**IN THE HIGH COURT OF SOUTH AFRICA**

**GAUTENG LOCAL DIVISION, JOHANNESBURG**

**CASE NO: 2012/20087**

(1) REPORTABLE: **YES**
(2) OF INTEREST TO OTHER JUDGES: **YES**
(3) REVISED: **YES**

**6 February 2015** .....

DATE SIGNATURE

In the matter between:

**KHOZA, N (on behalf of minor child Z)** Plaintiff

and

**MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH AND SOCIAL DEVELOPMNET OF THE GAUTENG PROVINCIAL GOVERNMENT** Defendant

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**JUDGMENT**

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**SPILG, J:**

**INTRODUCTION**

1. The Plaintiff sues the defendant in delict alleging that her son's deformity was due to medical negligence. It is alleged that the negligence arose during the

course of his delivery in the maternity ward at the Chris Hani-Baragwanath Hospital *('Chris Hani-Bara')* during the evening of 24th May 2008 through to just before dawn on the following day.

2. The parties are agreed that at this stage the court is to determine only whether there was negligence and if so whether it was a cause of or contributed to her son's condition. The issue of quantum has been separated for later determination should this court find in the plaintiff's favour on the merits.

**BACKGROUND**

3. The plaintiff is the mother of Z who is now almost 6 years old.

   Z displays symptoms associated with some form of cerebral palsy. It is common cause that he suffers from a severe neurological disability which is manifested by *inter alia*, microcephaly, a profound mental handicap, autism-like aloofness, epilepsy, dyspraxic patterns of motor skills, incontinency and the absence of spasticity and communicative skills.

4. The plaintiff's experts contend that Z suffers from hypoxic ischemic encephalopathy ('HIE') due to a partial prolonged intra-partum[1] hypoxic-ischaemic brain injury which occurred over several hours during labour.

5. As I understand it, for the purposes of the case, HIE is a deficiency of oxygen in the tissues which affects the functioning of the brain caused by an inadequate flow of blood to it due to a constriction or blockage of the blood vessels supplying it. The consequence of an acute HIE event during birth is that an infant presents with specific neurological abnormalities during the first 24 hours after delivery.

6. However HIE might not be the only cause of such a condition. Infection, trauma, inborn errors in metabolism and other genetic disorders may be the cause. These

1. [1] Intra-partum brain injury is an insult to the brain of the foetus which occurs during labour. See also Prof Smith's medico-legal at p63 para 67.4 (which was not disputed).

are described as non-hypoxic-ischemic events. Moreover the direct cause of the acute event might be a stroke rather than a deficiency of oxygen due to a constriction or blockage of blood vessels supplying the brain.

7. The parties are also agreed that the child's condition did not arise from any event that might have occurred after his birth and they also exclude any pre-natal genetic or congenital condition as a possible cause. That leaves only the possibility of foetal distress during pregnancy or birth.

8. The undisputed facts are that the Plaintiff, then 21 years of age, had attended the Chiawelo clinic at 14h45 on 25 May 2008 to give birth to her child. The clinic's notes record that the plaintiff's contractions had commenced at 11h00 that morning and that she was in labour from about then.

9. The clinic referred her to Chris Hani-Bara because of a diagnosis noted as "*a big baby query*". The records confirm that the plaintiff was admitted to the hospital later that day at approximately 18h00, was 5cm dilated and was assessed to be in an active phase of labour. The hospital also noted that the clinic had referred the plaintiff for a '*big baby'.*

10. A doctor had ordered a non-stress test at the time of her admission. The plaintiff was however only transferred to the labour ward at 20h45. It is also apparent that she was placed on a cardio-topographic monitoring machine (a *'CTG*').

11. The CTG is used to detect foetal distress. It monitors the foetal heart rate ('*FHR*') simultaneously with the uterine contraction. The purpose is to establish how the foetus reacts to the stress of the mother's contractions.

    Certain of the fundamental aspects of this case concern whether the CTG was in fact monitored, the relevance of the disappearance of a number of the CTG reports and whether the records that are available had been tampered with.

12. At 11h15 an examination was conducted. It revealed that the plaintiff was 7 cm dilated, there was grade II meconium stained liquor and the descent of the foetus was still 3/5ths above the pelvic brim.

    This indicated labour was slow as her cervical dilatation had only increased from 5 cm at 18h00 to 7 cm and the foetus had not descended at all.

    The CTG was also noted to be "reactive". It meant that the foetus was not in distress.

13. The next clinical examination was early the following morning at 02h00. The CTG was said to be positive. Unless there are factors to the contrary this would indicate that the foetus was still not distressed.

14. It was at this stage that syntocinon was prescribed. Syntocinon is a drug administered intravenously to augment uterine contractions. The plan was to review the situation and in the absence of any progress to perform a caesarean section. It is clear that the hospital records were altered, although the question is whether they were deliberately tampered with or whether a genuine error was immediately corrected.

15. The altered record reads;

    "*Synto **5** in 1l R/L- 60 – 120 – 180 -240 dpm*
    *Review in **4** hrs. If no progress for c/s"*

    The quantities of 5 and 4 were altered. The original document was produced and it is incontrovertible that the original note was to provide 2 units of syntocinon (not 5 units) and that the patient's condition was to be reviewed in 2 hours (not 4 hours). The reference to *'dpm'* is to drops per minute

16. It is apparent that syntocinon was not administered immediately but at 02h30 if regard is had to the relevant record. This means that the purported recording of the CTG at 02h00 was taken before the drug was administered. It is the last

purported recordal taken from the CTG traces. The defendant claims that the CTG traces were lost.

17. There were however other recordings upon which the defendant relies. In particular reliance is placed on the labour partogram which contains handwritten plots noted by the nursing staff on a series of charts. The partogram is divided into six charts all referenced against the same time lines, which are half an hour apart from each other. In effect the charts provide for the monitoring of the required vital signs and urine samples at half hourly intervals which the staff member (either mid-wife, sister or even the duty doctor) plots by making a mark or note in the appropriate line or block of each chart.

18. The first section of the partogram plots the foetal heart rate, the second plots the cervical descent against three lines running at 45 degrees from left to right and commencing just short of the centre of the chart. The first line is the alert line, the second is the transfer line and the third is the action line. Appropriate medical intervention must be taken when the foetal heart rate reaches, or passes to the right of, the alert line.

    The third chart plots contractions per 10 minutes. The fourth records when a drug is administered. The fifth chart records the mother's pulse rate and the last chart records urine samples.

    At the bottom of the partogram provision is made for the signatures of each staff member responsible for making the plots on the relevant time line. In this way each sister responsible for completing the specific plotting at the alleged time must sign for the plot or note he or she recorded on the partogram.

19. It was evident from a consideration of the original partogram produced that the time line was incorrectly recorded and that the contractions per 10 minute recordings were significantly tampered with thereby suggesting heightened contractions at certain stages when in fact it was an over-write of a much slower contraction rate recordal. Moreover the time when syntocinon was administered

was incorrectly noted by half an hour. The defendant's duty doctor and one of the duty nurses sought to provide an explanation during their testimony.

20. After syntocinon was first administered and up to the time the plaintiff gave birth at 05h20, which would include the last two hours when contractions would have been accelerated, there is no record produced that she was monitored or that the CTG, which was still allegedly attached, was itself being monitored by the doctors or nursing staff. Even accepting that the plotting on the partogram was recorded at the indicated time, the last recordal of;

    a. the foetal heart rate was at 03h30 although there is no signature by the sister who ostensibly made the recordal;

    b. the cervix descent, which records the mother's dilation, was last noted at 03h00;

    c. the contractions per 10 minutes was ostensibly at 04h00 but again there is no signature after 03h00;

    d. the pulse was at 03h00

    e. Moreover syntocinon is recorded on the partogram as being administered for the first time at 01h00 commencing at '*60l'* drops per minute, then at 02h00 at 120dpm, at 02h30 at 180dpm and at 03h00 at 240dpm.

21. Accordingly the hospital records, if correct, reflect that the foetus showed no distress at 02h00 before syntocinon was administered (the recording on the partogram that it was administered prior to 02h00 is clearly incorrect and brings into question whether the partogram was filled in much later). The other hospital records show that it was prescribed at 02h00 and obtained from the hospital's pharmacy at 02h30.

Syntocinon was administered in what at best can be described as a much heavier dosage than initially contemplated yet there was no adequate monitoring of the mother and child. This was despite the initial note also directing a review in two hours after the first administration of the drug in order to determine whether a caesarean section should be performed. It is common cause that there had been no review two hours after syntocinon was first administered (irrespective of whether that time was 02h00 or 02h30).

22. Z was delivered at 05h20 on the morning of 26 May 2008.

**THE ISSUES**

23. At the commencement of the trial the defendant accepted that the child suffers from brain damage and the other sequelae complained of. However every other element of the plaintiff's claim was put in issue (with damages left over for later determination if this court found in the plaintiff's favour). The elements of causation in dispute therefore involved;

    a. Whether the injuries were sustained during labour or as a consequence of some pre-exiting congenital or other condition suffered either by the mother or the foetus;

    b. Whether the injuries were sustained after birth;

    c. If the injuries were sustained during birth whether it involved a partial prolonged hypoxic-ischaemic insult.

24. *Mr Mkhabela* on behalf of the defendant vigorously cross examined the seven experts called by the plaintiff on causation and negligence. However in his prepared heads handed up during argument, it was conceded that the plaintiff had established that the foetus had sustained a partial prolonged hypoxic ischaemic injury during labour which caused the brain injury.

25. During the course of the submissions *Mr van der Walt* on behalf of the plaintiff was prepared to accepted, for the purposes of argument, that it could not demonstrate any act or omission on the part of the medical staff prior to 23h15 which constituted negligence.

26. In the result the case has been reduced to the following issues for determination;

    a. Whether there was any act or omission on the part of the medical staff during the period between 23h15 on 24 May 2008 until the infant was delivered at 05h20 on the following morning which amounted to negligence;

    b. If so, whether such negligence caused or contributed to the hypoxic-ischaemic injury or whether the injury was due to some other cause.

27. The defendant contended that the plaintiff did not produce any evidence to show that the medical staff were negligent, and even if they were negligent it did not cause or contribute to the HIE. In this regard it is common cause that the brain of the foetus also suffered a stroke during labour.

28. I proceed to deal with whether there was any conduct, whether by way of act or omission, on the part of the medical staff between 23h15 and 05h20 on the following morning.

29. The starting point is the defendant's contention that there is no hospital record to demonstrate foetal distress and that the evidence of the medical staff, in particular of Sister Songica and Dr. Moagi, demonstrated that proper procedures were followed including the monitoring of the patient and foetus.

**ABSENCE OF THE CTG RECORDS**

30. It is correct that the plaintiff is unable to rely on the CTG. However the reason is that the CTG tracings at the critical period are missing.

    Nonetheless the defendant submits that the court is left with the evidence of the plotting done by the medical staff on the partogram, reinforced by the *vive voce* evidence it presented. In particular the defendant relies on the evidence of Sister Songica who claimed that she had regularly monitored the CTG traces and that the points and markings she had plotted or made on the partogram were those she had taken from the CTG tracings

31. It is common cause that this is not the first time in a claim of negligence involving the Chris Hani-Bara maternity ward that CTG recordings have disappeared. In *Ntsele v MEC for Health, Gauteng Provincial Government [2013] 2 All SA 356 (GSJ)* my brother Mokgoatlheng J noted at para 116 that all the clinic and hospital notes were missing from the patient's file and that no explanation was offered.

32. In the present case the file was called for. It contained every document one would expect save for the critical CTG tracings. No proper explanation was offered. On the contrary Dr Mtsi who was called by the defendant confirmed that CTG records should be kept in the mother's file.

    Furthermore the last reference to the CTG in the clinical notes is at 02:00. This is prior to syntocinon being administered.

33. The CTG recordings are possibly the single most important monitoring device during labour to detect foetal distress and appear to be essential where labour is being induced by the use of prescribed drugs, such as prostin and syntocinon.

In this regard I refer to Lamont J in *Makgomarela v Premier of Gauteng and Another* (2011/35273) [2012] ZAGPJHC 217 (1 November 2012) at paras 6 to 8. At para 18 of the judgment the court said;

*"Had the mother and baby been monitored as required the monitoring would have yielded data which would have enabled the medical team to intervene at an early stage so as to prevent hypoxia occurring. A CTG could have been used to effect tracings on a continuous basis as such was available at the hospital*"

In cases where a CTG machine is used, its recordings are regarded as the key evidence.

34. Moreover sections 13 and 17 of the National Health Act 61 of 2003 require not only that the records of hospitals and clinics be maintained and safely stored but also that adequate controls of access are put in place. The provisions read;

***13 Obligation to keep record***

*Subject to National Archives of South Africa Act, 1996 (Act 43 of 1996), and the Promotion of Access to Information Act, 2000 (Act 2 of 2000), the person in charge of a health establishment must ensure that a health record containing such information as may be prescribed is created and maintained at that health establishment for every user of health services*.

***17 Protection of health records***

*(1) The person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.*

*(2) Any person who-*

*(a) fails to perform a duty imposed on them in terms of subsection (1);*

*(b) falsifies any record by adding to or deleting or changing any information contained in that record;*

*(c) creates, changes or destroys a record without authority to do so;*

*(d) fails to create or change a record when properly required to do so;*

*(e) provides false information with the intent that it be included in a record;*

*(f) without authority, copies any part of a record;*

*(g) without authority, connects the personal identification elements of a user's record with any element of that record that concerns the user's condition, treatment or history;*

*(h) gains unauthorised access to a record or record-keeping system, including intercepting information being transmitted from one person, or one part of a record-keeping system, to another;*

*(i) without authority, connects any part of a computer or other electronic system on which records are kept to-*

*(i) any other computer or other electronic system; or*

*(ii) any terminal or other installation connected to or forming part of any other computer or other electronic system; or*

*(j) without authority, modifies or impairs the operation of-*

*(i) any part of the operating system of a computer or other electronic system on which a user's records are kept; or*

*(ii) any part of the programme used to record, store, retrieve or display information on a computer or other electronic system on which a user's records are kept,*

*commits an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding one year or to both a fine and such imprisonment*. (Emphasis added)

35. It is apparent on a reading of section 17 of the National Health Act that the legislature has taken a very serious view on the failure to keep medical records and on their disappearance, falsification or being tampered with. Stiff penalties are prescribed under section 17(2).

36. The application of sections 13 and 17 may have evidential ramifications in civil suits. The cases referred to indicate that the overwhelming evidence presented in

*Ntsele* and *Makgomarela* was that where it is utilised, the CTG is the single most important and reliable monitoring device during the critical phases of labour. See the evidence presented in *Ntsele* at para 17 where the court noted the evidence of Dr Heyns in the following terms;

> *The continuous monitoring of the foetal heart beat rate by CTG is very critical in assessing whether the foetus is not in distress as a result of insufficient oxygenated blood supply to the foetal brain. The failure to continuous monitor the foetal heart beat rate resulted in the foetal heart completely stopping due to the lack of oxygenated blood supply to the foetal brain. A's failure to breath and cry was a consequence of him having suffered brain damage.*

This was also the evidence presented in the present matter by one of the country's leading professionals in the field, Prof Smith, and supported by all the other medical experts called. Prof Smith testified that once the administration of syntocinon was commenced on the plaintiff, the CTG should have been regularly monitored. This evidence could not be challenged. On the contrary it was the defendant's case that the mother had been on a CTG machine and that there had been regular monitoring of and readings taken from the CTG traces.

37. On these facts the CTG traces constitute the original and foundational documentary evidence having been produced directly by the machine . See *The South African Law of Evidence* (2nd ed) by Zeffertt & Paizes at pp830-1. See also *Principles of Evidence* (3rd ed) by Schwikkard & van der Merwe at para 20.3.1 pp 405-6 .

The subsequent alleged noting of the CTG data and the *vive voce* evidence of its alleged content is hearsay evidence.

Unless there is a satisfactory explanation as to why the original documents are not available, a court is entitled to treat such '*secondary'* evidence with caution or

even refuse to allow it into evidence. See *Vulcan Rubber Works (Pty) Ltd v SAR&H* 1958(3) SA 285(A) at 296D-H where Schreiner JA said;

> *"The starting point in considering the admissibility of such evidence is the statutory provision which, in each province, refers the Courts in matters of hearsay to the law of evidence in England. Though there is reference in our cases to the statutory requirement that facts must be proved by the best evidence, I do not think that it is really relevant. Weaker evidence is not excluded by the availability of uncalled stronger evidence except in the case of documents, when the original must be produced or its absence properly explained. In that case the secondary evidence itself proves the existence of the better evidence, namely, the original. No doubt the difference between evidence and hearsay can be said to be an illustration of a broad rule favouring the use of the best evidence, but the better way of stating the position is that hearsay, unless it is brought within one of the recognised exceptions, is not evidence, i.e. legal evidence, at all.*
> *There is no doubt that Brunette's statements about the reports he had received from other officials were of the nature of hearsay. In several modern cases in South Africa statements of a generally similar kind have been admitted (see Garment Workers' Union v de Vries and Others, 1949 (1) SA 1110 (W); Rex v Ferguson, 1949 (3) SA 69 (N); Gibson v Arnold & Co. (Pty.) Ltd., 1951 (2) SA 139 (T)). In the last named case reference was made to Naik v Pillay's Trustee, 1923 AD 471, where, at p. 477, DE VILLIERS, J.A., appears to give recognition to a principle of necessity as affording a ground for the admission of evidence that would otherwise be inadmissible. There is no doubt that the exceptions to the rule against hearsay have come into existence mainly because there was felt to be a strong need for such exceptions if justice was to be done. But that is a different thing from recognising a principle that the rule against hearsay may be relaxed or is subject to a general qualification if the Court thinks that the case is one of necessity.*
> (Emphasis added)

38. The *Vulcan* case concerned the law of evidence prior to the enactment of the Law of Evidence Amendment Act, 45 of 1988 (*'the Amendment Act'*).

*39.* In *S v Ndhlovu and others* 2002 (6) SA 305 (SCA) the court was obliged to consider the constitutionality of section 3 of the Amendment Act. In doing so the SCA (per Cameron JA (at the time) at para 14) approved the passages in *Vulcan* at 296F that *'hearsay, unless it is brought within one of the recognised exceptions, is not evidence, ie legal evidence, at all*" but said that what the Amendment Act had brought about was a fundamental change to permit the relaxation of the evidentiary rules by allowing hearsay evidence to be received only if it is in the interests of justice to do so and relied on the statement to that effect by Navsa JA in *Makhathini v Road Accident Fund 2002 (1) SA 511 (SCA*) at para 21.

40. It was however necessary for the court in *Ndhlovu* to also deal with the necessary distinction between the admissibility of evidence and its reliability and its application in light of the Amendment Act. This aspect is relevant for present purposes because the SCA explained that the mere relaxation of the hearsay rule does not result in the automatic admissibility of hearsay. The court stressed, by way of illustration at paras 29 to 31, that;

> *"[29] …. When hearsay evidence is tendered, the person on whose credibility the probative value of the hearsay depends may (i) testify and confirm its correctness; (ii) not testify; (iii) testify but deny ever making the hearsay statement; (iv) testify and admit making the statement but deny its correctness; (v) testify but neither confirm nor deny making the statement.*
>
> *[30] If the witness, when called, disavows the statement, or fails to recall making it, or is unable to affirm some detailed aspect of it (situations (iii) - (v) above), the situation under the Act is not in substance materially different from when the declarant does not testify at all. The principal reason for not allowing hearsay evidence is that it may be untrustworthy since it cannot be subjected to cross-examination. When the hearsay declarant is called as a*

*witness, but does not confirm the statement, or repudiates it, the test of cross-examination is similarly absent, and similar safeguards are required.*

*[31] The probative value of the hearsay evidence depends primarily on the credibility of the declarant at the time of the declaration, and the central question is whether the interests of justice require that the prior statement should be admitted notwithstanding its later disavowal or non-affirmation. And though the witness's disavowal of or inability to affirm the prior statement may bear on the question of the statement's reliability at the time it was made, it does not change the nature of the essential inquiry, which is whether the interests of justice require its admission.*

41. The SCA concluded at para 32 that;

*"hearsay not affirmed under oath is admissible only if the interests of justice require it".*

42. The same considerations apply in civil proceedings. *See Giesecke & Devrient Southern Africa (Pty) Ltd v Minister of Safety and Security* 2012 (2) SA 137 (SCA) at para 24 *per* Brand JA. There does not appear to be anything in the Constitutional Court decision of *Savoi and Others v National Director of Public Prosecutions and Another* 2014 (5) SA 317 (CC) at para 44, 46 and 49 that might qualify the key aspect of the *ratio* in *Nhlovu* or *Makhathini* that a court in the interests of justice may either hold hearsay evidence inadmissible or may admit it as part of the evidential material but ultimately find it unreliable or untruthful.

43. If these considerations are applied to the present case then the following features appear relevant;

    a. There has been no explanation for the disappearance of the CTG tracings;

    b. Aside from the ordinary obligations of medical practitioners to maintain their patient's records the National Health Act expressly legislates for it.

The policy considerations that underlie the legislation are self-evident. *Prima facie* it would appear not to be in the interests of justice to condone, without an acceptable explanation, a failure on the part of a state institution to comply with a positive obligation imposed by statute, and enforced by significant penalties, to ensure that records are preserved, are not tampered *and* that proper access controls are put in place.

c. The same staff members responsible for monitoring patients under their care are responsible for the regular appraisal of the records and for ensuring the safekeeping of these records in their patients' files. Accordingly the person responsible for the care of the patient, which includes regular monitoring or examination, is also the gatekeeper of the records;

d. There is no suggestion that the internal procedures are inadequate to ensure the safe custody of the contents of a patient's file. Quite the contrary picture was painted by senior staff as to who can access the files and the signing out procedures.

e. The medical staff responsible for maintaining the patients' medical records has the most to gain by ensuring their safekeeping as the records are the surest way of demonstrating that they had monitored and carried out proper procedures. The same staff members also have the most to gain by the disappearance of the contents of a patient's file if they failed to carry out their duties. They are also the ones who would be giving hearsay evidence because of the disappearance of the original record. The risk of unreliability because of manufactured evidence is high and the ability to cross examine effectively compromised;

f. The last feature in itself is not decisive, as unreliable evidence may be admitted (see *Savoi* ) although not ultimately accepted as having much weight. In the present case the strongest reason for not accepting the nursing sister's plots on the partogram as a correct recordal of the CTG traces (having claimed to use the traces as her source material) is

because the partogram itself was tampered with and significantly altered. Moreover certain entries could not have been plotted at the time claimed because the chronology does not accord with other hospital records, such as the pharmacy's drug register.

44. I would therefore have no difficulty in finding that the graphs on the partogram which purportedly recorded the CTG tracking as well as the sister's evidence as to what the CTG in fact recorded constitutes inadmissible hearsay. If I am wrong and I have exercised my discretion incorrectly then I would have no hesitation in rejecting the testimony of Sister Songica and Dr Moagi regarding the CTG readings. My reasons appear later.

45. In my view the inadmissibility of hearsay testimony is not necessarily the only consequence that results from the failure to produce the CTG records without an adequate explanation. That is a negative consequence which provides little comfort to a plaintiff who still bears the onus of demonstrating negligence. In medical negligence cases the issue often arises whether the injury to the patient was due to negligence, non-actionable mistake or another unrelated cause. Accordingly the application of *res ipsa loquitur* may be an unruly horse in certain cases.

Nonetheless in suitable cases it may be appropriate as appears from its application in *Ntsele*. In that case Mokgoatlheng J considered that a failure to produce the potentially exculpatory evidence of any clinical or hospital notes, *"justifiably call for the invocation of the maxim res ipsa loquitur"* (at para 124). The learned judge added at paras 125 and 126;

*[125] In Naude NO v Transvaal Boot and Shoes (supra) in the head note it is stated: "Whether a case is one to which the expression res ipsa loquitur applies or not the burden of proving negligence is on the plaintiff who alleges it; there is no burden of proof on the defendant to disprove negligence. Where, however, the case is one where the occurrence speaks for itself proof is required from the defendant to rebut the presumption arising from the fact that the occurrence speaks for itself: he must produce evidence sufficient to*

*destroy the probability of negligence presumed to be present prior to the testimony adduced by him. If he does so, then on the conclusion of the case the inference of negligence cannot properly be drawn.*

*[126] Because the defendant has failed to discharge the evidential burden disproving a causal connection between the negligence of his employees and A's cerebral palsy, the summation that the eventuality speaks for itself is unanswered."*

46. In *Ntsele* all the clinic and hospital records had disappeared without explanation and no member of the medical staff gave evidence. The defendant only called an expert whose evidence was unceremoniously rejected by the court.

In the present case, however, the defendant called both the duty sister and the doctor who had been responsible for prescribing and administering syntocinon.

47. In summary, the failure to produce the original medical records which are under a hospital's control and where there is no acceptable explanation for its disappearance or alleged destruction;

a. may result in the inadmissibility of '*secondary'* evidence if the interests of justice so dictate, whether such evidence is of a witness who claims to have recalled the contents of the lost document or to have made a note of its contents on another document;

b. cannot of its own be used to support an argument that a plaintiff is unable to discharge the burden of proof because no one now knows whether the original records would exonerate the defendant's staff from a claim of negligence.

c. may result in the application of the doctrine of *res ipsa loquitur* in an appropriate case;

d. may result in an adverse inference being drawn that the missing records support the plaintiff's case in matters where the defendant produces other contemporary documents that have been altered, contain manufactured data or are otherwise questionable irrespective of whether the evidence of secondary witnesses called in support is found to be unreliable or untruthful;

48. In the present case the doctrine of *res ipsa loquitur* cannot be applied to demonstrate that there was negligence on the part of the hospital's staff which caused or contributed to HIE. The reason is that the defence has been able to demonstrate that the foetus suffered a stroke which may or may not inevitably have resulted in HIE irrespective of the most competent medical intervention.

49. However the preliminary question remains whether any inference can be drawn of negligence on the part of the medical staff. If answered in the plaintiff's favour the remaining issue will be whether that was a cause of or contributed to HIE.

**GROUNDS OF NEGLIGENCE**

50. The starting point is that there is no evidence of any congenital or other prenatal abnormality suffered by either the plaintiff or the foetus.

51. Since the defendant conceded that the child sustained the injuries while the mother was in labour it follows that the insult to the foetus must have occurred while the mother was being treated in the labour ward.

52. The plaintiff relied on several grounds of negligence on the part of the medical staff. For present purposes it is sufficient to deal with two, albeit that they appear to be interrelated.

The first is that the medical staff failed to properly monitor or review the mother and foetus when there was a duty to do so. The other is that the medical staff was negligent in that too high a dose of syntocinon was administered.

53. The two grounds of negligence intersect if the medical staff had a duty to properly monitor or review for foetal distress when syntocinon, a scheduled drug with its admittedly dangerous effects, was administered to induce labour. I intend to confine the enquiry to that aspect.

54. However before doing so it is necessary to deal with Mr Mkhabela submission that the plaintiff did not plead a failure to monitor or review as a ground of negligence. In my view, however broadly or inelegantly the grounds may have been pleaded it was evident to the defendant from receipt of the plaintiff's expert reports that this was a ground relied upon. The defendant cross examined the plaintiff's experts extensively on this issue and its own experts covered this in their reports as did the duty staff during their evidence in chief. Accordingly the defendant cannot now be heard to say that it was caught unawares or that it did not deal with this ground fully during the trial. At no stage did it object to the reception of evidence which related to this ground.

55. In view of the plaintiff's limitation of the period from which the negligent conduct is said to have commenced it is only a necessary to start with the last important hospital note prior to 23h15.

**THE HOSPITAL NOTES**

56. At 22h45 the Plaintiff was admitted to the labour ward. Although no physical or vaginal examination was performed it was recorded that the Plaintiff's contractions were "*moderate"* and that the "*NST*"[2] was "*reactive*" which would indicate that the foetus was not experiencing any stress at that point in time.

57. The Plaintiff was then reviewed at 23h15 on the 24th of May 2008 and it was recorded in the birth file that the plaintiff's cervix was 7 cm dilated. This was plotted to the right of the transfer line on the partogram.

[2] 'NST' is the acronym for the Non-stress Test which is a means of monitoring the foetal heart rate and pattern.

A grade II meconium stained liquor was also noted. Liquor is the amniotic fluid surrounding a foetus and "*MSLII*" meant that the liquor was moderately stained.

Furthermore the presenting part of the foetus was still 3/5ths above the pelvic brim and the plaintiff was noted as experiencing mild to moderate contractions.

58. In regard to the foetus it was noted that a heart rate was present and the CTG was said to be "*reactive*". The height of fundus was recorded as "*34/40*", 34 being a measurement in centimetres. It was also noted that the gestation period was into its 38th week.

The plan of action advocated by the doctor at this time was to allow the mother to progress in labour.

59. The next significant note is contained in the partogram at 01h00 on the following morning. It recorded that there was still moderately meconium stained liquor.

60. After that and at 02h00 it was recorded that the plaintiff was extremely restless, that there was foetal movement, and that the CTG was positive. It was however noted that labour was progressing slowly.

It was at this stage that the Dr Moagi prescribed aterax and syntocinon.

It has already mentioned that the note that had been overwritten now read that the mother was to be reviewed in 4 hours' time and that a caesarean section was to be performed if there was no progress. Originally the note directed a 2 hour review. At this stage I am satisfied, having regard to the various pamphlets and the evidence led on the proper procedures to be applied when syntocinon is administered, that the note should not have been altered and that a review should not have been delayed beyond the two hours. Dr Moagi gave evidence and could provide no acceptable explanation that would not have compromised him if in fact he had directed that the patient only be reviewed 4 hours later.

This is strong corroboration to support the probability that the time was altered subsequently to explain why there had been no review of the mother's and foetus' condition despite the administration of syntocinon, even in the altered dosage that was recorded and even if Dr Moagi's evidence is accepted as to what the altered dosage meant is accepted.

61. At 02h30 the following note was made;

*"Pt has been seen by the doctor @ 02h00 and has been made 5 cm dilated".*

However the partogram had earlier recorded the cervical dilatation at both 23h00 and at 02h00 to be 7cm.

These discrepancies between the partogram and other hospital records indicate that, at the least, portions of the former were manufactured after the event.

In any event as pointed out by Prof Smith plotting of the cervical dilatation, whether at 5 and 7 cms, still falls to the right of the action line and indicates that there was no progress in the patient's cervical dilatation for a protracted period of time.

At this stage the foetal heart rate was recorded as 136 beats per minute

Once again there is an anomaly. It appears that syntocinon and aterax (a sedative) were only administered at 02h30, not at 02h00 or the earlier time recorded on the partogram.

62. The doctor's note at 02h00 required syntocinon to be administered in a dosage of "5 IU / ℓ " in Ringer Lactate commencing at a rate of 60 drops per minute and increasing steadily to 120 then 180 and then 240 drops per minute. As mentioned earlier this was also an overwrite of the original note which required only '*2IU* '). "*IU / ℓ*" is a reference to International Units per litre.

63. There are no further notes or other records made from 02h30 until the birth of Z at 05h20.

Most disturbing is that the partogram is supposed to regularly record in graphic form the course of labour and provides for alert and action lines to prompt intervention if the curve deviates from the norm. It is clear from the expert testimony presented by the plaintiff that the partogram was incomplete. Of particular relevance is that ;

a. the plaintiff's contractions were entered only until 04h00;

b. the maternal pulse rate was entered only until 03h00;

c. the foetal heart rate was entered only until 03h30;

d. the cervical dilatation was plotted only until 02h00;

e. information regarding liquor, moulding, caput, effacement, station and application were plotted only until 02h00;

f. there were no entries of a foetal heart rate baseline recording between 20h00 and 23h00 and again between 00h30 and 01h30.

64. Aside from the failure to record essential information required on the partogram there are glaring anomalies when a comparison is done between what was recorded and the notes contained in other hospital records. For instance, labour was noted to have begun at 22h00 but on the "*Admission in Labour form"* contractions commenced at 11h00 on the morning of 24 May.

I have already mentioned that an examination of the original partogram reveals that the contractions per 10 minutes were materially tampered with in order to indicate that contractions had significantly increased. Sister Songica could not explain with any degree of conviction how this came about, nor why the marks

she made did not coincide with the time lines reflected on the partogram when regard is had to other objective evidence.

65. I am satisfied that the partogram was significantly tampered with and that some of the marks were plotted well after the event since if they had been plotted contemporaneously there could not be any error as to time. It is difficult to comprehend how such a glaring confusion as to time could have arisen if contemporary recordings had been made as required. The irresistible inference is that the partogram was tampered with and that there was either a complete lapse in the proper monitoring and review of the plaintiff or if a partial lapse then when the duty staff realised that the patient and foetus were in distress they sought to ensure that the records would not implicate them. Those are the only two possible scenarios.

66. The onset of the second stage of labour was at 05h15. The evidence is that the second stage of labour commences when a patient's cervix is fully dilated, which is at 10cm. Z was delivered shortly after at 05h20.

67. The final stage of labour occurred at 05h25. Accordingly the total duration of active labour was recorded as 7 hours 25 minutes. However this is blatantly incorrect, since at the latest it commenced at 18h00 which meant a duration of some 11½ hours.

68. The "*Neonatal Discharge Summary*" recorded that there was asphyxia at time of birth and also that there had been a single seizure. The note clearly indicated that there were no other seizures. Anti-convulsion medication was administered. The assessment was that the baby had HIE. Various examinations, medication and courses of treatment were undertaken at the hospital and the mother and child were eventually discharged from hospital on 4 June.

69. It is unnecessary to deal with the follow up procedures and the sequelae of the child's HIE as they are admitted. The hospital diagnosis was that Z sustained a moderate hypoxic-ischemic encephalopathy insult.

**NEGLIGENCE**

70. I am satisfied that even without drawing inferences from the failure to produce the CTG traces, the defendant's nursing staff failed in their duty to monitor the mother and foetus, either properly or at all, after syntocinon was administered. Moreover if the doctor had overwritten his initial note to record that a review was to be undertaken in 4 hours then that in itself was negligent having regard to the quantity of syntocinon he had prescribed and their administration over a period with increasing dosages of the drug.

71. Returning to the duties of the nursing staff, it is not disputed that a failure to undertake regular monitoring of the mother and the foetus when labour was protracted and syntocinon had been prescribed is negligent. It is therefore unnecessary to review the obligations and duties of nursing staff whether prescribed or otherwise.

    The issue of negligence turns at that stage on whether the nursing staff or duty doctor had complied with the duty of care they owed to properly monitor the progress of the labour.

72. Sister Songica claimed that she was in regular attendance at the plaintiff's bedside, had properly monitored the progress of mother and foetus and that any errors or omissions contained in the partogram were due to her nor having an opportunity to record them contemporaneously due to pressure of work.

73. Sister Songica was a very unconvincing witness. She kept changing her version when confronted with the glaring anomalies contained in the partogram when compared to the other hospital records produced. Perhaps the most telling is the clear tampering with the chart recording contractions per 10 minute. Not only does it not make sense bearing in mind the fact that contractions did not increase to any degree until syntocinon was administered, but it does not accord with all the other relevant contemporaneous notes

74. Dr Mtsi was called by the defendant to provide evidence of compliance by the nursing staff with the hospital's protocols to show that there had been no negligence. However when shown the evidence that had been revealed during cross-examination she conceded that there were glaring inaccuracies and errors. She also conceded that the dosage of syntocinon was wrong and admitted that the partogram is woefully inadequate. None of these features to which she admitted had been contained in her expert summary and she was unable to proffer an explanation for the omissions.

75. It is not disputed that syntocinon is *per se* a dangerous drug. The protocol itself states that it should be administered with care and constant monitoring.

76. Sister Songica provided the only *vive voce* evidence regarding the alleged proper monitoring of the plaintiff. In my view Mr van der Walt was correct when contending that her evidence is a mass of contradictions, He identified the following to which there was no real answer from the defence in argument:

    a. She testified that she was the person who had filled in the partogram. It then appeared that she could not have been the sister who had completed some of the blocks on the partogram. The latter appears to be correct in that Dr Moagi confirmed that he completed some of the blocks on the partogram. This would have been along the 02h00 timeline;

    b. Sister Songica subsequently said that the last five signatures at the bottom of partogram were hers. Later this was retracted;

    c. She then claimed that she was only responsible from the time syntocinon had been administered at 02h00 (although her handwriting appears earlier on and on the partogram syntocinon is reflected as having been administered prior to 02h00). This nonetheless contradicts another

hospital record which reflects that the administration of Syntocinon commenced later at 02:30;

d. She claimed that she was not involved with the plaintiff's care after 04h00. Later she testified that she was involved and again changed her mind about whether the signature at the bottom of the timeline was hers;

e. When questioned about the administration of syntocinon being entered in the wrong time slot on the partogram, she endeavoured to explain the time blocks as being at hourly intervals and not of 30 minutes. When confronted with the document and shown why that could not be so she reverted to the correct times. When it is once again shown to her that this would mean that the times did not correlate, she tried to change her version yet again;

f. She testified that she had monitored properly, but did not have a chance to complete the partogram due to having to give her attention to other patients.

She stated that it would take her a full minute to record the maternal heart rate and also a full minute to monitor the FHR on the CTG.

When it was pointed out to her that it would take her two seconds to draw a simple cross, she had no real logical explanation as to why she did not fill in the partogram at the time she claimed to have observed the CTG tracer;

g. When she was confronted with the period of time, from 04h00, when there absolutely no completion of any part of the partogram, she again could not provide a logical answer as to why, if she did monitor, she did not plot her observations with a cross or dot, which would have taken only a matter of seconds.

77. I am satisfied that Sister Songica was a dishonest witness and was covering up both in her evidence and by altering the partogram, the failure on her part and on the part of those she supervised to properly monitor the mother and foetus. Since the defendant accepts that there was foetal distress it is evident from Prof Smith's testimony that this would have shown on the CTG and the staff should have taken remedial action.

78. In my view the plaintiff has demonstrated that the defendant was negligent in failing to properly monitor (including review) the progress of labour at least from the time that syntocinon was administered. This was the clear import of Prof Smith's testimony.

79. The final question is whether the failure to monitor would have averted HIE or whether it would have occurred in any event.

**HIE CAUSED BY NEGLIGENCE OFSTAFF**

80. The defendant sought to contend that the partial prolonged HIE was possibly triggered by the arterial stroke recorded in the medical notes. If that is so then it is irrelevant whether the staff was negligent or not. The argument goes that no amount of monitoring could have averted the onset of the stroke and its *sequelae*.

81. The defendant called Dr Weinstein to support this possibility. In my view counsel's submission attempts to put a gloss on the evidence of Prof Smith and

Dr Lippert and fails to take into account the concessions made by Dr Weinstein. Firstly Dr Weinstein accepted Dr van Ransburg's opinion to the effect that it was the intrapartem HIE that triggered the arterial stroke. Accordingly the stroke was not an independent event but rather a consequence. This was also borne out by the fact that there was only one episode recorded of a stroke.

82. In other words on the probabilities Z's condition was at the least caused by a stroke which had been triggered by the depletion of oxygen and glucose to the cerebral region which resulted in brain damage and this occurred during child birth. I should add for completeness that it was common cause that starvation of oxygen and glucose would have occurred either because of the mother's contractions or because the umbilical cord was strangling the child.

83. I am therefore satisfied that foetal distress would have been averted and Z would not have sustained HIE had the defendant's staff properly monitored the plaintiff during labour and after syntocinon had been administered.

**COSTS**

84. The plaintiff sought the usual cost orders and in addition claimed the costs of counsel preparing the heads of argument, the costs of the experts called including their travel costs as they are all based in Stellenbosch.

85. I am satisfied that the preparation of the heads of argument was justified. The trial was lengthy with two key elements of the delict contested; namely what injury was actually sustained and whether it was due to the negligence of the hospital's staff. The defendant only conceded causation during argument. It was salutary to submit heads in the circumstances as both party's sets were of great assistance.

I am also satisfied that the issues were complex and warranted the engagement of two counsel.

86. The opinion evidence of all the experts was necessary, save for Prof Viljoen. His report and evidence did not assist as he had undertaken a superficial investigation into the plaintiff's histology and the nominal evidence regarding the child's father was unsubstantiated hearsay.

87. Finally; the plaintiff's legal representatives elected to choose the team of experts. This is one of a number of medical negligence cases where the same team of experts is used around the country by the same lawyers.

88. It is evident that Prof Smith is possibly the leading authority in a very specialised field and can also provide a broader level of expert knowledge as a number of specialist disciplines need to be traversed. I consider that he is essential to the legal team. However the other experts are drawn from around him and there is nothing to suggest that there are not suitably qualified experts in these other fields who live in Gauteng or that the cost implications would be greater despite the Stellenbosch team having to be flown up.

89. The use of experts who are at same university as Prof Smith is obviously convenient for the plaintiff. However the experts do not have the uniqueness within their disciplines to the same degree as warrants setting Prof Smith apart for the reasons given earlier.

90. Accordingly the plaintiff may well have been able to find equally competent experts locally. Only convenience resulted in their appointment.

**ORDER**

91. I accordingly granted an order that;

***1.*** *The negligence of the staff of the Chris Hani-Baragwanath Hospital on 24 and 25 May 2008 caused the brain damage suffered by the minor child, Zamokuhle Khoza;*

***2.*** *The defendant is ordered to pay 100 % of the agreed or proven damages of the plaintiff acting in her representative capacity as a result of such brain damage;*

***3.*** *The defendant is to pay the costs of the plaintiff (such costs order to exclude the costs orders already made) which shall include;*

a. *The costs of two counsel and counsel's fees in respect of the preparation of heads of argument;*

b. *the costs attendant upon the obtaining of the medico-legal reports of the following expert witnesses:*

i. *Prof Smith;*

ii. *Dr Langenegger;*

iii. *Dr van Rensburg;*

iv. *Dr Lippert;*

v. *Prof Nolte; and*

vi. *Prof Lotz.*

c. *The preparation, reservation and appearance fees of Prof Smith, Prof Lotz, Dr Langenegger and Dr Lippert;*

d. *The costs of Prof Smith shall include the reasonable costs of two return flights by air from Cape Town to Johannesburg and his reasonable and necessary accommodation costs.*

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SPILG, J

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DATES OF HEARING: 28 April, 2 May, 5-8 May, 12-15 May,19 and 20 May 2014

DATE OF ORDER: 2 February 2015

DATE OF JUDGMENT: 6 February 2015

DATE OF REVISION: 9 February 2015

LEFGAL REPRESENTATIVES:

| | |
|---|---|
| FOR PLAINTIFF: | Adv N van der Walt |
| | Wim Krynau Attorneys Inc. |
| FOR DEFENDANT: | Adv R B Mkhabela |
| | State Attorney |