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

CASE NO. 226/2017

In the matter between:

Z[...] N[...] **Plaintiff**

and

THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH, EASTERN CAPE PROVINCE **Defendant**

JUDGMENT

COLLETT AJ:

Introduction

[1] The plaintiff has issued summons against the defendant claiming damages for and on behalf of L[…] N[…] (hereinafter referred to as '*LN*') relating to the alleged negligent treatment that she received during her confinement and the birth of *LN* at the Nessie Knight Hospital (hereinafter referred to as '*NKH*').

[2] At the outset of the trial, the court made an order separating the issues of merits and quantum in terms of *rule 33(4*) of the *Uniform Rules of Court* (hereinafter referred to as *'the Rules*'). Accordingly, the trial proceeded solely on the issue of the

negligence by the employees of the defendant, it being alleged that the plaintiff and *LN in utero* and at birth during the period 29 and 30 August 2002, received substandard care at *NKH.*

[3] The gist of the matter is whether the hypoxic ischaemic encephalopathy (hereinafter referred to as '*HIE*') was caused by the employees of the defendant during the active and second stage of labour as a consequence of substandard care.

[4] The salient issues for determination are best summarized as follows:

1. The exact nature of the *hypoxic ischaemic encephalopathy* (hereinafter referred to as '*HIE*') suffered by *LN*.

2. Whether the *HIE* suffered by *LN* occurred during labour and/or at birth as a consequence of the substandard care of the defendant's employees.

3. Whether the *HIE* resulted in the intellectual cognitive impairment from which *LN* suffers.

[5] Whilst this trial at first blush seems somewhat complex and convoluted, when separating the wood from the trees, this court is enjoined to consider whether the employees of the defendant, and in particular the nursing staff and/or doctor involved in the management of the plaintiff's labour, were negligent in that treatment. Axiomatically, whether such negligence, if found to exist, gave rise to the *HIE* and *sequelae* suffered by *LN*.

Pre-trial admissions

[6] The court has been referred, in argument, to the contents of the pre-trial minute dated 11 February 2020 (hereinafter referred to as the '*first pre-trial*') which is premised upon the parties confirming that they were duly authorised to attend the conference, deal with the business raised therein and agree where agreements were reflected. The undermentioned admissions are significant:

1. The obstetric history of the plaintiff was recorded, and the parties agreed that the summary of the labour documents and medical records accorded therewith.

2. The parties further agreed that the plaintiff's ID copy, L[...]'s ID copy, road to health chart and hospital records from *NKH* discovered by the parties are admitted as evidence and are what they purport to be subject to the right of either party to dispute an entry, the correctness or authenticity thereof.

[7] At this stage the expert reports of *Professor Lotz*, *Dr Redfern* and *Dr Wright*, inclusive of their opinions, were not admitted and the defendant indicated that it would appoint experts to assess *LN* and prepare reports.

[8] On 19 January 2021 a further pre-trial conference (hereinafter referred to as the '*second pre-trial*') was held by the parties. Aside from confirming the admissions made during the *first pre-trial*, the parties concluded the following agreements:

1. The injury displays a mixed pattern of prolonged partial (peripheral) and perirolandic, basal ganglia (BGT) (central) hypoxic injury.

2. The findings of the MRI study suggest that genetic disorders as a cause of *LN's* brain damage is unlikely.

3. The MRI findings suggests that inflammatory or infective causes are unlikely as causes of *LN's* brain damage.

[9] In addition hereto, the parties recorded as follows:

1. That the medico-legal reports prepared and the joint minute between *Professor Lotz* and *Professor Andronikou*, including all the opinions reflected therein, can be handed in as evidence without formal proof.

[10] A further pre-trial conference was held on 10 May 2022 (hereinafter referred to as the '*third pre-trial*') wherein, significantly, the agreement relating to the joint

minute between *Professors Lotz* and *Andronikou* was re-iterated. The parties further agreed as follows:

1. The parties agreed that the joint minute of *Professor Cooper* and *Dr Redfern* would be handed in as evidence in respect of the following issues as recorded in the pre-trial agenda more particularly paragraphs 5.1; 5.3; 5.6 and 5.7 which read as follows:

> *'5.1 That the maternity case record shows that, after an uncomplicated pregnancy, L[...] was born via vaginal delivery at estimated 41 week's gestation at NKH.*
>
> *5.3 That the intention had been to transfer the mother to NMAH prior to delivery for emergency caesarean section.*
>
> *5.6 That the paediatric experts agree that the reports of both Professors Lotz and Andronikou describe changes consistent with a mixed pattern of prolonged partial and acute profound hypoxic ischemic injury.*
>
> *5.7 That the joint minute of Dr Redfern and Professor Cooper be handed in as evidence of the agreements reflected therein.'*

2. The following was agreed upon relating to paragraph 5.2:

> *'5.2 There was prolonged second stage (1h50min) and fetal bradycardia for at least 90 minutes prior to deliver, and the intention had been to transfer the mother to NMAH prior to delivery for emergency caesarean section. The defendant placed on record that Dr Cooper agrees and notes that the recorded bradycardia was 100/min which is below the limit of 110min'*

3. The maternity case record (hereinafter referred to as *'maternity record')* could be handed in as evidence of what it purported to be:

1. That the brief clinical notes made when the plaintiff was admitted to hospital in the latent labour indicates that the plaintiff had no complications during the antenatal period and this suggests that it is unlikely that *LN* suffered the brain injury before the onset of labour;

2. That there was no history of postnatal cause for *LN's* brain injury;

3. That there was evidence of fetal distress;

4. That it is unlikely that an *abruptio placenta* occurred in the second stage of labour;

5. That the joint minute of *Dr Ebrahim* and *Dr Swan* be handed in as evidence of the agreements reflected therein.

4. The Guidelines for Maternity Care (2002) (hereinafter referred to as '*Maternity Guidelines*') were admitted as evidence without formal proof.

Expert evidence

Professors Lotz and *Andronikou*

[11] The joint minute of *Professors Lotz* and *Andronikou* was agreed upon at the *second* and *third pre-trial* conference. The significant features of the joint minutes are:

(a) The experts agree that the injury displays a mixed pattern of prolonged partial (peripheral) and perirolandic, basal ganglia thalamus (BGT) (central) hypoxic ischemic injury.

(b) The experts agree that the findings of the MRI study suggest that genetic disorders as a cause of *LN's* brain damage are unlikely.

(c) The experts agree that the MRI findings suggest that inflammatory or infective causes are unlikely as causes of *LN's* brain damage.

(d) That the injury occurred in a term brain from 36 weeks onward.

(e) The nature of the injury is not in dispute, but the probable cause and timing was deferred for a review of the clinical and obstetric records by specialists in the neonatology and obstetric fields.

[12] The *viva voce* evidence of *Professor Lotz* expanded upon the contents of his report (despite the early admission of its correctness in material respects as further evidenced by the joint report).

<u>*Professor Cooper* and *Dr Redfern*</u>

[13] Both paediatric experts, *Professors Lotz* and *Andronikou* describe changes consistent with mixed patterns of prolonged partial and acute profound hypoxic ischemic injury but agreed that the MRI cannot time the injury other than to indicate that it occurred at term gestation. They agreed that there was a prolonged second stage of labour and documented fetal bradycardia for at least 90 minutes prior to delivery with an intention to transfer the plaintiff to *NMAH* for a caesarean section. Furthermore, they agreed that there is limited information regarding the condition of the baby at and after delivery besides Apgar scores which are inconsistent with the documented fetal distress and bradycardia.

[14] The neonatal encephalopathy is critical to the timing of *LN's* brain injury, particularly with regards to the *intrapartum* period. The only examination available was performed one hour forty minutes after the delivery of *LN* and demonstrated signs of neonatal encephalopathy to which there appeared to be consensus. However, *Professor Cooper* preferred to interpret the singular inscription of *LN's* condition as *'statis'* prior to discharge and that he received his first immunizations to unequivocally confirm that any abnormal signs of encephalopathy had settled. Regrettably for *Professor Cooper,* the reliability and timing of the inscriptions is

unknown and nobody testified on the accuracy or circumstances of the recordals rendering the relevancy hearsay.

[15] *Professor Cooper* was of the opinion that *LN* developed only a mild neonatal encephalopathy which had settled by 12 hours after birth and that according to *Volpe's Neurology of Newborn*[1] (hereinafter referred to as *'Volpe'*), only moderate and severe encephalopathy resulted in neurological *sequelae*, whereas mild encephalopathy does not result in long term neurological *sequelae. Dr Redfern* referred to the same page in *Volpe* and stated that later neurodevelopmental follow-up had also identified disability in infants that had mild encephalopathy. In addition, he referred to recent research of *Conway et al*[2] where the authors indicated that disability in a group of children with mild encephalopathy may only appear as intellectual, behavioural or learning disabilities at an older age.

<u>*Drs Swan and Ebrahim*</u>

[16] *Drs Swan* and *Ebrahim* both agreed that the MRI cannot time the injury other than to show that it occurred at gestation. *Dr Ebrahim* opined that the hypoxic injury mixed pattern, in accordance with *Volpe,* and evolved over several hours rather than minutes. *Dr Swan* stated that as the MRI findings indicated both a prolonged partial and an acute profound pattern, in this instance it could be concluded that there was a possible decompensation of fetal bradycardia that had commenced before onset of labour.

[17] *Dr Swan* referred to *Volpe* regarding factors relating to the timing of hypoxia-ischemic as the aetiology of neonatal *HIE* namely:

a) fetal distress / fetal risk for hypoxia/ischemia

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[1] Volpe JJ. Neurology of the Newborn, 6th edition 2018

[2] *Conway, J.M. et al.* (2018) 'Mild hypoxic encephalopathy and long term neurodevelopment outcome – A systematic review', Early Human Development, 120, pp. 80 – 87. Doi: 10.1016/j.earlhumdev.2018.02.007. *Murray, D. M et al.* (2016) "Early EEG Grade and Outcome at 5 Years After Mild Neonatal Hypoxic Ischemic Encephalopathy', PEDIATRICS, 138(4). Doi: 10.1542/peds.2016-0659; *Prepunpong, C et al.* (2018) 'Prospective research on infants with mild encephalopathy: The PRIME study', Journal of Perinatology, 38)1), 99. 80 – 85. Doi: 10.1038/jp.2017.164.

b) resuscitation and/or low Apgar scores and

c) overt neurological syndrome in first hours or days of life.

He mentioned that there was evidence of fetal distress in the last hour of labour and a tight cord which could be a sentinel event. No other factors were present.

[18] Both *Drs Ebrahim* and *Swan* accept the opinion of *Dr Redfern* that there was no history of a postnatal cause for *LN's* brain injury. *Dr Ebrahim* considered it most probable that the brain injury and intellectual disability was due to a severe hypoxic injury that occurred *intrapartum* whereas *Dr Swan* opined rather that it was exacerbated *intrapartum*.

[19] *Dr Ebrahim* stated that the partogram does not indicate that the fetal heart rate was checked before, during and after contractions as stipulated in the *Maternity Guidelines* during the first stage of labour. In addition the *Maternity Guidelines* specify that CTG monitoring should have been used as the plaintiff was post term. Accordingly, it is not known if fetal decelerations were present during the first stage of labour. A fetal bradycardia was present during the second stage.

[20] *Dr Swan*, did not agree that the plaintiff was post term but regarded her as post- date and therefore not in a high risk category. However, he agreed that monitoring should be done before, during and after contractions. He said an abrupt change from normal heart rate to bradycardia was clearly noted at full dilation.

[21] *Dr Ebrahim* stated that the nature of the injury is indicative of evolving over hours rather than minutes so it is likely that the decelerations/fetal distress was present several hours before the birth stage of labour and throughout the second stage.

[22] *Dr Swan* stated that there is no conclusive evidence of a compromised fetal heart rate throughout the first stage of labour but bradycardia was noted at full

dilation at 23h00. Although meconium was noted when membranes ruptured at 21h00, the amount was not graded. He agreed that if *CTG* had been done more subtle signs of fetal distress may have been noted.

[23] Both obstetricians concluded that *abruptio placenta* was unlikely to have occurred in the second stage of labour. They both agreed that if fetal heart rate monitoring was carried out correctly during labour, decelerations/fetal distress ought to have been detected earlier and the delivery expedited resulting in a healthy baby with normal brain function albeit that *Dr Swan* added the rider that '*if sophisticated monitoring had been available*'. However, he accepted that the deviation from the standard guidelines was not to document the fetal heart rate before, during and after contractions.

[24] *Dr Ebrahim* concluded that the failure to diagnose fetal distress in the first stage of labour probably resulted in the hypoxic brain injury and intellectual disability of *LN*. *Dr Swan* was of the view that a combination of fetal priming and an unavoidable cord complication contributed to the hypoxic brain injury and intellectual disability of *LN.*

[25] *Dr Redfern* indicated that the Apgar scores of 8 at one and five minutes are not sustainable given the prolonged fetal bradycardia and the evidence of the plaintiff that *LN* did not cry and was placed in an incubator. Added to this is the dangers of relying on the Apgar scores as recorded by *Sineka,* whose general expertise is questionable. *Volpe* also regarded the dangers of relying on Apgar scores in such a context as '*fraught with hazards'.*[3]

[26] *Dr Keshave* disagreed with *Dr Redfern* and said that the Apgar scores were in-keeping with the discharge of *LN* on the same day, the administration of the BCG immunization and that if *LN* sustained a significant degree of hypoxic ischemic injury, he would have been far worse with neurological defects typical of cerebral palsy. Curiously, *Dr Keshave* conceded that if there was bradycardia then the Apgar

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[3] See Volpe 537

scores are unlikely to have been correctly measured which is significant given the clear documentation of bradycardia.

Dr Keshave, Professors Gericke and Christiansen

[27] *Dr Keshave* indicated that in the absence of evidence relating to fetal distress, depression at birth and neonatal encephalopathy, then the brain injury *intrapartum* becomes less probable. *Dr Redfern*, however, suggests that based on the plaintiff's evidence that the baby did not cry at birth and the '*twitching'* which lasted for a week this is consistent with the neonatal encephalopathy revealed at the first examination.

[28] *Dr Keshave*, whilst accepting that the examination revealed the presence of mild encephalopathy, noted that the baby was born with microcephaly having a head of 32cm at 41 week gestation which would indicate an insult prior to 34 week gestation which would add to the risk of neonatal encephalopathy. *Dr Redfern* opined that the head circumference was just below the 3rd centile for 41 week gestation and not indicative of congenital/primary microcephaly and was probably measured inaccurately considering that he has a normal head circumference as an adult.

[29] *Dr Keshave* indicated that *LN* presents a mainly intellectual disability and microcephaly that has persisted from birth with a head circumference of 52cm in a 20 year old is indicative of an antenatal insult or genetic aetiology as being most probable. He stated that according to *Volpe,* seizures after 24 hours of birth are not related to *intrapartum* asphyxia but rather antenatal insults or postnatal injury. *Professor Christiansen* was not called to testify on behalf of the defendant, but the joint minute between him and *Professor Gericke* was handed in by agreement. However, he stated in his report that the head circumference of *LN* as an adult was normal which brings into question the alleged congenital microcephaly at birth based on a head circumference below the 3rd percentile. This is also supported by *Professor Gericke* and accordingly adds merit to *Dr Redfern's* theory of inaccurate measurement at birth.

[30] *Dr Keshave* agreed with *Dr Redfern* that intellectual disability without cerebral palsy is a recognised *sequelae* of hypoxic ischemic encephalopathy but opined that the microcephaly at birth and its persistence, positive genetic results, lack of cerebral palsy and even postnatal results should also be considered as causes of the injury.

[31] *Professor Gericke* in his report refers to the ANK3 gene as a novel mutation which has yet to be proven of any clinical significance and cannot be attributed to be pathogenic in this case. *Dr Keshave* disagreed and stated that the presence of a variant of unknown significance (hereinafter referred to as '*VUS'*) does not mean it is not clinically relevant.

[32] *Dr Redfern* persisted that clinical significance cannot be attributed to a *VUS* without a formal, multi-step process so the genetic test must be considered negative for the purposes of the court and it also does not fit the clinical presentation of *LN.* According to him, of the few cases of ANK3 mutation outlined in the literature, none of them had small head circumference at birth or as adults or hypoxic ischemic damage on an MRI so there is no logical connection with *LN* in this matter. *Dr Keshave* proposed that even if the mutation is currently a *VUS,* in three years it may be labelled a pathological variant and therefore there is a strong case to indicate that the mutation played a vital role in the present case.

Factual witness evidence

Z[...] N[...]

[33] The plaintiff was in good health during her pregnancy and attended regular antenatal visits at the Nxotwe Clinic. She was a *primigravida* 17 years old when she was admitted to *NKH* for labour and delivery of *LN*. The plaintiff's relevant evidence was that her blood pressure and fetal heart rate was checked by the nursing staff intermittently and she was vaginally examined to establish her level of dilation. She indicated that she experienced severe labour pains.

[34] At a certain stage, the nursing staff were not happy with the condition of the unborn *LN* because of slow progress and summoned a doctor to examine the

plaintiff. The doctor upon examining the plaintiff ordered that an ambulance be called to convey her to Nelson Mandela Academic Hospital (hereinafter referred to as '*NMAH'*) for the performing of a caesarean section. Apparently, the ambulance was delayed in arriving and the plaintiff was assisted by two nurses to vaginally deliver *LN*. Significantly, according to the plaintiff, *LN* did not cry at birth, looked grey and floppy. According to her, *LN* was placed in an incubator, was not well, would not feed and was '*twitching*'. She was assured by the nursing staff that this was because *LN* was tired as a result of the prolonged labour.

[35] The plaintiff and *LN* were discharged on the same day but *LN* was not well and continued to *'twitch'*. The plaintiff took *LN* to the Nxotwe Clinic on 31 August 2002 and was informed that she should not have been discharged from hospital. The '*twitching*' subsided after a week. The plaintiff testified that *LN* delayed in walking and talking. She also testified about the psychological effects resulting from the birth of *LN* which were not challenged.

Sister NC Sineka

[36] *Sister Sineka*, testified that she was a qualified midwife at the time. When testifying, she indicated that she had no independent recollection of her involvement but could reconstruct based on the *maternity records*. She was not qualified as an expert witness. She testified that she had delivered 4 or 5 babies. She was also not qualified on expertise regarding Apgar scoring. Significantly, she confirmed that she had never read the *Maternity Guidelines* and had no knowledge of them.

[37] She was of the view that a single reading of the fetal heart rate determined over 30 seconds which fell within the normal range was reassuring of fetal well-being during labour which was the procedure that she adopted for fetal monitoring. Despite testifying that she observed and recorded contractions every thirty minutes, she was unable to convincingly explain the shading which appeared not to have been made contemporaneously. She did, however testify that the plaintiff was 7cm dilated and having strong contractions. When questioned as to when the active phase of labour begins, she responded as follows:

> '*I am still trying to remember, M'Lady. It is active when the contractions have to be strong.'*

[38] She indicated that she was not taught neither did she record the fetal heart rate before, during and after a contraction. She testified that there was nothing that she did to assist *LN* from when the low fetal heart rate was detected until the plaintiff gave birth.

[39] The partogram contained further inaccurate recordings, more particularly, an Apgar score of 10/10 which the *Sineka* said was a '*mistake*' which she should of '*scatched off'.* Furthermore, she observed the presence of meconium for four hours and understood that if it was '*thick*' it could indicate a problem with the fetus. She accepted the proposition that she recorded the meconium in red ink because she must have regarded it as significant. However, her version was that she did not grade it because there is no space on the partogram. Her evidence regarding the recording of the Apgar scores raised doubt as to whether she fully comprehended the scoring procedure particularly in view of her concession that she was not familiar with the *Maternity Guidelines.*

[40] She confirmed completing the first examination of *LN* an hour and forty minutes after birth. Despite recording a '*sick'* baby and other clearly compromised conditions, she attempted to explain the same as being as a result of *LN* '*waking up from sleep*' prior to the examination in an endeavour to justify the recordings. She stated the following in a further attempt to persuade the court that *LN's* examination was normal:

> '*Because of other many things, M'Lady, that I observed that are normal. To mention a few: the temperature was normal, the nutrition seemed to be normal; the behaviour seemed normal; the colour seemed normal, those made me think that the child, M'Lady was normal.'*

Evaluation

The pleadings

[41] The factual basis of the plaintiff's claim is set out in paragraphs 4 to 17 of the Particulars of Claim to which the defendant ultimately filed an Amended Plea on 13 May 2019. Noteworthy is that other than raising the *defence* that the hospital did not perform caesarean sections '*due to lack of capacity'* and that a decision to refer the plaintiff to '*UGH'* was made, none of the defences raised at trial relating to *genetics* or *'fetal priming factors'* were raised.

[42] Regrettably, the trial evolved into a somewhat hapless and prolonged narrative of expert evidence the basis of which was not pleaded. None of this evidence addressed the elephant in the room, which was whether the plaintiff received substandard care, particularly regarding the fetal monitoring during labour resulting in *LN* suffering *HIE,* and causally, the associated *sequelae*. As will become more apparent hereunder, what developed was nothing more than an unfortunate and speculative side-show not in-keeping with the expert testimony and facts as would have been expected in the circumstances of the case, particularly in view of the pleadings, the pre-trial admissions and joint minutes.

Rule 37 admissions

[43] The purpose of *rule 37* of *the Rules* is to facilitate efficiency in the conduct and conclusions of litigation. The *rule* envisages the expedition of trials with the potential limitation of issues resulting in cost-saving for all litigants. To permit a party to resile from agreements reached at a pre-trial conference would frustrate and negate the very purpose of the *rule* aimed at limiting the disputed issues of the litigation.[4] Our courts have repeatedly held that where parties have consciously agreed on issues that curtail the proceedings, save for special circumstances, the parties must be held to such agreements.[5]

[44] Significantly, from the *first pre-trial conference,* there was consensus as to the injury that *LN* had suffered. *Inter alia,* the *maternity records* of the plaintiff were

[4] *MEC for Economic Affairs, Environment and Tourism, Eastern Cape v Kruizenga* 2010(4) SA 122 (SCA)

[5] *F & I Advisors (Edms) Bpk v Eerste Nasionale Bank van Suidelike Afrika Bpk* 1999 (1) SA 515 (SCA) at 524 E-H

admitted as proof of what they purported to be, and the *Maternity Guidelines* were admitted without formal proof.

[45] During the ensuing pre-trial conferences, further admissions were made as outlined earlier. Of particular significance was the admissions that the brief clinical notes made when the plaintiff was admitted to hospital in latent labour indicated that the plaintiff had no complications during the antenatal period thus suggesting that it was unlikely that *LN* suffered the brain injury before the onset of labour and that there was no history of a postnatal cause for *LN's* brain injury. Crucially, it was admitted that there was evidence of fetal distress. The MRI study (and opinion of both parties' experts) suggested that genetic disorders as a cause of *LN's* brain damage was unlikely. The defendant is not entitled to resile from agreements made between the parties in the absence of special circumstances.

Expert Evidence

[46] At this juncture, I consider it prudent to consider the purpose of expert evidence presented at court prior to having reference to the applicable evidence in the present matter. An expert witness testifies as to an opinion based upon his/her expertise in a particular area with the function to assist the court in arriving at a conclusion relating to issues which the court does not possess the requisite knowledge.

[47] The expert witness is required to satisfy the court based upon his/her special skills or experience as to why the opinion expressed should be acceptable and decisive of the issue. The decision on the opinion is for the court to pronounce. The position is succinctly stated by Kriegler J in *S v M*[6] and cited with approval in *NSS obo AS v MEC for Health, Eastern Cape Province*[7] as follows:

> *'A court's approach to expert evidence has been dealt with on many occasions. This court is not bound by expert evidence. It is the presiding officer's function ultimately to make up his own mind. He has to evaluate the*

[6] *S v M* 1991 (2) SARC 91(t) AT 352
[7] 2023 (6) SA 408 (SCA)

expertise of the witness. He has to weigh the cogency of the witness's evidence in the contextual matrix of the case with which he is seized. He has to gauge the quality of the expert qua witness. However, the wise judicial officer does not lightly reject expert evidence on matters falling within the purview of the expert witness's field.'

[48] Whilst the expert is required to provide the court with the benefit of his/her expertise, this does not absolve the expert from providing the court with an objectively unbiased opinion and should not wander into presenting evidence which defies the logic and scientific expertise which he/she is professed to possess. The court is enjoined to assess on a balance of probability what has been established based on the facts and the cogency of the experts reasoning. The court must bear in mind that when dealing with medical certainty which may be uncertain it should not wantonly accept statements made by experts.[8]

[49] In *Oppelt v Head: Health, Department of Health*[9], the Constitutional Court aptly summarized the approach to be adopted by the court:

'*As a rule, that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their reasoning, preparatory to the court's reaching its own conclusion on the issues raised. The experts agree that a review of the clinical and obstetric records by appropriate specialists in the field of neonatology and obstetrics to be essential in determining the cause and probable timing of this hypoxic ischemic injury'*

[50] Regrettably, during the course of the evidence presented by certain of the defendant's experts, this court was frequently drawn down the proverbial rabbit hole with speculative opinions frequently neither based on proper facts, admissions or plausible scientific evidence.

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[8] *MF v Road accident fund* 2023 (1) SA 52 para 35 SCA AT PARA [34] ; *JA obo DMA v The Member of the Executive Council for Health, Eastern Cape*, [2022] 2 All SA 112(ECB); 2022 (3) SA 475 (ECB) para 12ff

[9] 2016(1) SA 325 (CC)

[51] In view of the critical admissions made by the parties, the content of the *maternity records* (that were admitted) and the evidence presented by particularly *Sineka*, the opinions presented to this court for consideration were beyond disappointing.

[52] Firstly, *Dr Swan*'s attempted to suggest that causation should be based on the existence of *fetal priming factors* prior to labour or the role of the umbilical cord found to be wrapped around the body and ankle of *LN* was nothing short of speculative and unsustainable. He further suggested a possible decompensation of fetal bradycardia that had commenced before the onset of labour. It deserves mention that the initial agreement regarding the clinical notes made when the plaintiff was admitted to hospital in latent labour indicating no complications during the antenatal period, rendered it unlikely that *LN* suffered the brain injury before the onset of labour.

[53] Moreover, in *Dr Swan's* own report regarding the umbilical cord in this matter, he concluded that:

> '*there is little evidence from the literature that a cord in such a situation would necessarily contribute in any significant way to fetal compromise'*.

Hence, the mere punting of this as a possibility of an acute sentinel event which could not have been anticipated and possibly a causative factor of *LN's* ultimate condition is most disconcerting. This opinion, included in the joint minute, was eventually conceded by him as speculative during his evidence. Nonetheless, it should never have seen the light of day given the lack of factual or scientific evidence upon which it was offered.

[54] Yet a further unsettling aspect of *Dr Swan's* evidence was his lack of regard to the evidence of *Sineka* either whilst preparing his report or giving evidence, more particularly, the absence of adequate fetal heart rate monitoring before, during and after contractions practically for the duration of the plaintiff's labour. Significantly, he conceded that the failure to monitor the fetal heart rate during labour was a significant risk factor for *HIE* and that *intrapartum* injuries of a prolonged partial

nature are avoidable if there is adequate fetal monitoring. Perhaps the most telling concession when faced with the methodology adopted by *Sineka* in monitoring the fetal well-being was that, according to *Dr Swan,* she would have had '*no chance at all of detecting any fetal distress if she monitored in that way'.*

[55] The disturbing feature of *Professor Cooper'*s evidence is that, despite his own concession that the records upon which he was to base his opinion we unacceptably '*sparse'* and that he required more information to formulated further views in the matter, he nonetheless offered an opinion albeit that it was subsequently amended once being provided with the neonatal examination, to include a mild encephalopathy at birth. His evidence was further marred by the fact that not only did he have no regard to the *viva voce* evidence of *Professor Lotz* but had not been apprised of the evidence of *Sineka* relating to the fetal monitoring (or lack thereof) during labour.

[56] Moreover, *Professor Cooper's* willingness to conclude (or rather speculate) that *LN* was well when he was discharged, despite the unequivocal documentary evidence of a compromised baby on the first examination, merely because of an entry '*satis'* and that *LN* had been given his immunizations which would only be administered to a healthy baby, is shocking. The inescapable conclusion is that he is prepared to draw unwarranted inferences from the very records that he regarded as '*sparse'* in the face of other damning evidence.

[57] Effectively, *Professor Cooper* failed to have regard to much of the evidence presented (or conceded) by the other experts such as *Redfern, Keshave, Lotz and Gericke*. Not surprisingly, he eventually agreed with *Dr Redfern*'s assertion that mild neonatal encephalopathy could give rise to a predominantly cognitive impact which, incidentally, was the outcome of *LN.*

[58] Despite the admissions regarding the unlikelihood of genetic involvement, discounting of postnatal causation and that the nature of the injury was to a brain of term gestation (36 weeks), *Dr Keshave* presented evidence that flew in the face of both admissions. Just to add insult to injury, he similarly had no regard to the

evidence of *Sineka* demonstrating a lack of appropriate fetal monitoring during labour.

[59] Aside from the fact that *Dr Keshave*'s opinion was based on a gene variant of uncertain significance, referred to as *VUS,* it was speculative and unsupported by science. He was simply unable to indicate how many ANK3 variants were pathological or benign or *VUS* either at the time of preparing his report or giving evidence. His evidence bordered on the bizarre especially when he encouraged the court to gaze into a crystal ball and determine that the ANK3 gene variant may sometime in the future be declared to be pathogenic instead of a VUS and based on this speculation (even on his own version), to find that it is associated with brain injuries of a hypoxic nature constituted by a mixed pattern.

[60] He presented no scientific evidence suggesting that and injury caused by this *VUS* could occur in the antenatal period or that there was an association between the ANK3 and the novel *VUS*, microcephaly, hypoxic injuries or mixed pattern *HIE.* More concerning is that he failed to take cognisance the fact that hypoxia and fetal distress had been diagnosed during the *intrapartum* stage when promoting his theory. His postulation of a viable alternative aetiology or causation beyond the *intrapartum* period failed dismally given that it was predominantly based on irrational, unscientific speculation.

The duty to monitor

[61] A professional person's failure to conform to the general level of skill and diligence possessed and exercised by a person of the same profession to which he or she belongs would ordinarily constitute negligence.[10]

[62] In *Goliath v MEC for Health*[11] in considering the issue of negligence it was stated as follows:

[10] *Goliath v MEC for Health, Eastern Cape* 2015 (2) SA 90 SCA at par 8
[11] *Supra* at par 18

'At the end of the trial, after all the evidence relied upon by either side has been called and tested, the judge has simply to decide whether as a matter of inference or otherwise he concludes on the balance or probabilities that the defendant was negligent and that such negligence caused the plaintiff's injury. That is the long and short of it.'

[63] The overarching question to be determined at the conclusion of all the evidence is whether there is sufficient evidence to draw an inference of negligence and as voiced in *Goliath supra*:

'... it is important to bear in mind that in a civil case it is not necessary for a plaintiff to prove that the inference that she asked the court to draw is the only reasonable inference. It suffices for her to convince the court that the inference that she advocates is the most readily apparent and acceptable inference from a number of possible inferences (AA Onderlinge Assuransie Assosiasie Bpk v De Beer 1982 (2) SA 603 (A); see also Cooper & another NNO v Merchant Trade Finance Ltd 2003 SA 1009 SCA).[12]

[64] A plaintiff is not required to establish the causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss.[13]

[65] Despite their differences, the majority of the experts who testified in this matter were *ad idem* that appropriate fetal monitoring that measured the fetal heart rate before, during and after the mother's contractions to assess any fetal distress, is consistent with the standard of reasonable care outlined in the *Maternity Guidelines* and a *sine qua non* for a safe delivery without any adverse outcomes.

[66] Where the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that the breach is the cause the harm. It must be established whether the act or omission of the defendant has been proved

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[12] *Supra* at par 19.
[13] *Minister of Safety and Security v Duivenboden* 2002 (6) SA 431 (SCA) at par [25].

to have causally or materially contributed to the harm suffered based on the '*but for*' test.

[67] The enquiry is whether, in the circumstances, *LN's* injury could have been avoided if *Sineka* had adequately monitored the plaintiff and her fetus, appropriately assessed the results which would in all likelihood have alerted her timeously to signs of fetal distress requiring her to apply established methods of intervention to avert harm to *LN.*

[68] It is clear from the evidence that not only did she fail to document the fetal heart rate readings appropriately, but on he own version, she only took one reading after listening for 30 seconds. In addition, she failed to adequately document the surrounding issues relating to the meconium present for some four hours (which she herself confirmed were significant) or the actual contractions. Besides that her actions failed to comply with the *Maternity Guidelines*, she confirms being unaware of such guidelines. This conduct undeniably misses the mark of the professional standard required. The mere fact that she documented the fetal heart rate according to her method is irrelevant and of cold comfort, effectively rendering the inscriptions recorded somewhat questionable and of no value to anyone.

[69] Her negligence does not only relate to her failure to monitor in terms of the *Maternity Guidelines* but whether *in casu,* the facts found to exist demonstrated that her monitoring and management of the plaintiff's labour over the relevant period, met the standard of a reasonable professional. Indeed, a perusal of the maternity records demonstrates '*sparse information',* inadequate reporting, blank pages and, on her own admission, errors that needed to be *'scratched out'.* This haphazard, inaccurate and sparse reporting can only but be indicative of the standard of management and monitoring of the plaintiff's labour.

[70] To my mind, this plausibly explains why fetal distress was not adequately recognised when it in all probability arose during the earlier phases of labour leading to the crisis that developed with the *HIE* insult to *LN.* Contrary to the defendant's supposition that *LN's* injury did not occur *intrapartum* and was unexpected, it was in all probability due to the failure of *Sineka* to have properly monitored the plaintiff and

LN's wellbeing, consistently and in relation to a developing crisis, which could have been averted by the fulfilment of the proper objectives of fetal monitoring.

[71] The importance of the fetal monitoring in managing potential negative outcomes is unquestionable and, if nothing else, conceded by the experts. *Dr Swan's* ambivalence that there was no *'conclusive evidence'* of the fetal compromise in the first stage does not exclude its existence as the evidence established that *Sineka* neither monitored nor recorded the fetal heart rate correctly during this period. The evidence established that at 19h00 the plaintiff was having strong contractions, was 7cm dilated and subject to the monitoring and care of *Sineka* until delivery and first examination of *LN.*

[72] To digress, the importance of establishing the heart rate before , during and after a contraction is because, the fetus will exhibit a response to what has happened during the course of the contraction, which it is necessary to confirm its wellbeing and oxygenation after the contraction. The monitoring after a contraction is to recognize when the fetus shows any evidence of hypoxia relative to a uterine contraction which typically presents as degenerative changes in the fetal heart rate. Monitoring can be performed by using a fetoscope or by way of electronic monitoring (by CTG).

[73] In any event, the fetal response to a contraction is not simply a recording of the heart rate but whether the fetus can sustain a uterine contraction without showing a cardiovascular response which is indicative of hypoxia during that event. This is the reason why the *Maternity Guidelines* stipulate the need to observe the heart rate before, during and after the contraction to establish the fetal well-being. The evidence of *Sineka* established that this critical monitoring was absent predisposing the fetus to the risk of harm and a negative outcome.

[74] The *Maternity Guidelines* prescribe different processes of monitoring during the various stages of labour. In the latent phase of labour, when the contractions are weak and relatively infrequent, assessment intervals are to be longer. Once there is active labour is reached the assessment periods are shorter. During the second

stage of labour, when the mother becomes fully dilated at 10 cm, and the frequency of the observations increases even further.

[75] The evidence of *Sineka* was somewhat disconcerting when asked to explain when the active stage of labour is reached, particularly considering the monitoring prescripts that are indicated for the different phases. It leaves one to ponder whether she possessed the reasonable standard of skill and knowledge to either monitor or manage the labour of the plaintiff. Furthermore, her evidence seemed to be that once the plaintiff was fully dilated and waiting to be transferred, she did not monitor her thereafter. This is unequivocal negligence compounded by the fact that on *Sineka*'s own version, she was unaware of the prescripts of the *Maternity Guidelines* and she was '*not taught that way*'. This, in itself, is a frightening admission.

[76] The necessity for fetal monitoring is obviously because fetal oxygenation during labour is always at risk as it is inherently a hypoxic process regardless of the pregnancy risks. Contractions that are too frequently or too strong, may interrupt the blood supply to the fetus causing it to become hypoxic hence monitoring is designed to observe signs of evolving fetal hypoxia. Sineka's evidence was that the plaintiff was having strong contractions, all the more reason for copious monitoring of the fetal condition. The experts were *ad idem* that fetal distress and bradycardia are undeniable features in the diagnosis of *HIE* at birth. The evidence, at the very, least demonstrates fetal bradycardia and distress in the active phase even on *Sineka's* questionable methodology. This scenario reasonably establishes the timing of the *HIE* injury suffered by *LN.*

<u>Analysis of the versions</u>

[77] It is trite that where there are two mutually destructive versions, the litigant upon whom the onus rests must be satisfy the court that its version is true and the other false before the onus is discharged.[14] Ultimately, the onus must be discharged on a balance of probabilities firstly by considering the qualitative assessment of the

[14] See: *National Employer's Mutual General Insurance v Gany* 1931 AD 187 at 199.

truth and/or inherent probabilities of the evidence of a witness and secondly by assessing which of the two versions is the more probable.[15]

[78] The evidence of *Sineka* and its shortcomings have been referred to *supra,* suffice to state that whilst she testified that she had no independent recollection of the event and would be basing her evidence on the *maternity record*, she did not hesitate to embellish her version when pressed for reasons relating to the recording of the first examination of *LN* to add facts, such as having woken up the baby, in an attempt to justify/explain her recording. Her understanding of what was required of her as a midwife on the day in question leaves much to be desired and renders reliance on her actions and recordings as parlous. Lastly, the paucity of the information on the maternity record combined with the errors and blank pages is a cause of grave concern.

[79] It deserves mention that despite the first examination indicating a *'sick'* baby with, at the very least mild encephalopathy, the '*Discharge Check and Plan'* was never completed and even the inscription of *'satis'* so readily referred to by the defendant's experts is *sans* time or basis. Significantly, *Dr Keshave* conceded that further evidence would be needed to establish the condition of *LN* after the first examination.

[80] It, regrettably, serves little purpose to refer to the *Maternity Guidelines* in reference to or analysing *Sineka's* evidence as she admits not having knowledge of them and accordingly failed to conform thereto. Whilst the *Maternity Guidelines* incidentally spell out the standardised care expected from doctors and nurses in respect of the management of mothers in labour and the delivery of their babies at state hospitals applicable at the relevant time, it must be accepted by the court that these standards were not followed by *Sineka*. It is common cause that these were the applicable guidelines and were admitted without the need of proof.

[81] The conduct of the defendant's employees upon which the plaintiff relies as constituting the grounds of negligence, and thus falling short of the standard of care

[15] *Selamolele v Makhado* 1988 (2) SA 372 (V) at 374

reasonably expected from medical practitioners and nursing staff with appropriate obstetric skill and knowledge, are set out in paragraph 11 of her particulars of claim. It is specifically pleaded that the plaintiff received substandard care at the relevant times of providing medical services to the plaintiff during her labour and to *LN* postnatally.

[82] None of the experts decry the reasonableness of fetal monitoring specifically aimed at assessing fetal distress and this is consistent with the standard of reasonable care outlined in the *Maternity Guidelines*. A failure to provide such monitoring will undoubtedly constitute negligence. The experts recognised a correlation between inadequate/failure of monitoring of the fetal heart rate and *HIE.*

[83] The plaintiff's evidence was direct and credible relating to the labour, birth and condition of the *LN* after birth. There is no reliable documentary evidence that challenges the version of the plaintiff . The plaintiff is not required to establish a causal link with certainty but merely to establish that wrongful conduct was probably the cause of loss upon a sensible retrospective analysis. Furthermore, where the plaintiff has presented evidence which of itself raises, at the very least, a *prima facie* case of negligence on the part of the defendant's servants, an obligation in the form of an evidential *onus* passes to the defendant to rebut such *prima facie* case and to explain how the injury came about. The defendant has dismally failed to discharge this evidential onus.

[84] Where the recordals in the maternity record made by the servants of the defendant assist the plaintiff and are prejudicial to the defendant, they are regarded as admissions and admissible against the defendant. Any entries which are used to benefit the defendant would need to be proved by those making them.[16] The entries, sparse as they are, are indicative of fetal distress, bradycardia, the presence of meconium and a *'sick'* baby at the first examination. These entries, coupled with the lack of completion of other records are admissions of the negligence of the defendant's employees.

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[16] *HN v MEC for Health, KZN* (1287/2014) [2018] ZAKZPHC 8 (4 April 2018) at paras [8] and [9]

Conclusion

[85] In considering the evidence, the asphyxia caused by the inadequate and negligent monitoring of the fetal heart rate during the labour period is, on the probabilities, the most plausible explanation for *LN's* condition. This conduct is undoubtedly substandard care at the hands of the defendant's employees. This negligent conduct causally led to the hypoxic ischemic encephalopathy suffered by *LN.* The failure on the part of such employees to foresee such harm and their consequent failure to take any steps to guard against its occurrence, amounts to negligence on the part of such employees.

[86] When considering the uncontroverted factual situation in its entirety and more particularly, the inadequate monitoring, this must have indubitably have contributed to and been the causative factor of the resultant damage to *LN*. This satisfies the '*but for*' test postulated in *Oppelt v Department of Health, Western Cape*.[17]In the circumstances, I find that the plaintiff has established that the defendant is liable for any damages flowing as a consequence of the established negligence of the defendant's employees as aforementioned.

Costs

[87] Lastly, there is the issue of costs to be determined by this court. It is trite that the court, when awarding costs, has a discretion which is to be exercised judicially whilst considering the facts of each case and balancing fairness to both parties.

[88] Plaintiff's counsel rebuked the defendant as an organ of state as having a constitutional obligation to litigate responsibly and yet coming to court without playing open cards with its own experts on the facts. Accordingly, counsel sought that this court award attorney client costs on a measure of displeasure at the defendant's conduct. The issue of costs was not fully ventilated by the parties in argument.

[17] 2016 (1) SA 325 (CC) at para 48.

[89] Whilst I do not intend to deviate from the usual order that the costs should follow the result, it would be remiss of this court to remain oblivious to the fact that the defendant presented evidence that was largely lacking in quality and ill-formulated.

[90] I have outlined the admissions and agreements emanating from the various pre-trial conferences and the joint minutes as well as the defendant's plea to plaintiff's claim. The ineluctable conclusion is that due and proper regard was neither given by the defendant to the admissions, undisputed facts nor the available evidence. Frequently, the defendant's experts delivered their evidence without reference to these facts, alternatively produced reports that failed to address important issues, compromising the quality of the evidence. The defendant was bound by the agreements reached at pre-trial stage and evinced in the joint minutes.

[91] The inescapable conclusion was the defendant's experts were repeatedly on the backfoot when being apprised of the true factual position during cross-examination and, despite gallant attempts at fancy footwork to remain consistent with their original narratives, concessions central to the plaintiff's case were forthcoming.

[92] Significantly, the Constitutional Court in *MEC for Health, Eastern Cape v Kirland Investments (Pty) Ltd*[18] pointed out that:

> *'[T]here is a higher duty on the state to respect the law, to fulfil procedural requirements and to tread respectfully when dealing with rights . . . . Government is not an indigent or bewildered litigant, adrift on a sea of litigious uncertainty, to whom the courts must extend a procedure-circumventing lifeline.'*

[93] Furthermore, the Constitutional Court in *Ex Parte Minister of Home Affairs*[19] stated that:

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[18] [2014] ZACC 6: 2014(3) SA 481 (CC); 2014(5) BCLK 547 (CC) at para 82; see also *Khumalo v Members of the Executive Council for Education; KwaZulu- Natal* [2013] ZACC49; 2014(5) SA 519 (CC); 2014 (3) BCLR 333 (CC) at para 51

[19] 2024 (2) SA 58 (CC) para [95]

'A higher duty is imposed on public litigants, as the Constitution's principal agents, to respect the law, to fulfil procedural requirements and to tread respectfully when dealing with rights'

[94] Moreover, there is a duty upon the litigant, duly guided by the expertise and ethical duties of its legal representatives, to ensure that cases are properly prepared and genuine arguable issues are ventilated. Our Constitutional Court further stated that:

'*The legitimacy of our judicial system, particularly the courts, will fall into disrepute if shockingly poor conduct of litigation … is allowed to continue unchecked'*[20]

[95] As a mark of displeasure, the Constitutional Court in *Ex Parte Minister of Home Affairs*[21] ordered certain officials and legal representatives to pay a portion of the litigation costs in their personal capacity.

[96] Whilst I do not intend to make a punitive costs award particularly since the issue of costs was not fully addressed during argument, the defendant is cautioned to ensure that litigation pursued before this court is of an acceptable standard thus avoiding fruitless and wasteful expenditure which, given the defendant's present predicament, it can ill afford. The litigation must be regarded as a joint venture and effort by the defendant and its legal representatives. Accordingly, failure to litigate responsibly, meritoriously and with the required circumspection may constitute grounds for adverse and/or punitive cost order as envisaged by the Constitutional Court.

[97] Accordingly, the following order is granted:

1. The defendant is ordered to compensate the plaintiff in her representative capacity in respect of any and all damages proven or agreed to have arisen from the Hypoxic Ischemic Encephalopathy suffered by L[...] on

[20] *Ex Parte Minister of Home Affairs Supra* para 110
[21] 2024(2) SA 58 (CC)

29/30 August 2002 and in respect of the plaintiff in her personal capacity in respect of such proven damages to which she is entitled to in consequence of L[...] having sustained the aforesaid injury.

2. The plaintiff is declared a necessary witness.

3. The defendant is ordered to pay the plaintiff's costs of the proceedings in respect of the merits on a party and party scale 'B' such costs include:

3.1 the cost of two counsel;

3.2 the costs of and associated with all postponements of the matter and all reserved costs;

3.3 the costs of the reports, qualifying expenses, costs associated with joint minutes, reasonable day reservation fees, travelling and subsistence, and of supplementary reports of the witnesses:

3.3.1 Professor Lotz
3.3.2 Professor Gericke
3.3.3 Dr Redfern
3.3.4 Dr Ebrahim

4. The costs of travelling and subsistence of the plaintiff's legal representatives, and of the plaintiff, for purposes of consultation and trial;

5. Interest on costs at the legal rate from a date 14 days after date of *allocatur* to date of payment;

6. The aforesaid costs are to be paid into the trust account of Messrs Sakhela Incorporated. The particulars are as follows:

Name of Account: Sakhela Inc Attorneys
Bank: First National Bank

Account No: 6[…]
Branch Code: 250109

S A COLLETT
ACTING JUDGE OF THE HIGH COURT

APPEARANCES:

For the Plaintiff : *Adv Dugmore SC*
with
Adv Malunga

Instructed by : Sakhela Inc
54 Stewart Drive
Baysville
EAST LONDON

For the Defendant : *Adv Mtshabe SC*
with
Adv Dukada

Instructed by : The Office of the State Attorney
17 Fleet Street
Old Spoornet Building
EAST LONDON

Date heard : 17, 27 January 2023
4, 5, 6 December 2023
2, 3, 4, 5, 8, 9 April 2024
31 May 2024

Date judgment delivered : 19 July 2024