

SAFLII Note: Certain personal/private details of parties or witnesses have been redacted from this document in compliance with the law and [SAFLII Policy](#)

**REPUBLIC OF SOUTH AFRICA
IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA**

CASE NO: 29050/2021

(1)	REPORTABLE: YES
(2)	OF INTEREST TO OTHER JUDGES: NO
(3)	REVISED: NO
10 June 2024	

In the matter between:

M[...], M[...]

First Plaintiff

M[...], R[...] A[...]

Second Plaintiff

and

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

Defendant

JUDGMENT

Kok AJ

Introduction

[1] This is a medical malpractice matter where the plaintiffs, in their capacity as parents and guardians, sued the defendant for damages suffered by their minor daughter, S[...] M[...] (S[...]) born on 31 August 2014 at the Chris Hani Baragwanath Hospital (CHBH), after having suffered a hypoxic ischemic injury (HII) to her brain due to the alleged negligence of the defendant's employees - the nursing staff and doctors who attended to S[...]s delivery. The plaintiffs did not proceed with their claims in their personal capacities. The plaintiffs led evidence and argued that the defendant is 100% liable. The defendant argued that it is not liable at all.

[2] After S[...]s mother's admission to the hospital on 30 August 2014 and thereafter until the discharge of S[...] on 12 September 2014, S[...] suffered the injury, as a result of which S[...] suffers from consequent conditions which were not present in S[...] as an unborn foetus at the time of her mother's admission to the hospital on 30 August 2014. These consequent conditions include cerebral palsy secondary to perinatal asphyxia, global developmental delay and intellectual disablement.

[3] At the commencement of the trial, I ordered a separation of issues in terms of Rule 33(4) as agreed to between the parties; *quantum* to stand over. I was consequently called upon to determine all issues relating to the defendant's liability to compensate S[...] for the damages she has suffered - wrongful omissions by the defendant's staff, negligence, and causation.

[4] Where appropriate in crafting this judgment, I relied extensively on counsels' heads of argument. I am deeply indebted to counsel for their comprehensive heads of argument and the authorities they cited.

The pleadings and trial bundle

[5] The parties agreed, as recorded in par 12.1 of the pre-trial minute of 23 November 2023, that the plaintiffs will be entitled to produce the discovered medical records kept by and obtained from the defendant, including hospital records and the notes and observations of the doctors who attended to S[...]s mother and S[...] at the hospital and contained in the trial bundle, as evidence in the trial and as constituting *prima facie*

proof of the truth of the content, without being required to call the author of each such document, but subject to the parties' right to lead oral evidence to rebut the correctness of any fact, observation or finding recorded in such document. In the opening address plaintiffs' counsel placed on record that the plaintiffs do not accept the correctness of the Apgar scores of 5/10 at one minute and 10/10 at five minutes which the plaintiffs did not accept or rely on, choosing rather to rely on a different note of the one-minute Apgar score of 2/10.¹ The defendant did not challenge any of the medical records.

[6] In paragraph 8(d) of their particulars of claim, the plaintiffs asserted that the nursing staff and doctors at CHBH failed to properly monitor and assess the condition of S[...]s mother and the unborn S[...] and failed to administer appropriate medical treatment. As will become clear in this judgment, this assertion covers the largest part of the admitted and proven facts and evidence.

[7] The defendant admitted that the control and administration of CHBH fell under her control and administration. The defendant also admitted that the nurses and doctors at CHBH were employed by the Department of Health and the Gauteng Provincial Government and that they acted in the course and scope of their employment with the Department of Health of the Gauteng Provincial Government. The defendant also admitted that the CHBH staff owed a legal duty to S[...] and S[...]s mother to render to them proper and appropriate medical treatment and to exercise the degree of skill and care which can be reasonably expected of a nurse or doctor in the prevailing circumstances. If the evidence shows that this duty was breached, wrongfulness would be established. The vicarious liability of the defendant, based on the admission in the plea, was not in dispute, pending proof of the elements of a delictual claim.

[8] The defendant in her plea put negligence and causation in dispute. The defendant did not plead that there was any other cause of the injury and consequent conditions. The defendant pleaded that there was a lack of available theatre time due to several emergency cases that were already awaiting surgery, which made the delay in performing

¹ According to the discharge note. Prof Smith testified, without being challenged on this point in cross-examination, that the 5/10 score cannot be correct, and that having regard to the recorded condition of the neonate the Apgar score was certainly lower than that.

a caesarean section on S[...]s mother unavoidable. The allegations in the plea (as amended in March 2023) are a verbatim repeat of the relevant statement in the expert report prepared by Dr Bowen (in December 2022), and were seemingly based on records in the medical records kept by employees at the hospital. I agree with the plaintiffs' submission that the written records constitute inadmissible documentary hearsay unless the author of the notes was called to testify, and unless the defendant was able to prove the correctness of the note with evidence of primary facts. The defendant is accordingly not entitled to rely on the written notes in the medical documents as constituting proof of the facts recorded. Even more important, it was in any event placed on record as a formal admission by both parties, in terms of section 15 of the Civil Proceedings Evidence Act 25 of 1965, that theatre II was unoccupied and available from 21h05 on 30 August to 01h00 on 31 August.

[9] The facts pleaded in paragraph 24 of the plea were obviously an attempt by the defendant to escape liability flowing from the failure to deliver S[...] within one hour, by pleading circumstances which would negate negligence on the part of the defendant's employees as a result of the delay in the caesarean section delivery. The one hour limit from decision to perform a caesarean section delivery to delivery of the child is taken from the guidelines in place at the time for tertiary level public hospitals.

[10] Based on the formal admission, and in any event no evidence to the contrary being led by the defendant, it was established during the trial that theatre II was not in use and available from 21h05 on 30 August to 01h00 on 31 August (3 hours 55 minutes) and was therefore available for performance of a caesarean section on S[...]s mother as soon as the decision was taken to deliver the baby by caesarean section. The defence that no theatre was available when the decision was taken to do the caesarean section delivery (which decision was taken at 23h30, but no later than midnight on 30 August 2014) must therefore fail. I explain in the judgment below why the joint minutes that recorded that no theatre was available, do not bind the parties.

[11] The defendant did not plead a lack of resources as an excuse. If it wished to raise this as a defence (as Dr Bowen, who admitted he is not an expert in the field of planning

for and providing medical resources, attempted to do in his expert report) it should have been specifically pleaded - *Oppelt v Department of Health, Western Cape*.²

The joint minutes of the experts

[12] The relevant experts (where both the plaintiffs and the defendant engaged experts in the same field) met and prepared and signed joint minutes. Save in respect of Professor Anthony (obstetrician and gynaecologist and maternal and foetal specialist for the plaintiffs) and Dr Bowen (obstetrician and gynaecologist for the defendant), there is a large measure of agreement on expert opinion between the experts, as reflected in the signed joint minutes.

[13] After a review of an MRI of S[...]’s brain, the radiologist experts Professor Lotz and Dr Swartzberg agreed that:

There is evidence of previous hypoxic ischemic injury (HII) in the brain;

The pattern of imaging findings supports a dominant prolonged partial hypoxic ischemic mechanism. Added changes in the perirolandic and parasagittal cortex suggests a more severe terminal hypotensive event secondary to the depletion of foetal reserves;

There are no findings of structural or congenital malformation of the brain;

There are no signs of an inborn error in metabolism;

The imaging features do not support a congenital infection with deleterious effects on the central nervous system, such as toxoplasmosis, rubella, cytomegalovirus, or herpes.

[14] Their agreement established that the cause of S[...]’s brain injury was a HII, the last part of which occurred after the foetal reserves had been depleted. As regards the cause and timing of this HII, they deferred to the opinions of the appropriate specialists in the field of obstetrics and neonatology.

² 2016 (1) SA 325 (CC) para 63.

[15] The nursing experts Dr Du Plessis and Dr Harris agreed that the nursing staff failed to do what they should have done, in that they did not do the following:

Assess the patient on admission to the hospital as per protocol. They did not perform an initial labour assessment and an admission CTG;

Inform a medical practitioner to assess the referred patient on arrival at the hospital, to confirm or exclude the reason for transfer (suspicion of a big baby);

Monitor the progress of labour (cervical dilatation, descent of the foetal head, presence of caput or moulding) to the hospital until 20h00 when the patient was already in the active phase of labour, and 6 cm dilated;

Assess foetal well-being from transfer until 20h00;

Execute an instruction by the attending doctor for continuous foetal monitoring and to repeat the CTG when he signed the CTG trace at 20h45;

Keep clear and accurate records, as evidenced by the lack of progress reports from 20h00 on 30 August 2014 until the doctor's note "at midnight".³ The partogram was unfilled from 20h00 to midnight. Continuous foetal monitoring was not done as instructed by the doctor. They failed to inform a doctor of the lack of descent of the foetal head before full dilatation of the cervix. There is lack of documentation of the progress of labour during the active phase between 20h00 and midnight, and it is unknown when exactly foetal distress occurred (the midwife documented that the patient was prepped for foetal distress).

Document that a program of treatment prescribed by a doctor was executed, namely the instruction for tocolysis and intrapartum resuscitation;

Do a comprehensive physical assessment of the newborn;

Complete the discharge summary report.

[16] The neurologist experts Professor Kakaza and Dr Van Rensburg agreed as follows. S[...]’s current neurological functioning is that she suffers from asymmetric slightly spasmodic, oddly erratic cerebral palsy with more involvement of the left side of the body, and she functions on the GM F CS level II. She has additional features of dyspraxia and poor balance. She has pseudo-bulbar paresis; she is cognitively impaired and has dysarthria and dysphasia. Her expressive speech is more impaired than her receptive

³ The probable time of the doctor's examination to which the note relates is 23h30, as explained by defendant's expert Dr Bowen, and accepted by plaintiffs' counsel.

speech; she has no history of epilepsy. S[...]’s clinical picture can be explained in full by the distribution of the injury seen on the MRI. It has been diagnosed as hypoxic ischemic brain injury, and no other possible cause for the injury was detected clinically or on the MRI. The cause for S[...]’s brain injury and current neurological dysfunction is probably hypoxic ischemic brain injury. They deferred to the obstetricians regarding the management of the pregnancy and labour and the exact timing of the injury and whether the injury was preventable.

[17] Professor Smith (specialist paediatrician and neonatologist) and Professor Cooper (specialist paediatrician and neonatologist) agreed as follows. Professor Smith also testified orally, while Professor Cooper did not:

The hospital records record that S[...]’s mother’s transfer from the clinic to CHBH occurred after 16h12. The first maternal observations (latent phase of labour) recorded at the hospital was at 17h05;

The records record the partogram was started at approximately 20h00 and was partly completed between 20h00 and midnight. The heading of the partogram contains a reference to “Cat II tracing”. At that time, it was already captured that there was a Category II (suspicious) foetal condition and that the cervix was 6 cm dilated;

The records record that at midnight⁴ on 31 August 2014 (meaning midnight when 30 August becomes 31 August - the date is incorrectly recorded as 1 September) it was noted that the cervix had been fully dilated for approximately 30 minutes and that there were strong contractions. The CTG tracing was categorised as category II;

The records record that the plan was to book the patient for a caesarean section.

The doctor booked a caesarean section but a note was made that there were eight emergencies on board, that both theatres were occupied with two foetal distress cases, and that “[S[...]’s mother] will follow”. The sister was told to tocolyse the patient, do intrapartum resuscitation and to carry out continuous foetal monitoring;

⁴ Although a time of 00h00 is written diagonally at the top left corner of the note, the examination by the doctor from which the information contained in the note was obtained, was probably at 23h30 on 30 August 2014.

The last recorded foetal review occurred in theatre at 01h15. The FHR was recorded as 112/min (low-normal). The note revealed that a decision was made to perform a caesarean section for “CPD⁵ foetal distress and big baby”;

The records record that the caesarean section was performed under spinal anesthesia;

The records record that a female baby was delivered at 02h10;

There are no primary factual neonatal records;

The discharge notes on day 12 of life (12 September 2014) record “HIE II”, being hypoxic ischemic encephalopathy of moderate degree, presence of seizure, that the neonate was not cooled, and that the Apgar scores were 2 and 9 at one and five minutes respectively;

The delay in performing the cesarean section contributed to the adverse neurological outcome, but they defer to the respective obstetric experts as to whether the outcome was avoidable by expedited earlier delivery.

[18] Professor Cooper, while agreeing, recorded that the lack of available theatre time made the delay in performing the caesarean section unavoidable. However, it became common cause during the trial (or should have become common cause) that Professor Cooper was clearly wrong in his assumption; his assumption being contradicted by the theatre register. The theatre register reflects that theatre II was available from 21h05 to 01h00 and was therefore available with all its personnel to have performed the caesarean section on S[...]’s mother during this period.

The CTG tracings

[19] It is common cause that the CTG tracings would have been the best available contemporaneous and objective evidence of the progress of S[...]’s mother’s labour and the condition of the foetus and of signs of foetal distress.

[20] The defendant's plea alleges that there was continuous foetal monitoring. However, the defendant produced only one tracing done on 30 August 2014 from about

⁵ Cephalopelvic disproportion.

20h10 to 20h35. Dr Bowen testified in cross-examination as to the working of a CTG machine and said that if it is switched on it automatically makes a tracing on a paper strip at 1cm per minute – that would then be 60cm per hour. If there was continuous CTG monitoring from 20h00, the tracing would have been 2.4 m long by midnight.

[21] The defendant, despite a Rule 35(3) request from the plaintiffs that the CTG tracings be produced, failed to produce any other tracings, and failed to give any explanation for the failure. The interpretation of two other CTG tracings as “Category II” are recorded in the nursing and clinical notes, and there are two other notes that patient was “on CTG”. I agree with the plaintiffs' contention that an adverse inference must be drawn against the defendant in that the CTG tracings would have been prejudicial to the defence of the matter and that this likely the reason why they were not produced.⁶ Prof Adam's testimony as to the staple on the front page of the hospital record, where the complete CTG tracing should have been stapled, is telling in this regard (see paras 32-33 of this judgment).

The evidence of the witnesses during the trial

[22] S[...]’s mother testified as follows. She was transferred from the clinic to the hospital where she arrived in the afternoon. She was taken to a ward where all the pregnant women received, and there a doctor performed a sonar examination on her abdomen. He said that he wanted to find out if the child was normal and well. The doctor said the child was well and that they would try to do a normal birth. The doctor instructed her to sit on a chair and wait. She waited and later her water broke (her membranes ruptured). When that happened, a sister took her to another ward (the labour ward). Between the time when she first saw the doctor and when her water broke, no one came to see her or examine her. In the labour ward the sister instructed her to get on a bed, a drip (intravenous line) was inserted and a machine was put on her abdomen (probably the CTG sensor belt). Later she had contractions and the nurse told her to push. She “pushed and pushed and pushed”, but the baby did not come out. She was pushing for more than an hour, after which the nurse went to call a doctor, who then said that the child won’t be

⁶ Compare *Khoza v MEC for Health and Social Development, Gauteng* 2015 (3) SA 266 (GJ).

able to come out and that she must get a caesarean. The doctor then left. Later the nurse pushed her on the labour ward bed to the door of the theatre. She waited at the theatre a long time. After she had been seen by the doctor, and when she was taken to theatre, she was lying on her back the whole time. No medication was given to her, but she was told to close her legs and not to push. She was not given any oxygen. The nurse then put her on top of a table in the theatre, and at that time only a nurse was there. She lay and waited for the doctor. A doctor came and gave her an injection in her spinal cord. She then had the operation and they told her that the child was a girl, but she did not see the baby. The child did not cry when it was born.

[23] Professor J Anthony (obstetrician, gynaecologist and foetal maternal specialist) and Professor J Smith (paediatrician and neonatologist) were called to testify for the plaintiffs, after S[...]’s mother had testified, as expert witnesses.

[24] Given the nature of the so-called joint expert minutes of Prof Anthony and Dr Bowen, it is no surprise that Prof Anthony was called to testify. The joint minutes ran to 57 pages and contained lengthy statements by both experts. The document's aim was seemingly not to limit the issues in dispute.

[25] The most pertinent parts of Professor Anthony’s evidence were as follows. He expressly confirmed the content of his expert report as being his honest and considered expert opinion. The evidence in chief elucidated the content of the report with reference to certain of the hospital records contained in the trial bundle; S[...]’s mother went into spontaneous labour at term and was referred to Baragwanath Hospital because of suspected foetal macrosomia (a big baby, which may not be able to be delivered by normal vaginal delivery); At the hospital foetal monitoring was instituted and carried out in a substandard fashion throughout. The development of foetal hypoxia will not have been detected on the basis of the documented foetal monitoring; The medical assessment was deferred for more than eight hours after admission and when first seen by the doctor, when the doctor instructed the sister to institute intrapartum foetal resuscitation; The inference arising from this intervention is that foetal distress of unknown duration was evident for more than two hours before delivery; The occurrence of diagnosed foetal hypoxia required both foetal resuscitation and expedited delivery of the foetus; There is no

evidence that the prescribed foetal resuscitation took place, and expedited delivery was also delayed leading to a prolonged second stage of labour; The duration of maternal bearing down was unknown to him from the hospital records. However, the unchallenged evidence of S[...]’s mother was that she had been bearing down as instructed by the midwife for more than an hour before she was examined by the doctor at about midnight, and Professor Anthony testified that this long period of bearing down would have increased foetal stress and foetal hypoxia and depleted the foetal reserves, as did Dr Bowen both in chief and under cross-examination; Having heard the unchallenged evidence of S[...]’s mother that she had been told by a sister to push, and had “pushed and pushed and pushed” for over an hour before she was examined by the doctor who decided that a caesarean section delivery must be done, it is probable that the foetus was already compromised (foetal reserves depleted) by the time of the doctor’s examination, and that the doctor had already at 20h45 suspected that there may be foetal distress, had recorded the presence of a category II CTG tracing (indicating a risk of foetal hypoxia), and had instructed that the CTG tracing be repeated; The interpretation of the 20h12 to 20h36 CTG tracing as category II was incorrect; however the attending doctor believed there was a cause for concern but then failed to monitor the patient thereafter; The partial prolonged hypoxia probably commenced while S[...]’s mother was pushing for over an hour, that hypoxic ischemic brain insult then set in, and continued in the period until she was taken to theatre and until delivery, resulting in hypoxic brain injury. The more profound grey matter brain injury followed the established partial prolonged hypoxic ischemia; The decision to delivery interval was prolonged (the accepted reasonable decision to delivery interval in a level three public hospital is a maximum of one hour); Consequently presumed foetal hypoxia was inadequately managed and labour allowed to continue while tocolytic therapy (along with other measures) was clearly indicated; Because the labour was allowed to continue, at delivery the head appears to have been engaged in the pelvis (1/5 head above pelvic brim); There is no evidence of any sentinel event in this case and the MRI findings of a mixed pattern is compatible with prolonged partial hypoxia which may have been aggravated during the second stage of labour by the prolonged duration of the second stage of labour with maternal bearing down efforts (which S[...]’s mother testified went on for more than an hour), and which were not documented and are of unknown duration (this was the position when he drew his report, but the unchallenged evidence of S[...]’s mother was that the bearing down

was for more than an hour before the doctor examined her at about midnight); The baby was delivered in need of supportive care, having been admitted to the sick nursery directly after being born. The baby was subsequently diagnosed with hypoxic ischemic encephalopathy; During follow-up in the paediatric period, MRI evidence of neurological injury were documented in keeping with injury to both the BGT and watershed areas of the brain; S[...]’s mother’s pregnancy was uncomplicated prior to the onset of labour (the unchallenged evidence of S[...]’s mother was that after her arrival at the hospital a sonar examination was carried out on her abdomen and she was assured that the foetus was well and that a normal vaginal delivery was planned); During labour foetal monitoring was substandard; At least 2 hours and 10 minutes before delivery (depending on whether the note in the hospital records with the time annotation of 00h00 was contemporaneous or retrospective), at the time S[...]’s mother was in the second stage of labour, foetal resuscitation was prescribed. There is no evidence that this was implemented. It is presumed that suspected foetal hypoxia had been diagnosed prior to this. Emergency caesarean section was planned at midnight on 30 August 2014; This operative delivery was prioritised as if this was a category 1 caesarean section; The emergency delivery was delayed for 2 hours and 10 minutes. There is no record of adequate foetal monitoring during this time and no evidence that foetal resuscitation was in progress during this period. S[...]’s mother’s unchallenged evidence was that after the doctor had examined her and told her that there would be a caesarean section delivery she received no medication - therefore no tocolytic agent was administered; she lay on her back and was told to close her legs - she was not placed on her left side; and no oxygen was administered. This establishes that no intrapartum resuscitation was carried out as had been instructed by the doctor.

[26] Consequently, the evidence is that of diagnosed foetal hypoxia which was inadequately managed and inadequately monitored from midnight (or from 23h30 if the note in the hospital records with the time annotation of 00h00 was retrospective and not contemporaneous) until delivery at 02:10.

[27] The consequences of foetal hypoxia would have been avoidable if proper protocols of intrapartum foetal monitoring had been followed allowing early diagnosis of foetal distress; the diagnosed foetal distress had been correctly managed according to the

prescribed management; expedited delivery had taken place within the prescribed decision to delivery intervals; and foetal resuscitation had been applied from the time it was prescribed until delivery.

[28] The most pertinent parts of Prof Smith's testimony not already reflected in Prof Anthony's testimony were as follows. He disputed the Apgar scores of 5/10 and 10/10, based on S[...]’s condition after delivery. S[...] *inter alia* did not cry at birth, did not breathe, had depressed muscle tone, and required physical breathing support (which was seemingly not provided). A prolonged partial hypoxic ischaemic brain injury fits the timeframe for foetal distress from probably 20h45 to delivery by 02h15. By 2014 devices were available with which to cool babies. The defendant did not suggest that the device was not available at CHBH. Cooling of the baby to a body temperature of 34 to 35 degrees has been shown to ameliorate brain injuries to babies in 45% of cases. S[...] should have been cooled.

[29] The defendant first called Professor Yasmin Adam as a factual witness. She attended court pursuant to a *subpoena duces tecum* which the plaintiffs caused to be issued and served on her. She brought to court the original hospital file relating to S[...]’s mother and S[...], and the original 2014 obstetric theatre register. She testified that she is the head of the obstetric unit at the hospital and was already in that position in 2014.

[30] She explained the system which was in place in 2014 and which was supposed to be followed when a patient was to undergo a non-elective caesarean section. The booking for a caesarean section had to be done by doctor, either a registrar or a consultant. If the doctor decided that the patient required a caesarean section delivery, the doctor would go to the theatre and write the patient up on the board and discuss the case with the anaesthetist and surgeon on duty at that theatre, and they would decide, having regard to other patients who required a caesarean section, who would go first. The patient would then be booked, a slip would be filled in, and the patient would be prepped for theatre and fetched at the right time. When the patient was brought to the theatre she would be brought up to a red line. The sister would check the consent for the surgery, check what her “booking bloods” were in case the patient needed a transfusion during the surgery, and would then take the patient across the red line into the theatre. When the

patient was in the theatre the anaesthetist would examine the patient and take her history from her. The sister would then clean the operation site and drape the patient. After that the surgery would proceed.

[31] She testified that in 2014 there were two obstetric theatres (theatre I and theatre II) which ran for 24 hours a day. She explained the entries set out on exhibit A (a typed version of the original theatre register which she had brought to court). The Roman figures "I" and "II" refer to the two theatres. In evidence in chief she was referred to the patient on line 623 and confirmed that that patient went into theatre II at 20h30 and left the theatre at 21h05. The next patient who was operated in theatre II (line 626 on the register) went into this theatre at 01h00 on 31 August 2014 and left the theatre at 02h00. She confirmed that theatre II was therefore unoccupied for 3 hours and 45 minutes from 21h05 on 30 August 2014 to 01h00 on 31 August 2014. At this point the defendant attempted to paint this time period as "down time" but it was not open to the defendant to do so, as she pleaded that all theatres were busy, and did not plead that staff was not available.

[32] In cross-examination she was referred to the 2007 South African National Maternity Guidelines, which she confirmed were in force and applicable in 2014. The next edition was issued in 2015. With reference to the instruction in the Guidelines that when CTG tracings are interpreted, the interpretation must be noted in the patient's records in case the tracing later goes missing, and that the tracing must be kept in the patient's file, she confirmed that this was the protocol which was supposed to be followed in the hospital in 2014, and that it was further protocol at the hospital that the nursing sister attending to the patient was required to staple the CTG tracings onto the cardboard file cover. She confirmed that the cover of the file which she had brought to court had a staple through the front of the cover, but that no CTG tracings were attached to the cover at the time she brought the file to court.

[33] In re-examination counsel for the defendant, with reference to the staple which was confirmed to be in place on the front cover of the file, asked her "*in instances where there*

is a staple which would have stapled the CTG”,⁷ under what circumstances the CTG tracings would be taken off. She replied that the tracings may be taken off if there had been a problem and clinicians have to discuss the case, in which event the tracings are taken off and put together and discussed. After that the tracings should get back to the file and be stapled to the file. In this particular instance she was unable to say what happened to the CTG tracings.

[34] Under cross-examination with reference to exhibit “A” she confirmed that theatre II had been unoccupied and available from 21h05 on 30 August 2014 until 01h00 on 31 August 2014. After she had testified, the typed version of the relevant original pages of the theatre register was handed in as exhibit “A”, and counsel for both parties “formally admitted on record”⁸ that the exhibit correctly reflects the times at which each patient entered and left each of the two theatres (ie when the two theatres were occupied and unavailable, and when they were unoccupied and available).

[35] Dr Bowen was called as an expert witness (obstetrician and gynaecologist) by the defendant. Much does not have to be stated here of what he testified to. Dr Bowen was a poor witness. His expert report also failed to meet the criteria set in caselaw, in particular that the facts on which his opinions were based were not identified, his process of reasoning was flawed, and he insisted on drawing factual inferences on matters outside his field of expertise, the drawing of which inferences is the function of the court. Significant parts of his expert report related to lack of resources and excessive workload at CHBH, which was not pleaded and was not part of his brief or something he could testify about as expert. In his testimony he displayed bias and lack of objectivity and was argumentative. His objectivity and demeanour improved towards the end of his cross-examination, and he made concessions which the plaintiffs accepted.

[36] Of concern is that Dr Bowen was called to testify without the defendant’s legal representatives providing him with the joint minutes of the other experts, without informing

⁷ The plaintiffs submitted that the framing of the question constitutes an admission by counsel for the defendant that the staple on the file cover had stapled CTG tracings to the file.

⁸ These were the words intentionally used by lead counsel for the plaintiffs to bring the admission within the ambit of section 15 of the Civil Proceedings Evidence Act.

him that there were two obstetric theatres at the hospital in August 2014, that a theatre was available during the crucial time period, and without informing him of S[...]’s mother’s unchallenged evidence.⁹ He repeatedly pointed to the lack of relevant information, and at a stage candidly stated that if he had been given all the information which he first came to know about while testifying, he would not have written the report he did. He voluntarily conceded that his report was poor.

[37] Dr Bowen confirmed that the 2007 South African Maternity Guidelines set the minimum standard of care and treatment of labour and delivery in South African public hospitals in 2014 and constitute the “benchmark” against which the conduct of the hospital personnel should be judged in this matter. He also confirmed that if a health care worker or clinician decided to follow a different course of management or treatment of a woman in labour this would have to be justified on clinical grounds. No such deviation from the benchmark was advanced by the defendant.

The assessment of the expert evidence

[38] The evidence by S[...]’s mother and the expert witnesses Prof Anthony and Prof Smith were not challenged or disputed in cross-examination. When defendant’s counsel intimated that he had no questions for Prof Anthony, I remarked to counsel that he therefore accepts all the consequences of failing to cross-examine and he affirmed this. After Prof Smith testified in examination in chief, counsel for the defendant only asked Prof Smith some questions relating to the ameliorative effects that cooling would have had for (the born) S[...] but did not challenge or dispute his evidence.

[39] *President of the Republic of South Africa and others v South African Rugby Football Union and others* is particularly instructive,¹⁰ where the Constitutional Court confirmed long-standing principles of cross-examination. If a disputed issue is not challenged in cross-examination, the party who called the witness may proceed on the basis that the unchallenged testimony is accepted as correct. This is a rule of professional practice and to be fair to the witness being cross-examined. What precisely is being

⁹ Compare *AM v MEC for Health, Western Cape* 2021 (3) SA 337 (SCA) para 22.

¹⁰ 2000 (1) SA 1 (CC) paras 61-63.

imputed must be clear from the cross-examination so that the witness can address the precise imputation. Not only that the testimony is to be challenged but how it is to be challenged must be clear to the witness. In the context of cross-examination by an expert witness, this should for example include specific questioning around the facts the expert relied on, how they made their inferences about their conclusions, on which specific facts the expert relied to come to specific conclusions, if their inferences and conclusions are logical and supported by the literature, and specific instances of putting the opposing views and conclusions of other experts to the expert being cross-examined. This is not done to comply with some box ticking approach to cross-examination or to contribute to the "theatre" of a trial, but to allow the witness being cross-examined to fairly respond to each of the detailed imputations. Their response may include a qualification of their evidence, or to explain an apparent contradiction, or to make it clear to the litigating party that further corroborating evidence may have to be called.

[40] I cannot speak on behalf of the defendant but in hindsight it appears as if the defendant strategy was to proceed on whatever basis the plaintiffs wished to build their case, allow the plaintiff to introduce how much evidence as they wished on negligent omissions by the hospital staff, then use Prof Bowen's evidence to introduce a "lack of resources" defence, that was not pleaded, and to somehow keep the plaintiffs to the recordal in the hospital records that there was no theatre available when the caesarean section should have commenced, in the face of their formal admission that a second theatre was available (and staffed). To have used Dr Bowen in this sense turned him into a co-litigant, not an expert witness. This was irresponsible litigation that should be met by an appropriate costs order.

[41] In light of no cross-examination having taken place, in principle the plaintiffs were accordingly entitled to close their case on the basis that the evidence which had not been properly challenged was accepted as correct by the defendant and to make their case on this basis. They would have to go further, though, and still explain in their closing address why the experts who testified on their behalf meet the requirements as set out in the caselaw. There would be no need to carefully compare their experts' testimony to the defendant's experts, and may proceed to build their case entirely on their own experts' testimony, but this testimony, considered on their own, would still have to meet judicial

scrutiny. Litigants are bound to the opinions expressed in the joint minutes (unless repudiated timeously). A court would not be bound to an opinion expressed in a joint minute, but would have to raise its misgivings during the trial and not leave it to judgment.¹¹ I expressed no such misgivings during the trial.

[42] The main considerations to keep in mind when evaluating expert evidence have been crystallised in *Coopers (SA) (Pty) Ltd v Deutsche Gesellschaft fur Schadlingsbekamp mbH*;¹² *Michael v Linksfield Park Clinic (Pty) Ltd*;¹³ *AM v MEC for Health, Western Cape*,¹⁴ and the further authorities cited therein:

The facts relied on by the expert and the opinions derived therefrom must logically hang together and the conclusion reached must be defensible. The conclusion reached must be reasonably of being drawn from the facts. It follows that these facts and opinions and reasoning process must be set out in an appropriately comprehensive and detailed manner. The authorities imply that the source of the facts relied on by the expert should be clear. The facts relied on should be in evidence. The more that reliance is placed on facts that are not in evidence, the less weight to be attached to the expert opinion as a whole.¹⁵ At the extreme, an opinion based on facts not in evidence has no value to a court. Judicial "proof" is not to be equated to scientific "proof". A court uses yardsticks such as reasonableness, a preponderance of probabilities, and the likelihood (sometimes expressed as percentage) of some event occurring.¹⁶ The court is the final arbiter of all facts and expert opinions.

The picture painted by the facts

¹¹ *Glenn Marc Bee v The Road Accident Fund* (093/2017) [2018] ZASCA 52 para 71.

¹² 1976 (3) SA 352 (A) 370-371.

¹³ 2001 (3) SA 1188 (SCA) paras 34-40.

¹⁴ 2021 (3) SA 337 (SCA) paras 17-22.

¹⁵ For example, Prof Bowen's recordal of the "fact" that no theatre was available. As per the plaintiffs' contention, this "fact" would be inadmissible hearsay evidence, as the author of the relevant recordal in the hospital records was not called to testify.

¹⁶ Prof Smith for example testified that in 45% of cases for cooling of the appropriate category of neonates, cooling alleviates the brain injury. This may be close enough to the "judicial" 50% to hold that cooling would probably have benefited Sentebale.

[43] On a balance of probabilities, having proper regard to the oral testimony and the experts' joint minutes, the following sequence of events played out.

[44] There was no pre-existing condition of S[...]’s mother or the foetus, nor any event preceding S[...]’s mother’s admission to hospital, which could constitute a probable cause of the hypoxic brain injury sustained by S[...].

[45] S[...]’s mother was admitted to hospital on 30 January 2014, a sonar was done of her abdomen and she was seen by a doctor who advised that the foetus was well and that they would try to do a normal delivery (despite for the known reason for her referral to the hospital being a suspicion of a “big baby” and CPD.¹⁷) No note was made of the foetal heart rate, but it can be accepted that the foetal condition was reassuring at the time.

[46] S[...]’s mother was in the latent phase of labour when she was admitted to the hospital.¹⁸ There was no assessment of the foetal condition in the period between 17h05 and 19h30. S[...]’s mother was assessed at about 19h30. This should be inferred from the fact that the partogram has its first entry of a foetal heart rate at 19h30 and lists the risk factors as “Cat II tracing”. The document providing for an initial assessment in labour, in which the clinical history should have been contained, was not completed.

[47] The handwritten notes of "Assessment 1" recorded that S[...]’s mother was 6 cm dilated, that S[...]’s mother reported good foetal movement, and that there was a category II "NST".¹⁹ There therefore must have been a CTG tracing, and the recording of the interpretation of the tracing is in accordance with the instruction in the Maternity Guidelines. There was therefore at this time reason to suspect that there may be foetal distress, but there is no note that a doctor was informed, and S[...]’s mother was not assessed by a doctor in this period. The recorded management was that S[...]’s mother was transferred to the labour ward, and that continuous foetal monitoring must

¹⁷ Under cross-examination Dr Bowen confirmed that from the time of her admission to the hospital, all the attending medical personnel would have been aware of the diagnosis of CPD.

¹⁸ Correctly conceded by Dr Bowen in cross-examination.

¹⁹ Prof Anthony explained that this means “non-stress test”, and NST is often used to refer to the CTG tracing done in the early stage of labour. It therefore refers to a category II CTG tracing.

commence. The tracing before 19h30 was probably only for a period and was then stopped by 19h30.

[48] A partogram was commenced at 19h30, with the first entry of a foetal heart rate of 148 bpm after a contraction, at that time. The existence of the category II CTG tracing was listed as a risk factor in the heading of the document. The entry at 19h30 records that the membranes are intact, as did the notes of "Assessment 1". The cervical dilatation is marked as 6cm at 20h00, and it is recorded that a drip was put up at 20h00, which accords with S[...]’s mother’s evidence that a drip was put up when she was transferred to the labour ward.

[49] The notes of "Assessment 1" at 19h30 record the further management to include starting continuous foetal monitoring on a CTG. CTG monitoring was then started and there is a section of a CTG trace available for the period from about 20h12 to 20h36. As per prof Anthony's evidence, on the probabilities, this is only part of a trace which started earlier, as the CTG section made available starts and ends abruptly and the part of the paper strip preceding it (i.e. before 20h12) has been cut off.²⁰ The preceding part probably included the Category II tracing noted by the sister in her note of "Assessment 1" at 19h30. The available tracing shows six to seven contractions every ten minutes over two consecutive ten-minute periods.²¹ However, the partogram over the same time period records less than three contractions every ten minutes, and the partogram is therefore clearly not a true and reliable record of contractions.²²

[50] At 20h45, a doctor assessed a CTG tracing (which may have included the tracing for the period before 20h12 and which the sister assessed at 19h30 as being category II) and wrote a note on the small section of strip which is available in the hospital records "Repeat please. Cat II". It is probable that the doctor was at this time aware of the "Assessment 1" note of a Category II CTG done at about 19h30, as the patient file would have been available to him and it was in that file that the CTG tracing on which he wrote was kept. A part of the puzzle in this matter, because the defendant did not make the

²⁰ This was the uncontested evidence of Prof Anthony

²¹ Confirmed by both Prof Anthony and Dr Bowen.

²² Confirmed by both Prof Anthony and Dr Bowen.

complete CTG available, it that it seems that at 20h45 the CTG was not running continuously, as if it was, it would not have to be “repeated”.

[51] There is no further note referring to a CTG until about 23h30, and no note that the doctor had called for or considered the repeat CTG tracing which he had instructed at 20h45 must be done. The probable inference, and which is also what S[...]’s mother testified, is that the doctor gave this patient no further attention until the nurse called him at about 23h30.

[52] Before 22h30 S[...]’s mother was fully dilated and had the urge to bear down. The sister told her to push, and she “pushed and pushed and pushed” for over an hour before she was seen by a doctor, but the baby did not come.

[53] The next recorded assessment of S[...]’s mother and the foetus is "Assessment 4", the time or date of which is obviously incorrect, as "Assessment 5" was at 00h20. The date for "Assessment 4" is written as 30-8-14, but the time as 00H30. If it was after midnight the date would have to be 31-8-14. The next assessment, "Assessment 5", is noted as 31-8-14 at 00h20, so assessment 4 must have taken place earlier. "Assessment 4" was probably at about 23h30, which is what the defendant pleaded and which Dr Bowen rationalised, and the plaintiffs accepted the time of 23h30. The notes record that the plaintiff was fully dilated, and that the doctor was notified and “booked her” - for a caesarean section delivery.²³ It follows that the doctor saw and assessed the plaintiff at about 23h30. The foetal heart rate was noted as “on CTG 156-160”. This does not accord with the foetal heart rate on the partogram at this time of 135 bpm, and again establishes that the entries on the partogram cannot be correct.

[54] S[...]’s mother was assessed by a doctor at about 23h30 and he booked her for a caesarean section and then wrote a note of his assessment and treatment plan. The note has a transverse written time and date 00h00 010914 at the top left corner, but the date is clearly incorrect and the time does not necessarily reflect the time of the examination, but probably is a date and time written after the event. The note records the foetal head as

²³ Dr Bowen confirmed in cross-examination that this is what "booked her" means.

3/5 above the pelvic brim (APB) and that there was minimal descent - the head was therefore still far above the pelvic floor. According to the Maternal Guidelines, if a nullipari has been pushing for over 45 minutes without delivery and the head is still higher than 2/5 (which it still was after more than an hour of pushing), an emergency caesarian section should have been done.²⁴

[55] The doctor's note at about midnight records the interpretation of a CTG tracing as category II (suspicious) with an FHR 120-180, and showing accelerations and decelerations. This note does not refer to the tracing done from about 20h12 to 20h36 and on which the doctor wrote a note at 20h45.²⁵ This was an indicator of foetal distress. The note records that the doctor told the sister to tocolyse the plaintiff and do intrapartum resuscitation, which is precisely the treatment which should be given if there is foetal distress and a caesarean section is to be done, as it reduces the stress on the foetus.²⁶ The doctor therefore at this time (somewhere between 23h30 and 00h00) diagnosed that there was foetal distress. The foetal heart rate of 120-180 in the midnight doctor's note also does not accord with the foetal heart rate of 138 marked on the partogram at 00h00. This again establishes that the entries on the partogram are not correct. There are sufficient grounds to draw the probable inference that the entries made on the partogram (save for the first entries when it was started) are an ex-post facto fabrication.

[56] The doctor's note also records his assessment of CPD, and possibly a big baby, while the foetal head was still 3/5 above the pelvic brim. According to the Maternity Guidelines this called for an urgent expedited delivery, but the doctor correctly decided that the foetal head was too high to attempt an assisted delivery (with forceps or vacuum extraction) and his plan was therefore to book S[...]’s mother for a caesarean section. Theatre II was available at the time and given a maximum acceptable period of one hour from decision to delivery, the baby could and should have been delivered by no later than 01h00. The doctor's note that both theatres were occupied with two foetal distress cases is contradicted by the formal admission of the theatre register entries as correct. Theatre I

²⁴ Confirmed in cross-examination by Dr Bowen.

²⁵ As Dr Bowen conceded in cross-examination.

²⁶ This was the unchallenged evidence of Prof Anthony and was also conceded by Dr Bowen in cross examination.

was occupied with a foetal distress case, but Theatre II had been open since 21h05 and was still open and available at the time of the doctor's decision.

[57] S[...]’s mother’s pulse and blood pressure were taken at midnight, but the foetal heart rate was not assessed or recorded. No analgesic medication was given to S[...]’s mother at any time during her labour, nor was tocolysis administered, nor was intrapartum resuscitation of the foetus carried out after "Assessment 5" and the doctor’s instruction at about midnight.

[58] The foetal heart rate was assessed at 00h20 “on CTG 172-123”. S[...]’s mother was received in Theatre I by 01h15. The nursing sister noted CPD and foetal distress. She was assessed by the anaesthetist, Dr Nomgana, who noted in his pre-operative assessment that she was to undergo a caesarean section for CPD and foetal distress. On the probabilities, he obtained this information from the doctor who booked S[...]’s mother at about midnight and who would have discussed her condition and the reasons for the caesarean section with the surgeon and anaesthetist. The anaesthetic was recorded as having started at 01h40 - 25 minutes after S[...]’s mother had arrived in theatre, with known CPD and foetal distress, and who had been booked for an emergency caesarean section before midnight, more than 1 hour 40 minutes before then.

[59] The theatre note by the surgeon recorded the indications for the surgery as “CPD and Fetal Distress”. In the pre-operative details on the form Foetal Distress is marked “YES”, and CPD was written by hand. On the probabilities, he obtained this information from the doctor who booked S[...]’s mother at about midnight, and who would have discussed her condition and the reasons for the caesarean section with the surgeon and anaesthetist. The cut was made by the surgeon at 02h05 and the baby was delivered at 02h10.

The defendant's case

[60] The heads of argument for the defendant is unfortunately not a model of clarity. The submissions do not follow logically and the relevance of long quotes from caselaw is

not immediately apparent. I deal with the heads of argument in the sequence that the contents of the document was presented.

[61] Both counsel relied on *Glenn Marc Bee v The Road Accident Fund* to reach differing conclusions.²⁷ Counsel for the plaintiffs argued that facts that were assumed to be correct by the experts and recorded as such in a joint minute cannot bind the parties if the true facts are established to be different. Counsel for the defendant argued that the facts agreed to in a joint minute bind the parties in all respects.

[62] As an important part of the defendant's case rests on the basis that the joint minutes bind the parties in all respects - all facts recorded in the minutes, howsoever obtained - I deal with this submission in some detail.

[63] An expert is required to set out the facts on which their opinion is based. However, where an expert relies on facts which appear in the hospital records and assumes that the facts are correct, or where the experts in joint minutes agree that certain facts are recorded in the hospital records and base their agreed opinions on those facts, the experts cannot by apparent agreement on the facts bind the parties or the court where those facts are clearly incorrect. I set out below my reasons for this conclusion.

[64] *Coopers*²⁸ established that an expert notice must contain "the facts or *data* on which the opinion is based. The facts or *data* would include those personally or directly known to or ascertained by the expert witness, e.g., from general scientific knowledge, experiments, or investigations conducted by him, *or known to or ascertained by others of which he has been informed* in order to formulate his opinions" (emphasis added). In other words, an expert in giving an opinion is entitled to rely on facts assumed to be correct, but which are to be established in some way other than the expert's own investigations - by the evidence of another witness, by agreement or by admission, for example. The facts recorded in hospital records fall in this last category.

²⁷ (093/2017) [2018] ZASCA 52.

²⁸ *Coopers (South Africa) (Pty) Ltd v Deutsche Gesellschaft für Schädlingbekämpfung MBH* 1976 (3) SA 352 (A) 371B-C.

[65] As I read *Glenn Marc Bee v The Road Accident Fund*,²⁹ it is so that a court is generally bound to the facts agreed to in a joint minute of experts. The context in which this legal principle was again confirmed in *Glenn Marc Bee* must however be firmly kept in mind. *Glenn Marc Bee* references *Thomas v BD Sarens (Pty) Ltd*,³⁰ where in para 12 of *Thomas* the court has in mind situations where the "experts are asked or are required to supply facts, either from their *own investigations*, or from their *own researches*" (emphasis added). This is also how the *Glenn Marc Bee* court understood the context - in para 64 of *Glenn Marc Bee* the SCA refers to a situation where "the parties engage experts who *investigate the facts*, and where those experts meet and agree upon those facts" (emphasis added). In these circumstances - where the experts themselves ascertain the facts and then meet and agree on those facts, it would make sense to hold the parties to the facts as ascertained by the experts themselves. But where experts work on an assumption, and that assumption is then clearly shown to be wrong as the trial proceeds, it may lead to inequitable outcomes if the parties would be bound to facts that are clearly incorrect.

[66] The inequitable outcome in the present case would be to hold the plaintiffs to an assumed fact - that no theatre was available - while the defendant formally admitted the typed theatre record which indicates that a theatre was indeed available.

[67] I do not read *Glenn Marc Bee* and *Thomas* to hold that under no circumstances whatsoever may the parties and the court deviate from the facts as agreed to in a joint minute. I also do not read these cases to hold that the only way to deviate from agreed facts in a joint minute is when a litigant clearly repudiates the agreement.

[68] The SCA in *MEC of Health and Social Development of the Gauteng Provincial Government v M*,³¹ in interpreting *Marc Bee*, stated that "this Court has discouraged departure from agreements previously reached by experts". The SCA could have stated that a departure from an agreement reached between experts is "disallowed" or "disallowed under all circumstances". The SCA's softer phrasing is telling.

²⁹ (093/2017) [2018] ZASCA 52 paras 64-78.

³⁰ [2012] ZAGPJHC 161.

³¹ (272/2022) [2024] ZASCA 21(05 March 2024) para 33.

[69] Paragraph 78 of *Glen Marc Bee* is particularly instructive: "Given the agreed ruling by the trial court, it was not open to the court *a quo*, and it is not, I respectfully consider, open to this court, to go behind the facts agreed in the forensic accountants' joint minutes. Apart from the fact that intervention by an appellate court would be impermissible, *it is simply not possible to say on the record whether the facts agreed in the forensic accountants' joint minutes are or are not the correct facts*" (emphasis added). In the present matter, there can be no doubt that the correct fact is as the parties agreed to when they formally admitted the theatre record into the court record.

[70] It follows that the plaintiffs cannot be held to the "fact" in the relevant joint minutes that no theatre was available.

[71] If I am wrong in my interpretation of *Glen Marc Bee* and *Thomas*, then I hold that the formal admission of the typed theatre record into the court record amounted to a clear repudiation of the "fact" recorded in the relevant joint minute that no theatre was available. Both parties in effect repudiated the joint minutes to the extent that no theatre was available. Plaintiffs' lead counsel in his opening address put the defendant on notice as well that plaintiffs do not accept that a second theatre was not available.

[72] Defendant's counsel further argued that the "oral evidence by the plaintiff's expert in relation to exhibit A [the typed theatre record] should be disregarded on the bases that the case the plaintiffs are attempting to make from the content of exhibit A is not pleaded in the particulars of claim and the plaintiffs' expert witnesses concerned have not dealt with it in their respective reports, neither have they filed any supplementary experts report regarding their opinion on the content of the exhibit A". These submissions have no merit, for the reasons set out immediately below.

[73] The plaintiffs *inter alia* pleaded that the defendant's medical staff "failed to administer appropriate medical treatment" to S[...]s mother and S[...]. Where a patient is earmarked for an emergency caesarean section, it would be "appropriate medical treatment" to immediately perform the caesarean section if a theatre is immediately

available. This is a conclusion a court may reach on the admitted and proven facts without having to rely on an expert's opinion to come to this conclusion.

[74] The parties agreed, as recorded in par 12.1 of the pre-trial minute of 23 November 2023, that the plaintiffs will be entitled to produce the discovered medical records kept by and obtained from the defendant, including hospital records and the notes and observations of the doctors who attended to S[...]’s mother and baby S[...] at the hospital and contained in the Trial Bundle, as evidence in the trial and as constituting *prima facie* proof of the truth of the content, without being required to call the author of each such document, but subject to the parties’ right to lead oral evidence to rebut the correctness of any fact, observation or finding recorded in such document.

[75] It was recorded in paragraphs 1.3 and 1.4 of the pre-trial minute of 25 January 2024 and placed on record in counsel's opening address that the plaintiffs do not accept the correctness of any recordal in the hospital records that there was no theatre available for performance of a caesarean section on S[...]’s mother between midnight on 30 August 2014 and 01H15 on 31 August 2014, and do not accept the correctness of the allegations made in paragraph 24 of the defendant’s plea insofar as the allegations are based on recordals made in the hospital records.

[76] It was formally admitted on the record of proceedings on 7 February 2024 by counsel for both parties that Exhibit “A” correctly sets out in typed form the entries in the relevant theatre register. Section 15 of the Civil Proceedings Evidence Act 25 of 1965, provides that it is neither necessary for a party to prove, *nor competent to disprove*, a fact admitted on the record of any civil proceedings (my emphasis). A formal admission can be made orally during the trial,³² as happened in the present matter.

[77] *Ex abundanti cautela* the plaintiffs relied on the agreement recorded in paragraph 12.1 of the pre-trial minute of November 2023 and elected to rely on these entries regarding the times at which theatre I and theatre II were in use on 30 August 2014 and 31 August 2014 as *prima facie* proof of these facts. I assume in favour of the defendant

³² *Joubert en 'n ander v Stemmet en andere* 1965 (3) SA 215 (O) 217C.

that her formal admission of the typed theatre record may have been withdrawn in case of a clear error. As it happened, the defendant did not withdraw the formal admission and adduced no contradictory evidence, from which it follows that theatre II was available from 21h05 on 30 August to 01h00 on 31 August (3 hours 55 minutes) and was therefore available for performance of a caesarean section on S[...]’s mother as soon as the decision was taken to deliver the baby by caesarean section. None of these facts and conclusions require an expert witness to assist the court.

[78] On the one hand, the defendant formally admitted the typed theatre record. On the other hand, the defendant still relied on the joint minutes that recorded that no theatre was available. While some practitioners may still view it as such, litigation is not supposed to be a game,³³ or an ambush.³⁴ Judicial resources are scarce. A matter that should have been settled on the merits turned into a six day trial. I come back to this point in the judgment where I discuss the cost order.

[79] Counsel for the defendant also submitted that the "defendant's expert was denied any opportunity during his oral evidence on the bases that it was not the defendant's case". With respect, counsel misconceived my upholding of the objection to his line of questioning. I disallowed questions relating to triage, not to the availability of a second theatre. Triage was not part of the plaintiffs' or the defendant's case.

[80] Counsel for the defendant submitted that the plaintiffs failed to prove negligence and/or causation, but did not raise clearly identifiable reasons for this assertion. Counsel referred to the joint expert minutes of Professors Smith and Cooper but did not identify which of the agreed facts or opinions point to the absence of negligence and/or causation, except for a possible implicit argument that wrongfulness was absent - that because the experts recorded that "the plan was to book the patient for a caesarean section. The doctor booked a caesarean section but noted '8 Emergencies on board. *Both theatres occupied with 2 FD's.*³⁵ Pt will follow', and 'tokolyse' and intrapartum resuscitation", that the injury to S[...] was unavoidable. Counsel in his heads of argument conceded that the

³³ *Glenn Marc Bee v The Road Accident Fund* (093/2017) [2018] ZASCA 52 para 67.

³⁴ *Glenn Marc Bee* para 79.

³⁵ My emphasis added.

"delay in performing the caesarean section *contributed*³⁶ to [the] adverse neurological out[come] but deferred the issue of whether the outcome was avoidable by expedited earlier delivery to the obstetrics experts". At best for the defendant, as I read this concession, was that she in any event admitted that some damage was caused to S[...] irrespective of the alleged unavoidably delayed caesarean section.

[81] Counsel then referred to the joint minute of Prof Anthony and Dr Bowen and seemingly wanted to emphasise that both experts agreed that the CTG tracing was normal. As illustrated in other parts of this judgment, the CTG tracing produced during the trial was not the complete tracing, and the evidence showed that S[...] probably suffered from foetal distress from at least 20h45.³⁷

[82] Defendant's counsel then quoted extensively from *The MEC for Health & Social Development, Gauteng v TM obo MM*³⁸ in his heads without explicitly clarifying how *TM obo MM* related to the present matter. In his oral submissions relating to *TM obo MM*, counsel argued that if during the trial new information or a document comes to light, the plaintiff should amend its particulars of claim to accord with the new information. Counsel argued that a scattergun approach to the particulars of claim is not acceptable and that the particulars of claim must be specific on the grounds of negligence to provide the defendant an opportunity to do its own investigations. Counsel again made the point that in the present case the joint minutes remains binding and cannot be revisited.³⁹ Counsel also argued that there was no evidence in the joint minutes that interim measures would produce a favourable outcome for S[...].

[83] In his oral reply to these oral submissions, counsel for the plaintiffs argued that *TM obo MM* should be taken to hold that where new evidence procured during the trial changes the grounds of negligence as originally set out in the particulars of claim, these new grounds must then be introduced by an amendment to the particulars of claim.

³⁶ My emphasis.

³⁷ The oral testimony of Prof Anthony and Prof Smith.

³⁸ (380/2019 [2021] ZASCA 110.

³⁹ I assume counsel implicitly argued that the minutes cannot be revisited and remains binding as no party gave timeous notice to repudiate the joint minutes.

Plaintiffs' counsel argued that *TM obo MM* does not hold that as new evidence emerges that the new evidence must be pleaded. This submission obviously raises Rule 18(4) and the distinction between *facta probanda* and *facta probantia*. The *facta probanda* are the "primary factual allegations which every plaintiff must make",⁴⁰ and the *facta probantia* are the "secondary allegations upon which the plaintiff will rely in support of his primary factual allegations".⁴¹ The plaintiff must plead "every fact that it would be necessary for the plaintiff to prove, if traversed, in order to support his right to the judgment of the Court".⁴² The plaintiff does not plead "every piece of evidence which is necessary to prove each fact".⁴³

[84] *TM obo MM* held by a 3-2 decision that the *facta probanda* were not pleaded.⁴⁴ The facts and relevant evidence obviously differs from the present matter; each case of alleged medical malpractice must be decided on its own facts and own experts' opinions. Take as one example the allegation in the particulars of claim in *TM obo MM* that the hospital was not "suitably, adequately and/or properly equipped to enable the timeous and proper performance of a [caesarean section] if and when required".⁴⁵ The court correctly held that the hospital had a properly equipped theatre, but that the case was built on the omission to have two or more functioning theatres.⁴⁶ The allegation in the particulars of claim did not cover the omission to have two or more theatres.⁴⁷ In the present matter, the plaintiffs alleged in their particulars of claim that the defendant's medical staff "failed to properly monitor and assess the condition of [S[...]'s mother] and the unborn S[...], and to administer appropriate medical treatment".⁴⁸ This allegation would to my mind cover the omission to have performed a caesarean section on S[...]'s mother in circumstances where a second theatre was available and where the unborn S[...] had already been experiencing foetal distress for some time - in other words, the

⁴⁰ *Jowell v Bramwell-Jones and Others* 1998 (1) SA 836 (W) 903A-B.

⁴¹ *Jowell v Bramwell-Jones and Others* 1998 (1) SA 836 (W) 903A-B.

⁴² *McKenzie v Farmers' Co-operative Meat Industries Ltd* 1922 AD 16 23.

⁴³ *McKenzie v Farmers' Co-operative Meat Industries Ltd* 1922 AD 16 23.

⁴⁴ Para 61.

⁴⁵ Para 61.

⁴⁶ Para 61.

⁴⁷ Para 61.

⁴⁸ Para 8d of the particulars of claim.

required *facta probanda* were pleaded. To make the present matter even more distinguishable from *TM obo MM*, the absence of an available second theatre was explicitly raised by the defendant in its plea.⁴⁹ The lack of a specific allegation in the plaintiff's particulars of claim did not prevent the defendant to conduct its own investigations as to the availability or unavailability of a second theatre. Its own document showed that a second theatre was available.

[85] As to defendant's argument that there was no evidence in the joint minutes that interim measures would produce a favourable outcome for S[...], the plaintiffs argued that Prof Anthony and Dr Bowen testified that interim measures do assist. I read through my trial notes carefully and Prof Anthony explained in some detail why interim measures are prescribed. His explanation was persuasive. The defendant elected not to cross-examine Prof Anthony on this (or any other) aspect of his testimony. Dr Bowen during evidence in chief confirmed that interim measures are common sense precautions.

[86] I return to defendant's counsel's extensive quoting from *TM obo MM*. Counsel in effect submitted that I am bound to the findings made in relation to the expert opinions expressed in *TM obo MM*, in particular the uncertain value of interim ameliorative measures and the rejection in *TM obo MM* of the "final hour hypothesis" expressed by one of the experts.

[87] Counsel submitted that "on the issue of interpartum resuscitation, oxygenation and lying on the left side, the SCA has already considered this issues in the matter referred to above, and found that there is no body of literature showing that interim measures have the effect of preventing the injury when applied". He further submitted that "the plaintiff's case is that the delivery by midnight would have avoided the outcome, the so-called final-hour hypothesis by Prof Smith, which hypothesis by the way has already been rejected by SCA in the case referred to hereinabove".

[88] As I understand *stare decisis*, I am not bound by findings of facts in previous decisions. In *National Director of Public Prosecutions v Vermaak*,⁵⁰ the SCA held that a

⁴⁹ Paras 24 and 31.1 of the amended plea.

⁵⁰ 2008 (1) SACR 157 (SCA).

court is bound to the "legal principles" and "ratio decidendi" expressed in decisions of higher courts.⁵¹ The expert opinions expressed by witnesses in a trial are part of the factual evidence. I am bound to carefully consider the expert opinions expressed in this trial and as recorded in the joint minutes, according to the legal principles as set out in for example *Michael v Linksfield Park Clinic (Pty) Ltd*⁵² and *AM v MEC for Health, Western Cape*,⁵³ but I am not bound by what experts may have testified to in other cases or to what higher courts may have determined on that factual testimony.

[89] Because causation is a legal test or principle, and because it has become a distinction related to causation, I am in terms of *stare decisis* also bound to keep the distinction in mind between an intrapartum *acute* profound brain injury and an intrapartum *prolonged partial* brain injury.⁵⁴ *TM obo MM* was a case of an acute profound injury,⁵⁵ not a partial prolonged injury as in the present matter. *TM obo MM* held that by the time that the caesarean section should have been performed, the injury had already occurred - in other words, the claim failed because the plaintiff could not prove causation.⁵⁶ The facts of the present matter are different. As I understand the evidence in this matter, some damage would already have occurred by the time the caesarean section should have been performed, and that the further inexcusable delay before the caesarean section was eventually performed, aggravated the injury. The delay was inexcusable because a second theatre was available. As I interpret the evidence, no "final hour hypothesis" was advanced in the present matter.

[90] Defendant's counsel submitted that the plaintiffs, only during the trial, sought to make two cases, both of which have not been pleaded: (a) That a second theatre was

⁵¹ Para 2.

⁵² 2001 (3) SA 1188 (SCA) paras 34-40.

⁵³ 2021 (3) SA 337 (SCA) paras 18-22.

⁵⁴ *The Member of the Executive Council for Health, Eastern Cape v Z M obo L M* (576/2019) [2020] ZASCA 169 paras 4 and 15; *MEC of Health and Social Development of the Gauteng Provincial Government v M* (272/2022) [2024] ZASCA 21 (05 March 2024) paras 23-27. *M v MEC for Health, Eastern Cape* (699/17) [2018] ZASCA 141 para 65 is very explicit about the difference between a partial prolonged type brain injury that occurs over hours and an acute profound type of injury in relation to causation.

⁵⁵ Eg paras 111 and 113.

⁵⁶ Para 127.

available during the time that the caesarean section should have been performed, "based solely on the face of the theatre register content and the times recorded therein, without knowing the reasons thereto"; and (b) "That the triage system should have favoured the plaintiff over the other patients, whose particulars appeared on the theatre register, as having undergone a C-section for the previous caesarean sections x 2". Counsel argued that these issues should have been raised explicitly in the pleadings by amending the original particulars of claim and should have been dealt with in the expert reports and/or joint minutes. In the absence of an amended particulars of claim and supplementary expert reports and/or joint minutes, the defendant argued that these bases for their claim are therefore not available to the plaintiffs.

[91] As to (a), as I conceive of plaintiffs' case, they *inter alia* pleaded and showed during the trial that a caesarean section was indicated and that the caesarean section was not timeously performed in accordance with the applicable guidelines. The *facta probanda* are that the nurses and doctors in attendance failed to administer appropriate medical treatment to S[...]s mother and S[...].⁵⁷ The *facta probantia* are *inter alia* that a caesarean section delivery was indicated and that an inexcusable and inordinate delay followed before S[...] was delivered, and that the delay was *inter alia* inexcusable because a second theatre was available and staffed. The availability of a second theatre formed part of the evidence of the trial, as it proceeded, based on a formal admission of the typed theatre record agreed to between the parties. As set out earlier in this judgment, a formal admission becomes part of the undisputed evidence in the case - it is not necessary to prove and it is not competent for a party to disprove, a fact formally admitted.⁵⁸ It is therefore also very difficult to understand counsel's submission that "the defendant's case is that delivery by midnight was impossible due to the unavailability of the theatre under the circumstances that prevailed at the time" - the formal admission that a second theatre was available and staffed may not be disproved.

[92] As to (b), whether triage may be fitted into any of the allegations in paragraph 8 of the particulars of claim or not, plaintiffs' counsel expressly disavowed any reliance on triage as part of its claim. Prof Anthony very briefly referred to triage in his evidence in

⁵⁷ Para 8(d) of the particulars of claim.

⁵⁸ Section 15 of the Civil Proceedings Evidence Act 25 of 1965.

chief, as an aside, and plaintiff's counsel did not ask any follow-up questions and did not ask for clarification. When defendant's counsel later in the trial raised triage, plaintiff's counsel objected and I upheld the objection, as triage was not part of the plaintiff's case. If I allowed the questions relating to triage, Prof Anthony would have had to be recalled as witness as he was not questioned in any detail on triage. I carefully read through my trial notes and none of the other witnesses testified about triage. Because a second theatre was available, triage did not enter the picture - as soon as a caesarean section was indicated, S[...]s mother should have immediately been taken to the available theatre.

[93] It follows that none of the defendant's submissions have any merit.

The delictual elements

Wrongful omission

[94] Where a duty not to cause harm exists, and that duty has been breached, wrongfulness would be established. A "(negligent) omission is unlawful only if it occurs in circumstances that the law regards as sufficient to give rise to a legal duty to avoid (negligently) causing harm".⁵⁹ I have bracketed negligence in the quotation so as not to conflate too many delictual elements all into one. Obviously delictual liability can only follow once all the elements have been proven. Wrongfulness is a separate enquiry from negligence. Wrongfulness is an objective enquiry implicating the legal convictions of the community and asking if it would be reasonable to impose liability. If it is established that a pregnant mother went into labour and was admitted to a hospital and after discharge from the hospital it was clear that the born child suffered from *inter alia* brain damage, that would establish wrongfulness,⁶⁰ unless a ground of justification such as impossibility or lack of adequate resources was established. I have already indicated that the defence of the unavailability of a theatre must fail. The defendant did not plea the lack of adequate resources. The defendant admitted that the CHBH staff owed a legal duty to S[...] and S[...]s mother to render to them proper and appropriate medical treatment. It follows that

⁵⁹ *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 12 as cited with approval in *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC) para 51.

⁶⁰ Compare *Oppelt* para 54.

the defendant's staff's omission to meet their duty not to cause harm to S[...] was wrongful. Wrongfulness does not implicate what the hospital staff did or not do; these questions are considered when negligence is considered.

[95] In *MEC of Health and Social Development of the Gauteng Provincial Government v M*,⁶¹ the SCA stated that "the approach adopted by this Court in determining whether there has been a breach of the legal duty to administer reasonable health care and skill in circumstances such as these is to distinguish between an acute profound and a partial prolonged HII". The SCA did not elaborate. This quotation read in isolation seems to implicate wrongfulness, but I fear I struggle to follow the SCA's reasoning in this regard. If a legal duty not to cause harm exists, and the foetus then suffers either an acute profound or a partial prolonged HII, wrongfulness would be established, in the absence of a ground of justification. If the defence is or "we took all possible reasonable precautions to avoid injury", to my mind the defence implicates negligence. If the defence is "there is nothing we could reasonably have done to avoid the injury", and if the SCA held that in case of an acute profound HII there is in effect nothing that can reasonably be done to avoid the injury, this could amount to a defence of impossibility, which would implicate wrongfulness.

Negligence

[96] The test for negligence is also an objective enquiry, but the question to be answered is distinct from the test for wrongfulness. The enquiry into negligence strictly speaking only arises once wrongfulness has been established. An objective reasonable medical member of staff is postulated, and the questions to be considered are whether such a member of staff would have reasonably foreseen the injury and would have taken reasonable preventative measures to avoid the injury.⁶²

[97] The plaintiffs argued that an adverse inference should be drawn against the defendant for failing to call any of the nurses or doctors who attended to S[...]’s mother

⁶¹ (272/2022) [2024] ZASCA 21 (05 March 2024) para 23.

⁶² *Kruger v Coetzee* 1966 (2) SA 428 (A) 430E-G.

during her labour and delivery,⁶³ and that the probable and proper inference is that there is no justifiable explanation other than a negligent failure to properly monitor and assess S[...]’s mother and the foetus and the failure to perform the caesarean section delivery at an earlier time. It is so that where a witness who is available and who may contribute to obtain a clearer picture of the facts is not called to testify, an inference is created that the litigant does not want that witness to testify because "he fears such evidence will expose facts unfavourable to him".⁶⁴ The inference may only be drawn if the witness was available.⁶⁵ From my trial notes it is not clear to me that the availability of the medical staff who attended to S[...]’s mother and S[...] was investigated.

[98] I agree with Professor Anthony’s unchallenged conclusion that in the absence of any other cause for the adverse outcome it is likely that the injury observed by the neuroradiologist developed during labour and would probably have been prevented by adherence to proper, prescribed standards of obstetric care.

[99] The evidence of the defendant’s witnesses did nothing to counter the factual evidence as contained in the hospital records, the oral evidence of S[...]’s mother and the two expert witnesses called for the plaintiffs, or to advance the defendant’s defence of the matter.

[100] In my view it flows logically from the exposition of the facts in this matter that the plaintiffs have proven the allegation in paragraph 8(d) of their particulars of claim that the nurses and doctors in attendance failed to properly monitor and assess the condition of S[...]’s mother and the unborn S[...] and to administer appropriate medical treatment. This allegation would cover the failure to continuously assess the foetal condition, the failure to timeously diagnose the conditions which rendered a caesarean section delivery necessary, the failure to administer appropriate medication, the failure to administer a tocolytic agent, the failure to carry out intrapartum resuscitation of the foetus, the delay in the delivery of S[...], and the failure to cool S[...] after her birth. Reasonable medical members of staff would have foreseen that these failures will cause injury to the foetus

⁶³ Counsel referenced *Raliphaswa v Mugivhi and others* 2008 (4) SA 154 (SCA).

⁶⁴ *Brand v Minister of Justice and another* 1959 (4) SA 712 (A) 715F.

⁶⁵ *Elgin Fireclays Limited v Webb* 1947 (4) SA 744 (A) 750.

and child and would have taken reasonable steps to avoid the injury, by for example regularly monitoring the foetal condition, and expediting the delivery of the baby by caesarean section once foetal distress was diagnosed, in light of the theatre that was immediately available.

Causation

[101] Causation consists of factual causation and legal causation.⁶⁶ For factual causation, in case of culpable omissions, the court's mental task is to "introduce into the facts a hypothetical non-negligent conduct of the defendant and then ask the question whether the harm would have nonetheless ensued".⁶⁷ The test is not mathematical or scientific or even philosophical; it is a practical test based on common sense and "everyday life experiences".⁶⁸ For legal causation, the test is to consider whether there is a "sufficiently close link" between the injury and the culpable omission.⁶⁹

[102] The test for causation has been refined to some extent by the SCA for intrapartum brain injuries. A distinction must be made between an intrapartum *acute* profound brain injury and an intrapartum *prolonged partial* brain injury.⁷⁰ A prolonged partial injury is caused when the foetus suffers from a cumulative lack of sufficient oxygen over time and is usually recognisable by a decreasing foetal heart rate.⁷¹ For the two types of injury,

⁶⁶ *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC) paras 35-50 conflates the two queries into one overarching test for causation.

⁶⁷ *Oppelt* para 48.

⁶⁸ *Oppelt* para 46.

⁶⁹ Eg *Oppelt* para 48.

⁷⁰ *The Member of the Executive Council for Health, Eastern Cape v Z M obo L M* (576/2019) [2020] ZASCA 169 paras 4 and 15; *MEC of Health and Social Development of the Gauteng Provincial Government v M* (272/2022) [2024] ZASCA 21 (05 March 2024) paras 23-27. Paras 23-27 read together implicates causation in that the SCA warns courts not to look for a cause of the injury by working backwards (to establish causation). *M v MEC for Health, Eastern Cape* (699/17) [2018] ZASCA 141 para 65 is explicit about the difference between a partial prolonged type brain injury that occurs over hours and an acute profound type of injury in relation to causation.

⁷¹ *The Member of the Executive Council for Health, Eastern Cape v Z M obo L M* (576/2019) [2020] ZASCA 169 para 15.

there are different relevant time periods and different causes.⁷² For example, in case of an acute injury, as I understand the SCA, a CTG tracing will likely not assist in providing prior warning of a sentinel event; a sentinel event usually being present in an acute injury.⁷³ In the present matter, a prolonged partial injury occurred. The evidence should therefore paint a picture of culpable omissions to meet the required standard of care over a prolonged time, a continuing failure to adequately address cumulative risks,⁷⁴ which in turn caused the injury. The joint minutes and witnesses' testimony paint precisely this picture. All the continuing and prolonged culpable failures may be attributed to the defendant's staff, so difficult questions of an "apportionment" of which omissions caused which injuries do not arise. It is the cumulative effect of all the culpable omissions taken as a whole that caused S[...]s injuries. "But for" all of these omissions, S[...]s injuries would probably not have occurred.⁷⁵

[103] No question of a possible remoteness of damage arises, so legal causation is also established - it is the same staff members in whose trust S[...]s mother placed herself and her unborn child who caused S[...]s injuries.

Costs

[104] The court order is that the defendant pays the costs on attorney and client scale. The following considerations as advanced by the plaintiffs lead me to this conclusion.

[105] The defendant unreasonably persisted in defending the matter on trial despite the agreements reached and recorded in the joint minutes of the experts, in particular the

⁷² *The Member of the Executive Council for Health, Eastern Cape v Z M obo L M* (576/2019) [2020] ZASCA 169 para 15.

⁷³ *MEC of Health and Social Development of the Gauteng Provincial Government v M* (272/2022) [2024] ZASCA 21 (05 March 2024) paras 25 and 31.

⁷⁴ Eg compare *The Member of the Executive Council for Health, Eastern Cape v Z M obo L M* (576/2019) [2020] ZASCA 169 para 16.

⁷⁵ The well-established *sine qua non* test - *Lee v Minister of Correctional Services* 2013 (2) SA 144 CC paras 40 and 41; *Mashongwa v Passenger Rail Agency of South Africa* 2016 (3) SA 528 (CC) paras 65 and 68.

agreements that S[...]’s brain injury was probably caused by intrapartum hypoxia during labour.

[106] The defendant’s legal representatives were either not properly prepared for trial, or embarked on the trial either recklessly without any reasonable basis to believe that the claim was defensible, or well-knowing that the defendant had no reasonable prospect of successfully defending the matter.

[107] The defendant failed to challenge any of the evidence given by S[...]’s mother and the two expert witnesses called by the plaintiffs and could and should have avoided the leading of their evidence by admitting the correctness thereof without them being called to testify. The defendant’s legal representatives knew that Professor Anthony and Professor Smith would be called to testify and would confirm the content of their reports, and must have decided before the trial commenced that their evidence would not be challenged in cross-examination.

[108] The defendant, after receiving the expert report of Dr Bowen in December 2022, in March 2023 amended par 24 of her plea in repeating *verbatim* the words of Dr Bowen, and raising the defence that there was no theatre available to perform an immediate caesarean section delivery on S[...]’s mother. Save for numerous bald denials, this was the only defence based on factual allegations which the defendant raised. However, the defence was unsustainable, as the defendant’s own theatre records, which the defendant did not initially discover but was later compelled to produce, establish that Theatre II was unoccupied and available from 21h05 on 30 August 2014 to 01h00 on 31 August 2014.

[109] The defendant’s legal representatives failed to furnish the joint reports of other experts, in which a number of issues had been agreed, to Dr Bowen, failed to provide him with the theatre register and inform him that there were two operational theatres at the hospital in 2014 and that theatre II was unoccupied at the relevant time, and failed to inform him of the unchallenged evidence given by S[...]’s mother on the first day of trial in his absence. This further information would clearly have had a material bearing on his evidence, as he himself conceded in cross-examination. Nevertheless, the defendant’s

counsel led Dr Bowen in examination in chief on the basis that the court should accept the correctness of the facts and opinions contained in the report he had prepared.

[110] The defendant's counsel led Dr Bowen in evidence in chief to repeat the unfounded and false defamatory allegation which he had made in the last part of the joint minute with Prof Anthony, where he alleged that S[...]s mother was an undocumented illegal immigrant. The defendant thereby became a party to this false and defamatory allegation.

[111] The defendant's employees at Chris Hani Baragwanath Hospital, without any justification or explanation for the failure to produce the CTG tracings, either suppressed, or failed to preserve, or destroyed the material evidence of the CTG tracings, which on the probabilities would have supported the plaintiffs' case, would have been adverse to the defendant, and if produced would materially have shortened, or avoided, the trial.⁷⁶

[112] The defendant unreasonably prolonged the trial by allowing Professor Anthony and Professor Smith to testify as to opinions already clearly set out in their expert reports, without then challenging their evidence in cross-examination, with the consequence that the defendant is deemed to have admitted their evidence. Notwithstanding this consequence, the defendant then called Dr Bowen to testify and express opinions contrary to those expressed by Professor Anthony and Professor Smith. In light of the failure to challenge the evidence of Professor Anthony and Professor Smith in cross-examination, there was no reasonable prospect that any contrary evidence by Dr Bowen would be accepted by the court.

[113] The defendant should reasonably have been aware, on a proper consideration of the available evidence and the admitted facts and opinions, and as pointed out in the opening address of plaintiffs' counsel, that there was no reasonable prospect of successfully defending the action.

⁷⁶ The South African Maternity Guidelines emphasise the importance of proper record-keeping, the preservation of the CTG tracings, and the recordal of the interpretation of the CTG tracings should they subsequently become lost.

[114] The plaintiffs' evidence concluded by 12h00 on the second day of trial. The defendant had failed to arrange the attendance of her own witnesses (knowing that defendant's counsel would not take time to cross-examine plaintiffs' witnesses) and then requested that the matter stand down to 11h00 on the third day for Dr Bowen to travel to Pretoria. Dr Bowen's evidence was concluded by 14h00 on the fourth day of trial, and although plaintiffs' counsel were ready to argue with written heads of argument on the fifth day (Friday), defendant's counsel requested that the matter stand down to Monday 12 February for argument in order for him to prepare written heads of argument. Had it not been for the time indulgences requested by the defendant (due to inadequate planning and preparation) the trial would have been concluded two days earlier.

[115] It is not necessary for the plaintiffs to establish improper or *mala fide* conduct on the part of the defendant to justify the award of punitive costs against the defendant.⁷⁷

[116] Counsel for the defendant did not deal with costs in his heads of argument. From counsel's closing argument it appears that he had sight of the original theatre record for the first time on the third day of the trial, when Prof Adams brought the original hospital records to court. This can only mean that the defendant's legal representatives were not prudent enough to obtain the original theatre record from CHBH much earlier. If it came to it, they should have travelled to the hospital and obtained the original records at source, towards the end of 2023 at the latest, when the request for further particulars in terms of Rule 21 was made. At worst for the defendant, on receipt of the original theatre record at the start of the third day of trial, the matter could have stood down for settlement negotiations. Instead, counsel for the defendant formally admitted the typed theatre record into the court record, which theatre record indicated that a second theatre was available at the time that a caesarean section should have been performed on S[...]s mother, and then "ambushed" the plaintiffs by advancing an argument in closing, after another three court days, that the plaintiffs were bound to the joint minutes that no theatre was available. The way the defendant litigated this matter deserves censure.

⁷⁷ *Shatz Investments (Pty) Ltd v Kalovyrrnas* 1976 (2) SA 545 (A); *MEC for Public Works, Free State v Esterhuizen* 2007 (1) SA 201 (SCA); *Sentrachem Ltd v Prinsloo* 1997 (2) SA (1) (A); *Savage and Lovemore Mining (Pty) Ltd v International Shipping Co (Pty) Ltd* 1987 (2) SA 149 (W).

ORDER

In the result, the following order is granted:

1.

The defendant is liable to compensate the plaintiffs in their representative capacities as parents and guardians of the minor child, S[...] M[...], for the damages suffered by S[...] as a result of the intrapartum hypoxic ischemic brain injury suffered by her during the first plaintiff's labour and the birth of S[...] on 30 and 31 August 2014 at Chris Hani Baragwanath Academic Hospital;

2.

The defendant is ordered to pay the plaintiffs' costs in respect of the trial relating to liability and causation on an attorney and client scale, such costs to include, but not to be limited to:

2.1. The reasonable costs consequent upon the obtaining of the medicolegal reports and the reasonable qualifying/preparation fees (if any) of:

2.1.1. Professor J W Lotz, neuro-radiologist;

2.1.2. Professor J Anthony, maternal and foetal specialist;

2.1.3. Dr D Du Plessis, nursing expert;

2.1.4. Professor J Smith, neonatologist;

2.1.5. Dr F Janse Van Rensburg, paediatric neurologist;

2.1.6. Dr G Gericke, geneticist;

of whom the plaintiffs have given notice in terms of the provisions of Rule 36(9)(a) and (b).

2.2. The costs consequent upon the employment of two counsel.

2.3. The plaintiffs' taxed or agreed attorney and client costs shall be paid into the trust account of the plaintiffs' attorney, Joseph's Incorporated, details of which are as follows:

NAME: J[...]S INC, TRUST ACCOUNT

BANK NAME: RMB PRIVATE BANK, JOHANNESBURG

ACCOUNT NO: 5[...]

BRANCH NO: 2[...]

REF: M. J[...]
M S[...]

3.

The following provisions shall apply regarding the determination and payment of the plaintiffs' abovementioned taxed costs:

3.1. the plaintiffs' attorney shall timeously serve the notice of taxation on the defendant's attorneys of record;

3.2. the plaintiffs' attorney shall allow the defendant 30 (THIRTY) calendar days to make payment of the taxed costs from date of settlement or taxation thereof;

3.3. should payment of the plaintiffs' taxed or agreed costs not be effected timeously, the plaintiffs will be entitled to recover interest at the mora interest rate, calculated from the 31st calendar day, after the date of the Taxing Master's allocatur, or after the date of settlement of costs, up to the date of final payment.

JA Kok

Acting Judge of the High Court

Delivered: This judgment is handed down electronically by uploading it to the electronic file of this matter on CaseLines. As a courtesy gesture, it will be emailed to the parties/their legal representatives.

For the plaintiffs:

NGD Maritz SC

MM Lingenfelder SC

Instructed by:

Joseph's Incorporated

For the defendant:

SM Malatji

Instructed by:

State Attorney

Dates of the hearing:

5-12 February 2024

Date of judgment:

10 June 2024