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

CASE NO. 3024/2019
Not reportable

In the matter between:

Y[...] T[...] obo H[...] N[...] T[...] **PLAINTIFF**

and

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

JUDGMENT

Rugunanan J

[1] H is a minor male aged 8 who was born on 17 September 2016 at 04h35 in East London at Frere Hospital (the hospital). The hospital is a provincial

establishment which is controlled and operated by the Eastern Cape Department of Health. It falls under the jurisdiction of the defendant who is in law responsible for any injury caused by the negligence of the medical and nursing staff (the medical/hospital staff) who are employed there.

[2] In September 2016 the plaintiff submitted to supervision, obstetric care and medical treatment administered by the defendant's hospital staff. It is common cause that H currently suffers from quadriplegic palsy – a condition ascribed to an injury to the brain that occurred during the plaintiff's labour and birthing when he was born in 'a hypoxic state having sustained neonatal encephalopathy in the intrapartum stage' (the injury). Maintaining that her child's injury arose from negligent treatment rendered by the hospital staff, the plaintiff instituted this action on 19 October 2019 in her personal and representative capacities in which damages in delict are vicariously claimed from the defendant.

[3] The claim in her personal capacity was premised on the contention that in consequence of the negligence of the hospital staff the plaintiff experienced severe psychological shock and trauma for which she will require counselling and treatment.

[4] Two special pleas were initially raised by the defendant. The first related to prescription of the plaintiff's claim for damages in her personal capacity.

[5] The second special plea concerned non-compliance with the notice provisions of the Institution of Legal Proceedings against Certain Organs of State Act[1]. The complaint was that the plaintiff failed to serve written notice upon the defendant in respect of either her claim in her personal capacity or in her representative capacity.

[6] By agreement between the parties the special pleas were resolved. The defendant did not pursue the issue of written notice and the plaintiff abandoned her claim for damages in her personal capacity.

[1] Act 40 of 2002.

[7] The trial ran on the claim in her representative capacity on behalf of the minor child. Following an order separating the issues of liability and quantum, the trial proceeded on 12 August 2024 until 15 August 2024 on the merits of the antecedent separated issue. Argument was heard on 4 October 2024, with each party having agreed to file written submissions.

[8] By agreement between the parties what fell to be determined by this Court were, firstly, the question whether the hospital staff (admittedly acting within the course and scope of their employment with the defendant) acted negligently in their treatment of the plaintiff during the course of her pregnancy, labour and birth of H and, secondly, whether such negligence, if proved, was causally connected to his injury.

[9] In both instances the onus lies with the plaintiff and the required standard is proof on a balance of probabilities.

[10] It is well to recap the tests for determining negligence and causation. Negligence is essentially about the failure to guard and take reasonable steps against the occurrence of foreseeable harm of a general nature.[2] The applicable test is whether or not the medical practitioner exercised reasonable skill and care; in other words, whether or not his/her conduct fell below the standard of a reasonably competent practitioner in his/her field.[3] In this context, the norm has always been:

> '… [I]n deciding what is reasonable the court will have regard to the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which the practitioner belongs.' [4]

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[2] The following preliminary attributes must be present: a reasonable person would have foreseen harm, and a reasonable person would have guarded against it – see *Kruger v Coetzee* 1966 (2) SA 428 (a) at 430E-F. The reformulation of the test to include foreseeable harm of a general kind appears in *Mukheiber v Raath* 1999 (3) SA 1065 (SCA) at 1077E-F; see also *Premier of the Western Cape and Another v Loots NO* [2011 ZASCA 32 para 13.

[3] *Castell v De Greef* 1993 (3) SA 501 (C) at 512A-B cited with approval in *Buthelezi v Ndaba* 2013 (5) 437 (SCA) para 15. The test was also confirmed in *Goliath v Member of the Executive Council for Health in the Province of the Eastern Cape* [2015] JOL 32577 (SCA), para 8.

[4] *MEC for Health and Social Development, Gauteng Province v MM obo OM* [2021] ZASCA 128 para 6 and footnote thereto. During argument the defendant referred to several cases emphasising the prescript of reasonableness, albeit in a factual context distinguishable from the present. See *Mitchell v Dixon* 1914 Ad 519; *Wapnick and Another v Durban City Garage and Others* 1984 (2) SA 414

[11] In that regard, the court often relies on the assistance of experts from the medical profession in navigating through the particular intricacies of the medical field. Although medical opinion is of value to the court, the ultimate decision of what is reasonable conduct in the circumstances is reserved for the court. It is worth noting that in arriving at their opinions, medical experts frequently apply a scientific level of proof approaching certainty. Courts must guard against adopting this standard.[5]

[12] On causation, the question to be asked is what would have happened if the negligent conduct or omission of the treating staff is mentally eliminated and hypothetically replaced with lawful conduct. If a plaintiff established that in such event his condition would on a preponderance of probabilities not have happened, he would be entitled to recover his damages because causation will be regarded as having been established as a fact.[6] In *Minister of Safety and Security v Van Duivenboden*[7] the Supreme Court of Appeal aptly summed up the position in the following terms:

> 'A plaintiff is not required to establish a causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.'

[13] The legal principles aforementioned inform the reasoning and order arrived at the conclusion of this judgment.

[14] The plaintiff pleaded that the defendant's hospital staff had been negligent in their management, supervision and treatment of her during the birth of H and that their negligence caused the injury and its sequelae for which damages are claimed on behalf of H.

(D&CLD); *Oppelt v Head: Department of Health Provincial Administration Western Cape* 2016 (1) SA 325 (CC); *Medi Clinic v Vermeulen* 2015 (1) SA 241 (SCA).

[5] *MEC for Health and Social Development, Gauteng Province v MM obo OM supra* para 6.

[6] *International Shipping Company (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) 700F-701G.

[7] *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 26.

[15] The plaintiff also pleaded that the staff knew or ought reasonably to have known that hers was a high risk pregnancy due to her obesity and due to the fact that she had previously delivered by caesarean section (in 2008). By reason of these factors she should not have been allowed to deliver by normal vaginal delivery, but instead she ought to have been booked for a caesarean procedure and her pregnancy from 15 September ought to have been properly monitored until the procedure was effected to ensure safe delivery of her child.

[16] On the negligence issue the evidence in support of the plaintiff's case was presented on the footing that there was a failure by the hospital staff to observe the applicable maternity care guidelines in the course of monitoring her pregnancy during her period of hospitalisation. It is not in dispute that the 2015 Guidelines for Maternity Care in South Africa were applicable at the time (the guidelines).

[17] The guidelines are intended for implementation in every South African health care facility and for training purposes at medical and nursing schools throughout the country. They contain the basic minimum standards of professionalism in health care that needs to be known by all professional staff at hospitals controlled and operated throughout the country by the various provincial departments of health.[8] They have been held to be the accepted national benchmark against which the standard of maternity care is measured and provided to parturient women. A departure or failure to observe them amounts to negligence.[9] Put otherwise, the guidelines construct the general level of skill and diligence to be exercised at the time.

[18] The defendant countered causal negligence and pleaded that the injury suffered by H was caused by the plaintiff's sole and exclusive negligence; alternatively, that she was contributorily negligent in that, *inter alia*, she experienced strong uterine contractions for several hours and delayed unreasonably in only presenting herself to the hospital for treatment at 01h26 on 17 September.

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[8] Foreward to the 2015 guidelines.
[9] *Nkamela obo ON v MEC for Health Eastern Cape* [2022] ZAECBHC 15 para 10.

[19] A substantial part of the defendant's case and argument was heaped on this issue. It has been put beyond doubt that in so far as a custodian parent litigates in his/her representative capacity their contributory negligence does not apply as a set off or apportionment of a debtor's liability to a minor child. Put another way, in a delictual action instituted by a parent on behalf of a minor, the contributory negligence of that parent has no effect in reducing the child's claim. The position may be different if the plaintiff persisted with her personal claim[10] (in which event the loss she suffered must lie where if falls[11]). With regard to the claim on behalf of H, the plaintiff's contributory negligence or apportionment does not arise. All that is required for imputing negligence to the defendant is proof of the so-called proverbial one percenter[12].

[20] The plaintiff gave notice for qualifying the following experts and their reports: Dr M Wright an obstetrician and gynaecologist (report dated 19 June 2019); Dr B Alheit, a diagnostic radiologist (reports dated 13 October 2020 and 17 June 2022); Professor A Coetzee, an anaesthetist/critical care specialist (report dated 31 July 2023); Dr Y Kara, a paediatrician (report dated 16 December 2019); and Professor J Anthony, an obstetrician (reports dated 27 November 2023 and 10 January 2024).

[21] The defendant filed notices in respect of: Dr C Nel, an obstetrician and gynaecologist (reports dated 3 March 2022, 1 April 2022, and 28 March 2023); Professor P Cooper, a paediatrician and neonatologist (reports 1 April 2022 and 3 April 2023); and Professor D Bishop, an anaesthetist (report dated 11 April 2023).

[22] Joint minutes were prepared by: Dr Wright and Dr Nel (dated 4 April 2020); Dr Kara and Professor Cooper (dated 4 June 2022); Professor Coetzee and Professor Bishop (dated 19 June 2024); and Professor Anthony and Dr Nel (dated 25 June 2024).

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[10] See *Van Vuuren v Ethekwini Municipality* 2018 (1) SA 189 (SCA) paras 33-34 in which the SCA expressly approved of the legal position set out in *RAF v Myhill NO* 2013 (5) SA 426 (SCA) paras 28-29.

[11] In this regard I allude to the defendant's heads of argument wherein reference is made to *Broude v McIntosh and Others* 1998 (3) SA 60 (SCA) at 75A-B.

[12] *Ndaba v Purchase* 1991 (3) SA 640 (NPD) at 641H.

[23] The evidence in its entirety including the pleadings, reports and joint minutes of the various experts is extensive and is a matter of record. For that reason it is intended only to focus on the most salient aspects for purposes of this judgment.

[24] On the merits the evidential matrix covered the testimony of the plaintiff followed by Dr Alheit, Dr Kara, and Professor Anthony. Testifying for the defendant was the only witness, Professor Cooper. Each expert confirmed the contents of his report when he testified. The parties also accepted that each of the experts had the requisite qualifications and clinical experience to testify in their specialities of professional competence. The joint minutes contextualised the issues identified for determination by the Court. Where necessary, each expert referred to his individual report.

[25] Dispensing with the need to call Professor Coetzee and Professor Bishop, their joint minute was admitted into evidence by agreement but was not addressed in argument. Dr Wright and Dr Nel did not testify. Their minute was subjected to comment by Professor Anthony even though its evidential status or admissibility was not dealt with during any of the series of rule 37 conferences between the parties. Although during the course of testifying Professor Anthony referred to select aspects of their minute, neither of the parties indicated that the minute was binding on either of them. It is not intended to disregard the minute in its entirety[13]. Where relevant on matters that are not in dispute it will be dealt with but argumentative matter that will otherwise add to the prolixity of this judgment will be not be recapitulated. As with that of Professor Coetzee and Professor Bishop, the minute, in any event, does not advance the case for either of the parties. The evidence of the experts who testified is sufficiently dispositive of the main issues for determination.

[26] In the preparation of their respective reports none of the experts who testified consulted directly with the plaintiff. The opinions detailed in their reports and in the joint minutes were postulated on their individual assessments of the hospital, medical and clinical records relating to H and the plaintiff (the medical records). From

[13] As in *MEC for Health and Social Development, Gauteng v MM obo OM* [2021] ZASCA 128 para 16.

that perspective no useful purpose would be served in navigating the testimony of the plaintiff in any particular depth.

[27] It is appropriate nonetheless to say something about the plaintiff at the outset. She was assisted by an interpreter. She was single witness on numerous aspects that did not accord with the medical records. She was evasive, inconsistent and manufactured her evidence to suit the moment. She was a highly unsatisfactory witness – justifiably hammered during cross-examination. While not a satisfactory witness in all respects, the proper approach in evaluating her evidence is not whether she was truthful or reliable in all that she said but whether her version assists in determining the balance of probabilities.[14] To that extent her evidence will be selectively mentioned.

[28] In recapping the approach to be taken in the evaluation of expert evidence, the Supreme Court of Appeal in *Michael and Another v Linksfield Park Clinic*[15] set out the position as follows:

> 'As a rule the determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of the essential reasoning, preparatory to the court's reaching its own conclusion on the issues raised… That being so, what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning.'

[29] In *MEC for Health and Social Development, Gauteng v MM obo OM*[16] the court observed (footnotes omitted):

> 'Such testimony, in a medical matter, amounts to an opinion on how accepted medical principles apply to the facts. It is admissible where the person rendering the opinion is qualified to do so. The opinion must be properly motivated so that the court can arrive at its own view on the issue. Where the

[14] Compare in this regard *Santam Bpk v Biddulph* 2004 (5) SA 586 (SCA) para 10.
[15] [2001] ZASCA 12 paras 34-36.
[16] [2021] ZASCA 128 para 17.

opinions of experts differ, the underlying reasoning of the various experts must be weighed by the court so as to choose which, if any, of the opinions to adopt and to what extent. The opinion of an expert does not bind a court. It does no more than assist a court to itself arrive at an informed opinion in an area where it has little or no knowledge due to the specialised field of knowledge bearing on the issues.'

[30] Turning to the evidence and reports, Dr Alheit explained the presentation of the injury to the brain of H as depicted in a MRI scan. He identified features of a watershed pattern. This was accentuated by two biomarkers in the thalamic region. The pattern is consistent with a hypoxic ischaemic injury that presented in its chronic phase. Describing its mechanism, he testified that the onset of the injury is an insult. Because labour is essentially a hypoxic event – contractions during labour that are either too frequent or too prolonged have the effect of impairing the blood flow and consequent oxygen provision to the foetus. The hypoxic insult is occasioned by a deprivation of blood and oxygen to the foetal brain and transforms into an injury if the deprivation endures long enough. Oxygenated blood is diverted away from the human part of the foetal brain (the cortex) towards the central part (the reptilian complex). The observed watershed pattern on the image depicted an injury that evolved over many hours and excluded a sentinel event.

[31] An MRI image only serves as a vehicle for identifying an injury. It does not assist for timing the insult or the injury. Dr Alheit's evidence was based on his interpretation of the image without reference to the hospital records. As a radiologist, he correctly refrained from commenting on the obstetric aspects of the plaintiff's management where this was attempted in cross-examination.

[32] In dealing with the remaining evidence, and stated in summary, the joint minute between Dr Wright and Dr Nel (only in so far as Professor Anthony agrees therewith) as well as the testimony of Professor Anthony supported by his joint minute with Dr Nel, establishes a timeline with the following being common cause (either as emerging from the evidence or standing as objective facts from the material at hand):

33.1 In 2008 the plaintiff had a previous pregnancy that was terminated by caesarean section for pregnancy-induced hypertension;

33.2 She attended the hospital and Central Clinic, East London for her antenatal care;

33.3 She was admitted to the hospital on 14 September 2016 at 08h45 with abdominal pain;

33.4 On admission she was not in labour and the foetal condition appears to have been good;

33.5 She was grossly obese with a BMI (body mass index) of 46 on admission on 14 September;

33.6 She requested a vaginal birth after caesarean section (VBAC);

33.7 The foetal head showed no signs of descending into the maternal pelvis prior to her going into labour which is not a favourable sign for a successful VBAC;

338 According to the guidelines, women with a BMI greater than 40 are not suitable for a VBAC because of the increased risk to both mother and baby;

33.9 Had elective caesarean surgery been considered it should have been done at admission stage as the plaintiff was then 38 weeks and 6 days pregnant;

33.10 The possible complications of a VBAC do not appear to have been noted in any detail in the hospital records;

33.11 The plaintiff was discharged on 16 September at 12h32 and could have been in the latent phase of labour;

33.12 She was readmitted on 17 September at 01h26 (the readmission) when she was in very advanced labour;

33.13 As per the pleadings it is admitted that on readmission the plaintiff presented with strong uterine contractions which had reportedly been present for several hours and that she wanted to bear down;

33.14 She was readmitted some 13 hours later and must have been in active labour for some hours prior to readmission;

33.15 From the time of readmission cardiotocography (CTG) tracings were abnormal and pathological indicative of a hypoxic insult;

33.16 Foetal hypoxia must have been present and established prior to readmission;

33.17 The risk of hypoxic insult to a foetus is proportional to the stage of labour;

33.18 H was born on 17 September at 04h35 following a caesarean procedure.

[33] In commenting on the obstetric management of the plaintiff, what preoccupied Professor Anthony, was the question whether the medical staff appreciated risk factors that indicated the need for intervention so that the injury would have been avoided. Affirming that the plaintiff's monitoring and treatment was substandard he postulated that there was a need for elective caesarean surgery when the plaintiff was admitted to the hospital on 14 September. The assessment indicated in the hospital records that she was eligible for a vaginal birth after caesarean section (VBAC) was inconsistent with the guidelines for managing her pregnancy and exposed her to the risk of emergency surgery on 17 September due to her advanced stage of labour. The deviation from the guidelines without good reason was

tantamount to subjecting the plaintiff to substandard treatment that increased the risk of foetal injury.

[34] To begin with, on date of initial admission the hospital records indicate that the plaintiff was complaining of lower abdominal pain. In his joint minute with Dr Nel, Professor Anthony notes that a diagnosis of labour could not be made because increasingly strong uterine contractions did not occur and no cervical dilation was observed during the admission. In the interval between 11h35 until 17h05 several CTG tracings were recorded. These indicated normal foetal wellbeing.

[35] When the plaintiff was seen by a doctor at 11h35 the records indicate the entry, 'request VBAC'. Prior thereto during an antenatal visit on 31 August 2016 her records indicate 'patient wants VBAC', and elsewhere it is shown 'eligible for VBAC'. In cross-examination the attempt was made to suggest to Professor Anthony that the entries pertaining to a VBAC emanated from requests by the plaintiff. Parenthetically, she was wedded to asserting the contrary. While acknowledging that he did not know what the process of interchange was between the attending doctor and the plaintiff on date of admission, Professor Anthony's sense was that the doctor thought that the plaintiff was eligible for a VBAC. Even if it is accepted that she requested a VBAC, Professor Anthony maintained that a patient in the position of the plaintiff is disempowered through lack of medical knowledge. There were risk factors that placed an obligation on the medical staff to counsel her that a VBAC was inadvisable and if she persisted in wanting it, the staff were obliged to document in clear terms that her choice was contrary to medical advice. This underscores the rationale for informed consent, with the patient being given the right to make an autonomous decision about what they wish to do provided that there is adequate disclosure of risks. The records offer no indication that the plaintiff was counselled on the risk factors that are contraindicative for a VBAC.

[36] According to Professor Anthony, the risk factors that were extant at the time of her admission included, the history of pregnancy-induced hypertension, her HIV status, and her obesity. The hypertension did not re-establish itself and the plaintiff was biologically suppressed since she was on HIV treatment. There was no

indication that these factors posed any significant risk except for her obesity signified by a BMI of 46 clearly documented by the medical staff.

[37] In terms of the guidelines the relevance of a BMI in excess of 40 is that elective surgery should take place and not a VBAC. On the plaintiff's initial admission no signs of foetal hypoxia were exhibited. Had there been a recognition that her obesity was a contraindication to a VBAC in circumstances where there was normal foetal wellbeing, Professor Anthony believes that elective surgery would have resulted in the delivery of a baby that had not been subjected to the process of labour and all the risks associated therewith. He explained that in the absence of complications to a patient, the benefit of elective surgery is that it is done by senior medical staff who are guaranteed to be available during normal hours. Emergency surgery on the other hand, suggests that there is a reason to perform a surgical procedure imminently. It is often done after hours (as it was in the present case), usually not by the most senior medical staff but by whoever is on duty at the time. This evidence was not disputed. Seen in this context the guidelines, in the case of a patient with a body mass index exceeding 40, indicated that elective surgery should take place to avoid an emergency.

[38] The hospital records indicate that observation of the plaintiff continued on 15 and 16 September. Sometime between 06h07 and 07h33 on 15 September she was examined in the labour ward and it was noted that her abdominal pain had diminished and that her pads had remained dry (contrary to her assertions that her water had burst the previous day and that the attending doctor had seen this). The overall assessment was that no significant change had been observed over the preceding 24 hours and if the plaintiff remained well she could possibly be discharged the following morning.

[39] On 16 September in the period 05h59 until 12h32 the plaintiff had been monitored and examined. The nursing notes reflect that she was 'draining liquor clear since Wednesday'. A doctor reviewed the plaintiff but the hospital notes are scant intimating a cursory examination. Given the explicit note in which liquor was described to be draining, Professor Anthony said that a careful and comprehensive clinical assessment was necessary albeit that there is no evidence of this having

taken place. In the absence of such an assessment Professor Anthony asserted that the plaintiff was inappropriately discharged at a stage when it was likely that she was going into latent labour (because she returned fully dilated upon readmission). Having sent the plaintiff home to labour unattended meant that the prescribed and necessary process of foetal monitoring during labour did not occur. In his joint minute with Dr Nel, Professor Anthony expresses the view that the decision to discharge the plaintiff at 12h32 on 16 September was a critical decision, unjustified in the brief note appended by the attending doctor at the time.

[40] On 17 September at 01h26 the plaintiff was readmitted with 'strong labour pains'. Vaginal examination revealed that she was fully dilated with bulging membranes that erupted spontaneously revealing meconium stained liquor. Professor Anthony opined that a fully dilated cervix defines the onset of the second stage of labour, and at that point the clock started running. The plaintiff was in the second stage of labour which meant that the entire first stage went by unobserved and unmonitored. He believed that the onset of foetal hypoxia was highly probable prior to the plaintiff's readmission when she was fully dilated. In his view it highlights the consequences that arose from the decision made just over 12 hours earlier to discharge the plaintiff home at a time when the nursing notes indicated she may have been going into latent labour. The onset of foetal hypoxia was highly probable prior to the plaintiff's readmission when she was fully dilated. Following her readmission, the finding of a 9 cm dilated cervix after the membranes had ruptured is not unusual and does not preclude the diagnosis of a 10 cm dilated cervix on presentation. A CTG was initiated[17] and exhibited prolonged decelerations and slow recovery. The decelerations were about 4 minutes apart. He considered that the tracing was pathological and indicative of a high probability of underlying foetal hypoxia. According to the guidelines, decelerations indicate the possibility of uterine rupture and are an indication for immediate repeat caesarean surgery. In the context of a VBAC, this would have been of immediate significance. A pathological tracing is an indication for immediate intrapartum foetal resuscitation which according to the guidelines entails *inter alia*: placing the woman in the left lateral position (for improving maternal cardiac output), administering oxygen with a face mask for

[17] apparently at 01h22(?).

improving the concentration of oxygen in blood transmitted to the foetus, and the administration of a tocolytic drug such as salbutamol for slowing down or reducing contractions. According to international guidelines[18] foetal oxygenation eases the return of a normal tracing allowing for the continuation of labour and the reversal of a hypoxic insult. None of these elements of intrauterine foetal resuscitation were done. There was no foetal resuscitation and no immediate recourse to caesarean surgery. This was in breach of the guideline recommendations and amounted to substandard care.

[41] A doctor arrived to examine the plaintiff at 02h30. The doctor was called because of the non-reassuring CTG tracing. The doctor's note in the hospital records indicates that it improved prior to the doctor's arrival. It was noted that the baby was clinically very big. The assessment and plan was that the plaintiff be afforded 30 minutes for bearing down in anticipation of shoulder dystocia and if no progress had been made by 03h00 then caesarean surgery be scheduled. At 02h45 the plaintiff was prepared for caesarean surgery and transferred to theatre. According to Professor Anthony, the doctor's evaluation of the tracing as 'improved' was irrelevant due to the fact that the tracing had insufficient criteria to be regarded as normal. This evidence was not contradicted. He testified that the doctor's assessment was incorrect. When the doctor saw the plaintiff, she had been fully dilated and bearing down from the time of readmission. According to Professor Anthony, from time of readmission this will have meant that she had been in the second stage of labour for more than one hour and bearing down for more than 30 minutes. The plaintiff's labour was prolonged. A prolonged second stage of labour is defined by the guidelines as: *(a)* the foetal head has not descended onto the pelvic floor after 2 hours of full dilation; and *(b)* delivery has not occurred after 45 minutes of pushing down in a nullipara, or 30 minutes of pushing in a multipara. Whereas the abnormal CTG tracing was the first clear indication for immediate caesarean delivery, the plaintiff's slow progress during the second stage of labour heightened the risk of uterine rupture (due to intra-abdominal adhesions) and was the second clear indication for immediate caesarean delivery in the case of a 'big baby'.

[18] The FIGO consensus group.

[42] Professor Anthony mentions in the joint minute (and Doctor Nel agrees) that a prolonged stage of labour is likely to precipitate or aggravate any underlying foetal hypoxia. The medical staff did not recognise this and the sole basis for planning surgery was their concern about dystocia rather than foetal distress. This was substandard care.

[43] It was canvassed with Professor Anthony during cross-examination that the plaintiff had strong uterine contractions for several hours prior to her readmission and delayed in presenting herself to the hospital[19], hence she prolonged the second stage of labour and advanced the risk of foetal injury associated therewith. On the question of delay Professor Anthony countered that the plaintiff on readmission presented herself for care and treatment in circumstances where there were clear indications for intervention and the medical personnel failed to intervene appropriately. In summing this up, it is Professor Anthony's stance that the failure by the medical staff to intervene appropriately assumes greater significance than the plaintiff's delay. Furthermore, Professor Anthony reasoned that the plaintiff was fully dilated when she was readmitted and that she delivered just over 3 hours later. While he believes that this may account for the evolution of the watershed pattern evidenced by the MRI scan, his evidence – as will be apparent from what follows below – indicates that his expertise in obstetric management/monitoring entailing foetal and maternal medicine only allows for determining the presence or timing of a hypoxic insult.

[44] Going back into the hospital records, the administration of anaesthesia took place at approximately 04h10 but was complicated by the plaintiff's obesity. This rendered it difficult for the anaesthetist to find the appropriate spot in her lumbar region for dispensing it. The hospital notes indicate that 10 attempts were made. Surgery commenced at 04h25 and the plaintiff's baby was delivered at 04h35. The delay in the anaesthetic procedure has been dealt with in the joint minutes by the anaesthetists and is common cause. The delay accentuates the failure by the hospital staff to recognise the plaintiff's obesity as a complicating factor in

[19] The admitted delay for several hours arises from the pleadings – see replication para 10.

emergency surgery that according to Professor Anthony, would have led to prolongation of foetal hypoxia.

[45] In scrutinising the timeframe in the above-mentioned narrative of events, Professor Anthony noted that the anaesthetic procedure commenced some 2 hours and 44 minutes after the plaintiff was readmitted and fully dilated with clear indications of foetal distress more than 1 hour and some 40 minutes after the doctor had assessed her and indicated that caesarean surgery be scheduled if the plaintiff did not deliver by 03h00. The delay was lengthy and was contrary to the international standard of 30 minutes known as the decision to delivery interval (DDI) for emergency surgery. The outer limit for intervention at 1 hour according to the South African guidelines was also breached.

[46] A further aspect of Professor Anthony's evidence bears relation to the distinction between a hypoxic insult and a hypoxic injury. Both involve a deprivation of oxygen but are entirely different. An insult is an occurrence of sufficient severity and sufficient duration to cause injury. Injury manifests once there is actual tissue damage due to oxygen deprivation. In the obstetric management or monitoring of a pregnancy it is only the capacity to identify the presence of an insult that exists – the timing of an injury cannot be made.

[47] As for the incursion of the insult, Professor Anthony, in a careful and logical analyses, reasoned that the progress of labour in a multiparous patient takes place extremely rapidly from 5 cm to 10 cm full dilation in about 2 hours. When the plaintiff was readmitted she was already in the second stage of labour. She was fully dilated and it is quite likely that the period of relatively intense labour prior to readmission would have been from 5 cm to 10 cm in the preceding 2 hours. This meant that the plaintiff would have spent already 2 hours outside the hospital before she was readmitted. Upon readmission she spent approximately 3 hours under the care of the doctors and hospital staff where on the CTG tracings there was evidence of foetal distress albeit with no appropriate medical response thereto. From this perspective Professor Anthony reasoned that the insult occurred in the greater period of the plaintiff's labour where she would have been at risk of developing foetal hypoxia in the hospital and not outside.

[48] In the joint minute between him and Dr Nel there is agreement that evidence of hypoxia was probably present before the plaintiff's readmission. This is evident from the abnormal and pathological CTG tracings. Tracings, however, do not measure the occurrence (understood to be timing) of an injury – it is in the second stage of labour when injury is most likely to take place. With that in mind Professor Anthony does not agree with the stance by Dr Nel (who concurs with Dr Wright) that some degree of brain injury occurred probably prior to the plaintiff's readmission due to her delay in seeking medical care. In this regard Professor Anthony sensibly desisted from commenting on the question of the timing of the injury which he believed fell within the domain of the paediatricians. He reasoned that it is the second stage of labour upon the plaintiff's readmission that supports the inference as to the probability of injury based on the 'epidemiology of adverse outcome'. He stressed that the second stage of labour was not prolonged by the defendant's persistence that the plaintiff delayed in getting to the hospital. The evidence in the hospital records indicates that her second stage of labour was prolonged due to substandard management and foetal heart rate monitoring that did not accord with the guidelines.

[49] While it is common cause that H suffered an intrapartum hypoxic injury, the issue for the paediatric specialists Dr Kara and Professor Cooper concerned the timing of the injury.

[50] In the preparation of his report Dr Kara was supplied with a statement obtained from the plaintiff. She explicated the history of her labour on admission and readmission. The inaccuracies in the statement compared to her oral testimony did not have any material effect on the opinion expressed by Dr Kara.

[51] His evidence reveals that a non-reassuring abnormal and pathological CTG tracing at the time of the plaintiff's readmission was an indicator for hypoxic stress or insult that most likely occurred before her readmission to the hospital. He supported the view by Professor Anthony that the second stage of labour commenced upon readmission when she was fully dilated. It is in this stage of labour that the risk of foetal brain injury is at its highest. His evidence as with that of Professor Anthony is

that the abnormal CTG tracing on readmission continued to be abnormal over several hours until delivery of the plaintiff's baby. The CTG trace offers no indication of the occurrence of the injury. According to Dr Kara, it signifies that the foetal heart enters the realm of decompensation or possible failure.

[52] In the present case there was no indication of the baby's heart having failed but the heart must have been compromised to the extent that it potentially affected circulation of blood to the foetal brain. The passage of several hours is consistent with the evolution of a brain injury in the form of a watershed pattern.

[53] Regarding the timing of the injury, Dr Kara opined that it is not known when it occurred and the issue had to be determined on the basis of possibility and probability. While it was possible that the injury occurred before the plaintiff's readmission, it was not probable. The rationality or logic in his reasoning becomes apparent from what follows below.

[54] It is recorded by agreement in the joint minute with Professor Cooper that following the birth of the plaintiff's baby:

'4. Apgar scores were recorded as 5/10 and 6/10, [the baby] was described to be flat, was resuscitated at birth with neopuff. Cord blood gases recorded severe intrauterine hypoxia and respiratory acidosis (pH was 6.8 and base excess -24)'

[55] In his description of the baby's blood gas level, Dr Kara said that it was 'terrible' and indicative of severe metabolic acidosis at birth. The baby was unresponsive (i.e. flat) and the records reveal that the baby was in a state of respiratory distress at birth. These indicators, in particular the acidosis, suggest that the bulk of the injury probably occurred during the second stage of labour after the plaintiff's readmission. In this, there is an underlying rationality that cannot be faulted.

[56] Having said that the bulk of the injury probably occurred during the second stage of labour, Dr Kara did not go beyond conceding the possibility that some of the

injury might have occurred before readmission. He fairly conceded in cross-examination that the plaintiff's delay may have occasioned some hypoxic insult prior to her readmission, but the occurrence of the insult did not mean that the injury occurred prior to readmission. The passage of approximately 3 hours from readmission to delivery had a material effect on the timing and level of the brain injury.

[57] The difference of opinion between Dr Kara and Professor Cooper concerned the possibility versus the probability of brain injury before the plaintiff's readmission. Their joint minute reflects overall agreement on the matters reflected therein save that their views differ on this issue.

[58] Professor Cooper appears to have been the major player in the defendant's case. None of the medical staff who were involved in the plaintiff's treatment during her confinement at the hospital were called to testify nor were any of the other experts in regard to whom notice had been given. As with Professor Anthony and Dr Kara, Professor Cooper's curriculum vitae shows him to be a highly competent and respected practitioner in his field.

[59] Professor Cooper agreed with Dr Kara that the bulk of the damage or injury occurred in the 3-hour period after readmission. In his opinion it was probable that at least some of the injury occurred prior to readmission although it was possible that all of it could have occurred after readmission, but on the probabilities he did not consider this to be the case.

[60] From a medical perspective it is not clear what each of the experts intended to convey by his use of the terms 'possible', probable and 'bulk' and there is no consensus between them for attributing a common meaning to each of these terms. Acknowledging that certainty from a scientific perspective is not the measure, a common sense approach must prevail.

[61] As indicated above, Professor Cooper's views are posited on facts that are common cause in the joint minute between him and Dr Kara, the material portions of which are reproduced hereunder for convenience:

‘5. [The baby] had encephalopathy with convulsions soon after birth. He was diagnosed as having had hypoxic ischaemic encephalopathy. There is no other probable cause of encephalopathy other than a hypoxic ischaemic injury which was confirmed on MRI scan. Dr Alheit described the pattern as a watershed type of injury together with features in keeping with perinatal hypoglycaemia. However there was no evidence of postnatal hypoglycaemia and it is probable that the MRI changes described by Dr Alheit in this regard were part of the intrapartum partial prolonged hypoxic ischaemic injury.

6. The blood gases which confirm metabolic acidosis, the concerns over foetal distress, the need for resuscitation, the moderate encephalopathy and the MRI scan findings make it probable that there was an intrapartum hypoxic ischaemic injury that resulted in the cerebral palsy.

7. The neonatal management was of a good standard and did not contribute to any further brain damage.’

[62] The text of the minute suggests that the experts laid emphasis on what they considered to be probable, barring the question of timing.

[63] Confronted specifically by this issue, Professor Cooper was asked by defendant’s counsel:

‘Could you briefly tell the court why you say it is not a mere possibility, it is a probability that the injury occurred prior to [the plaintiff’s] admission?’

[64] He responded ‘… [T]here has been a lot of research into this particular pattern of brain injury as to how long it takes of the so-called partial prolonged episodes to cause brain damage and the difficulty is that one does not really know what has been going on in utero and so it is very difficult to answer that question’.

[65] He then proceeded to elaborate that there were several thousands of babies with hypoxic ischaemia that were born annually at a hospital where he previously served for several years. Significantly, he points out that '… if the intervention was prompt usually an hour or 2, sometimes 3, all this kind of compromise, the baby did not develop…'

[66] Professor Cooper's reference to the several thousand babies does not bind the Court in accepting his opinion on the probability that at least some of the injury occurred prior to the plaintiff's readmission. Contrary to Dr Kara, it is not sufficiently motivated to provide a candid basis for its acceptance nor is it sufficient to absolve the defendant from liability. Underlying Professor Cooper's response is the notable mention of prompt intervention, a thesis Professor Anthony persistently advocated when he stated that the plaintiff's second stage of labour was prolonged because of substandard management and monitoring that did not accord with the guidelines.

[67] With prompt intervention being the central and underlying tenet in the evidential matrix and the paediatric experts saying that the bulk of the damage or injury occurred in the 3-hour period after plaintiff's readmission when risk of foetal injury was greatest, common sense suggests that the greater part of the injury occurred after the plaintiff's readmission. For that reason I do not agree with the submission by the defendant that causation has only been established to a point.

[68] Applying the principles referenced in the cases mentioned earlier, I find that the plaintiff has established on a preponderance of probabilities that the substandard treatment given to her amounts to negligent conduct on the part of the defendant's hospital staff and that such conduct probably caused the injury suffered by her minor child.

[69] The only remaining issue is the question of costs.

[70] The norm is that costs follow the result. In other words, the unsuccessful party pays the costs of the successful party.

[71] At the conclusion of argument a draft order was handed up on behalf of the plaintiff. The order made provision for costs on scale C in respect of the fees of counsel. No submissions were made in support thereof. The default scale must apply.

[72] The defendant argued that the costs of the plaintiff's experts who were not qualified at trial should not be factored. This is a matter for debate at taxation and can be dealt with by the taxing master in his/her discretion.

[73] Before concluding something must be said about the matter at the commencement of the trial. It was certainly not plain sailing and necessitated a lengthy adjournment on the morning of the first day to enable the plaintiff's legal team to attend to housekeeping matters pertaining to indices and annexures to reports *et cetera*. Despite the adjournment to get things in order it was tardy and irksome for material to have been handed up from the bar for incorporation among the court papers and having at times to reconcile inconsistent pagination. Apart from being a distraction it impedes the primary adjudicative function of the court.

[74] It is salutary to remind practitioners that court time is a valued resource in high demand; that efforts should be made for ensuring housekeeping matters are in order beforehand – not only as a courtesy to the court but to an opponent as well – so that a matter on the roll commences promptly at the appointed time.

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

1. The defendant is liable for all such damages as the plaintiff in her representative capacity may prove arising from the negligent treatment of the plaintiff and her minor child, H[...], born on 17 September 2016 during the plaintiff's labour at Frere Hospital, East London.

2. The quantification of the plaintiff's claims for damages on behalf of the minor H[...] is postponed *sine die.*

3. The defendant is ordered to pay the costs relating to the separated issue of liability, including all reserved costs, if any together with interest thereon at the legal rate from a date 14 (fourteen) days after *allocatur* and/or agreement to date of payment, which costs shall furthermore include:

    3.1 The costs attendant upon obtaining the medical-legal reports and/or addendum reports and/or joint minutes and addendum joint minutes, if any.

    3.2 The reservation fees, if any, together with the qualifying fees, if any, of the plaintiff's expert witnesses together with travelling costs and accommodation costs, if any, in respect of whom notices in terms of rule 36(9)*(a)* and *(b)* have been filed of record.

    3.3 The costs of holding all pre-trial conferences between legal representatives for both the plaintiff and the defendant, including senior counsel's fees in respect thereof.

    3.4 The costs of the hearing from 12 to 15 August 2024 and on 4 October 2024, including counsel's day fees.

    3.5 The costs of preparing for consultations and trial.

    3.6 The costs of drafting heads of argument.

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JUDGE OF THE HIGH COURT

Appearances:

For the Plaintiff: *A D Schoeman SC*, Rob Menzies & Associates Inc., c/o Huxtable Attorneys, Makhanda (Ref: Mr Huxtable).

For the Defendant: *R T Williams SC*, Instructed by The State Attorney c/o Whitesides Attorneys, Makhanda (Ref: Ms Asmal).

Dates heard: 12 – 15 August 2024.
Argument: 04 October 2024.
Date delivered: 23 January 2025.