

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

CASE NO: AR 403/2021

In the matter between:

**THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH, KWAZULU-NATAL**

APPELLANT

and

SIMANGELE SIBAHLE MBATHA

DEFENDANT

ORDER

Having read the papers and after hearing counsel, the following order is made:

In the circumstances, I make the following order:

1. The appeal succeeds only in so far as it relates to costs.
2. The order of the court a quo is set aside and is replaced with the following:

‘1 The defendant is ordered to pay all damage as proved of agreed for N[...] S[...], arising out of the negligence of the defendant’s employees during his birth on 21 June 2012.

2. The defendant is ordered to pay the plaintiff’s costs of suite on a party and party scale.

3. The matter is adjourned sine die for the determination of quantum.

3. The appellant is ordered to pay the costs of the appeal.

JUDGMENT

Date Delivered:

Masipa J et K Pillay J et R Singh AJ concurring:

Introduction

[1] The appellant, a Member of the Executive Council for Health, KwaZulu-Natal appeals against the judgment of Ncube J. delivered on 11 February 2020. The appellant is in charge of and in control of Hlabisa Hospital, where the cause of action in this matter arose. The respondent is the mother and natural guardian of a minor child N[...] L[...] S[...] ('NLS'). She claimed damages against the hospital for medical negligence arising from a deficiency that arose during the birth of NLS on 21 June 2012. Subsequently, NLS was diagnosed with spastic quadriplegic cerebral palsy.

[2] When the matter came before the trial court, the parties agreed as common cause that:

(a) the minor child suffered from spastic quadriplegic cerebral palsy, a permanent position which was grade 5 meaning that it was severe;

(b) the condition is accompanied by the presence of hypoxic ischemic encephalopathy (HIE) which is brain damage due to lack of oxygen;

(c) the size of the minor child's head was normal at birth;

(d) the brain damage is shown in the MRI scan and, as agreed to between the radiologists, indicates that the injury was of a mixed nature showing partial prolonged and acute profound damage occurring in term infants which means that the child was then at full gestation;

(e) a partial prolonged injury occurs over time, in most cases over several hours;

(f) the respondent fell in the morning before she went to hospital;

(g) the respondent was admitted to the hospital on 18 June 2012 and gave birth three days later on 21 June 2012;

(h) on admission the respondent was found to be a primigravida in that it was her first pregnancy, her blood pressure was moderately raised and as an indication of high blood pressure, the respondent had swollen feet;

(i) she was diagnosed with pre-eclampsia, she was treated with Aldomet to lower her blood pressure and Cytotec was administered to induce labour;

(j) Cytotec increased the frequency of contractions to speed up the baby's delivery; and

(k) the baby was delivered by means of vacuum extraction

[3] At the time of the incident, the respondent, aged 21, resided in Xula village, Mtubatuba and attended antenatal clinics at Sipho Zungu Clinic.

The facts

[4] On 19 June 2012, around 10h00 the respondent tripped and fell while at home and was rendered unconscious. She could not specify the duration of her unconsciousness. Being eight months pregnant, she managed to turn and landed on her back during the fall sustaining a tear on her knee which became swollen. Her upper body was stiff for a while. Approximately six months earlier, while pregnant, she consulted a traditional healer but discontinued using traditional medicine shortly thereafter.

[5] Pursuant to the fall, a neighbour assisted her to the clinic. Despite feeling no pain, she sensed an unusual heartbeat. She arrived at the clinic around 16h30, when

on examination a nurse informed her of her elevated blood pressure. An ambulance was called and arrived at night. The respondent was transferred to Hlabisa hospital arriving at 20h00. She was admitted to the maternity ward. Upon admission, Dr Phumlani Theophilus Cele, noted a painful and swollen knee and conducted a CTG scan.

[6] Nothing eventful occurred on 20 June 2012. The morning of 21 June 2012 saw the respondent moved to another ward where Sister Thobile Rose Mbatha managed her labor. At about 03h00, a nurse inserted a tablet to manage her labour due to escalating blood pressure was elevating further. Contractions ensued.

[7] Sister Mbatha monitored the respondent's active labour at two-hour intervals, assessing the foetal heart rate with a Doppler machine. A vaginal examination revealed seven centimetres dilation. The decision was made to monitor the foetal heart rate at half-hourly intervals. According to the respondent Cardiotacogram (CTG) was used to monitor her for ten minutes every four hours.

[8] The respondent avers that Dr Cele suggested a caesarean section, but the hospital staff denied his presence at the hospital that day. Dr Mkhulise, an intern doctor, supervised Sister Mngomezulu but was not involved in the delivery. According to the respondent, when she started to feel pain, Dr Cele conducted a vaginal examination and applied a CTG belt inducing labour with Cytotec. The respondent's membranes ruptured at 12h00.

[9] Sister Mbatha reported rapid labour progression, dilating the respondent by 14h30. The foetal heart rate was 130 beats per minute. Between 14h30 and 15h00, the respondent pushed but the maternal effort was poor. Sister Mngomezulu, an advanced midwife was notified.

[10] Sister Annie Thembile Mngomezulu confirmed poor maternal effort and decided on a vacuum delivery, which Sister Madonsela corroborated. Sister Mngomezulu ensure all prerequisites were met and chose a size five vacuum cup for the respondent's first delivery. The baby was delivered with the second pull. The foetal heart rate was within limits and the mother's blood pressure was fine. Contrary

to the respondent's version, Sister Mngomezulu's evidence was that she called Dr Mkhulise to supervise.

[11] Sister Mngomezulu, stated that she did not need a doctor's supervision. She followed all the necessary protocols for a vacuum delivery. The vacuum cup slipped once and was re-applied. NLS was delivered with the second pull and had a chignon which is caused by the pressure applied on the scalp by a vacuum cup. NLS had a caput or swelling of the head of 2+. This is a normal and is caused when the baby moves through the pelvis. Caput is graded in severity from nil to three. completed and signed documents, including the labour summary, reflecting NLS's satisfactory condition on delivery. The respondent's version differs, claiming Dr Cele's involvement and multiple unsuccessful attempts to before her son's delivery.

[12] The respondent conceded during cross-examination that her evidence on the delivery was hearsay. The first time she saw NLS he appeared very fragile and his head appeared swollen. The doctor said that NLS's head was deformed because his blood had gone to the head. Accordingly, that NLS would have to stay in the hospital or could die. Dr Cele said that the nurses had injured the baby. NLS did not cry after birth and the doctor performed an oronasal suction to his nose and he then cried. They stayed in hospital for a month. At the commencement of the trial, NLS was aged six and could not speak, sit or do anything for himself.

[13] According to Sister Madonsela, NLS weighed 3460 grams on delivery, had a heart rate above 100 beats a minute and Apgar score of 6/10 a minute and 10/10 at five minutes. She and Sister Mngomezulu jointly estimated the Apgar score. He required oxygen due to blue colouration. It seemed to be common cause that the oronasal suction was performed and NLS was normalized after five minutes although it was disputed as to who conducted it. She mentioned that there was no need for resuscitation. According to her, when NLS was examined after birth, there was no abnormalities and NLS was fine when he was taken to the post-natal ward. She accepted that a well person would not be placed on continuous oxygen. She had no comment on a report that the baby was seen with a cracked skull.

[14] Sister Madonsela did not observe cephalohematoma on NLS despite the medical evidence confirming this and therefore could not explain how it occurred. she only observed that NLS had a chignon as was testified by Sister Mngomezulu. She denied any negligence on the part of the hospital staff. While she denied falsification of hospital records, she admitted uncertainty as to when the hospital record was completed.

[15] Sister Madonsela disputed that she did not examine NLS before recording him as 'normal'. Her description of NLS's moro reflex was did not accord with that of Prof Davies. According to Prof Davies, NLS was so badly brain damaged, that he would not have had a moro reflex. It was suggested that she simply ticked the box on the form all at once and failed to record the chignon as an abnormality, amongst others.

[16] Sister Ngubane a basic midwife recorded the foetal heart rate. Sister Madonsela was not present when sister Ngubane was progressing labour. She only responded when Sister Ngubane shouted for help and so did Sister Mngomezulu, and Dr Mkhulise. She did not comment on the allegation that the hospital managers recorded that the baby was delivered by a medical officer and a midwife.

[17] Sister Mngomezulu had 15 years' experience when NLS was delivered. The foetal heart rate was within limits and the mother's blood pressure was fine. Having followed the necessary vacuum delivery procedure, her evidence was that the entire process took two minutes and the pull was easy.

[18] According to the Guidelines¹, as an advanced midwife, she did not need a doctor's supervision. She personally completed and signed the hospital records, having carried out the vacuum extraction. She denied any falsification of the records and also denied that a nurse reported an injury to NLS or a cracking skull. It was clear during cross-examination that she did not have an independent recollection of

¹ See Third Edition of the Guidelines for Maternity Care in South Africa: A Manual for Clinic, Community Health Centres and District Hospitals published by the Department of Health in 2007 at Chapter 4headed abnormalities of the second Stage of labour.

the delivery of NLS and relied on hospital records. despite lacking independent recollection, stands by the hospital records and denies any wrongdoing.

[19] Dr Cele, attended to the respondent on 4 May 2012, 25 May 2012 and again on 19 June 2012. He saw again her again on 22 June 2012 when he reviewed her post-delivery hypertension. He disavowed the respondent's testimony that he attended to her vacuum extraction, received a call during the process and left the delivery to a nurse. Extraction is sensitive and sterile. He would not have answered a call during such a procedure.

[20] Responding to the judge a quo's inquiry, Dr Cele acknowledged that no medical officers were present during NLS's delivery. He contended that an advanced midwife would have sufficed, and any reference to a medical officer in the hospital records could not have been Dr Mkhulise, as she was not a medical officer at the time.

[21] On 9 September 2015, the respondent consulted Dr NC Kapongo, a paediatrician employed by the appellant at the appellant's instance. He examined NLS who was three years old at the time. Dr Kapongo who is not fluent in Zulu communicated in English with the respondent. Despite the respondent disputing the presence of an interpreter, nurse CS Mhlongo assisted with interpretation.

[22] Dr Kapongo elicited the circumstances surrounding the respondent's fall within revealed that she had lost consciousness at some point. Her family took her to a traditional healer who advised her to go to a hospital. Dr Kapongo focused on how the collapse could have affected the baby, speculating on various medical scenarios. The respondent mentioned being unconscious for approximately 30 minutes. He speculated on different medical scenarios that could have had an impact on the child.

[23] The respondent's version of walking to the nearby clinic contradicted what she told Dr Kapongo. Dr Kapongo encountered difficulty eliciting details about the fall, as the respondent repeatedly stated that she could not remember. Discrepancies between Dr Kapongo's record and Dr McLynn's report regarding the respondent's

visit to a traditional healer were acknowledged, with Dr Kapongo conceding a potential misunderstanding. Dr Kapongo's findings on NLS were recorded as an insult to the brain, with the timing of the perinatal insult deemed almost impossible to pinpoint.

[24] Dr Kapongo, in retrospect, discredited the version of a well-baby with a normal Apgar score at birth, considering the severity of observed neurological sequelae. He questioned the delay in taking the respondent to a nearby hospital after her fall, positing its potential impact on the results.

[25] Dr McLynn, the respondent's expert gynaecologist in private practice, formerly worked as an obstetrician in public practice. He highlighted Guidelines for Maternity Care in South Africa, emphasizing risk cases such as young mothers, first-time pregnancies (primigravida), and conditions like high blood pressure or bleeding before labour. In such instances, the midwife would be expected to inform a medical officer (a doctor) who would examine the patient and formulate a plan for admission and/or delivery.

[26] The respondent's first pregnancy, coupled with increased risk due to raised blood pressure, prompted concern about potential complications such as eclampsia. Dr McLynn criticized the three-day delay in inducing labour, the use of Cytotec, stating that its brittle and unpredictable action required proper observation. He argued that a caesarean section would have been more appropriate.

[27] Dr McLynn contested Dr Kolis's suggestion that the respondent's collapse at home explained the poor outcome. He considered it speculative, proposing alternatives such as supraventricular tachycardia or hypotensive syndrome. Dr Kara, the respondent's paediatrician, noted that blood pressure readings were normal initially, then abnormal, leading to antihypertensive medication. Dr McLynn criticized the use of Cytotec, stating that its brittle and unpredictable action required proper observation. He argued against inducing labour with high blood pressure, advocating for a caesarean section instead.

[28] Dr McLynn emphasized the importance of continuous monitoring during labour, citing the insufficiently conducted CTG recordings in this case. He argued that the records, including the CTG, did not support the respondent's claim that the fall caused the brain damage. He posited that the problem occurred during the second stage of labour. Despite inadequate CTG recordings, he maintained that the evidence did not align with the fall causing the brain damage. Dr McLynn expressed suspicion about the vacuum delivery process, citing cephalohematoma² and swelling of the head. Dr Koll deemed the vacuum delivery normal, asserting it was not responsible for the brain damage. His assessment of NLS excluded intrapartum cause for hypoxia.

[29] According to Dr McLynn there are protocols when the baby is delivered through vacuum extraction. There are risks of damage to the baby's head. If the pull is prolonged, it may create great damage to the tissue resulting in sub-galeal haemorrhage. Midwifery or nursing staff are trained to deal with normal uncomplicated deliveries. He criticized the doctor leaving the delivery process to the nurses stating that it was unacceptable for a doctor to be absent approximately 2 hours. While he accepted that midwives can assess whether vacuum delivery is feasible, he said that it is an exception for a midwife to carry out a vacuum delivery.

[30] In a joint minute by Drs McLynn and Koll agreed that the first stage of labour was adequately monitored. Dr McLynn argued that correct protocols would have made it impossible for the application of the cup and the delivery period to take two minutes. This was because among others, a pull is conducted when the mother contracts and in normal labour, the contractions are every three minutes. According to Dr Koll, less than two minutes was sufficient.

[31] Dr McLynn expressed concern about NLS not crying after delivery, the doctor inserting a tube in his nose, and the subsequent diagnosis of cephalohematoma caused by the mere use of a vacuum which created a Chignon. Secondly, if the second stage of labour was delayed, there would be caput (soft tissue swelling) from the mother's pushing. The cephalohematoma was only identified a day later. The

² A swelling of the head due to a collection of blood below periosteum of the skull induced by trauma either of using vacuum or trauma of letting the baby fall on concrete floor on the head.

records reveal that the neonatal doctor suspected that there was hypoxia brain injury to the baby's brain. He suggested other potential causes aside from vacuum delivery, such as forceps delivery or a slip and fall.

[32] Drs Koll and McLynn agreed on inadequate recordings of clinical examinations and CTG procedures. Dr McLynn criticized the insertion of Cytotec, given its potential adverse effects and the lack of clear control in pregnancy. He acknowledged the expected results of the CTG but argued that that defects in the procedure could have missed abnormalities in the baby. He however did not strictly stick to a sentinel event. He accepted also that there are multiple potential causal pathways which leads to cerebral palsy in infants but said that this did not negate the fact that intrapartum hypoxia plays a significant degree.

[33] Dr McLynn partially agreed with Dr Koll's findings, acknowledging the difficulty in proposing an accurate sequence of events or determining the exact timing of NLS's brain injury based on incomplete evidence. He suggested that MRI reports could provide information on the location and timing of the damage and deferred this to a radiologist. Dr McLynn believed that the delivery process was contributory to the outcome. Due to incomplete records as a result of poor record keeping. Dr Koll found it challenging to comment on the timeliness or adherence to proper standards for neonatal resuscitation. Dr McLynn noted the immediate application of nasal oxygen to NLS, suggesting that, despite appearing well at birth according to medical records, NLS might have needed to be better based on paediatric history.

[34] Dr Kara, after examining NLS, diagnosed him with spastic quadriplegic cerebral palsy of grade 5. He associated this with injuries close to birth and noted dyskinetic cerebral palsy as well. Dr Kara believed that the injuries occurred close to the time of birth, indicated by subsequent changes in NLS's head size. The CTG reading before labour showed no abnormalities. He argued against inducing labour when foetal compromise is suspected, pointing out that the respondent was allowed to continue carrying the child for three more days, indicating no concern for foetal compromise. He questioned the likelihood of the fall causing a convulsion lasting for a sufficient duration to result in an injury to the foetus.

[35] Like other experts, Dr Kara expressed concern about the need for more records, mainly the sparse information on the foetal heart rate and the absence of information on procedures followed. He emphasized the importance of consistent record-keeping and monitoring according to protocols to identify and address potential risks during labour. In a joint minute Dr Kara and Prof. Davies agreed that there were no known antenatal risk factors for cerebral palsy. Apgar scores were recorded as 6/8 by Dr Kara and 6/10 by Prof Davies. They both agreed that Apgar scores were in isolation not confirming or refuting intrapartum asphyxia. Also, that Apgar scores may be elevated by resuscitation.

[36] Like Dr McLynn, they note that oxygen was administered and that the nursing records showed that on arrival to the nursery, NLS had difficulty breathing and had cephalohematoma which was not in keeping with a normal baby. They noted normal blood pressure and foetal heart rate until the day labour was induced. They both agreed that there was no doubt that NLS had severe onset of a moderately severe neonatal encephalopathy lasting several days. Prof. Davies highlighted the absence of a sentinel event and any evidence suggesting suboptimal intrapartum obstetric care. They both recommended referring the conduct and management of labour to an expert obstetrician. The childhood MRI scans recorded evidence of hypoxic ischemic injury. Notably, none of the parties called a radiologist to explain the results of the MRI.

[37] Dr Kara noted some evidence of acute, profound injury and possible injury and possible hypoglycaemia. Prof. Davies disputed the presence of recorded hypoglycaemia on hospital records. They both concluded that since the respondent's placenta was normal, hypoxic ischemia was the likely cause of the encephalopathy. Dr Kara considered induction of labour, vacuum extraction, and resuscitation at birth as indicating a high risk of intrapartum insult. Both experts agreed that the injury likely occurred during labour, with Prof. Davies emphasizing the absence of another cause for cerebral palsy. They pointed out that the incomplete records hindered commenting on whether required standards were followed, and evidence of substandard neonatal resuscitation could have compounded the outcome.

[38] Dr Kara raised concerns about the inconsistency between delivery records describing a satisfactory condition and the neonatal nurse's report of difficulty breathing, resuscitation, and cephalohematoma. He argued that if a baby was delivered in perfect condition, it was unlikely to develop cerebral palsy four years later. In Dr Kara's opinion, induction of labour, vacuum extraction and resuscitation at birth indicate a high risk of intrapartum insults. The findings of the MRI, and the presence of moderately severe changes several days with a reasonable exclusion of encephalopathy at birth made it probable that the injury occurred during labour. This was a sign of neurological compromise. Prof. Davies added that incomplete records made it difficult to determine the exact timing of the brain injury.

[39] Both Dr Kara and Prof. Davies agreed that hypoxic-ischemic encephalopathy occurs predominantly during labour. Dr Kara theorized that the injury likely happened after the induction of labour. While not sure, it was considered probable. Prof. Davies concurred that the injury occurred during the intrapartum period, and although not sure, it was a probable explanation.

Litigation history

[40] The trial addressed two key questions: whether the appellant's hospital staff was negligent in the treatment of the respondent during labour, failing to monitor her and NLS adequately, and if so, whether such negligence caused the child's brain injury resulting in cerebral palsy. The court, relying on *Blyth v Van den Heever*³, outlined the negligence issue around determining the factual cause of the child's condition and whether negligence on the part of the appellant could have prevented it by exercising reasonable professional care and skill.

[41] Both parties presented evidence, including hospital records, during the trial. However, the court *a quo* found the records could have been more helpful due to incompleteness and contradictions. Dr McLynn's testimony contradicted the *prima facie* picture of normal childbirth presented by the records. The court found his testimony reliable and honest, while Dr Koll's credibility was questioned for

³ *Blyth v Van den Heever* 1980 (1) SA 191 (A) at 196.

attributing the brain injury to the respondent's fall. Dr Koll's opinion was rejected because, on examination, no harm to the foetus was detected.

[42] Inconsistencies in hospital records led the court to suspect falsification to cover up unrecorded events. Discrepancies included conflicting accounts of vacuum extraction, the absence of caput in labour graphs but its presence in vacuum delivery records, and contradictions in NLS's post-birth condition. The court a quo found that the most junior nurse monitored the respondent for three hours during labour, contrary to guidelines requiring more frequent monitoring. Proper monitoring could have detected foetal distress, allowing consideration of alternative delivery methods.

[43] The court concluded that proper monitoring could have revealed NLS's distress, prompting timely action. Instead, the respondent was left in the care of nursing staff and an unqualified Dr Mkhulise. The court noted the respondent's high-risk status and her induction with Cytotec, suggesting she should have been attended by a medical officer or suitably qualified midwife.

[44] The court held the appellant liable for costs on an attorney and client scale, citing the appellant's untenable position and the persistence in trial despite the weaknesses in their case. The court a quo found the appellant was 'flogging a dead horse'. It stated that the appellant's expert, Prof Davies had conceded that the appellant's expert, Prof Davies had conceded that the appellant's case had to fail. Also, because the Appellant's Counsel had during trial frequently stood the matter down to take instructions 'presumably on possible settlement' and the appellant had persisted with the trial. The court a quo found also that parties and their legal representatives are under a duty to act reasonably and put an end to proceedings 'when it's clear as to which side the scale tilts'.

[45] In considering leave to appeal, the court a quo that the grounds of appeal mainly concerned factual findings. It addressed the issue of cephalohematoma development, attributing it to difficult vacuum extraction. Additionally, that while Dr Michel's statement was that a medical officer ordered and performed by Sister Mngomezulu. The court a quo rejected Dr Koll's evidence that sentinel event causing acute profound injury was the loss of consciousness was not recorded on the clinic

or hospital records. The loss of consciousness was not recorded by Dr Kapongo. It rejected Dr Koll's claim that the sentinel event causing acute, profound injury was the respondent's fall and loss of consciousness.

[46] The court emphasised the principles in *R v Dhlumayo*⁴, stating that the trial court's conclusion is presumed correct unless there is a misdirection of facts. The appellant failed to show reasonable prospects of success on appeal, leading to dismissing the application for leave to appeal. The Supreme Court of Appeal granted leave to appeal.

Submissions

[47] The respondent's particulars of claim alleged that the medical personnel were negligent, leading to the child's cerebral palsy and permanent impairment. The critical issues before the court were whether the hospital personnel were negligent in labour treatment, particularly in monitoring the respondent and NLS. If negligence was established, the second issue was whether this negligence caused NLS's injury and subsequent cerebral palsy.

[48] The appellant argued that the trial court prematurely concluded that settling the matter early would have been prudent. The respondent countered, suggesting that the appellant's counsel considered settling upon hearing the respondent's incomplete oral evidence on the first trial day. Arising from a discussion which was held in chambers with both counsel, the appellant contends that it was clear that the trial judge accepted the untested and incomplete oral evidence of the respondent being that she heard one of the nurses mentioning that the baby had a cracked skull which allegation was said to be to have been proven as false or to be an exaggeration. The appellant denied requesting a stand-down for settlement instructions, asserting that the only delay was due to the non-arrival of its expert, Dr Koll to assist in preparing for the cross-examination of Dr McLynn.

[49] The appellant contested the trial court's characterization of hospital records as incomplete and contradictory. It argued that the court's suggestion of poor record-

⁴ *R v Dhlumayo and Another* 1948 (2) SA 677 (A) at 706.

keeping leading to potential falsification lacked evidence. The appellant asserted that the trial court overlooked Dr Koll's evidence regarding the respondent's earlier fall and its consequences. It criticised the court for accepting a non-normal delivery without considering contradictory evidence from its witnesses.

[50] The appellant claimed there was no evidence of record falsification, emphasising the testimony of its nurses. It contended that NLS was normal at birth despite required resuscitation. Dr Koll's evidence that diagnosing Hypoxic Ischemic Encephalopathy (HIE) immediately after birth is challenging was presented to counter the court a quo's conclusions. The appellant argued that the trial court misunderstood the CTG recording, asserting that the evidence indicated normalcy. The court a quo was criticised for misinterpreting Dr McLynn's statements about CTG recordings and for misunderstanding the Guidelines for Maternity Care in South Africa⁵ regarding the necessity of a qualified medical officer during childbirth.

[51] The appellant submitted that there was no evidence before the court a quo to suggest that NLS's condition at birth was unsatisfactory. The appellant disputed the court's rejection of the midwives' evidence and Dr Koll's assessment of cephalohematoma. It criticised the court for accepting Dr McLynn's views on cephalohematoma and moulding without considering contrary evidence by Dr Koll whose evidence was that where there is no moulding, it reassures them that vacuum will work. The court a quo was also criticised for accepting Dr McLynn's evidence that cephalohematoma was induced by trauma and was associated with vacuum and forceps delivery which was disputed by both Dr Koll and Prof Davies who said that it could also be seen in normal child birth. The appellant relied on the Dorland's Illustrated Medical Dictionary, 2nd Edition at p330 where cephalohematoma is defined as 'a usually benign condition seen frequently in the new born as a result of bone trauma.

[52] The appellant asserted that the court failed to grasp Dr Kara and Prof Davies' views on the timing of the incident. It highlighted the concession by Dr Kara regarding the potential impact of the mother's fall, aligning with Dr Koll's stance. The

⁵ Guidelines for Maternity Care, (Department of Health RSA, 2007, 3rd Edition at p52).

appellant emphasized the importance of the respondent's fall, arguing that her symptoms were consistent with NLS's injury, as explained by Dr Kara, the MRI scan reports that it was a mixed pattern injury of prolonged and acute profound hypoxic ischemic injury. As there was no evidence of foetal distress, the appellant claimed that the evidence supported the fall as the cause of NLS's injury, impacting the brain's compensatory system.

The Test for Medical Negligence

[53] The test in medical negligence cases is well established and need not be repeated. The issues are:

- (i) *“What factually was the cause of the ultimate condition of [the plaintiff];*
- (ii) *Did negligence on the part of the respondent [defendant] cause or materially contribute to this condition.”*

[54] The test is on a balance of probabilities, namely the court has to find which is the most likely explanation.

[55] The respondent contends that poor monitoring and record-keeping by the appellant were the most likely causes of NLS's condition. This failure, she argues, led to undetected foetal distress, with the administration of Cytotec for labour induction identified as a probable cause. The respondent asserts that the appellant did not effectively challenge her evidence, particularly regarding the harm to NLS resulting from her fall and lying on her back, remains largely uncontradicted and should not be undermined through belated arguments around credibility.

Applicable Law

[56] The appellant places significant emphasis on the difficulty of pinpointing the time of the injury. However, in *MEC for Health, Limpopo v LWM obo DM*⁶ dealing with a medical negligence claim resulting in cerebral palsy arising from child birth the following was stated:

⁶ *MEC for Health, Limpopo v LWM obo DM* [2022] ZASCA 146.

“In my opinion, it is fallacious to posit that where a woman in labour has not been monitored by hospital personnel at all during the most critical stage of her labour, the MEC responsible for the relevant hospital should escape liability arising from the negligence of its employees purely on the basis that the exact timing of the hypoxic injury of an acute profound nature cannot be ascertained. To do so would be to ignore uncontested evidence that, on probabilities, shows a link between the negligence and the harm that ensued.”

[57] In *S v Hadebe*,⁷ the court outlined well-established principles governing appeals against factual findings. Absent demonstrable misdirection, the trial court’s findings are presumed correct and should only be disregarded if the evidence shows them to be clearly wrong. The respondent contends that the court of appeal should defer to the trial court’s factual findings, given its advantageous position to assess witnesses credibility. These principles extend to credibility findings by the trial court, and absent irregularities or misdirection, the court of appeal is bound by such findings unless convinced of their apparent incorrectness. The respondent asserts that the reasoning of the court a quo is sound.

[58] In *Buthelezi v Ndaba*⁸, the court found the application of the *res ipsa loquitur* maxim inappropriate in cases involving surgical intervention due to the complexity of the human body’s reactions. While accepted as correct, its application depends on the specific facts of each case.

[59] *Louw v Patel*⁹, emphasised the importance of logical reasoning in evaluating expert evidence. The court is not obliged to absolve a defendant based on expert opinions that lack logical foundation. Conflicting expert views must be considered, and a court must weigh expert evidence as a whole.

[60] The appellant’s argument that the evidence of the respondent’s expert witnesses should be discounted labelling them as hired guns cannot be sustained. On the evidence nothing suggested that they were unreliable and sought to mislead

⁷ *S v Hadebe* 1997 (2) SACR 641 (SCA) at 645 E-F

⁸ *Buthelezi v Ndaba* 2013 (5) SA 437 SCA at 443 B-E, relying on *Van Wyk v Lewis* 1924 AD 438 at 462.

⁹ *Louw v Patel* [2023] ZASCA 22 at para 19-21.

the court for the benefit of the respondent. Accordingly, reliance on *Motswai v Road Accident Fund*¹⁰ is misplaced. Notably, in the current matter, there were expert witnesses for both the appellant and the respondent and joint pre-trial minutes delivered. Therefore, the risk, of a lack of impartiality, if any, does not arise. Courts would not be able to assess medical risks without expert evidence; however, it is ultimately the duty of the court to assess such evidence and determine on a balance of probabilities whether a case has been made out by a plaintiff.

[61] The role of expert witnesses was eloquently stated in *A M and Another v MEC Health*¹¹, Western Cape where it was held that expert witnesses provide the court with abstract general knowledge in their area of discipline to enable the court to understand the issues arising in litigation including generally accepted practices and they provide their own inferences and opinions on the issue and furnish grounds for drawing those inferences. The court will not blindfoldly accept the evidence and will have to make its own factual findings.

[62] Given the facts in this case and the evidence provided by experts, their role in supplying relevant information is evident. The court a quo was responsible for evaluating this evidence and making decisions based on what it deemed as probable under the circumstances. Liability in negligence by hospital staff requires proof that damages resulted from their negligence. A negligent omission is only unlawful when which the law regards as sufficient to give rise to a legal duty to prevent harm.¹²

[63] In *AN v MEC for Health, Eastern Cape*¹³ it was stated that ‘*to be liable for loss the act or omission must have been wrongful and negligent and must have caused the loss. Wrongfulness involves the breach of a legal duty. It must therefore be proven that the wrongful conduct (the act or omission) of the appellant’s staff caused the baby to suffer brain damage*’. Accordingly, in order for the respondent to succeed, in her claim, she must satisfy the requirements of causation being in respect of both factual causation and legal causation. To succeed, the respondent

¹⁰ *Motswai v Road Accident Fund* 2013 (3) SA 8 (GSJ).

¹¹ *A M and Another v MEC Health, Western Cape* [2020] ZASCA 89; 2021 (3) SA 337 (SCA) para 17.

¹² See *AM obo KM v The Member of the Executive Council for Health, Eastern Cape* [2018] ZASCA 141 at para 18.

¹³ *AN v MEC for Health, Eastern Cape* [2019] ZASCA 102 at par 3.

must establish both factual and legal causation. The ‘but-for’ test, as outlined in *Oppelt v Department of Health, Western Cape*¹⁴, involves determining whether, but for the defendant’s wrongful conduct, the harm would have ensued. The test is based on probability, not certainty.

[64] In *ZA v Smith and Another*¹⁵, the court stated that in cases of conduct by omission, the enquiry on whether but for the defendant’s wrongful and negligent failure to take reasonable steps, the plaintiff’s loss would have ensued. It is trite that the ‘but for’ test is based on common sense and the plaintiff must establish on a balance of probabilities and not with certainty that but for the defendant’s wrongful and negligent conduct, the harm would not have ensued.

[65] In *AN v MEC for Health, Eastern Cape*¹⁶, the court set out the test for factual causation as being ‘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.’

[66] *Goliath v MEC for Health, Eastern Cape*¹⁷, states that professional including nurses are expected to perform their duties with the requisite skill and diligence exercised by members of their profession. In the performance of their duties, nurses owe a legal duty to patients in their care to prevent harm. Consequently, their failure to do so is wrongful and where any damage ensues as a result of such conduct, liability will result.

[67] In *MEC for Health, Western Cape v Qole*¹⁸, it was held that: “... *The legal duty owed by the medical staff at the various health facilities to the respondent and her baby entailed that they adhere to the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which they*

¹⁴ *Oppelt v Head: Health, Department of Health, Provincial Administration: Western Cape*, [2015] ZACC 33; 2016 (1) SA 325 (CC); 2015 (12) BCLR 1471 (CC) para 37.

¹⁵ *ZA v Smith and Another* [2015] ZASCA 75; 2015 (4) SA 574 (SCA) ; [2015] All SA 288 (SCA) para 30.

¹⁶ Fn 12 at par 4.

¹⁷ *Goliath v MEC for Health, Eastern Cape* [2014] ZASCA 182; 2015 (2) SA 97 (SCA) at para 8.

¹⁸ *MEC for Health, Western Cape v Qole* [2018] ZASCA 132 at par 37.

belong. They have no duty to provide the highest possible degree of professional skill. Only reasonable care and skill was required. The respondent had to prove, through credible and persuasive evidence that the doctors and nurses failed to adhere to the required standards.”

[68] In *M v MEC for Health, Eastern Cape*¹⁹, where the appellant was unable to locate the source and timing of hypoxia ischemia due to poor and deceitful record keeping by the hospital staff, and after considering expert evidence that the absence of proper monitoring would create a risk to the appellant and the foetus, the court found that factual causation had been proven. It found on the probabilities that the minor child would not have been injured had the mother been properly monitored. All expert witnesses who testified in this matter agreed that there was a failure to keep proper records which would have assisted them and the court to determine whether there had been adequate monitoring of the respondent and the minor child and to determine the time, if any of the sentinel event which resulted in the injury to the minor child. In view of their failure to keep proper record, it is unclear as to when the injury occurred.

Analysis

The fall

[69] The respondent's fall on 18 June 2012 is undisputed. According to her, the only injury she sustained was a bruised knee. The clinic examination revealed elevated blood pressure. However, neither the clinic nor hospital records indicated any harm or risk to the foetus. The suspicion of potential harm arises only in the reports of Dr Kapongo and later Dr Koll. Prof Davies initially rejected this view but later attempted to align himself with Dr Kapongo's perspective, contradicting his stance.

[70] Dr McLynn identified two possibilities, supraventricular tachycardia and hypotensive syndrome, as potential causes of the respondent's fall. However, he had not encountered instances where either condition resulted in brain damage to the

¹⁹ *M v MEC for Health, Eastern Cape* [2018] ZASCA 141 at para 43.

baby. Dr Kara, in contrast, expressed the opinion that even if the fall caused a convulsion lasting 20 minutes, it must be demonstrated that the cardiovascular collapse lasted over 20 minutes, which he rejected in this case. Importantly, Drs Kara and McLynn's opinions were well-informed, unlike the vague and speculative statements by Dr Koll and Prof Davies, who asserted the fall was the sentinel event without supporting evidence. Upon admission to the hospital, the respondent's blood pressure was elevated, but the CTG report indicated regular foetal heart rate, remaining normal until the delivery on 21 June 2012. Dr Kara's uncontested testimony was that labour would not have been induced if a foetal compromise were suspected. The court a quo's acceptance that the fall was not the cause of the injury was well-found and stands unassailable.

The monitoring

[71] The high-risk nature of the respondent's labour was uncontested. As a primigravida with elevated blood pressure, she received medication for treatment. Dr McLynn, in detailed testimony, criticised the use of Cytotec and outline associated risks. Given these risks, continuous monitoring was deemed necessary, which, unfortunately, was lacking. With proper monitoring, hospital staff could have made informed decisions, potentially contributed to the missed opportunities for monitoring potential risks. While the CTG results indicated a normal foetal heart rate, Dr McLynn noted that this did not rule out other foetal abnormalities.

[72] Considering the shared concern about insufficient records, Dr Kara thought there needed to be evidence of appropriate labour management. Both Dr Kara and Prof Davies deferred to an obstetrician, with Drs Koll and McLynn are the relevant authorities. However, Dr Koll offered no assistance, and Dr McLynn's testimony indicated poor labour management. The court a quo rightly raised concerns about leaving the monitoring of such a high-risk primigravida with elevated blood pressure in the care of a junior nurse, especially when Cytotec induced labour. In light of these circumstances, I concur with the court a quo's conclusion that there was inadequate monitoring and poor labour management.

The delivery

[73] There is no dispute that the CTG was not adequately used as a monitoring tool. Although the information from the CTG showed no signs of foetal distress, there is a disagreement about whether Dr Cele or Sister Mngomezulu conducted the delivery. Dr McLynn's opinion, accepted by the court a quo, was that, given the evident high risk in this case, a medical officer should have delivered the baby rather than an experienced midwife. The continuous risk of oxygen deficit to the baby from contractions due to the use of Cytotec, coupled with inadequate CTG use, hindered the recording of the foetal heart rate. The reliability of Apgar scores was also questioned, given that they were estimated and possibly influenced by resuscitation. The court a quo rightly acknowledged the inadequacy of monitoring in this high-risk situation.

[74] I accept similarly to the court a quo, Dr Kara and Prof Davies that the baby was delivered by sister Mngomezulu. This is however concerning when the risks involved are considered. There was a continuous risk of oxygen deficit to the baby arising from contractions as a result of the use of Cytotec. According to Dr McLynn due to inadequate use of CTG, it was not helpful to provide adequate recording of the foetal heart rate. The Apgar scores of 9/10 were clearly not reliable for two reasons firstly, it was conceded by sister Madonsela that these were recorded from an estimated she made with Sister Mngomezulu and secondly, these could have been affected by resuscitation. Additionally, Dr Kara and Prof Davies agreed that Apgar scores were in isolation not coming or refuting intrapartum asphyxia.

[75] According to sister Mngomezulu, recorded the delivery as satisfactory. Notably, this is contradicted by Dr Kara and Prof Davis. While they could not point at a sentinel event, they agree that this occurred during the second stage of labour. They deferred to a radiologist to identify the exact timing of the brain injury. However, party deemed it necessary to call a radiologist. This was only necessary to identify the exact timing of the sentinel event.

[76] Despite the delivery being recorded as satisfactory, the neonatal nurse noted difficulty in breathing and cephalohematoma, with records indicating resuscitation. Dr Kara and Prof Davies concurred that the average head size at birth, coupled with postnatal microcephaly, favoured an injury close to delivery. They agreed that no

cause of cerebral palsy other than intrapartum hypoxic-ischemia was present and that intrapartum injury was more common than antepartum or postnatal.

[77] The facts of this case resemble those in *M v MEC for Health, Eastern Cape*²⁰ where the experts disagreed because the respondent was unable to locate the source and timing of hypoxic ischemia. This was due to poor record keeping by the hospital staff. It is no surprise that the court a quo found that there had been falsification of the record to cover up the negligence. The Apgar scores indicated the child's condition as satisfactory yet he was described as having difficulty to breathe. Sister Madonsela's Moro reflex was disputed by Prof Davies whose evidence was that NLS was so badly damaged that he could not have Moro reflex. Labour graphs showing no caput yet vacuum delivery records show 3+ caput. While the NLS's condition after birth is recorded as satisfactory, he was given oxygen. While I may not label the record keeping as falsified, it is indeed questionable.

[78] The appellant argues that there is no evidence that there was foetal distress during labour or delivery. This is clearly not supported by the fact NLS did not cry after birth and was given oxygen. Even Dr Kapongo accepts the respondent's version of a floppy infant as discrediting the version of a well-baby with normal Apgar at birth. The only distinction is that he seeks to attribute this to her fall when there is no factual evidence to support this.

[79] After considering expert evidence, it is evident that the absence of proper monitoring, coupled with poor record-keeping during labour, resulted in NLS's injury, presenting as cerebral palsy. The court a quo correctly found factual causation established. The probabilities suggest that proper monitoring would have prevented the minor child's injury. On a balance of probabilities, the respondent successfully demonstrated the alleged lack of monitoring, sub-optimal care, or poor management during the delivery process.

In Chamber events

²⁰ Fn 18 above.

[80] The appellant's raised an issue that the presiding judge in the court a quo called them in chambers and expressed his opinion that the it did not have a valid defence and was surprised that the appellant that the child had a cracked skull. It was contended that the judge had accepted the respondent's untested and incomplete oral evidence as the matter was at this stage part heard. The allegations proved to be false during evidence. In reply, the respondent submitted that it was improper for the appellant to raise issues discussed in chambers. Secondly that if there had been concerns about the judge's impartiality this should have been raised by following numerous appropriate avenues. It submitted also that this was raised ex-post facto clutching straws.

[81] I agree with the respondent in this regard. It is indeed improper for the appellant to raise issues discussed in chambers which are typically confidential. Furthermore, if the appellant had concerns about the judge's impartiality, proper procedures should have been followed. It smells of desperation that the appellant continued to subject itself to the trial proceedings and only when it does not succeed cries fowl. The court finds no merit in this point, affirming that the appellant, represented by experienced counsel, could have taken appropriate steps to protect its interest during the trial if indeed he was of the view that the impartiality of the court a quo was compromised. Accordingly, I see no merit in this point.

Costs

[82] The court a quo awarded costs against the appellant on the attorney and client scale, characterising the appellant's actions as "flogging a dead horse," especially in light of Prof Davies' concession in the joint minute with Dr Kara. The court also considered the matter as standing down several times for settlement, with the appellant insisting that on proceeding with its defence.

[83] The appellate court may only interfere with the court a quo's cost award if it finds that the lower court was influenced by wrong principles or misdirection of the facts. The Constitutional Court in *Limpopo Legal Solutions & another v Eskom Holdings Soc Ltd*²¹ outlined the limited grounds for interference. The court

²¹ *Limpopo Legal Solutions & another v Eskom Holdings Soc Ltd* 2017 (12) BCLR 1497 (CC) para 20.

emphasized that an appellate court should only intervene if the lower court's discretion were not exercised judicially, was influenced by wrong principles, or reached a decision that could not reasonably have been made with the proper consideration of all relevant facts and principles.

[84] In *Public Protector v South African Reserve Bank*²² the court considered the circumstances in which an award of costs on an attorney and client scale should be granted, as being where there is fraudulent, dishonest, vexatious conduct and conduct that amount to an abuse of court process. The court in *Plastic Converters Association of South Africa (PCASA) v National Union of Mineworkers Union of South Africa and others*²³ found that such a cost order is extraordinary and should be reserved for cases where a litigant conducted itself in a clear and indubitably vexatious and reprehensible [manner]. Such an award is intended to be very punitive and indicative of extreme abuse.

[85] While the appellant's argument appears to be convincing, as to the punitive costs order by the court *a quo*, the test on appeal as stated in *Public Protector* para 144 is that:

'Ordinarily, it would be inappropriate for an appeal court to interfere in the exercise of a true discretion, unless it is satisfied that the discretion was not exercised judicially, the discretion was influenced by wrong principles, or a misdirection on the facts, or the decision reached could not reasonably have been made by a court properly directing itself to all the relevant facts and principles. There must have been a material misdirection on the part of the lower court in order for an appeal court to interfere. It is not sufficient, on appeal against a costs order, simply to show that the lower court's order was wrong.'

[86] On the merits of this case, this court believes that the award for a punitive costs order was influenced by wrong principles or an apparent misdirection by the

²² *Public Protector v South African Reserve Bank* 2019 (6) SA 253 (CC) para 8.

²³ *Plastic Converters Association of South Africa (PCASA) v National Union of Mineworkers Union of South Africa & others* (JA112/14) [2016] ZALAC 39; (2016) 37 ILJ 2815 (LAC).

court a quo. However, the court sees no reason why costs should not follow the result.

Order

[87] In the circumstances, I make the following order:

1. The appeal succeeds only in so far as it relates to costs.
2. The order of the court a quo is set aside and is replaced with the following:
‘1 The defendant is ordered to pay all damages as proved of agreed for N[...] S[...], arising out of the negligence of the defendant’s employees during his birth on 21 June 2012.
2. The defendant is ordered to pay the plaintiff’s costs of suite on a party and party scale.
3. The matter is adjourned sine die for the determination of quantum.
3. The appellant is ordered to pay the costs of the appeal.

M B Masipa J

K PILLAY J

I agree

R SINGH AJ

I agree

Matter heard on : 17 March 2023

Judgment delivered on: 30 November 2023

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