



**IN THE HIGH COURT OF SOUTH AFRICA
KWAZULU-NATAL DIVISION, PIETERMARITZBURG**

CASE NO: AR286/2022

In the matter between:

ADVOCATE CHAMELLE JAIPAL N.O.

APPELLANT

(Plaintiff in the court *a quo*)

and

**THE MEMBER OF THE EXECUTIVE COUNCIL
FOR HEALTH, PROVINCE OF KWAZULU-NATAL**

RESPONDENT

(Defendant in the court *a quo*)

ORDER

On appeal from: KwaZulu-Natal Division of the High Court, Durban (Steyn J sitting as court of first instance):

1. The appeal is upheld with costs, such costs to include the costs consequent upon the employment of two counsel.
2. The order of the court *a quo* dismissing the appellant's claim on the merits is set aside and replaced with the following:
 - '1. The defendant is liable for such damages as the plaintiff may prove arising from the negligent management of her labour and delivery on 21 July 2011.

2. The defendant is directed to pay the plaintiff's costs to date on the party and party scale as taxed or agreed, such costs to include (but not be limited to):
 - 2.1 The reasonable and necessary fees of the undermentioned experts, including their costs of their preparation to qualify themselves to testify at the trial, the costs of their reports, the costs incurred by them in the preparation of the joint minutes, their reservation and attendance costs (not limited to the amount of R1 500) (where appropriate) and for consultations with the plaintiff's attorney and senior counsel, namely:
 - 2.1.1 Dr D.M McLynn, specialist obstetrician and gynaecologist;
 - 2.1.2 Dr Yatish Kara, paediatrician; and
 - 2.1.3 Professor J W Lotz, professor of radiology.
 - 2.2 The cost of obtaining and the production of MRI scan of the brain, including the costs of the anaesthetist and hospital fees that were necessary to obtain the said MRI scan and all reports relating thereto.
 - 2.3 The reasonable and necessary costs of the plaintiff's attorney attending upon consultation with the aforementioned expert witnesses and the plaintiff.
 - 2.4 The costs of senior counsel, including the reasonable and necessary costs of preparation for the trial and the costs of attendance by senior counsel, including the reasonable and necessary costs of preparation for the trial and the costs of attendance by senior counsel upon consultations with the aforementioned expert witnesses and with the plaintiff.
 - 2.5 The costs of senior counsel in the perusal of the transcript of the evidence at the trial and all other documents pertaining to the plaintiff's claim, the drafting and preparation of heads of argument, preparation for and appearing to argue the matter.
 - 2.6 All reserved costs, including all costs of counsel in having the matter certified ready for trial at the case flow conference hearings.
3. The matter is adjourned sine die for determination of the quantum of the plaintiff's claim.'

JUDGMENT

Delivered on:

Bedderson J (Henriques J and Broster AJ concurring):

Introduction

[1] This appeal arises from the judgment of Steyn J, delivered on 9 February 2022, in which the trial court dismissed the plaintiff's medical negligence claim (the court a quo).¹ Leave to appeal was subsequently granted.

[2] The appellant was substituted as curator ad litem for the minor child, E, following the death of her mother, the original plaintiff (the mother).

[3] The primary question in this appeal is whether the medical staff at the Lower Umfolozi District War Memorial Hospital (the hospital) were negligent in their management of the mother's labour and delivery, and whether such negligence caused the injuries suffered by E, who was later diagnosed with cerebral palsy and hypoxic–ischaemic encephalopathy (HIE).

Background facts

[4] The common cause facts reveal that the mother attended antenatal care at the Ndlangubo Clinic near Mbengeni during her pregnancy. The antenatal records reflect seven clinic visits and disclose no material complications prior to the onset of labour.

[5] The evidence established that at approximately 21h00 on 18 July 2011, the mother experienced the onset of labour pains. During the early hours of 19 July 2011, at approximately 04h30, she experienced blood-stained or reddish fluid discharge,

¹ *K v Member of the Executive Council for Health for the Province of KZN* [2022] ZAKZDHC 8.

accompanied by abdominal pain radiating into her back. She thereafter presented at the clinic for assessment.

[6] On admission at approximately 07h00, the clinical records reflected moderate uterine contractions, cervical dilation of 2 cm, foetal head engagement at 4/5 above the pelvic brim and a foetal heart rate of 140 beats per minute. The foetal condition was assessed as satisfactory, and continuous cardiotocograph (CTG) monitoring was commenced.

[7] A reassessment conducted at approximately 11h30 revealed no progress in cervical dilation, which remained at 2 cm, despite ongoing strong uterine contractions. The foetal heart rate remained within normal limits at 140 beats per minute. The attending clinicians recorded a diagnosis of 'poor progress'.

[8] The clinical records further reflect that the mother's condition was discussed with Dr Turner, however, neither the substance of that consultation nor the clinical advice given was recorded. The mother was informed that she should be transferred to hospital because 'she did not have (sic) sufficient opening for [her] to be able to give birth'.

[9] The mother arrived at the hospital at approximately 14h00. The admission assessment recorded a cervical dilation of 2 cm with foetal head engagement remaining at 4/5 and diagnosed early labour. The mother was admitted for continued observation and CTG monitoring.

[10] Subsequent examinations demonstrated a gradual progress of labour. At 19h03, cervical dilation had increased to 3 cm. The CTG was recorded as reactive, analgesia was administered, and reassessment after two hours was planned. At 22h00, the partogram reflected cervical dilation of 4 cm.

[11] By midnight, cervical dilation was recorded at 8 cm, the foetal head had descended to 3/5 above the pelvic brim, and CTG remained reactive. Artificial rupture of the membranes was performed, clear liquor was observed, and monitoring continued.

[12] The hospital records, however, disclosed material irregularities in the maintenance of the partogram. An earlier entry reflecting cervical dilation of 6 cm at midnight had been erased. A further entry at 02h00 reflecting cervical dilation at 8 cm was also subsequently erased.

[13] At approximately 03h00, cervical dilation remained at 8 cm with the foetal head engaged at 2/5 above the pelvic brim. The mother was noted to be restless and experiencing strong contractions. Although the CTG was recorded as reassuring, medical review was requested and the antenatal note bore an illegible signature.

[14] By approximately 03h30, cervical dilation had advanced to between 9 and 10 cm. At that stage, the clinical records recorded foetal head moulding and documented that the CTG machine was no longer functioning. Doppler monitoring was substituted. Importantly, the foetal heart rate exceeded 155 beats per minute and decelerations were observed during contractions. Delivery within the following hour was anticipated.

[15] The records relating to the subsequent examination at 04h30 reveal notable inconsistencies. Although cervical dilation was recorded at 9 cm, the notes simultaneously recorded a reactive CTG, absence of caput and moulding, and an intention to reassess after a further two hours, notwithstanding the earlier indication that delivery was imminent.

[16] At approximately 05h15, the mother was found to be fully dilated. The clinical records indicate that she was transferred for delivery. An episiotomy had already been performed and, owing to poor maternal effort, vacuuming extraction was performed. Delivery was recorded as being without technical difficulty, although the mother sustained a second-degree perineal tear.

[17] E was delivered at approximately 05h30 by vacuum extraction under the supervision of Dr Monti. The delivery records note poor maternal effort, repair of the episiotomy and that the paediatric team had been alerted. E was born in a depressed condition, with Apgar scores of 3 out of 10 at both one and five minutes. A subsequent record made at approximately 05h45 confirmed the live birth of a female infant by vacuum extraction, although the recorded Apgar scores are illegible. E was later diagnosed with spastic cerebral palsy and HIE.

Grounds of appeal

[18] The appellant contends that the court a quo erred in several respects, namely:

- (a) By accepting that the mother's labour exceeded the duration set out in the Maternity Care Guidelines but found it was not significantly prolonged. While it held that the hospital staff should have monitored the mother more frequently, it concluded there was no causal link between this failure and the harm to the mother.
- (b) By accepting the authenticity and reliability of the partogram, despite material alterations, erasures and inconsistencies;
- (c) By admitting CTG traces whose origin and authenticity were disputed;
- (d) By preferring the evidence of the respondent's expert, Dr Archer, despite concerns regarding his independence and objectivity;
- (e) By rejecting expert joint minutes and expert evidence that linked the intrapartum hypoxic event to E's cerebral palsy; and
- (f) By concluding that negligence had not caused the injury, despite acknowledged deficiencies in monitoring, record keeping and compliance with the Maternity Care Guidelines.

Analysis

[19] This appeal turns on whether the court a quo correctly assessed the evidence relating to negligence and causation and whether it was justified in dismissing the appellant's claim.

[20] It is common cause that E suffered birth asphyxia, HIE, and subsequently developed cerebral palsy. The dispute concerns whether these injuries were caused by negligent intrapartum management and whether the evidence established the requisite causal connection.

[21] The court a quo accepted that aspects of the respondent's record-keeping were unsatisfactory. It acknowledged deficiencies in the hospital notes, inadequacies in the partogram, uncertainty regarding certain entries and short-comings in compliance with the Maternity Care Guidelines. Despite these findings, however, the court relied substantially on the same records in rejecting the appellant's case.

[22] This approach presents a difficulty, especially where the reliability of contemporaneous medical records has been materially undermined. The deficiencies identified by the court a quo were not peripheral. They related directly to the monitoring of labour, the recording of foetal heart rate observations and the chronology of events during the critical periods preceding delivery. The crucial importance of medical records has been authoritatively dealt with in *Madida obo SSM v MEC for Health for the Province of KwaZulu-Natal*:²

'[10] In terms of ss 13 and 17 of the National Health Act 61 of 2003 the defendant's employees have a statutory duty to preserve and protect such hospital and medical records. Failure to do so opens the defendant's employees to criminal prosecution and liable on conviction to a fine or to imprisonment for a period not exceeding one year or to both such fine and imprisonment.

[11] The Health Professions Council's Guidelines on the keeping of patient records dated May 2008 applies to health care practitioners in both the private and public service. It identifies what constitutes health records, why documents or materials should be retained and what information is compulsory for recording. *It prohibits alteration of records and requires reasons for any amendments to be specified on the record. Errors may be corrected but the date of the change must be entered and the correction signed in full. The original record must remain intact and fully legible. Additional entries at a later date must be dated and signed in full.* The guidelines also provide for the retention of health records, which must be stored in a safe place and if stored electronically then safeguarded by passwords. In the case of minors their records must be kept

² *Madida obo SSM v MEC for Health for the Province of KwaZulu-Natal* [2016] ZAKZPHC 27.

until the minor's twenty-first birthday. For mentally incompetent patients the records must be kept for the duration of the patient's life. Health records kept in a provincial hospital or clinic including the records of minors and mentally incompetent patients may only be destroyed with the authority of the Deputy Director General concerned.

[12] I have detailed the National Health Act and Guidelines to emphasise their importance and the rationale and seriousness with which the health professions view the keeping of patients' records. So when they are not available when they should be there is potentially a breach of a rule of law and codes of good practice. Non-compliance with statutory requirements and codes of good practice that impact directly on the health of members of the public is cause on its own to refuse the adjournment. To do otherwise would lead to the mistaken inference that the court is prepared to condone or tolerate the illegality. The lack of a bona fide explanation for the unavailability of the records fortifies my opinion.' (My emphasis and footnotes omitted.)

[23] The absence of reliable monitoring during the period between approximately 00h00 and 03h00 on 20 July 2011 is of particular concern. That period coincided with a critical stage of labour. The absence of contemporaneous observation limits the ability of the court to draw firm conclusions regarding the foetal condition during that time. In these circumstances, the absence of recorded foetal distress cannot automatically be equated with proof that no foetal distress existed, as found by the court a quo.

[24] The court a quo further accepted the evidence of Dr Archer, despite the competing expert opinions, especially those contained in the joint minutes prepared by experts appointed by both parties which were not challenged. In particular, reference is made to the joint minute of the radiologists where they agreed that the MRI findings demonstrated a mixed acute profound and prolonged partial hypoxic injury. Similarly, the paediatric experts agreed that E's cerebral palsy was attributable to an intrapartum hypoxic insult.

[25] The court a quo's treatment of the joint expert minutes is inconsistent with the approach endorsed by the Supreme Court of Appeal in *Bee v Road Accident Fund*.³ In that matter, the court emphasised that agreements recorded in joint minutes serve to

³ *Bee v Road Accident Fund* [2018] ZASCA 52; 2018 (4) SA 366 (SCA) (*Bee*).

narrow disputes and ordinarily bind the parties unless properly challenged.⁴ The consensus reached between the radiologists and paediatricians regarding the nature and timing of the hypoxic injury constituted significant evidential material that required cogent reasons before being rejected. No such reasons appear from the judgment of the court a quo.

[26] The court a quo's preference for Dr Archer's evidence does not adequately engage with the objective MRI findings or the consensus reflected in the joint minutes.

[27] On the issue of whether the mother's labour was significantly prolonged, the court a quo deals with this in paragraphs 71, 72, 73, 78 and 87 of its judgment and essentially found that Dr McLynn incorrectly placed reliance on the entries made in the medical records in respect of the mother's commencement of labour that I have referred to in paragraph 5 above. The court a quo failed to take into account the evidential value of medical records in coming to this conclusion. Koen J in *HN v MEC for Health, KZN*⁵ stated the following:

'[8] Statements in the medical records that are favourable to the Defendant are hearsay where the author thereof was not called to testify, and hence not admissible... No application was made for the admission thereof in evidence in terms of section 3 of the Evidence Law Amendment Act 1998, but even if there was, it would be unlikely to have succeeded as there was no evidence that the author thereof was no longer available to give that evidence...

[9] Recordings favourable to the Plaintiff's case in establishing negligence and liability generally, and accordingly damaging to the Defendant's case, made as part of the records kept by the Defendant's servants, are however on a different footing. They constitute admissions by the servants of the Defendant made in the ordinary course of discharging their duties, which are binding against the Defendant. The Defendant's staff are obliged to make these statements by recording the medical position as it unfolds in the records. They have an obligation to speak on behalf of the Defendant and dispute what is recorded, if indeed incorrect.'

⁴ Ibid para 66.

⁵ *HN v MEC for Health, KZN* [2018] ZAKZPHC 8.

[28] If one accepts that the trained medical staff are obliged to record the medical condition of the mother as it unfolds then the submissions in paragraph 76 of the appellant's heads of argument cannot be faulted, namely: -

'Even if the plaintiff's labour only commenced at the time reflected in her testimony (04h30), the period until which she entered the active phase of labour was seventeen hours and thirty minutes and thirty minutes, more than twice the period of eight hours suggested in the Guidelines. The court a quo saw fit to ignore the evidence of Dr McLynn as being based on incorrect facts. The incorrect facts referred to was the alleged discrepancy between the oral testimony of the plaintiff regarding her experiences at approximately 04h30 as opposed to the recordal in the records that the labour commenced at 21h00 the night before. It is more likely that the staff recorded the commencement of labour based on information provided at the time by the plaintiff as opposed to her oral testimony some eleven years later. The court a quo accordingly misdirected itself in ignoring the evidence of Dr McLynn.'

[29] The court a quo further accepted that the labour may have exceeded the parameters contemplated by the Maternity Care Guidelines and that monitoring ought to have been more frequent. It also recognised deficiencies in compliance with established obstetric protocols. Despite making these findings, it nevertheless concluded that negligence had not been established and that no causal connection had been demonstrated. This conclusion is difficult to reconcile with the totality of the evidence. The purpose of the Maternity Care Guidelines is to ensure the timely detection of foetal compromise and to facilitate intervention before irreversible injury occurs. A failure to monitor appropriately necessarily impairs the ability of health care providers to identify developing complications. Where such failures coincide with incomplete records and subsequent evidence of an intrapartum hypoxic injury, the significance of these omissions cannot be discounted.

[30] The evidence, viewed as a whole, establishes prolonged labour, inadequate monitoring during critical periods, deficiencies in record-keeping and delayed intervention. Those findings are consistent with the expert consensus that E sustained and intrapartum hypoxic injury.

[31] In these circumstances, the conclusion reached by the court a quo that there was no evidence of foetal distress and no causal connection between the negligent management of labour and the injuries sustained by E cannot be sustained.

[32] In determining factual causation, the question is whether the negligent conduct probably caused the injury. This approach was adopted in *Minister Safety and Security v Duivenboden*⁶ at paragraph 25 where the following is stated: -

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

[33] This approach was adopted by the Constitutional Court in *Lee v Minister of Correctional Services*.⁷ The inquiry is one of probability rather than certainty. The court must consider the evidence holistically and determine whether, on a balance of probabilities, the injury would have been avoided had reasonable steps been taken. The court a quo appears to have required a level of certainty that exceeds the standard contemplated by *Lee*.

Conclusion

[34] The court a quo materially misdirected itself in its assessment of the evidence. It attached undue weight to disputed hospital records, despite recognising significant deficiencies in those records. It failed to accord proper weight to the consensus in the expert joint minutes and did not adequately address the implications of admitted departures from accepted standards of obstetric care.

[35] On a proper consideration of the evidence, the probabilities favoured the conclusion that the respondent's employees failed to monitor and manage the mother's

⁶ *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) para 25.

⁷ *Lee v Minister of Correctional Services* [2012] ZACC 30; 2013 (2) SA 144 (CC) (*Lee*).

labour in accordance with accepted professional standards and that such failures contributed to the intrapartum hypoxic injury sustained by E.

[36] The appeal must therefore succeed. It follows that the appellant is entitled to the costs of the appeal, having regards to the importance of the matter to the appellant as well as the complexities of the matter, it was a sensible precaution to engage the services of two counsel. Accordingly, the costs to be awarded in this matter must include the costs consequent of two counsel.

Order

[37] The following order is made:

1. The appeal is upheld with costs, such costs to include the costs consequent upon the employment of two counsel.
2. The order of the court a quo dismissing the appellant's claim on the merits is set aside and replaced with the following:
 - '1. The defendant is liable for such damages as the plaintiff may prove arising from the negligent management of her labour and delivery on 21 July 2011.
 2. The defendant is directed to pay the plaintiff's costs to date on the party and party scale as taxed or agreed, such costs to include (but not be limited to):
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 - 2.1.1 Dr D.M McLynn, specialist obstetrician and gynaecologist;
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 - 2.2 The cost of obtaining and the production of MRI scan of the brain, including the costs of the anaesthetist and hospital fees that were necessary to obtain the said MRI scan and all reports relating thereto.

- 2.3 The reasonable and necessary costs of the plaintiff's attorney attending upon consultation with the aforementioned expert witnesses and the plaintiff.
- 2.4 The costs of senior counsel, including the reasonable and necessary costs of preparation for the trial and the costs of attendance by senior counsel, including the reasonable and necessary costs of preparation for the trial and the costs of attendance by senior counsel upon consultations with the aforementioned expert witnesses and with the plaintiff.
- 2.5 The costs of senior counsel in the perusal of the transcript of the evidence at the trial and all other documents pertaining to the plaintiff's claim, the drafting and preparation of heads of argument, preparation for and appearing to argue the matter.
- 2.6 All reserved costs, including all costs of counsel in having the matter certified ready for trial at the case flow conference hearings.
3. The matter is adjourned sine die for determination of the quantum of the plaintiff's claim.'


BEDDERSON J
HENRIQUES J
BROSTER AJ

Date Of Hearing: 26 January 2024

Date of Delivery: 07 July 2026

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