IN THE HIGH COURT OF SOUTH AFRICA
(EASTERN CAPE DIVISION : EAST LONDON CIRCUIT COURT)

CASE NO. EL1118/2022

In the matter between:

P[...] M[...] obo
Y[...] M[...] **Plaintiff**

and

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

JUDGMENT

COLLETT AJ:

Introduction

[1] The plaintiff issued summons against the defendant claiming damages on behalf of *Y[...]* (hereafter referred to as '*YM*') relating to a brain injury sustained by her allegedly as a consequence of negligent treatment she received during her birth and confinement in Frere Hospital, East London (hereinafter referred to as '*FH*')

[2] The parties agreed that there would be a separation of issues in terms of *Rule 33(4)* of the *Uniform Rules of Court* (hereinafter referred to as '*the Rules'*) with liability to be established firstly and quantum to stand over for later determination. Accordingly, the trial proceeded solely on the issue of the alleged negligence of the defendant's employees. The plaintiff alleged a breach of duty of care and negligence by the defendant's employees at *FH* towards her and *YM in utero* during her confinement from 2 to 5 November 2021.

[3] The crux of the matter is whether the *hypoxic ischaemic encephalopathy* (hereinafter referred to as '*HIE*') suffered by *YM* was caused by the negligent conduct of the defendant's employees at *FH.*

[4] The issues for consideration in this matter are limited. It is common cause that an injury to *YM* occurred *intrapartum* causing *YM* to be born asphyxiated, requiring resuscitation and giving rise to the *HIE* and *sequelae* suffered by *YM.*

[5] The gist of the negligence alleged by the plaintiff appears to be, the failure to monitor the plaintiff adequately or at all, the administration of doses of *Misoprostol* which were higher than recommended causing *tachysystole* and *hyper uterine* contractions and the failure to timeously perform a *caesarean section*.

[6] Whilst the defendant admits the *HIE* due to perinatal asphyxia, it is denied that the same was occasioned by the negligence of the defendant either in relation to the administration of the *Misoprostol*, monitoring or the alleged delay in performing a *caesarean section*. The defendant avers that due to the plaintiff's non-cooperation, which was tantamount to a refusal of medical treatment, the defendant's employees were unable to adequately monitor the plaintiff. Accordingly, the defendant's employees were not alerted to the events that may have led to the *HIE* and thus provided with an opportunity to make appropriate interventions to address any impending *HIE*.

Rule 37 Admissions

[7] The efficiency in the conduct and conclusion of litigation is, *inter alia*, facilitated by *rule 37* of *the Rules* which envisages the expedition of trials by 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.[1] 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.[2]

[8] It was specifically agreed at a *pre-trial conference* on 12 April 2023, that the medical records, expert reports and clinical notes would be accepted into evidence as what they purport to be without the necessity of formal proof. The medical and clinical records at *FH* will be referred to as '*maternity records'* for the sake of convenience.

[9] There was similarly no dispute regarding *The Guidelines for Maternity Care in South Africa, fourth edition 2016* (hereinafter referred to as '*Maternity Guidelines'*) which were accepted without formal proof.

[10] Significantly, the *pre-trial minute* dated 12 April 2023 records:

'documents can, without further proof, serve as evidence of what they purport to be and may be proved without the need to prove the whole document and/or to reach further agreement regarding the proof of documents at the trial; and

Clinical notes be accepted into evidence as being what they purport to be without the necessity of formally providing the documents, but without

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

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

necessarily admitting the correctness of the contents of the documents in question'

[11] It deserves mention that the plaintiff at no stage either sought to retract the admissions or contest the correctness thereof and accordingly remains bound thereby. Nonetheless, as will become apparent hereunder, the plaintiff contended that the entries made by *Sister Nyenyeko* should be rejected by the court as hearsay evidence and are thus inadmissible. Whilst this is in conflict with the aforementioned agreement, it will be considered further hereunder.

The pleadings

[12] The factual basis of the plaintiff's claim is set out in the *amended particulars of claim* containing some twenty-eight grounds of negligence. The defendant denied the grounds of negligence but specifically that the plaintiff endured a prolonged labour, that it breached a legal duty or obligation, that its employees were negligent or provided the plaintiff with substandard care, that the administration of *Misoprostal* and *extra amniotic saline infusion* ever caused *tachysystole* or that the employees did not administer *tocolytic* or agents with such effect on the plaintiff.

[13] The defendant pleaded that the conduct of the defendant's employees, even if established, was not causally related to the development of *YM's* brain injury. The defendant specifically pleaded that the plaintiff's uncooperative conduct which persisted in the labour ward and refusal to accept the required maternal and fetal monitoring, hampered the monitoring and management of the plaintiff.

[14] Lastly, the defendant pleaded that but for the plaintiff's conduct and refusal of medical treatment, the employees of the defendant would have been alerted to the onset of the development of *HIE* and could have taken appropriate and timeous interventions.

[15] During the of the trial, more particularly after the plaintiff had testified and during the cross-examination of *Dr Ndjapa-Ndamkou* (hereinafter referred to as '*Dr Ndjapa'),* defendant's counsel became aware that the *maternity records* in possession of both parties were incomplete and that additional documentation was available. The matter was postponed to afford both parties an opportunity to consider the additional documentation and take such steps as they may deem necessary.

[16] Significantly, after the postponement and having completed her testimony, the plaintiff amended her *particulars of claim* and the following were pleaded as additional grounds of negligence:

'13.20 Failed to perform the Caesarean section at the earliest indication <u>that the Plaintiff was being uncooperative</u> to the extent of being unable to be adequately monitored;

13.22 Failed to perform the Caesarean section at the earliest <u>indication of the plaintiff being uncooperative</u> at 03:00 on the 5 November 2021, as opposed to at 07:30 when the Caesarean section was performed for the same reason of the Plaintiff being uncooperative, which allowed hypoxia to develop and persist and causing damage to the fetus.' (own emphasis)

[17] In essence, despite the plaintiff's evidence that she was <u>not</u> uncooperative, the amendment to the pleadings was directly in conflict therewith. Significantly, the non-cooperation by the plaintiff is central to the consideration of the care afforded to the plaintiff by the defendant's employees and the issue of negligence.

<u>Joint Minutes</u>

<u>Dr B. Alheit and T. Kamolane</u>

[18] A joint minute was filed by the radiologists. Essentially, they agreed on a watershed (prolonged partial pattern) hypoxic ischaemic injury. The experts deferred the cause and probable timing of the *HIE* to the experts in neonatology and obstetrics.

Professor Cooper and Dr Kara

[19] A joint minute was filed by the paediatricians. It was agreed that upon the plaintiff's admission on 2 November 2021 there was no concern over the fetal condition despite hypertension and therefore unlikely that there was any brain injury. The plaintiff was induced on 3/4 November but active labour commenced at 01h00 on 5 November 2022.

[20] *YM* was born by *caesarean section* on 5 November 2021 at 07h00 with Apgar scores of 3/10; 6/10 and 7/10 as a flat baby who was resuscitated for 12 minutes with neurological depression at birth. There was no objective evidence of fetal distress.

[21] It deserves mention that *Dr Kara* did present *viva voce* evidence at the trial essentially concerning the brain injury of *YM* which, it was understood, was not in dispute. He concluded that the *HIE* probably occurred during the *intrapartum* period. The exact timing could not be pinpointed.

Dr Ndjapa-Ndamkou and *Mama-Asu Afau Peprah*

[22] The agreement was that there were gaps in the fetal heart rate monitoring which may have resulted in the baby being born with birth asphyxia. However, the experts differed on whether the defendant's staff were negligent or whether this was due to the lack of cooperation by the plaintiff.

[23] A doppler scan on admission revealed that *YM* had a chord around her neck. Both obstetricians agreed that there was a need for delivery but differed on the mode of delivery. The plaintiff's condition was clinically stable and her blood results were normal suggesting that there was sufficient time to attempt

induction of labour. Both doctors testified during the trial and their evidence is referred to *infra.*

Factual Evidence

P[...] M[...]

[24] The plaintiff was a 29 year old *prima gravida* who attended at *FH* on 2 November 2021, after being referred by the clinic pursuant to an antenatal visit, for elevated blood pressure. Upon arriving at *FH,* there was no indication of high blood pressure but after being examined, she was admitted to *FH* seemingly as she was at term gestation and was being observed for *pre-eclampsia*. A *cardiotocography* (hereinafter referred to as '*CTG'*) was performed showing good variability of fetal heart rate.

[25] The plaintiff testified about '*a bulb'* being inserted into her and to drinking 50ml of *Misoprostal* at a time from around 11. She was given *Misoprostal* after 3 hours and again about 3 to 4 times. She was examined every 3 hours. She confirms that a *'belt'* (obviously referring to the *CTG*) was put on her to check contractions during the administration of *Misoprostal* and also indicated that the *'belt'* was used to check the child's heartbeat. She experienced cramps at 21h00 that were intense and she called the nurse and was instructed to get on the bed. The *'belt'* was put on her and she received a vaginal examination whereafter she was told that she was about to give birth so she must quickly go to the labour ward.

[26] According to the plaintiff, the labour ward was on the upper level and she was crawling up the stairs carrying her *'plastic'* containing with her clothes and food. When she arrived at the labour ward, she was told to climb on the bed and the heartbeat of her child and her blood pressure were checked. The contractions were intense and she was told to push and this was around 23h00 to 24h00 whilst the nurse was sitting at the door. She indicated that at some stage a drip was inserted into her arm and she was told to get up and quickly go to the theatre after the heart rate was checked.

[27] She was not given anything for pain. She was told to get out of bed because the baby was coming and she said:

> *'MS M[...] I felt, M'Lady that if there was something that is coming from me… there was too much blood that was coming M'Lady down the leg'*

[28] She was made to walk to theatre being pushed by the staff who were shouting at her whilst she was carrying the drip with her hands and testified:

> *'MS M[...] I arrived at the theatre opening the door on my own the doctor inside was shocked asking myself why did they let me go by myself on feet'*

[29] The plaintiff, in referring to the doctors, said:

> *'MS M[...] they assisted me to avoid to suppress the head of the child and to always keep my legs opened'*

[30] She received an injection at *'the back of the waist on the upper part'* and shortly thereafter a *caesarean section* was performed and the baby was born. She was apparently told that she gave birth at 07h00. She did not see *YM* or hear her cry. On 6 November 2021 she was taken to the nursery by a nurse where she saw *YM.* The nurses '*shouted*' at her saying she caused damage to *YM* who could not breastfeed and was fed with a syringe. They were discharged on 15 November 2021. The plaintiff denied that she was not cooperating with the staff. This stance was re-iterated when she was recalled to testify pursuant to the additional *maternity records* that were presented by the defendant's counsel and despite the amendment to the *particulars of claim* regarding her non-cooperation.

Sister Mahlulo

[31] *Sister Mahlulo* testified that she was working at *FH* as an advanced midwife and was on duty on 4 November 2021. She said that plaintiff came from M5 to her ward M2 when she was in active labour and stated as follows:

'MS MAHLULO *M[...] came to me when she was from M5, M5 ward. When she was from M5 ward she came to me. This M5 ward, M' Lady is an antenatal ward. The come from M5 to M2 ward when they are about to give birth*

MR BODLANI *yes, continue*

MS MAHLULO *The escorting nurse then will brief you with notes and the condition of the patient she is escorting at that time, M' Lady. When she was brought to me she was at the stage which is called active labour, M'Lady. That simply means, she was about to give birth'*

[32] She vaginally examined the plaintiff on arrival at the labour ward at 23h15 and established that she was 3 to 4 cm dilated and in active labour. The *CTG* that had been performed in M5 ward was normal (reactive). The plaintiff was reported to be in pain so *Sister Mahlulo* sedated the plaintiff with 50 mg of *Pethadine* and 25 mg of *Promethazine* for pain and progress of labour. This was recorded in the *maternity record.*

[33] At 0h48, *Dr Valentine,* who was called by *Sister Mahlulo,* recorded a normal *CTG,* confirmed that the plaintiff was 3 to 4 cm dilated and instructed that the plaintiff was to be reviewed at 03h15. Patients in the latent phase of labour are reviewed four hourly according to protocol.

[34] *Sister Mahlulo* was being assisted in the labour ward by *Sister Nyenyeko.* Around 03h15 she was made aware that the plaintiff had become uncooperative, climbing out of the bed and removing the *CTG.* A recording in the *maternity records* was made by *Sister Nyenyeko* in this regard and the behaviour of the plaintiff was witnessed by *Sister Mahlulo.* She testified that she had also offered the plaintiff a *CTG* but she refused.

[35] *Sister Mahlulo* testified about the plaintiff's non-cooperation stating that she had been *'pushing'* since 4cm dilated, refused to lie on the bed or have fetal or maternal monitoring. She counselled the plaintiff regarding her conduct to no avail and then sought the assistance of *Dr Valentine* around 04h00. She made a recording in the *maternity records* at 04h00 to this effect.

[36] She testified that *Dr Valentine* came to the plaintiff around this time and counselled her about the dangers of refusing observations and fetal monitoring. She testified that as she was not able to monitor the fetal heartrate because the plaintiff refused the *CTG,* she would be unable to intervene if problems arose requiring remedial action. Her evidence was that besides her, *Dr Valentine* and *Sister Nyenyeko* attempted to counsel the plaintiff but to no avail.

[37] She was unable to use a fetoscope because the plaintiff was *'…not prepared to cooperate, she was a bit violent, she could not take instructions*' rendering it impossible as the plaintiff would be required to lie still for at least ten minutes for her to use the fetoscope. Essentially, the plaintiff refused medical assistance and *Sister Mahlulo* recognised that she had the right to do so.

[38] She testified that there was no protocol for administering psychiatric medication[3] to the plaintiff and that when administering medication the following steps were required:

'MR BODLANI	*In any event, for you to sedate a patient who is in labour, what do you do, do you just give her medication. What are the steps*
MS MAHLULO	*Firstly, you don't just administer, you first make that CTG to assess the conditions inside*
MR BODLANI	*and then, if the foetal wellbeing is good, what do you do*
MS MAHLULO	*you then administer*

[3] a proposition put to her pursuant to *Dr Ndjapa* having made a comment that even psychiatric patients can be treated

MR BODLANI *if you determine that either the foetal wellbeing is not good or the foetus will not cope with sedative elements, what do you do*

MS MAHLULO *you won't give her Pethidine, because those are muscle relaxant'*

[39] She testified further as follows regarding administering pain medication to the plaintiff:

'MR BODLANI *Yesterday you did testify to the effect that during your conversations with the plaintiff she would say she was in pain. Do you remember that*

MS MAHLULO *Yes I remember that*

MR BODLANI *why did you not administer pain medication for her, and this is beyond 03.15 on the 5th November 2021. This is more so just for your own benefit, this is more so because we know that at about, just after 23:00pm on the 4th November you have been able to prescribe Pethidine and Promethazine*

MS MAHLULO *That's correctly so yes*

MR BODLANI *Why in this case did you not do it after 3am on the 5th of November*

MS MAHLULO *Before you administer a sedation or a pain reliever, you ought to assess the condition of the foetus*

MR BODLANI *you have already testified about your ability to do so earlier*

MS MAHLULO *I said so yes'*

[40] She testified that an uncooperative patient is not just left but that such a patient is counselled, advised and the importance of what you are doing is explained. She testified as follows regarding her problems with the plaintiff's uncooperative behaviour on that day and the steps she took in this regard:

'MS MAHLULO *because of the conditions of that day I tried my best to monitor the patient. The doctor came along and counselled or talked with the patient, the patient even closed her legs and wasn't cooperative, it is then that I called the doctor M'Lady, since I said I cannot deliver this patient…It's to talk or counsel the patient, telling her that observation of this foetus is very important, even calling the doctor to tell the doctor what the patient is doing, in which manner…adding on those two was to attempt to put the CTG back'*

[41] *Sister Mahlulo* was at pains to explain the *CTG* monitoring and the use of a fetoscope. She indicated that a fetoscope was a manual observation of the fetal heartrate and contractions whereas the *CTG* '*does all those things on its own'* which can then be read and interpreted. Her evidence was that the recordings on the partogram were sourced from the *CTG.*

[42] *Sister Mahlulo* testified that she had managed to examine plaintiff and had established that she was fully dilated. She specifically testified about the challenges of the plaintiff's lack of cooperation when she was fully dilated as follows:

'MR BODLANI *Alright, Did Ms M[...] simple cooperate with you when you sought or when you prepped her for caesarean section.*

MS MAHLULO *She did not cooperate with me*

MR BODLANI you *just give the court the details of that non-cooperation if may*

MS MAHLULU *Firstly, I called the doctor and the patient talked with the doctor. I told the doctor that the patient was fully dilated, she was ready to deliver the baby. And the patient was refusing to lie down on the bed. That would render it difficult because she must be on the bed to be delivering. If she would have delivered on her feet, the baby could fall down on the floor and get injured. I explained to the*

doctor that I cannot deliver the patient in those circumstances. The doctor then decided that the patient must be taken to theatre, operating theatre. I went back to the patient and then I told her the news that she was going to be taken to the operating theatre. When we were about to go to theatre there are some preparation are done, M'Lady. The drip must be inserted. Tocolysis must also be administered to do away with contractions. A catheter must be inserted. She was giving me problems on these items I have just numerated. At last, she lie down on the bed. As I said that when I was administering tocolysis she bit me. She refused all other things otherwise this refusal is one of the rights of the patient, M'Lady. The rights for her to refuse are accompanied with responsibilities. Responsibilities about herself, even to her baby. I prepared her for theatre. She was conveyed to theatre'

<u>*Dr Valentine*</u>

[43] *Dr Valentine*, testified that during November 2021 he was working, *inter alia*, at *FH* as a grade 1 medical officer. He confirmed being on the evening call for 4 to 5 November 2021, that he had treated the plaintiff and performed a *caesarean section* on her. He confirmed that after having been called by *Sister Mahlulo,* he counselled the plaintiff at about 04h00 regarding the dangers of not being able to monitor her and the fetal heartrate. He was again summoned by *Sister Mahlulo* for the same reason a bit later but was in theatre performing a *caesarean section* at the time.

[44] After leaving the theatre, he reviewed the plaintiff at around 06h00, again counselled her stating that if they were unable to monitor her properly this posed a danger to the baby. He personally witnessed her uncooperative behaviour. Based on the plaintiff's uncooperative behaviour and a '*suspicious' CTG* at 05h06 which did not have adequate trace, and because the plaintiff

was refusing to be monitored by the *CTG,* he made a decision to perform a *caesarean section* for non-cooperation. Ordinarily, this is not an indication for a *caesarean section*.

[45] He reasonably believed that after the counselling on the first occasion, the plaintiff would cooperate and did not see any need to perform a *caesarean section* at that stage. He indicated that whilst it is essential that the fetal heartrate be monitored, this is not possible if the patient is not cooperating.

Dr Bhana

[46] *Dr Bhana* testified that during November 2021, and more particularly on 5 November 2021, she was employed in the anaesthesia department of *FH* as a medical officer and was on call. In summary, she stated that she met the plaintiff who was aggressive, violent and verbally abusive, outside the theatre when they wanted to take her into the theatre. She asked the plaintiff whether she wanted to have the operation to which the plaintiff responded that she did. She indicated that the plaintiff's uncooperative behaviour made it difficult for her to examine her and administer the spinal anaesthesia but after several attempts, she succeeded.

Mr Sidloyi

[47] Essentially, the witness testified that they were unable to secure the presence of *Sister Nyenyeko* as she had relocated to Saudi Arabia and was not contactable. The evidence was not challenged.

Expert Evidence

[48] Prior to having reference to the applicable expert evidence which will be considered hereunder, I regard it as prudent to analyse the purpose of expert evidence presented at court. The testimony of an expert witness relates to an opinion based upon his/her expertise in a particular area for the purpose of

assisting the court in arriving at a conclusion relating to issues of which the court does not possess the requisite knowledge.

[49] It is incumbent upon the expert witness 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. It is for the court to consider the opinion and to arrive at a decision based thereon. The position is succinctly stated by *Kriegler J* in *S v M*[4] and cited with approval in *NSS obo AS v MEC for Health, Eastern Cape Province*[5] 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 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 witness. However, the wise judicial officer does not lightly reject expert evidence on matters falling within the purview of the expert witness's field.'

[50] In providing the court with the benefit of his/her expertise, the expert is not absolved from presenting an objectively unbiased opinion without wandering into the presentation of evidence which defy the logic or scientific expertise which he/she is professed to possess. The established facts and the cogency of the experts reasoning will be assessed by the court on a balance of probability. 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.[6]

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[4] *S v M* 1991 (2) SARC 91(t) AT 352
[5] 2023 (6) SA 408 (SCA)
[6] *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

[51] In *Oppelt v Head: Health, Department of Health*[7], 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*'

[52] The expert evidence presented in this matter will be considered and analysed in relation to the areas underpinning the alleged negligence by the defendant's medical staff.

The administration of Misoprostal

[53] Seemingly, the plaintiff alleges that the administration of *extra amniotic saline infusion* and *Misoprostal* by the defendant's medical staff was negligent and pleaded as follows:

'13.16 continuously induced the plaintiff's labour by the administration of excessive dosages of Misoprostal and extra amniotic saline infusion, which caused the Plaintiff to suffer tachysystole (the condition of excessively frequent uterine contractions during delivery);

13.17 failed to adequately monitor and manage the Plaintiff's excessive contractions, and/or alternatively infuse tocolysis agents to reduce the frequency and severity of the Plaintiff's contractions.'

[54] The *maternity records* as supported by the evidence reveal that, despite the plaintiff's referral to *FH* for high blood pressure on 2 November 2021, she was

[7] 2016(1) SA 325 (CC)

observed to be in a stable condition on 3 November 2021, whereafter a decision was taken to induce labour with *EASI* (*extra amniotic saline infusion)* and thereafter *Misoprostal*. Whilst plaintiff's counsel did not specifically present evidence or cross-examine on the administration of *EASI*[8]*,* the *maternity records* reveal that it commenced on 3 November 2021 at 17h15 and was discontinued at 20h15 whereafter the plaintiff slept peacefully with no complaints. It is recorded that the *Misoprostal* was commenced on 4 November 2021 at 06h00 until 21h00. It was common cause that monitoring must take place during the time that *Misoprostal* is administered as potential side effects are *tachysystole* and *hyper-uterine* activity.

[55] *Dr Mama-Asu Afau Peprah* (hereinafter referred to as *'Dr Peprah'*) explained the physiology of *tachysystole* and concluded that it was not present in the plaintiff's situation:

> *'DR PEPRAH: So tachysystole, essentially what tachysystole is is that it talks about the contractions of the mother. Ideally the normal is to have three to four contractions in 10 minutes. If it exceeds this, so it is five contractions in 10 minutes or more, what happens is that there can, it can compromise the blood supply to the baby because then the baby does not get enough time to recover with each contraction because during each contraction there is minimal oxygen and blood flow going to the baby. So that is what tachysystole is and Misoprostal is a drug that can cause you to you have more contractions than you is supposed to. That is a known fact…so the contractions, part of the monitoring is to check these contractions and make sure there is no tachysystole and with each entry from 6am to 21h00 initially it says nil. Nil, nil, meaning there are contractions at all and then they start to comment on the*

[8] And the plaintiff referred to the insertion of '*a bulb'* which was in all likelihood *EASI*

nature of the contractions from 19h00 which is mild and mild, which means that is not tachysystole'

[56] The record completed in connection with the administration of the *Misoprostal,* all but one entry, recorded the fetal heart rate as *'reactive' CTG* indicating that it was normal. The *CTG* entry recorded at 16h00 was responded to by *Dr Valentine* as possible '*loss of contact'* whereafter he ordered a repeat CTG and continuous *CTG* monitoring. The *Misoprostal* was stopped and not administered again until 19h00. The contractions are recorded as *'nil'* up until 19h00 and 21h00 whereafter they are recorded as *'mild'*.

[57] *Dr Ndjapa* conceded under cross-examination that there was no evidence of *tachysystole*[9]:

'MR BODLANI	*What we must accept from this is that at the time when they looked at the contractions following the administration of the Miso at the time that it was, the contractions were mild*
DR NDJAPA	*correct*
MR BODLANI	*At best*
DR NDJAPA	*correct*
MR BODLANI	*and before then there were no contractions*
DR NDJAPA	*correct*
MR BODLANI	*and the sum total to be taken out of this is that there was no tachysystole, at least on the timeframes indicated on the document that we are dealing with*
DR NDJAPA	*correct. By 21h20 it says, mild contractions. Alright'*

[58] Furthermore, under cross-examination with reference to the partogram entry at 01h30 and 03h00 on 5 November 2021, which was after the administration of *Misoprostal* had stopped, *Dr Ndjapa* conceded that there was no indication of *tachysystole*:

[9] as alleged in the plaintiff's *particulars of claim*

'*MR BODLANI*	*okay, and at, between, correct me if I am wrong, but between half past 1 on the 5th and 3am, contractions were mild*
DR NDJAPA	*correct*
MR BODLANI	*again, that is not an indication of tachysystole*
DR NDJAPA	*correct*
MR BODLANI	*neither is it an indication of a hyper-uterine activity of any sort*
DR NDJAPA	*correct*
MR BODLANI	*so, that at best they were mild*
DR NDJAPA	*correct*
MR BODLANI	*now if we read the partogram in conjunction with page 1 of the document where the labour induction with oral Misoprostol is, then we must accept that the position of contractions was not only mild until 9pm on the 4th, we must accept that in fact the position is that contractions were mild beyond 21h00 on the 4th and the 5th*
DR NDJAPA	*that is correct*
MR BODLANI	*thank you, M'Lady. What I have just dealt with you, Doctor is that on the records that we have there is no confirmed case of tachysystole in this case*
DR NDJAPA	*no, that is correct*
MR BODLANI	*nor is there any confirmed case of hyper-uterine activity*
DR NDJAPA	*that is correct'*

[59] This position confirmed by *Dr Peprah.* Moreover, both experts confirmed that a dose of *Misoprostal* only lasts for 45 minutes. Considering that the last dose was administered at 21h00 on 4 November 2021, *Dr Peprah* indicated that there was zero possibility of it still having been active in the plaintiff's body at 05h00 on 5 November 2021.

[60] *Dr Peprah* further testified that the initial *Misoprostal* doses of 25mcg did not yield contractions and was increased to 50mcg at 14h00 as can be seen from

the chart. There was no *Misoprostal* administered thereafter until 19h00 and 21h00 when *'mild'* contractions were noted.

[61] An evaluation of the evidence does not sustain the alleged negligence asserted by the plaintiff in her *particulars of claim*. As mentioned, there was no evidence or challenge to the administration of *EASI.* The administration of *Misoprostal* was, according to both experts, appropriately monitored and there was no evidence of *tachysystole.* The *CTG* was '*reactive'* and at 16h00, after a '*suspicious*' *CTG*, not only was the *CTG* repeated but the plaintiff was retained on continuous *CTG* monitoring with *Misoprostal* being omitted until 19h00 on instructions of *Dr Valentine*. This is clearly evident from the *maternity records* of the plaintiff. Thereafter, the *CTG* was normal and '*mild*' contractions were recorded at 19h00 and 21h00 with a 2cm dilation. The chart reveals that *Misoprostal* was administered over a period of 15 hours only despite the evidence from the experts that induction could occur over a 24 hour period.

[62] Neither the *viva voce* evidence nor the *maternity records* establish either the *continuous* use of *EASI or Misoprostal* or the existence of *tachysystole*. The *maternity records* were admitted by both parties as aforementioned and there was no challenge to the correctness of these recordings.

[63] Whilst, *Dr Ndjapa* sought to establish that the dosage of 50mcg of *Misoprostal* was excessive*, Dr Peprah* testified that even though the dosage may not be common practice, it was permissible in accordance with the *WHO Guidelines*. The chart reveals that the plaintiff initially received three doses of 25mcg *Misoprostal* with no contractions being recorded whereafter the dose was increased to 50mcg at 14h00. At 16h00 *Dr Valentine* ordered a repeat CTG and continuous CTG monitoring thereafter. Misoprostal at 50mcg was discontinued according to the *maternity records* until 19h00. Although no contractions were recorded at 16h00, according to the *maternity records,* The reasonable conclusion is that *Dr Valentine* was managing the administration of the *Misoprostal* based on the possible response thereto. Nonetheless, even at best for the plaintiff, if it were to be considered an excessive dose, it

did not yield any negative outcome to the plaintiff who experienced *'mild'* contractions from 19h00 and *'reactive' CTG's,* hence no indication of fetal compromise or *hyper-uterine* activity.

[64] Moreover, at 23h15 when *Sister Mahlulo* recorded the plaintiff as being in active labour and 3 to 4cm dilated, according to the experts, the *Misoprostal*, would have no longer been active in the plaintiff's body as it lasted for 45 minutes with the last dosage having been administered at 21h00. Accordingly, it is apparent that the *Misoprostal* merely induced and established the labour, nothing more.

[65] *Dr Ndjapa's* opinion as contained in his report relating to the consequences and effects of *Misoprostal* on the plaintiff are neither supported by his own evidence in this matter nor the *maternity records.* Accordingly, such opinion is misplaced and nothing more than a hypothesis or conjecture which is of no consequence to this court. Regrettably, *Dr Ndjapa* seems to have premised his report on a somewhat biased reasoning in favour of the plaintiff on this and other issues where he was inclined to exaggerate matters with unsustainable conclusions when tested against the facts. This was repeatedly demonstrated under cross-examination.

[66] Lastly, the Plaintiff's counsel put the following to *Dr Peprah* and her response, in conjunction with the concessions of *Dr Ndjapa,* unequivocally excluded *Misoprostal* as a ground of negligence or the alleged reason for the pain experienced by the plaintiff:

' MR MALUNGA: *Okay, because it is part of the plaintiff's case that the dosage itself created a situation, that there was increased uterine contractions which increased the pain and that was one of the causes of the plaintiff being uncooperative.*

DR PEPRAH: *May I add something to that, M'Lady? We have also said that I mean she became uncooperative at about 3 o'clock which was after the six hours where we have said that*

Misoprostal would be metabolised and excreted from the body. So I do not think it would be relevant at that stage.'

Non-cooperation of the plaintiff

[67] South African common law provides that people with decisional capacity may refuse medical treatment with regards to an illness or injury with such decision-making emanating from the fundamental right to self-determination. This right includes the right to bodily integrity relating directly to the doctrine of informed consent and acknowledging the autonomy of a patient to make decisions regarding whether he or she wishes to receive medical treatment.[10]

[68] Informed consent to treatment renders an act lawful and avails the defence of *volenti non fit iniuria. Ackerman J,* recognised in *Castell v De Greeff* [11] that the patient's judgment regarding his or her interest is decisive:

'It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment'

[69] Our *Constitution*[12] affords the right of a person to preservation of dignity, the right to freedom and security of person and particularly to bodily integrity, thus providing a basis to refuse medical treatment.

[70] Whilst other jurisdictions have promoted the *'potential interests'* of a fetus to be born alive before recognising the right of a pregnant patient to refuse medical treatment, in South African law a fetus has not been regarded as *'a person vested with rights such as constitutional right to life'*.[13]

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[10] *Castell v De Greeff* 1994 (4) SA 408 (c) at 420J; 422 H-J
[11] *Supra* p 421C
[12] Act 108 of 1996 Section 10, 12(2)(b)
[13] *Christian Lawyers Association and Minister of Health* 2004; BLRC 1086(T); *S v Mshumpa* 2008(1) SACR 126 para 56; *Road Accident Fund v Mtati* 2005 (6) SA 215 (SCA)

[71] Our courts have recognised a patient-based approach in claims for damages based on negligence for failure to warn a patient of material risks or complications in a treatment or surgical procedure. The reasoning is that a patient's freedom to self-determination includes the right to decide whether she wants to undergo surgery encompassing the entitlement to refuse medical treatment. The consent to surgery or medical treatment includes acceptance of the responsibility for unintended harm in the medical treatment in the sense envisaged in the principle *volenti non fit injuria.*[14]

[72] Seemingly, a patient must have knowledge and appreciate the material risk when consenting to medical treatment, put differently, the patient must be warned of the material risks. Such risks have been regarded as being material when analysing a patient's consent such as to constitute a justification to excluded wrongfulness when:

'A risk is regarded as material when a reasonable person in the patient's position, if warned of the risk, would likely attach significance to it; or where the medical practitioner is aware that the patient, if warned, would likely attach significance to it.'[15]

[73] Axiomatically, there appears to be no logical reason why the same principle should not be extended to a person who refuses medical treatment.

[74] Despite the plaintiff's *viva voce* evidence clearly disputing her lack of cooperation and, by implication her refusal to be appropriately monitored or examined, this was gainsaid by the amendment to the *particulars of claim* specifically incorporating the plaintiff's lack of cooperation.[16] Furthermore, there was no significant cross-examination of the defendant's witnesses asserting the plaintiff's cooperation.

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[14] *Castell v De Greeff* 1994 (4) SA 408 (C) ("*Castell*"). Also see *Van Wyk v Lewis* 1924 AD 438 at 451;
Correira v Berwind 1986 (4) SA 60 (ZH) at 63

[15] *Castell v Greeff supra* (p426 F-H)

[16] This was not pleaded as an alternative claim

[75] Save for reference to the fact that even psychiatric patients can be treated, there was no evidence that the plaintiff was at any stage mentally incompetent. On the contrary, the plaintiff's counsel constantly punted that a *caesarean section* should have been performed earlier, which would have required not only the cooperation of the plaintiff but also the required mental capacity to consent thereto. The mere suggestion that the plaintiff's cooperation may have been compromised by her mental state during labour because it was *'painful,'* is inimical to her being in a state of mind to consent and fully appreciate the risks of a *caesarean section*.

[76] The *viva voce* evidence supported by the *maternity record,* unquestionably establishes that the plaintiff was uncooperative, aggressive and violent towards the defendant's employees from approximately 03h00 on 5 November 2021. The probability that the medical staff would have fabricated the non-cooperation and behaviour of the plaintiff is unconscionable considering that it was repeatedly documented by them. Furthermore, the *maternity records* reflect an entry by *Sister Nyenyeko* at 03h00 who was attending to a request from the plaintiff for assistance, recording certain observations clearly pursuant to an examination and significantly also recording that *CTG* was commenced. The first entry of non-cooperation was made at 03h15 on 5 November 2021 as follows by *Sister Nyenyeko:*

'Came back patient removed CTG and went out of bed saying that it makes her contract more. Resisting to put it back' (own emphasis)

[77] At 04h00 *Sister Mahlulo* recorded as follows:

'Patient is not cooperating at all has been pushing since 4cm dilated. Refuses to lie on the bed, fetal monitoring or maternal observations. Walks up and down the patent (sic). Dr Valentine informed. Spoke to patient about the dangers of refusing observations and fetal monitoring.' (own emphasis)

[78] *Dr Valentine* confirmed that he was summoned by *Sister Mahlulo* as a consequence of the plaintiff's uncooperative conduct. He testified that he went to the labour ward and counselled the plaintiff as follows:

'DR VALENTINE *Sorry. <u>That if I cannot monitor the pregnancy or the baby, it could be a danger to the baby.</u> That is what I told her that night. Yes*

MR BODLANI *As I understand Sister Mahlulo's evidence, that is referred to as counselling a patient. Is that correct*

DR VALENTINE *yes'*

(own emphasis)

[79] Thereafter, at 05h30 a further entry was made by *Sister Mahlulo*:

'<u>Patient is refusing CTG</u>. She is fully dilated walking up and down. Refuses to lie down and is walking down the passage' (own emphasis)

[80] The evidence presented by *Dr Valentine* and *Sister Mahlulo* was that due to the plaintiff's continued uncooperative behaviour, refusal of monitoring and maternal interventions, *Sister Mahlulo* again summoned *Dr Valentine* whilst he was in theatre performing a *caesarean section.* Upon finishing in theatre, he went to attend to the situation. He recorded a note in the *maternity records* at 06h10 and testified as follow:

'DR VALENTINE: *I was busy in theatre with a case. I was called by sister, Sister Mahlulo. <u>Patient is very unco-operative. She refuses PV. Refuses to be placed on CTG for monitoring</u>. CTG, the heart rate at query 100 but <u>unable to do a full tracing, unable to do CTG</u>. And then plans for emergency Caesar.'* (own emphasis)

[81] There is a further note in the *maternity records* at 06h00 by *Sister Mahlulo* recording as follows:

'Patient reviewed by Dr Valentine decided to do caesarean section. Patient bit me on the elbow while giving Salbutamol for tocolysis. Fortunately she did not puncture the skin' (own emphasis)

[82] Thereafter at 06h20 a further note was made in the *maternity records* by *Sister Mahlulo* recording as follows:

'Patient prepared for caesarean section. Consent obtained. Patient still refusing to be attended. Refusing to be done CTG before caesarean section. (own emphasis)

[83] The '*Theatre Notes For The Caesarean section'* record as follows:

'uncooperative patient, unable to monitor foetus' (own emphasis)

[84] On the *'Consent To Surgical Procedure,' Dr Valentine* recorded as follows:

'*Caesarean section for uncooperative patient. Risk, bleeding, hysterectomy, infection, injury to bladder bowl, injury to baby'* (own emphasis)

[85] Dr Valentine's evidence was that whilst he ultimately performed a *caesarean section*, he did not do so earlier because:

> *'DR VALENTINE: And at that point I did not feel like there was an indication yet for it. I thought if I could counsel the patient that she would eventually listen to us and work with us and we could safely monitor the labour and the baby… I tried to counsel the patient for us to let her, monitor the baby and the labour. Then I went to theatre after that. I (indistinct) Caesar after that and then when I came from theatre afterwards, I came to review the patient and I made a decision then'*

[86] It is abundantly clear that the plaintiff's uncooperative, aggressive and violent behaviour perpetuated right up to the doors of the theatre as established by the evidence of *Dr Bhana* who was the anaesthetist on the 5 November 2021 and testified as follows:

DR BHANA: '…so, my experience Ms M[...] was when I met her she was outside the theatre, she was apparently agreeable for theatre. So, when we had to take her into theatre she was very aggressive and very violent. She swore at us, calling us names… because for me I have to assess her before she goes into theatre. With the assessment part, she was very violent, she was very vulgar using those words towards, towards me. So, and there was a point where I even ask her, does she want to go into theatre for this operation, which she said she does want to go to theatre for the operation. And then when I took her… I asked because she was not cooperating with us. When I was assessing her outside of theatre. Because before the patient goes into theatre, I have to also assess her, so I can know when doing my spinal, is she agreeable for spinal, did she sign the, did she sign the consent and if maybe something happens, like a complication happens it have to incubate. So, I had to do those assessment. So, now with her she was not cooperating when I was assessing her for those things. So now that is where I had to ask, did she go, does she want to go to theatre' (own emphasis)

[87] Cumulatively, the evidence establishes that from the first sign of non-cooperation by the plaintiff at 03h15 until the decision by *Dr Valentine* to perform the *caesarean section* around 06h00, the plaintiff was and remained wholly uncooperative despite the best endeavours of the medical staff to arrest the spiralling non-cooperation and refusal of maternal monitoring and *CTG.* It is clear that even after the plaintiff was informed of the decision to perform a *caesarean section* and had consented thereto, her uncooperative and unacceptable conduct perpetuated, effectively obstructing the medical

staff in the fulfilment of their duties in preparation of the *caesarean section*. The ineluctable conclusion is that the plaintiff authored her situation with her own decisions and conduct. Other than counselling and attempting to persuade the plaintiff, medical staff were effectively hamstrung and obliged to give effect to the plaintiff's refusals of treatment.

[88] In the absence of any evidence to the contrary, the plaintiff possessed full mental capacity and was repeatedly warned of the risks attached to her uncooperative behaviour, particularly the inability to monitor the fetus with the *CTG* and should have attached significance to such counselling. It was reasonable for *Dr Valentine* (and the nursing staff), who readily admitted that patients in labour may be uncooperative, to have concluded that having counselled the plaintiff and making her aware on the risks, she would likely attach significance thereto and cooperate.

[89] Both *Dr Ndjapa* and *Dr Peprah* recognised that counselling provided to an uncooperative patient was appropriate action.

The duty to monitor and perform a caesarean section earlier

[90] The failure by a professional person 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.[17]

[91] *Saldulker JA* in *MM obo ELM v Member of the Executive Council For Health: Eastern Cape*[18]stated as follows:

'What is expected is the general level of skill and diligence which is possessed and would ordinarily be exercised by a reasonable member of the branch of the profession to which he or she belongs under similar circumstances' (own emphasis)

[17] *Goliath v MEC for Health, Eastern Cape* 2015 (2) SA 90 SCA at par 8
[18] *(580/2022) [2023] ZASCA 130 (12 October 2023)* at para 20

[92] The overriding question is whether the failure of the defendant's medical staff to monitor the well-being of the plaintiff and fetus was negligent in the circumstances of this matter and whether the *caesarean section* should have been performed earlier.

[93] It is clear from the evidence that the disputed period is between 04h00[19] to 06h00 on 5 November 2021. The alleged negligence cannot be assessed exclusively in terms of the prescripts promoted in the *Maternity Guidelines.* Consideration must be afforded, *in casu*, to the facts found to have existed regarding the monitoring and management of the plaintiff's labour during the relevant period. These must be measured against the standard of reasonable professionals in similar circumstances to those of the defendant's medical staff.

[94] The *maternity records* over the period in question are replete with annotations of the lack of cooperation, failure to follow instructions, violent, aggressive and abusive conduct by the plaintiff. They are peppered with repeated attempts by the relevant nursing staff and doctors, to reason and seek acquiescence from the plaintiff in the performance of their duties whilst counselling her as to the dangers and risks associated with her behaviour.

[95] Both *Dr Valentine* and *Sister Mahlulo* admitted that they were unable to monitor in terms of the *Maternity Guidelines* and this inability in the circumstances was echoed as a reality by *Drs Ndjapa* and *Peprah.* To my mind, this plausibly explains why the usual standard of monitoring was rendered impossible as a direct consequence of the plaintiff's conduct and her refusal to be placed on a *CTG* and/or be examined and/or to follow the instructions of the medical staff entrusted with her labour and the delivery.

[96] It is self-evident that the importance of fetal monitoring in managing the safe delivery of the fetus is a given and was recognised by the medical staff who

[19] The fetal heart rate was recorded at 141 bpm

repeatedly counselled the plaintiff regarding the dangers of her uncooperative behaviour. The nursing staff and the *Dr Valentine* were faced with a situation which was dependant upon the plaintiff agreeing to proper monitoring in circumstances where she had the right to refuse treatment which would have to be respected. *In casu,* the lack of consent, alternatively, refusal by the plaintiff to be monitored or heed reasonable instructions placed the medical staff in the unenviable position of trying to perform their duties as professionals with the plaintiff's conduct thwarting their best endeavours.

[97] *CTG* monitoring had been the chosen method of monitoring since the plaintiff's admission and the plaintiff was no stranger to the *CTG* by the time that she adopted her uncooperative behaviour at 03h15. There was no challenge to the suitability of *CTG* as an adequate means to monitor the fetal well-being other than the plaintiff's alleged comment recorded in the *maternity records* that it increased the contractions which proposition was never tested during the trial. Indeed, the evidence establishes that it was an all-encompassing method to accurately assess the fetal heartrate and the plaintiff's contractions. During her evidence, it is clear that the plaintiff was aware of the purpose of '*the belt*'.

[98] I digress to provide a description of the *CTG* monitoring which is also termed fetal cardiotocography. It is electronic recording of the heartrate of the fetus. This monitoring during labour involves the placing of sensory devices on the abdomen of the mother providing two outputs being the audible sound of the fetal heart rate with a printed *CTG* trace representing a graphical result of the *CTG* monitoring. The *CTG* trace represents the fetal heart rate on the upper portion and the bottom line reflects the mother's uterine contractions.

[99] It is clear from the evidence of *Sister Mahlulo,* supported by the *maternity records* that the plaintiff was fully dilated at 05h30 and that she was unable to deliver *YM* due to the plaintiff, *inter alia,* refusing to lie down on the bed. *Dr Valentine* indicated that her lack of cooperation and the inability to monitor particularly after a *'suspicious' CTG* at 05h06, which could not be re-done due to the plaintiff's non-cooperation and refusal, informed his decision at 06h00

to perform a *caesarean section.* His evidence was that there was no indication prior hereto that a *caesarean section* should be performed. Both experts confirmed that a *caesarean section* is not usually indicated for non-cooperation. It is further probable, from the evidence of *Sister Mahlulo* and *Dr Bhana,* that the plaintiff's non-cooperation even after the decision was made by *Dr Valentine* delayed the operation.

[100] The evidence establishes repeated attempts at monitoring by the defendant's medical staff during the period in question, hampered by the uncooperative conduct of the plaintiff. There is accordingly no cogent evidence supporting either a need or a delay in the decision to perform or the performance of the *caesarean section* other than that which may have been orchestrated by the plaintiff. Put differently, there were no objective indicators necessitating a *caesarean section* particularly as documented in the *Maternity Guidelines.* This was canvassed by defence counsel during the presentation of the evidence.

Analysis of the versions

[101] It is trite that where there are two mutually destructive versions, the litigant upon whom the onus rests must satisfy the court that its version is true and the other false before the onus is discharged.[20] Ultimately, the onus must be discharged on a balance of probabilities firstly by considering the qualitative assessment of the truth and/or inherent probabilities of the evidence of a witnesses and secondly by assessing which of the two versions is the more probable.[21]

[102] Whilst there is much to be said about the plaintiff's evidence, I do not intend to repeat that which has already been canvassed in any detail. As mentioned *supra*, the plaintiff's pleadings were amended to include non-cooperation which effectively contradicted the plaintiff's *viva voce* evidence. Moreover, during cross-examination scant details of the plaintiff's version were put to the

[20] See: *National Employer's Mutual General Insurance v Gany* 1931 AD 187 at 199.
[21] *Selamolele v Makhado* 1988 (2) SA 372 (V) at 374

defendant's witnesses. The shortcomings and improbabilities in the plaintiff's evidence are highlighted in the *maternity records* representing a contemporaneous recording of the events as they unfolded during the plaintiff's confinement and labour. These were admitted during the *pre-trial* stage as aforementioned.

[103] The plaintiff's cause of action was premised upon the negligence and/or substandard care by the defendant's employees constituting a breach of a legal duty and some twenty-eight grounds of negligence were listed, the bulk of which did not feature in the evidence presented by the plaintiff.

[104] The plaintiff's evidence regarding her trip to and arrival at both the labour ward and the theatre, the non-administration of pain killers and for tocolysis and the curious evidence about the doctors keeping her legs open so that she did no suppress the head of the baby, find no corroboration in the evidence before this court. Indeed, these versions were never put to the defendant's witnesses.

[105] Significantly, under cross examination the plaintiff presented a version which was entirely at odds with her pleaded case and the evidence when she commented as follows to defendant's counsel:

'MR BODLANI *Alright. It is common cause that your baby was injured during birth, that is your claim surely you agree on that*

PLAINTIFF *Yes, by the time I was coming from the labour ward, M'Lady, walking my feet to the theatre.*

MR BODLANI *Let me get that right. Is it your evidence that the injury to the baby – I just do not want to misunderstand you. Are you saying your evidence is that the injury to the baby occurred when you left the labour ward and walked to the theatre on your version*

PLAINTIFF *Yes, I am saying that'*

[106] Furthermore, the plaintiff's evidence both in chief and under cross-examination was that she was not uncooperative with the nursing staff or doctors. Ultimately, despite the plaintiff's evidence, the grounds of negligence upon which the plaintiff's case appeared to be premised, seemed to be crystalized as follows:

> *'MR MALUNGA* *Dr Valentine, it is the plaintiff's case that faced with a non- cooperation and having not being used other alternatives, the caesarean section ought to have been done earlier'*

[107] *Dr Valentine's* stance remained constant, and in-keeping with the evidence of *Dr Ndjapa* and *Dr Peprah* that the first thing to do when a patient is uncooperative is not a *caesarean section* and that counselling a patient is appropriate conduct. This is precisely what was repeatedly attempted by the nursing staff and *Dr Valentine* from 03h15 and seemingly with '*intermittent*' success because it is apparent from the *maternity records* that some form of maternal monitoring took place, for example, the entry at 05h30 reflects the plaintiff being fully dilated (10cm) and *Sister Mahlulo* indicated in her evidence that she recorded this after examining plaintiff. *Dr Peprah* testified that *Dr Valentine* would have had to exercise his discretion based on his clinical experience as non-cooperation is not an indication for a *caesarean section*.

[108] It is not sufficient to adopt the stance of an armchair critic akin to those professing expertise along the sidelines of a sporting event as the reality of the situation can only be appreciated by stepping into the shoes of those involved in the management of the plaintiff's labour on that day. It is from this perspective that the alleged negligence must be assessed.

[109] The nursing staff were faced with an uncooperative patient from 03h15 and this is well documented in the *maternity records*. *Drs Peprah, Ndjapa, Bhana* and *Valentine* all weighed in on the importance of the cooperation by the patient and the reasonableness of the actions taken to exact cooperation from

the plaintiff. I do not propose to repeat the conduct of the plaintiff, suffice to state that the probabilities support the evidence as presented by the defendant's witnesses, *Dr Valentine, Sister Mahlulo* and *Dr Bhana* which was corroborated by the *maternity record.*

[110] The overriding consideration is the effect that the plaintiff's conduct had upon the health professionals charged with the medical care during her labour. The resounding conclusion is that they were severely compromised in performing their duties, particularly in terms of the *Maternity Guidelines*.

[111] The nursing staff were prevented from monitoring or evaluating the plaintiff due to her refusal to be placed on a *CTG,* to remain on the bed, to follow instructions[22] or to be subjected to maternal observations. She displayed aggressive, abusive and violent behaviour towards them. In short, she refused the treatment being offered after being made aware of the risks attached thereto.

[112] The evidence established that there were two nursing sisters in the labour ward with four patients and *Dr Valentine* was the medical officer on duty. This certainly does not lead to a conclusion consistent with an inability to afford the plaintiff with adequate care albeit that it was suggested by plaintiff's counsel. When the plaintiff became uncooperative as aforementioned, the nursing staff sought to reason with her and advise the dangers of her conduct. This was documented in the *maternity records* and *viva voce* evidence was presented in this regard.

[113] When this did not yield results, it was elevated to *Dr Valentine* who counselled the plaintiff at around 04h00 and gave instructions for her further management, reasonably expecting this to result in a positive outcome. Thereafter, around 05h00, he was again summoned whilst in theatre performing a caesarean section on another patient, due to a *'suspicious'* albeit incomplete *CTG* and the continued non-cooperation of the plaintiff.

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[22] The evidence and records establish that plaintiff had been '*pushing from 4cm'*

Significantly, this demonstrates that the nursing staff were attempting to monitor the fetal heart rate despite the plaintiff's continued uncooperative behaviour. Moreover, this decries any suggestion that she was just '*left*' by the nursing staff due to her non-cooperation as insinuated by plaintiff's counsel.

[114] *Dr Valentine* again attended upon the plaintiff at 06h00 after being called by *Sister Mahlulo* and made a decision to perform a caesarean section for non-cooperation as clearly his previous endeavours had not assisted and the plaintiff had persisted with her conduct despite his counsel. Under cross-examination, his answer sums up his decision:

'*DR VALENTINE*: *…But then I realized when I reviewed her that I was not going to win after trying to counsel her, trying to get – realising at that point I was not going to win. That is why I decided to do the Caesar at that point only.'*

[115] It is noteworthy that at the examination performed on the plaintiff at 03h00, there were no signs of fetal distress and this situation was confirmed by both experts. Furthermore, the fetal heartrate recorded at 04h00 was 141 bpm also not evidencing fetal distress. Moreover the *maternity records* reflect that the plaintiff was attended to and/or monitored or monitoring was attempted.[23]. The evidence of *Dr Bhana* is that she saw and examined the plaintiff prior to the operation. This further dispels any notion that the plaintiff was not attended to and left to her own devices and is respectfully not sustainable.

[116] *Dr Peprah* agreed with the evidence of *Sister Mahlulo* that even in the face of fetal distress, the nursing staff would not have been able to take any of the steps as contained in the *Maternity Guidelines* because of the lack of cooperation by the plaintiff.

[23] 03h15 (*Sister Nyenyeko)*, 04h00 (*Sister Mahlulo* and *Dr Valentine and FHR 141),* 05h06 ('*suspicious'CTG),* 05h30 (*Sister Mahlulo)*, 06h00 (*Sister Mahlulo* and *Dr Valentine*), 06h20 (*caesarean section* preparations), 06h55 (*caesarean section*)

[117] At this stage it is necessary to analyse the plaintiff's conduct. Her refusal to be monitored and managed must be viewed as an *'informed refusal'.* She must have been fully aware of the purpose of the *CTG* and maternal examinations prior to her uncooperative behaviour and was repeatedly warned of the risks associated with refusing same. Nowhere in her evidence did she suggest not being aware of the purpose of the *CTG* or as she referred to it, '*the belt'.* She at no stage testified that she was uncooperative, even though her counsel sought to establish, albeit belatedly, during the cross-examination of *Dr Peprah* that her non-cooperation was due to the extreme contractions caused by the *Misoprostal.* As mentioned *supra,* this situation was established to be both inaccurate and unsustainable. In the circumstances, the only reasonable conclusion is that she refused the monitoring, instructions and advices by the staff and should reasonably have been aware of the consequences of her actions. It was within the plaintiff's right to make such a decision and the staff were required to respect same.

[118] Despite the plaintiff's consent to a *caesarean section*, she thereafter continued with her aggressive, abusive and uncooperative behaviour right up to the theatre doors. This included a refusal of monitoring with the *CTG* during preparation for the operation. As mentioned, it is reasonable to deduced that her conduct even after consenting to the *caesarean section* in all likelihood caused further delays particularly in view of *Dr Bhana's* evidence.

[119] Notwithstanding it being put to the defendant's witnesses that even psychiatric patients can be treated, there is no evidence to suggest that the plaintiff was not *compos mentis* during this period. Her behaviour undoubtedly dictated and directed the course of events, that much is evident. For the plaintiff to contend that the defendant's employees were negligent in failing to monitor her adequately or at all is preposterous considering that she was the proximate cause of their inability. As mentioned, both *Dr Peprah* and *Ndjapa* agreed that the counselling the plaintiff was appropriate action in the circumstances.

[120] Moreover, a *caesarean section* for non-cooperation is not a usual indicator for such an operation with its attendant risks. This much was also agreed and conceded by *Drs Peprah* and *Ndjapa* respectively. From the inception of the *'suspicious' CTG* at 05h06 to which *Dr Valentine* (who was in theatre) was alerted, his review of the plaintiff and decision to perform a *caesarean section*, probably out of desperation due to her behaviour, was conceded as being reasonable by *Dr Ndjapa.* The consensus was that a *caesarean section* was not the first line of call for non-cooperation. Finally, the *caesarean section* in this matter decisively and explicitly confirms the non-cooperation of the plaintiff.

[121] The objection to the admissibility of the entries made by *Sister Nyenyeko* who did not testify, are without merit as they formed part of the *pre-trial admissions* and were made in the presence of *Sister Mahlulo* and with her knowledge surrounding the circumstances and content thereof. Furthermore, they constitute one of the recognisable exceptions as provided in the *Law of Evidence Amendment Act* [24]which reads as follows:

'(1) Subject to the provisions of any other law, hearsay evidence shall not be admitted as evidence at criminal or civil proceedings, unless-

(a) each party against whom the evidence is to be adduced agrees to the admission thereof as evidence as such proceedings;

(b) …

(c) The court, having regard to –

…

(vi) any prejudice to a party which the admission of such evidence might entail; …"

[24] ACT 45 of 1998 section 3(1)(a) and (c)(vi)

[122] The uncontroverted evidence of Mr Sicelo Sidloyi (Sidloyi) on the whereabouts of Sister *Nyeyeko* accords with the jurisdictional factors in *Section 34(1)(b) of the Civil Proceedings Evidence Act*[25] for the admissibility of documentary evidence. During *Sister Mahlulo's* cross-examination, the correctness of the entries were not challenged. Furthermore, no prejudice was alleged or proven to exist. Accordingly, I find no reason for the exclusion of the entries made by *Sister Nyenyeko.*

[123] The plaintiff's evidence was riddled with improbabilities and regrettably smacked of a conscious attempt to attack the care of the nursing staff, perhaps understandably, because of the condition of *YM*. Her memory was selective and she frequently changed her narrative regarding the attention she received from the nursing staff and the doctor(s). Her version was not put in any detail to the defendant's factual witnesses for comment. Notably, her evidence is not supported by the *maternity records.* She was far from a satisfactory or credible witness. I have no hesitation in accepting the truthfulness of the evidence presented by the defendant's witnesses which is corroborated by the *maternity records* in all material respects. In addition the amended *particulars of claim* including the plaintiff's non-cooperation overtly support the defendant's evidence.

Negligence and causation

[124] It is trite that negligence can only be established if a reasonable person would foresee the reasonable possibility that his or her conduct word cause harm and patrimonial loss to another person and would take reasonable steps to guard against such eventuality. In *Goliath v MEC for Health*[26] in considering the issue of negligence it was stated as follows:

'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

[25] Civil Proceedings Evidence Act 25 of 1965
[26] *Supra* at par 18

defendant was negligent and that such negligence caused the plaintiff's injury. That is the long and short of it.'

[125] At the conclusion of all the evidence, the crucial question to be determined 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).[27]

[126] Once wrongful conduct has been proven, a plaintiff must only establish that the wrongful conduct was the probable cause of the loss and not to establish the causal link with certainty.[28]

[127] The *Maternity Guidelines* are consistent with the standard of reasonable care expected of healthcare professionals and a *sine qua non* for the safe delivery of a baby without adverse results. Even if the defendant has negligently breached a legal duty and the plaintiff has suffered harm, it must still be proved that such breach was the cause the harm and whether the act or omission of the defendant has been proved to have causally or materially contributed to the harm suffered based on the '*but for'* test.

[128] What is required is a finding based on the legal standard of proof and not one based upon scientific precision. The plaintiff has to prove her case on a

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

balance of probabilities[29] which probabilities are determined upon the facts tempered with an element of experience and common sense.[30]

[129] *Van Zyl DJP* in *VN on behalf of PN v The MEC for Health and Social Development Eastern Cape* stated:

'Applying the standard of proof to the test for factual causation, the enquiry is directed at identifying the more probable of any one cause against the backdrop of the negligent act found proved, including the available evidence as a whole, which in a matter such as the present, will include, but is not limited to, expert opinion"[31]

[130] In the absence of established negligent conduct the issue of causation does not arise. In *Lee v Minister of Correctional Services*[32] the Constitutional court stated that causation as an element of liability involves the factual enquiry into whether the negligent act or omission caused the harm giving rise to the claim. If this is answered in the affirmative, then legal causation arises and the question to be considered is whether the negligent act is sufficiently close or directly linked to the loss giving rise to the liability whilst establishing whether that such loss is not to too remote.

[131] The plaintiff failed dismally to prove her case on a balance of probabilities. She would, expectedly be unable to do so without being honest as to her actual conduct during her labour and confinement at *FH.* Her evidence was mostly not put to the defendant's witnesses under cross-examination. Regrettably, much of her evidence was somewhat fictitious and farcical in many respects rendering it implausible and deserving of rejection. Whilst it is not uncommon for labouring mothers to display uncooperative behaviour as readily conceded by the medical witnesses, the extreme and unexplained conduct of the plaintiff is neither fathomable nor capable of justification.

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[29] *Ocean Accident and Guarantee Corporation LTD*
[30] *Za V Smith & Another* [2015] 3 All SA 288(SCA) at para [30]
[31] (132/2015) [2021] ZAE CPHEHC 50 (31 August 2021) para [69]
[32] *Lee v Minister of Correctional Services* [2012] ZACC 30; 2013 (2) SA 044 (CC); 2013 (1) SACR 213 (CC)

[132] A court of law can only weigh up the proven facts without concerning itself with speculating on evidence that was never adduced, or which does not follow by reasonable inference from the proven facts.[33] At the end of the day, the plaintiff must satisfy this court that the inference that she seeks to be drawn is the most apparent and acceptable inference of all possible inferences.

[133] Despite the numerous grounds of negligence advanced in the plaintiff's *particulars of claim,* it appears that the ultimate ground upon which the negligence is premised is the failure to timeously to perform a *caesarean section* due to a failure to monitor and in so doing, prevent harm to *YM*. This is fraught with uncertain variables. The constant uncooperative behaviour of the plaintiff cannot be swept under the mat. The evidence established that the plaintiff maintained her uncooperative conduct indefinitely and such conduct was unpredictable, uncompromising with no evidence to even demonstrate the probability that she would have consented to a *caesarean section* earlier or that there was any indicator requiring such operation. The first relevant '*suspicious' CTG* was at 05h06 and at 05h30 *Sister Mahlulo* records that the plaintiff is refusing *CTG* which was self-evidently a necessity. The nursing staff and *Dr Valentine* attended to the plaintiff by 06h00 as is evident by the entry of *Sister Mahlulo* recording that *'Patient reviewed by Dr Valentine decided to do caesarean section…'.*

[134] This court cannot infer from any objective evidence that a *caesarean section* was either indicated or warranted earlier, that the timing of the *caesarean section* was inappropriate or that the plaintiff would have even cooperated in this regard as her serial uncooperative behaviour was consistently present. To embark on such inferential reasoning would involve a speculative approach which is not consistent with a finding of the defendant's liability.

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[33] *Bates Lloyd Aviation (Pty) Ltd v Aviation Insurance Co*. 1985 (3) SA 916 (A)

[135] The level of care provided by the defendant's medical employees accords with the requirements of a *diligens paterfamilias* as outlined in *Kruger v Coetzee*[34] as follows*:*

'For the purposes of liability culpa arises if-

(a) a diligens paterfamilias in the position of the defendant –

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

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

(b) the defendant failed to take such steps.'[35]

[136] The defendant's employees were required to exercise such skill and expertise as professionals would have in their situation. Whilst being mindful of the importance of monitoring and management during labour to avoid a negative outcome, the plaintiff's conduct and particularly her refusal of treatment, rendered it impossible for the employees of the defendant to be alerted to the onset of any mechanism that may have led to the development of the brain injury of *YM.* Undeniably, they were deprived of any opportunity that may have been warranted to make appropriate interventions to address or prevent such brain injury. Accordingly, they could not have foreseen the harm to *YM.*

[137] The evidence adduced does not establish that the defendant's employees were negligent in their management and monitoring of the plaintiff. They performed their duties with the requisite skill and standard as required and dictated in the circumstances of the matter. Put differently, the probabilities inherent in the evidence do not establish negligence of any nature that may

[34] 1966 (2) SA 428(A)
[35] Ibid at 430 E-F

have led to the *HIE* suffered by *YM.* There are no objective facts from which culpable conduct of the defendant can be inferred. Moreover, there is no indication(whatever that may have been) that if the *caesarean section* was performed earlier it would have averted *YM's* condition. The joint minute of the paediatricians confirmed that there were no objective indications of fetal distress.

[138] Regrettably, the plaintiff created of her own crisis in which the nursing staff and *Dr Valentine* were unwitting participants trying by their best endeavours to avert a most unsatisfactory situation. The indubitable conclusion is that the plaintiff has failed to discharge the onus of proving the negligence and consequent liability of the defendant.

[139] The conclusion relating to the absence of negligence in this matter due to the plaintiff's refusal to be monitored or managed and her non-cooperative behaviour is not to be construed as a trapdoor for the general avoidance by the defendant of liability for substandard care on the basis of an uncooperative patient. On the contrary, the non-cooperation and the outcome is peculiar to the facts of the present case which are well documented and supported by *viva voce* evidence.

Conclusion

[140] This court has no hesitation in concluding that the evidence does not support a conclusion that the conduct and standard of care provided by *Dr Valentine* and/or the nursing staff to the plaintiff fell short of that which would be expected of reasonable professionals in the circumstances of this matter.

[141] To my mind, the medical staff at *FH* did nothing other than could reasonably have been expected of them in the circumstances and there is no objective evidence or other reasonable inference justifying a contrary conclusion. Accordingly, the plaintiff has failed to discharge the onus of establishing negligence or causation on the part of the defendant relating to the treatment that the plaintiff received at *FH* by the defendant's medical staff.

Costs

[142] Whilst the general rule is that costs follow the result, it is difficult to make such an order in the present matter. The litigation costs would be substantial and given that it is common cause that the plaintiff has the burden of a disabled child, I am mindful of the effect of such a costs order. Accordingly, in the interests of justice and fairness, I consider it appropriate that each party must pay its own costs.

[143] Accordingly, the following order is issued:

1. The plaintiff's claim is dismissed.

2. Each party is to pay her/its own with costs.

S A COLLETT
ACTING JUDGE OF THE HIGH COURT

APPEARANCES:

For the Plaintiff	:	Adv SY Malunga Adv T. Coto
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Date heard	:	7.08.2023; 8.08.2023; 10.08.2023 9.01.2024; 10.01.2024; 11.02.2024 13.05.2024; 14.05.2024; 15.05.2024 16.05.2024; 17.05.2024; 19.07.2024
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