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REPUBLIC OF SOUTH AFRICA



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

CASE NO: 2014/32504

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

.....
DATE

.....
SIGNATURE

In the matter between:

**M, A
obo L M**

Plaintiff

and

**THE MEMBER OF THE EXECUTIVE COUNCIL FOR
HEALTH OF THE GAUTENG PROVINCIAL GOVERNMENT**

Defendant

SUMMARY

Delict – claim for damages – medical negligence – clinic and hospital medical staff – causation – *onus* of proof – evidence of single witness not controverted by defendant – plaintiff succeeding in making out a *prima facie* case against defendant’s employees –

Delict – duty of care owed to plaintiff and her unborn baby – defendant and nursing staff failing to keep patient’s hospital/medical records – contravention of sections 13 to 17 of the National Health Act 61 of 2003 as well as guidelines for good practice – ethical guidelines of Health Professions Council of South Africa (HPCSA) – and guide for maternity care in South Africa and the Rules of the South African Nursing Council in terms of the Nursing Act 50 of 1978 – crucial importance of patients’ hospital/medical records particularly in civil litigation.

J U D G M E N T

MOSHIDI, J:

INTRODUCTION

[1] The plaintiff has instituted action against the Member of the Executive Council for Health of the Gauteng Provincial Government (*“the defendant”*) in her representative capacity as the mother and the guardian of the minor child L M (*“L”*).

[2] For present purposes, paragraphs 4, 5, 7 and 8 only of the particulars of claim are relevant. These allege as follows:

“4.

4.1 *On the 17th of May 2010, Plaintiff went to Mohlakeng Clinic for the birth of her child after which she was*

transferred by ambulance to Leratong Hospital, with her then unborn son, L.

- 4.2 *Plaintiff endured several hours of labour in circumstances where a Caesarean section was indicated.*
- 4.3 *On the 17th of May 2010, L was born by normal vaginal delivery.*
- 4.4 *As a result of the prolonged labour and failure to timeously perform a Caesarean section to deliver L, L was diagnosed as suffering from cerebral palsy, due to asphyxia during Plaintiff's labour and/or during L's delivery and/or birth.*
5. *As a result of Plaintiff's prolonged labour and the failure to timeously perform a Caesarean section to deliver L, L suffered a hypoxic-ischaemic incident due to perinatal asphyxia, causing him to sustain severe brain damage, as a result of which he is suffering from cerebral palsy, mental retardation and epilepsy ('the complication').*
6.
 - 6.1 *The complication occurred as a result of the negligence of the Defendant, alternatively, as a result of the negligence of the Defendant's employees and/or authorized representatives, further alternatively, as a result of the combined and cumulative negligence of the Defendant, his aforesaid employees and/or agents.*
 - 6.2 *The aforesaid negligence constitutes a breach of the legal duty which rested on the Defendant, his employees and/or his authorized representatives.*
7.
 - 7.1 *The Defendant was negligent in one, more or all of the following aspects:*
 - 7.1.1 *he failed to permanently, alternatively, temporarily employ the services of a suitably qualified and experienced medical practitioner who would be available and able to examine, manage and/or give appropriate advice in respect of a patient's labour (particularly the Plaintiff) and to perform a Caesarean section if and when required at the aforesaid hospital;*

- 7.1.2 *he failed to ensure that at least one medical practitioner as referred to in paragraph 7.1.1 above was in attendance at all material times;*
- 7.1.3 *he failed to permanently, alternatively, temporarily, employ the services of suitably qualified and experienced nursing staff, who would be able to assess, monitor and/or manage the Plaintiff's labour;*
- 7.1.4 *he failed to ensure that Mohlakeng Clinic and/or Leratong Hospital was suitably, adequately and/or properly equipped to enable timeous and proper performance of a Caesarean section if and when required;*
- 7.1.5 *he failed to take any and/or all reasonably required steps to ensure proper, timeous and professional assessment of patients, their monitoring and management of labour and assistance at birth process;*
- 7.1.6 *he failed to implement such steps as could and would reasonably be required to prevent the occurrence of the complication;*
- 7.1.7 *he failed to avoid the complication when, by the exercise of reasonable care and diligence, he could and should have done so.*
- 7.2 *The Defendant's aforesaid employees and/or authorized representatives were negligent in one or more or all of the following respects, in that he/she/they:*
 - 7.2.1 *failed to properly and/or sufficiently assess and examine the Plaintiff upon her admission;*
 - 7.2.2 *failed to monitor Plaintiff's labour and foetal well-being appropriately, with sufficient regularity, or at all;*
 - 7.2.3 *failed to note or appreciate, either sufficiently, timeously or at all, the Plaintiff's labour was not progressing appropriately or as required in the circumstances;*
 - 7.2.4 *failed to request assessment and/or examination of Plaintiff by a qualified medical practitioner upon her admission to the Mohlakeng Clinic and/or Leratong Hospital;*

- 7.2.5 *failed to perform or request performance of accurate and/or proper cardio-topographic tracings ('CTG tracings') of the foetal heart rate and maternal contractions and/or failed to recognize that the foetal heart rate on the cardio-topograph was completely unsatisfactory;*
- 7.2.6 *failed to monitor the foetal heart rate appropriately, timeously or with sufficient frequency and/or at all and/or failed to detect that L was in foetal distress;*
- 7.2.7 *failed to note and/or appreciate the significance of the lack of appropriate and/or timeous progress of Plaintiff's labour;*
- 7.2.8 *failed to monitor, either appropriately, timeously, with sufficient frequency and/or at all, Plaintiff's labour and/or failed to heed Plaintiff's requests for urgent medical assistance and/or ignored such requests;*
- 7.2.9 *failed to perform a proper and accurate partogram;*
- 7.2.10 *failed to summon, timeously or at all, for purposes of assessment, advice and/or appropriate action, the assistance of a specialist gynaecologist, alternatively, a suitably qualified medical practitioner, further alternatively, any other medical practitioners in circumstances where it was necessary and/or indicated to do so;*
- 7.2.11 *failed to perform or request to be performed, timeously or at all, a Caesarean section on Plaintiff in circumstances where it was necessary and/or indicated to do so;*
- 7.2.12 *failed to advise Plaintiff, timeously or at all, that prolonged labour and/or a failure to perform a Caesarean section timeously, could jeopardize the health of Plaintiff's unborn child;*
- 7.2.13 *failed to inform Plaintiff, timeously or at all, of any and all circumstances which would and could prevent the nursing staff and/or the attendant medical practitioner from rendering reasonable medical, nursing and/or midwifery services with such professional skill and diligence and could reasonably be expected of medical practitioners, nursing staff and/or midwives;*

- 7.2.14 *failed to obtain a comprehensive and/or complete and/or sufficient obstetric history from Plaintiff;*
 - 7.2.15 *failed to provide and/or render the requisite reasonable medical, surgical, nursing and midwifery services with such professional skill and diligence as could reasonably be expected of medical practitioners, nurses and/or midwives in the particular circumstances;*
 - 7.2.16 *failed to ensure that the emergency Caesarean section was performed without delay;*
 - 7.2.17 *failed to prevent the delay in delivering L and the consequences thereof when, by the exercise of reasonable skill, care and diligence, such consequences could and should have been prevented;*
 - 7.2.18 *failed to provide and/or render adequate and/or appropriate neo-natal resuscitation immediately after birth of L;*
 - 7.2.19 *failed to prevent L from suffering an hypoxic-ischaemic incident, causing him to sustain severe brain damage, as a result of which he is suffering from cerebral palsy, mental retardation, and epilepsy when, by the exercise of reasonable skill, care and diligence, it could and should have been prevented.*
8. *As a result of the aforesaid breach of legal duty referred to above, L:*
- 8.1 *suffered foetal distress and perinatal birth asphyxia, with result brain damage, cerebral palsy, mental retardation and epilepsy;*
 - 8.2 *experience pain, suffering and discomfort, and will continue to experience pain, suffering and discomfort in future as a result of:*
 - 8.2.1 *cerebral palsy;*
 - 8.2.2 *mental retardation;*
 - 8.2.3 *epilepsy;*
 - 8.2.4 *marked development delay and speech deficits;*

8.2.5 behavioural problems;

- 8.3 *underwent hospital, medical and related treatment, and will undergo such treatment in future, the details of which are set out hereunder;*
- 8.4 *required and will require various modalities of therapy, special adaptive aids and devices, specialized schooling, permanent and continuous care, the details of which are set out hereunder;*
- 8.5 *experiences a loss of amenities of life and will experience such a loss in future, as would be experienced by a person of the same age and status as L, who suffered the same complication as was suffered by him, particularly the inability to function independently and to enjoy the freedom of independent and unrestricted mobility, and the permanent lack of meaningful privacy, social interaction and communication, parenthood, and living and growing old with a loved one;*
- 8.6 *experienced a permanent and total disability and will experience same in future;*
- 8.7 *will experience a loss of earnings, alternatively, earning capacity, in future as a result of permanent and total inability to generate any meaningful income;*
- 8.8 *will in future suffer psychological problems;*
- 8.9 *will require the services and protection afforded by a Trustee, to protect any and all funds awarded for his future care and treatment;*
- 8.10 *is permanently disfigured as a result of the cerebral palsy."*

[3] The defendant filed a special plea and pleaded to the above allegations. In the light of the developments discussed later below, it is unnecessary to deal with the contents of the pleas.

THE ESSENCE OF PLAINTIFF'S CASE

[4] For the sake of brevity, the essence of the plaintiff's claim is based on alleged negligence on the part of the medical and/or nursing staff based at the Mohlakeng clinic (*"the clinic"*) and the Leratong Hospital (*"the hospital"*) resulting in L sustaining brain injury during the intrapartum period – the period from the start of labour until the birth of L – and as a result whereof L has developed cerebral palsy.

SEPARATION OF ISSUES

[5] At the pre-trial conference held by the parties on 4 December 2017, it was agreed to separate the issue of liability from the determination of plaintiff's claim of quantum of damages, and that this trial should proceed only on the issue of liability. At the commencement of the trial, I duly granted an order for the separation of the issues in terms of the provisions of Uniform Rule 33(4) of the Uniform Rules of Court. As a consequence, the trial proceeded on the issue of liability only, whilst the quantum of damages was postponed *sine die*.

[6] In an endeavour to prove her case, the plaintiff testified extensively on what occurred to her on the 17/5/2010. The plaintiff also called as a witness, Dr Linda Ruth Murray, a senior obstetrician and gynaecologist ('Dr Murray'). However, prior to dealing with the evidence of these two witnesses, I

should record the following: at the close of the plaintiff's case, the defendant closed its case without presenting any oral evidence.

SOME COMMON CAUSE FACTS

[7] It is common cause that the defendant has abandoned both its special pleas and they will accordingly require no consideration by this Court. The plaintiff's *locus standi* to institute these proceedings on behalf of the L, is also not in dispute and will no longer be considered. The defendant has also admitted that, at all relevant times hereto the clinic and the hospital fell under the authority of alternatively, was controlled by further alternatively, was operated by the Department of Health of the Gauteng Provincial Division. It is further common cause that the defendant, through its employees, had a legal duty to treat the plaintiff and the unborn child with such skill, care and diligence as could reasonably be expected of medical practitioners and nursing staff under similar circumstances and, further, that the staff at the clinic and hospital were acting within the cause and scope of their employment with the defendant. It is further common cause between the parties that there are no antenatal or labour-related medical records available in this matter. There are accordingly no medical records available pertaining to the plaintiff's pregnancy and to what transpired during her labour and the delivery of L. In fact, the first document that had reference to the birth of L emanates from a "*Progress Note*" that was completed, at about 21h25 on 17 May 2010, some 35 minutes after the birth of L. In the light of the non-availability of the relevant medical records, the plaintiff's version of events, as

is shown later below, will be the only version of what transpired on 17 May 2010 that can serve as a factual premise on which any findings in this matter can be made. As shown later also below, the parties, having considered the oral evidence of Dr Murray, as well as the contents of the several joint minutes which have been placed before the court by agreement between the parties as the evidence of the respective expert witnesses, are in agreement that: in the event that the plaintiff's evidence is accepted, the appropriate order would be that the defendant is liable for plaintiff's agreed or proven damages in her representative capacity; alternatively, in the event that the plaintiff's evidence is rejected, the appropriate order would be that the plaintiff's claim be dismissed. It also appears to me, from the above agreement between the parties that the defendant accepts, in the light of the evidence of Dr Murray and the various agreements reached between the expert witnesses, that the intra-partum obstetric care that was rendered to the plaintiff by the defendant's employees was substandard and that they therefore were negligent, and that such negligence was the cause of the brain injury sustained by L, provided, of course, that the plaintiff's version of what occurred on the day in question is acceptable to this Court. I deal later hereunder with the agreements between the various expert witnesses.

THE PLAINTIFF'S EVIDENCE

[8] The plaintiff testified. In the circumstances of the case, it is truly unnecessary to recall in greater detail all her evidence. She resided in Mohlakeng Township, Randfontein. She initially testified in English but after the court intervened, she was assigned an interpreter. At the time of her

evidence, the plaintiff was 29 years old. Her highest school qualification is Grade 11, with no other training or further education. The pregnancy under discussion was her first at about 21 years old. Prior to the incident, the plaintiff suspected that she was pregnant. This was later confirmed at the Mohlakeng Clinic. Antenatal (before birth) care was initiated and she was issued with a green card in which the necessary entries were recorded on each visit. The plaintiff complied with all the clinic's requirements/instructions until she was about eight months pregnant. At no stage was she informed by the clinic's nursing staff that there was anything untoward with the progress of her pregnancy or any concerns about the health of her baby. As a result of the agreements between the parties, there is only one remaining issue in dispute between the parties. This issue is a factual one and revolves around the simple question as to whether or not the plaintiff's evidence regarding the events that transpired on 17 May 2010 could be accepted by this Court.

[9] In addition to the above, on or about 1 February 2010, the plaintiff testified that she attended her last appointment with a private medical practitioner, Dr N Kazadi. The purpose of the visit and the previous ones was to monitor the pregnancy and to determine the gender of the baby. Although the gender could not be determined, Dr Kazadi assured the plaintiff that the baby was progressing well, and that her due date was in the vicinity of the first week of May 2010.

[10] On 17 May 2010, at about 14h00 the plaintiff was at home. She specifically mentioned that she recalled the time (14h00) because the school

children were walking pass her home from school on a daily basis at that time. The children attended a nearby school. For what is worth, this aspect of the time becomes relevant in the judgment later. The plaintiff suspected that her waters have broken after she went to the toilet to urinate, and observed a yellowish discharge. The plaintiff called her mother who came and saw. The mother confirmed the event. The plaintiff and her mother proceeded to walk to the nearby Mohlakeng clinic, a walk of about 15/20 minutes. On the way there, they met the plaintiff's boyfriend.

AT THE MOHLAKENG CLINIC

[11] The plaintiff testified that she arrived at the clinic at about 15h00. She was attended to by the nursing staff. She produced her green antenatal card and provided certain information on request. All this was written down in what appeared to be a register.

[12] The plaintiff was given a gown to wear and to lie on a bed. The attending midwife placed a black belt horizontally across her stomach. The belt was attached to a screen behind the plaintiff. The belt was then removed and the midwife conducted an internal examination. The plaintiff was told that her baby was still far and plaintiff was told to go and wait in another room (apparently a waiting room) where her mother and boyfriend were. She complied.

[13] The plaintiff said that at some stage during the wait she went to the toilet where she also vomited. She called the midwife who played down her concerns, and said that it was normal to vomit, and in any event, the baby was still far away. The plaintiff continued to experience pain. Later that afternoon, whilst lying on the bed, the plaintiff felt as if her baby was “*coming out*”. She called the midwife again. The latter came and repeated that the baby was still far, and that the plaintiff should desist from making noise because she was scaring other people in the clinic.

[14] The plaintiff testified that later, at about 18h30 she again called for assistance from the nursing staff. The midwife responded that the plaintiff was unnecessarily noisy, and that the staff were watching television during a popular program called Rhythm City. The plaintiff said that she continued to be uncomfortable with pain. At about 19h30, apparently when the Rhythm City program came to an end, the midwife came to the plaintiff and asked her to lower her voice. The midwife put on a glove and conducted a vaginal examination. When the midwife pulled out her finger, the glove came out with what the plaintiff described as “*number 2*” on it. The midwife looked shocked. It was the first time that the plaintiff observed “*number 2*” that day. The midwife called her colleague, a midwife as well. There was a discussion between the midwives. The plaintiff was informed that she could not have her baby delivered at the clinic as they did not have the requisite “*equipment*”. An ambulance was called urgently. The plaintiff was informed that she should not push as it could result in losing her baby. A drip was put on the plaintiff. This assessment of the plaintiff was only the second one that day after an initial

assessment earlier at the clinic at about 15h00. There were no other assessments or reviews or monitoring of the foetus between her arrival at the clinic, and the assessment shortly before she was transferred to the hospital.

[15] She said that she did not wait long for the arrival of the ambulance at the clinic. There, prior to her transfer, the midwife completed certain forms which were handed to the ambulance driver for the attention of the staff at the hospital. The ambulance arrived at the hospital after a journey lasting some 20 to 25 minutes.

AT THE LERATONG HOSPITAL

[16] On arrival at the hospital, the plaintiff was taken directly to the maternity ward. She was asked to go to the toilet first to pass urine as, according to her she was “*full*” with water because of the drip she had on. She tried to urinate without success. However, on her way back to the ward, she managed to urinate. She was laid on a bed and assisted by the one midwife who held her hand behind the plaintiff’s head, and pushed forward. The midwife used a “*razor*” to “*cut her vagina*”, and the baby was delivered at about 20h50.

[17] The plaintiff testified that she was shown the baby after birth to confirm his gender. The plaintiff observed that her baby, L, was green with “*number 2*”, and that he did not cry. He was “*beaten*” twice on his buttocks to make him cry without any success. The plaintiff overheard a discussion between

the midwives with the news that L had died whereupon a doctor was called for help. The doctor arrived shortly thereafter and asked the midwives why they said that L was dead if there was still a heartbeat. The doctor physically ran with L to the Intensive Care Unit (“ICU”) where he was put on oxygen.

[18] The plaintiff testified that she saw L on the morning of 18 May 2010. He was still in ICU, placed in a “glass”, and on a drip, and was receiving oxygen. The plaintiff was told that L had fitted overnight. She was unable to breastfeed L at the time. The plaintiff said that she was discharged from hospital on 18 May 2010, while L remained in the ICU for several days until he was discharged after about 11 days. On his discharge, the plaintiff testified that she was informed by the doctor that L was going to be “different” with no accompanying explanation therefor. The plaintiff was also told that L’s muscles would be stiff as a result of which he had to be kept in some light. The stiffness of the muscles, she was told, was because L did not receive sufficient oxygen to his brain upon birth. The plaintiff’s parting shot in evidence-in-chief was that she remembered all the above events and details well because it happened to her.

THE CROSS-EXAMINATION OF PLAINTIFF

[19] The plaintiff was cross-examined closely. At the end of the cross-examination, there truly emerged nothing eventful and of significance tempering with the plaintiff’s core-version in regard to the events of 17 May

2010. She essentially stuck to her core-version as to what happened to her at both the clinic and later at the hospital.

[20] The plaintiff remained adamant that she was attended to by two nursing staff at the clinic, and that there were no other pregnant mothers who required their attention. The TV set from which the nursing staff were watching the Rhythm City episode was situated diagonally opposite the room in which the plaintiff was accommodated.

[21] In regard to what may be of relative relevance in the determination of the issue in dispute, the plaintiff was confronted with the contents of her affidavit in support of a condonation application in terms of the provisions of section 3(2) of the Institution of Legal Proceedings against Certain Organs of State Act 40 of 2002 (*“the Institution of Legal Proceedings Act”*). In that affidavit, the plaintiff, in particular paragraphs 21, 22, 23, 24, 25 and 26 omitted to specify exact times of the various incidents described by her at the clinic and at the hospital on 17 May 2010. This, as opposed to specific times she recalled in her oral evidence. The plaintiff agreed with the omissions alleged. In the end, it was put to the plaintiff, in my view not with any overt conviction, that she was fabricating her evidence in regard to the times. The plaintiff denied this proposition. The plaintiff testified that in regard to the reason for her transfer to the hospital, no specific *“equipment or equipments”* were mentioned to her.

THE EVIDENCE OF DR MURRAY

[22] As mentioned above, Dr Murray testified as a witness for the plaintiff. She was sitting in court throughout the testimony of the plaintiff. In the light of the agreements reached, and in particular the contents of the various joint minutes of the experts, it is again truly unnecessary to traverse in detail the evidence of Dr Murray. The observation that, not only did she explain in medical terms the evidence of the plaintiff, but also corroborated in large measure the version of the plaintiff, is well-grounded. Dr Murray compiled a joint minute with her counterpart, Dr P C Koll ("*Dr Koll*"). It is preferable to first deal with the contents of all the joint minutes, prior to engaging in a full assessment of the plaintiff's evidence.

THE VARIOUS JOINT MINUTES

[23] The plaintiff's radiologists, Prof J Lotz ("*Prof Lotz*") and counterpart, Dr T Westgarth-Taylor ("*Dr Westgarth-Taylor*") compiled a joint minute. In it the radiologists agreed, amongst others, that the injury is hypoxic-ischemic (brain damage in a new born infant as a result of inadequate oxygen supply) in nature, and that it shows a pattern of acute and profound (central) hypoxic-ischemic injury; that the findings of the Magnetic Resonance Imaging ("*MRI*") study suggest that genetic disorders as a cause of L's brain damage is unlikely; and that the MRI findings suggest that inflammatory or infective causes are unlikely as causes of L's brain damage.

[24] The neonatologist-paediatricians, Drs D Pearce for the plaintiff and V R Mogashoa, for the defendant, respectively, in an attempt to assist the court in respect of causation and/or origin of and the timing of L's diagnosis and neurological disability, agreed that: L suffers from a mixed cerebral palsy (predominantly dystonic) and gross motor functional classification scale V, indicative of physical impairments severely restricting movement, that L is capable of very limited independent mobility, and his core-morbidities include severe intellectual disability, lower limb contractures, kyphosis, and severe global development delay; and that the MIR, performed on 10 February 2014 reveals, diagnostic features of an acute profound hypoxic-ischemic injury, and that there are no MIR features to suggest intracranial, congenital infections, congenital anomalies, metabolic disorders, inflammatory conditions or haemorrhage. They further agreed that, the timing of the insult is most likely intra-partum (occurring during labour or child birth) (emphasis added), and that having regard to the ACOG2014, and based on available records, intra-partum hypoxia (loosely translated: a deficiency of oxygen in the tissues during birth), is the most probable cause of the neonatal encephalopathy (any of the various diseases that affect the functioning of the brain) (emphasis added) in L. Significantly, these experts agreed that it is important that records of labour are kept/found in order to understand what event led to the acute/profound insult in a new born baby. The experts also agreed that on the available history and records, an antenatal insult can be excluded, as far as possible (emphasis added).

[25] There was no significant agreement between the respective obstetricians, Drs Murray and Koll. The latter express the view that he prefers to base his expert opinion on recorded facts. He also expressed in his own medico-legal report that he is unable to assist the court in the present matter. This attitude quite correctly too, emphasises the need for health institutions such as the clinic and the hospital in this matter to compile, keep and store safely patients' medical records, until claims of this nature have been finalised. In the light hereof, I prefer to deal with Dr Murray's expert and uncontroverted opinions in the evaluation of the plaintiff's evidence and the applicable legal principles.

SOME APPLICABLE LEGAL PRINCIPLES

[26] First, some applicable legal principles. The plaintiff was the only witness in regard to what occurred to her on 17 May 2010, as well as her interaction with the nursing staff. On the other hand, the defendant tendered no oral evidence at all. Section 16 of the Civil Proceedings Evidence Act 25 of 1965 (*"the CPEA"*), which came into operation on 2 May 2005, provides as follows:

"Judgment may be given in any civil proceedings on the evidence of any single competent and credible witness."

[27] In regard to criminal proceedings, the equivalent of section 16 of the CPEA is section 208 of the Criminal Procedure Act 51 of 1977 (*"the CPA"*).

For example, in *S v Sauls* 1981 (3) SA 172 (A) at 180, it was said that there is no rule-of-thumb test or formula to apply when it comes to the consideration of the credibility of a single witness. The trial court should weigh the evidence of the single witness and should consider its merits and demerits and having done so, should decide whether it is satisfied that the truth has been told despite shortcomings or defects or contradictions in the evidence. See also *S v Webber* 1971 (3) SA 754 (A); and *S v Jackson* 1998 (1) SACR 470 (SCA) at 476 to 477, where the application of the traditional cautionary rule in criminal trials was somewhat watered down. Although the *onus* of proof in criminal proceedings is completely different from that in civil proceedings, such as in the instant matter, the principles there in regard to the evidence of a single witness in civil proceedings, are arguably still good law.

[28] In the present matter, plaintiff's counsel relied extensively on *Santam Bpk v Biddulph* 2004 (5) SA 586 (SCA) for the submission that findings of credibility should not be adjudicated in isolation but required to be considered in the light of proven facts and the probabilities of the matter under discussion. In that judgment, the Supreme Court of Appeal at paragraph [5] said:

"Whilst a Court of appeal is generally reluctant to disturb findings which depend on credibility it is trite that it will do so where such findings are plainly wrong (R v Dhlumayo and Another 1948 (2) SA 677 (A) at 706). This is especially so where the reasons given for the finding are seriously flawed ... It is equally true that findings of credibility cannot be judged in isolation, but require to be considered in the light of proven facts and probabilities of the matter under discussion."

See also paragraph [10] of the same judgment for the proposition that a single witness ought not be satisfactorily in all material respects, and that the proper

test is not whether a witness is truthful or indeed reliable in all that he/she says, but whether on a balance of probabilities the essential features of the story which he/she tells are true. See also *Bruck v Williams* [1997] JOL 1684 (C) at pages 31 and 32.

[29] In regard specifically to the *onus* of proof in civil proceedings, our law is also well-settled by now. No undue repetition is necessary. In short, he/she who alleges/asserts, as in this case, must prove. Some seventy-two years ago, and in *Pillay v Krishna and Another* 1946 (A) 946, the Court said, *inter alia*, that:

“Commenting on this passage Solomon CJ, said in Spain’s case, at p 79: ... In this statement of the law by Kotze JP, the Natal Provincial Division in its judgment in this case concurred, and I think we should also accept it, except in so far as it refers to the onus being placed on the defendant. For the onus to prove his case always lies on the plaintiff: if, in the circumstances stated by Kotze JP, no evidence is given by the defendant, provisional sentence will be granted: on the other hand, if evidence is called by the defendant, it will be for the Court to determine whether, in the circumstances, a sufficiently clear case has been made out by the plaintiff to justify the granting of provisional sentence.”

See also *Webster v Mitchell* 1948 (1) SA 1186? (W) in regard to the incidence of a *prima facie* case and the balance of probabilities in the case of temporary interdicts. In the instant matter, unlike than in the *Pillay v Krishna and Another* case, *supra*, it is common cause that the defendant proffered no oral evidence, and therefore there are no opposing versions. This makes the approach or technique in resolving two mutually irreconcilable contended for by the plaintiff in *Stellenbosch Farmers’ Winery Group Ltd and Another v*

Martell Et Cie and Others 2003 (1) SA 11 (SCA) at paragraph [5], not strictly applicable, although the principles therein enunciated remain instructive.

EVALUATION OF THE PLAINTIFF'S EVIDENCE

[30] In the instant matter, the only criticism levelled against the evidence of the plaintiff, in both cross-examination, and in the defendant's heads of argument, and indeed, worthy of consideration, was the following: whilst in evidence-in-chief, the plaintiff provided full details of the exact or approximate times of the incidents of the fateful day i.e. 17 May 2010, she however, did not do so in the previous affidavit in support of condonation as mentioned above. In this regard, the plaintiff, in cross-examination, was confronted with the contents of the said affidavit which she deposed to in December 2007 in support of the condonation mentioned under the Institution of Legal Proceedings Act.

[31] In that condonation affidavit, the plaintiff did not specify times of the occurrences on 17 May 2010, as opposed to the detailed times in her oral evidence. It is my considered view that the criticism levelled against the plaintiff in this regard and in other respects, was not justified at all in the circumstances of this matter, for a number of reasons. For starters, and if I may borrow again from the guidelines in criminal proceedings, not all contradictions affect a witness's credibility. In *S v Mkhle* 1990 (1) SACR 95 (A) at 98e-g, Nestadt JA said:

“Contradictions per se do not lead to the rejection of a witness’s evidence. As Nicholas J, as he then was, observed in S v Oosthuizen 1982 (3) SA 571 (T) at 576B-C, they may simply be indicative of an error. And (at 576G-H) it is stated that not every error made by a witness affects his credibility; in each case the trier of fact has to make an evaluation; taking into account such matters as the nature of the contradictions, their number and importance, and their bearing on other parts of the witness’s evidence.”

In applying these principles to the facts of the instant matter, it is clear that there were no material and/or internal contradictions in her evidence. Secondly, the purposes and processes in condonation applications, especially under the Institution of Legal Proceedings Act, are different from those in a civil trial. Thirdly, there was nothing inherently improbable about the plaintiff’s version as a whole. The plaintiff, a layperson in both medicine and the law, and clearly unsophisticated, tried as best as she could to relate what happened to her even at the risk of breaking down emotionally in the witness stand. Other than suggesting that the plaintiff was fabricating her evidence, there was no other specific version put to her in cross-examination to show the contrary. In *President of the RSA v South African Rugby Football Union* 2000 (1) SA 1 (CC) at paragraph [61] the Court said:

“The institution of cross-examination not only constitutes a right, it also imposes certain obligations. As a general rule it is essential, when it is intended to suggest that a witness is not speaking the truth on a particular point, to direct the witness’s attention to the fact by questions put in cross-examination showing that the imputation is intended to be made and to afford the witness an opportunity, while still in the witness box, of giving any explanation open to the witness and of defending his or her character ...”

Lastly, on this aspect, the plaintiff’s version of what occurred on 17 May 2010, was not countered by any other evidence, and stood as the only version. The

alleged contradiction or contradictions do not affect the core version of the plaintiff.

[32] In rendering her version, the plaintiff impressed as a truthful, credible and reliable witness throughout. It was her first pregnancy at the age of about 21. She merely became a victim of unexpected circumstances over which she had no control at all.

[33] In addition to the above, the plaintiff's version was corroborated extensively by the expert opinion of Dr Murray over and above the contents of Dr Murray's joint minute with her counterpart, Dr Koll. Such portions of Dr Murray's evidence also remained unchallenged.

THE CORROBORATION OF PLAINTIFF'S EVIDENCE

[34] A few examples only of the corroboration will suffice. The plaintiff's evidence in regard to the issuing to her of the green antenatal card, as well as its purpose, by the clinic, was objectively confirmed by the evidence of Dr Murray; the evidence of the plaintiff about her visits to a private medical practitioner, Dr Kazadi, was confirmed by the print-out of the ultra-sound sonar. That was prior to 17 May 2010; the plaintiff's evidence that a midwife placed a black belt horizontally across her stomach which was attached to a screen, was confirmed by the evidence of Dr Murray, and that this is a

reference to a CTG-machine that is to monitor the foetal heart-rate; the plaintiff's evidence regarding the presence of "*number 2*" on examination at the clinic, following a vaginal examination, was confirmed by the evidence of Dr Murray that this refers to the presence of meconium (the first stools of a new born baby); the plaintiff's evidence that the midwife appeared "*shocked*" when she observed the meconium, was confirmed by Dr Murray to the effect that thick meconium is associated with the foetal distress; the evidence of the plaintiff that the second assessment occurred about 19h00 (17 May 2010), was confirmed objectively by the fact that this assessment, resulting in the urgent summoning of the ambulance, as well as the unchallenged evidence that the travel distance between the clinic, and the hospital, was about a 20 to 25 minutes' drive, occurred prior to her documented arrival time at the hospital at 19h45, the evidence of the plaintiff that she was asked on arrival at the hospital to first visit the toilet to urinate because she was "*full*" with water, was confirmed objectively by the evidence of Dr Murray that such is standard practice where a patient was on a drip since the baby cannot be delivered if the mother's bladder is full; the plaintiff evidence that a "*razor*" was used to "*cut her vagina*" was confirmed by Dr Murray who testified that there is indeed such a medical procedure, namely an episiotomy (a surgical cut made at the opening of the vagina during child birth); the plaintiff's evidence that her baby, Luynda, was "*green with number 2*", when he was shown to her, and that he was not crying after birth, was again confirmed by the entries recorded in a "*Progress Note*", at 21h45 on 17 May 2010.

[35] In my view there are other features of the plaintiff's uncontroverted evidence which show aggravating and humiliating conduct on the part of the nursing staff, at both the clinic and later at the hospital. I refer here to the evidence that the nursing staff when asked for assistance, repeatedly told the plaintiff that "*the baby was far*"; that the plaintiff should desist from making noise; and that the nursing staff were engaged in watching a television episode, "*Rhythm City*", instead of carefully monitoring the pregnancy. The high-water mark of the unacceptable and unprofessional conduct came when the nursing staff at the clinic, suddenly and after extended visit by the plaintiff, told her that she should not have her baby delivered there due to the lack of unexplained equipment. The trauma for the plaintiff did not end there. At the hospital, and following a discussion between the midwives, and after delivery of the baby through the vagina, the plaintiff was told that her baby had died, when this was not the case. Indeed, Dr Murray testified regarding the "*perinatal death data sheet*", that the sheet is completed only in the event of foetal or neonatal death, and that someone commenced to fill in the sheet, but did not complete it, almost as if the author initially presumed that the baby had died. To make it worse for the plaintiff, upon the discharge of her baby, L, she was told that L was going to be "*different*", and that the cause thereof was that L did not receive sufficient oxygen to the brain when he was born. The latter fact was confirmed objectively by the expert evidence regarding the mechanism of the baby's injury, namely an hypoxic-ischemic brain injury. Indeed, there are numerous instances where the evidence of the plaintiff was corroborated fully by the evidence of Dr Murray. It is concerning to me that the diagnosis, treatment, assessment and monitoring the progress of the

plaintiff's pregnancy until delivery, was substandard, and plainly in violation of her constitutional rights, notably, the right to dignity (section 10 of the Constitution), and the right to health care (section 27 of the Constitution) etc.

THE ABSENCE OF HOSPITAL RECORDS

[36] Prior to concluding on the disputed issue namely, whether the evidence of the plaintiff was acceptable and satisfactory to establish any negligence on the part of the medical staff of the defendant, I must first deal with one other issue forming the series of undesirable conduct on the part of the defendant's staff members. That is the absence of the relevant and applicable medical/hospital records of the plaintiff's pregnancy and the later delivery of her baby, L, at both the institutions involved here.

[37] It can hardly be in dispute that such records are crucial and completely indispensable in the adjudication of cases such as the instant one. This deficiency of necessity results in certain consequences. I can put it no higher. In this regard, certain provisions of the National Health Act 51 of 2003 (*"the Health Act"*) are rather instructive. To start with, the purpose of the Health Act provides, *inter alia*, that it is:

"To provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services ..."

The preamble provides amongst others, that:

“The State must, in compliance with section 7(2) of the Constitution, respect, protect, promote and fulfil the rights enshrined in the Bill of Rights, which is a cornerstone of democracy in South Africa; in terms of section 27(2) of the Constitution the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to have access to health care services, including reproductive health care; section 27(3) of the Constitution provides that no one may be refused emergency medical treatment; in terms of section 28(1)(c) of the Constitution, every child has the right to basic health care services; and, in terms of section 24(a) of the Constitution, everyone has the right to an environment that is not harmful to their health or well-being.”

[38] More pertinent to the instant matter, are the provisions of sections 13 and 17(1) of the Health Act. The former provides that:

“Subject to National Archives of South Africa Act 1996 (Act 43 of 1996), and the Promotion of Access to Information Act (2 of 2000), the person in charge of a health establishment must ensure that the health record containing such information as may be prescribed is created and maintained at that health establish for every user of health services.”

On the other hand, section 17(1) of the Health Act provides that the person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorised access to those records and the storage facility in which, or system by which, records are kept (emphasis added).

[39] There can be no doubt that, when regard is had to section 1 of the Health Act, namely the definitions clause, that: the Mohlakeng Clinic and the Leratong Hospital fall within the purview of health establishments; that they

render health services; and that the plaintiff in this case was a user of the health services at the relevant time.

[40] From the above provisions, it is more than plain that: the defendant and its employees at both the clinic and the hospital (doctors, midwives, nurses, registrars and interns) not only had the duty to ensure that the plaintiff received proper medical treatment, but also thereafter to create, maintain, keep and store her medical records. The records are crucial documents, and the absence thereof invariably make the adjudication of ensuing litigation extremely difficult, as occurred in this matter. The defendant and its employees had both a constitutional and statutory obligation to, and must have made and kept meticulous clinical and hospital notes and records relating to the plaintiff's treatment. The applicable provisions of the Health Act are peremptory. In addition, the above provisions also make it clear that not only must medical records be kept, but also that adequate controls of access thereto must be put in place. It is equally apparent that the Legislature has taken a very serious view of the failure to keep patients' medical records, as well as on the disappearance, falsification or tempering with such records. See in this regard *Khoza v MEC for Health and Social Development, Gauteng* [2015] 2 All SA 598 (GSJ) at paragraph [35], and *Ntsele v MEC for Health, Gauteng Provincial Government* [2013] 2 All SA 356 (GSJ).

[41] In regard to medical doctors specifically, they require registration with the Health Professions Council of South Africa ("HPCSA"), which was established by the Health Professions Act 56 of 1974, as amended. It is

interesting that medical practitioners are obliged to keep patients' medical records in terms of the Health Professions Council's Ethical Professional Guidelines. Clause 9 of the Guidelines (updated up to September 2016), provides, *inter alia*, that:

“Health records should be stored in a safe place and if they are in electronic format, safeguarded by passwords. Practitioners should satisfy themselves that they understand the HPSA’s guidelines with regard to the retention of patient records on computer compact discs. Health records should be stored for a period of not less than six (6) years as from the date they became dormant. In the case of minors and those patients who are mentally incompetent, health care practitioners should keep the records for a longer period. For minors under the age of 18 years health records should be kept until the minor’s 21st birthday because legally minors have up to three years after they reach the age of 18 years to bring a claim. This would apply equally for obstetric records ... Notwithstanding the provisions ... above, the health records kept in a provincial hospital or clinic shall only be destroyed if such destruction is authorised by the Deputy Director-General concerned ...”

[42] The above Guidelines of the HPCSA for medical practitioners are equally instructive for purposes of the instant matter. The Guidelines apply additionally to the medical doctor who treated the plaintiff and the plaintiff's baby at the Leratong Hospital on 17 May 2010. The guidelines also emphasise the importance and crucial nature of patients' records, in particular in the case of minor children, such as occurred in the present matter. In the case of the midwives and nursing staff who attended to the plaintiff, their conduct would additionally be subject to the Guide for Maternity Care in South Africa, and the Rules of the South African Nursing Council issued under the Nursing Act 50 of 1978. (See in this regard *N N and Member of the Executive Council for Health, Eastern Cape* (unreported case no 2571/2013).) Indeed,

several of the expert witnesses involved in this matter have expressed utter frustration of not having available the hospital records, and therefore not being able to assist the court. In my view, the frustration was well-grounded, particularly where no acceptable and plausible explanation was advanced for the absence of such records.

CONCLUSION

[43] I must conclude on the issue for determination before me. In paragraph nine (9) of the plaintiff's written heads of argument, it is submitted that:

"The court is not called upon to make any findings in respect of negligence and causation." (cf defendant's heads of argument)

Having reviewed the entire matter now, I do not agree entirely. I need to say more, which I do immediately hereunder.

[44] I have already dealt with, and evaluated the evidence of the plaintiff. I accepted her evidence, which was corroborated sufficiently, as satisfactory in all material respects. It was uncontroverted. The evidence, without the necessity of drawing any adverse inferences against the defendant, or even applying the *maxim res ipsa loquitor*, established a rather strong *prima facie* case of negligence on the part of the employees of the defendant at both the clinic and at the hospital, for a number of reasons. See in this regard *Goliath v MEC for Health, Eastern Cape* 2011 (2) SA 97 (SCA) [10]. The evidence of the plaintiff as assessed in totality, and objectively, also proved that the

negligence caused the insult and injury which occurred to the plaintiff's baby on 17 May 2010.

[45] The classical case in which the test for negligence for liability was articulated, as pointed out in the defendant's heads of argument, is *Kruger v Coetzee* 1966 (2) SA 428 (A). At page 430E, the Court in that case said:

"For the purposes of liability culpa arises if –

(a) a diligence 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."

There is also no doubt that the plaintiff bears the *onus* to prove negligence on a balance of probabilities, as was enunciated in, *inter alia*, *Monteoli v Woolworths (Pty) Ltd* 2000 (4) SA 735 (W) at paragraphs [25] to [29], where it was said, *inter alia*, that the *onus* of proving negligence on a balance of probabilities rests with the plaintiff, that sometimes, however, a plaintiff is not in a position to produce evidence on a particular aspect, that less evidence will suffice to establish a *prima facie* case where the matter is peculiarly in the knowledge of the defendant, and that in such situations, the law places an evidentiary burden upon the defendant to show what steps were taken to comply with the standards to be expected, and finally, that the *onus* nevertheless remains with the plaintiff. See also *Minister of Safety and Security v Mhofe* [2007] 4 All SA 697 (SCA) at paragraph [9].

[46] In regard to causation, in *Minister of Safety and Security and Another v Carmichele* 2004 (3) SA (SCA), the Court at paragraph [55] said:

“Causation has two elements. The first is that the factual issue which has to be established on a balance of probabilities by a plaintiff ... and the answer has to be sought by using the ‘but-for-test’ ...:

‘In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful and posing of the question as to whether upon such an hypothesis plaintiff’s loss would have ensued or not. If it would in any event have ensued, the wrongful conduct was not a cause of the plaintiff’s loss; aliter, if it would not so have ensued.’”

See also paragraph [72] of the same judgment, and *Sonny and Another v Premier, Province of KwaZulu-Natal and Another* [2010] 1 All SA 169 (KZP).

[47] I have already found earlier in the judgment that the plaintiff has succeeded, on a balance of probabilities, to prove negligence on the part of the defendant’s employees. To emphasise, the negligence is based on, *inter alia*, the fact that: the plaintiff’s pregnancy was plainly not adequately assessed, monitored and treated timeously at both the clinic and the hospital; the plaintiff suffered hours of labour in circumstances where a caesarean section delivery was indicated; the nursing sisters at both the clinic and the hospital rendered medical care, midwifery treatment and monitoring to the plaintiff and the foetus in respect of her labour and delivery of her baby, L, in a negligent, and non-caring manner, and in breach of their duty of care owed to the plaintiff. The negligence described, was causatively related to the birth of the child, L, by vagina, which resulted in the injury, as set out in the particulars

of claim. The defendant must be held liable for the plaintiff's proven or agreed damages.

COSTS

[48] I deal briefly with the issue of costs, which is a discretionary matter. The costs should follow the result. No credible reason has been advanced why this should not be the case. In fact, whilst preparing the judgment, I developed a rather strong inclination to award costs on a punitive scale. This, largely due to the manner in which the defendant's case was presented, and the humiliation and pain and shock which must have been inflicted on the plaintiff, particularly when she was informed that her baby had died, when it was not so. She was also told in unspecified terms that her baby, L, would be "*different*". I have, however, decided against my costs inclination.

ORDER

[49] In the result the following order is made:

1. The defendant shall pay 100% (one hundred percent) of the plaintiff's agreed or proven damages in her representative capacity for and on behalf of her minor child, L M ("L"), which damages flow from the neurological injury sustained by L during labour and delivery at the Mohlakeng Clinic and Leratong

Hospital on or about 17 May 2010 and the resultant cerebral palsy (and is *sequelae*) which he suffers from.

2. The defendant shall pay the plaintiff's taxed or agreed party and party costs of suit on the High Court scale, such costs to include (but not necessarily be limited to) the following:

- 2.1 the costs attendant upon the obtaining of the medico-legal reports and/or addendum reports and/or joint minutes, if any, of the following expert witnesses:

- 2.1.1 Professor Smith (Neonatologist);

- 2.1.2 Dr Murray-Vollmer (Obstetrician and Gynaecologist);

- 2.1.3 Professor Lotz (Radiologist);

- 2.1.4 Dr Pearce (Paediatric Neurologist); and

- 2.1.5 Burger Radiologists (MRI scan on 10 February 2014).

- 2.2 the qualifying and appearance fees and preparation costs in respect of Dr Murray;
 - 2.3 the reasonable and necessary air transport and accommodation costs and expenses in respect of Dr Murray; and
 - 2.4 the reasonable fees of counsel in respect of the preparation of heads of argument.
3. The defendant shall pay interest on the plaintiff's taxed or agreed costs of suit at the prescribed statutory rate calculated from 31 (thirty one) days after agreement in respect thereof, or from the date of affixing of the taxing master's allocatur, to date of payment.

D S S MOSHIDI
JUDGE OF THE HIGH COURT
GAUTENG LOCAL DIVISION, JOHANNESBURG

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INSTRUCTED BY	THE STATE ATTORNEY
DATE OF HEARING	8 FEBRUARY 2018
DATE OF JUDGMENT	20 April 2018