

**IN THE HIGH COURT OF SOUTH AFRICA
(EASTERN CAPE LOCAL DIVISION – MTHATHA FULL COURT)**

Case no : CA: 20/2024

Date of hearing: 21 October 2024

Date delivered: 16 September 2025

In the matter between:

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

Appellant

And

SS obo ES

Respondent

JUDGMENT

MAJIKI ADJP:

[1] With the leave of the court *a quo*, the appellant, Member of the Executive Council for the Department of Health, Eastern Cape (MEC), appeals against the judgment and order in favour of the respondent's claim, in respect of liability. The respondent, sued the MEC for the damages sustained by E[...], due to a brain injury she sustained at the time of her birth at Zitulele hospital, Mqanduli. The respondent opposes the appeal. The main issue in the appeal concerns the finding that the hospital staff were negligent in treating the respondent and that their conduct caused her injury.

[2] The court *a quo* had ordered the separation of the issue of quantum of damages, in terms of rule 33(4) of the Uniform Rules of Court (the rules), for determination at a later stage. The MEC was ordered to pay 100% (one hundred per cent) of the respondent's agreed or proven damages in her representative capacity for and on behalf of E[...] for the injury suffered by E[...] during labour and delivery on 11 March 2014 and the resultant cerebral palsy she suffers from.

[3] The respondent's case was that E[...] suffered a brain injury, because of a hypoxic ischaemic event during the birth process, and has cerebral palsy. Further, E[...]’s injury during the intrapartum period was occasioned by the negligent conduct of the hospital staff. The court *a quo* agreed with her. The appellant, on the other hand, disputed that the management of E[...] at the hospital was inadequate. Alternatively, if the medical staff were found to have been negligent, the MEC denies that their negligence caused E[...]’s condition. In this court, the appellant contends that the respondent, as an onus-bearing party, did not prove her case about the hospital staff's negligence and causation, on a balance of probabilities.

[4] The grounds of appeal are briefly that the court *a quo* erred in finding that the respondent proved her case, on a balance of probabilities. The court *a quo* compared the parties' evidence and pronounced its preference. It did not separately consider the issues of negligence and causation. Thereby, it did not make a distinct finding on the elements with respect to each. Concerning causation, the issues raised include IUGR, a tight nuchal chord, and rapid progression in 40 minutes, as well as the probable contribution of these factors to the dominant acute, profound component of the hypoxic ischemic injury, as depicted in the MRI scan. Secondly, the court *a quo* erred in its interpretation and application of the principle articulated in *Bee v RAF* 2018 (4) SA 366 SCA at paras 64 to 67, in relation to an expert witness's resiling from a joint minute

previously concluded. Thirdly, the court *a quo* applied an interpretation of admissibility that was inconsistent with the provisions of Section 3 of the Law of Evidence Amendment Act, 45 of 1988 (the amendment Act) in relation to the medical records, where the author was not called to testify. This led to the facts arising from the medical records not being considered as well as the evidence of expert witnesses, Dr Mtsi and Prof Cooper, being rejected. The last ground is that the court *a quo* erred in rejecting Prof Cooper's conclusion concerning the presence of significant IUGR, on the basis that the evidence did not support it, because the respondent's gestational period was unknown.

[5] The court *a quo* found that after 17h00, the hospital staff did not continue to monitor the respondent. Specifically, she was not monitored between 17h20 and 18h20. They failed to adhere to what was required in terms of the applicable Guidelines for Maternity Care in South Africa, 2007, 3rd edition (the guidelines) concerning the management of foetal distress. The trial court found that there was no dispute that at 17h00 the respondent was placed on cardiotocography (CTG). Thereafter, according to the respondent, a nurse would come, have a look at the screen and leave. According to the clinical notes, at 17h20 bradycardia was noted, and intrauterine resuscitation was performed. There was no indication that the respondent was given hexoprenaline 10 micrograms IV. She was also not prepared for an immediate caesarean section. At 18h30, the CTG was not reassuring. The doctor did not personally come at 18h45, to assess the condition of the respondent when informed of the foetal condition. At 19h05 the doctor instead gave instructions that the intervention that was done since 17h20 be applied and that there should be close monitoring. Despite management, decelerations were noted about three times, at 19h00. Notwithstanding, the foetal heart rate was still dropping, the clinical staff continued with the intrauterine resuscitation for more than an hour, although labour was not progressing.

[6] According to the court *a quo*, it was common cause between Drs Njapa and Mtsi, the experts for the appellant and the respondent respectively that at no stage was the CTG normal, both at the stage of bradycardia and after intrauterine resuscitation was commenced. The clinical staff was aware that vaginal delivery was not imminent. During the cross-examination of Dr Njapa, there was no suggestion on behalf of the respondent seeking to challenge his opinion of what constituted foetal heart rate recovery in obstetrics. That was also the case with the respondent's assertion that the caesarean section was indicated when there was bradycardia. Additionally, tachycardia reduces variability and late decelerations. His evidence about late decelerations was not challenged. Dr Mtsi confirmed that before 20h00 the CTG never revealed a normal heart rate, yet she did not accept that at 20h00 the condition had deteriorated.

[7] The court *a quo* also found that Dr Mtsi's opinion was not independent, her evidence did not assist the court, but she gave evidence to protect the defendant. The court *a quo* held that she testified differently from what was in her medico-legal report, which testimony she gave after the respondent closed her case. That was found to be unacceptable. The court *a quo* recorded that Dr Mtsi conceded that the management of the appellant's labour was substandard. Dr Mtsi's opinion was found to be speculative and unacceptable, which the court *a quo* said she conceded. Prof. Cooper's theory of IUGR, which sought to imply that the baby was born at term and with placental insufficiency was also not accepted because Prof. Cooper had conceded that the gestational period was not known. The court *a quo* found that his theory was not supported by evidence. The conclusion about the experts' evidence is recorded in the ruling on causation. The court *a quo* found the evidence led on behalf of the respondent by Dr Njapa and Dr Kara to be impressive. It was recorded that the court *a quo* was persuaded to find, without a doubt, that the negligence of the appellant's employees caused the injury to E[...].

[8] Regarding causation, the court *a quo* found that the appellant's employees ought to have foreseen the reasonable possibility that their conduct would harm the foetus. They should have taken steps to guard against such an occurrence. Had they immediately delivered the respondent's baby, at the time she was not fully dilated, due to poor labour progress, E[...] would not have been injured.

[9] The issue for determination in this court is whether the respondent proved her case on a balance of probabilities, including whether the court *a quo* correctly considered the issues of negligence and causation, and whether it made appropriate findings on the elements in respect of each. Further, whether the evidence led on behalf of the appellant was correctly rejected.

[10] During the trial, the medical records were referred to at length, however, no one from amongst those upon whom the probative value of the contents depended, was called to testify in support thereof. It is considered essential to address this aspect first. More hinges on the extent to which the medical records ought to have been considered, including the fact that the records formed the basis of the experts' opinions. The approach adopted by the court *a quo*, following the principle in *HN v MEC FOR HEALTH, KZN* (1287/2014) [2018] ZAKZPHC 8 (4 April 2018), has been outlined in the grounds of appeal above. In essence, it states that the parts favourable to the MEC's case should not be considered, they are hearsay and not admissible. Only those that are in the respondent's favour are to be accepted. The argument on behalf of the appellant in this court is that the Amendment Act makes no distinction between the parties. The records are either admissible or not admissible. A party cannot seek to both agree and object to the admission of the same records. The respondent's legal representative never objected to the admission of the records. The court *a quo* ought to have taken full cognisance of the records regardless of the party they favoured.

[11] The submission on behalf of the respondent is that the principle in *HN v MEC FOR HEALTH, KZN* was applied correctly. However, the submission made in that regard does not seem to be entirely consistent with the blanket approach formulated in the *KZN* case. The submission seeking to support the application of the principle is, *‘where the factual testimony collides with the records, unless a witness who was present during labour and or made the entries on the records testifies, uncontroverted factual evidence carries the day.’* The argument goes further to say that, it becomes imperative also with reference to the evaluation of expert evidence. In my view, this does not imply that evidence favourable to the MEC should not be admissible. Instead, what is contained in the record ought to be weighed against the factual testimony, which, in all probability, the latter would carry more weight.

[12] With regard to the admissibility of the contents of the discovered documents, without the author having to testify about the correctness of the contents thereof, further, where the person who discovered them did not dispute the veracity of the records, in *Rautini v Passenger Rail Agency of South Africa* [2021] ZASCA 158 (8 November 2021), the court stated:

‘[11] The contents of the hospital records and medical notes constituted hearsay evidence, and it is trite that hearsay evidence is prima facie inadmissible. The discovery thereof by the appellant in terms of the rules of court does not make them admissible as evidence against the appellant, unless the documents could be admitted under one or other of the common law exceptions to the hearsay rule.

[12] It is common cause that the respondent’s counsel made no application for any of the hearsay evidence to be admitted in terms of s 3 of the Law of Evidence Amendment. In the circumstances, the full court’s finding that material differences existed between the appellant’s version and the medical records

regarding where he fell from the train, the cause of his fall and his first lucid recollection after the fall, was erroneous...'

[13] The medical records would therefore not be admissible as they constitute hearsay evidence. However, the record does not seem to reveal that there was an objection to their admission, instead, the experts relied on them extensively. The respondent's experts were at liberty to criticise even the parts that ordinarily would favour the appellant. Having done so, the respondent also sought that, in dealing with the records, their admission should be limited to instances where the contents favoured the respondent. The submission by the respondent's counsel, which this considers to be correct, is that the evaluation of the records ought to be such that where they collide with a factual witness, the latter's evidence ought to carry more weight. In my view, this submission does not support the view that records should be considered in part, focusing on the aspects that favour the respondent. The records, if considered, the consideration should be based on the entire record. Then, the competing evidence should be evaluated and afforded its due weight, otherwise, it would be prejudicial to prefer parts of the records for one party selectively and not the other.

[14] The respondent was the only witness who testified about her attendance at the clinics and hospital throughout her pregnancy, until post-delivery. Her daughter, E[...], was born on 11 March 2024. She was a primigravida born on 5 December 1992 in Macosa location in Mqanduli. In November 2013, she did not know the date, so she went to the Mqanduli clinic for her epilepsy treatment. She had missed and did not know when she had her last menstrual period. Her urine sample test on the said day was inconclusive. A blood test was also performed, the results would be available the following month. In December 2013, her pregnancy was confirmed, she was told that she was at the beginning of the sixth month of pregnancy. She was not told that there was anything wrong with the

foetus. When she went back in January 2014, her ante-natal clinic cards were missing. She was, however, examined and told that there was nothing wrong. In February, she decided to attend Mpunzana clinic because her clinic cards had gone missing at Macosa clinic. At Mpunzana clinic, she was given her maternal case record to keep.

[15] On 11 March, around 07h00 she went to Macosa clinic, for her routine antenatal check-up, she also reported that she was experiencing backache and waist pains. She was informed that she had vaginal discharge, she was given tablets and sent home. She could not recall if she was given a further return date. Around 09h00, she arrived at home and took the treatment she was given. The pains persisted, so she and her mother departed for the Mqanduli clinic between 10h00 and 11h00. She still estimated her arrival time at the clinic to have been around 11h00. She disputed the record from the clinic that she was attended to around 14h00 and that the ambulance took her at 14h30. After vaginal palpation, she was confirmed to be in labour. She was referred to the hospital because of her history of epilepsy, there was no doctor at the clinic. At about 13h00, she was transported in an ambulance with her mother, they reached the hospital around 14h00. She was wheeled in. In about five minutes, she was registered. Thereafter, she was taken to the maternity ward. The nurse told her that she did not appear to be in labour and asked her to urinate. However, after vaginal palpation, around 15h00, the nurse confirmed that indeed she was in labour.

[16] She was next attended to around 17h00 when a nurse put a belt around her stomach with something like a computer. The same nurse returned to her around 18h00, made notes and left and the nurse did the same again around 19h00. Around 20h00, she screamed because of the intensity of the pain. The nurse who approached, when at the door, commented that the baby's head was visible. One nurse pressed her abdomen whilst another performed an episiotomy. The doctor

came, and the baby was delivered. The baby did not cry, the doctor left with the baby.

[17] The baby was put in something like a glass box (incubator), she was given oxygen with nasal tubes. The respondent was given a mug and a syringe, expressed breast milk, sucked it with the syringe and had the baby fed with tubes. After about five days, the baby was given to her to breastfeed. At seven years old, the baby would not crawl, walk or speak. She never attended school.

[18] In her particulars of claim, the respondent, in relation to the minor child, pleaded:

‘The defendant was negligent in one, more or all of the following respects:

13.1 At the Mqanduli Community Health Centre, she failed to:

13.1.1 permanently, alternatively temporarily employ the services of suitably qualified and experienced nursing practitioners who understood the adverse consequences of use of phenytoin 300mg, Degranol 200 mg BD by pregnant women; and

13.1.2. train the employees on the adverse consequences of phenytoin 300mg, Degranol 200 mg BD on pregnant women.

13.2. At the hospital, she failed to:

13.2.1. permanently alternatively temporarily employ the services of a suitably qualified and experienced medical practitioners who would be available and able to examine, manage and/or give appropriate advice in

respect of the respondent's labour and to perform a caesarean section if and when required to.

13.2.2. ensure that at least one medical practitioner was in attendance at the hospital at all the material times relevant hereto;

13.2.3. permanently, alternatively temporarily employ the services of suitably qualified and experienced nursing staff who would be able to properly assess, monitor and/or manage the respondent's labour;

13.2.4. ensure that the hospital was suitably, adequately and/or properly equipped to enable the timeous and proper performance of a caesarean section if and when required by the respondent;

13.2.5. take any or all reasonable steps to ensure proper, timeous and professional assessment of patients, their monitoring and management of labour and transfer of patients to other suitable hospitals and/or medical facility indicated, required and/or requested; and

13.2.6 prevent E[...] from suffering cerebral damage at birth and the consequences thereof when, by exercise of reasonable care, skill and diligence, he could and should have done so.

14. On 11 October 2013, 14 November 2013 and 20 December 2013, the employees at Mqanduli Community Health Centre were negligent in taking the action and steps pleaded in paragraph 7 above.

15. *On 11 March 2014, the defendant's aforesaid employees were negligent in delaying to deliver the baby in one, more or all of the following respects, in that he, she, they:*

15.1 *Having assessed the respondent at 14h05 as being in labour with the cervix being 3 cm dilated and at 17h00 (3 (three) hours later) having found:*

15.1.2 *that there had been no progressive dilation of the cervix over the three-hour period; and*

15.1.3 *that there was evidence of foetal compromise with bradycardia and foetal heart rate dropped up to 100 b/m they failed to deliver the foetus.*

15.2 *Let the condition and/or situation pleaded in paragraph 15.1 above persist to 19h00 without any intervention.*

15.3 *Let the condition and/or situation pleaded in paragraph 15.1 above persist to 20h00 without any intervention.*

15.4 *Failed to expedite the delivery at 20h00 by ventouse extraction even though there was clear evidence of foetal compromise and in circumstances where the presenting part was engaged (the foetal head having been 1/5 above the brim.)*

CAUSATION

16. *As a result of the aforesaid negligence and breach of the legal duty referred to above, E[...]:*

16.1. Experienced pain, suffering and discomfort and will continue, for as long as she lives, to permanently experience pain, suffering and discomfort in future as a result of the permanent and pronounced cerebral palsy...'

[19] The appellant in her amended plea stated:

'4.1 The defendant denies all allegations of negligence and/or breach of legal duty on the part of the defendant.

4.2 In amplification the defendant pleads as more fully set out below.

4.2.1 The respondent presented at Mqanduli Community Health Centre at approximately 14h05 where she was assessed at 14h30 and found to be in labour.

4.2.2 The respondent was a known epileptic.

4.2.3 The respondent was referred to the Hospital for management.

4.2.4 The respondent and foetus were monitored on an ongoing basis and in accordance with applicable prescripts, which monitoring included continuous cardiotography ('CTG'). The tracings of the CTG, while not re-assuring at some time, showed good recovery and variability in between.

4.2.5 E[...] was born through vaginal delivery at approximately 20h55

.

4.2.6 E[...]’s Apgar scores at birth were recorded as 5/10 at 1 minute and 6/10 at 5 minutes.

4.2.7 *E[...]* suffered intra-uterine growth restriction ('IUGR') which was not and could not be) detected during the respondent's pregnancy as she booked only 11 February 2014 – only four weeks before she went into labour and delivered *E[...]* on 11 March 2014 – and therefore too late.

4.2.8 *E[...]* was born with a tight nuchal cord x2 around the neck after the respondent's first stage of her labour had progressed rapidly to full dilation in just 40 minutes...

4.3 Alternatively to paragraph 4.1 above, and in the event of the above Honourable Court finding that the medical staff and staff providing related services at Zithulele Hospital negligently and wrongfully breached their duties in one or more of the respects alleged in the amended particulars of claim, or at all, the defendant denies that such negligence and/or breach contributed to, or was a cause of, the outcomes alleged and/or any damages which the respondent may prove she or *E[...]* has suffered and accordingly denies the contents of paragraphs 7 to 15 of the amended particulars of claim.

4.4 Alternatively to paragraphs 4.1 and 4.3 above and in the event of the above Honourable Court finding that the medical staff and staff providing related service at Zithulele Hospital negligently and wrongfully breached.

[20] In relation to the amended plea the respondent in replication stated:

‘... 6.1 The averments and diagnosis of intrauterine growth restriction is speculative at best; and

6.2 At the birth of *E[...]*, she was not diagnosed to have had intrauterine. growth restriction.

7. *In the alternative to the pleading in paragraph 4 above, the respondent avers that she was not a late booker, she having booked in November 2013 at Mqanduli Community Clinic when a urine-based pregnancy test was done and later confirmed with a blood test in December 2013.*

8. *In addition to the pleading in paragraph 4 of the respondent's amended particulars of claim, with which the respondent persists, the respondent avers that:*

...

8.5 *The above medical practitioners and nursing staff who were involved in the rendering of advice, medical supervision, medical care, antenatal care, nursing care, treatment and management of the respondent's pregnancy with E[...], medical supervision, midwifery care, obstetric care during the respondent's attendance at Mqanduli Community Health Centre on Mpunzana Clinic on 11 February 2014 and 11 March 2014;*

8.5.1 *were either permanent or temporary employees.*

8.5.2 *were acting within the course and scope of their employment as servants of the department. Alternatively, were duly authorised agents of the department who were acting as such in fulfilment of the department's vicarious, statutory and constitutional obligations to the respondent to render medical examination, care and treatment to the respondent as a patient?*

8.5.3 *undertook to examine, render proper and appropriate medical, nursing advice and care to treat the respondent who was then pregnant on 11 February 2014 and 11 March 2014, as was reasonably required of them in the circumstances.*

8.5.4 were individually under a duty of care to render appropriate medical advice, medical supervision, medical care, appropriate treatment to the respondent and the respondent's foetus whilst she was pregnant with E[...] and render appropriate and proper medical, midwifery, and obstetric care during the respondent's pregnancy labour and to do so with such skill, care and diligence as could reasonably be expected from the medical practitioners and nursing staff at Mpunzana Clinic.

8.5.5 were duly authorised agents of the department who were acting as such in fulfilment of the defendant's vicarious obligation to the respondent and E[...] to render medical treatment, care and advice to the respondent as a patient.

8.5.6 were and are not known to the respondent.

9. In addition to the pleading in paragraphs 7,8 and 9 of the respondent's amended particulars of claim, with which the respondent persists, the respondent avers that:

9.1 Upon presentation at Mpunzana Clinic on 11 February 2014 and 11 March 2014 the employees of the department who were stationed there at and who attended to her antenatal care did not render appropriate and proper antenatal care to her;

9.2 Negligently failed to, on 11 February 2014:

9.2.1 take from the respondent the appropriate and relevant history which would have rendered it possible for them determine the extent, propriety and adequacy of foetal growth;

9.2.2 *plot the respondent's history on the antenatal graph which would have rendered it possible for them determine the extent, propriety and adequacy of foetal growth in view of the respondent's last normal menstrual period, measurement of the height of fundus, palpation of the height of fundus and determination of the expected delivery date; and*

9.2.3 *plot the findings on the antenatal graph which would have informed them if the foetus was growth restricted or not;*

9.3 *Negligently failed to, on 11 March 2014;*

9.3.1 *take from the respondent the appropriate and relevant history which would have rendered it possible for them determine the extent, propriety and adequacy of foetal growth; and*

9.3.2 *plot the antenatal graph which would have informed them if the foetus was growth restricted or not.*

9.4 *The above omissions, individually and/or cumulatively, were negligent and causative of the brain injury to E[...] in that they deprived the employees who attended to the respondent's antenatal care at Mpunzana Clinic and those who attended to the respondent's labour at Zithulele Hospital knowledge that the foetus had intrauterine growth restriction so that they would have managed the labour accordingly.'*

NEGLIGENCE

[21] The applicable legal principles for determining whether the respondent had proved negligence on the part of the appellant's employees in treating her are set out in the judgment of the court *a quo*. The following dictum in *Kruger v Coetzee* 1966 (2) 428 (A) 430 is still approved as authoritative for assessing negligence:

‘For the purposes of liability culpa arises if –

- (a) *diligens paterfamilias* in the position of the defendant –
 - (i) would foresee the reasonable possibility of his conduct injuring another
 - (j) 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.’

In the present case, the guidelines applied to the management of the respondent whilst under the care of the defendant's employees.

[22] Both parties presented expert evidence, which, together with their opinions, sought to establish whether the said employees were negligent in treating the respondent. In *Buthelezi v Ndaba* 2013 (5) SA 437 (SCA) para 15, the court cited the principle set out in *Castell v De Greef* 1993 (3) SA 501 (C) at 512A-B as follows:

‘The test remains always whether the practitioner exercised reasonable skill and care or, in other words, whether or not his conduct fell below the standard of a reasonably competent practitioner in his field’.

[23] The court *a quo* summarised the opinions of the radiologists, Prof. Lots, for the appellant, and Dr Swatzberg for the respondent, on the type of injury suffered by E[...]. There was no dispute between the parties' expert witnesses about the findings of radiologists, following E[...]'s MRI scan on 17 August 2018. In their joint minute, they recorded:

- the study shows mixed pattern of prolonged partial (peripheral) and acute profound (central) hypoxic ischemic injury;
- the findings of the MRI study suggest that the generic or metabolic disorders are unlikely causes of the brain injury;
- the MRI findings suggest that the inflammatory or infective causes are unlikely as causes of the child's brain damage;
- a review of the clinical and obstetrical 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.

Indeed, the parties presented evidence from the relevant experts to determine the probable cause and timing of the injury. Dr Ndjapa, for the respondent and Dr Mtsi, for the appellant, the gynaecologist and obstetricians, Dr Kara, for the respondent and Prof. Cooper, for the appellant, the paediatricians and neonatologists, testified. Their evidence was based on the medical records together with information from the respondent, in the main.

[24] The judgment of the court *a quo* summarised the maternity case records. This court agrees that the medical records do not provide a clear and complete record. It is necessary to refer to the following parts of the medical records. The respondent was first seen at Mpunzana clinic on 11 February 2014. The notes about essential facts and the record on the graph indicate that it was the first antenatal visit at 32/40 weeks of pregnancy, she was recorded as a late booker. No abnormalities were detected in the antenatal tests run on her. Where the

records are supposed to indicate what was used to establish the gestation, there is no indication of her last menstrual period. Height symphysis fundus measurement must have been taken. The antenatal graph or South African protocol was not plotted. The respondent returned to the clinic on the morning of 11 March 2014. She was assessed as being 34 weeks pregnant. The graph was again not plotted. She was complaining of pain in her waist. She was given treatment for a vaginal infection.

[25] Later that day, she went to the Mqanduli community health care centre, complaining of labour pains since 06h00. She was assessed after 14h05, she was recorded as being at 36 weeks of pregnancy. She was confirmed to be in labour with mild contractions. Foetal heart rate was 121 beats per minute. Membranes were not felt but show seen. She was 3 centimetres dilated. The plan was to refer to the hospital, she was a known epileptic. The partogram at 14h30 has a similar record, it is also plotted that she was in the active phase.

[26] The next record is at Zithulele hospital at 17h20. The maternal condition is recorded as good, and she seemed to be coping well with contractions. Bradycardia is indicated at 100 beats per minute and picks up to 120 beats per minute. She was still 3 centimetres dilated. The note reads *'put on left lateral position, oxygen given via...mask* [appearing on the next line] *PV done. Still 3cm dilated with show mask and 1l R\lactate* [ringers] *running well. Contraction moderate to strong. At 18.45 doctor informed about the problem, no problem continue with the current management.*

[27] At 19h00, decelerations are noted about three times. The doctor on call was called to see the patient, the patient is still on continuous CTG. Oxygen was given in 1 litre ringers lactate and lying in the left lateral position. Foetal heart rate drops

up to 100 beats per minute. At 19h05, Dr Glaze records, 39 weeks of pregnancy. She was 3 centimetres dilated with good, strong contractions. She was concerned about late decelerations on CTG with loco looks. Doctor also recorded, *'just early decelerations with good recovery and good variability in between. Several also witnessed decelerations to 100 beats per minute but good recovery to 140. Plan keep on lateral position and oxygen. Keep on CTG and monitor closely. If not progressing or they are late decelerations call the doctor'*. At 20h00, foetal condition recorded as CTG still up and down, in the summary of labour the record is more specific and reads, since arrival CTG up and down, 90 to 136 beats per minute. Overall assessment and management records show that the primigravida progressed rapidly from 3 centimetres to fully dilated within 40 minutes. She had not yet reported an urge to bear down.

[28] The summary of labour records, she *'started bearing down at 20h30'*. At 20h55 baby was delivered, floppy, flat, cord tightly twice around the neck. Hypoxic ischemic encephalopathy recorded as problems during new-born (HIE). At 21h40 Dr Blaze's clinical findings are, *'the baby needs resuscitation via bag valve mask with oxygen tone and only agonal breathing initially but heart rate good. Continue bag valve mask rescue breaths for 7 minutes until spontaneous respiration achieved. Head cooling commenced, IV cannula sited (fluids to commence) no mouth feeding.'* Dr Kara, the respondent's neonatologist, explained, the baby was on IV fluids of neonatalyte at 4 millilitres per hour. On 12 March it is recorded that the baby was sucking well. On 18,19 and 20 February, the baby was fed through a tube.

[29] According to the appellant, failure to comply with the guidelines does not necessarily establish negligence. A finding about the standard of care exercised would still need to be made. In this court, it was submitted, on behalf of the appellant, that the court *a quo* was obliged to consider the standard of the

management of the respondent's labour. For the court *a quo* to conclude that the respondent's employees were negligent, the court *a quo* had to find that the management was substandard.

[30] Paragraphs 5 and 6 above record the management of the respondent's labour. That, after the diagnosis of bradycardia at 17h20, and the intervention to which all experts agree was correct, there was no monitoring until 18h20. This is consistent with the respondent's testimony that, the same nurse returned to her around 18h00. The doctor did not come at 18h45 when advised of the problem, the respondent was still 3cm dilated. Instead, the same management was continued, she was not given hexeprenaline and was not prepared for immediate caesarean section. The court *a quo* also recorded how the guidelines were not followed.

[31] Thereafter, the court *a quo* refers to the issues recorded regarding the CTG, and notes that, despite management, decelerations were noted three times at 19h00. The court *a quo* then analysed the crucial aspects of Dr Njapa's evidence that were not challenged. The court *a quo* rejected Dr Mtsi's evidence and stated its reasons, among others, that on 11 March 2020, she signed a joint minute with Dr Ndjapa and made various concessions. Dr Mtsi did not sign another joint minute that the doctors compiled on 25 January 2021, Dr Mtsi said she received the information after signing on 11 March 2020. The court *a quo* recorded that she had conceded that, by appending her signature to the joint minute, she was communicating that she knew what the case was about, she had all the relevant information and that the contents of the joint minute were a true reflection of her understanding of the case. The court *a quo* held her to the joint minute of 11 March 2020. The court *a quo* also found that Dr Mtsi testified differently from what was stated in her medico-legal report, she adapted her evidence as the trial progressed and changed her stance after the respondent closed her case. Her

conduct could not avail for the respondent. Considering the court *a quo*'s ruling on the issue of joint minutes, it is not clear to what extent Dr Mtsi's evidence, which was based on the addendum and her oral testimony, was considered.

[32] The issue of resiling from the joint minute requires consideration at this stage. According to the appellant, the court *a quo* incorrectly applied the principle enunciated in *Bee v RAF* 2018 (4) SA 366 (SCA) at paragraphs 64 - 74. The court *a quo* should have considered whether Dr Mtsi proffered a sufficient explanation for her to resile from the joint minute.

[33] In *Bee, supra*, the court, in general, endorsed the approach in *Thomas v BD Sarens (Pty) Ltd* [2012] ZAGPJHC 16. The approach is that when parties engage experts to investigate the facts, and those experts meet and agree upon those facts, a litigant may not repudiate the agreement, unless it does so clearly and, at the very latest, at the outset of the trial. In the absence of a timeous repudiation, the facts agreed to by the experts enjoy the same status as facts which are common cause on the pleadings or facts agreed in a pre-trial conference. Where experts reach agreement on a matter of opinion, the litigants are likewise not at liberty to repudiate the agreement. In endorsing the approach, the court did so, subject to some qualifications.

[34] The court affirmed that the fundamental feature of case management, is that litigants are required to reach an agreement on as many matters as possible to limit the issues to be tried. Where the matters in question fall within the realm of the experts rather than lay witnesses, it is entirely appropriate to insist that the experts in like disciplines meet and sign joint minutes. Facts and opinions on which the experts agree are not quite the same as admissions by or agreements between the litigants themselves, directly or through their legal representatives. A witness is not an agent of the litigant who engages him or her. Expert witnesses,

nevertheless, stand on a different footing from other witnesses. A party cannot call an expert witness without furnishing a summary of the expert's opinions and reasons therefor. Where experts were directed to and had met and filed joint minutes, the joint minute will correctly be understood as limiting the issues on which evidence is needed. If a litigant for any reason does not wish to be bound by the limitation, fair warning must be given. In the absence of repudiation (i.e. fair warning), the other litigant is entitled to run the case on the basis that the matters agreed between the experts are not in issue. Where the expert, rather than the litigant, wishes to depart from what he or she has previously agreed to, the same rules of fair play apply. The experts should notify the attorney through whom they were engaged, and a warning should be given to the other side. In such cases, there will often be a further procedural requirement, the furnishing of a supplementary report by the experts whose views have changed. The limits on repudiation, particularly its timing, are matters for the trial court. It is important that, the repudiation be clear and timeous.

[35] In this regard the majority in *HAL obo MML v MEC for Health Free State* 2022 (3) SA 571 (SCA) at para 49 stated: *'It is trite that where experts agree on a matter of fact in a joint minute, the parties are bound by the agreement and may not, without more, deviate from the agreement, without proper explanation and the consideration of prejudice'* (emphasis mine).

[36] In the present case, it does not appear that at the beginning of the trial, it was placed on record that Dr Mtsi no longer wished to be bound by the joint minute of 11 March 2020. She was also not led about the said joint minute in her evidence in chief. It was during cross-examination that counsel for the respondent insisted that, the minute was signed and was before the court, she ought to answer questions arising from it. Dr Mtsi explained that she signed the said minute in error. Upon her realising that, she informed the respondent's expert. She said she

had also received information and a CTG report, after she had signed the joint minute. They agreed to sign another joint minute. She prepared the subsequent minute, signed it and sent it to her counterpart. Dr Ndjapa informed her that the respondent's legal representatives instructed her not to sign it. The latter minute, dated 28 August 2020, is part of the record.

[37] The record indicates that the court *a quo* was satisfied with the reasoning that appears at paragraph 31 above and that Dr Mtsi had conceded that, as an expert, she had a responsibility to be independent when expressing an opinion, equip herself with all relevant information before preparing a medico-legal report and commenting on a joint minute. The court *a quo* expressed no view about the qualification in *Bee, supra*, whether Dr Mtsi timeously warned that she did not want to be bound by the joint minute. The aspect of prejudice was also not taken into consideration. That also applies to the reasons Dr Mtsi advanced for her wish not to be bound by the initial joint minute. Dr Mtsi explained that she was confused because on 19 November 2019, she signed a joint minute with Dr Sekawabe. She had read that doctor's report, not Dr Ndjapa's. She thought the joint minute with Dr Ndjapa was based on Dr Sekawabe's report and that the joint minute was with Dr Sekawabe. She said she was unwell at the time, she was not in a state to engage in such an exercise. She would never have agreed to the issues that she did with Dr Ndjapa. She acknowledged that she erred.

[38] In this court's view, the respondent's legal representatives were aware of Dr Mtsi's position, around the time she prepared the second joint minute. Dr Mtsi also prepared an addendum, which was served on 24 August 2020. What she testified about appeared in paragraph 1 of the addendum. This court holds that the repudiation was timeous, as a result there could be no prejudice. Dr Mtsi should not have been held to the joint minute with Dr Ndjapa.

[39] According to the appellant, the respondent failed to establish that a reasonable person in the position of the appellant's employees would have foreseen the reasonable possibility that their conduct would injure E[...] and cause her patrimonial loss. Further, that they would have taken reasonable steps to guard against such an occurrence and that the appellant's employees failed to do so. Concerning the CTG, it was submitted that Dr Ndjapa confirmed that the attending clinician must have had the original CTG before her when endorsing the medical records. She recorded late decelerations to 100 beats per minute and good recovery to 140. Dr Ndjapa concluded that CTG could assist, but that it should be deferred to the attending clinician rather than relying on it after the fact. The attending clinician would have considered the CTG marked 127 to 132 running between 18h10 to 19h00.

[40] According to the appellant, such constituted continuous monitoring because the procedure is that, each minute gets recorded and printed on the CTG. Dr Ndjapa, in cross-examination, agreed with Dr Mtsi that there was good variability, in contrast to her earlier testimony that the CTGs were abnormal and remained non-reassuring.

[41] As a starting point, to determine whether the respondent's management was substandard to the extent of constituting negligence, this court considers how the court *a quo* viewed the evidence tendered on behalf of the parties in that regard. The respondent bore the burden of proving such negligence.

[42] The judgment of the court *a quo* records that the obstetricians throughout agreed on several aspects regarding how the respondent was treated. Those are not different from what is recorded above regarding medical records. The summary of the experts' evidence is also sufficiently recorded in the judgment of the court *a quo*, it is not necessary to repeat it in detail. As for their conclusions,

their opinions differed. Dr Mtsi no longer agreed with these, that there was a need for immediate delivery, the possible exposure of the foetus to hypoxia over a period, long enough to cause cerebral damage resulting in cerebral palsy, and that the poor outcome could have been prevented.

[43] Both doctors, Ndjapa and Mtsi, agreed that the CTG showed bradycardia at 17h20 and the initial reaction by the medical staff to it was appropriate. She was still 3cm dilated. Dr Ndjapa testified that the normal heart rate is between 110 and 160 beats per minute. Anything below 110 is a deceleration, even if lasting less than a minute. Deceleration could be associated with foetal oxygenation and related acidosis or hypoxia. There are various types of decelerations, the early, late and variable. A heart rate above 160 beats per minute is tachycardia. According to the medical records, the foetal heart was dropping to 100, beats per minute and picking up to 120 beats, in the summary of labour it is indicated that it dropped to 90 beats. Labour was not progressing. The respondent was coping well with contractions. Dr Ndjapa said the respondent had been in labour for 8 hours, from 06h00 to 14h05. The doctor accepted what was plotted regarding the active phase. She said a caesarean section was indicated. There was bradycardia at 18h45 when the doctor was called and did not come until 19h05. Dr Glaze noted there were good contractions, the same treatment must be continued. Dr Ndjapa said that even though Dr Glaze recorded good variability, with decelerations to 100 beats, and good recovery to 140 beats, that was not helpful. There was no indication of whether the decelerations were early or late. E[...] suffered hypoxia for an extended period, enough to cause cerebral palsy.

[44] Dr Mtsi disagreed with the suggestion that caesarean section was indicated at 17h20. However, she conceded that the onset of bradycardia was not known, the respondent was last seen upon arrival. She agreed that at that stage, no one recorded foetal distress, however, she said there was no indication of whether

bradycardia lasted for more than 10 minutes. What Dr Mtsi said were indications for a caesarean in terms of the guidelines, foetal distress, failed labour and breached presentation were not presented to Dr Ndjapa. Dr Mtsi said only foetal distress was present in E[...].

[45] Furthermore, according to the Figo guidelines, the baseline of 110 beats per minute would need to persist for more than 10 minutes. In South Africa, it is indicated in two parts. The one referring to 110 beats and another referring to below 110 beats, which goes to 100 beats. 100 beats used to be regarded as very dangerous and indicated for immediate delivery. With discussions and guidelines, it was realised that such a heartbeat could occur in normal pregnancies and labour. There was a need to investigate the reason, react and see if there was a response to the correction. Thereafter, correction would commence. Dr Mtsi agreed that there was a sufficient indication for a caesarean section, however, that would follow only after the cause had been found. She said there was also a need to check if it showed improvement or not. The drop of under 100 beats was a sufficient warning that the foetal heartbeat was not normal. It was not a warning to have a caesarean section performed, without investigation. Ringer's lactate would suffice. She said it would have been indicated if the situation had been observed over time and had worsened.

[46] She said what Dr Ndjapa described as deceleration, was variability. According to her interpretation, a normal CTG did not necessarily mean that there should be no deceleration at all. If the deceleration was repetitive, category 2 meant it was suspicious, and category 3 meant it was pathological. There was no evidence of reduced variability. The three decelerations were not described in the record. The CTG in the present case was not normal. The suspicious CTG was situated between normal and pathological. At 19h00, there was a good recovery and good variability in between. However, she said the quality of the CTG was

poor, it would have been reckless to rely on it. Dr Mtsi also, seemingly, wanted to rely on the tachycardia indicated by the same CTG. She stated that no proper investigation and monitoring was undertaken, even in that regard. Furthermore, when she was asked if bradycardia and tachycardia could coexist, she agreed that they could not. However, she said they can happen in a short space of time.

[47] Dr Mtsi said nuchal cord 2 times was problematic, which could somewhat cause a lack of oxygen. She, however, agreed that, if the foetal heart rate were monitored by internal examination, the nuchal cord would have been detected. It became tighter with stronger contractions. The record indicates that at 19h05, Dr Glaze had instructed that the respondent must be closely monitored. She agreed that according to the guidelines, the foetal heart rate must be listened to every 30 minutes before, during and after a contraction. Nothing happened until 20h00, she agreed with Dr Ndjapa that between 20h00 and 20h55, CTG showed that the situation had deteriorated, and nothing could be done to save E[...]. She conceded that if a caesarean delivery had been done at 19h00, E[...] could have been delivered. She also conceded that, even though foetal distress was not ticked at birth in the clinical records, the fact that E[...] was assessed for encephalopathy suggests that care was required. The record that, there were no abnormalities when E[...] had no suck reflexes was not accurate.

[48] Dr Mtsi testified that fifty-five minutes before birth, no one was able to account for the respondent's fully dilated state. At 19h20, contractions were said to be moderate. Both doctors agreed that a caesarean section could not be performed by then. She said the respondent was high risk, insofar as she would suffer fits; she was not an obstetric high risk. She agreed with Dr Ndjapa that if delivery was imminent, E[...] had to be delivered immediately through vacuum extraction, if necessary. Dr Ndjapa had also said most patients with medical conditions were high risk.

[49] The medical records and the uncontroverted evidence of the respondent shed light on the non-monitoring period from 14h30 to 17h20. The applicable guidelines were not followed, to monitor the respondent two hourly in the latent phase and every 30 minutes in the active phase before, during and after a contraction. Dr Ndjapa recorded that, consistent with the evidence of the respondent, she was in labour for 8 hours, between 06h00 and 14h05. There was no foetal distress noted at 14h30. It is common cause that the graph was not plotted between 14h30 and 20h00. Distress was noted at 17h20. Dr Mtsi said there was no conclusion that there was foetal distress. She, however, acknowledged that when E[...] was assessed, there were problems at birth, and care was required. The investigation that Dr Mtsi said had not been undertaken, was the responsibility of the hospital staff. They had plenty of time from 17h20 to about 20h00. Instead, the subsequent monitoring was at 18h45, despite bradycardia having been noted about one and a half hours prior. Even what was agreed to by the experts, that there was no monitoring until 18h20, consistent with the respondent's testimony, that, the same nurse returned to her around 18h00, constitutes a period of an hour. The respondent was 3cm dilated, and labour was not imminent. According to the guidelines, labour should be minimised and the patient should be prepared for a caesarean section.

[50] At 19h05, Dr Glaze had given instructions for close monitoring. That was not done, the next record is at 20h00. Even if Dr Ndjapa had conceded variability, and that the initial response at 17h20 was correct, the medical staff did nothing else after that. The respondent was not adequately monitored, her condition was not investigated and there was no effort to deliver her earlier, until she was fully dilated. Furthermore, E[...]’s condition at birth, as recorded at paragraph 28 above, is also telling regarding distress. Above the requirements of the guidelines, the respondent’s situation, at least, after 14h20 and 19h05, required the exercise of more care, treatment and attention. Dr Mtsi’s opinion would not alter the

overwhelming evidence of substandard care. The court *a quo* may well not have distinctly recorded the finding on negligence separately. Still, in the final analysis, this court agrees that a reasonable person in their position would have foreseen a reasonable possibility that their conduct might injure the respondent and cause her patrimonial loss. The hospital staff should have monitored the progress of labour more closely, intervened by administering medication to slow down labour and expedite delivery, but they failed to do so.

CAUSATION

[51] Having found that the employees of the appellant were negligent in treating the respondent, she still had to prove that such negligence caused E[...]’s injury. The issues raised by the appellant on causation include IUGR, a tight nuchal cord, and rapid progression in 40 minutes, which probably contributed to the dominant acute, profound component of the hypoxic ischemic injury, depicted in the MRI scan. The judgment of the court *a quo* sets out the applicable principles in this regard. In *International Shipping Co (Py) Ltd v Bently* 1990 (1) SA 680 (A) at 700, the court formulated the following approach:

‘The law of delict causation involves two distinct enquiries. The first is a factual one and relates to the question as to whether the defendant’s wrongful act was a cause of respondent’s loss. This has been referred to as ‘factual causation’. The enquiry as to factual causation is generally conducted by applying the so-called ‘but for’ test which is designed to determine whether a postulated cause can be identified as a sine qua non of the loss in question. In order to apply this test one must make a hypothetical inquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an

hypothesis respondent's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the respondent's loss; aliter, if it would not so have ensued. If the wrongful act is shown in this way not to be a causa sine none of the loss suffered, then no local liability can arise. On the other hand, demonstration that the wrongful act was causa sine qua non of the loss does not necessarily result in legal liability. The secondary enquiry then arises, viz, whether the wrongful act is linked sufficiently closely or directly to the loss for legal ability to ensue or whether, as it is said, the loss is too remote. This is basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes referred to as 'legal causation'.

[52] According to the appellant, the court *a quo*'s judgment does not disclose a consideration and evaluation of the two enquiries outlined above. This appears to be justified when one considers how the court *a quo* framed the finding on causation. However, the court *a quo* recorded all that was required in one finding. The Court *a quo* found that Dr Ndjapa and Dr Kara left no doubt that the cause of E[...]’s injury was a consequence of the negligence on the part of defendant’s employees. The evidence of Dr Mtsi and Prof. Cooper was not impressive; it was unsubstantiated by the facts of the case. Dr Mtsi’s opinion was speculative. Had immediate delivery of E[...] been done, E[...] would not have been injured.

[53] This court must consider causation and engage in the exercise involving the two enquiries. The judgment also sufficiently summarised the evidence relevant to the aspect of causation. All the experts agreed that in partial prolonged injury, the insult to the foetus occurs in a period longer than an hour before birth. It was suggested that Volpe is the only author who holds the view that partial prolonged injury may occur from an hour to hours or days before birth. In the acute profound hypoxic ischemic injury, the insult occurs 30 minutes before birth. Prof. Cooper said the acute injury occurs in the last 45 minutes and not more than 50 minutes

before birth. Where there is a sentinel event, the debate about hours does not arise. There are sentinel events, like a tight cord around the neck that may be recognised much later or may not be recognised, which may have been the origin of the sentinel event. However, that was not recognised in E[...]’ case. Despite that, the case sought to be made on behalf of the appellant was that, E[...]’s IUGR primed her for birth hypoxia. Furthermore, the rapid progression of the respondent’s labour from 3 cm to fully dilated contributed to, together with the tightening of the nuchal cord at a time when it was too late to detect, intervene and prevent, led to the progression of hypoxia immediately before her delivery.

[54] Dr Mtsi said the respondent had no early clinic visits, her two visits were late, 4 weeks before the birth of E[...] and on the day of her birth. IUGR could not be assessed. She also opined that IUGR associated with placental insufficiency, rapid descent, tight nuchal cord and the possibility of amnionitis were also risk factors which could contribute to E[...]’s outcome. However, from an obstetrician's point of view, there was no evidence of an amniotic fluid infection, and the placenta was not tested. She also conceded that the rapid progress could have been reduced with tocolysis. Furthermore, if the nuchal cord were present at 14h05, when the respondent was monitored, it would have been detected. It became tighter as the contractions intensified and the head descended. According to Dr Mtsi, if plotting was done on the morning of 11 March 2014, IUGR may have been suspected. This accords with what the respondent’s experts said that, had there been appropriate monitoring, even with IUGR, which was not being conceded, there could have been an intervention, followed by a better outcome.

[55] Dr Kara, in the joint minute with Prof. Cooper, agreed that E[...] would be growth-restricted if he were born at term, not if born at 36 weeks. He explained that this would be subject to whether the respondent's statement that her last

menstrual period was on 1 June 2013 was accurate. That would be the only factor that supports injury before labour, which constitutes 0,1 per cent. However, many factors suggest that the injury occurred during labour. The two experts disagreed about the accuracy of the record of the neonate's size, which was necessary for estimating the age of the foetus. According to Dr Kara, if E[...] were born at term, the clinical staff ought to have picked up that E[...] was small and treated him as a high risk. The medical records are inconsistent in that at 14h05 they reveal a birth at term, according to the last menstrual period. During the initial assessment, she was estimated to be 36 weeks by palpation, but based on fundal height assessment, this could have indicated a gestational age of more than 36 weeks. Dr Glade assessed pregnancy to be 39 weeks by date, which is not so meaningful without palpation. According to the measurement, the foetus grew from 32 weeks to 36 weeks in 4 weeks. There was no evidential basis for the measurement of the foetus at 32 weeks or on 11 March 2014. Dr Kara said the measurements of head size and length were in keeping for a 39-week baby. If E[...] was 36 weeks at delivery, the weight of 2.5 kg was on the 50th per centile, the length of 49cm was below the 90th per centile, and the head size was 34cm, which was in the 90th per centile. That was not supportive of IUGR. The weight of E[...] was small for the age of 39 weeks; it would be closer to 36 weeks. The head size and length are less accurate than the weight measurement. However, there was no precise indication of the gestation period. Considering the size of the head, which was normal, it was improbable that E[...]’s injury occurred antenatally. Usually, but not in all instances, head growth gets stunted after injury, depending on the part of the brain that was injured. If the brain were injured in utero before labour, the brain would stop growing. If injured in two to three weeks before delivery, the brain would slow down, the size of the head would be small. However, the head may still be big whilst the brain is small, for example, if the head is filled with fluid. That did not exclude an injury occurring a day before labour, for example. E[...] was recorded as normal at birth and during the examination with Dr Kara. He corrected

the reference to postnatal microcephaly, he said it was an error. Dr Van Rensburg pointed it out to him, it also did not accord with his clinical findings.

[56] It is worth mentioning at this stage that the respondent had said she was at Macosa clinic earlier and was advised to return to the clinic after three months. Dr Kara also said she told him that she first booked at the clinic when she was three months pregnant. According to Dr Ndjapa, in her first visit, she was directed to return in three months.

[57] Prof. Cooper, based on the measurement of E[...], opined that E[...] had IUGR when the respondent got into labour and that primed E[...] for injury. The stress of labour was the final straw. According to Prof. Cooper, Dr Kara disagreed because he did not accept that the respondent reached 40 weeks of pregnancy. 80 to 90 per cent of growth-restricted babies do not suffer adverse consequences during labour. If E[...] were part of the 10 per cent, with proper monitoring, the risk would have been detected. That would have been a sign that E[...] was experiencing concerns of hypoxic ischemia, which calls for an appropriate intervention before the injury occurs. He disagreed with the suggestion that growth-restricted babies have a risk of hypoxic ischemic injury that is 30 times higher than that of babies that do not have growth restriction. Only 0,1 per cent of babies with IUGR had brain injury. 0,005 per cent of babies who are not growth restricted have brain injuries. IUGR increases the risk of foetal brain injury. Dr Mtsi had also said a growth retarded foetus would show if in trouble, which also points to the issue of lack of monitoring.

[58] Dr Kara agreed that the onset of late IUGR was usually due to placental insufficiency; however, he explained that it did not imply that placental insufficiency was sufficient to cause brain injury. The risk of IUGR is that it may affect the ability of the baby to withstand the stress of labour. A decision would

have to be made about the mode of delivery to protect the baby from that stress, 10 per cent attributed to urethral placental failure. With adequate perfusion, pregnancy could continue without damage to the foetus. HIE at birth is suggestive of intrapartum. There was no evidence that epilepsy treatment was attributed to asphyxia and cerebral palsy. He said that because he did not know the gestation period, he would not know if E[...] was growth-restricted. Prof. Cooper conceded in cross-examination that there was no evidence suggesting placental insufficiency because the placenta was not tested. Even the record that it was normal would not give sufficient information, without microscopic examination.

[59] Prof. Cooper said Dr Kara's reference to 38 weeks was the old definition. Prof. Cooper based the computation of the gestation period on the fact that the respondent had said she missed her period in July. The length and head circumference at birth were on the 50th percentile for a 40-week gestation, within the normal range, but the weight was well below the 10th percentile and just above the 3rd percentile. That indicated significant asymmetrical intrauterine growth restriction. Dr Mtsi had said the recording of gestation of 34 weeks on the date of delivery was a mistake, it was later corrected. Prof. Cooper said that, in the two suggested periods, 36 weeks and 40 weeks, 36 weeks was highly unlikely, given the way the asymmetry was presented in the 36-week gestation. Furthermore, in view of the significant asymmetrical intrauterine growth restriction and poor antenatal attendance, with lack of any information about the foetal well-being during the last four weeks of pregnancy, the chance of the partial prolong component occurring before labour was substantial. Prof. Cooper agreed that to place a baby at a particular percentile, one must know the age of pregnancy. If the growth parameters were not plotted, it could not be concluded whether there was IUGR or not. It would be difficult to assess IUGR because of the need to follow the pregnancy for months, from 20 weeks.

[60] Prof. Cooper opined that the partial prolonged injury occurred prior to labour. According to Dr Ndjapa the insult occurred and developed into an injury. According to Dr Kara, there was a possibility that the injury occurred prior to labour, but there was little reason to support this possibility. In a joint minute dated 15 November 2019, between Dr Van Rensburg, the appellant's neurologist and Dr Kara, they agreed that E[...] has dyskinesia cerebral palsy. Her head size was normal. According to Dr Kara, it is commonly associated with hypoxic ischemia. The said injury is specific to injury during labour. The probability that E[...] was injured during labour was 80 per cent, with the presence of neonatal encephalopathy. What happened during labour, the monitoring and progress of labour, informs the timing of the injury. The APGAR scores were 5/10 at one minute and 6/10 at five minutes. That she was described as flat suggested that her actual score was lower than the recorded one.

[61] Furthermore, according to the respondent, the respondent had no risks during pregnancy, except for epilepsy. Upon admission, the foetus was assessed to be in good condition. A parthogram indicating that the foetal heart was normal could not be accurate, given the CTG readings. Prof. Cooper deferred the issue of CTG to obstetricians. Dr Kara also testified that according to the medical records, at 5 minutes after birth, E[...] had slow respiration, and the placenta looked well. There was no record of foetal distress. Caput, HIE were noted. In his opinion, a normal tone was not consistent with a floppy, flat baby with weak reflexes and abnormal movements. E[...] was kept in an oxygen bag and mask for seven minutes. The body cooling also follows severe foetal compromise in labour. The HIE score was 3. The features in E[...] were all consistent with encephalopathy. The MRI scan finding also pointed to injury during birth. It would have been essential to give glucose to a baby that was exposed to foetal compromise to prevent further brain injury from hypoglycaemia.

[62] Dr Kara firmly stated that there was no record that E[...] was fed orally. The record only reflects cup feeding on 15 March 2014 and that she was fed with a tube on 18 and 19 March 2014. This is correct, it accords with the respondent's evidence that she expressed milk and fed E[...] with a mug and syringe. Dr Kara opined that E[...] could not have had a good suck because she was not feeding. The respondent also disputed to him that E[...] was sucking well and she confirmed cup or tube feeding. Subtle convulsions or fits could be misinterpreted as sucking noises. E[...] only sucked after two weeks. She had convulsions on 16 March 2014 at 05h10. Volpe, in considering the timing of injury, says foetal distress, resuscitation at birth and neonatal encephalopathy point to the injury during labour. According to Dr Kara, antenatal injury was uncommon. E[...]’s injury occurred close to delivery, there were no signs that the foetus was suffering at 14h05. The clinical staff did not appropriately manage the foetal distress, after 17.20.

[63] The authors in *Law of Delict, fifth edition, Neetheling, Potgieter and Visser* at page 168 state that the inserting method used by our courts to determine causation in instances of omission is nevertheless a realistic approach to causation and is logically more well-founded than the removal of something that is obviously the cause of a consequence to demonstrate the existence of factual causation. That requires engaging in a mental hypothetical exercise of replacing the omission with a lawful positive act. In *Minister of Safety v Carmichelle* 2004 (3) SA 305 (SCA) at paragraph 56, quoted with approval from *Minister of safety and Security v Van Duivenboden* 2002(6) SA 431 (SCA), that:

‘A respondent is not required to establish the causal link with certainty but only to establish that the wrongful conduct was probably a cause of the loss, 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.’

In *Minister of Police v Skosana* 1977 (1) SA 31 (A) at paragraph 34, the court held that factual causation requires a determination of whether that negligent act or omission caused or materially contributed to harm giving rise to a claim.

[64] This court agrees with the principles applied by the court *a quo* in relation to the approach to expert evidence. The opinion should follow proper motivation; the court must be able to weigh and choose between differing opinions based on sufficient reasoning provided by the expert. The court would then be assisted to arrive at an informed decision in special fields where it has no expertise. In *Michael and another v Linksfield Park Clinic (Pty) Ltd and another* 2001 (3) SA 1188 (SCA), from paragraph 37, the court held that what is required in evaluating the experts' evidence is to determine whether and to what extent their opinions are founded on logical reasoning. It is only on that basis that a court can determine whether one of the two conflicting opinions should be preferred. An opinion expressed without a logical foundation can be rejected. But it must be borne in mind that in the medical field, it may not be possible to be definitive. Experts may legitimately hold diametrically opposed views and be able to support them by logical reasoning.

[65] In this court's view, the respondent has established, on a balance of probabilities, that had there been proper monitoring and E[...] been delivered when the CTG continued to be non-reassuring whilst bradycardia was still noted, despite the initial intervention, E[...]’s harm would have been prevented. Both Dr Ndjapa and Dr Mtsi agreed that the CTG was never reassuring. Dr Mtsi conceded in cross-examination that the respondent's care was substandard. Dr Ndjapa's opinion that E[...] may have been exposed to hypoxia over a long time is logical and accords with the fact that there is no record of monitoring from 14h30 to 17h20. With growth restriction, there was no support for the proposition that IUGR probably caused E[...]’s injury. It was based on the suggestion that the

respondent was a late booker. The evidence revealed that there was no certainty in that regard. The respondent testified that she initially went to Mqanduli clinic in November 2013, her pregnancy was confirmed in December 2013 to be at six months. She was also advised that there was nothing wrong with the foetus. That evidence was not disputed. Dr Kara gave a logical explanation about why the injury pointed to the injury during labour. Furthermore, there is no dispute that with the acute, profound injury, which is the final insult, had there been appropriate monitoring, intervention would have been necessary before the final insult occurred. Even with restricted growth, if it existed, it has been shown that proper monitoring would have been a meaningful intervention, which could have spared E[...] from the final insult. In the final analysis, this court is satisfied that the respondent proved on a balance of probabilities that the negligence of the employees of the appellant caused E[...]’s injury.

[66] Regarding legal causation, in the circumstances of this case, more specifically as stated in the preceding paragraph, the respondent proved that the conduct of the appellant’s employees suffered by E[...] is sufficiently closely or directly linked to the harm. It is not too remote from the conduct of the appellant’s employees. E[...]’s harm was foreseeable and the appellant’s employees should have taken steps to prevent it.

[67] Finally, it is reasonable to impose liability because the appellant’s employees breached the duty of care owed to the respondent by failing to conform to a reasonable standard of care. Their conduct also amounted to a breach of legal duty not to harm E[...].

In the result,

1. The appeal is hereby dismissed with costs, such costs to include the costs of two counsel. From the date rule 67A of the Uniform Rules of the Court came into effect, the costs shall be on scale C.

B MAJIKI
ACTING DEPUTY JUDGE PRESIDENT
HIGH COURT

I agree:

R W N BROOKS
JUDGE OF THE HIGH COURT

I agree:

M MHAMBI
ACTING JUDGE OF THE HIGH COURT

Appearances

Counsel for the Appellant	:	Adv Ntsaluba SC / Ms Young
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