public duty. There is no merit in its disregard of the medical evidence to the contrary. Our Constitution and particularly the values enshrined in the Bill of Rights require committed service from the public sector, a commitment eerily absent in this case.

131. In these circumstances the defendant's conduct warrants a punitive cost order. Although I invited counsel during argument to make additional written submissions to me about why a punitive cost order should not be made against the defendant, I received no such submissions. I fail to appreciate why the taxpayer should bear the sole brunt of the failure by the public service to perform its duties adequately.

132. As regards the lamentable conduct of the litigation by the state attorney, see *Minister of Rural Development and Land Reform v Griffo Trading CC*.[17] At no stage during the trial as a representative of the state attorney in court. Defendant's counsel was without a copy of the extract of dr van den Heever's report as it appears in the liability bundle and was handed a copy by the plaintiff's representatives. Blame would also have to be ascribed to the state attorney's office for the failure to comply with time periods and court orders.

[17] Judgment of Bertelsmann J 12440/11 Gauteng Division, Pretoria

VI **THE ORDER**

133. It is declared that the defendant is 100% liable for the plaintiff's damages arising out of the birth with disability of Menzi Polite Lushaba.

134. The defendant is liable for costs on the attorney and client scale, such costs to include (and referred to hereafter as the "costs")

134.1. the wasted costs occasioned by the adjournment on 13 September 2013;

134.2. the costs of the reports of the plaintiff's experts and their qualifying and attendance fees (including the costs wasted by the defendant's late delivery of its expert summary) including the costs of:

134.2.1. Prof J Smith, paediatrician and neonatologist;

134.2.2. Dr A van den Heever, gynaecologist;

134.2.3. J W Lotz, professor of radiology;

134.3. the costs of the plaintiff's legal representatives and the said experts for consultations between them;

134.4. the incidental necessary medical costs occasioned by the MRI scan on Menzi, including the fees of the paediatrician and anaesthetist;

134.5. the costs of hotel accommodation and transport, being the cost of air travel, a hired vehicle and e – tolls for the hearings in September 2013 and October 2014, for the plaintiff's legal representatives and witnesses;

134.6. the costs of all pre – trial proceedings;

134.7. the costs of the plaintiff's attorneys' local agent;

134.8. all other costs of this cause, including the costs of two counsel, where so employed;

134.9. all wasted costs occasioned by the defendant's failure in preparedness and laxity in complying with court orders, time periods prescribed by the rules of court and time periods for preparation for trial including but without detracting from the meaning of this sub – paragraph, the wasted costs occasioned by the late filing of the defendant's expert report on Friday, 3 October 2014.

135. A rule nisi issues, calling upon the defendant to show cause on Tuesday 28 October 2014 at 10h00 why he should not be held personally liable de boniis propriis on the attorney and client scale, jointly and severally with the defendant on attorney and client scale, for the costs.

136. Alternatively to the preceding paragraph and should the defendant be of the view that he should not be held personally liable, he should identify such persons in the department of Health of Gauteng, as well as such persons in the office of the state attorney, who should be personally held liable for the costs as well as the reasons why they should be so held liable.

137. The defendant's affidavits, dealing with the preceding two paragraphs, should be filed and served by no later than Thursday 23 October 2014 at 12h00.

R M ROBINSON AJ
16 OCTOBER 2014

Date of Hearing: 09 October 2014
Date of Judgment: 16 October 2014
Plaintiff's Counsel: Adv. L. Pillay SC with (Adv. M.A. Oliff)
Instructed by: Justice Reichlin Ramsamy (Durban)
Defendant's Counsel: Adv. K. Lengane
Instructed by: State Attorney Johannesburg