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**IN THE HIGH COURT OF SOUTH AFRICA
(EASTERN CAPE DIVISION, BHISHO)**

REPORTABLE

Case No: CA30/2022

Case No: 239/2019

Date heard: 12/06/2023

Date delivered: 20/07/2023

In the matter between:

N[...] J[...]

APPELLANT

and

**MEMBER OF THE EXECUTIVE COUNCIL FOR
THE DEPARTMENT OF HEALTH, EASTERN CAPE**

RESPONDENT

FULL COURT APPEAL JUDGMENT

NOTYESI AJ :

Introduction

[1] This is an appeal against the judgment and order granted by the Court *a quo*, (Matebese AJ) against the Appellant, who as a Plaintiff, had instituted a medical negligence claim against the Respondent, the Member of the Executive Council for the Department of Health, Eastern Cape (MEC).

[2] The Appellant's claim was in her own name and on behalf of her newborn, who had suffered cerebral palsy as a consequence of a hypoxic ischemic encephalopathy during the birth process.

[3] Having been called upon to adjudicate the matter on the issue of liability only, the Court *a quo* found that the Appellant was an unreliable witness and rejected her evidence as well as the joint minutes between experts on the basis that the joint minutes were based on the unreliable evidence of the Appellant. The Court *a quo* also found that the opinion by the radiologists was speculative and mere conjecture because there was no evidence explaining the alternative pathways or the cause of the kind of injury pattern suffered by her newborn.

[4] The appeal served before this Court with the leave of the Court *a quo*.

[5] The Appellant contended, before this Court, that the Court *a quo* erred in not attaching any, or at least enough weight to the joint minutes of experts. It was submitted that the Court *a quo* erred in not finding that, in view of the agreement reached by the experts in the joint minutes, it was not necessary for the Appellant to call further witnesses on the agreed issues and that the Court *a quo* was bound to adjudicate the matter based on such agreement by experts because there was no valid repudiation or withdrawal of the agreement by any of the parties. The Appellant also submitted that the Court *a quo* erred in its assessment of expert evidence and by substituting the direct uncontradicted expert evidence with its own logic and in this regard, the Court *a quo* committed a misdirection because the Appellant's evidence was corroborated by the radiologists in their joint minutes.

[6] The appeal is also founded on the ground that the Court *a quo* had adopted an incorrect approach in assessing the Plaintiff's evidence. In this regard, the Appellant contended that her evidence should have been assessed based on the objective facts, that her evidence was reliable and that the Respondent's negligence was proved on the basis of the uncontradicted objective evidence as reflected from the available records. In addition, the Appellant contended that the finding of the Court *a quo* that the absence of the prenatal and obstetrics records being a mere

neutral factor warranting of no adverse inference to be drawn against the Respondent, was a misdirection. In this regard, the Appellant contended that the Court *a quo* had trivialised the obligations of the Respondent to keep and maintain medical records pertaining to the Appellant's attendance at both clinic and hospital, for treatment and monitoring and the subsequent birth of her newborn.

[7] On the contrary, the Respondent contended that the Appellant failed to give satisfactory and credible evidence that the medical staff employed by the Respondent caused or acted negligently resulting in the brain injury sustained by the Appellant's newborn. Concerning this, the Respondent contended that the evidence given by the Appellant was full of contradictions and therefore the Court *a quo* correctly rejected the Appellant's evidence and that of the Appellant's experts. The Respondent contended that the opinions of the Appellant's experts were based on unreliable evidence from the Appellant.

[8] Insofar as the Appellant complains about the missing records, the Respondent submitted that the Respondent was also prejudiced by the missing records and therefore, there was no basis upon which the Court *a quo* could have drawn an adverse inference against the Respondent.

Issues to be decided

[9] The issue before the Court *a quo*, as in this Court, is whether the medical staff were negligent in their treatment of the Appellant and, if so, whether their negligence caused her newborn to suffer hypoxic ischemic encephalopathy resulting in cerebral palsy.

Background

[10] These facts are largely common cause and they are summarised from the judgment by the Court *a quo*.

(a) The Appellant, aged 26 years at the time, was pregnant.

(b) On 11 September 2009, she experienced contractions during the afternoon. The precise time of when she experienced those contractions is not apparent from the record.

(c) The Appellant attended Baziya Clinic for attention and examination. For the reason that she had a prior caesarean birth, she was transferred to the Mthatha General Hospital.

(d) The Appellant was transported by ambulance to the Mthatha General Hospital. On her arrival, she was admitted for purposes of giving birth to her newborn.

[11] According to the Appellant, she was examined at the Mthatha General Hospital through an instrument that is used to listen to the baby's heart rate and her vagina was also examined. Thereafter she was told that she was still far from delivery. At the time of her examination, she could still experience the contractions and they were strong and painful. The Appellant testified that she was not examined through a cardiotocography, although an instrument was used for her examination.

[12] According to the Appellant, nothing was done to her from 22h00 until 00h00 (midnight), when a nurse approached and examined her with a finger, after which the nurse informed her that she was about to deliver and that she instructed her to push, although nothing happened.

[13] There are no prenatal and obstetric records. There is no indication about when the Appellant started to experience contractions, when she arrived at the Baziya Clinic and the exact time, whether she was transferred to the Mthatha General Hospital and what time exactly she arrived at the Mthatha General Hospital. Most significantly, there are no records to reflect the time when the Appellant was first attended by nurses and the doctors at the Mthatha General Hospital, what type of attention was given to the Appellant and the monitoring intervals that were afforded to the Appellant, if any. The available records relate to the time of birth and the condition at birth and also the diagnosis and treatment given at the Nelson

Mandela Academic Hospital subsequent to the transfer of her newborn from the Mthatha General Hospital.

[14] In this regard, the available records reveal that on 12 September 2009 at approximately 06h35, the Appellant gave birth. Her newborn weighed 3200g. The Appellant gave birth through normal vaginal delivery. The neonatal examination showed that her newborn was pink, afebrile and with a heart rate of 120bpm. Her chest was clear, she had a normal cardiovascular examination, female genitalia, reflexes, some flexion, moro and sucking reflex present and the assessment at the time was that of low Apgar scores and meconium aspiration and that close monitoring was recommended.

[15] The available records of 12 September 2009 further revealed that the Appellant's newborn was transferred to the Nelson Mandela Academic Hospital from the Mthatha General Hospital with a problem of low Apgar scores and fits. The Apgar scores were recorded as 5/10 and 7/10. The examination at the Nelson Mandela Academic Hospital reflected that the Appellant's newborn suffered a hypoxic ischemic encephalopathy grade II. Dormicum (an antiepileptic sedative) was administered to abort seizures.

[16] A neonatal observation of 13 September 2009 noted the following:

- (a) Hypoxic ischemic encephalopathy grade II; and
- (b) An attack of fits with cycling movements at 14h00.

[17] On 14 September 2009, a central nervous system examination was performed, and it revealed lethargy (a pathological state of sleepiness or deep unresponsiveness and inactivity) and hypotonia (a state of low muscle tone).

[18] On 15 September 2009, the records show that no further seizures were noted, although lethargy and hypotonia were still evident and hypoxic ischemic encephalopathy grade II scores had improved to 7 with no sodium levels in the blood being reported.

[19] On 16 September 2009, the hypoxic ischemic encephalopathy grade II was still reported with no fits or seizures noted on the day.

[20] On 17 September 2009, the evaluation once more recorded hypoxic ischemic encephalopathy grade II and hyponatremia with the examination of the respiratory and cardiovascular systems showing within normal limits. The Appellant's newborn was reported still as lethargic and dull with weak response to stimulation and the hypoxic ischemic encephalopathy grade II score had improved to 6.

[21] On 18 September 2009, no further attacks were reported. The baby was still noted as dull and floppy and on interpretation she looked very ill.

[22] An MRI brain scan done on 3 August 2018 (8 years 11 months after the birth of the Appellant's newborn) revealed that the predominant pattern is that of T2 and FLAIR hyperintensities in the peri-rolandic cortex and ventro-lateral aspects of the thalami. In the appropriate clinical history setting, the pattern and location of injury may be suggestive of an old hypoxic ischemic injury in its chronic state of evolution, in a term infant that was exposed to acute profound asphyxia. The thalami may be affected by various other conditions such as infection, systemic or metabolic disease, neuro-degeneration, and vascular conditions. The correlation with the clinical history, biochemistry, neonatal and obstetric records are strongly advised to confirm the most probable cause and the timing of the injury.

The pleadings

[23] In her particulars of claim, the Appellant had alleged that the employees of the Respondent, including the medical practitioners or doctors and nurses who treated her at the Baziya Clinic were negligent in that:

23.1 They failed to properly or sufficiently regularly monitor the Appellant or the condition of the foetus.

23.2 They failed to comply in respect of the monitoring and management of the Appellant's labour with appropriate guidelines for maternity care.

23.3 They failed to monitor the Appellant or the foetus with sufficient care and skill so as to enable the detection timeously of the onset of foetal distress and/or hypoxia.

23.4 They failed to detect the onset of foetal distress and/or foetal hypoxia.

23.5 They failed, following the onset of foetal distress and/or foetal hypoxia, to institute appropriate treatment modalities in respect of the condition or to effect an immediate and timeous caesarean section.

23.6 They failed to prevent the development of hypoxia and hypoxic ischemic encephalopathy.

23.7 They failed to prevent the occurrence of the injury (the Hypoxic Ischemic Encephalopathy Grade II) while the Appellant and her foetus were under the monitoring and care of the Department's employees at the clinic from 09h00 until 22h00 on 11 September 2009.

23.8 They failed to discern or detect either timeously or at all, as they could and should have done, that the Appellant was a candidate for caesarean section.

23.9 They failed to expedite the transferral of the Appellant to the hospital when the foetus developed hypoxia and/or foetal distress.

[24] The Appellant further alleged in her particulars of claim that the Mthatha General Hospital, doctors and nurses who treated her were negligent in that:

24.1 They failed to properly treat and manage the foetal condition of hypoxia and/or foetal distress.

24.2 They failed to immediately or timeously deliver the Appellant's newborn, by way of caesarean section if necessary, when they knew or ought to have known that time was of the essence and that the Appellant's newborn was severely at risk by reason of hypoxia and/or foetal distress.

24.3 They failed, following the onset of foetal distress and/or foetal hypoxia, to institute appropriate treatment modalities in respect of this condition and to effect an immediate or timeous caesarean section.

24.4 They failed to deliver the baby timeously, by caesarean section if necessary, when it became medically advisable and appropriate to do so.

24.5 They failed to prevent the development of hypoxia and hypoxic ischemia encephalopathy.

24.6 They failed to prevent the occurrence of the Hypoxic Ischemic Encephalopathy Grade II while the Appellant and her foetus were under the monitoring and care of the Department's employees at the hospital from approximately 22h00 until approximately 6h36 when the Appellant's newborn was delivered on 12 September 2009.

[25] The Appellant had alleged that the medical practitioners and nursing staff both at the Clinic and Hospital acted in breach of their duty of care and were negligent in her treatment and that of her newborn. It was alleged that they treated the Appellant and her newborn in a sub-standard manner and were negligent in one or more of the following respects:

25.1 They failed to properly assess and diagnose the condition of the Appellant and her unborn child upon admission and failed to implement proper treatment modalities in respect of the Appellant and her unborn child.

25.2 They failed to properly monitor the Appellant and her unborn child and failed to detect the onset of hypoxia.

25.3 They failed to subject the Appellant to a cardiotocography machine in circumstances where they could or should have done so.

25.4 They failed to take all necessary and reasonable steps to expedite the delivery of the Appellant's child through caesarean section in circumstances where they could or should have done so.

25.5 They failed to take all reasonable and necessary steps to ensure the transfer of the Appellant to a higher-level medical facility for the urgent delivery of the Appellant's unborn child.

25.6 They failed to provide the Appellant and her unborn child with medical care and attention and monitoring of reasonable standards when they could and should have done so.

25.7 They failed to prevent foetal distress in circumstances where they could and should have taken steps which would have adequately controlled the said condition.

25.8 They failed to take any adequate steps to prevent the developing of intrapartum asphyxia in consequence of prolonged labour, in circumstances where they could and should have diagnosed this condition and taken appropriate remedial action in respect thereof.

25.9 They failed to monitor the foetal heart rate either properly or at all and failed to detect the onset of foetal distress.

25.10 They failed to diagnose prolonged labour and complications associated therewith when they could and should have done so.

25.11 They failed to provide any adequate treatment in respect of foetal distress following upon prolonged labour when they could and should have done so.

25.12 They failed to monitor the newborn child immediately after birth in circumstances where they could and should have done so.

25.13 They failed to give regard to the newborn's clinical state including the inability to feed and neurological state when they could and should have done so.

25.14 They failed to provide early intervention with supportive care and possible therapeutic hypothermia to improve the newborn's neurological outcome.

25.15 They failed to immediately transfer the newborn to a high-level hospital immediately after noticing that she did not cry during birth, was floppy and had seizures when they could have done so.

25.16 They failed to take any/or any adequate steps to prevent the development of seizures when they could or should have done so.

[26] In the plea, the Respondent admitted that the Appellant and her newborn were treated at the Clinic and Hospital and their duty of care towards the Appellant and her newborn.

[27] The Respondent denied that its employees, both at the Clinic and Hospital, acted in breach of their duty of care or that they were in any manner negligent. The Respondent averred in the plea that the nursing staff and doctors, both at the Clinic and Hospital, treated the Appellant and her newborn in accordance with the required and acceptable standards of care.

The pre-trial minutes

[28] The parties filed a pre-trial minute in accordance with Uniform rule 37. In terms of the minutes, the following agreements were recorded:

28.1 That the Appellant's pregnancy was uncomplicated as she never suffered from any chronic illnesses such as hypertension (high blood pressure), diabetes, epilepsy, tuberculosis, antepartum haemorrhage or cardiac disease and screening tests for HIV and syphilis infection proved negative.

28.2 That the neonatal records indicated that the newborn was born at Mthatha General Hospital at term gestation by normal vaginal delivery.

28.3 That the time of birth is stated as 06h35 on the 12 September 2009 with a birth weight of 3200g.

28.4 That the length at birth and head circumference was not recorded and the Apgar scores were 5 (Heart rate = 2, respiration=1, colour = 1, tone=1, response to stimulation=0 after 1 minute and 5 sub scores not noted) after 5 minutes and 7 (Heart rate=2, respiration=2, colour=1, tone=1, response to stimulation=1) after 10 minutes.

28.5 That the diagnosis stated on the problem list is low Apgar scores and meconium aspiration.

28.6 That the neonatal examination at 07h00 revealed a newborn that was pink, afebrile (no fever), heart rate 120 beats per minute (normal), chest clear, normal cardiovascular examination (normal first and second heart sound with no murmurs), female genitalia, reflexes: some flexion, Moro and sucking reflex present and the assessment at the time was that of low Apgar scores and meconium aspiration.

28.7 That further review at 10h15 noted:

- (i) the presence of a caput (soft tissue swelling of the scalp) and puffy face.
- (ii) neurological examination revealed low muscle tone (hypotonia).

- (iii) the possibility of meconium aspiration syndrome is queried.
- (iv) the seizure.
- (v) blood glucose measurement was 3.2 mmol/L (normal).
- (vi) the plan of action was to arrange transfer to the neonatal unit (NNU) at Nelson Mandela Academic Hospital.

28.8 That the neonatal observation chart dated 12/9/2009 reports that:

- (i) the baby was pink on arrival.
- (ii) she was noted to be mildly distressed although breathing spontaneously in room air.
- (iii) fitting (seizures) were also reported.
- (iv) the plan of action was to nurse the baby in a warmer and to administer oxygen via nasal prongs.
- (v) dormicum (anti-epileptic sedative) 0.5 mg was administered with effect.
- (vi) at 11h30:
 - Dr Kondlo examined the baby and ordered dormicum to be administered;
 - in addition, the following blood investigations were requested: full blood count (FBC), Urea and electrolytes (U&E),

C-reactive protein (CRP), blood culture, VDRL (serological test for syphilis infection), glucose;

- treatment advised included the administration of intravenous fluids (NNL=neonatalyte), oxygen via nasal prongs and monitoring seizures.

(vii) at 11h40 cycling movements were noted and phenobarbitone (2nd anti-epileptic medication) 60mg intravenously was administered.

(viii) dextrostix (blood sugar) at 12h00 was noted to be high (11 mmol/L).

(ix) at 17h10, further cycling and fisting (or fitting) was noted and dormicum 0.4 mg was once again administered and dextrostix was normal (3.1 mmol/L).

(x) that the day 1 neonatal observation chart dated 13/9/2009 noted the following findings:

- hypoxic ischemic encephalopathy grade II;
- had an attack of fits with cycling movements at 14h00;
- dormicum 0.4 mg given with very little effect;
- dextrostix at 18h00 was very high (25.4 mmol/L);
- at 23h00 had an attack of fits, desaturate (drop in oxygen levels) dormicum given with effect.

(xi) that on day 2 (14/9/2009) Central nervous system (CNS) examination revealed:

- lethargy (a pathological state of sleepiness or deep unresponsiveness and inactivity) and hypotonia (a state of low muscle tone);
- the patient was reported as sedated;
- the grasp and Moro reflex was reported as reduced;
- Hypoxic Ischemic Encephalopathy Grade II score=9 and diagnosis is stated as Hypoxic Ischemic Encephalopathy Grade II;
- plan of management was to continue treatment, to note the presence of seizures on a seizure chart, to initiate feeds via a nasogastric tube, to give NNL at 6 ml/hr and to get the outstanding blood investigation results;
- blood investigations on day 2 revealed the following results: Sodium 121 (low) potassium 7.8 (high) urea 8.9 (high) and creatinine 87 (high);
- it was noted that the blood example was haemolysed (destruction, damage or breakdown of red blood cells). (When red blood cells are damaged it causes haemoglobin to leak from the cells and this may affect the accuracy of the blood tests);
- the C-reactive protein measured 5.7 mg/L (normal) (CRP is a marker of the inflammation in the body. It is used to identify the presence of inflammation or infection in the body).

(xii) on day 3 (15/9/2009):

- no further seizures since the 13/9/2009;
- lethargy and hypotonia was still evidence on CNS examination;
- the Hypoxic Ischemic Encephalopathy Grade II score improved to 7 and Hyponatremia (low sodium levels in the blood) was reported and blood investigations were repeated.

(xiii) on day 4 (16/9/2009):

- the diagnosis is stated as Hypoxic Ischemic Encephalopathy Grade II and hyponatremia;
- the baby's condition is reported as the same;
- last fitted 2 days ago;
- blood investigations on day 4 revealed low serum sodium of 130 mmol/L, potassium of 5.5 mmol/L (normal) and elevated urea 6.5 mmol/L. This time the blood sample only showed minor haemolysis.

(xiv) on day 5 (17/9/2009):

- evaluation once again recorded Hypoxic Ischemic Encephalopathy Grade II and hyponatremia as the working diagnosis;
- examination of the respiratory and cardiovascular systems was within normal limits;

- CNS examination revealed a normotensive anterior fontanel;
- the newborn is reported as still lethargic and dull with weak response to stimulation;
- the Hypoxic Ischemic Encephalopathy score improved to 6;
- assessment was 'still sick' and the plan was to continue treatment, to increase the feeds to 24 ml x 8; to continue the normal saline drip at rate of 5ml/hr and to repeat blood investigations.

(xv) that on day 6 (18/9/2009):

- evaluation noted no further attacks;
- feeds were administered via a nasogastric tube;
- the newborn was still noted as dull and floppy;
- interpretation was that the baby 'looks very ill.

28.9 That the Nelson Mandela Academic Hospital neonatal discharge summary reports that discharge occurred on 20 September 2009 (after 8 days in hospital). The head circumference on discharge was 38cm. Main problems encountered were hypoxic ischemic encephalopathy grade II and hyponatremia.

28.10 That neonatal review at 1 month of age (15/10/2009) reported that the newborn was well except for on-and-off diarrhoea. Oral dehydration sachets

(Orsol) were prescribed. The diagnosis is stated as hypoxic ischemic encephalopathy grade II.

28.11 That clinical review at 3 months of age (10/12/2009) reported the presence of a cough, no seizures at home and no episodes of diarrhea. However, neurological examination revealed early signs of cerebral palsy, i.e. abnormal posture, extended legs, head lag, cycling movements and increased tone in all 4 limbs and the assessment was that of a mild respiratory tract infection and spastic cerebral palsy.

28.12 That clinical review at 4 months of age (11/2/2010), reported that the newborn was admitted with left sided seizures. The medical notes report a background of hypoxic ischemic encephalopathy grade II. Neurological examination revealed no focal neurological signs and phenobarbitone 30 mg in the evenings was prescribed. Discharge medication also included multivitamins, paracetamol and amoxicillin (antibiotic).

Expert joint minutes

[29] The parties filed joint minutes and these are between (a) the paediatric neurologists, Prof Ronald van Toorn and Dr Amith Keshave; (b) the radiologists, Prof J W Lotz (JL) and Dr Zuzile Zikalala (ZZ); and (c) the obstetricians, Dr Ebrahim and Dr Vuyelwa L P Baba.

[30] The agreement between the radiologists states that:

‘The MRI study defines structural damage to the perirolandic cortex and the basal ganglia, thalamic complex (BGT), constituting a cerebrocortical-deep nuclear pattern.’

[31] The agreement between the paediatric neurologists states that:

‘16. Prof R van Toorn The 2019 (reaffirmed) ACOG neonatal encephalopathy and the neurological outcome task force describes 4 patterns

of selective neuronal injuries (in term infants with neonatal encephalopathy) which reflect the severity, duration, the nature of the insult (page 150). The second form of selective neuronal injury is the cerebral-deep nuclear neuronal injury pattern, which combines neuronal damage in the deep nuclear grey matter with injury in the cerebral cortex, usually the parasagittal area of the perirolandic cortex. This is referred to on imaging studies as “cerebral deep nuclear” pattern. It is my opinion that this is the MRI pattern evidence on I[...]’s MRI scan. Dr Keshave agreed.’

[32] Dr Keshave had recorded in the joint minute the statement below:

‘Upon review of the WES and Metabolic screen, there is no other factors that could account for I[...]’s current clinical presentation and MRI scan, other than hypoxic ischemic encephalopathy. However, the presence of negligence in view of the absence of maternal records remains to be determined, and hence the opinion of an obstetrician should be sought.’

[33] The obstetricians recorded in their joint minute that due to the absence of medical reports, they based their report on Ms J[...]’s recollection of events around her pregnancy, labour, delivery and the available documents. During the interview with the Appellant, she was speaking in Xhosa and her version was interpreted on her behalf.

The trial and evidence

[34] At the commencement of the trial, the parties confirmed before the Court *a quo* that the issue to be determined was only negligence and that causation was not an issue. I quote from the record below:

‘Court: Thank you, Mr Du Plessis. Mr Mtshabe, just to confirm something. Are you in agreement that the issue that we are going to deal with is only negligence, causation, is not an issue.

Mr Mtshabe: That is correct, M’Lord.’

[35] The Appellant largely testified about her labour. She testified that her newborn was her third child. The first child was born by caesarean section and the second child was born by normal vaginal delivery. In respect of her newborn, she had attended her antenatal care at Basiya Clinic in Mthatha, from the fifth month of her pregnancy. There were no reported difficulties with her pregnancy, save for a minor discharge that was treated.

[36] According to the Appellant, she had experienced labour pains on 11 September 2009 and went to the Basiya Clinic at about 19h00. Upon her arrival, she was examined by means of a certain instrument that was used to hear the baby's heartbeat and a finger was put by the nurse on her and she was informed that she was not ready to deliver at the time.

[37] According to the Appellant, she was advised that it would not be proper for her to deliver thereat because she had previously had a caesarean section and for that reason, she was transferred to the Mthatha General Hospital. On the way to the Mthatha General Hospital, she was transported by an ambulance and in her recollection, she arrived at the Mthatha General Hospital at 22h00. Upon her arrival at the hospital, she was examined through an instrument that is used to listen to the baby's heart rate. Her vagina was also examined and thereafter she was told that she was still far from delivery. According to the Appellant, she was not examined by means of a cardiotocography, although, an instrument was put on her stomach and the nurses listened through their ears.

[38] The Appellant testified that from 22h00 until 00h00 nothing was done. Only at 00h00 did a nurse examine her with a finger after which the nurse told her that she was about to deliver and that she was instructed by the nurse to push, and at that stage, nothing happened. According to the Appellant, at the Mthatha General Hospital, there was no further examination of the baby's heart rate, except for the first one that had occurred at 22h00. She testified that her newborn was born on 12 September 2009 at 06h35 in the morning.

[39] According to the Appellant, after delivery, her newborn was taken from her and she only learned that her newborn had been taken to the Nelson Mandela Academic Hospital, where she was admitted to ICU. She testified that her newborn is currently unable to eat on her own and that she needs to be assisted as she cannot do anything for herself.

[40] During cross-examination, the Appellant was asked questions about time periods relevant to the start of experiencing labour pains, attending to the Basiya Clinic, arrival at the Basiya Clinic, transferral to Mthatha General Hospital, monitoring at the hospital and the subsequent delivery of her newborn. The Appellant gave contradictory times in this regard as she did not confirm what she told the experts, Dr Ebrahim and Dr Baba. The Respondent's version was not put to the Appellant.

[41] The next witness for the Appellant was Prof Van Toorn. In brief, his evidence was that he was requested to give an opinion regarding the cause and timing of the Appellant's newborn's brain injury. He agreed with the MRI analysis and the findings of the radiologists in their joint minutes. He testified that, in the case of Appellant's newborn, there was no recorded sentinel event and according to him, the injury might have been caused by a series of events over a prolonged period of time. He testified that if there was a sentinel event it would have been recorded in the neonatal records and according to him there is no indication of such a sentinel event from the Nelson Mandela Academic Hospital's records. He stated that the type of injury to the child is a partial prolonged type of injury.

[42] For completeness in this regard, I quote the findings of the radiologists as contained in the joint minute—

‘(i) There is evidence of previous hypoxic-ischemic injury in this child's brain.

(ii) The MRI study defines structural damage to the perirolandic cortex and the basal ganglia, thalamic complex (BGT), constituting a cerebrocortical-deep nuclear pattern. In the appropriate clinical context of a sentinel event, the pattern may be referred to as an acute profound hypoxic ischemic injury.

In the absence of a clearly defined sentinel event, the same pattern may occur due to alternative pathways of serial events over a prolonged period of time. In this context, we attach the most recent communication endorsed by The new-born Brain Society Guidelines and Publications Committee, and defer to clinical and obstetrical experts to evaluate the described pattern against the available clinical and obstetrical records.

(iii) The experts agree that there are no findings of structural or congenital malformation of the brain.

(iv) The experts agree that there are no signs of an inborn error of metabolism.

(v) The experts agree that the imaging features do not support a congenital infection with deleterious effects on the central nervous system, such as toxoplasmosis, rubella, cytomegalovirus or herpes.'

[43] Prof Van Toorn concluded his evidence by saying that the brain damage of the Appellant's newborn is because of lack of oxygen, lack of blood and that is what appears from the MRI scan, although he had difficulty to comment on how long the insult occurred, but according to the pattern of injury, it was probably prolonged.

[44] The next witness was Dr Ebrahim, a specialist obstetrician and gynaecologist. In essence, Dr Ebrahim testified that the maternity guidelines, which is the manual for the standard of care in labour indicates that a person who has a previous caesarean section, once she is in labour, the foetal heart rate should be monitored using a cardiotocography monitor and that monitoring should be continuous for the duration of the labour. He agreed that, due to the shortage of cardiotocography machines in hospitals, it is acceptable to use the monitor for a short period, 20 or 30 minutes. In this case, Dr Ebrahim stated that as the Appellant had a history of a caesarean section, she required the cardiotocography monitoring, the reason being that there is a risk of the scar being placed under stress and monitoring the foetal heart rate can give signs of a warning of the weakening of the scar and before the scar ruptures.

[45] Dr Ebrahim listed the disadvantages of just listening to the foetal heart rate without the use of a cardiotocography machine. In this regard, he testified that there would be no record for review whenever there are complications. Secondly, in patients with a previous caesarean section, listening to the heartbeat is not enough to check for intactness of the scar. He further testified that, although a breakdown in the scar is not common with a person with a previous caesarean section, it is rare and that is why patients with a previous caesarean section are allowed to go into labour and if it does occur, then maintaining monitoring with the cardiotocography provides adequate notice for intervention to take place without a catastrophe occurring.

[46] According to Dr Ebrahim, the main reason that the foetal rate must be monitored is to ensure that the foetus remains well oxygenated in labour. The oxygen supply to the foetus comes from the mother via an umbilical cord into the foetal circulation. Dr Ebrahim testified that, if that supply is reduced, or if it begins as normal and it undergoes a reduction during the course of labour, because of the stress of labour, then the foetus responds by alterations in the foetal heart rate. That would indicate that the oxygen levels are becoming insufficient for the vital needs of the foetus. Essentially, it is the need of the brain, heart and kidneys which are the main organs. The foetus responds by slowing the heart rate and by monitoring the heart rate and detecting these changes in the heart rate, which are called deceleration, they provide warning signs that if the sequence of events is allowed to continue, the foetus will suffer serious injury and possible death. According to Dr Ebrahim, that warning in labour occurs two to three hours and sometimes four hours before the actual damage takes place.

[47] Dr Ebrahim suggested that it is highly likely that, in this case, foetal distress occurred without being detected during labour and that, if the nursing staff had carried out foetal heart rate monitoring satisfactorily in this period, foetal distress would have been detected early enough to enable urgent delivery of the baby by an emergency caesarean section. According to Dr Ebrahim, if this had been done, it is probable that the baby would have been born in a healthy condition without hypoxic brain injury.

[48] Dr Ebrahim, quoting from his report, stated that:

‘Thus despite the lack of essential neonatal clinical records and placental histology, the cause of a reverse HIE, hypoxic ischemic encephalopathy, was most probably intrapartum hypoxia/acute foetal distress. This was not detected because foetal heart rate monitoring was probably not conducted satisfactorily in labour. The degree of foetal distress was severe enough to cause significant neonatal HIE in her (that is in the baby) which subsequently progressed to cerebral palsy. This sequence of events is the most likely explanation for her disability. If appropriate monitoring and management was carried out, these complications and unlikely to have occurred and she would most probably have been born in a healthy state.’

[49] Dr Ebrahim testified that if there is no proper monitoring, there is one of two scenarios, the one is that absent proper monitoring, warning signs would not be picked up, and the second scenario is that, if there is proper monitoring, but is ignored or the nurses do not recognise the warning signs, the situation would occur.

[50] Dr Ebrahim had explained the manner in which an injury had occurred and in his explanation, he said (and I quote):

‘It all relates to the way the foetus responds to a lack of oxygen. Essentially, as the oxygen supply is reduced to the foetus, the foetus has a means to ration the oxygen according to the hierarchy of needs and the foetus naturally sends oxygen when it is in short supply mainly to the heart and to the brain and to an extent to the kidneys. So those are the organs that are preferentially supplied with oxygen when there is a reduction in oxygen supply to the foetus. But of course, if that reduction continues, then there comes a time where the oxygen supply to the brain itself is placed under threat. And when that happens, then the brain itself will decide which portions are more deserving of the oxygen within the brain. So if the supply is reduced gradually, then the brain will deprive the areas of thoughts and the areas of emotion and personality and intelligence and send the oxygen to the parts of the brain that

are controlling the heart and the respiration because that is a survival mechanism. But if the supply is reduced to the brain suddenly, the brain does not have a chance to auto regulate and under those circumstances the most vulnerable areas die first.'

[51] In the opinion of Dr Ebrahim, the child suffered a lack of oxygen as a result of the stress of labour and the warning signs were not detected because the monitoring was not appropriate and as a consequence, it was only recognised at birth that this child had suffered severe distress during the course of labour and that is when resuscitation and other measures were implemented to try and save, firstly the life of the child and to optimise the health of the child as best as could be done given that the window of opportunity in labour had diminished.

[52] Dr Ebrahim's cross-examination centred around the inconsistent time period given to him by the Appellant. It was suggested that his opinions would be based on incorrect facts.

[53] The Respondent had called two witnesses, Dr Amith Keshave and Dr Vuyelwa Baba. Dr Keshave testified that he consulted with the Appellant and that he also examined the Appellant's newborn. He found the child to be suffering from cerebral palsy. He testified further that in trying to determine the probable cause of the cerebral palsy, one had to look at the baby's head size and compare it to the length and weight of the baby. According to Dr Keshave, unfortunately, with the Appellant's newborn, there was no recorded length and it was only the weight and the head size that were recorded. The head size was above 97 percentiles, which was, according to him, above average.

[54] Dr Keshave testified that under normal circumstances, and considering the head size, the normal birth weight of the Appellant's newborn ought to have been 3.8 kg, however, in this case, the weight was 3.2 kg. He testified that there was a possibility of intra-uterine growth restriction. In Dr Keshave's opinion, the baby had no reserves to go through a birth process and this was the probable cause of the injury suffered by the Appellant's newborn.

[55] Dr Keshave testified that there was no evidence on record of any hypoxic ischemic encephalopathy between 06h35 and 7h35 and that the diagnosis of hypoxic ischemic encephalopathy was only done at 10h15 and there is no explanation for such delay. He further testified that the seizures were only noted on the minor child at 11h30, according to the records.

[56] Dr Keshave conceded that there is hypoxic injury which occurred intrapartum, but he contended that the hypoxic injury could have occurred during the birth process and as a result of the intra-uterine growth restriction – a contention which is nowhere apparent in the Respondent's pleadings.

[57] During cross-examination, it was put to Dr Keshave that in the joint minute he suggested a whole exam sequencing which involves the looking at the genes and the metabolic screen of the child so as to exclude other factors that may have caused the cerebral palsy and that the whole exam sequencing came out negative which he confirmed. It was then put to Dr Keshave that when all the other factors that may have led to the cerebral palsy came out negative, he then resorted to intra-uterine growth restriction to which he responded by simply saying that the child had a predisposing condition in the form of a head circumferences that was above 90 in size and a birth weight that was nearly 25.

[58] It was further put to Dr Keshave, during cross-examination that on probability there would be warning signs of any hypoxic ischemic encephalopathy and that those warning signs would have been picked up through proper monitoring. His response was that he would rather defer to obstetricians but where the child had intra-uterine growth restriction the probability is that the injury would have occurred in the last minutes of the delivery.

[59] The next witness called by the Respondent was Dr Vuyelwa Baba, an obstetrician and gynaecologist. She testified that she conducted a virtual interview of the Appellant on 11 December 2020 and the Appellant, at the time, was with her minor child, the Appellant's newborn. She testified that her opinions were largely based on the history and information provided by the Appellant.

[60] Dr Baba testified that, according to the Appellant, her lower abdominal pains started around 15h00 on 11 September 2009 whilst she was at home and she went to her local clinic around 16h00 and arrived at the clinic around 18h00. Dr Baba testified that the Appellant had advised her that her membranes ruptured at the local clinic and she was then transferred to hospital because she had a previous caesarean section and that she arrived at the hospital around 19h00 on the same day.

[61] Dr Baba was informed by the Appellant that upon her arrival at the hospital around 19h00, she was assessed and seen by a doctor and was told that the foetal heart rate was fine and that she was still far from delivering. The Appellant further advised her that she recalls calling for assistance around 21h00 and a nurse came to assist her and she was told that the foetal heart was fine and she was not about to deliver.

[62] According to Dr Baba, the Appellant advised that she again called for help at 23h00 and a different nurse came to review and asked her to push the baby as she was ready to deliver and that the baby was born shortly after midnight.

[63] Dr Baba was informed by the Appellant that the Appellant's newborn did not cry at birth and was taken to ICU.

[64] Dr Baba confirmed that there were no medical records and that she relied on the information that she received from the Appellant and the limited available records in preparation of her report.

[65] According to Dr Baba the weight of the baby at birth was 3200g as reflected in the neonatal records and the Apgar score at birth was 5/10 which was low and would have required resuscitation.

[66] In her report, Dr Baba concluded that the clinical management carried out by the staff at the local clinic was appropriate up to the transfer to the hospital. She also concluded that the labour in the hospital, according to what the patient said, also seemed adequate and following national protocols. Dr Baba noted some discrepancy

concerning the delivery time as the Appellant said she delivered around midnight, whereas the neonatal records reflect that she delivered at 06h35.

[67] Dr Baba testified further that during the latent phase of labour the guidelines prescribe that the foetal heart rate must be monitored every 2 hours and that during the active phase of labour they prescribe that monitoring must occur every 30 minutes and before, during and after every contraction.

[68] During cross examination, Dr Baba confirmed that she had sight of the joint minutes of the radiologists, Prof Lotz and Dr Zikalala, as well as the obstetricians.

[69] Dr Baba testified that when consulting with the Appellant, it was not clear whether cardiotocography was done or not and that the Appellant was speaking in isiXhosa and therefore, she was unable to confirm whether cardiotocography was done or not. Dr Baba was able to glean from the Appellant that the foetal heart was checked as the Appellant advised her that a horn was used to listen to the baby's heart. Dr Baba further confirmed that the Apgar scores at 1 minute were 5/10, at 5 minutes they were 5/10 and then at 10 minutes they improved to 7/10 and that the Appellant's newborn was quickly taken to ICU and transferred to Nelson Mandela Academic Hospital where the Appellant's newborn was diagnosed with hypoxic ischemic encephalopathy. Dr Baba, under cross-examination, accepted that there was no recorded sentinel event in respect of the Appellant's newborn. However, Dr Baba could not agree that the fact that it was not recorded means that it did not exist. Dr Baba stated that the sentinel event may not have been communicated though it existed and so with the unavailability of the maternity case records one cannot tell whether there was a sentinel event noted at birth which was not communicated to Nelson Mandela Academic Hospital or not.

[70] Dr Baba conceded that the Appellant was a high risk for the reasons of her caesarean section scar and that was the reason for her referral to the hospital. In this regard, Dr Baba testified that, according to guidelines, 2 hourly monitoring for the Appellant was required during the latent phase of labour and the active phase of labour half hourly monitoring is prescribed. She confirmed that she was not furnished

with any information regarding the monitoring of the Appellant from midnight until the birth of the child at 06h35 on the morning of 12 September 2009.

The legal framework for delictual liability

[71] To obtain a judgment holding the defendant liable to pay delictual damages, the court in *Minister of Safety & Security v Van Duivenboden*¹ stated that the plaintiff must prove, on a balance of probabilities, that the act(s) or omission(s) of the defendant was wrongful and negligent, and caused loss. The approach in our law to the plaintiff's claim is not controversial.

[72] It is trite that in order to succeed in her delictual claim for damages, the plaintiff must establish that the wrongful and negligent conduct of the Respondents nursing and medical staff, acting within the course and scope of their employment, caused her harm.

[73] The correct approach for establishing the existence or otherwise of negligence was laid down in *Kruger v Coetzee* decades ago and remains the same. This test rests on two bases, namely, reasonable foreseeability and the reasonable preventability of damage. It is important to emphasise that what is required is foresight of the reasonable possibility of harm ensuing; foresight of a mere possibility of harm does not suffice. What is or is not reasonably foreseeable in a particular case is a fact bound enquiry that entails the consideration of all the circumstances of the case. Health professionals such as doctors and nurses are required to dispense reasonable care by adhering to the level of skill and diligence exercised by members of their profession, failing which they would be negligent.

[74] In the circumstances of this case, the hospital staff, doctors and nurses, who attended to the Appellant will be found to have been negligent if, in dispensing medical care to the Appellant, they failed to foresee the possibility of harm occurring in circumstances where similarly qualified health professionals in the same position would have reasonably foreseen this possibility and would have taken steps to

¹ *Minister of Safety & Security v Van Duivenboden* 2002 (6) SA 431 SCA para 12.

prevent it.² Put otherwise, negligence concerns a deviation from a particular standard of conduct.

[75] In *Kruger v Coetzee*³ it was held-

‘For the purposes of liability culpa arises if–

(a) a diligens paterfamilias in the position of the defendant (or his employees)–

(i) would foresee the reasonable possibility of his (their) conduct injuring another in his person or property and causing him patrimonial loss; and

(ii) would take reasonable steps to guard against such occurrence; and

(b) the defendant (or his employees) failed to take such steps.’

[76] In *The Member of the Executive Council for Health, Eastern Cape v DL obo AL*,⁴ Molemela JA (as she then was) dealing with the test for causation held:

‘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 damage 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 not, factual causation has

² *The Member of the Executive Council for Health, Eastern Cape v DL obo AL* [2021] ZASCA 68 para 8.

³ *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430E.

⁴ *Ibid* para 9.

not been established and one is left with only wrongful conduct without proof that it caused the harm suffered.'

[77] In *Naude NO v Transvaal Boot and Shoe Manufacturing*⁵ it was held:

'Although the onus of proving negligence is on the plaintiff, the plaintiff does not have to adduce positive evidence to disprove every theoretical explanation which is exclusively within the knowledge of the defendant, however unlikely, that might be devised to explain (his paraplegia) in a way which would absolve the defendant and his employees of negligence.'

[78] In *Mitchell v Dixon*⁶ it was held:

'A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.'

[79] In *Monteoli v Woolworths (Pty) Ltd*⁷ the court confirmed that the onus, nevertheless, remains with the plaintiff. The defendant has an evidential burden to show what steps were taken to comply with the standards to be expected.

[80] In *Minister of Safety & Security & Another v Carmichele*⁸ the court confirmed that causation has two elements:

'1. The factual issue to be established on a balance of probabilities by the plaintiff by using the "but for" test would involve the mental elimination of the wrongful conduct in the posing of the question as to whether upon such hypothesis, the plaintiff's loss would have ensued or not;

⁵ *Naude NO v Transvaal Boot and Shoe Manufacturing* 1938 AD 379 at 392.

⁶ *Mitchell v Dixon* 1914 AD 519 at 525.

⁷ *Monteoli v Woolworths (Pty) Ltd* 2000 (4) SA 735 (W) at 127.

⁸ *Minister of Safety & Security & Another v Carmichele* 2004 (3) SA 305 (SCA).

2. The legal causation, namely whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensure or whether, as it is said, the loss is too remote. This is a juridical problem and considerations of policy may play a part in the solution thereof.'

[81] In *Caswell v Powell Duffryn Associates Collieries*⁹ Lord Wright remarked:

'Inference must be carefully distinguished from conjecture or speculation. There can be no inference unless there are objective facts from which to infer the other facts from which it is sought to establish. In some cases, the other facts can be inferred with as much practical certainty as if they had been actually observed. In other cases the inference does not go beyond reasonable probability. But if there are no positive proved facts from which the inference can be made, the method of inference fails and what is left is mere speculation or conjecture.'

[82] In the notice of appeal in the present case, it was submitted that the Court *a quo* had erred in not attaching any, alternatively, sufficient or appropriate evidential weight to the agreement reached between overlapping experts as expressed in their respective joint minutes. The contention by the Appellant, in this regard, was that the Court *a quo* erred in not taking into account that as a result of the agreements embodied in the joint minutes, there was no need for the Appellant to adduce evidence on the agreed issues and that the Court *a quo* had no foundational basis for not accepting the agreement between the radiologists that the injury, in the absence of a sentinel event, had occurred over a long period of time.

[83] The contention, as I understand, is that the Court *a quo* had erred in ignoring the agreement and or the joint minutes by experts.

[84] This contention raises the question as to the effect of an agreement recorded by experts in a joint minute.

⁹ *Caswell v Powell Duffryn Associates Collieries* [1939] 3 All ER 722 (HL) at 733.

[85] In *Bee v RAF*¹⁰ Rogers AJA said:

‘The appellant’s counsel referred us to the judgment of Sutherland J in *Thomas v BD Sarens (Pty) Ltd* [2012] ZAGPJHC 161. The learned judge said that where certain facts are agreed between the parties in civil litigation, the court is bound by such agreement, even if it is sceptical about those facts (para 9). Where the parties engage experts who investigate the facts and where those experts meet and agree upon those facts, a litigant may not repudiate the agreement “unless it does so clearly and, at the very latest, at the outset of the trial” (para 11). In the absence of a timeous repudiation, the facts agreed by the experts enjoy the same status as facts which are common cause on the pleadings or facts agreed in a pre-trial conference (para 12). Where the experts reach agreement on a matter of opinion, the litigants are likewise not at liberty to repudiate the agreement. The trial court is not bound to adopt the opinion but the circumstances in which it would not do so are likely to be rare (para 13). Sutherland J’s exposition has been approved in several subsequent cases, including in a decision of the full court of the Gauteng Division, Pretoria, in *Malema v Road Accident Fund* [2017] ZAGPJHC 275 para 92.

“In my view we should in general endorse Sutherland J’s approach, subject to the qualifications which follow. A fundamental feature of case management, here and abroad, is that litigants are required to reach agreement on as many matters as possible so as to limit the issues to be tried. Where the matters in question fall within the realm of the experts rather than lay witnesses, it is entirely appropriate to insist that experts in like disciplines meet and sign joint minutes. Effective case management would be undermined if there were unconstrained liberty to depart from agreements reached during the course of pre-trial procedures, including those reached by the litigants’ respective experts. There would be no incentive for parties and experts to agree matters because, despite such agreement, a litigant would have to prepare as if all matters were in issue. In the present case the litigants agreed, in their pre-trial

¹⁰ *Bee v Road Accident Fund* 2018 (4) SA 366 (SCA) paras 64-66.

minute of 14 March 2014, that the purpose of the meeting of the experts was to identify areas of common ground and to identify those issues which called for resolution.”

[86] In *MEC for Health and Social Development, Gauteng v MM on behalf of OM*¹¹ Gorven JA held:

‘Of some importance in this matter is the status of such joint minutes. They recorded areas of agreement and disagreement of the expert witnesses of the parties. A pre-trial meeting agreed that, where there was agreement between two or more expert witnesses, that agreement was binding on the parties. In that regard, this Court has held—

“Where, as here, the court has directed experts to meet and file joint minutes, and where the experts have done so, the joint minute will correctly be understood as limiting the issues on which evidence is needed. If a litigant for any reason does not wish to be bound by the limitation, fair warning must be given. In the absence of repudiation (i.e. fair warning), the other litigant is entitled to run the case on the basis that the matters agreed between the experts are not in issue.”

It follows, as a necessary corollary, that where there is no agreement, the minutes must be disregarded. If a party wishes to rely on what a witness records in a minute where there is no agreement, evidence on that point is necessary before it may be taken into account.’

[87] The parties, in this case, rely upon evidence of experts. The experts who testified are experienced in their respective fields. As a result of the expert reports and testimonies, the issues were narrowed down substantially. The starting point would be to evaluate and resolve the conflict in the testimony of the experts for the Appellant and the Respondent. In doing such an evaluation, the Full Bench of this

¹¹ *MEC for Health and Social Development, Gauteng v MM on behalf of OM* [2021] ZASCA 128 para 16; See also *AS obo S v The Member of the Executive Council for the Department of Health, Eastern Cape*, unreported judgment (ECD), Case No 29/2022 paras 68-69.

Division in *J.A obo D.M.A v Member of Executive Council for Health, Eastern Cape*¹² held:

‘The opinion of a witness is generally inadmissible. “In the law of evidence, ‘opinion’ means any inference from observed facts, and the law on the subject derived from the general rule that witnesses must speak only to that which was directly observed by them.” Opinion is admissible if it is relevant. Relevance is in turn determined by the issues in the matter. If the opinion can assist the court in determining an issue, it has probative value, otherwise it is superfluous. Expert opinion evidence is received when the issues require special skill and knowledge to draw the right inferences from the facts stated by the witnesses.’

[88] The Full Bench of the Eastern Cape in *J.A obo D.M.A* discusses several types of conflicts in expert evidence that may present itself in any given case.¹³

[89] The first is a conflict about the assumed facts. Expert opinion must have a factual basis. The facts upon which an expert opinion is based must be proved by admissible evidence.

[90] A second conflict in the expert opinion may lie in the analysis of the established facts and the inferences drawn therefrom by the opposing witnesses. The cogency of the expert opinion depends on its consistency with proven facts and on the reasoning by which the conclusion is reached. The source for the evaluation of this evidence for its cogency and reliability are: (a) the reasons that have been provided by the expert for the position adopted by him/her; (b) whether that reasoning has a logical basis when measured against the established facts; and (c) the probabilities raised on the facts of the matter. It means that the opinion must be logical in its own context, that is, it must accord with, and be consistent with all the established facts, and must not postulate facts which have not been proved.

¹² *J.A obo D.M.A v Member of Executive Council for Health, Eastern Cape* [2022] ZAECHC 1; [2022] 2 All SA 112 (ECB); 2022 (3) SA 475 (ECB) para 10 – see also the authorities referred to in the judgment.

¹³ *Ibid* at 9-17.

[91] The inferences drawn from the facts must be sound. The logic of the opinion must be consistent, and the reasoning adopted in arriving at the conclusion in question must accord with what the accepted standards of methodology are in the relevant discipline.

[92] The reasoning will be illogical or irrational and consequently unreliable, if (a) it is based on a misinterpretation of the facts; (b) it is speculative, or internally contradictory or inconsistent to be unreliable; (c) if the opinion is based on a standard of conduct that is higher or lower than what has been found to be the acceptable standard; and (d) if the methodology employed by the expert witness is flawed. What flows from this is that the mere fact that an expert opinion is unchallenged, does not necessarily mean that it must be accepted. However, if that evidence is based on sound grounds and is supported by the facts, there exists no reason not to accept it.

[93] Other considerations relevant in this context are (a) the qualifications and the experience of the expert witnesses with regard to the issue he or she is asked to express an opinion on; (b) support by authoritative, peer-reviewed literature; (c) the measure of equivocality with which the opinion is expressed; (d) the quality of the investigation done by the expert; and (e) the presence or absence of impartiality or a lack of objectivity.

[94] What is ultimately required is a critical evaluation of the reasoning on which the opinion is based, rather than considerations of credibility. Should it not be possible to resolve a conflict in the expert opinion presented to the court in this manner, that is, when the two opposing opinions are both found to be sound and reasonable, the position of the overall burden of proof will inevitably determine which party must fail.

[95] It is worth emphasising that the onus as a determining factor 'can only arise if the tribunal finds the evidence pro and con so evenly balanced that it can come to no such conclusion. Then the onus will determine the matter. But if the tribunal, after

hearing and weighing the evidence, comes to a determinate conclusion, the onus has nothing to do with it, and need not be further considered.’¹⁴

[96] The third type of conflict, which may arise in expert evidence is that of competing theories of a purely scientific nature. The choice between two conflicting theories is informed primarily by the extent to which the theory is regarded as being established and has gained general acceptance within the specific scientific community in the particular discipline to which it belongs. Whether or not a theory has been sufficiently established must be measured against considerations such as whether it can, and has been tested; whether it is the product of reliable principles and methods that have been reliably applied to the facts of the case; and whether it has been subjected to peer review and publication.

[97] The fourth and final conflict may also arise in the context of what the accepted standard of conduct of a medical professional is in certain circumstances. Typically, medical negligence cases deal with the situation where an injury is alleged to be in complete discord with the recognised therapeutic objective and techniques of the operation or treatment involved. Expert opinion, in this context, is aimed at determining whether the conduct of a professional person in a particular field accords with what is regarded as a sound practice in that field. Again, the method adopted is to evaluate opinion evidence with the view of establishing the extent to which the opinions advanced are founded on logical reasoning.

[98] What is evident from the foregoing is that the evaluation of expert opinion in determining its probative value and the considerations relevant thereto are determined by the nature of the conflict in the opinion, and the context provided by all the evidence and the issues which the court is asked to determine. In general, it is important to bear in mind that it is ultimately the task of the court to determine the probative value of expert evidence placed before it and to make its own finding with regard to the issues raised.

¹⁴ *N.D.B obo J.W.K v Road Accident Fund* [2023] ZAECQBHC 7 para 14.

[99] Faced with a conflict in the expert testimony of the opposing parties, the court is required to justify its preference for one opinion over another by a careful and critical evaluation thereof. Further, the primary function of an expert witness is to guide the court to a correct decision on questions, which fall within that expert's field. To that extent, the expert witness has a duty to provide the court with abstract or general knowledge concerning his or her discipline, and the criteria necessary to enable the court to form its own independent judgment by the application of the criteria to the facts proved in evidence.

[100] Accordingly, the mere 'pitting of one hypothesis against another does not constitute the discharge of the functions of an expert.'¹⁵

[101] Finally, it is not the function of the court to develop its own theory or thesis and to introduce on its own accord evidence that is otherwise founded on special knowledge and skill. *Ex hypothesi*, such evidence is outside the learning of the court. The function of the court is restricted to deciding a matter on the evidence, or accepting or rejecting the proffered expert evidence.

[102] There is a general obligation placed upon the parties in cross-examination of witnesses, including experts, to put the parties' case to the witness being cross-examined. The reason for this is to allow the witness to deal with the evidence where he differs with such evidence.

[103] In this regard, *Small v Smith*¹⁶ and *President of the Republic of South Africa v SARU*¹⁷ support the position taken by this Court. Expert witnesses should provide independent assistance to the court by way of objective, unbiased opinions. An expert witness is not required to assume the role of a legal practitioner or that of the court.

[104] An expert witness must state facts or assumptions upon which his or her opinion is based. The expert must not omit to consider the material facts that should

¹⁵ *J.A obo D.M.A v Member of Executive Council for Health, Eastern Cape* [2022] ZAECHC 1; [2022] 2 All SA 112 (ECB); 2022 (3) SA 475 (ECB) para 17.

¹⁶ *Small v Smith* 1954 (3) SA 434 (SWA).

¹⁷ *President of the Republic of South Africa v SARU* 2000 (1) SA 1 (CC) paras 61-65.

detract from his concluded opinion. It is not expected of the court to simply accept the opinions of experts. The expert's evidence must be logical and his or her conclusions must be reached with knowledge of all the facts.

[105] In *Schneider NO and Others v AA and Another*¹⁸ Davis J discusses the duties of an expert with reference to some authorities, whereafter he makes the following statement, with which I agree:

'In short, an expert comes to court to give the court the benefit of his or her expertise. Agreed, an expert is called by a particular party, presumably because the conclusion of the expert, using his or her expertise, is in favour of the line of argument of the particular party. But that does not absolve the expert from providing the court with as objective and unbiased an opinion, based on his or her expertise, as possible. An expert is not a hired gun who dispenses his or her expertise for the purposes of a particular case. An expert does not assume the role of an advocate, nor gives evidence which goes beyond the logic which is dictated by the scientific knowledge which that expert claims to possess.'

[106] In *Michael and Another v Linksfeld Park Clinic (Pty) Ltd & Another*¹⁹ the court had the following to say when considering expert evidence:

'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

¹⁸ *Schneider NO and Others v AA and Another* 2010 (5) SA 203 (WCC) at 211 E-J; see also *Mediclinic Ltd v Vermeulen* 2015 (1) SA 241.

¹⁹ *Michael and Another v Linksfeld Park Clinic (Pty) Ltd & Another* 2001 (3) SA 1188 (SCA) para 40.

has been proved or disproved – instead of assessing, as a Judge must do, where the balance of probabilities lies on a review of the whole of the evidence.”

[107] The Appellant’s newborn was born during September 2009. There are no prenatal and obstetric records. The Appellant gave her evidence on 7 February 2022, that is approximately 12 years later. The only available records relate to the period after birth and those are the records from Nelson Mandela Academic Hospital.

[108] When the Appellant complained about the missing records, the Court *a quo* gave short shrift to the complaint and refused to draw any adverse inference against the Respondent. The Court *a quo* found that the absence of records is a neutral factor. There was no evidence to question whether a diligent search for the records was conducted and who conducted such a search, if any, for these missing records.

[109] In relation to the availability of the records, the National Health Act 61 of 2003 deals with the maintenance of records and section 13 provides:

‘Subject to National Archives of South Africa Act, 1996 (Act No 43 of 1996), and the Promotion of Access to Information Act, 2000 (Act No 2 of 2000), the person in charge of a health establishment must ensure that a health record containing such information as may be prescribed is created and maintained at that health establishment for every user of health services.’

[110] Section 17 provides–

‘The person in charge of a health establishment in possession of a user’s health records must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.’

[111] The Appellant was a single witness in relation to her labour and birthing process. The Respondent only relied upon expert evidence. The Court *a quo* rejected her evidence as unreliable.

[112] One of the grounds of appeal is that the Court *a quo* erred in finding that the evidence of the Appellant was unreliable in circumstances where her evidence was corroborated by the objective records which are available. In these circumstances, the Court will consider the principles applicable to a single witness.

The contentions of the parties

[113] Mr *Du Plessis SC*, counsel for the Appellant, questioned the Court *a quo*'s criticism of the radiologists' joint minute where they agreed that, in the absence of a sentinel event the 'acute profound' pattern of injury may have occurred over a prolonged period of time and that there was no document which was attached to the joint minute and evidence by the radiologists to explain the alternative pathways. In this regard, Mr *Du Plessis* submitted that the findings by the Court *a quo* ignores the joint minutes between and the evidence of the other experts that were called, who all corroborated the statement by the radiologists and explained in detail how the alternative pathway may cause this type of injury over a period of time.

[114] In advancing the point, Mr *Du Plessis* contended that it was not necessary for any of the parties to call their respective radiologists. Relying on the authority of *Bee v Road Accident Fund*²⁰ and *Thomas v BD Sarens (Pty) Ltd*,²¹ he contended that it has long been accepted that a fact agreed upon in a joint expert minute is a fact of which no evidence need to be tendered at trial, for it is considered a fact that a court can, and must, accept as true.

[115] Mr *Du Plessis* submitted that parties are bound to the agreement reached between experts in joint minutes, although such agreements are capable of repudiation, so long as the repudiation is clear and timeous. He further relied, in this regard, on the authority of *MEC for Health and Social Development, Gauteng v MM obo OM*.²²

²⁰ *Bee v RAF supra* paras 64-66.

²¹ *Thomas v BD Sarens (Pty) Ltd* [2012] ZAGPJHC 161 para 9.

²² *MEC for Health and Social Development, Gauteng v MM obo OM* [2021] ZASCA 128.

[116] The upshot of Mr *Du Plessis*' contention was that the Respondent was bound to the agreements reached in the joint minutes, including that of the radiologists and that it was not necessary for the Appellant to have led the evidence of its radiologist. Accordingly, Mr *Du Plessis* submitted that the Court *a quo*'s finding in this regard was a misdirection and therefore cannot stand.

[117] Mr *Du Plessis* contended that the Respondent, in relation to the agreement of the radiologists, did not lead any evidence contrary to that of the radiologists and as his submission goes, it was incorrect for the Court *a quo* to reject the agreement purely based on its own logic, which had no factual foundation. Mr *Du Plessis* pointed out that there is simply no evidence whatsoever to support the findings of the Court *a quo* in relation to the agreement of the radiologists. In this regard, Mr *Du Plessis* referred to the agreement reached between the experts, which I find it apposite to quote:

'The agreement between the radiologists states that–

- (ii) The MRI study defines structural damage to the perirolandic cortex and the basal ganglia, thalamic complex (BGT), constituting a cerebrocortical-deep nuclear pattern.

The agreement between Prof van Toorn and Dr A Keshave states that–

16. Prof R van Toorn The 2019 (reaffirmed) ACOG neonatal encephalopathy and the neurological outcome task force describes 4 patterns of selective neuronal injuries (in term infants with neonatal encephalopathy) which reflect the severity, duration, the nature of the insult (page 150). The second form of selective neuronal injury is the cerebral-deep nuclear neuronal injury pattern, which combines neuronal damage in the deep nuclear grey matter with injury in the cerebral cortex, usually the parasagittal area of the perirolandic cortex. This is referred to on imaging studies as “cerebral deep nuclear” pattern. It is my opinion that this is the MRI pattern evident on I[...]’s MRI scan.

Dr A Keshave : Agreed.'

[118] Mr *Du Plessis* further submitted that the pattern of injury as described in both agreements involves a severe partial insult / asphyxia of prolonged duration, especially where no sentinel event was recorded. He therefore contended that the finding should have been made on the basis of the agreement reached by the experts' as stated in the joint minutes.

[119] In respect of the findings by the Court *a quo*, that even though no sentinel event may have occurred in this case, it does not detract as a matter of logic from the fact that the damage was from the asphyxia typically caused by sentinel events, i.e. profound asphyxia which causes injury over a relatively short period of time.

[120] In this regard, Mr *Du Plessis* submitted that the evidence by the respective experts relating to an injury that occurs without there being any prior warning signs, was on the basis of a sentinel event being present. In such a case the injury is sudden and usually not foreseeable. Mr *Du Plessis* contended that it was common cause that in this case there was no sentinel event.

[121] In advancing the Appellant's case, Mr *Du Plessis* submitted that the radiologists who examined the MRI scan without having any information of the clinical picture, agreed that the injury was to the deep nucleus of the Appellant's newborn's brain. It was further agreed that, in the absence of a sentinel event, the injury occurring over a period of time should be considered and referred to relevant literature in that regard.

[122] Mr *Du Plessis* pointed out that, in this regard, the manner in which such an injury occurred was explained by both Prof Van Toorn and Dr Ebrahim and that their evidence corroborated and strengthened the agreement reached by the radiologists.

[123] Mr *Du Plessis* submitted that the Court *a quo*'s findings that the radiologists do not explain how the alternative pathways may cause this type of injury over a period of time does not take cognisance of the evidence. In this regard, Mr *Du*

Plessis submitted that the Court *a quo* erred in simply ignoring the evidence, especially when there was no contrary evidence by the Respondent. For this reason, it was submitted that the Court *a quo* erred in its approach of the evidence.

[124] Mr *Du Plessis* contended that the evidence of Prof Van Toorn and Dr Ebrahim had sufficiently explained how the alternative pathway could cause the kind of injury pattern and that the Court *a quo* was incorrect to characterise the evidence as pure speculation and conjecture. The submission was that the Court *a quo* had no basis of rejecting the evidence of Dr Ebrahim and prefer its own logic for the reason that a court should never act as an expert in a field in which it has no knowledge.

[125] Mr *Du Plessis* submitted that the Court *a quo* had confused the warning signs with the injury, and in this regard, it was submitted that even though the injury may have occurred in the last 15 minutes before birth, the foetus was in distress over a prolonged period of time prior to that. Accordingly, Mr *Du Plessis* submitted that the simple fact is that the injury could have been prevented if there had been proper monitoring of the foetal heart rate and this is irrespective of whether the injury may have occurred in the last 15 minutes. The contention is that all that matters is what happened prior and whether the injury could have been prevented.

[126] Mr *Du Plessis* submitted that whatever interpretation is preferred, what is clear is that there was a severe partial asphyxia with prolonged duration and that is in line with the pattern of the injury as agreed by the radiologists and the paediatric neurologists. Mr *Du Plessis* contended that the finding of the Court *a quo* that the injury occurred over a relatively short period of time was without factual and scientific evidence.

[127] Mr *Du Plessis* further contended that the Respondent did not agree with the proposition that the MRI features would be diagnostic of an acute profound (central) hypoxic ischemic injury of the brain now in a chronic stage of evolution. He contended that in the absence of agreement and there being no evidence to support it, it was simply wrong for the Court *a quo* to nevertheless make a finding to this effect.

[128] Mr *Du Plessis* also submitted that the Court *a quo* erred in finding that the evidence of the Appellant was unreliable in circumstances where the Appellant's evidence was corroborated by the objective evidence in the form of records and to reject, on that basis as well, the evidence of the experts. It was submitted that the Court *a quo* should have found that the expert evidence presented on behalf of the Appellant was factually sound and logically cogent and fitted in completely with the factual evidence of both the Appellant and the hospital records that were available.

[129] Mr *Du Plessis* submitted that the Court *a quo* should have held that the evidence of the Appellant was extremely valuable in excluding the probability of a brain injury occurring in utero or after birth as her evidence confirms that the foetus was found to be healthy during all antenatal assessments and not exposed to any of the injuries suggested by the Respondent's experts. Mr *Du Plessis* contended that the Court *a quo* should have considered what was held in the matter *M obo M v The Member of the Executive Council for Health of the Gauteng Provincial Government*²³ where Moshidi J held that:

'Section 16 of the Civil Proceedings Evidence Act, provides as follows:

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

. . . The trial court should weigh the evidence of the single witness and should consider its merits and demerits and having done so, should decide whether it is satisfied that the truth has been told despite shortcomings or defects or contradictions in the evidence.

. . . [A] single witness ought not be satisfactory in all material respects. The proper test is not whether a witness is truthful or indeed reliable in all that he/she says, but whether on a balance of probabilities the essential features of the story which he/she tells are true. Not all

²³ *M obo M v Member of the Executive Council for Health of the Gauteng Provincial Government* [2018] ZAGPJHC 77 paras 26-28 & 31.

contradictions affect a witness's credibility. In *S v Mkohle*²⁴ Nestadt JA said—

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

[130] On the contrary, Mr *Nabela*, who appeared for the Respondent, contended that the first difficulty with the Appellant's case is the absence of medical records and that is more prejudicial to the Respondent. In this regard, he submitted that the Court *a quo* was correct on rejecting the call by the Appellant to draw adverse inference against the Respondent. He submitted that the Appellant, in such circumstances, had a duty to give credible evidence and she failed to do so.

[131] Mr *Nabela* submitted that the Appellant's evidence is full of contradictions, such that it would not be safe to rely upon and therefore, the Court *a quo* correctly rejected the Appellant's evidence. In this regard, Mr *Nabela* relied on the authority of *Mthuki v The Member of the Executive Council of the Gauteng Provincial Government*.²⁵

[132] Mr *Nabela* submitted that the Appellant had an onus to prove through credible and persuasive evidence, that medical staff had failed to adhere to the required standards and therefore, she failed to discharge the onus resting upon her. Mr *Nabela* contended that the fact that harm had been occasioned was not on its own most that medical staff had caused it, or that they had done so negligently or even

²⁴ *S v Mkohle* 1990 (1) SACR 95 (A) at 98E-G.

²⁵ *Mthuki v The Member of the Executive Council of the Gauteng Provincial Government*, unreported judgment (GD), Case No 2013/3793 para 29 (6 November 2018).

that resulted to the brain injury. In this regard, Mr *Nabela* relied on the case of *Goliath v Member of the Executive Council for Health, Eastern Cape*²⁶ and *Van Zyl v Frohlich and Others*.²⁷

[133] The upshot of Mr *Nabela*'s submissions was that based on the contradictions in the evidence of the Appellant, the credibility of the Appellant destroyed the foundation of her expert evidence and opinion and that the appeal should fail on this basis.

[134] I will now evaluate the submissions and consider the parties' submissions.

Evaluation and analysis

[135] As already stated, the parties agreed, at the commencement of the trial, that the only issue for determination was limited to negligence and that causation was not an issue. Whether the concession by the Respondent on the issue of causation was well made, is another matter. This Court must still consider the question, if negligence is established, whether it caused the Appellant's newborn's hypoxic ischemic injury resulting in cerebral palsy.

[136] It is well established law that a Court of appeal is only at liberty to interfere with the findings of fact and inferences drawn by the trial Court, if there is a clear misdirection on the facts by the trial Court and the Court of appeal is satisfied that the trial court had reached a wrong conclusion. In *Minister of Safety & Security and others v Craig*²⁸ Navsa JA held:

'Although courts of appeal are slow to disturb findings of credibility, they generally have greater liberty to do so where a finding of fact does not essentially depend on the personal impression made by a witness' demeanour, but predominantly upon inferences and other facts and upon

²⁶ *Goliath v MEC for Health, Eastern Cape* 2015 (2) SA 97 (SCA).

²⁷ *Van Zyl v Frohlich and Others* 1999 JOL 5507 CA.

²⁸ *Minister of Safety & Security and others v Craig* 2011 (1) SACR 469 SCA para 58.

probabilities. In such a case a court of appeal with the benefit of a full record may often be in a better position to draw inferences.'

[137] On a crucial aspect about the availability of records, the Court *a quo* found, without any evidence or some form of factual basis that:

'Both parties were, in my view, equally handicapped by the unavailability of the medical records, the plaintiff had to rely on her memory in relation to the events of 11 September 2009, which was more than 12 years to date of the hearing of the matter. The defendant, on the other hand, as expected in circumstances where there are no records, obviously found it difficult to identify even the witnesses that were involved in the diagnosis, admission, monitoring and treatment of the plaintiff.'

In my view, this finding does not bear close scrutiny.

[138] The Court *a quo* proceeded to state:

'Accordingly, and in my view, the absence of the records is a neutral factor in this case. It cannot be used in favour of any of the parties. Neither can it be used against any of the parties and, accordingly, no adverse inference can be drawn against any of the parties, at least on the facts of this case.'

[139] The Court *a quo* was manifestly wrong in this regard. There is a legal duty on the nurses at the clinic, the doctor and nurses at the hospital to record the treatment accorded to the Appellant and the Appellant's newborn. The Respondent's employees were obliged to and must have made and kept punctilious clinic and hospital records pertaining to the Appellant's treatment. Insofar as the clinic and hospital notes are missing from the Appellant's file and that of the Appellant's newborn, there is a duty on the clinic and hospital record custodian staff in terms of

sections 13 and 17 of the National Health Act²⁹ to safeguard the Appellant and her newborn's clinic and hospital records.³⁰

[140] Curiously, the Respondent, who admittedly has a statutory obligation to keep and maintain records of health users, furnished no explanation nor gave any form of evidence about the missing records and whether any diligent search was conducted to find the records.

[141] In my view, it is simply not enough for the Respondent to allege that the medical records went missing. In this case, there is simply a paucity of information from a party that has an obligation to give the explanation. The reasoning by the Court *a quo* that the question of the missing records is a neutral factor has no factual foundation. I agree with Mr *Du Plessis* that an adverse inference against the Respondent ought to have been drawn in these circumstances, especially when the Court *a quo* criticised the Appellant about her contradiction on dates and time periods relating to her labour and the birth of the Appellant's newborn. Those records would have easily resolved such questions.

[142] The Court *a quo* has found the Appellant to be an unreliable witness and, on that basis, found that the rejection of the Appellant's evidence has a detrimental effect on the cogency and the reliability of the opinions of the expert witnesses.

[143] The Court *a quo* went on to find that the Appellant's evidence that she was not monitored from 10h00 until she delivered, to be unreliable. This finding too has no basis and cannot stand. I agree with Mr *Du Plessis*' submission in this regard. The Appellant's evidence should be assessed in light of the objective facts and if that is done, no doubt, her evidence should be reliable. In the Respondent's available records of Nelson Mandela Academic Hospital, the Appellant was last checked at 00h00. She delivered at 06h35 in the morning. The record from Nelson Mandela Academic Hospital is objective evidence. The Court *a quo* ought to have considered this objective evidence. It did not do so.

²⁹ Sections 13 and 17 of the Act.

³⁰ *Ntsele v Mec for Health, Gauteng Provincial Government* [2012] ZAGPJHC 208; [2013] 2 All SA 356 (GSJ).

[144] In *MA obo LM v The Member of the Executive Council for Health of the Gauteng Provincial Government*,³¹ in an action where Moshidi J had to decide upon the quality and veracity of the evidence of a mother in labour where the medical records in respect of the obstetric care were not available, Moshidi J held that the trial court should weigh the evidence of the single witness and should consider its merits and demerits, and having done so, should decide whether it is satisfied that the truth has been told despite shortcomings or defects or contradiction in the evidence.

[145] In *Santam Bpk v Biddulph*³² Zulman JA held:

‘(a) Whilst a court of appeal is generally reluctant to disturb findings which depend on credibility it is trite that it will do so where such findings are plainly wrong (*R v Dhlumayo and Another* 1948 (2) SA 677 (A) 706). This is especially so where the reasons given for the finding are seriously flawed. Over-emphasis of the advantages which a trial court enjoys is to be avoided lest an appellant’s right of appeal “become illusory” (*Protea Assurance Co. Ltd v Casey* 1970 (2) SA 643 (7) 648 D-E and *Munster Estates (Pty) Ltd v Killarney Hills (Pty) Ltd* 1979 (1) SA 621 (A) 623H-624A). It is equally true that findings of credibility cannot be judged in isolation but require to be considered in the light of proven facts and the probabilities of the matter under consideration.

(b) An analysis of the evidence as a whole, including that of Sigasa, proper regard being had to the probabilities, leads to the conclusion that the finding of credibility by the court a quo is untenable (cf *Stellenbosch Farmer’s Winery Group Ltd and another v Martell et Cie and others* 2003 (1) SA 11 (SCA) para 14I-15E. Almost at the outset of its judgment the court a quo concluded that the appellant’s claim depended exclusively upon the evidence of Sigasa. This

³¹ *MA obo LM v The Member of the Executive Council for Health of the Gauteng Provincial Government*, unreported judgment (GD), Case No 2014/32504.

³² *Santam Bpk v Biddulph* 2004 (5) SA 586 (SCA).

was not a correct assessment of the matter since the court was plainly obliged to consider the evidence of all the other witnesses called by the appellant.

(c) Quite apart from the bare say-so of Sigasa the Court had before it as objective facts, not dependent on the credibility of any witness . . .’

[146] The Court *a quo* found the Appellant’s evidence to be unreliable, based on contradictions about time periods of when the Appellant first experienced labour pains, the time of arriving at the Baziya Clinic, the time of transfer to the Mthatha General Hospital and the time of arrival at the Mthatha General Hospital.

[147] Quite apart from the evidence of the Appellant, the Court *a quo* had before it, as objective facts, not dependent on the credibility of any witness, the following – (i) the records from Nelson Mandela Academic Hospital which reflect the time of the Appellant’s newborn’s birth; (ii) the experts joint minutes; (iii) the Rule 37 conference minutes; (iv) undisputed evidence that the Appellant attended at Baziya Clinic, (v) that she was transferred to Mthatha General Hospital; (vi) that she was last seen by the nurse at 00h00; and (vii) that the Appellant was not checked until she gave birth at 06h35 on 12 September 2009.

[148] It is self-evident that when the Appellant attended to Baziya Clinic, she was experiencing labour pains and it would be unreasonable to expect her in such a condition to have a precise recollection of the time when she started to experience those pains. It is also telling that when she was transferred to the Mthatha General Hospital, she was still enduring labour pains and she would not be able to precisely recollect the time that she arrived at the Mthatha General Hospital.

[149] The confusion relating to time frames given by the Appellant to the experts and her recollection in this regard, becomes more apparent on close reading of the expert reports. In this regard, Dr Baba, in her report, recorded as follows:

‘On 11 September 2009, N[...] experienced lower abdominal pain around 15h00. She went to the local clinic around 16h00 on the same day... Patient arrived at the hospital around 19h00, according to her recollection.’

[150] Based on this report, it is self-evident that the Appellant did not remember the exact time and that she was merely giving estimates and therefore, it is incorrect for the Court *a quo* to rely on the inconsistencies based on estimated times. In *S v Mkohle*³³ it was held—

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

[151] Consequently, for the reasons that the knowledge of the treatment accorded to the Appellant on 11 September 2009 and 12 September 2009, is peculiarly within the knowledge of the Respondent’s employees, and the Respondent has not adduced any direct cogent evidence or produced clinical and obstetric records, the version of the Appellant should be accepted to the extent that it is corroborated by the objective available medical records. There is no basis for the Court *a quo*’s approach of compartmentalising evidence. In this regard, the Court *a quo* erred in rejecting the Appellant’s evidence.

[152] The Appellant, a lay person in both medicine and the law, and an unsophisticated person, tried to relate her version. There was no suggestion that her version was false or that she was not telling the truth. In cross-examination no version was put to her on behalf of the Respondent.

[153] In *President of the Republic of South Africa v South African Rugby Football Union*³⁴ it was held:

³³ *S v Mkohle* 1990 (1) SACR 95 (A) at 98e-g, see also *MA obo LM v The Member of the Executive Council for Health of the Gauteng Provincial Government* supra at para 31

³⁴ *President of RSA v SARU* supra para 61.

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

[154] Having regard to the conspectus of the evidence, the Court *a quo* erred in rejecting the evidence of the Appellant solely based on contradictions in her evidence and more importantly, in circumstances where no version was put by the Respondent to her. The evidence of the Appellant was valuable in excluding the probability of a brain injury occurring before or after birth as her evidence confirmed that the foetus was found to be healthy during all antenatal assessments. The evidence of the Appellant leads to the conclusion that she was last checked at the hospital at 00h00 and that she gave birth at 06h35. That would be a period of approximately 6 hours and 25 minutes of non-monitoring amounting to negligence.

[155] Another crucial aspect is that the Court *a quo* had ignored the joint minutes. The reasons for the Court *a quo* ignoring the joint minutes of the radiologists is simply that there were no documents attached to the joint minutes and that there was no evidence led by the radiologists to explain their agreement. This finding, too, is untenable.

[156] In *Bee v RAF*³⁵ it was held that:

‘Facts and opinions on which the litigants’ experts agree are not quite the same as admissions by or agreements between the litigants themselves (whether directly or, more commonly, through their legal representatives) because a witness is not an agent of the litigant who engages him or her. Expert witnesses nevertheless stand on a different footing from other witnesses. A party cannot call an expert witness without furnishing a summary

³⁵ *Bee v RAF supra* at 384G-J.

of the expert's opinions and reasons for the opinions. Since it is common for experts to agree on some matters and disagree on others, it is desirable, for efficient case management, that the experts should meet with a view to reaching sensible agreement on as much as possible so that the expert testimony can be confined to matters truly in dispute. Where, as here, the court has directed experts to meet and file joint minutes, and where the experts have done so, the joint minute will correctly be understood as limiting the issues on which evidence is needed. If a litigant for any reason does not wish to be bound by the limitation, fair warning must be given. In the absence of repudiation (i.e. fair warning), the other litigant is entitled to run the case on the basis that the matters agreed between the experts are not in issue.'

[157] I agree with the contentions of Mr *Du Plessis* that the Respondent was bound to the agreement reached in the joint minutes, including that of the radiologists and that it was not necessary for the Appellant to have led the evidence of her radiologists. The conclusion by the Court *a quo* that there were no documents attached to the joint minutes and that there was no evidence from the radiologists is a clear misdirection and the Court *a quo* had clearly erred in this regard. More significantly, the Respondent did not lead evidence to contradict the agreement reached between the radiologists, nor was any prior indication of 'fair warning' given. The Court *a quo* was not entitled to reject the agreement purely based on its own logic without any form of foundation.

[158] In *JA obo DMA v The Member of the Executive Council for Health, Eastern Cape*,³⁶ Van Zyl DJP, relying on other authorities, held:

'[It] is not the function of the court to develop its own theory or thesis and to introduce on its own accord evidence that is otherwise founded on special knowledge and skill. *Ex hypothesi*, such evidence is outside the learning of the court. The function of the court is restricted to deciding a matter on the evidence placed before it by the parties, and to choose between conflicting expert evidence, or accepting or rejecting the proffered expert evidence.'

³⁶ *JA obo DMA v MEC supra* para 17.

[159] The radiologists agreed that the MRI study defines structural damages to the perirolandic cortex and the basal ganglia, thalamic complex (BGT) constituting a cerebrocortical-deep nuclear pattern.

[160] In turn, Prof Van Toorn and Dr Keshave stated as follows in their joint minutes:

‘16. Prof R van Toorn The 2019 (reaffirmed) ACOG neonatal encephalopathy and the neurological outcome task force describes 4 patterns of selective neuronal injuries (in term infants with neonatal encephalopathy) which reflect the severity, duration, the nature of the insult (page 150). The second form of selective neuronal injury is the cerebral-deep nuclear neuronal injury pattern, which combines neuronal damage in the deep nuclear grey matter with injury in the cerebral cortex, usually the parasagittal area of the perirolandic cortex. This is referred to on imaging studies as “cerebral deep nuclear” pattern. It is my opinion that this is the MRI pattern evident on I[...]’s MRI scan.

Dr A Keshave : Agreed.’

[161] The Court *a quo* ought to have approached the matter based on the above agreements and did not do so and that was a misdirection. It does not seem from the judgments of the Court *a quo* that its attention was drawn to the cases of *Bee v RAF*, *MEC for Health and Social Development*, *Gauteng v MM on behalf of OM* and other cases that deal with the effect of a joint minute in the absence of repudiation.

[162] The Court *a quo* found that, even though no sentinel event may have occurred in this case, it does not detract as a matter of logic from the fact that the damage was from the asphyxia typically caused by sentinel events, i.e., profound asphyxia which causes injury over a relatively short period of time. The radiologists examined the MRI without having any information of the clinical picture and agreed that the injury was to the deep nucleus of the Appellant’s newborn’s brain. They

further agreed that, in the absence of a sentinel event, the injury occurring over a period of time should be considered and referred to relevant literature in that regard.

[163] Correctly so, Mr *Du Plessis* pointed out that the manner in which such an injury occurred had been explained in detail by Prof Van Toorn and Dr Ebrahim and that their evidence corroborated and strengthened the agreement reached by the radiologists.

[164] It was incorrect for the Court *a quo* to suggest that there was no explanation on how the alternative pathways may cause this type of injury over a period of time and in my view, such finding failed to take cognisance of the evidence of Dr Ebrahim and Prof Van Toorn. Their evidence was not disputed by the Respondent.

[165] The Respondent's experts, Dr Keshave and Dr Baba, merely gave speculative evidence which was incapable of casting any doubt on the otherwise acceptable opinion of the Appellant's experts. The opinions by the Appellant's experts were based on sound grounds and was supported by facts, joint minutes and agreement of parties and the reports.

[166] Dr Keshave suggested for a whole exam sequencing which involves looking at the genes and the metabolic screen of the Appellant's newborn in order to exclude other factors that may have caused the cerebral palsy. As soon as the whole exam sequencing results became negative, he then suggested another possible cause as intra-uterine growth restriction, on the basis that the child had a predisposing condition in the form of a head circumference that was above 90 in size and a birth weight that was nearly 25.

[167] When it was suggested to Dr Keshave that there would be warning signs of any hypoxic ischemic encephalopathy and that those warning signs would have been picked up through proper monitoring; he did not dispute the proposition. He, however, was non-committal and deferred to obstetricians. Dr Baba accepted that, according to the records, the Appellant was last checked at 23h00 before delivery of the Appellant's newborn at 06h35. This would be a concession of a non-monitoring for a period of about 6 hours and 25 minutes. That period is long enough to cause a

severe partial insult/asphyxia of prolonged duration. It is immaterial whether or not it would have occurred in the last 15 minutes.

[168] From reading of Dr Keshave's report and his evidence, including that of Dr Baba, and the joint minutes, it is evident that the Respondent's experts were unable to raise any cause of the injury to the Appellant's newborn other than the cause identified by Dr Ebrahim and Prof Van Toorn in the joint minute and their reports.

Findings

[169] On the whole, the evidence, and in particular the joint minute prepared by the expert witnesses: (i) the paediatric neurologists, Prof Ronald van Toorn and Dr Amith Keshave; (ii) the radiologists, Prof J W Lotz, Dr Zuzile Zikalala; and (iii) the obstetricians, Dr Ebrahim and Dr Baba, supports the opinion that the brain injury sustained by the Appellant's newborn and the disabilities that later followed were the result of a severe partial insult of prolonged duration and that the injury could have been prevented if there was proper monitoring of the foetal heart rate.

[170] I have considered the fact that the Court *a quo* suggested that it may have occurred in the last 15 minutes. In my view, that is immaterial on the basis that what is important, is what must have happened prior to the 15 minutes and whether the injury could have been prevented from occurring. The undeniable evidence is that the Appellant was not monitored for a period of approximately 6 hours and 25 minutes and that was not in terms of the maternity care guidelines. There was clearly a deviation from a recognised standard which, in the circumstances, amounted to negligence.

[171] The injury is consistent with the conduct of the Respondent's medical staff and nurses, allowing a severely prolonged labour of the Appellant to continue with no monitoring, exposing the foetus to a lack of hypoxic type brain injury. The Appellant's experts have, in my view, objectively evaluated the available facts and the limited medical records logically and carefully. On the other hand, the Respondent's

experts, Dr Keshave and Dr Baba, were non-committal and speculative in their analysis.

[172] I agree with Mr *Du Plessis*' submissions that there had been inadequate monitoring during the birth process when there would have been danger signs such as a prolonged labour process, high risk relating to previous caesarean section and other signs of distress of the foetus. The child has been born in a compromised position with low Apgar scores. The MRI shows a hypoxic ischemic encephalopathy insult of a partial prolonged nature. The insult must have taken place during the intrapartum period when regard is being had to the entire body of evidence.

[173] The admitted facts in the pre-trial minute, joint expert minutes and the objective facts, which are largely common cause, establish the Appellant's case on a balance of probabilities.

[174] I find that the employees of the Respondent had negligently breached their duty of care obligations and that such negligence caused the Appellant's newborn to suffer a hypoxic ischemic encephalopathy insult of a partial prolonged nature. The conclusion is that the Respondent is liable to compensate the Appellant.

[175] For these reasons, the appeal must succeed.

[176] The general rule that costs should follow the event shall apply and I have not been persuaded differently. The matter was fairly complex and justifies the employment of two counsel. The Appellant is entitled to the costs of two counsel. The Appellant is also entitled to the costs of the experts that have been employed.

Order

[177] In the result, I would make the following order:

- (a) The appeal succeeds with costs, including costs of two counsel, where applicable;

(b) The order of the Court a quo is set aside and is substituted with the following order–

(1) The defendant shall pay 100% (one hundred percent) of the plaintiff's agreed or proven damages suffered in her representative capacity for and on behalf of her minor child, I[...] J[...] ('the minor'), which damages flow from the neurological injury sustained by the minor during labour and delivery at the Baziya Health Care Centre and Mthatha General Hospital on or about the 12th of September 2009 and the resultant cerebral palsy (and its sequelae) which he suffers from.

(2) The defendant shall pay the plaintiff's taxed or agreed party and party costs on the High Court scale pertaining to the action and up to the finalisation of the issue of liability, which costs shall include (but not necessarily be limited to) the following:

2.1 the costs attendant upon the obtaining of the medico-legal reports and any addenda thereto and of procuring joint minutes (including any addenda thereto) in respect of the following expert witnesses:

2.1.1 Professor R van Toorn;

2.2.2 Professor J W Lotz;

2.2.3 Dr A Ebrahim;

2.2 the preparation, reservation and appearance fees of Professor Van Toorn and Dr Ebrahim;

2.3 the reasonable expenses of their travelling costs in respect of Professor Van Toorn and Dr Ebrahim as well as their reasonable accommodation costs;

2.4 the costs consequent upon the employment of senior and junior counsel;

2.5 the reasonable costs in respect of counsel's fees with regards to the perusal of all expert medico-legal reports and any addenda thereto (where applicable), including joint minutes (where applicable) as well as the preparation and consultations fees, including, but not limited to, the telephonic consultation(s) with the plaintiff's expert witnesses, in order to prepare such witnesses for trial;

2.6 the cost of and consequent upon the minor's attendance of consultations, evaluations and/or assessments by any expert witness and/or any related special investigation required by any such expert;

2.7 the cost of preparation of sufficient court bundles for use during the trial;

2.8 the reasonable fees of counsel in respect of the preparation of heads of argument.

(3) The defendant shall pay interest at the applicable prescribed statutory rate on the costs referred to in paragraph 2 above, calculated from a date 31 (thirty-one) days from the date of such agreement or from the date of affixing of the taxing master's allocatur to the date of final payment.

M NOTYESI
ACTING JUDGE OF THE HIGH COURT

BROOKS J:

I agree

R W N BROOKS
JUDGE OF THE HIGH COURT

RUGUNANAN J :

I agree

M S RUGUNANAN
JUDGE OF THE HIGH COURT

Appearances

Counsel for the appellant:	<i>Mr Du Plessis SC</i> together with <i>Mr Sambudla</i>
Attorneys for the appellant:	<i>Sakhela Incorporated</i>
	East London

Counsel for the respondent:	<i>Mr Mtshabe SC</i> together with <i>Mr Nabela</i>
Attorneys for the respondent:	<i>The State Attorney</i>
	East London