

**IN THE HIGH COURT OF SOUTH AFRICA
KWAZULU-NATAL LOCAL DIVISION, DURBAN**

CASE NO. D7918/2015

In the matter between:

K[....]

PLAINTIFF

and

**THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH FOR THE PROVINCE OF KZN**

DEFENDANT

ORDER

The following order shall issue:

1. The plaintiff's claim is dismissed.
2. There is no order as to costs.

JUDGMENT

Steyn J:

[1] '[T]he interaction between the law and medicine can, and usually does, present complex challenges, particularly where, as here, a minor suffers a hypoxic ischaemic (HI) event during the birth process.'¹

The aforesaid statement by Ponnann JA, writing for the majority in *M v MEC for Health*² is also true in the present matter.

¹ *M. v MEC for Health, Eastern Cape* (699/17) [2018] ZASCA 141 (1 October 2018), para 45.

² *Ibid.*

[2] In this action, the plaintiff, a 35-year-old adult female, seeks compensation for damages in the amount of R14 010 000 in her personal capacity, and as mother and legal guardian of her minor daughter, E. The plaintiff gave birth to E on 20 July 2011 at the Lower Umfolozi District War Memorial Hospital (the hospital), a State hospital in KwaZulu-Natal.

[3] The defendant is the Member of the Executive Council for the Department of Health, KwaZulu-Natal, and is sued in her nominal capacity as the political head of the KwaZulu-Natal Department of Health as envisaged in the State Liability Act 20 of 1957, it being vicariously responsible for the delictual actions and commissions committed in health centres under its care.

[4] At the onset of the trial it was confirmed that the merits of the matter had been separated from the quantum in terms of Uniform rule 33(4) and, that the matter was proceeding only on the issue of liability.

The particulars of claim

[5] The plaintiff alleges in her particulars of claim that the employees of the defendant were negligent in one or more of the following aspects on 19 and 20 July 2011, in that they:

- (a) Failed to monitor and properly record the progress of her labour having regard to the presenting complications.
- (b) Failed to react to the presenting complications, which were indicative of foetal distress with the reasonable possibility of permanent damage to E.
- (c) Failed to take due cognisance that the plaintiff's excessively prolonged labour created the reasonable possibility of permanent damage to E.
- (d) Failed to keep proper records, which would have alerted them to the complications that were presenting.
- (e) Failed to take steps to deliver E by emergency caesarean section timeously, when this was reasonably necessary and medically appropriate in the circumstances.
- (f) Failed to obtain the assistance of suitably qualified medical practitioners to attend to the delivery and pre and post-natal care of E.
- (g) Failed to take steps to expedite the labour, which was progressing slowly.

- (h) Failed to report the poor progress of labour to the on-duty obstetric medical officer.
- (i) Failed to adequately plot the partogram, which would have alerted them to the arising complications and subsequent danger to the foetus.
- (j) Failed to adequately monitor the foetus during the labour, especially during the second stage of labour.
- (k) Failed to investigate and identify the cause of delay of the first stage of labour and enact appropriate intervention.

[6] It has also been averred that as a direct consequence of the alleged negligence of the said employees of the defendant, E suffered severe hypoxia and was born with hypoxic ischaemic encephalopathy (HIE), which leaves her with permanent impairment.

[7] The defendant denies the averments made by the plaintiff.

Common cause facts

[8] The broadly common cause facts in this matter are:

- (a) The plaintiff was admitted to the hospital on 19 July 2011 at 14h00 at which time she was 2 cms dilated.
- (b) At all relevant times the medical staff involved in the treatment of the plaintiff at the hospital were employed by the defendant and acted within the course and scope of their employment.
- (c) At 19h00 on 19 July 2011, the plaintiff was 3 cms dilated.
- (d) According to the partogram, at 22h00 on 19 July 2011, she was 4 cms dilated.
- (e) At 24h00 the cervical dilation was 8 cms.
- (f) At 03h30 on 20 July 2011, she was dilated between 9-10 cms.
- (g) At 05h35 on 20 July 2011, her baby, E, was delivered by vacuum extraction.
- (h) The plaintiff, who was a primigravida,³ delivered at term,⁴ a female baby, E, weighing 3520 grams; measuring 52 cms in length and had a head circumference of 38 cms.
- (i) E suffers from cerebral palsy.

³ A woman who had no previous deliveries.

⁴ That is, a fully developed pregnancy.

[9] Important factually is to determine whether the doctors and nurses that treated the plaintiff during the labour process adhered to the level of skill and diligence that should have been exercised by them in their professions⁵ or whether they were negligent. Any negligence should be causally connected to the harm suffered.

Legal principles

[10] It is trite that a plaintiff, in a case such as this, has to prove on a balance of probabilities that the conduct complained of caused the harm in respect of the compensation sought. As stated in *Lee v Minster for Correctional Services*:⁶

‘There can be no liability if it is not proved, on a balance of probabilities, that the conduct of the defendant caused the harm. This is so because the net of liability will be cast too wide.’⁷ (Original footnote omitted.)

[11] It remains the duty of the plaintiff to prove on a balance of probabilities that the conduct complained of, caused the harm.⁸ Most recently, the Supreme Court of Appeal (SCA) in *The Member of the Executive Council, Department of Health, North West v NAM obo TN*,⁹ a cerebral palsy case, re-affirmed the evidential rule as follows:

‘The general rule is that he or she who asserts must prove. Thus, in a case such as this the plaintiff must prove that the damage sustained by her minor child was caused by the defendant’s clinic staff’s negligence. The failure of a professional person to adhere to the general level of skill and diligence possessed and exercised at the same time by the members of the branch of the profession to which he or she belongs would normally constitute negligence. 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 or she is bound to employ reasonable skill and care.”’¹⁰ (Original footnotes omitted, my emphasis.)

⁵ See *Van Wyk v Lewis* 1924 AD 438 at 444.

⁶ *Lee v Minster for Correctional Services* 2013 (2) SA 144 (CC).

⁷ *Ibid* para 39.

⁸ *M. v MEC for Health*, *supra*, note 1, para 65.

⁹ *The Member of the Executive Council, Department of Health, North West v NAM obo TN* (035/2020) [2021] ZASCA 105 (26 July 2021).

¹⁰ *Ibid* para 20.

[12] The SCA in the majority judgment in *HAL obo MML v MEC for Health, Free State*¹¹ confirmed that the maxim *res ipsa loquitur* should rarely find application in cases based on alleged medical negligence. It held:

‘[81] The application of the *res ipsa loquitur* maxim is not appropriate in this case. There is no evidence of what caused the child’s brain injury and when it occurred. In *Van Wyk v Lewis* this Court cautioned that the maxim should rarely, if ever, find application in cases based on alleged medical negligence, where it has not been established what went wrong, and where the views of experts are all based on speculation – giving rise to various but equally feasible possibilities – as to what might have resulted in the injury being sustained. This is such a case.

[82] The general rule is that he who asserts must prove. As Innes CJ explained in *Van Wyk v Lewis*, the question of onus is of capital importance. A plaintiff who relies on negligence must establish it. If at the conclusion of the case the evidence is evenly balanced, a plaintiff cannot claim a verdict; for he or she will not have discharged the onus resting upon him or her. While true that an intrapartum injury cannot be excluded in this case, both antenatal and postnatal injuries cannot be excluded either. Nor is any one of them more probable than any other. As such, an intrapartum injury is not the most plausible inference to be drawn from the proven facts.’ (Original footnotes omitted.)

[13] Essentially, the plaintiff avers that E’s birth was mismanaged and that the mismanagement lead to E’s cerebral palsy. In determining the cause of E’s cerebral palsy or what contributed to it, the standard of proof is one on a balance of probability.¹²

Opinion Evidence

[14] Since both parties relied mostly on expert testimony, it is important to consider the approach that should be adopted by a court where the opinions expressed by

¹¹ *HAL obo MML v MEC for Health, Free State* (Case no 1021/2019) [2021] ZASCA 149 (22 October 2021).

¹² In *Miller v Minister of Pensions* [1947] 2 All ER 372 (KB) at 374A-B, Lord Denning analysed the distinction between succeeding on a balance of probabilities and failing on a balance of probabilities as follows: ‘If the evidence is such that the tribunal can say: “We think it more probable than not,” the burden is discharged, but, if the probabilities are equal, it is not.’

experts are considered. In *Michael & another v Linksfeld Park Clinic (Pty) Ltd & another*¹³ it was held:

[36] That being so, what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL (E)). With the relevant *dicta* in the speech of Lord Browne-Wilkinson we respectfully agree. Summarised, they are to the following effect.

[37] The Court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The Court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached “a defensible conclusion” (at 241G - 242B).

[38] If a body of professional opinion overlooks an obvious risk which could have been guarded against it will not be reasonable, even if almost universally held (at 242H).

[39] . . .

[40] . . . This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of *Dingley v The Chief Constable, Strathclyde Police* 200 SC (HL) 77 and the warning given at 89D - E that

“(o)ne cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a Judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or

¹³ *Michael & another v Linksfeld Park Clinic (Pty) Ltd & another* 2001 (3) SA 1188 (SCA).

disproved - instead of assessing, as a Judge must do, where the balance of probabilities lies on a review of the whole of the evidence".¹⁴ (My emphasis.)

[15] It is well established that what is expected of a medical practitioner is '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'.¹⁵

[16] The evaluation of expert testimony was highlighted by the majority of the SCA in *BEE v Road Accident Fund*¹⁶ as follows:

'My colleague has cited a number of local and foreign cases dealing with the assessment of contested expert testimony. I agree that in such cases a court must determine whether the factual basis of a particular opinion, if in dispute, has been proved and must have regard to the cogency of the expert's process of reasoning. Matters are quite different, in my respectful opinion, where experts in the same field reach agreement. In such a case, as I have said, a litigant cannot be expected to adduce evidence on the agreed matters. Unless the trial court itself were for any reason dissatisfied with the agreement and alerted the parties to the need to adduce evidence on the agreed material, the trial court would, I think, be bound, and certainly entitled, to accept the matters agreed by the experts. In the present case the trial court did not require the parties to lead further evidence on the matters on which the experts agreed. The trial court was perfectly entitled to act as it did. In *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingsbekämpfung mbH* 1976 (3) SA 352 (A) Wessels JA foreshadowed that an expert's bald opinion, if uncontroverted, might carry weight (371G). All the more so, where experts for the opposing parties share the same opinion.'¹⁷ (My emphasis.)

[17] In *Bolitho v City and Hackney Health Authority*,¹⁸ Lord Browne-Wilkinson stated the following with regard to expert evidence:

'[I]n my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number

¹⁴ Ibid paras 36, 37, 39 and 40.

¹⁵ *Van Wyk v Lewis* supra note 5, at 444 (my emphasis).

¹⁶ *BEE v Road Accident Fund* 2018 (4) SA 366 (SCA).

¹⁷ Ibid para 73.

¹⁸ *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL).

of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a "*responsible* body of medical men." Later, at p. 588, he referred to "a standard of practice recognised as proper by a competent *reasonable* body of opinion." Again, in the passage which I have cited from *Maynard's* case [1984] 1 W.L.R. 634, 639, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives—responsible, reasonable and respectable—all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.'¹⁹ (My emphasis.)

[18] In *Pricewaterhousecoopers Inc v National Potato Co-Operative Ltd*,²⁰ the SCA examined when expert opinion would be admissible and held as follows:

'Opinion evidence is admissible "when the Court can receive 'appreciable help' from that witness on the particular issue". That will be when:

" . . .by reason of their special knowledge and skill, they are better qualified to draw inferences than the trier of fact. There are some subjects upon which the court is usually quite incapable of forming an opinion unassisted, and others upon which it could come to some sort of independent conclusion, but the help of an expert would be useful."

As to the nature of an expert's opinion, in the same case, Wessels JA said:

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

¹⁹ Ibid at 241G-242B.

²⁰ *Pricewaterhousecoopers Inc v National Potato Co-Operative Ltd* 2015 JDR 0371 (SCA).

conclusion, including the premises from which the reasoning proceeds, are disclosed by the expert.”²¹ (Original footnotes omitted, my emphasis.)

[19] In *AM & another v MEC for Health, Western Cape*²² the functions of an expert witness were defined by Wallis JA as follows:

‘Something needs to be said about the role of expert witnesses and the expert evidence in this case. The functions of an expert witness are threefold. First, where they have themselves observed relevant facts that evidence will be evidence of fact and admissible as such. Second, they provide the court with abstract or general knowledge concerning their discipline that is necessary to enable the court to understand the issues arising in the litigation. This includes evidence of the current state of knowledge and generally accepted practice in the field in question. Although such evidence can only be given by an expert qualified in the relevant field, it remains, at the end of the day, essentially evidence of fact on which the court will have to make factual findings. It is necessary to enable the court to assess the validity of opinions that they express. Third, they give evidence concerning their own inferences and opinions on the issues in the case and the grounds for drawing those inferences and expressing those conclusions.’²³ (Original footnotes omitted, my emphasis.)

Causation

[20] The SCA recently re-affirmed the principles relating to causation in *The Member of the Executive Council for Health, Eastern Cape v DL obo AL*²⁴ as:

‘The test for factual causation is whether the act or omission of the defendant has been proved to have caused or materially contributed to the harm suffered. Where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach is what caused the harm suffered. In the present matter, the question is whether the brain damaged sustained by AL would have been averted if the hospital staff had properly monitored the mother and foetus and had acted appropriately on the results? If so, factual causation is established. If

²¹ Ibid para 97.

²² *AM & another v MEC for Health, Western Cape* 2021 (3) SA 337 (SCA).

²³ Ibid para 17.

²⁴ *The Member of the Executive Council for Health, Eastern Cape v DL obo AL* (Case no 117/2020) [2021] ZASCA 68 (03 June 2021).

not, factual causation has not been established and one is left with only wrongful conduct without proof that it caused the harm suffered.'²⁵ (Original footnotes omitted, my emphasis.)

[21] The majority of the SCA in *AN obo EN v Member of the Executive Council for Health, Eastern Cape*²⁶ defined the test for factual causation as follows:

'The test for factual causation is whether the act or omission of the defendant has been proved to have caused or materially contributed to the harm suffered. Where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach is what caused the harm suffered.'²⁷ (My emphasis.)

Guidelines

[22] The plaintiff placed reliance on the provisions of the 2007 National Maternity Guidelines (Maternity Guidelines)²⁸ and reference will be made to these guidelines. The different phases of labour are very relevant to the plaintiff's case and, I therefore consider it necessary to list the phases in terms of the Maternity Guidelines applicable in South Africa. The first stage of labour consists of two phases - the latent phase during which cervical dilation is less or equal to 3 cms, whilst the active phase of the first stage is from 4 cms dilation until the cervix is fully dilated. The second stage is from full dilation until delivery. The third stage is from the delivery of the infant until the delivery of the placenta. It is with the aforesaid listed phases and stages in mind that the evidence will be examined and evaluated in accordance with the applicable legal principles.

Joint minutes prepared by the expert witnesses

[23] Before I summarise the evidence tendered during the trial, it is necessary to have regard to the content of the joint minutes filed by the expert witnesses. The content of the minutes delineates the issues which are common cause and highlights the issues in dispute between the parties.

²⁵ Ibid para 9.

²⁶ *AN obo EN v Member of Executive Council for Health, Eastern Cape* [2019] 4 All SA 1 (SCA).

²⁷ Ibid para 4.

²⁸ See The Department of Health Guidelines for Maternity Care in South Africa 3 ed (2007) and the discussion of labour at 34-55.

[24] The joint minute²⁹ of Dr D McLynn and Dr C Archer, the expert obstetricians and gynaecologists, confirms inter alia the following points of agreement:

- (a) The plaintiff should have been investigated and treated for a urinary infection on the basis of persistent leukocytosis.
- (b) E's birth weight was 3520 grams and the Apgar score following birth at one minute was 3/10, at five minutes was 3/10, and at ten minutes was 6/10 in the hospital documents.
- (c) E was diagnosed with birth asphyxia, HIE and seizures.
- (d) There is good evidence to support the existence of neonatal encephalopathy in the hours and days following birth.

[25] Dr McLynn and Dr Archer complied and finalised their minute on 3 June 2019. The date becomes important in light of the fact that no cardiotocographs (CTGs) were available for inspection when the minute was compiled. The defendant produced the CGTs at the trial. I shall return to the issue of the CGTs later in this judgment.

[26] The experts disagree on the fact that the labour process was prolonged.

(a) Dr Archer, for the defendant, noted that:

‘ . . . the Plaintiff was a primigravida who was admitted in the latent phase of labour. At 22h00 her cervix was 4 cm dilated which meant she was in the active phase of the first stage of labour. Two hours later at midnight she was 8 cm dilated with bulging membranes. At 03h00 she was still 8 cm dilated which means that she had crossed the alert line. The Dr was notified which was the correct response. At 03h30 she was assessed by the doctor. The cervix was now 9-10 cm dilated (still between the alert and action lines). At 04h30 she was fully dilated. The action line had still not been reached and labour was progressing. At 04h40 the CTG was reactive. The decision to intervene by assisted vaginal delivery was made one hour into the second stage and the child was delivered at 05h35.

²⁹ See joint minute between Dr D.M. McLynn and Dr C. Archer – Expert Obstetricians and Gynaecologists, Bundle A at 11-14.

SA Maternity Guidelines³⁰ allow one hour for descent of the presenting part (assuming no fetal distress) from the start of the second stage and a further 40 minutes of pushing in the case of a primigravida, and twenty minutes in a multigravida. The delivery in this case was completed within one hour and five minutes of the commencement of the second stage of labour (before the action line intersected with the 10 cm dilation horizontal line).'³¹

(b) Dr McLynn, for the plaintiff, disagrees with the aforesaid opinion on the following bases:

'a] the partogram had been incorrectly drawn up;

b] at 0000 the alert line had been reached and the action line well crossed at 0300; the [Obstetric Medical Officer] OMO should have been alerted at 0000; OMO attended to the patient at 0430 some 1 hour and 30 minutes later according to the records;

c] there are two corrections on the MOH partogram at 6cms and 8 cms; see crossed out X markers.

d] the dilation of the cervix at 04h30 is recorded as 9cms not fully dilated;'³²

[27] Dr Archer is of the view that the area where criticism could be raised is after 04h40 when the CTG was reactive. Thereafter, there was no evidence of continuous monitoring. The decision to intervene was however made one hour into the second stage, and 50 minutes after the CTG had revealed a reactive trace indicating a healthy fetus. He agrees with Dr L Govender, a qualified obstetrician and gynaecologist employed at the hospital as Head of Obstetrics, that had monitoring revealed foetal distress at that point, the correct decision would have been to expedite the delivery, which the doctor on duty did by applying a vacuum extraction.

[28] Dr Archer opined that 'the evidence for the timing of the HI injury points to the intrapartum period, but evidence that this was the result of negligence is lacking'.³³

³⁰ See Exh F, The Department of Health Guidelines for Maternity Care in South Africa 3 ed (2007).

³¹ Joint minute between Dr D.M. McLynn and Dr C. Archer – Expert Obstetricians and Gynaecologists, Bundle A at 11-12.

³² Ibid at 12.

³³ Ibid at 13.

Dr McLynn disagreed and stated that the labour was poorly managed basing his view on an inspection of the medical records.

[29] Dr Archer stated that the presence of neonatal encephalopathy suggests that the timing of the HI injury was during the peripartum period (from 37 completed weeks of pregnancy to four weeks post-delivery), and that the evidence of a partial prolonged injury occurring intrapartum is lacking. In his view:

‘There is no compelling evidence up until 04h40 of a non-reassuring CTG trace which might have indicated a fetus in distress during labour so the partial prolonged injury pattern on MRI, which suggests an insult occurring over several hours must point to an injury that predated this admission, whereas the acute profound injury pattern is in keeping with a major insult that according to Janet Rennie and Lewis Rosenbloom and Joseph Pasternak and Michael Gory usually occurs towards the end of labour. It is impossible to know which injury caused the most damage in this case.

What is clear though is the acute profound injury could have happened whilst plans to perform the vacuum extraction were being made, and which therefore could have been neither anticipated nor prevented.³⁴ (Original footnotes omitted, my emphasis.)

[30] He relied on the following references:

‘Ref: 1 *Review: How long have we got to get the baby out? A review of the effects of acute and profound intrapartum hypoxia and ischaemia. Janet Rennie and Lewis Rosenbloom. The obstetrician & Gynaecologist 2011:13.169-174*

2 *The Syndrome of Acute Near-Total Intrauterine Asphyxia in the Term Infant. Joseph F Pasternak and Michael T. Gory. Pediatr Neurol 1998; 18: 391-398.*³⁵

[31] Dr Archer further stated that from a:

‘. . . liability perspective, an injury that occurred during the antepartum period should not be considered the result of negligence, and likewise an HI injury resulting in an acute profound pattern sustained very late in labour, would on the balance of

³⁴ Ibid.

³⁵ Ibid.

probability have occurred so late and with such impact as to be rendered unavoidable'.³⁶

[32] Dr McLynn disagrees with Dr Archer on the basis that some injuries will occur in the antepartum period devoid of liability and some will not. He also disagrees with Dr Archer's opinion in that the injury could have occurred at a very late stage and that it could not have been prevented. He never substantiated his opinion by referring to any authorities or data.

[33] I consider it is necessary to quote from the references relied on by Dr Archer in more detail. Dr Archer's opinion is supported by the authors Rennie and Rosenbloom³⁷ where they state:

'Acute profound or acute near-total brain injury

Evidence of the way that the mature human baby reacts to hypoxia combined with ischaemia has now accrued from relatively large numbers of MRIs from babies in the neonatal period and beyond. There are two basic patterns of damage seen as a result of intrapartum hypoxic ischaemia at term. The first pattern is usually termed acute profound damage. . .³⁸

The areas of the brain that were damaged after this catastrophic asphyxia insult included the basal ganglia and thalami together with the inferior colliculi. . .³⁹

Children with longer insults tended to have damage both to the deep grey matter and to the subcortical white matter. Barkovich's group in San Francisco have impressive experience of MRI, studying over 6000 cases of neonatal encephalopathy in term and near-term babies. Their carefully performed and sequential MRI studies, which include spectroscopy, were targeted at determining when the insult occurred, not how long it lasted. These interesting serial studies show that some babies probably

³⁶ Ibid.

³⁷ See J Rennie and L Rosenbloom 'How long have we got to get the baby out? A review of the effects of acute and profound intrapartum hypoxia and ischaemia' (2011) 13 *The Obstetrician & Gynaecologist* 169-174.

³⁸ Ibid at 170.

³⁹ Ibid at 171.

sustain their brain damage 2-3 days before birth but they do not shed much light on the duration of insult required to damage the neonatal brain. . .⁴⁰

While there is clear variability both in the fetal reserve and in the duration and degree of the insult, we are now of the opinion that the concept that damage begins to accrue after 10 minutes of an acute profound hypoxic ischaemic insult, originally constructed from the results of the work of Windle and Myers. . . .⁴¹

[34] The radiologists' joint minute,⁴² prepared by the expert radiologists Prof J Lotz and Dr D Reitz reflects that there is 'a mixed pattern of acute profound (central) and prolonged partial (peripheral) hypoxic ischaemic injury' as per the Magnetic Resonance Imaging (MRI) brain scan. The two experts also agree that the MRI findings suggests that inflammatory or infective causes are unlikely as causes of E's brain damage. Neither of the two experts were called by the parties.

[35] The expert paediatricians, Drs P Moodley and Y Kara, filed a joint minute⁴³ and agreed that E:

' . . . was delivered by vacuum extraction, was resuscitated at birth and there was evidence of a moderately severe encephalopathy after birth with convulsions. Head cooling was commenced. The admission diagnosis was HIE.'

They also agreed that there was no evidence of dysmorphism. They agreed that: '[t]he probable cause for the cerebral palsy is an intrapartum hypoxic ischemic injury noting poor progress in labour, vacuum extraction, resuscitation at birth, encephalopathy after birth, multiple organ injury, post natal microcephaly'.

[36] They disagreed on whether E had scoliosis and lumbar lordosis. Dr Kara opined that E did, and Dr Moodley opined that E had no scoliosis.

[37] From the contents of the joint minutes prepared by all of the experts it is evident:

⁴⁰ Original footnote omitted, Ibid at 173.

⁴¹ Ibid at 174.

⁴² See joint minute between Prof J.W. Lotz and Dr Reitz – Expert Radiologists, Bundle A at 7-8.

⁴³ See joint minute between Dr Kara and Dr Moodley – Expert Paediatricians, Bundle A at 3-4.

- (a) The pattern of E's injury is a mixed injury of acute profound and partial prolonged.
 - (b) The plaintiff's pregnancy was without major complications and she was managed as low risk.
- [38] What remained in dispute between the experts was:
- (a) Whether the plaintiff received sub-standard care during her labour process due to insufficient observations of the foetal or maternal condition, and more importantly, whether the care that was exercised was below the standard and norms prescribed and set out in the Maternity Guidelines. In issue is the factual cause of harm suffered by E and whether the defendant's employees failed to prevent the harm.
 - (b) The identification of the damage causing event, the timing of its occurrence, and whether it was accompanied by negligence on the part of the defendant's employees causally linked to the negligent conduct.

Evidence

[39] I shall now turn to the evidence adduced during the trial. The plaintiff testified and confirmed that her daughter, E, was born at the hospital on 20 July 2011. According to her, when she went to urinate at approximately 04h30 on 19 July 2011, she saw a reddish fluid and felt pains coming and going from her stomach to her back. She then decided to go to the clinic where she was transferred to the hospital to be attended to. She estimated that she arrived at the hospital at 14h30 and was examined by the nurses and a doctor. At about 20h00, she was taken from the maternity ward and placed in the labour ward where she was examined by a nurse who also put a CTG belt on her.

[40] It appears from the plaintiff's testimony that the belt was the CTG belt. The obstetricians' experts explained that the CTG monitoring is an electronic recording of the heartrate of the foetus. There is an audible noise of the foetal heart rate and the machine gives a printout, called a CTG trace, which is a graphical print of the results of the CTG monitor. The trace reflects the foetal heart rate and also the mother's uterine contractions.

[41] The plaintiff's evidence was that she was alone until midnight. A nurse then returned and said that she was not ready to give birth, so she gave her an injection⁴⁴ to sleep. In the early hours of the morning of 20 July 2011 the nurse came back accompanied by an doctor, who then attended to her.⁴⁵

[42] This doctor gave orders and asked that a machine be brought, which was then inserted in her and switched on. By the third time of using the machine, E was delivered. Before she even had a chance to see E, the nursing staff took E away to another part of the hospital. When the morning staff commenced their shift, she went to one of the nurses and asked whether she had given birth to a boy or girl. She was instructed to go and fetch her own file and bring it to the nurses. Hereafter, she was informed that E was a girl and that she was in the nursery. She was then taken to the post-natal ward without seeing E. Three weeks later, she and E were discharged from the hospital. For her six-month check-up, the plaintiff took E to the Ngwelezana Hospital where she was informed that E suffers from cerebral palsy

[43] The plaintiff's first expert, Dr McLynn, confirmed his report contained in Bundle B. He viewed the following two points as significant when the plaintiff was first examined, namely:

- (a) The urine blood.
- (b) That she was 2 cms dilated at 07h00 on 19 July 2011.

He, however, considered the start of the labour as 21h00 on 18 July 2011. This fact is not in accordance with the viva voce evidence of the plaintiff who stated that she went into labour at 04h30 on 19 July 2011. I shall return to the commencement of the labour later in this judgment.

[44] Dr McLynn opined that labour starts 'when the mother starts to attain or experience regular contractions, and that's associated with dilation of the cervix'. The fact that the foetal heart rate was 140/B/M was a reassuring sign to him, since it is the standard foetal heart rate of a mature baby. He disagreed with the diagnosis that the plaintiff was a 'low risk' patient. In his opinion, as a primigravida, she carried

⁴⁴ The medical records show that she received pethidine.

⁴⁵ None of the doctors or nursing staff that examined the plaintiff or attended to her during the labour process testified when the defendant called its witnesses.

increased risks over and above women who have babies for the second, third or fourth time.

[45] According to him, the Maternity Guidelines require the personnel overseeing a childbirth to examine the patient every four hours. The plaintiff, however, had not been examined in five hours at one stage of the labour. His evidence was that the plaintiff's dilation from 4 to 8 cms was rapid. He emphasised that the Maternity Guidelines define active labour to commence when there is a 4 cm dilation, whereafter the mother must be monitored two hourly.

[46] He opined that the partogram⁴⁶ appears to be suspicious as some information has been rubbed out. According to him, the partogram shows that the plaintiff progressed from 4 to 8 cms in a matter of two hours, which is unusual for a primigravida. E was born flat, which means that she was not breathing properly, and the Apgar score of 3 out of 10 is a very low score.

[47] According to his calculations the birth lasted 32 hours and 35 minutes, which exceeds the general time of ± 18 hours for a primigravida. In his view, it was a delayed - prolonged labour. Dr McLynn's calculation was, however, based on a clinical note and not on the plaintiff's factual evidence, which revealed that she commenced labour at 04h30 in the morning of 19 July 2011.⁴⁷ I shall return to this contradiction in the evaluation of the evidence.

[48] In cross-examination Dr McLynn was challenged on his opinion that the latent phase⁴⁸ was prolonged, especially since the defendant's expert is of the opinion that there was false labour. His response was that Dr Archer misinterpreted the hospital records. He was questioned on any suspicious manipulation of the partogram, especially where the entry of 6 cms was erased at 24h00 and marked as 8 cms. He

⁴⁶ See Exh E, the partogram of Mbali Khumalo.

⁴⁷ See transcript at 4 lines 4-6.

⁴⁸ The latent phase in terms of the Maternity Guidelines (supra note 27) at 36, requires the following routine monitoring:

- 'Blood pressure and pulse rate 4 hourly
- Temperature 4 hourly
- Uterine contractions 2 hourly
- Fetal heart rate 2 hourly
- Vaginal examination 4 hourly'.

contended that the erasure was unusual but not 'suspicious'. On further probing by counsel for the defendant regarding his ill-founded suspicion, his response was, 'I'm just saying that it is unusual and it's suspicious, ja.'⁴⁹

[49] He was asked to give his opinion on what he regarded as false labour. He responded that labour depends on two entities:

- (a) That there is a change in the texture of the cervix.
- (b) That the patient is having regular uterine contractions.

In his view, the fact that there was effacement and that the plaintiff was 2 cms dilated means that Dr Archer is wrong in stating that the plaintiff presented with false labour. It was put to Dr McLynn that his opinion 'that there was evidence of cephalopelvic disproportion and. . . caput moulding' was unfounded and speculative.⁵⁰ He conceded that it is speculative. Importantly, he agreed that the vacuum extraction in this case was an appropriate intervention by the medical staff, but that it was exercised at the wrong time.

[50] When questioned on the time that the injuries occurred, he opined, correctly in my view, that the radiologists are the best suited experts to express an opinion on the timing of the injuries. In his view, the limitations for an acute profound injury are 'somewhere in the region of about three to four hours, and the other is in the region of about 10 to 12 hours', but he agreed that he is no expert in the sub-speciality of radiology.⁵¹ When asked on whether an earlier intervention, like a caesarean section, would have prevented the injury to E, he stated that it would not have 'prevented' it, but would have been more beneficial. This concession by Dr McLynn is important since the plaintiff averred in the particulars of claim that the defendant was negligent, in that it failed to take steps to deliver E by emergency caesarean section. This averment was not supported by the evidence of the plaintiff's own expert.

[51] In his view, the standard labour ward obstetric practice would have mandated an identification of why the first stage of the labour was delayed. More so because

⁴⁹ See transcript at 67 lines 18-19.

⁵⁰ See transcript at 84 lines 11-15.

⁵¹ See transcript at 98 lines 21-22.

the labour dragged on until a crisis evolved that resulted in the vacuum extraction. It is necessary once more to state that Dr McLynn was relying on the wrong time for the commencement of labour. In order to determine whether there is any undue delay, the time of the start of the labour should be taken into account along with the timing of the delivery, and whether the period is excessive.

[52] The second expert called by the plaintiff was Dr Kara. He filed a joint minute with the defendant's paediatrician in which both of them concluded that the probable cause for E's cerebral palsy was an intrapartum hypoxic ischemic injury, as stated earlier in this judgment.

[53] Dr Kara opined that the injury suffered by E was not a true acute profound injury, but rather an extension of a prolonged partial injury. In his view, it was the extended prolonged partial injury that had led to the damage of the basal ganglia and thalamus of the brain.

[54] This opinion was not proffered by Dr Kara in his medico-legal report⁵² nor in the joint minute filed. In his report he concluded that:

- (a) E was born at term, was not growth retarded, had a normal head size at birth, was flat, floppy, and had moderate respiratory distress at birth and had to be resuscitated. The attending paediatrician diagnosed her as HIE grade 2.
- (b) E had convulsions and other features of encephalopathy that lasted several days and there appears to be no other cause for the encephalopathy other than hypoxic ischemic injury.
- (c) There is adequate evidence to link the brain injury and cerebral palsy to intrapartum events since there is reasonable fulfilment of the ACOG and Volpes' criteria.

[55] Inasmuch as there was no confirmed foetal distress at labour, his opinion was that it is probable that there was foetal distress. Dr Kara did not offer a factual foundation for this opinion. In fact the Maternity Guidelines lists the following signs as fetal distress:

⁵² See medico-legal report by Dr Yatish Kara – Paediatrician, Bundle B at 15-27.

- (a) Baseline fetal heart rate $\geq$ 160 beats per minute;
- (b) Baseline fetal heart rate $<$ 110 beats per minute;
- (c) Variability persistently $<$ 5 beats per minute on CTG, in the absence of sedating drugs;
- (d) Late decelerations of fetal heart rate.

He did not identify these signs. Originally Dr Kara in his report stated that there is an 'inability to confirm foetal compromise in labour (due to lack of foetal CTG traces) but it is probable that it is present.'

[56] Dr Kara clearly ventured into the domain of the radiologists, neurologists and obstetricians. His evidence has to be weighed against the evidence of the radiologists as contained in the joint minute discussed earlier. Not only were Dr Kara's opinions not contained in his report, they were also not in the joint minute filed by him. The opinions not based on his expertise remain speculative and are not of any real assistance in this matter.

[57] This concluded the evidence on behalf of the plaintiff.

[58] The defendant adduced the evidence of Drs Archer, Govender and Popa. Dr Archer's opinions, as per the joint minute filed and contained in his report, were dealt with earlier in this judgment.

[59] Dr Archer's opinion was that intervention in the latent phase of labour does not require any intervention beyond checking on the mother and child and establishing that the mother is fine, and if necessary, providing her with adequate analgesia. He explained that it was probable that the plaintiff remained dilated at 2 cms for some time because it was not a true latent phase of labour, and in all likelihood an expression of false labour, which is fairly common amongst woman in their first pregnancy.

[60] Under cross-examination, he stated that it was irrelevant to the outcome of the case that nothing was done during the prolonged latent phase since it did not impact on the outcome. He based his opinion on the fact that there were no signs of foetal distress during the first stage (latent and active phase) or during the second

stage of labour. He further stated under cross-examination that the acute profound damage probably occurred very late, possibly around 04h50. The delivery took place 45 minutes later.

[61] In cross-examination he was asked whether the injury suffered by baby E would have been foreseen during the labour process in circumstances where monitoring was done. His response was that E was born severely asphyxiated, so he does not believe that when they tried to deliver E they would have been aware of that. In fact, even if they had been aware of it there was absolutely no way that they could have delivered her any quicker than they actually did.

[62] Dr Govender was called not to give expert testimony but to deal with the facts relating to the CTGs that were previously in the hospital file and then went missing. She confirmed her knowledge of the contents of the file as she had previously prepared an opinion in relation to the plaintiff's claim. She was provided with the file by Dr Popa, the medical manager of the hospital. Dr Govender made no entries in the clinical records but could confirm that the clinical records of the plaintiff and the CTGs were in the file and that she had made a note on the CTGs. As head of Obstetrics at the very same hospital she could also confirm that the CTG machines used at the hospital are old models which require staff to physically enter the name of the patient on the CTG printout.

[63] She was asked to respond to Dr Popa's earlier affidavit, which states that no CTGs could be found in the file. She explained that she wrote her report in February 2016, and that when she reviewed the documents for purposes of her report, the same CTGs were in the file. She also testified that Dr Popa retired at the end of April 2019.

[64] Dr Popa was the medical manager of the hospital from 1 October 2010 to 1 May 2019, prior to her retiring. She confirmed that she deposed to an affidavit on 11 April 2019 stating that she could not locate the plaintiff's file. She assumed it was misplaced because eventually it was located. A number of files had been re-arranged and placed in a new filing cabinet, so when she looked for the file it could not be found hence her affidavit. She testified that the hospital serves a big

catchment area and that they attend to approximately 8 000 to 9 000 births per year. This concluded the evidence on behalf of the defendant.

Evaluation

[65] Whilst E undoubtedly suffers from one of the most serious and heart-breaking conditions, this court is mindful in its evaluation that the plaintiff has to discharge her burden of proof and that this court is duty bound to consider all of the facts and issues objectively and impartially.

[66] The mixed pattern of injury as identified by the radiologists renders this case more complex than others. Any omission of the defendant's employees needs to be causally linked to E's condition in order for this court to find the defendant liable to compensate the plaintiff. In *Medi-Clinic Ltd v Vermeulen*,⁵³ the SCA held:

'In conclusion, the plaintiff has suffered such terrible consequences that there is a natural feeling that he should be compensated. But, as Denning LJ correctly remarked in *Roe v Ministry of Health* [1954] 2 All ER 131 (CA) at 139:

"But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure."⁵⁴ (My emphasis.)

[67] In determining the most probable cause of E's cerebral palsy it is necessary to assess the facts as presented, and the objective opinions of the experts who testified on behalf of the plaintiff and the defendant. It is therefore important that the opinions should be based on existing facts.⁵⁵ This brings me back to the time when the plaintiff went into labour.

⁵³ *Medi-Clinic Ltd v Vermeulen* 2015 (1) SA 241 (SCA).

⁵⁴ *Ibid* para 33.

⁵⁵ See *Stock v Stock* 1981 (3) SA 1280 (A) at 1296E-F.

[68] The plaintiff's obstetrician regarded the latent phase of the labour as prolonged, and as an obstetric expert, considered the labour to have been in the region of 32 hours. Both counsel were asked during the writing of the judgment to make further supplementary submissions since the plaintiff's viva voce evidence contradicts a clinical note found in the plaintiff's bundle that the labour commenced at 21h00 on 18 July 2011.

[69] The plaintiff filed supplementary heads. It was submitted therein that the plaintiff was not asked any questions regarding the entry in the medical records that reported that she had experienced labour pains since 21h00 on 18 July 2011. However, the plaintiff's own senior counsel lead her evidence and must have been aware that Dr McLynn expressed an opinion that the latent phase was prolonged since labour commenced on 18 July 2011. No questions were asked by plaintiff's counsel about her certainty regarding the onset of labour. In essence, it has been submitted that this court should find that the clinical record that was made on 19 July 2011 by a person not called as a witness should be preferred above the plaintiff's direct evidence.

[70] In my view, the direct evidence from the plaintiff as E's mother is the best evidence to consider regarding the onset of labour. There can be no better evidence than from the woman who was experiencing the labour pains to testify about them. This is what the plaintiff said:

Mr Pillay Just a moment, Mr Interpreter. I want to know why you decided to leave and go to the clinic in the first place. --- M'Lady, I had woken up at night, I had gone to urinate. There was something that was reddish or bloodish in colour and some fluid of some sort that came out of me, and these are, amongst others, things that I had been told if this should be seen I must then go to the clinic.

Were there any other signs you experienced that night? ---M'Lady, I had experienced pains ...[intervention]

Interpreter The witness indicates in the stomach. --- towards my back. I must, however, state the signs were not intense by then.

Mr Pillay Yes. When you say, “by then”, are you able to give us any indication of time? When did this blood appear, when did these pains happen? --- M’Lady, I estimate it must have been at about half past four. It is as a result of these pains that I got up and got myself to go and urinate, and then I saw and observed things that I had already explained.

Yes. Now when you say, “half past four”, was that half past four at night, in other words in the early hours of the morning? --- Yes, it was still in the morning, very early in the morning.

Yes. Now did these pains – before you got to the clinic tell us about that pain, did it come and go, was it continuous? --- M’Lady, what prompted me to go to the clinic was having the pain disappearing and once more coming back, and it was that on and off that led me to eventually go to the clinic.

Yes, so you arrived at the clinic in the morning. --- Yes.

And we know they tested you at the clinic. ---Yes.’ (My emphasis.)

[71] The plaintiff was never confused nor uncertain as to when labour commenced. She is by far the best witness to explain when she experienced any pain and contractions. On her version, labour started on the morning of 19 July 2011 at 04h30. The plaintiff was a good witness who never contradicted herself. Her direct evidence must on a balance of probabilities trump the recordal made by an unknown individual at the clinic. The recordal of the labour pains that started on 18 July 2011 at 21h00 remains hearsay without any factual foundation. The plaintiff’s reliance on *Ngobese v MEC for Health, KZN*⁵⁶ is misplaced given the circumstances of this case, especially since the plaintiff testified. The plaintiff’s testimony was straightforward and is accepted as reliable. On a balance of probabilities, it is found that the plaintiff went into labour on 19 July 2011 at 04h30.

⁵⁶ *Ngobese v MEC for Health, KZN* [2019] JOL 43767 (KZP).

[72] In light of the court's findings that the plaintiff's evidence is to be preferred on the issue of the commencement of the labour process, it cannot be that the first stage of the labour was prolonged. Dr McLynn's opinion regarding the prolonged labour is without a factual basis. Reliance was also placed by plaintiff's counsel on *Davies v MEC for Health, KwaZulu-Natal*⁵⁷ where the court accepted that a mixed pattern of injury occurs when there is a long stage of labour with the partial prolonged injury occurring initially and the acute profound injury occurring during the second stage of labour when there is a crises at hand. The decision of the court was however overturned by the full court of this division.⁵⁸

[73] Any management of the plaintiff's labour must be evaluated against the factual finding that the latent phase was not prolonged.

[74] Counsel for the plaintiff asked that the evidence of Dr Archer, for the defendant, be rejected where it is contradiction with the plaintiff's experts. This court was also referred to two other decisions where Dr Archer was criticised. In my view, it is his evidence before this court that will be evaluated and considered. Dr Archer's opinions in other litigated matters cannot be accepted as authoritative or criticised without knowing the full history of each of the matters and having evaluated the data and proof on which his opinions were based. Dr Archer was cross-examined and did not speculate about facts or data when he testified. In fact, he made the necessary concessions and did not venture outside his field of expertise. The reliance of the plaintiff on *Khuzwayo obo SZ Khuzwayo v MEC for Health, KwaZulu-Natal*⁵⁹ to reject his evidence is misplaced. Dr Archer supported his opinions with authoritative data and his evidence is found to be reliable.

[75] This brings me to the partogram which is used to note the condition of the mother and the foetus as well as the progress of the labour. No reason was given by the defendant why the authors of the notes were not called, but, the changes to the partogram are changes which at best could be labelled by Dr McLynn as suspicious but not fraudulent. In fact, it was not shown that the changes were made to assist the

⁵⁷ *Davies v MEC for Health for the Province of KwaZulu-Natal* 2019 (JDR) 0500 (KZP).

⁵⁸ *MEC for Health for the Province of KwaZulu-Natal v Davies* 2021 JDR 1257 (KZP).

⁵⁹ *Khuzwayo obo SZ Khuzwayo v MEC for Health, KwaZulu-Natal* unreported case no 13820/14) dated 9 April 2018.

defendant in its case. The partogram showed that the foetal heart rate was monitored every half an hour as required by the Maternity Guidelines.

[76] The plaintiff averred that the personnel failed to adequately plot the partogram which would have alerted them to arising complications and subsequent danger to the foetus, but this was not proved on a balance of probabilities.

[77] I stated earlier that the conclusion reached by Dr McLynn that the plaintiff's labour was prolonged was not based on the evidence of the plaintiff. The experts on behalf of the plaintiff, as well as the defendant made a good impression generally. However, the opinions that were based on incorrect facts or speculation will be ignored. Insofar as Dr McLynn relied on an entry in the medical records which was not proved, it is found that the evidence does not pass the requirement test for the acceptance of opinion evidence as stated in *Oppelt v Department of Health, Western Cape*.⁶⁰ The evidence of Dr Kara that was outside his field of expertise suffers the same fate.

[78] On the evidence before this court it cannot be found that there was a prolonged period during which the foetal brain was subjected to hypoxia. As stated earlier, Dr McLynn incorrectly placed reliance on an entry in the medical records that the labour commenced on 18 July instead of 19 July 2011.

[79] It is necessary to deal with the plaintiff's contention that the CTG traces are inadmissible. Evidently the CTG traces presented a problem for the plaintiff since it showed that the foetus was monitored and there was no foetal distress. Inasmuch as the CTG traces were provisionally admitted, when the plaintiff's experts testified, this court has to make a decision on the admissibility after consideration of all the evidence including defendant's witnesses.

[80] Earlier in this judgment it was found that the plaintiff was a credible witness. She confirmed that a belt was connected to her and that traces were printed during the labour process. Dr Govender confirmed that the CTG traces produced in court,

⁶⁰ *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC).

were the CTG traces that she found in the plaintiff's file. She was not mistaken about the identity of the traces since she had made notes on the traces. The CTG traces bore the name of the plaintiff and they showed that the machine stopped working at 03h30. The medical records in addition confirm that the doptone was used to monitor the foetal heart rate until 4h30 when the CTG was reactive again.⁶¹ So any suggestion that the traces were falsified or not belonging to the plaintiff must fail in light of Dr Govender's evidence. Counsel for the plaintiff argued that the CTG traces constitute hearsay evidence since the medical personnel were not called to testify. This is correct, but it does not mean that the evidence should be excluded. It is necessary to consider s 3(1)(c) of the Law of Evidence Amendment Act 45 of 1988 (the LEAA) in dealing with the hearsay evidence. Firstly, it was the plaintiff who requested the CTG traces and who threatened to launch an urgent application to compel the discovery of the said traces. When the traces were produced and showed no foetal distress this court was asked by the party who requested them, to exclude them as inadmissible.

[81] Secondly, all of the experts testified about the CTG traces and were cross-examined on the issue of monitoring the foetus. The CTG traces are therefore very relevant to the issue of monitoring the foetus and the foetal heart rate. In my view having due regard to the interests of justice, these traces should be admitted as admissible evidence. The partogram also shows that the foetal heart rate was monitored until 03h30. No evidence was adduced that the heart rate was not monitored, and if that is accepted then it could only be monitored by the CTG machine or the doptone. The probabilities support the use of the CTG machine and the fact that the CTG traces produced were that of the plaintiff.

[82] Navsa JA summarised the purpose of the LEAA succinctly in *Makhathini v Road Accident Fund*:⁶²

'[27] The purpose of the Act is to allow the admission of hearsay evidence in circumstances where justice dictates its reception. In *Metedad v National Employers'*

⁶¹ See page 6 Bundle H.

⁶² *Makhathini v Road Accident Fund* 2002 (1) SA 511 (SCA); also see *Savoi and others v National Director of Public Prosecutions and another* 2014 (1) SACR 545 (CC) paras 44, 46 and 49.

General Insurance Co Ltd 1992 (1) SA 494 (W) it was stated as follows at 498I-499G:

“It seems to me that the purpose of the amendment was to permit hearsay evidence in certain circumstances where the application of rigid and somewhat archaic principles might frustrate the interests of justice. The exclusion of the hearsay statement of an otherwise reliable person whose testimony cannot be obtained might be a far greater injustice than any uncertainty which may result from its admission. Moreover, the fact that the statement is untested by cross-examination is a factor to be taken into account in assessing its probative value. ...There is no principle to be extracted from the Act that it is to be applied only sparingly. On the contrary, the court is bound to apply it when so required by the interests of justice.”

In each case the factors set out in s 3(1)(c) are to be considered in the light of the facts of the case. The weight to be accorded to such evidence, once it is admitted, in the assessment of the totality of the evidence adduced, is a distinct question.⁶³ (My emphasis.)

[83] Mbha J held in *Giesecke and Devrient South Africa (Pty) Ltd v Tsogo Sun Holdings (Pty) Ltd and another*⁶⁴ that it is trite that the rule concerning the inadmissibility of non-testimonial evidence is more relaxed in civil proceedings than criminal proceedings, I agree with this finding. In these proceedings the medical records⁶⁵ were introduced by the plaintiff. These very same records refer to the monitoring of the foetal heart rate and a CTG machine being used.

[84] The SCA in *S v Ndhlovu and others*⁶⁶ held that prejudice in the context of hearsay evidence would be limited to the procedural prejudice:

‘The suggestion that the prejudice in question might include the disadvantage ensuing from the hearsay being accorded its just evidential weight once admitted must be discountenanced, however. A just verdict, based on evidence admitted because the interests of justice require it, cannot constitute “prejudice”. In the present case, Goldstein J found it unnecessary to take a final view, but accepted

⁶³ Ibid para 27.

⁶⁴ *Giesecke and Devrient South Africa (Pty) Ltd v Tsogo Sun Holdings (Pty) Ltd and another* 05/27893 (2010) ZAGPJHC 41 (25 May 2010), para 38.

⁶⁵ See Bundle H.

⁶⁶ *S v Ndhlovu and others* 2002 (2) SACR 325 (SCA).

that “the strengthening of the State case does constitute prejudice”. That concession to the proposition in question, in my view, was misplaced. Where the interests of justice require the admission of hearsay, the resultant strengthening of the opposing case cannot count as prejudice for statutory purposes, since in weighing the interests of justice the court must already have concluded that the reliability of the evidence is such that its admission is necessary and justified. If these requisites are fulfilled, the very fact that the hearsay justifiably strengthens the proponent’s case warrants its admission, since its omission would run counter to the interests of justice.’⁶⁷ (My emphasis.)

[85] I am satisfied that the CTG traces, despite being hearsay evidence, should be allowed in the interests of justice as admissible evidence. Dr Archer’s opinion that there was no evidence of any foetal distress during the latent phase, active phase or the second stage on the medical records is far more probable than the evidence adduced by the plaintiff’s experts.

[86] This brings me to the question whether there was an acute profound injury i.e. a sentinel event, such as a ruptured uterus, an abruption of placenta, cord prolapse or any other form of cessation of blood supply to the foetus. This list is not exhaustive. No evidence was placed before this court that there was such a sentinel event.

[87] According to the Maternity Guidelines the latent phase is prolonged where it exceeds eight hours.⁶⁸ The plaintiff was admitted to the hospital at 14h00 on 19 July 2011 and commenced the active phase of labour at 22h00, which means that the latent phase commenced at 04h30 on 19 July 2011. She was in the active phase of labour for approximately seven and a half hours. Dr McLynn’s evidence was that the latent phase of a primigravida (which the plaintiff was) is usually between twelve to fourteen hours and the active phase between four to six hours. What is clear from the evidence of Dr McLynn and Dr Archer is that both experts estimated the latent phase of a primigravida to exceed the duration recommended in the Maternity Guidelines. Having found that the plaintiff commenced labour at 04h30 on 19 July

⁶⁷ Ibid para 50.

⁶⁸ See Maternity Guidelines at 44.

2011, it cannot be found that the plaintiff's labour was significantly prolonged on any account.

[88] The next question is whether the plaintiff was managed appropriately during the active phase of labour. It is evident that the plaintiff reached the active phase at 22h00 and was then examined at 24h00; 03h00; 03h30; 04h30 and 05h35. The vacuum extraction followed at 05h35. Dr Archer's evidence was that the decision to intervene was made one hour into the second stage, and 50 minutes after the CTG revealed a reactive trace. If the monitor showed any foetal distress, could the delivery be expected any sooner? The evidence before court shows that the doctor on duty applied vacuum extraction which expedited the delivery.

[89] If the acute profound injury was suffered whilst the staff were planning the vacuum extraction, then it ought to have been proved that it was to be anticipated in order to prevent it. Importantly, it was not proved that there was a need to deliver E earlier as to avoid damage. Dr McLynn conceded that a caesarean section would not have prevented the HIE injury suffered.⁶⁹

[90] Dr Archer's version that the acute profound injury probably occurred very late during the labour process at 04h50 is more probable than the evidence of plaintiff's expert, Dr McLynn. At that late stage the vacuum extraction was the most expedient method to get the baby out. The plaintiff's own expert Dr McLynn agreed that the vacuum extraction was the most appropriate intervention and that a caesarean section would not have prevented the injury suffered by E.

[91] I accept that in terms of the Maternity Guidelines the hospital staff ought to have monitored the plaintiff more frequently during the active phase. But can it be said that their failure resulted in such a risk that caused the brain damage suffered by E? The short answer is 'no' as it was not proved that there were any warnings of a sentinel event.⁷⁰ There is, in my view, no causal relationship between the lack of monitoring of the plaintiff in the active phase and the harm caused to E. The plaintiff

⁶⁹ See para 50 of this judgment.

⁷⁰ See *AN obo EN v Member of the Executive Council for Health, Eastern Cape* [2019] 4 All SA 1 (SCA) para 26.

has failed to prove on the objective facts that the defendant's lack of monitoring caused the damage suffered.

[92] The following question must be asked:

'[W]ould the brain damage have been avoided if the hospital staff had properly monitored the mother and foetus and had acted appropriately on the results? If so, factual causation is established. If not factual causation has not been established and one is left with only wrongful conduct without proof that it caused harm suffered.'⁷¹ (My emphasis.)

[93] *In casu* the source of the harm is not known and has not been established. No factual cause was proved. The Constitutional Court in *Mashongwa v Passenger Rail Agency of South Africa*⁷² held:

'Lee never sought to replace the pre-existing approach to factual causation. It adopted an approach to causation premised on the flexibility that has always been recognised in the traditional approach. It is particularly apt where the harm that has ensued is closely connected to an omission of a defendant that carries the duty to prevent the harm. Regard being had to all the facts, the question is whether the harm would nevertheless have ensued, even if the omission had not occurred. However, where the traditional but-for test is adequate to establish a causal link it may not be necessary, as in the present case, to resort to the Lee test.'⁷³

(My emphasis.)

[94] I am not persuaded on the facts that the injury to E was caused by the conduct of the personnel working at the hospital. In the result I find that the plaintiff has failed to prove, on a balance of probabilities, causative negligence on the part of the defendant's medical staff working at the hospital, and accordingly the action must fail.

[95] With regard to costs, costs generally follow the result. What struck me as immensely insensitive in this matter is the treatment that the plaintiff received from

⁷¹ Ibid para 8.

⁷² *Mashongwa v Passenger Rail Agency of South Africa* 2016 (3) SA 528 (CC).

⁷³ Ibid para 65.

the staff after her baby, E, was born with brain damage. This new mother having had an episiotomy and having experienced a difficult birth was told by the staff to go and fetch her own file.⁷⁴ At this time she was merely enquiring about the sex of her child. Furthermore, the personnel ought to have exercised greater care in the completion of the partogram. In my view, any changes ought to have been initialled so that the individual in charge could be identified at a later stage. There ought to have been a greater focus on the Maternity Guidelines, notwithstanding that they were only guidelines. I would have expected a more diligent search to have been conducted by the hospital staff in locating the file and the records in the file than what was executed in this matter. In my view the plaintiff should not be mulcted with costs. Inasmuch as the plaintiff has failed to prove her case on a balance of probabilities, I am not disposed to make a costs order against her in light of some of the factors I have identified. These factors did not cause or contribute to the injury suffered but they do impact on the issue of costs.

Order

[96] The following order shall issue:

1. The plaintiff's claim is dismissed.
2. There is no order as to costs.

Steyn J

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⁷⁴ See para 42 of this judgment.

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Date of Judgment : 09 February 2022